STATE OF IOWA
IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

IOWA DENTAL BOARD
AGENDA
April 23-24, 2015

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa
Members: *Steve Bradley, D.D.S., Board Chair; Steven Fuller, D.D.S., Board Vice Chair; Matthew McCullough, D.D.S., Board Secretary; Kaaren Vargas, D.D.S.; Tom Jeneary, D.D.S.; Mary Kelly, R.D.H.; Nancy Slach, R.D.H.; Diane Meier, Public Member; Lori Elmitt, Public Member*

Thursday, April 23, 2015

COMMITTEE MEETINGS:

9:00 A.M. **EXECUTIVE COMMITTEE**

10:00 A.M. **DENTAL HYGIENE COMMITTEE**
(See separate committee agendas)

1:00 P.M. **BOARD MEETING:**

OPEN SESSION

I. CALL MEETING TO ORDER – ROLL CALL *Full Board*

II. 1st OPPORTUNITY FOR PUBLIC COMMENT *Steven Bradley*

III. APPROVAL OF OPEN SESSION MINUTES *Steven Bradley*
a. January 22, 2015 – Quarterly Meeting
b. February 25, 2015 – Teleconference

IV. REPORTS
A. EXECUTIVE DIRECTOR'S REPORT *Jill Stuecker*

B. LEGAL REPORT *Sara Scott*

C. ANESTHESIA CREDENTIALS COMMITTEE REPORT *Kaaren Vargas*
a. Actions Taken by the Committee on General Anesthesia & Moderate Sedation Permit Applications

b. Other Committee Recommendations, if any

D. CONTINUING EDUCATION ADVISORY COMMITTEE REPORT *Lori Elmitt*

a. Recommendations: RE: Continuing Education Course Applications
b. Recommendations: RE: Continuing Education Sponsor Applications
c. Other Committee Recommendations, if any

E. BUDGET REVIEW COMMITTEE REPORT *Steven Fuller*

a. Review of Quarterly IDB Financial Report
b. Other Committee Recommendations, if any

F. EXECUTIVE COMMITTEE REPORT *Steven Bradley*

a. Other business, as necessary

G. LICENSURE/REGISTRATION COMMITTEE REPORT *Matt McCullough*

a. Actions Taken by the Committee on Applications
b. Pending Licensure/Registration Application, If Any, Will Be Discussed under Agenda Item IX

H. DENTAL HYGIENE COMMITTEE REPORT *Mary Kelly*

a. Pending Dental Hygiene Applications, If Any, Will Be Discussed under Agenda Item IX
b. Report RE: Actions Taken at the Dental Hygiene Committee Meeting

I. DENTAL ASSISTANT REGISTRATION COMMITTEE *Steven Bradley*

a. Committee Update
b. Committee Appointment(s)
c. Nominations of additional dental assistant member(s)

J. EXAMINATIONS REPORTS – CRDTS (CENTRAL REGIONAL DENTAL TESTING SERVICE) –

a. CRDTS – Dental Steering Committee Report *Steven Bradley*
b. CRDTS – Dental Hygiene Examination Review Committee Report *Mary Kelly*
c. CRDTS – Dental Examination Review Committee Report *Kaaren Vargas*

K. IOWA PRACTITIONER REVIEW COMMITTEE REPORT *Brian Sedars*

a. Quarterly Update

L. EDUCATIONAL STANDARDS FOR EXPANDED FUNCTIONS TRAINING REPORT *Nancy Slach*

a. Committee Update
b. Recommendations RE: Expanded Functions Course Applications: Lifepoint Dental, Impact Dental Training and Davidson Family Dentistry

c. Other Committee Recommendations, If Any

V. ADMINISTRATIVE RULES/ ADMINISTRATIVE RULE WAIVERS *Phil McCollum*

a. Vote on Notice of Intended Action – Iowa Administrative Code 650 – Chapter 10 "*General Requirements*"
b. Review of Public Comments for Iowa Administrative Code 650 – Chapter 27 "*Standards of Practice And Principles of Professional Ethics*"
c. Vote on Adopted and Filed for Iowa Administrative Code 650 – Chapter 27 "Standards of Practice and Principles of Professional Ethics"
d. Review Public Comments for Iowa Administrative Code 650 – Chapter 1 "*Definitions*"*
e. Review Public Comments for Iowa Administrative Code 650 – Chapter 20 "*Dental Assistants*" *
f. Discuss Iowa Administrative Code 650 – Chapter 20.15 (153) "*Expanded function training approval*"

*Comments provided in the original meeting materials only include comments received as of 4/9/2015. Additional comments received as of 4/22/2015 have been added to the meeting materials for review.

VI. SECURITY/INFORMATION TECHNOLOGY UPDATE *Phil McCollum*

a. Yearly ISO Compliance
b. Database Upgrade

VII. LEGISLATIVE UPDATE *Jill Stuecker*

VIII. OTHER BUSINESS *Jill Stuecker*

a. Discussion on Documentation for Expanded Functions Certification
b. Discussion and Decision on Board Committees
c. Discussion and Decision on Committee Members
d. Discussion on Botox
e. Discussion on Teledentistry
f. Discussion Related to Smile Care Club
g. Review of IDPH Public Health Supervision Report
h. Discussion on Strategic Planning
i. Discussion on Time and Agenda for Board Teleconference, May 14, 2015
j. Discussion on Board Meeting Format
k. Discussion on Board Meeting Dates for 2016

IX. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS**

a. Ratification of Actions Taken on Applications Since Last Meeting *Christel Braness*
b. Pending Licensure/Registration Applications, if any**

X. 2nd OPPORTUNITY FOR PUBLIC COMMENT *Steven Bradley*

4:00 p.m.

XI. EXECUTIVE DIRECTOR PERFORMANCE REVIEW***

Friday, April 24, 2015

8:30 a.m.

CLOSED SESSION**

I. ACTION, IF ANY ON CLOSED SESSION ITEMS

a. Approval of Closed Session Minutes
b. Licensure/Registration Applications
c. Statement(s) of Charges
d. Combined Statement(s) of Charges, Settlement Agreement(s) and Final Order(s)
e. Settlement Agreement(s)
f. Final Hearing Decisions
g. Final Action on Non-Public Cases Left Open
h. Final Action on Non-Public Cases Closed
i. Other Closed Session Items

II. CONTINUE WITH ANY CLOSED SESSION AGENDA ITEMS**

OPEN SESSION

III. ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS

a. Approval of Closed Session Minutes
b. Licensure/Registration Applications
c. Statement(s) of Charges
d. Combined Statement(s) of Charges, Settlement Agreement(s) and Final Order(s)
e. Settlement Agreement(s)
f. Final Hearing Decisions
g. Final Action on Non-Public Cases Left Open
h. Final Action on Non-Public Cases Closed
i. Other Closed Session Items
j. Other Open Session Items, If Any

IV. ADJOURN

NEXT REGULARLY SCHEDULED TELECONFERENCE: MAY 14, 2015
NEXT QUARTERLY MEETING: JULY 23-24, 2015

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515-281-5157.

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members, presenters or attendees or to facilitate meeting efficiency.

**These matters may constitute a sufficient basis for the board to consider a closed session under the provisions of section 21.5(1), (a), (c), (d), (f), (g), and (h) of the 2015 Code of Iowa. These sections provide that a governmental body may hold a closed session only by affirmative public vote of either two-thirds of the members of the body or all of the members present at the meeting to review or discuss records which are required or authorized by state or federal law to be kept confidential, to discuss whether to initiate licensee disciplinary investigations or proceedings, and to discuss the decision to be rendered in a contested case conducted according to the provisions of Iowa Code Chapter 17A.

***Pursuant to Iowa Code section 21.5(1)(i), this portion of the meeting may be held in closed session at the request of the individual.

IOWA DENTAL BOARD

MINUTES
January 22, 2015
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members	**January 22, 2015**
Steven Bradley, D.D.S.,	Present
Steven C. Fuller, D.D.S.	Present
Matthew J. McCullough, D.D.S.	Present
Thomas M. Jeneary, D.D.S.	Present
Kaaren G. Vargas, D.D.S.	Present
Mary C. Kelly, R.D.H.	Present
Nancy A. Slach, R.D.H.	Present
Diane Meier, Public Member	Present
Lori Elmitt, Public Member	Present

Staff Members
Phil McCollum, Christel Braness, Brian Sedars, Dee Ann Argo, Janet Arjes

Attorney General's Office
Sara Scott, Assistant Attorney General

Other Attendees
Jeannene, Veenstra, R.D.A., Iowa Dental Assistants Association
Lynh Patterson, Delta Dental of Iowa
Rachel Patterson-Rahn, I-SMILE Coordinator
Tom Cope, Iowa Dental Hygienists' Association
Nadine DeVoss, R.D.H., Iowa Dental Hygienists' Association
Carol Van Aernam, R.D.H., Iowa Dental Hygienists' Association
Sue Hyland, R.D.H., Iowa Dental Hygienists' Association
Becki Brommel, Brown, Winnick for Iowa Dental Association
Kim Howard, R.D.H., I-SMILE Coordinator
Larry Carl, Iowa Dental Association
Francisco Olalde, University of Iowa, Iowa Health Professions Tracking Center
Jane Slach, R.D.A. Iowa Dental Assistants Association
Mark Markham, D.D.S., Midwest Dental – Atlantic
Sue Milonas, R.D.H., MCPH

Katie McBurney, R.D.H., Marion County Public Health
Jeremy Carlson, Marion County Public Health
Melissa Tangen, Dental Dental of Iowa
Sheila Temple, R.D.H. I-SMILE Coordinator
Kim Howard, R.D.H. I-SMILE Coordinator
Arlene Prather-Okane, Black Hawk County Health
Lori Brown, R.D.H., Des Moines Area Community College
Nancy Adrianse, R.D.H., Iowa Primary Care Association
Sue Winker, R.D.H., HCT VNS
Sara Schlievert, R.D.H., Iowa Department of Public Health
Bob Russell, D.D.S., Iowa Department of Public Health
R. Bruce Cochrane, D.D.S., Iowa Dental Association
Tena Springer, Primary Health Care
Stephen Thies, D.D.S., Iowa Academy of General Dentistry

I. CALL TO ORDER FOR JANUARY 22, 2015

Dr. Bradley called the open session meeting of the Iowa Dental Board to order at 10:01 a.m. on Thursday, January 22, 2015. A quorum was established with all members present.

Roll Call:

Member	Bradley	Elmitt	Fuller	Jeneary	Kelly	McCullough	Meier	Slach	Vargas
Present	x	x	x	x	x	x	x	x	x
Absent									

II. 1st OPPORTUNITY FOR PUBLIC COMMENT

Dr. Bradley stated that due to the large number of attendees, comments would be limited to those who had not previously submitted written comments.

Dr. Bradley asked everyone to introduce themselves. Dr. Bradley allowed the opportunity for public comment.

Ms. Patterson-Rahn asked to revisit some of her comments made during the meeting of the Dental Hygiene Committee since not everyone was present at that meeting. Ms. Patterson-Rahn expressed her concerns regarding the petition for rulemaking and the impact it could have on programs such as WIC, which is a federal program. These programs can be critical points of access to the public. Ms. Patterson-Rahn also expressed her support for the proposal to allow dental assistants to work in the school-based sealant programs.

Mr. Cope thanked the Board for their work in moving forward on the issue of allowing dental assistants to help dental hygienists in public health settings. The Iowa Dental Hygienists' Association had some concerns about the draft of Iowa Administrative Code 650—20.1(6), which was submitted for consideration. Some of the roles addressed in the draft are services, which may not be necessary within a public health setting. Some of the tasks noted would most likely be

performed by the dental hygienist. The intent of the rule is to allow dental assistants to help dental hygienists in those settings, not perform services in place of the dental hygienists.

Ms. Brommel, on behalf of the Iowa Dental Association, reported that the Iowa Dental Association had submitted information with regards to the petition for rulemaking. Ms. Brommel reported that they had read all of the comments received, and wanted to clarify that there is no intent to eliminate programs such as WIC. Ms. Brommel believed that it might be possible to accept the Iowa Dental Association's proposal, without eliminating those kinds of programs.

Ms. Brommel spoke in regards to the tiered approach with dental assistants and expanded functions. Ms. Brommel stated that the services listed under level 2 do not appear to be related to the services listed under level 1. It did not appear that training in level 1 expanded functions would be necessary in order to complete training in level 2. The Iowa Dental Association would ask the Board to consider removing the proposed requirement for training in all level 1 services prior to training in level 2 services. The Iowa Dental Association will submit more formal comments as appropriate.

Ms. Hyland addressed the issue related to the public health supervision for dental assistants. The approved site listing in the proposed rules is different than the list of sites allowed for dental hygienists. Ms. Hyland would like the lists to be consistent. Mr. McCollum stated that the purpose of the draft today is for discussion. Mr. McCollum reported that he took the language, which exists in the Iowa Code as it relates to the practice of dental assistants. The Board is constrained by the authorities granted in Iowa Code.

Mr. Carl, Iowa Dental Association, stated that Dr. Steven Rabedeaux asked that the Board be thanked for consideration of his request to lower the clinical practice requirement prior to dental assistants training in expanded functions.

Ms. Temple asked to add to her written comments. Ms. Temple stated, that as mentioned in the Dental Hygiene Committee meeting, public health programs are not implemented without thought and consideration. Need assessments are completed, and are subject to review by an advisory committee prior to implementation. The advisory committee is comprised of a diverse group when considering these matters. These programs are implemented after reviewing the needs of the community.

III. APPROVAL OF OPEN SESSION MINUTES

- *October 17, 2014 – Quarterly Meeting Minutes*

❖ MOVED by MEIER, SECONDED by KELLY, to APPROVE the open session minutes as submitted. Motion APPROVED unanimously.

- *October 31, 2014 – Meeting Minutes*

❖ MOVED by ELMITT, SECONDED by JENEARY, to APPROVE the open session minutes as submitted. Motion APPROVED unanimously.

- *November 10, 2014 – Teleconference Meeting Minutes*

❖ MOVED by JENEARY, SECONDED by MEIER, to APPROVE the open session minutes as submitted. Motion APPROVED unanimously.

- *December 9, 2014 – Meeting Minutes*

❖ MOVED by KELLY, SECONDED by FULLER, to APPROVE the open session minutes as submitted. Motion APPROVED unanimously.

IV. REPORTS

EXECUTIVE DIRECTOR'S REPORT

Dr. Bradley stated that there would be two reports. Dr. Bradley asked Mr. McCollum to speak first since he served as interim director. Dr. Bradley stated that that Ms. Stuecker would provide a report thereafter.

Dr. Bradley asked everyone to welcome Ms. Stuecker as the new executive director of the Iowa Dental Board.

Mr. McCollum also welcomed Ms. Stuecker. Mr. McCollum thanked everyone for their participation over the last year. Mr. McCollum thanked Board staff for stepping up and helping make the last year go as well as it did.

Dr. Bradley thanked Mr. McCollum for filling in and for his hard work.

Ms. Stuecker stated that she was excited to be here. Ms. Stuecker stated that it is obvious that this is a group of people who care very much about the work that they do, and that she looked forward to being a part of that.

Ms. Stuecker reported that staff is working towards developing an annual report. Ms. Stuecker provided a brief overview of data related to the Board's licensees, registrants, and permit holders. Mr. McCollum provided an overview of the dental assistant classifications for those who were unfamiliar with those designations.

Ms. Stuecker also provided some data about the number of complaints received and reviewed by the Board.

Ms. Stuecker thanked Mr. McCollum for his help. Ms. Stuecker reported that the staff is a small group tasked with a lot of work. Board staff has worked to streamline and improve upon the work and keep things moving forward.

LEGAL REPORT

Ms. Scott stated that she had nothing to report.

ANESTHESIA CREDENTIALS COMMITTEE REPORT

Dr. Vargas reported that the Anesthesia Credentials Committee recently met to review applications and to discuss other committee-related matters. Dr. Vargas provided an overview of the committee's actions. The committee has asked for additional training information in response to two applications for moderate sedation permits; and denied a request for consideration of previously-completed DOCS training and sedation experience out of state.

CONTINUING EDUCATION ADVISORY COMMITTEE REPORT

- *Recommendations RE: Continuing Education Course Applications*
- *Recommendations RE: Continuing Education Sponsor Application(s)*

Ms. Elmitt reported that the Continuing Education Advisory Committee met recently. Ms. Elmitt provided an overview of the committee's recommendations.

- ❖ MOVED by ELMITT, SECONDED by KELLY, to APPROVE the committee's recommendations as submitted. Motion APPROVED unanimously.

- *Other Committee Recommendations, If Any*

BUDGET REVIEW COMMITTEE REPORT

- *Review of Quarterly IDB Financial Report*

Dr. Fuller reported that the committee had not met recently; though they intend to meet soon to discuss related items.

ANNUAL FEE REPORT

Mr. McCollum reported that the Board typically completes its annual fee review each October. The Board did not complete this at the last meeting. Mr. McCollum asked Ms. Braness to provide an update. Ms. Braness reported that the Board was provided a copy of the updated budget. The revisions include more accurate information following the close of the previous fiscal year. Based on current projections, there is sufficient revenue through the end of the fiscal year.

- *Other Committee Recommendations, If Any*

There were no other recommendations from the committee.

EXECUTIVE COMMITTEE REPORT

Dr. Bradley reported that the committee met earlier that morning. The items that were discussed and required action by the Board will be addressed later in the meeting.

LICENSURE/REGISTRATION COMMITTEE REPORT

- *Actions Taken by Committee on Applications*

Dr. McCullough provided an overview of the applications reviewed and actions taken by the committee since the last quarterly Board meeting. A list of actions taken by the committee was included in the Board members' folders.

- ❖ MOVED by MCCULLOUGH, SECONDED by VARGAS, to APPROVE the list as submitted. Motion APPROVED unanimously.

- *Pending Licensure/Registration Applications, If Any – Will be Discussed under Agenda Item VIII*

- *Other Committee Recommendations, If Any*

There were no other recommendations from the committee.

DENTAL HYGIENE COMMITTEE REPORT

- *Pending Dental Hygiene Applications, If Any – Will be Discussed Under Agenda Item VIII*
- *Report RE: Actions Taken at Dental Hygiene Committee Meeting*
- *Committee Recommendations, If Any*

Ms. Kelly reported the Dental Hygiene Committee met earlier that morning. The committee discussed the Iowa Dental Hygienists' Association's proposed language regarding expanded functions for dental hygienists. The committee directed staff to draft proposed amendments relating to expanded functions that will be brought back for discussion at the next meeting.

Ms. Kelly reported that the committee also discussed the Iowa Dental Association's petition for rulemaking to Iowa Administrative Code 650—Chapter 10. The committee voted to suggest denial of the petition for rulemaking

Ms. Kelly reported that the committee also discussed a request for rule waiver. The committee has recommended approval. This item will be addressed by the Board later in the meeting.

DENTAL ASSISTANT REGISTRATION COMMITTEE REPORT

- *Committee Update*
- *Committee Recommendations*
- *Dental Assistants and Public Health Supervision*

Dr. Bradley reported that the committee had not recently met.

Mr. McCollum stated that the committee was considering additional appointments to the committee. Ms. Braness reported that the Board had received a number of requests to serve on the committee; however, not all of the candidates submitted information about their background. That information will be forwarded to the committee for further consideration.

Ms. Kelly asked how large the committee would be. Ms. Braness believed that there were currently 5-6 members on the committee. It would depend upon the number of appointees. Ms. Kelly asked for clarification that there may be three dental assistants on the committee after the future appointments are made. Ms. Braness stated that this was correct assuming two (2) more dental assistants were appointed.

EXAMINATIONS REPORT

- *CRDTS – Dental Steering Committee Report*

Dr. Bradley reported that he served on the Steering Committee. Dr. Bradley stated that the committee reevaluates and validates the examination each year.

- *CRDTS – Dental Hygiene Examination Review Committee Report*

Ms. Kelly reported that the committee will meet in July 2015.

- *CRDTS – Dental Examinations Review Committee Report*

Dr. Vargas reported that she was unable to attend the recent meeting; however Dr. Vargas intends to attend the next meeting in April 2015.

QUARTERLY IPRC REPORT

Mr. Sedars provided an overview of the current IPRC data.

EDUCATIONAL STANDARDS FOR EXPANDED FUNCTIONS TRAINING TASK FORCE REPORT

Ms. Slach reported that the committee has not met recently. The committee is awaiting further direction from the Board.

V. ADMINISTRATIVE RULES/PETITION FOR RULE WAIVER

- *For Discussion – Proposed Amendments to Ch. 10, "General Requirements"*

Mr. McCollum reported that the Iowa Dental Hygienists' Association has proposed some draft language. Mr. McCollum stated that he will continue to work with the interested parties and present another draft at the next meetings of the Dental Hygiene Committee and the Board.

- *Draft for Discussion – Proposed Amendments to Ch. 20, "Dental Assistants"*

Mr. McCollum reported that this is a draft for discussion. This draft is not intended to serve as a Notice of Intended Action. At the last meeting, the Board indicated two priorities with the proposed changes to Iowa Administrative Code 650—Chapter 20: allow dental assistants to work under a level of public health supervision, and to make further changes to the expanded functions rules based on the recommendations of the original expanded functions task force.

Mr. McCollum recommended that the Board move forward on the proposed revisions to chapter 20. Mr. McCollum recommended that a revision also be made to Iowa Administrative Code 650—1.1 to ensure that the definitions are consistent throughout Iowa Administrative Code 650.

Mr. McCollum reported that some items were added to the proposed changes based on a number of questions and suggestions received over time. For example, one addition is to allow the use of curing lights under general supervision. Current rules allow intraoral suctioning under general supervision. The use of a curing light was added to clarify that this would allowed also. These items were added for consideration in order to clarify the rules. Mr. McCollum stated that he was open to comments and further suggestions.

Mr. McCollum stated that another proposed addition to chapter 20 is for clarification with regards to general supervision. Mr. McCollum wanted to be clear that this would not be a change in regulation, but rather for clarification. The Board and the Attorney General's office have always interpreted the regulations to require a dental examination prior to a dental assistant providing services under general supervision. The rules allow dentists to delegate duties to dental assistants based on a diagnosis, which requires an examination by the dentist. This proposed change is intended only to provide further clarification. The language would match the language used for dental hygienists.

Provisions have also been added to allow dental assistants to work under public health supervision. The language is very similar to the language used for dental hygienists with a few exceptions as already noted.

Mr. McCollum reported that if the Board were to agree on these changes, the Board would consider a Notice of Intended Action at its next meeting.

Ms. Kelly asked that the Board review each section of the proposed revisions individually.

Ms. Kelly stated that she was pleased to see the clarification with respect to the definition of general supervision. Ms. Kelly believed that this will eliminate some confusion and misinterpretation.

Ms. Kelly asked if further clarification might be needed in regards to retraction as it relates to the proposed public health supervision rules. Ms. Kelly wondered if further clarification may be recommended. Dr. Fuller did not believe it needed to be included since these were general duties and could be completed under general supervision. Dr. Fuller recommended adding the use of an intraoral camera. Ms. Kelly agreed since dental radiography is currently allowed under general supervision.

Mr. McCollum stated that the Board has attempted to stay away from lists; however, in this case it may be appropriate. Mr. McCollum indicated that the use of intraoral camera could be added. The other Board members agreed. Ms. Elmitt agreed that the intraoral cameras should be included since this is different from dental radiography but increasingly necessary.

Mr. McCollum clarified that these are procedures that could be completed when the dentist is not in the office.

Ms. Kelly stated that she did not have any comments about the public health supervision language.

Ms. Kelly addressed the proposed changes to expanded functions. Ms. Kelly inquired about the training. The language makes reference to allowing training, "which may include on the-job-training offered by a dentist licensed in Iowa." The committee recommended training be completed through an ADA-accredited program for level 2 expanded functions. Ms. Kelly asked how that language may affect the recommendation for level 2 training.

Mr. McCollum stated that in order to complete training in level 2, a dental assistant must complete training in all level 1 items as described by the proposed the rule, which was just cited. Ms. Elmitt asked if a dental assistant could train without going through a formal program. Mr. McCollum stated that level 1 items would not require formal training, though that would still be an option. Ms. Kelly stated that she did not see a reference to training requirements for level 2. Mr. McCollum stated that level 2 would have its own educational requirements, though those have not been fully defined. In order to train in level 2, they must be certified as a level 1 provider, and pass a Board-approved entrance examination with a score of 75%.

Ms. Kelly recommended adding specific language to require training through an ADA-accredited program. Mr. McCollum believed that the original task force proposed all training for level 2 duties be completed through the University of Iowa College of Dentistry. Ms. Kelly agreed; however, she did not see the language included. Dr. Bradley stated that this would be added.

Ms. Slach inquired about the proposal to require training in all level 1 expanded functions prior to training in level 2 expanded functions. Ms. Slach asked if the Board wanted to require this prior to allowing training in level 2. Dr. Jeneary and Ms. Elmitt stated that training in all level 1 duties should be required prior to training in level 2 duties. Mr. McCollum stated that this had been a clear preference by the Board at the last meeting to ensure a broader base of education. Dr. Fuller noted that it would make enforcement easier.

Mr. McCollum reported that item #5 of the level 2 expanded functions was changed to "tissue conditioning." Mr. McCollum also left in the reference to "soft reline" where the denture is not relieved or modified.

Dr. Jeneary stated that he did not recall the discussion related to the placement and shaping of amalgam and composites for level 2 expanded functions. Ms. Kelly reported that this was a recommendation that came out of the first expanded functions committee. Mr. McCollum stated

that a vote has not yet been taken on these recommendations. Mr. McCollum stated that this was the time to discuss any concerns related to these proposals.

Dr. Jeneary stated that he felt very strongly that a dentist should perform those tasks and that dental school was the appropriate place to receive training.

Dr. Bradley asked the Board members to comment on this. Ms. Elmitt was on the task force when this was discussed at length. Since the procedure is reversible; Ms. Elmitt did not have a problem with this. Dr. McCullough stated that he was okay with this. Ms. Kelly stated that she had served on the task force also, and was okay with this since it would require the dentist to check the quality of the work provided. Ms. Slach stated that she was in favor of allowing this so long as it was performed under direct supervision, and left to the discretion of the dentist as to whether to allow this within their practice. Ms. Meier and Dr. Vargas agreed with the previous comments.

Ms. Kelly recommended that Iowa Administrative Code 650—20.5 be updated to include the use of an intraoral camera to be consistent. Mr. McCollum agreed that it would match the language used earlier in the draft.

Ms. Kelly commented on the portion of the draft, which addressed dental assistants working under public health supervision. Ms. Kelly recommended updating the language used in the proposed section Iowa Administrative Code 650—20.16(1), (2), and (3) to match the settings allowed for dental hygienists. Ms. Scott stated that they would need to look at that this further. The statutory authority uses specific language with regards to where a dental assistant can practice. The language in the draft of Iowa Administrative Code 650—Chapter 20 uses the language used in Iowa Code. Ms. Scott did not believe that the language is interchangeable. Ms. Scott stated that Board may need to define public health agencies. Mr. McCollum stated that was his intent with the draft, which was submitted. Board staff may need to look at this further in order to find the best way to be consistent, and remain in compliance with the statutory limitations.

Mr. McCollum stated that his intent was to get away from a list of physical locations. Rather, the language in the code may better address the issue of approved locations without being too specific. Ms. Scott asked Ms. Kelly what her concerns were about the proposed language. Ms. Kelly thought that the language might be a little too broad; however, she would want to review it further. Ms. Kelly believed that comments should be requested on this issue prior to finalizing the language.

Mr. McCollum stated that he would leave the language as currently drafted until comments are received, and would proceed accordingly. Ms. Kelly stated that the Board may want to look at how to address some programs that may be privately funded. Ms. Kelly gave the example of the Des Moines Health Center, which does not receive funds from local, state or federal governments. Mr. McCollum reminded the Board that they need to be careful not to exceed the statutory authority provided in Iowa Code in regards to this definition.

Mr. McCollum reported that a few of the proposed revisions differed from the requirements that dental hygienists working under public health supervision are subject to. There is a proposed requirement that dental assistants working in public health supervision provide a copy of the

agreement to the Board office. A copy of the agreement would also be submitted to the Iowa Department of Public Health. A copy of the annual report must also be provided to the dentist providing the supervision. This would allow the dentist to be better informed about the services provided.

Ms. Kelly stated that the Iowa Department of Public Health recommends that a copy of the annual report be provided to the supervising dentist. The updated forms ask if the dentist is provided a copy. Ms. Kelly asked representatives from the department to comment on this. It was indicated that the addition to the form was new enough that there was insufficient data available.

Ms. Braness asked to comment on the new forms. Ms. Braness reported that she had been made aware of the fact that some licensees were having difficulty downloading the public health supervision forms on the Board's website. Ms. Braness has been working to find a solution to this problem; however she has been unable to find a solution to date. Ms. Braness stated that she could email a copy to licensees if they were unable to access it through other means.

Ms. Kelly inquired about the report to Iowa Department of Public Health that dental assistants would be required to submit. Ms. Kelly asked if this would duplicate paperwork since the dental assistants would be working in conjunction with dental hygienists. Mr. McCollum stated that the connection is with the supervising dentist, not the dental hygienist. Mr. McCollum also noted that it was hard to know what future requirements would be. Therefore, Mr. McCollum felt that the requirement should remain in place. Ms. Slach and Mr. McCollum felt the proposed requirement was more flexible, taking into account any future changes.

- ❖ MOVED by KELLY, SECONDED by VARGAS, to DRAFT a Notice of Intended Action for Iowa Administrative Code 650—Chapter 20 with the language as discussed, and to DRAFT a Notice of Intended Action for Iowa Administrative Code 650—1.1 to mirror the language used in chapter 20. Motion APPROVED unanimously.

- *Notice of Intended Action – Ch. 27"Standards of Practice and Principles of Professional Ethics"*

Mr. McCollum reported that the Board had a draft Notice of Intended Action for consideration. The proposed changes would require dentists to keep study models and casts for six (6) years after the date that the treatment is completed. Mr. McCollum incorporated the suggestion made by Dr. Cochrane at the last meeting to allow the dentist to turn those over to the patient. Mr. McCollum added a provision to require offices to hold the models for at least one year prior to releasing them to the patient in case something would happen.

Dr. Vargas questioned the timeline for pediatric patients based on the draft language. Mr. McCollum stated that the specific provision regarding study models is limited to 6 years from the completion of treatment. The language to which Dr. Vargas was referring is the general requirement for record keeping. The new addition would allow offices to dispose of study models and casts six (6) years after the date of treatment.

Ms. Kelly recommended updating the language regarding keeping study models for one year before turning over to patient. Ms. Kelly asked that the language be clarified. Mr. McCollum went over the language to clarify the intent of the language. The language would allow office to turn over study models and casts to patients one year after the completion of treatment, rather than having to keep them for the six (6) years as otherwise required by rule.

- ❖ MOVED by JENEARY, SECONDED by FULLER, to APPROVE/FILE the Notice of Intended Action. Motion APPROVED unanimously.

Mr. McCollum reported that a public hearing is scheduled for March 13, 2015 as noted in the draft submitted. This item will be revisited at the next Board meeting.

- *Update – Ch. 29, "Sedation and Nitrous Oxide Inhalation Analgesia"*
- *Update – Ch. 52, "Military Service and Veteran Reciprocity"*

Mr. McCollum reported that these rule changes have been adopted by the Board. The changes will go into effect February 11, 2015.

- *Petition for Rulemaking – Iowa Dental Association – IAC 650—10.5(1), "General Requirements"*

- ❖ MOVED by KELLY, SECONDED by SLACH, to DENY the petition for rulemaking.

Ms. Scott provided an overview of the petition for rulemaking and what the request included. The Iowa Dental Association filed the petition asking the Board to remove the language "local, state or federal public health programs" from Iowa Administrative Code 650—10.5(1).

Ms. Scott reported that numerous public comments were received. The public comments were made available for review. The Iowa Dental Association filed the petition in response to an interpretation made by the Board at the last meeting. The Board interpreted local, state or federal public health programs to include correctional facilities.

The Board must take action on the petition and a written response will be forwarded.

Ms. Scott stated the comments made in writing and during the Dental Hygiene Committee meeting earlier that morning raised concerns about WIC and other federal programs that would be impacted by the removal of this language.

Ms. Elmitt stated that it's important to keep the public in mind, and the impact this may have. Ms. Elmitt state that she understood the intent behind the request; however, the effect of striking the language would be profound and she had concerns about that impact.

Mr. Bradley stated that if the petition were to be denied nothing would change with respect to the administration of the current public health supervision program.

Ms. Slach stated that there are concerns about having a specific list of approved locations since local, state, and federal programs may change. If they were not included in the specific list, new programs could be excluded.

- The vote was taken. Motion APPROVED unanimously.

Ms. Scott reported that she looked into this issue with the correctional facilities. Ms. Scott requested more information from the Department of Corrections. Ms. Scott made clear that the Board was within its authority to interpret the rule. In reviewing all of the information from the Department of Corrections and the initial request, Ms. Scott stated that the interpretation was not sufficiently helpful to the Department of Corrections to affect policy.

Ms. Scott stated that correctional facilities do not clearly fit into the current rules in the same way as the other approved programs. The prisoners have certain rights, which may need to be met. The intent of the initial request was to allow the dental hygienists to perform cleanings more frequently without requiring a current examination. Public health supervision may not be needed to address this concern.

Ms. Scott stated that this may be a good opportunity to look at this issue more closely and see if it fits in the model of the other programs. There are distinct differences with respect to correctional facilities. The Board may need to look at how to address the correctional facilities since they may not fit with the framework of the current rules. Ms. Scott recommended that the Board review this further.

Ms. Kelly reported that she and Mr. Sedars had been in contact with the dental hygienist, who submitted the original request, who may be a new employee within the correctional system. Ms. Kelly further reviewed the original request. Ms. Kelly stated that since an examination is required upon intake into the system and every two years thereafter, Ms. Kelly would see this as a general supervision issue.

Ms. Kelly asked to preface her motion by stating that the Board would still have the right to interpret the rule as needed. Ms. Kelly believed that this was still a public health issue.

- MOVED by KELLY, SECONDED by FULLER, to send a letter clarifying that public health supervision is not required for correctional facilities, and that these issues are addressed under general supervision. Motion APPROVED unanimously.

- *Rule Waiver Request – Jessie Martin – IAC 650—22.4(3), "Dental Assistant Radiography Qualification"*

Ms. Braness reported that Ms. Martin submitted a request for rule waiver of the requirement, which states that training in dental radiography must have been completed within the previous two (2) years. Ms. Martin is a graduate of an ADA-accredited dental assisting program; she graduated approximately five (5) years ago.

Ms. Martin was informed that she would be eligible for dental assistant trainee status. Trainee status would provide updated training so long as she completed six (6) months as a dental assistant trainee. By completing six (6) months as a dental assistant trainee, Ms. Martin would be eligible for a radiography qualification. Ms. Arjes reported that Ms. Martin also had the option to complete a formal course of study. The course fee is $400.

Dr. Bradley stated that this is a question as to whether the cost of the formal course of study is a hardship. Ms. Braness reminded the Board members that dental assistant trainee status was also an option available to Ms. Martin. Dental assistant trainee status would allow her to begin working as a dental assistant right away.

Ms. Elmitt asked if Ms. Martin was eligible for dental assistant trainee status. Ms. Braness reported that Ms. Martin had not yet been issued a dental assistant registration. Ms. Arjes confirmed that Ms. Martin had applied for registration, though it had not yet been issued.

Ms. Arjes stated that the Board had previously approved two other similar rule waiver requests. Ms. Braness indicated that it was her understanding that the other waiver requests varied in that dental assistant registration had already been issued in those other cases, and they were, therefore, ineligible for dental assistant trainee status.

Dr. Vargas reported that she had a dental assistant trainee; and she did not believe that this posed a hardship. Ms. Kelly stated that the dentist would be required to be present in the room as services were provided. Ms. Braness reported that the personal supervision requirement varied depending upon the services being provided. In some instances, a dentist would be required to be present in the room; however, in other cases, another licensee or registrant could provide the personal supervision. Mr. McCollum stated that dentists needed to provide the personal supervision for all intraoral procedures, and that another licensee or registrant could provide supervision for extraoral services.

Ms. Slach asked if Ms. Martin could be informed of her options. Ms. Braness reported that Ms. Martin had been informed of her options; however a reminder of the options could be provided.

- ❖ MOVED by ELMITT, SECONDED by MCCULLOUGH, to DENY the request. Motion APPROVED unanimously.

- *Rule Waiver Request – Mackenzie Meyer, R.D.H. – IAC 650—11.7(1)b, "Licensure to Practice Dentistry and Dental Hygiene"*

Ms. Braness stated that as Ms. Kelly reported earlier in the meeting, the Dental Hygiene Committee recommended approval of the waiver request. Ms. Braness reported that Ms. Meyer graduated from dental hygiene school in May 2013. Ms. Meyer failed to complete her application for local anesthesia permit. Ms. Meyers' current employer wishes for her to obtain a permit to administer local anesthesia. Iowa Administrative Code 650—Chapter 11 requires applicants for a local anesthesia permit to have completed training in local anesthesia within 12 months of the date of application, or to demonstrate use of local anesthesia in another state, which allows its use by

dental hygienists. Ms. Braness reported that the date of graduation is used as the end date of training for those who complete local anesthesia training while in dental hygiene school.

Ms. Braness stated that it is increasingly difficult for dental hygienists to find local anesthesia courses outside of dental hygiene school. In many cases, licensees have to go out of state to obtain training when they can find it. Ms. Meyer has been informed that she could complete new training; however, she is asking that a rule waiver be granted given the difficulty in locating a new course. Ms. Braness also reported that the rules regarding reinstatement allow a licensee to reinstate the local anesthesia permit without additional training if it is reinstated within two years of the date it lapsed. Ms. Meyers is within two (2) years of the end date of her initial training.

- ❖ MOVED by KELLY, SECONDED by SLACH, to APPROVE the rule waiver.

Dr. Fuller inquired as to why a separate permit is required, apart from the issue of revenue, if dental hygienists receive training in dental hygiene school. Ms. Braness stated that current rules require a permit to administer local anesthesia; however, the Board can discuss this in the future if they want to change the requirements to administer local anesthesia.

Ms. Slach stated that the reason permits were required initially was that not all licensees had completed training in local anesthesia. Dr. Fuller understood this to be the case; however, he did not understand why the requirement was still in place.

Ms. Kelly asked to Ms. Braness to add this to the Dental Hygiene Committee agenda for future discussion.

- ➢ The vote was taken. Motion APPROVED unanimously.

Ms. Braness reported that the Dental Hygiene Committee and the Board could review this further in the future. Board staff has discussed the concerns of the 12-month requirement for training, particularly in light of the difficulty locating courses. Ms. Slach stated that since local anesthesia requires direct supervision, there is less concern than if it were allowed under general supervision.

Mr. McCollum stated that one thing that the Board must consider is that fees must be set in accordance with expenditures. If the fee should be eliminated, it may need to be added elsewhere to compensate for the loss in revenue. The Board may revisit this issue at a future meeting.

- ▪ *Other Recommendations, If Any*

There were no other recommendations for discussion.

VI. LEGISLATIVE UPDATE

Mr. McCollum reported that the proposed legislation to make the executive director position an at-will position has been introduced as senate study bill 1016. On January 15, 2015, it was assigned to the Human Resources committee. Lobbyists have registered their support for the proposed legislation.

Ms. Stuecker is awaiting her lobbying status before going to the legislature to address this.

VII. OTHER BUSINESS

ANNUAL FEE REVIEW

Ms. Braness reported that this item was discussed earlier in the meeting.

EXAMINATION REQUEST

Ms. Braness reported that the Board received a letter from a dental student at the University of Minnesota College of Dentistry, which was signed by a number of other dental students. The letter asked that the Board to consider accepting Canada's licensure examination as an alternative to CRDTS. The letter stated that qualified dental professionals may be discouraged from becoming licensed in Iowa as a result of Iowa's acceptance of the CRDTS examination. The dental student expressed concerns about the administration of a clinical examination on live patients. The dental student believed that the training and experience received in dental school, in addition to alternative licensure examinations should be sufficient for licensure.

Ms. Kelly reported that Minnesota is the only state in the United States to accept the Canadian examination.

Ms. Kelly asked what the implications would be for someone coming from Minnesota who was getting licensed here. Ms. Kelly indicated that licensing requirements would need to be similar. Ms. Braness stated that it would depend upon the pathway on which someone applies for a license. The requirements for licensure by examination and credentials vary. Ms. Braness provided an overview of current licensing requirements.

The Board chose to take no action at this time.

CONTINUING EDUCATION TRACKING AND MANAGEMENT TOOL REQUEST

Mr. McCollum reported that this was forwarded to the Board members for their information. This letter is from a company that offers services, which would allow licensees to track continuing education online.

AMERICAN ASSOCIATION OF ORTHODONTICS LETTER

Mr. McCollum reported that this letter was forwarded to provide information about some online orthodontic services. There are now ways whereby members of the public can receive orthodontic treatment over the internet. The letter was intended to serve as a notice that this may affect Iowa.

Mr. McCollum stated there have not received any complaints on this type of service to date. If so, the Board would investigate as needed to determine that anyone involved in treatment is properly credentialed.

DENTAL WELLNESS PROGRAM

Ms. Stuecker reported that this item was added to the agenda based on concerns which Dr. Fuller expressed to her.

Dr. Fuller stated that he recently saw a patient on the Dental Wellness Program, who two years prior, had been healthy. The patient's x-rays suggested problems that needed immediate treatment. However, because the patient was on the Dental Wellness Program, Dr. Fuller was unable to treat the full scope of her problem because she had not yet earned full benefits. Dr. Fuller is concerned that the Dental Wellness Program asks dentists to be unethical and commit malpractice since licensees cannot easily treat patients like this except on an emergency basis.

Dr. Fuller reported that after initially seeing a patient, the dentist must write up a treatment plan and submit it for approval. Enhanced benefits are earned only six (6) months after core benefits are administered. The dentist cannot perform restorative care before this six (6) month period. Ms. Slach indicated that work can be performed on an emergency basis if it effects at least 50% of the tooth. Dr. Fuller stated that the treatment must still be approved. Ms. Kelly stated that services can be provided if there is pain, and the claim can be submitted. Dr. Fuller asked Ms. Kelly if she has gone through the approval process.

Ms. Slach stated that some changes have been made in the area of periodontics. Ms. Slach indicated that they have been open to their requests. Ms. Slach stated that with scaling and root planing, changes have been made to the process. Initially, they could only provide prophylaxis and debridement if you couldn't do probing. Now, if there is a medical reason, or with sufficient information, they can provide scaling and root planing on level 1; they do not have to wait the six (6) months for level 2. Dr. Bradley asked if they had to submit for preapproval. Ms. Slach stated that you can provide the services so long as the reasons for treatment are fully documented in the patient record.

Ms. Kelly asked if you have to submit for approval for any dental plan. Ms. Kelly believed that there are provisions, which allow licensees to provide services. Dr. Fuller stated that licensees can get them out of pain, but may not be able to do much else without approval.

Ms. Kelly stated that Delta Dental has a lot of information on their website. Dr. Fuller indicated that there are a lot of requirements in place. Ms. Slach agreed with Dr. Fuller. Ms. Slach also noted that the reimbursement rates are low.

Dr. Fuller stated that Delta Dental is administering the program in conjunction with the Iowa Medicaid Enterprise. Dr. Fuller reported that no complaints with the Dental Wellness Program have been received by the Board; however, as with Title XIX patients, complaints may begin to be received. Dr. Fuller stated that licensees can provide the services; however, it may be a liability risk to them.

Ms. Slach recommended communicating with Delta Dental. The issues may be addressed if additional complaints are received. Dr. Fuller stated that the problem is that Delta Dental is

administering the Iowa Medicaid Enterprise program, which is paid for by the federal government. Dr. Fuller believed that the state is trying to shift Title XIX patients into the Dental Wellness Program since the federal government will cover the costs for three (3) years.

Ms. Kelly asked if someone from Delta Dental could speak about this at the next meeting. Ms. Tangen, Delta Dental of Iowa, stated that they would be willing to discuss this program with the Board. Ms. Stuecker will be in touch with Ms. Tangen.

VIII. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS

RATIFICATION OF ACTIONS TAKEN ON APPLICATIONS SINCE LAST MEETING

Mr. Braness reported that the Board was provided an updated list of actions taken in response to applications for license, registration, qualification, and permit.

Ms. Braness stated that the report could be updated to reflect information, which the Board members may want to review. Ms. Braness stated that comments could be forwarded to herself or Mr. McCollum.

- MOVED by SLACH, SECONDED by MCCULLOUGH, to approve the list as submitted. Motion APPROVED unanimously.

PENDING LICENSURE/REGISTRATION APPLICATIONS

- *Christina Martinez, R.D.H.*

This application was discussed in closed session.

IX. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Dr. Bradley allowed the opportunity for public comment.

Mr. Cope stated that he was encouraged by the discussion about dental assistants helping in public health supervision programs. There are concerns about current programs utilizing dental assistants and the legalities of that. Mr. Cope asked the Board to not take action in these cases until the new rules are in effect.

Dr. Cochrane is pleased to see advancement on the expanded functions issue. Dr. Cochrane stated that the original intent was to help dentists offer greater services to patients. By tying level 1 to level 2, there may be some restriction on practice in offices. Dr. Cochrane would like to see some other method of qualifying for training in the level 2 duties.

Mr. Carl reported that the retired volunteer license bill has been assigned to subcommittee. The first subcommittee meeting is scheduled for Tuesday, January 27, 2015, 8:00 a.m. at the capitol.

Mr. Carl also wanted to inform the Board that according to the Des Moines Register, Governor Branstad's administration is on track to move administrative processes currently provided by the Iowa Medicaid Enterprise to a managed care organization. Mr. Carl believed that there may be ramifications of that, particularly for programs like the Dental Wellness Program. If the administration moves forward as indicated, the Iowa Dental Association's leadership intends to ask the administration to have the dental benefits carved out, similar to the Dental Wellness Plan. The Iowa Dental Association would like those services delegated to organizations that are familiar with dental care in Iowa.

Mr. Carl thanked the Board, if he understood correctly, for abandoning the informal guidance as it related to correctional facilities. Mr. Carl asked for clarification about the Board's actions today. Ms. Scott stated that a letter would be sent to the Department of Corrections stating that they do not need public health supervision since it would fall under general supervision based on the requirements of an examination of prisoners without a certain timeframe. Additional follow up will be handled as necessary.

Dr. Thies addressed the expanded functions issues, and the issues of tissue conditioning and modification of dentures. Dr. Thies stated that dentures, when they are treated with conditioner, are modified. Dr. Thies recommended altering the language to remove the parenthetical from the proposed draft. Dr. Fuller stated that he did not believe that the intent is to have the dental assistant to modify the denture. Dr. Thies stated that this should be clarified, and that the Board should consider removing all language after "tissue conditioning" in the draft. Dr. Bradley stated that the Board would take this under advisement.

Dr. Thies believed that the recommendation to retain models for one year after treatment could be problematic since treatment could be episodic. Dr. Thies is concerned that the licensees may be required to keep models for the full 6 years. Dr. Thies recommended disposal after treatment is completed. Dr. Thies stated that storage for models is burdensome. Dr. Thies did not believe that peers keep models. Dr. Thies stated that he will submit formal comments during the public comment period.

Dr. Thies stated that, speaking on behalf of the Iowa Academy of General Dentistry, they are in support of requiring training in all level 1 duties prior to training in level 2. Dr. Thies stated that the Iowa Academy of General Dentistry felt strongly that the educational process should be similar for dental assistants and dental hygiene. The rules should require the same level of education and training.

Dr. Markham asked for clarification on level 2 and if training would be limited to the University of Iowa College of Dentistry. Dr. Bradley confirmed that this was correct. Dr. Markham asked if that is just for the state of Iowa or if it is a national designation. It was indicated that these proposals are limited to Iowa.

Ms. Slach reported that the Educational Standards for Expanded Functions Task Force has not yet recommended final training requirements. The task force will meet again to discuss this further. Ms. Braness reported that the intent was to complete the training in conjunction with the University of Iowa College of Dentistry and that some of the training may occur at the dental office. There

are still details that need to be worked out. Ms. Kelly agreed with this; and clarified that final competency testing would likely occur at the University of Iowa College of Dentistry.

Ms. Jane Slach stated that the idea would be to possibly expand the training to other schools in the future after the program is better established. Ms. Braness stated that some programs had indicated an inability to provide this training due to lack of equipment and other concerns. Dr. Markham asked if there is a potential time frame. Ms. Kelly stated that this has not yet been determined since the University of Iowa College of Dentistry was reluctant to develop curriculum without further direction from the Board. Ms. Slach believed that it may depend upon the interest and the ability of the college of dentistry to accommodate the participants. Dr. Markham thanked the Board for their work on the expanded functions issues.

Ms. McBurney commented on the expanded functions issues and agreed with Dr. Cochrane about the intent being a need to provide more services to the underserved. Ms. McBurney recommended adding language to this section to address underserved patients. Dr. Bradley stated that the Board would take that under consideration.

Dr. Bradley reiterated that no changes would be occurring within the public health programs based on the actions of the Board at this meeting.

- The Board took a brief recess at 11:47 a.m.
- The Board reconvened at 12:18 p.m.

X. CLOSED SESSION

- MOVED by JENEARY, SECONDED by FULLER, for the Board to go into closed session at 12:19 p.m. on Thursday, January 22, 2015, pursuant to Iowa Code Sections 21.5(1) (a), (d) and (f) to discuss and review applications, complaints and investigative reports which are required by state law to be kept confidential and to discuss whether to initiate disciplinary investigations or proceedings.

Member	Bradley	Elmitt	Fuller	Jeneary	Kelly	McCullough	Meier	Slach	Vargas
Aye	x	x	x	x	x	x	x	x	x
Nay									
Absent									

Motion APPROVED by ROLL CALL.

- The Board went into closed session at 12:19 p.m.

XIV OPEN SESSION

- MOVED by JENEARY, SECONDED by FULLER, to return to open session. Motion APPROVED unanimously.

- The Board reconvened in open session at 3:40 p.m. on January 22, 2015.

ACTION ON CLOSED SESSION ITEMS

1. Closed Session Minutes

- MOVED by MEIER, SECONDED by VARGAS, to APPROVE the closed session minutes for the October 17, 2014 quarterly meeting. Motion APPROVED unanimously.

- MOVED by MEIER, SECONDED by VARGAS, to APPROVE the closed session minutes for the October 17, 2014 hearing for Cynthia D. Adams, Q.D.A. Motion APPROVED unanimously.

- MOVED by MEIER, SECONDED by VARGAS, to APPROVE the closed session minutes for the October 31, 2014 meeting. Motion APPROVED unanimously.

- MOVED by MEIER, SECONDED by VARGAS, to APPROVE the closed session minutes for the November 10, 2014 teleconference meeting. Motion APPROVED unanimously.

2. Disciplinary Orders

- MOVED by MEIER, SECONDED by VARGAS, to APPROVE the proposed Settlement Agreement and Final Order in the Matter of Paul R. Schultz, D.D.S., file numbers 10-087, 13-0017. Motion APPROVED unanimously.

- MOVED by MEIER, SECONDED by VARGAS, to APPROVE the proposed Settlement Agreement and Final Order in the Matter of Lance P. Forbes, D.D.S., file numbers 12-059, 12-091. Motion APPROVED unanimously.

- MOVED by MEIER, SECONDED by VARGAS, to APPROVE the proposed Combined Statement of Charges, Settlement Agreement and Final Order in the Matter of Brenda J. Clark, Q.D.A., file number 14-0097. Motion APPROVED unanimously.

- MOVED by MCCULLOUGH, SECONDED by FULLER, to APPROVE the proposed Combined Statement of Charges, Settlement Agreement and Final Order in the Matter of Craig D. Stater, D.D.S., file number 15-0001. Motion APPROVED unanimously.

- MOVED by MEIER, SECONDED by VARGAS, to DENY the Request for Reconsideration of Application to Modify Board Order in the Matter of Andre Q. Bell, D.D.S., file number 06-055. Motion APPROVED unanimously.

3. Final Action on Cases

- MOVED by MCCULLOUGH, SECONDED by FULLER, to CLOSE file number 13-066. Motion APPROVED unanimously.

- MOVED by MCCULLOUGH, SECONDED by FULLER, to CLOSE file number 14-0085. Motion APPROVED unanimously.

- MOVED by MCCULLOUGH, SECONDED by FULLER, to CLOSE file number 14-0120. Motion APPROVED unanimously.

- MOVED by MCCULLOUGH, SECONDED by FULLER, to KEEP OPEN file number 14-0141. Motion APPROVED unanimously.

- MOVED by MCCULLOUGH, SECONDED by FULLER, to CLOSE file number 14-0147. Motion APPROVED unanimously.

- MOVED by MCCULLOUGH, SECONDED by FULLER, to KEEP OPEN file number 15-0001. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0132. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0133. Motion APPROVED unanimously. Vargas recused.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0134. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0142. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to KEEP OPEN file number 14-0146. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to KEEP OPEN file number 14-0148. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0150. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to KEEP OPEN file number 14-0151. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0152. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0153. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0154. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0156. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0158. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0159. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0160. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 14-0161. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by MEIER, to CLOSE file number 14-0162. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to CLOSE file number 13-021. Motion APPROVED unanimously.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to KEEP OPEN file number 13-0087. Motion APPROVED unanimously.

4. *DH Committee Recommendations*
   - ❖ MOVED by KELLY, SECONDED by SLACH, to APPROVE the issuance of a dental hygiene license to Christina M. Martinez, R.D.H. and close file number 15-0002. Motion APPROVED unanimously.

5. *Licensure/Registration Issues*
   - ❖ MOVED by VARGAS, SECONDED by FULLER, to CLOSE file number 14-0174. Motion APPROVED unanimously.

   - ❖ MOVED by VARGAS, SECONDED by FULLER, to APPROVE the remedial education for a dental student that failed CRDTS twice. Motion APPROVED unanimously.

6. *For Board Discussion*
   - ❖ MOVED by JENEARY, SECONDED by ELMITT, to CLOSE item #1 under this heading on the closed session agenda. Motion APPROVED unanimously.

   - ❖ MOVED by JENEARY, SECONDED by ELMITT, to CLOSE item #2 under this heading on the closed session agenda. Motion APPROVED unanimously.

   - ➢ The Board went into closed executive session for a performance review at 3:47 p.m.

XVII. ADJOURN

The meeting was adjourned at 4:15 p.m. on January 22, 2015.

NEXT MEETING OF THE BOARD

The next meeting of the Board is scheduled for April 23-24, 2015, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.

IOWA DENTAL BOARD

MINUTES
February 25, 2015
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members	**February 25, 2015**
Steven Bradley, D.D.S.,	Present
Steven C. Fuller, D.D.S.	Present
Matthew J. McCullough, D.D.S.	Present
Thomas M. Jeneary, D.D.S.	Present
Kaaren G. Vargas, D.D.S.	Absent
Mary C. Kelly, R.D.H.	Present
Nancy A. Slach, R.D.H.	Absent
Diane Meier, Public Member	Present
Lori Elmitt, Public Member	Present

Staff Members
Jill Stuecker, Phil McCollum, Christel Braness, Dee Ann Argo, Brian Sedars, Janet Arjes

Attorney General's Office
Sara Scott, Assistant Attorney General

I. CALL TO ORDER FOR FEBRUARY 25, 2015

Ms. Stuecker called the open session meeting of the Iowa Dental Board to order at 12:32 p.m. on Wednesday, February 25, 2015. The meeting was held by electronic means in compliance with Iowa Code Section 21.8. The purpose of the meeting was conduct time-sensitive Board business. It was impractical to meet in person with such a short agenda and on such short notice. A quorum was established with seven (7) members present.

Roll Call:

Member	Bradley	Elmitt	Fuller	Jeneary	Kelly	McCullough	Meier	Slach	Vargas
Present	x	x	x	x	x		x	x	
Absent						x			x

II. 1st OPPORTUNITY FOR PUBLIC COMMENT

Ms. Stuecker asked that the public members participating in the teleconference introduce themselves.

Ms. Stuecker allowed the opportunity for public comment.

Mr. Cope stated that he was pleased to see the Board moving forward on the public health supervision rules as they relate to dental assistants. Mr. Cope stated that the items listed in Iowa Administrative Code 650—20.16(2)b(3), (4), and (5) should not be included in the final version of the proposed rules. Mr. Cope believed that those duties should be completed by the dental hygienists.

III. DECISION AND ORDER: IN THE MATTER OF LISA M. KUCERA, CASE No. 14-0041

- ❖ MOVED by BRADLEY, SECONDED by FULLER, to APPROVE the order as drafted.

Member	Bradley	Elmitt	Fuller	Jeneary	Kelly	McCullough	Meier	Slach	Vargas
Yes	x	x	x	x			x		
No					x			x	
Absent						x			x

Motion APPROVED by roll call, 5-2.

IV. ADMINISTRATIVE RULES

- Iowa Administrative Code 650—Chapter 1, *"Definitions"*

Ms. Stuecker provided an overview of this request. At the January 2015 meeting of the Board, staff was instructed to draft proposed rule amendments relating to dental assistants. The proposed rulemaking for Iowa Administrative Code 650—Chapter 1 would update the definition of "general supervision of a dental assistant" to more closely match the definition for "general supervision" provided in Iowa Administrative Code 650—Chapter 20.

Mr. McCollum reported that if the Notice of Intended Action were approved, it would start the rulemaking process. There would be time for public comment. Mr. McCollum stated that this may not be the final version adopted by the Board, and that this was not a final document. Should the Board make any changes to Iowa Administrative Code 650—Chapter 20, Iowa Administrative Code 650—Chapter 1 would be updated to reflect those changes as needed.

Ms. Stuecker reported on the proposed change in language for Iowa Administrative Code 650—Chapter 1.

- ❖ MOVED by BRADLEY, SECONDED by JENEARY, to APPROVE the Notice of Intended Action as drafted. Motion APPROVED unanimously.

- Iowa Administrative Code 650—Chapter 20, *"Dental Assistants"*

Mr. McCollum provided an overview of the proposed changes. Mr. McCollum explained that the proposed changes in language to supervision requirements were not changes to the requirements for general supervision of dental assistants; rather, the changes were intended to make clearer the current supervision requirements. Mr. McCollum reported that the proposed changes also included the addition of permissible services, which could be performed under general supervision; increased the number of expanded functions procedures that could be delegated to registered dental assistants; and addressed education and training requirements for those procedures. Mr. McCollum also reported that the proposed changes would allow dental assistants to work under public health supervision.

Mr. McCollum indicated that there was discussion at the last Board meeting regarding the training of level 2 expanded functions. The Board proposed limiting training in level 2 expanded functions to the University of Iowa College of Dentistry. The draft proposal included language allowing level 2 expanded functions training at the University of Iowa College of Dentistry or other CODA-approved programs. Mr. McCollum explained that all expanded functions training would require pre-approval by the Board. This would allow the expansion of level 2 expanded functions training in the future, if appropriate.

- ❖ MOVED by BRADLEY, SECONDED by JENEARY, to APPROVE the Notice of Intended Action as drafted. Motion APPROVED unanimously.

V. OTHER BUSINESS

EXPANDED FUNCTIONS COURSE APPROVAL

Ms. Braness indicated that due to time constraints discussion on these expanded functions course requests would be limited. If necessary, these items would be tabled until the April 2015 Board meeting in the event more thorough discussion would be required.

- *Lifepoint Dental*

Ms. Braness provided an overview of the request. Lifepoint Dental has requested approval of all nine (9) current expanded functions. The course materials were forwarded the expanded functions task force for review and recommendation.

Ms. Braness reported that, to date, three (3) of seven (7) task force members had responded. All three (3) indicated approval for the course as submitted, with a few points of clarification about current regulations.

Ms. Slach stated that she would prefer to have the entire task force meet to further review the requests. Ms. Slach reported that she had further reviewed both expanded functions courses, and had some suggestions for changes. Ms. Slach preferred to speak about these concerns with the entire task force prior to making a decision. Dr. Bradley agreed.

Ms. Slach suggested that the task meet prior to the April 2015 meeting. Ms. Meier agreed that this was a good idea.

Ms. Elmitt asked what the proposed timeline would be for approval. Ms. Elmitt was aware that there was a lack of expanded courses functions available, and the sponsors of the requested training were awaiting approval.

Ms. Slach stated there are some problems with the courses as far as the details of the requests. Ms. Elmitt asked if there were concerns with both requests. Ms. Braness stated that the Board was currently discussing the request from Lifepoint Dental. Ms. Kelly asked Ms. Slach if she had concerns with the Lifepoint Dental request. Ms. Slach stated that she had concerns with both courses. Ms. Slach indicated that it would take too long to address each of her concerns at this time. Ms. Slach stated that it would be better for the task force to do the committee work and to come back to the Board with a recommendation.

- ❖ MOVED by JENEARY, SECONDED by BRADLEY, to table a decision until the task force is able to meet and further discuss these requests as proposed. Motion APPROVED unanimously.

- *Impact Dental Training*

Ms. Braness provided an overview of the request. Impact Dental Training has requested approval of all nine (9) current expanded functions. The course materials were forwarded the expanded functions task force for review and recommendation.

Ms. Braness reported that four (4) of the seven (7) task force members responded, recommending approval of the course. The other task force members had not responded to date.

Dr. Fuller asked who Impact Dental Training is. Ms. Braness reported that Alan Swett, D.D.S. and Lisa Swett, R.D.H. founded Impact Dental Training to provide continuing education courses. Impact Dental Training has expanded their coursework to include training in expanded functions if the request were approved by the Board.

Ms. Slach stated that this request was entirely didactic, and did not include a lab component. The proposed laboratory training would be done in the private dentists' offices. Ms. Slach believed that the task force needed to discuss this further since she believed that the intent of the rules was to include both clinical and laboratory training in order to be approved. Ms. Slach recommended tabling the discussion for further review by the task force.

- ❖ MOVED by SLACH, SECONDED by BRADLEY, to table the decision pending further review by the expanded functions task force. Motion APPROVED unanimously. Ms. Elmitt abstained.

Ms. Elmitt asked about the potential timeline. Ms. Braness stated that she would reach out to the task force members with the intent to schedule a meeting in March, if possible.

LANCE FORBES, D.D.S. – APPROVAL FOR PRESCRIBING COURSE

Mr. Sedars provided an overview of the request. Dr. Forbes submitted a course for review and approval by the Board as required by the January 2015 order issued to him by the Board. Mr. Sedars believed that the course was presented by Boston University.

- MOVED by BRADLEY, SECONDED by JENEARY, to APPROVE the course as submitted.

Ms. Slach asked if there was a request from Dr. Forbes asking to have some of the testing requirements waived. Mr. Sedars stated that a request has not been received to date; though, the Board may see such a request at a later date.

- Vote taken. Motion APPROVED unanimously.

UPDATE ON SENATE FILE 200 – *"A BILL FOR AN ACT RELATING TO THE EMPLOYMENT AND DUTIES OF THE EXECUTIVE DIRECTOR OF THE DENTAL BOARD."*

Ms. Stuecker stated that the bill passed in the Senate on February 24, 2015. The bill passed 49-0. The bill will be moving over to the House of Representatives, and will start at the subcommittee level.

Ms. Stuecker reported that she has heard that there may be some resistance to the bill in the House of Representatives, particularly from Representative Linda Miller. Ms. Stuecker will continue to follow up with Representative Miller on this matter. Ms. Stuecker stated that the proposed bill made sense since it would make the position of the executive director of the Dental Board consistent with the Boards of Medicine and Nursing. Ms. Stuecker has referenced the statutory language with respect to the Boards of Medicine and Nursing.

Ms. Stuecker asked that the Board members who had an interest in contacting the committee members to let her know. Dr. Bradley asked Ms. Stuecker to provide the Board members with a list of the committee members. Ms. Stuecker stated that she would forward that information.

Ms. Stuecker reported that the proposed legislation from the previous year died in the House of Representatives as well.

Dr. Bradley reported having met with Representative Miller numerous times last year after the bill was voted down. Dr. Bradley reported that he intended to meet with Representative Miller the next week.

UPDATE ON SENATE FILE 202 – *"A BILL RELATED TO LICENSURE OF RETIRED VOLUNTEER DENTISTS AND DENTAL HYGIENISTS."*

Ms. Stuecker reported that the bill has passed in the House of Representatives. The bill is pending in a Senate subcommittee.

Ms. Stuecker reported that Mr. McCollum inquired about a quote from the database vendor to implement and manage the proposed license type should the bill be signed into law. The estimate to implement these changes was $90,000. Ms. Stuecker reported that the Board could not absorb this cost without discussing fee increases in the future. Should the bill be signed into law, which is likely, this license type may be managed on paper or with minimal changes to the current database. This is not an ideal solution; however, the Board has agreed to do this.

Ms. Stuecker stated that the Board will need to keep an eye on the number of licensees who may transition over to the retired volunteer license, since there would be an impact on the revenue of the Board. Mr. Stuecker and Mr. McCollum ran some quick numbers to provide an estimate of the impact on revenue. If 10% of all dentists and dental hygienists over the age of 65 switched over to a retired volunteer license, the Board's revenue would decrease by $9,000 over a two-year period. If 20% of licensees over the age of 65 switched over to retired volunteer license, the two-year impact would be a decrease of $18,000. The participation in this program will need to be closely monitored to see what the short term and long term impacts are.

Ms. Kelly asked if the Board has registered support for the legislation. Ms. Stuecker stated that the Board had not registered support or opposition to the proposed legislation. Dr. Bradley stated that the Board ought to support this.

Ms. Braness reported that a motion of the Board, made during a Board meeting in October 2014, stated that Board would only register legislative support if specific language was used in the proposed legislation. Ms. Braness stated that the Board could change their position on this; however, she wanted to reference the earlier motion in case that impacted the Board's position on the matter.

Ms. Stuecker stated that if the legislation should be passed, Board staff would monitor this closely for the impact on revenue.

VI. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Ms. Stuecker offered the opportunity for public comment.

No comments were received.

VII. ADJOURN

- MOVED by BRADLEY, SECONDED by FULLER, to adjourn the meeting. Motion APPROVED unanimously.

The meeting was adjourned at 12:57 p.m. on February 25, 2015.

NEXT MEETING OF THE BOARD

The next meeting of the Board is scheduled for April 23-24, 2015, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.

REPORT TO THE IOWA DENTAL BOARD

FYI

DATE OF MEETING: April 23-24, 2015
RE: **Actions Taken by the Committee on Applications for Sedation Permits**
SUBMITTED BY: **Anesthesia Credentials Committee**

COMMITTEE ACTIONS TAKEN ON APPLICATIONS

The committee voted to take action on the applications as indicated below:

- *Ashley Sunstrum, D.D.S. – Moderate Sedation Permit*
  - APPROVED application for issuance of the moderate sedation permit.

- *Mitch Driscoll, D.D.S. – Moderate Sedation Permit*
  - APPROVED application for issuance of the moderate sedation permit.

ACTION

REPORT TO THE IOWA DENTAL BOARD

DATE OF MEETING: April 23-24, 2015
RE: **Recommendations: Course & Sponsor Requests**
SUBMITTED BY: **Continuing Education Advisory Committee**
ACTION REQUESTED: Board Action on Committee Recommendation

COMMITTEE RECOMMENDATIONS*

The committee requests that the Board accept the following recommendations:

CONTINUING EDUCATION COURSE REVIEW

1. **Mississippi Valley Oral Surgery** – "Managing Anesthesia in the Office (600 series)" – Requested 15 hours for completion of all components, 601-610 **- APPROVED**
2. **Eastern Iowa Community College District** – "Dental Emergencies for the Dental Team" – Requested 2 hours **- APPROVED**
3. **Fort Dodge Oral & Maxillofacial Surgery** – "Precision, Predictability, and Profitability of Implant Prosthetics" – Requested 2 hours **- APPROVED**
4. **Great River Oral & Maxillofacial Surgery, P.C.** – "Drug-Related Problems in the Dental Office" – Requested 3 hours **- APPROVED**
5. **Periodontal Specialists** – "Dentistry Dedicated to Excellence: Taking a Stand Against Periodontal Disease" – Requested 6 hours **- APPROVED**
6. **Shawn Reese, D.D.S.** – "Lunch & Learn from Periodontist to General Dentist" – Requested 2 hours **- APPROVED**
7. **Hall-Perrine Cancer Center, Mercy Cedar Rapids** – "2015 Spring Cancer Care Update for Dental Health Professionals" – Requested 2 hours **- APPROVED**
8. **Iowa Public Health Association** – "2015 Iowa Governor's Conference on Public Health" – Requested 10 hours **– DENIED due to lack of topics related to the practice of dentistry.**
9. **Iowa Academy of General Dentistry** – "Customized Implant Solutions – With Introductions to All-on-4 Treatment Concepts" – Requested 6 hours **- APPROVED**
10. **Iowa Academy of General Dentistry** – "Occlusion Based on Biologic Models of Health" – Lecture; Diagnosis Made Simple Using an Accurate Articulator System" - Participation – Requested 8 hours lecture, 16 hours participation **- APPROVED**
11. **Iowa Primary Care Association** – "Mental Health First Aid Training" – Requested 8 hours (Reconsideration) **– DENIED due to lack of discussion related to application of this information to the practice of dentistry.**

12. **Iowa City Dental Hygienists' Association** – "Integrative Medicine" (Previously submitted as Integrative Medicine: 3 Secrets to a Longer, Healthier Life for Your Patients and You") – Requested 3 hours (Reconsideration) **- APPROVED**

CONTINUING EDUCATION SPONSOR
The CEAC recommended:

1. Mississippi Valley Oral & Maxillofacial Surgery - **APPROVED**
2. Iowa Dental Hygienists' Association (Recertification) - **APPROVED**

Proposed Motion:
I move that the Board accept the committee's recommendations as indicated above.

* PLEASE NOTE: The Continuing Education Advisory Committee is scheduled to meet again on April 14, 2015. An updated list of recommendations from the committee will be provided at the Board meeting.

REPORT TO THE IOWA DENTAL BOARD

FYI ONLY

DATE OF MEETING: April 23, 2015
RE: **Quarterly Report on IPRC Activities**
SUBMITTED BY: Brian Sedars, Health Professions Investigator
ACTION REQUESTED: None.

The Iowa Practitioner Review Committee evaluates, assists, and monitors the recovery, rehabilitation, or maintenance of dentists, hygienists, or assistants who self-report impairments. As necessary, the Committee notifies the Board in the event of noncompliance with contract provisions.

The IPRC is both an advocate for the health of a practitioner and a means to protect the health and safety of the public.

The Board's administrative rules require the Committee to submit a quarterly report to the Board on the activities of the IPRC. Below is the quarterly report.

Iowa Dental Board

Iowa Practitioner Review Committee

Current Numbers (as of 04/09/15)	2015 Totals
Self Reports	0
Current Participants	15
Contracts under Review	0
Discharged Participants	1

REPORT TO THE IOWA DENTAL BOARD

ACTION

DATE OF MEETING: April 23-24, 2015
RE: **Recommendations Regarding Expanded Functions: RE: Course Approval**
SUBMITTED BY: **Educational Standards for Expanded Functions Task Force**
ACTION REQUESTED: Board Action on Committee Recommendations

COMMITTEE RECOMMENDATIONS – REQUEST FOR REVIEW OF EXPANDED FUNCTIONS COURSES

The committee has recommended approval of the following expanded functions course requests:

- Lifepoint Dental – Requested approval for all 9 current expanded functions
- Impact Dental Training – Requested approval for all 9 current expanded functions
- Davidson Family Dentistry – Requested approval for all 9 current expanded functions.

Along with the recommendations for course approval, the committee also recommended that each of the course providers require a minimum score of 75% for the post-course competency examination; and that a reminder be included in the final correspondence noting that the post-course competency examination must be taken *after* all training is completed pursuant to Iowa Administrative Code 650—Chapter 20.

STATE OF IOWA

IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

March 18, 2015

To: Members of the Iowa Dental Board and all interested parties

Re: Draft language to allow dental hygienists to perform expanded function procedures

While the goal is to work on new rule language, the discussion always comes back to which of the current dental assistant expanded function procedures can a dental hygienist perform pursuant to their current scope of practice.

Education and training issues aside, if the procedure is currently listed, it can be legally performed right now, and most likely is, so we need to be sure that we do not create an undue hardship for those offices currently utilizing dental hygienists to perform those procedures. If the Board would like to put additional education and training requirements in place for those procedures, or consider requiring continuing education in those areas, then that should be addressed separate from these rule amendments, as the purpose of these amendments is to allow new procedures to be performed and to set the education and training requirements for them.

Current rule 20.3(3) states that a dentist may delegate an expanded function procedure to a registered dental assistant provided that they have completed board-approved training. It does not say anything about delegating those procedures to a dental hygienist. Board rule 20.2 defines a dental assistant and specifically states that the term 'dental assistant' does not include persons licensed to practice dental hygiene.

My interpretation of these rules is they allow dentists to delegate a group of expanded function procedures to dental assistants that they could not otherwise perform. I am not saying that a dental hygienist cannot perform some of these same procedures, but when they are, they are doing so under their DH license, under the scope of their own practice, as Chapter 20 does not apply to them.

The purpose of these new amendments is to allow dental hygienists to perform these same procedures, so we need to determine which are already covered by their current scope and which procedures need to be added or clarified, so that these rules are clear and concise to everyone.

Currently, here is the list of the nine (9) dental assistant expanded function procedures per 20.3(3):

a. Taking occlusal registrations;
b. Placement and removal of gingival retraction;
c. Taking final impressions;

d. Fabrication and removal of provisional restorations;
e. Applying cavity liners and bases, desensitizing agents, and bonding systems;
f. Placement and removal of dry socket medication;
g. Placement of periodontal dressings;
h. Testing pulp vitality; and
i. Monitoring of nitrous oxide inhalation analgesia.

Below is the current scope of practice for a dental hygienist per 10.3(1):

a. **Educational.** Assessing the need for, planning, implementing, and evaluating oral health education programs for individual patients and community groups; conducting workshops and in-service training sessions on dental health for nurses, school personnel, institutional staff, community groups and other agencies providing consultation and technical assistance for promotional, preventive and educational services.

b. **Therapeutic.** Identifying and evaluating factors which indicate the need for and performing (1) oral prophylaxis, which includes supragingival and subgingival debridement of plaque, and detection and removal of calculus with instruments or any other devices; (2) periodontal scaling and root planing; (3) removing and polishing hardened excess restorative material; (4) administering local anesthesia with the proper permit; (5) administering nitrous oxide inhalation analgesia in accordance with 650—subrules 29.6(4) and 29.6(5); (6) applying or administering medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries.

c. **Preventive.** Applying pit and fissure sealants and other medications or methods for caries and periodontal disease control; organizing and administering fluoride rinse or sealant programs.

d. **Diagnostic.** Reviewing medical and dental health histories; performing oral inspection; indexing dental and periodontal disease; making occlusal registrations for mounting study casts; testing pulp vitality; analyzing dietary surveys.

e. The following services may only be delegated by a dentist to a dental hygienist: administration of local anesthesia, placement of sealants, and the removal of any plaque, stain, calculus, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish.

I am also including Iowa Code 153.15

153.15 Dental hygienists — scope of term. A licensed dental hygienist may perform those services which are educational, therapeutic, and preventive in nature which attain or maintain optimal oral health as determined by the board and may include but are not necessarily limited to complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, obtaining and preparing nonsurgical, clinical and oral diagnostic tests for interpretation by the dentist, and preparation of preliminary written records of oral conditions for interpretation by the dentist. Such services shall be performed under supervision of a licensed dentist and in a dental office, a public or private school, public health agencies, hospitals, and the armed forces, but nothing herein shall be construed to authorize a dental hygienist to practice dentistry.

In the table below I have attempted to match the current DA expanded function procedures to the corresponding duties listed in the current scope of practice for a DH. There is always discussion concerning “it’s about the same thing” or “the procedures are similar”, but my goal is to try to match duties that are as identical as possible and then discuss each one individually.

Current DA Expanded Function procedures	Matching DH scope procedure
a. Taking occlusal registrations;	a. making occlusal registrations for mounting study casts
b. Placement and removal of gingival retraction;	b.
c. Taking final impressions;	c.
d. Fabrication and removal of provisional restorations;	d.
e. Applying cavity liners and bases, desensitizing agents, and bonding systems;	e. * see below
f. Placement and removal of dry socket medication;	f. applying or administering medicaments prescribed by a dentist
g. Placement of periodontal dressings;	g. Applying pit and fissure sealants and other medications or methods for caries and periodontal disease control **AND** applying or administering medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries
h. Testing pulp vitality; and	h. testing pulp vitality
i. Monitoring of nitrous oxide inhalation analgesia.	i. administering nitrous oxide inhalation analgesia

Taking occlusal registrations: The closest matching procedure listed in chapter 10 appears to be more specific and limiting, as it states "making occlusal registrations for mounting study casts". That wording appears to limit the making of such registrations to a specific purpose. That purpose being the positive reproduction of teeth and surrounding structures for the purpose of study and treatment planning. It does not appear to cover occlusal registrations taken for other purposes, such as for full dentures, partials, sleep appliances, etc… I do not know why the more restrictive language was used, but we can't simply ignore it. My suggestion would be to leave this language as is, to continue to allow hygienists to make occlusal registrations for mounting study casts, and add the broader "Taking occlusal registrations for purposes other than mounting study casts" as an expanded function, which would require additional education and training.

Placement and removal of gingival retraction: This procedure involves the lateral movement of the gingival margin away from the tooth surface and is most generally performed during the preparation of teeth during crown and bridge procedures. Retraction cord is also sometimes used when placing restorations on teeth where the cavity goes below the gum line to provide access to the tooth surface. I do not see a similarly worded procedure listed in chapter 10. While there is no question that hygienists work in the gingiva every day, chapter 10 primarily makes reference to

procedures that are preventive in nature that relate to caries and periodontal disease control, not to restorative procedures or dental prosthesis.

Taking final impressions: I do not see a similarly worded procedure listed in chapter 10.

Fabrication and removal of provisional restorations: I do not see a similarly worded procedure listed in chapter 10. It does list "removing and polishing hardened excess restorative material" but that is specific to the excess material only, not the making or removing of the restoration itself.

***Applying:**

(1) cavity liners and bases: This is part of a restorative procedure. The dentist has already removed the caries. The liner/base is to prevent microleakage, inhibit bacteria growth, and to promote adhesion. I do not see a similarly worded procedure listed in chapter 10.

(2) desensitizing agents: I believe this would be covered under "applying or administering medicaments prescribed by a dentist."

(3) bonding systems: This is most typically part of a restorative procedure and would not be performed without a dentist present. It is to ensure that the filling material adheres to both the dentin and the enamel. I do not see a similarly worded procedure listed in chapter 10.

Placement and removal of dry socket medication: I believe this would be covered under "applying or administering medicaments prescribed by a dentist."

Testing pulp vitality: Clearly covered with same wording.

Monitoring of nitrous oxide inhalation analgesia. Clearly covered by the ability to administer nitrous oxide inhalation analgesia.

Below I have listed the new expanded function procedures proposed by the Board's task force, to see which of the new duties are already covered under the current scope for hygienists. I have removed the first 9 procedures listed above to focus only on the newly listed procedures which would be classified as Level 1 procedures for dental assistants.

New proposed Expanded function procedures (DA Level 1)	Matching DH scope procedure
10. Removal of adhesives (hand instrumentation only)	removal of any plaque, stain, calculus, or hard natural or synthetic material
11. Preliminary charting of existing dental restorations and teeth	performing oral inspection; indexing dental and periodontal disease + **10.3(3)** data collection

Removal of adhesives (hand instrumentation only): I believe adhesives would be covered under removal of synthetic material, but I would recommend that is be clarified in the new rule so it is clear to everyone.

Preliminary charting of existing dental restorations and teeth: I believe this would be covered by the above wording, but the wording doesn't match. I would recommend that is be clarified in the new rule so it is clear to everyone.

I would recommend that we try to use as similar of wording as possible, so that readers can easily find the same duties listed within this chapter that are listed in chapter 20 for dental assistants.

One option would be to create a Certified Level 1 provider within Chapter 10 to include only those procedures which are not specifically listed within the current scope. Educational and training requirements could then be defined for those new procedures, as could the level of supervision required. These changes would expand the current scope of practice.

The Level 1 procedures for dental hygienists would include:

1. Taking occlusal registrations for purposes other than mounting study casts;
2. Placement and removal of gingival retraction;
3. Taking final impressions;
4. Fabrication and removal of provisional restorations; and
5. Applying cavity liners and bases and bonding systems.

The supervision requirements for these procedures could then be set out in rule. Since the majority of these procedures require the presence of a dentist for an adjunctive procedure, I would suggest that the taking of occlusal registrations for purposes other than mounting study casts could be performed under general supervision, all other expanded function procedures would require direct supervision.

The education and training requirements for these new procedures could then mirror those for dental assistants.

The remaining dental assistant expanded function procedures that are not specifically worded the same, yet are covered under the current scope of a dental hygienist, could then be added to the existing rule language so that they would be clearly identifiable to all. These changes would be for clarification purposes only, and not an expansion of scope.

The removal of adhesives could be added to therapeutic:

> b. **Therapeutic.** Identifying and evaluating factors which indicate the need for and performing (1) oral prophylaxis, which includes supragingival and subgingival debridement of plaque, and detection and removal of calculus with instruments or any other devices; (2) periodontal scaling and root planing; (3) removing and polishing hardened excess restorative material; (4) administering local anesthesia with the proper permit; (5) administering nitrous oxide inhalation analgesia in accordance with 650—subrules 29.6(4) and 29.6(5); (6) applying or administering

medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries; (7) removal of adhesives.

The preliminary charting of existing dental restorations and teeth could be added to Diagnostic:

d. **Diagnostic.** Reviewing medical and dental health histories; performing oral inspection; indexing dental and periodontal disease; preliminary charting of existing dental restorations and teeth, making occlusal registrations for mounting study casts; testing pulp vitality; analyzing dietary surveys.

This would address all eleven (11) of the procedures that are being proposed as Level 1 procedures for dental assistants; it would allow readers to clearly find the same procedures listed in both chapters; it would clearly define the training, education, and supervision requirements; and it would not disrupt care currently being provided by practicing dental hygienists or create any undue hardship.

We could then model the language to cover Level 2 procedures to those being proposed in Chapter 20, so the two would match. For a dental hygienist to be able to perform any of the Level 2 procedures, they must first meet the education and training requirements for ALL of the procedures and become certified as a Level 2 provider, there would be no option to pick and choose individual Level 2 procedures. They must also become certified in ALL Level 1 procedures before beginning training as a Level 2 provider. These requirements mirror the requirements for dental assistants.

Please find attached a Notice of Intended Action incorporating the language discussed above.

Phil McCollum
Associate Director
Iowa Dental Board

DENTAL BOARD[650]

Notice of Intended Action

Pursuant to the authority of Iowa Code sections 147.76 and 272C.2, the Dental Board hereby gives Notice of Intended Action to amend Chapter 10, "General Requirements," Iowa Administrative Code.

The purpose of the proposed amendments are as follows: to clarify that the removal of adhesives and the preliminary charting of existing dental restorations and teeth are permissible services a dental hygienist may perform under the supervision of a licensed dentist; and to allow dental hygienists to perform expanded function procedures which may be delegated by a licensed dentist; and set the education and training requirements for those expanded function procedures.

The interpretation of current rules allow a dental hygienist to remove adhesives and to perform the preliminary charting of existing dental restorations and teeth. These amendments would clarify and list these specific procedures so that the wording is consistent with the procedures listed as expanded function procedures.

Current rules do not allow a dentist to delegate expanded function procedures to a dental hygienist. These amendments would allow a dentist to delegate expanded function procedures to a dental hygienist, defines each expanded functions procedure, defines the supervision requirements when performing expanded function procedures, and sets the education and training requirements for the expanded function procedures.

Any interested person may make written comments on the proposed amendments on or before XXXX, XX, 2015. Such written materials should be directed to Phil McCollum, Associate Director, Iowa Dental Board, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa 50309, or sent by e-mail to phil.mccollum@iowa.gov.

There will be a public hearing on XXXX, XX, 2015, at 2 p.m. in the Board office, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa, at which time persons may present their views orally or in writing.

The proposed amendments are subject to waiver or variance pursuant to 650—Chapter 7.

After analysis and review of this rule making, a positive impact on jobs has been found for dental hygienists who will now be able to perform more procedures.

These amendments are intended to implement Iowa Code sections 153.15.

The following amendments are proposed

ITEM 1. Amend subrule **650—10.3(1**) as follows:

b. Therapeutic. Identifying and evaluating factors which indicate the need for and performing (1) oral prophylaxis, which includes supragingival and subgingival debridement of plaque, and detection and removal of calculus with instruments or any other devices; (2) periodontal scaling and root planing; (3) removing and polishing hardened excess restorative material; (4) administering local anesthesia with the proper permit; (5) administering nitrous oxide inhalation analgesia in accordance with 650—subrules 29.6(4) and 29.6(5); (6) applying or administering medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries; (7) removal of adhesives.

ITEM 2. Amend subrule **650—10.3(1**) as follows:

d. Diagnostic. Reviewing medical and dental health histories; performing oral inspection; indexing dental and periodontal disease; preliminary charting of existing dental restorations and teeth, making occlusal registrations for mounting study casts; testing pulp vitality; analyzing dietary surveys.

ITEM 3. Adopt the following new subrule **650—10.3(8)**

10.3(8) Expanded Function Requirements

a. **Supervision requirements.** A dental hygienist may only perform expanded function procedures which are delegated by and performed under the supervision of a dentist licensed pursuant to Iowa Code chapter 153. The taking of occlusal registrations for purposes other than mounting study casts may be performed under general supervision, all other expanded function procedures shall be performed under direct supervision.

b. **Expanded Function training required.** A dental hygienist shall not perform any expanded function procedures listed in this chapter unless the dental hygienist has successfully met the education and training requirements and is in compliance with the requirements of this chapter.

c. **Education and training requirements.** All expanded function procedure training must be prior-approved by the Board. The supervising dentist and the dental hygienist shall be responsible for maintaining in each office of practice documentation of successful completion of the board approved training.

d. Expanded function procedure training for Level 1 procedures shall be eligible for board approval if the training is offered through a program accredited by the Commission on Dental

Accreditation of the American Dental Association (ADA) or another program, which may include on-the-job training offered by a dentist licensed in Iowa.

Training must consist of the following:

1. An initial assessment to determine the base entry level of all participants in the program.
2. A didactic component;
3. A laboratory component, if necessary;
4. A clinical component, which may be obtained under the personal supervision of the participant's supervising dentist while the participant is concurrently enrolled in the training program; and
5. A postcourse competency assessment at the conclusion of the training program.

e. Expanded function procedure training for Level 2 procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or a program accredited by the Commission on Dental Accreditation of the American Dental Association.

10.3(9) Expanded Function Providers.

a. **Basic Expanded Function Provider.** A dental hygienist who does not wish to become certified as a Level 1 or Level 2 provider may perform select Level 1 expanded function procedures provided they have met the education and training requirements for those procedures and are in compliance with the requirements of this chapter. A dentist may delegate to a dental hygienist only those Level 1 procedures for which the dental hygienist has received the required expanded function training.

b. **Certified Level 1 Provider**. A dental hygienist must successfully complete training for all Level 1 expanded function procedures before becoming a certified Level 1 provider. A dentist may delegate any of the following expanded function procedures to a dental hygienist who is a certified Level 1 provider:

Level 1 procedures:

1. Taking occlusal registrations for purposes other than mounting study casts ;
2. Placement and removal of gingival retraction;
3. Fabrication and removal of provisional restorations;
4. Applying cavity liners and bases and bonding systems for restorative purposes;
5. Taking final impressions

c. **Certified Level 2 Provider.** A dental hygienist must become a certified Level 1 provider and successfully pass a Board-approved entrance exam with a score of at least 75% before beginning training to become a certified Level 2 provider. A dental hygienist must successfully complete training for all Level 2 expanded function procedures before becoming a certified Level 2 provider. A dentist may delegate any of the Level 1 or Level 2 expanded function procedures to a dental hygienist who is a certified Level 2 provider:

Level 2 procedures:

1. Placement and shaping of amalgam following preparation of a tooth by a dentist;
2. Placement and shaping of composite following preparation of a tooth by a dentist;
3. Forming and placement of stainless steel crowns;
4. Taking records for the fabrication of dentures and partial dentures;
5. Tissue conditioning (soft reline only, where denture is not relieved or modified);

These procedures refer to both primary and permanent teeth.

McCollum, Phil [IDB]

From: Richard Downs <rick.downs3430@gmail.com>
Sent: Monday, January 26, 2015 5:00 PM
To: McCollum, Phil [IDB]
Subject: models

Mr. McCollum

I am in favor of dental models being given to the patient immediately at the completion of treatment, if the dentist does not want to keep them. Please add my comment to the discussion.

Richard Downs DDS

This email has been checked for viruses by Avast antivirus software.
www.avast.com

McCollum, Phil [IDB]

From: Jessica Lawson <jlklawson@gmail.com>
Sent: Monday, January 26, 2015 9:55 PM
To: McCollum, Phil [IDB]
Subject: study casts/model retention

Good evening Phil,

In response to recent activity about modifying study model retention, I would propose that in lieu of dentists retaining them for one year following treatment, that we give them to patients immediately following completion of treatment plans. This is also advantageous as it allows the patient to store any prosthetic work that may distort if not on the model, and frees up a lot of space in our practices that already seem to be over-run by supplies and technology:-)

Thank you for your consideration. Sincerely, Dr. Jessica Lawson

--
Dr. Jessica Lawson
Lawson Family Dentistry, LLC
4444 NW 128th St.
Urbandale, IA 50323
515-278-4366 (phone)
www.lawsondentistry.com

McCollum, Phil [IDB]

From: arehak@mchsi.com
Sent: Tuesday, January 27, 2015 1:00 PM
To: McCollum, Phil [IDB]
Subject: Requirement to keep patient diagnostic models

Dear Mr. McCollum,

I request that there should be no requirement to keep diagnostic models at all. It is rare that they would have any use. I have never used models older than about two months in any patient treatment. If a patient has long term extended treatment needs I might have an occasion to keep models. However, this is very infrequent. Usually, I have no need for models when treatment is complete and I usually have photos.

If I have a condition that needs documentation for future needs I use our intraoral camera. The information stays in the computer not making a bunch of useless clutter someplace.

As an absolute minimum I suggest that models can be given to the patient or their parents immediately when I no longer need them for treatment.

The only time I see even any minimal cause to keep models might be for orthodontic patients. Even then I consider photographs sufficient to keep in the office and give the models to the patient.

Best Wishes,
Adrian

Adrian Rehak, DDS, PC
Mt. Vernon Road Dental
1000 42nd Street SE, Ste B
Cedar Rapids, IA 52302

arehak@mchsi.com
www.TheCedarRapidsDentist.com
Office: 319-362-3179
Fax: 319-362-9586

McCollum, Phil [IDB]

From: Dick Kohler <dickkohler1952@gmail.com>
Sent: Tuesday, January 27, 2015 3:07 PM
To: McCollum, Phil [IDB]
Subject: Re: Models

Sorry Phil, I misunderstood the rule, thanks for clarification. I think Dentists usually try to do what's best for each patient. The new rule would be an improvement, should there be a rule like this at all?

Sent from my iPad

> On Jan 27, 2015, at 11:33 AM, McCollum, Phil [IDB] <Phil.Mccollum@iowa.gov> wrote:
>
> Dr. Kohler:
>
> The purpose of this rule amendment is to reduce the burden on dental offices. Under current rules, dentists are required to keep study models for 6 years after the LAST date of examination, prescription, or treatment. That 6 year timetable does not even start until AFTER the patient leaves an office, so offices have to maintain those models for a very long time period.
>
> What this amendment does, is reduces the amount of time that an office has to maintain such models. The 6 year time period starts at completion of treatment, and the dentist would also have the ability to send the models home with the patient after 1 year, if they so choose.
>
> Could you please elaborate on your concern so that I'm sure that I understand. We are trying to reduce requirements in response to feedback from offices, not add to them.
>
> PHIL McCOLLUM
> ASSOCIATE DIRECTOR
> OPERATIONS | SYSTEMS ADMINISTRATION
> IOWA DENTAL BOARD
> 400 SW EIGHTH STREET, SUITE D | DES MOINES, IOWA 50309
> OFFICE: 515-281-3739 | FAX: 515-281-7969 www.dentalboard.iowa.gov
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>
> -----Original Message-----
> From: Dick Kohler [mailto:dickkohler1952@gmail.com]
> Sent: Monday, January 26, 2015 12:39 PM
> To: McCollum, Phil [IDB]
> Subject: Models
>
> Phil, this is another example of over legislating, many of us already comply with this when we can, but many times the models are damaged or destroyed by shipment or lab. What about those of us that see nursing home patients, who keeps their models. Please make it a recommendation and not a rule, we all try hard to do the best for our patients, this is an area we should handle ourselves.
> Please feel free to pass this on or contact me. Dr. Richard (Dick)

> Kohler Sent from my iPad
>
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McCollum, Phil [IDB]

From: Dr. Matt Hansen <drhansen@centralparkdentistry.com>
Sent: Wednesday, January 28, 2015 8:48 AM
To: McCollum, Phil [IDB]
Subject: Model Policy

Thank you for taking input on model policies. I believe the option to dispense to the patient their dental models—their dental record is an excellent idea. Because if it is ever important to them to have them, they have it. The more transient a population is, the more difficult it would be to pass them out after a year's time. Like in college communities,for instance.
Also, I know the board realizes many processing procedures end up breaking some models, too.
Let's find a better way to do model storage. The photos we now more commomly have on file tell a much bigger story.

Thank you.

Dr Matt Hansen
Mason City, IA

McCollum, Phil [IDB]

From: McCollum, Phil [IDB]
Sent: Tuesday, February 17, 2015 8:09 AM
To: 'Tony Kalb'
Subject: RE: Study models and Casts

Dr. Kalb:

The purpose of this rule amendment is to reduce the burden on dental offices. Under current rules, dentists are required to keep study models for 6 years after the LAST date of examination, prescription, or treatment. That 6 year timetable doesn't start until AFTER the patient leaves an office, so offices have to maintain those models for a very long time period.

What this amendment does, is reduces the amount of time that an office has to maintain such models. This new 6 year time period starts at the completion of treatment, and the dentist would also have the ability to send the models home with the patient after 1 year, if they so choose.

If your question is more about why keep them at all, that would be for the purpose of review in competency cases.

Please let me know if you have any other questions.

PHIL McCOLLUM
ASSOCIATE DIRECTOR
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From: Tony Kalb [mailto:tkalb@kalbdds.com]
Sent: Friday, February 13, 2015 11:18 AM
To: McCollum, Phil [IDB]
Subject: Study models and Casts

I am at a loss as to why dentists should keep all study models and casts for 6 years after completion of treatment. What are the reasons behind this? I've been told in the not too distant future with digital impressions stone models and casts will be a thing of the past.

Best regards,
Tony J Kalb DDS.

McCollum, Phil [IDB]

From: BBB6IN96@aol.com
Sent: Wednesday, March 04, 2015 12:58 PM
To: McCollum, Phil [IDB]
Subject: Remove keeping patient models/cast

Dear Phil McCollum:

In regards to dentists keeping patient models/casts.
I have been practicing for over 30 years and it has been on only rare occasion an old model/cast has been mildly useful but not absolutely necessary to have it.
*
For the dentist to save models/casts is extremely burdensome and is an organizational challenge not to mention the amount of space required to keep them.
*
I believe and propose, the dentist should be allowed to give all the models/casts to the patient **immediately** upon completion of treatment, so that they have the responsibility of retaining them if they so desire.
*
Respectfully,
Robert L. Byrum, D.D.S., P.C.

Iowa Dental Board,

Regarding the proposed action to amend the code involving study models and casts, the proposed amendment is a good proposal because it limits the time period required to retain study models and casts to six years. It provides the alternative option to dispense the models to the patient. However, the requirement that the dentist must retain the models for one year after treatment before dispensing the models to the patient defeats the purpose of the proposal.

Patient treatment can be episodic. Patients may not return for any treatment in one year or many years. If the patient does not return for treatment in one year or any time thereafter, then the dentist must retain the models for six years. Model storage is space consuming and burdensome for a dental practice. Models are made for study models, denture repairs, whitening treatment, athletic mouth guards, bruxism guards, dentures, single crowns, bridges, and implant treatment. Multiple models may be made for one treatment. When treatment is completed, it is burdensome to store and retain all of the models for a six year period.

Upon treatment completion, it is reasonable to dispense the models to the patient at that time when the patient is available to receive them. The patient can be the responsible party to retain the models. If a dentist is concerned about model retention in special situations then the dentist can make the decision to retain them.

Please remove the requirement that the dentist must retain the models for one year after treatment and allow the models to be dispensed to the patient at the time of treatment completion.

Thank you,

Dr. Stephen Thies
Legislative chair
Iowa Academy of General Dentistry

McCollum, Phil [IDB]

From: ksedars@mchsi.com
Sent: Wednesday, March 11, 2015 11:49 AM
To: McCollum, Phil [IDB]
Subject: Proposed changes to Iowa Code

Hello Phil,

I am writing to voice my personal concern about the proposed changes to the Iowa Code regarding the requirements to retain patient models. As I'm sure you can imagine, the space required to retain all patient models for any period of time is quite significant and impractical. Additionally, the organization and "filing" of such models requires costly administrative time that could be much better spent elsewhere. In my career, I cannot think of an occasion in which a previously-made model was needed after the intended treatment was completed. This is especially true of the day-to-day working models that are returned from dental labs with our routine crown/bridge/denture type of work.

I am in strong support of eliminating the requirement to retain models in-office altogether, and would be in favor of allowing the models to be dispensed to patients once the treatment is finished. In situations where further use of a model is necessary, we would of course retain it until it is no longer needed. These changes seem to be logical, and in no way detrimental to a patient's quality of care. Thank you for your consideration of these changes.

Sincerely,
Kelly Sedars, DDS
Adel Family Dentistry, PC
(515)993-3701

McCollum, Phil [IDB]

From: rick.downs3430@gmail.com
Sent: Wednesday, March 11, 2015 11:40 AM
To: McCollum, Phil [IDB]
Subject: Model Keeping

I believe this requirement should be eliminated. Many models are destroyed in the fabrication of the prosthesis or orthodontic appliance made. Many impression materials are not permanent. Models for dentures and orthodontic appliances such as retainers and positions are destroyed and the models were made with impression materials that do not last. How would records be kept on such cases. It is extremely burdensome to then expect duplicate models be made just for the purpose of records.

In addition to that, digital models are often lost when software is updated or replaced. I know for example, that Cerec models and cases were all lost when a new software was put in.

I do not know of any dentist who keeps all their models. This is a near impossible task. Giving patients models that do survive is an ok idea but having a dentist save crown prep models, denture models and bleaching tray models, among others, is just not practical.

I and all dentist I know do save orthodontic models either in stone or digitally. A before and after model is saved. I do not believe interim models used to check progress should be required to be saved.

Some impressions are never poured up into models and can be saved apart from being poured up. They are taken with facebows and indexes. Are those to be saved too. It would seem to me that this would be just as important as a model, if you are using that logic. On complex cases, I so sometimes save these diagnostic materials. I think judgment is required on such cases. Surgical stents are also a good diagnostic aid. If you are going to require all records of any kind be saved, you are then going to be more consistent but I believe a requirement in this is just as burdensome and unnecessary as a blanket all or nothing requirement of keeping all models is.

Why would a crown prep model be saved. You cannot tell if the margin is correct because it was trimmed by the dentist to what he or she thought it should be. The core shape would tell you next to nothing about how close your are to pulp or if it is tapered too much because clinical conditions can change that drastically.

If I think of more I will write again.
Richard Downs
Sent from Windows Mail

McCollum, Phil [IDB]

From: Kristen Berning <kristenberning@gmail.com>
Sent: Wednesday, March 11, 2015 1:20 PM
To: McCollum, Phil [IDB]
Subject: Dental study model retention

To: Phil

Re: Dental study model storage

I am concerend with the requirement to store all restorative models for 6 years after patient treatment. Models are used for many numerous procedures on a frequent basis: study models, models for retainers, models for whitening trays, models for dentures or partials, models for crowns. Model storage is burdensome requiring substantial office space, organization, and employee time.

Also, our office uses many digital models, that have duplicate models made. These models should not be required to be stored, if there is a digital copy stored. We also take many digital photos which are stored on the computer and can represent a patient's record.

Dental treatment can be episodic. Dental patients may not return in one year. Some patients come only when something hurts. Some patients switch dentists and will not be here in 1 year. Some patients move to other cities. Thus the dentist must store the models until the patient returns or six years whichever occurs sooner. There will be thousands and thousands of dental models. Every crown that is done requires at least 2 models.

A reasonable alternative would be dispensation of the models to the patient at the time of treatment completion. The patient would have the responsibility of maintaining and storing the models. This would reduce model storage in the office and give the patient the responsibility for model storage. I support this idea of giving the models to the patients at the time of treatment.

Thank you,
Kristen Berning

--
Kristen Berning, D.D.S., F.A.G.D

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McCollum, Phil [IDB]

From: tedm102063@aol.com
Sent: Wednesday, March 11, 2015 1:36 PM
To: McCollum, Phil [IDB]
Subject: retention/dental models

I can see no clinical or medical/legal reason for the need to store dental models for other than complex cases.

It would be an undo expense and burden for dentists to have to somehow catalogue and store the huge numbers of cases done every year for simple routine dental care.

If the alternative is immediately giving the models to patients then I would support that.

Ted Murray DDS, MAGD, AAACD

McCollum, Phil [IDB]

From: Alexia Murray <alexiamurray@gmail.com>
Sent: Wednesday, March 11, 2015 4:07 PM
To: McCollum, Phil [IDB]
Subject: Dental Study Model Storage

Phil,

The requirement to store all casts or models for 6 years after patient treatment is concerning. Models are used for many numerous procedures on a frequent basis: study models, models for retainers, models for whitening trays, models for dentures or partials, models for crowns. Every crown that is done requires at least 2 models. Model storage is burdensome requiring substantial office space, organization, and employee time.

Our office uses many digital models, that have duplicate models made. These models should not be required to be stored if there is a digital copy stored. We also take many comprehensive digital photos which are stored on the computer and can represent a patient's record.

For some patients, dental treatment can be sporadic. Dental patients may not return, some patients come only when something hurts, some switch dentists, and some move to other cities. Thus the dentist must store the models until the patient returns or six years later, whichever occurs sooner. An average dental office with two thousand active patients would then have thousands and thousands of dental models.

Additionally, referring back to old models for treatment a patient may want to complete 1 to 6 years later are inaccurate and do not represent the current state of a patient's dentition. It would be below the standard of care to use these models, requiring new models to be made in the patient's best interest. As a consequence, some patients would need several models, **multiplying** the storage needed. With high quality digital photos and radiographs, patients and dentists are able review their dentition and supporting structures during exams and consults.

A reasonable alternative would be dispensation of the models to the patient at the time of treatment completion. The patient would have the responsibility of maintaining and storing the models. This would reduce model storage in the office and give the patient the responsibility for model storage. I support this idea of giving the models to the patients at the time of treatment.

Thank you,
Alexia Murray, DDS

McCollum, Phil [IDB]

From: jkurth@waukondental.com
Sent: Wednesday, March 25, 2015 9:33 AM
To: McCollum, Phil [IDB]
Subject: RE: response to models' proposal

Yes, that is correct. I felt there should not be a change. But after your clarification I can see the merits of the proposed change and do support that. Thank you Amber McCarville

"MAKE sure it is a great day!"
Judy Kurth
Serving the DRs, staff, and patients of
Northeast Iowa Dental, P.C., Waukon/Monona
Dental Associates of Decorah, P.C.,
Dental Associates of Prairie du Chien, P.C.
(563) 568-3983 (Office)

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From: McCollum, Phil [IDB] [mailto:Phil.Mccollum@iowa.gov]
Sent: Wednesday, March 25, 2015 9:17 AM
To: jkurth@waukondental.com
Subject: RE: response to models' proposal

Thank you for your response. There does seem to be some confusion related to these rules.

Just to clarify, the existing code requires dentists to keep study models for 6 years after the LAST date of examination, prescription, or treatment. That 6 year timetable does not start until AFTER the patient leaves an office, so offices currently have to maintain those models the entire time the patient is in your practice plus 6 years after they leave.

The new proposed rules, reduce the amount of time that an office has to maintain such models. This new proposed timeline would start at completion of treatment, and the dentist would also have the ability to send the models home with the patient after 1 year, if they so choose.

Just so I'm clear and register your comment the proper way, you are against these new rules and do not believe the amount of time models must be maintain should be reduced, but left in place as is, correct.

PHIL McCOLLUM
ASSOCIATE DIRECTOR
OPERATIONS | SYSTEMS ADMINISTRATION
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From: jkurth@waukondental.com [mailto:jkurth@waukondental.com]
Sent: Wednesday, March 25, 2015 8:37 AM
To: McCollum, Phil [IDB]
Subject: response to models' proposal

After reading the AGD information regarding the proposal on storing models, I am in favor of no change to current wording in the Iowa Dental Code. Amber McCarville, D.D.S.

"MAKE sure it is a great day!"
Judy Kurth
Serving the DRs, staff, and patients of
Northeast Iowa Dental, P.C., Waukon/Monona
Dental Associates of Decorah, P.C.,
Dental Associates of Prairie du Chien, P.C.
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McCollum, Phil [IDB]

From: jkurth@waukondental.com
Sent: Tuesday, March 24, 2015 2:58 PM
To: McCollum, Phil [IDB]
Subject: response to model retention proposal

We are a group practice in NE Iowa. After reading the information our Doctors have the following responses:

"Make no changes to the existing wording in regards to dental models. If this does not happen, then allow the distribution of models to the pt at the time of treatment completion"
Mark G. FoheyD.D.S.

"Avoid legislation on this issue and let dentists make the call regarding if a model needs to be kept or not. If this is not a choice, then allow dispensing of the models at the time of treatment completion." Jessica M. Wilke, D.D.S.

"I support the alternative of dispensing the models to the pt at the time of treatment completion" Linda S. Carstens, D.D.S. Steven L. Kurth, D.D.S.

"first choice is they must be kept for 6 yrs with the inclusion they may be distributed to pt after one year" Christi Larson, D.D.S.

"MAKE sure it is a great day!"
Judy Kurth
Serving the DRs, staff, and patients of
Northeast Iowa Dental, P.C., Waukon/Monona
Dental Associates of Decorah, P.C.,
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DENTAL BOARD [650]

Pursuant to the authority of Iowa Code section 147.76 and 272C.2, the Dental Board adopts an amendment to Chapter 27, "Standards of Practice and Principles of Professional Ethics," Iowa Administrative Code.

Notice of Intended Action was published in the Iowa Administrative Bulletin on March 4, 2015, as ARC# 1897C.

The amendment intends to reduce the retention schedule for study models and casts. Current rules require dentists to maintain study models and casts for a minimum of six years after the date of last examination, prescription, or treatment. If it involves a minor, then they shall be maintained for a minimum of either (a) one year after the patient reaches the age of majority (18), or (b) six years, whichever is longer. The amendment would require that study models and casts only be maintained for six years following the date that treatment is completed. As an alternative, dentists may provide such study models and casts to the patient for retention one year after completion of treatment.

A public hearing was held on March 25, 2015 at 2:00 p.m. at the office of the Iowa Dental Board. There were no attendees. There were seventeen written comments received. Eight comments asked that there be no retention schedule but supported the option to provide such study models and casts immediately upon completion of treatment to the patient; three supported providing such study models and casts immediately upon completion of treatment to the patient; two asked for no retention schedule at all; two supported the proposed changes; one asked for no change to current requirements, but would support option to provide such study models and casts immediately upon completion of treatment to the patient; and one supported change provided that such study models and casts could immediately be delivered to the patient.

This amendment was approved by the Board on April 23, 2015.

After analysis and review of this rule making, no impact on jobs has been found.

This amendment will become effective on XXXX, 2015.

This amendment is intended to implement Iowa Code section 153.33 and 153.34.

The following amendments are adopted.

Amend rule 650—27.11(153) as follows:

650—27.11 (153,272C) Record keeping. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Records shall be permanent, timely, accurate, legible, and easily understandable.

27.11(1) *Dental records.* Dentists shall maintain dental records for each patient. The records shall contain all of the following:

a. *Personal data.*

(1) Name, date of birth, address and, if a minor, name of parent or guardian.

(2) Name and telephone number of person to contact in case of emergency.

b. *Dental and medical history.* Dental records shall include information from the patient or the patient's parent or guardian regarding the patient's dental and medical history. The information shall include sufficient data to support the recommended treatment plan.

c. *Patient's reason for visit.* When a patient presents with a chief complaint, dental records shall include the patient's stated oral health care reasons for visiting the dentist.

d. *Clinical examination progress notes.* Dental records shall include chronological dates and descriptions of the following:

(1) Clinical examination findings, tests conducted, and a summary of all pertinent diagnoses;

(2) Plan of intended treatment and treatment sequence;

(3) Services rendered and any treatment complications;

(4) All radiographs, study models, and periodontal charting, if applicable;

(5) Name, quantity, and strength of all drugs dispensed, administered, or prescribed; and

(6) Name of dentist, dental hygienist, or any other auxiliary, who performs any treatment or service or who may have contact with a patient regarding the patient's dental health.

e. *Informed consent.* Dental records shall include, at a minimum, documentation of informed consent that includes discussion of procedure(s), treatment options, potential complications and known risks, and patient's consent to proceed with treatment.

27.11(2) *Retention of records.* A dentist shall maintain a patient's dental record for a minimum of six years after the date of last examination, prescription, or treatment. Records for minors shall be maintained for a minimum of either (a) one year after the patient reaches the age of majority (18), or (b) six years, whichever is longer. Study models and casts shall be maintained for six years following the date that treatment is completed. Alternatively, study models and casts may be provided to patients for retention one year after completion of treatment. Proper safeguards shall be maintained to ensure safety of records from destructive elements.

27.11(3) *Electronic record keeping.* The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, a dentist shall keep either a duplicate hard copy record or use an unalterable electronic record.

27.11(4) *Correction of records.* Notations shall be legible, written in ink, and contain no erasures or white-outs. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line and be initialed by a dental health care worker.

27.11(5) *Confidentiality and transfer of records.* Dentists shall preserve the confidentiality of patient records in a manner consistent with the protection of the welfare of the patient. Upon request of the patient or patient's legal guardian, the dentist shall furnish the dental records or copies or summaries of the records, including dental radiographs or copies of the radiographs that are of diagnostic quality, as will be beneficial for the future treatment of that patient. The dentist may charge a nominal fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees.

R. Bruce Cochrane, D.D.S., P.C.
Practice Limited to Periodontics

1611 1st Avenue North
Fort Dodge, Iowa 50501
515-576-8151

18 West 4th Street
Spencer, Iowa 51301
712-262-9395

318 South Maple
Carroll, Iowa 51401
712-792-6313

310 East Call St.
Algona, IA 50511
515-395-2340

RECEIVED
MAR 16 2015
IOWA DENTAL BOARD

March 10, 2015

Iowa Dental Board
400 SW 8th Street
Des Moines, Iowa 50309

Dear Board,

I am in receipt of Dr. Steve Rabedeaux's email with regards to his thoughts on expanded functions. I think the positions he is taking are well thought out and logical. I would like to voice my support for these concepts.

I appreciate your interest in this, thank you again.

Sincerely,

Bruce

R. Bruce Cochrane DDS
RBC/jmh

Cc; Steve Rabedeaux

www.doctorcochrane.com • rbrucecochrane@live.com

THE DENTAL PRACTICE, P.C. TDP

Steven G. Rabedeaux, DDS, MAGD

March 17, 2015

RECEIVED
MAR 19 2015
IOWA DENTAL BOARD

Iowa Dental Board
400 SW 8Th Street, Suite D
Des Moines, IA 50309

RE: EXPANDED FUCTION DENTAL ASSISTANT

Dear Iowa Dental Board,

I am most pleased with the proposed change in rules to allow expanded function training after 1 year for office trained assistants. That is very significant in rural areas where it is difficult to find trained assistants let alone those who have expanded function certification. Kudos!

Other thoughts about expanded function dental assisting as you consider a next level:

I question the importance of periodontal dressing training in level 1. I no longer use dressings for periodontal surgeries, as they are detrimental to healing. I am not aware of anyone who still does use them. This makes getting the clinical experiences to pass this area very challenging because the actual materials are not easily available and the usage is low or non-existent. Recommendation: Drop it.

The relevance is that the way the proposed rules read, all the areas in level 1 must be completed as a requirement to apply for level 2 training. The fabrication of provisional restorations, pulp testing, bite registration, final impressions, placing liners and adhesives and gingival isolation have transferable and relevant skills to the level 2 tasks. The other areas don't.

Further, monitoring of nitrous oxide is only meaningful in offices that have nitrous. That makes it nearly impossible for an assistant wishing to complete level 1 training in it's entirety to get the necessary clinical experiences needed for that task (let alone keep the skill current). Recommendation: Separate it.

A very useful task to consider would be the ability to adjust dentures with indicator pastes and indelible markers, provide soft tissue liners and replace them. With removable prosthetics, there is little or no chance for irreversible things to occur. This fits best under the level 1 group of expanded tasks. Consider an orthodontic office where a non-expanded function assistant is permitted to adjust retainers and active removable appliances on a daily basis. It is what they are trained to do. In some cases they fabricate

1919 1st Avenue E., Newton, IA. 50208 641-792-2780 / drrab@pcpartner.net www.thedentalpractice.net

them. And they should. They do it well. I noted this as a proposed group 2 task. That's excessive regulation.

I realize the board is looking to make this administratively simple. In the present form, it does not reflect current clinical practice. It will be difficult for many to complete the entire level 1 set. A practical solution would be to drop the periodontal pack entirely, move dry socket dressing to non expanded status, consider adding removable appliance/prosthetic adjustment and make nitrous oxide monitoring a separate certification just as radiography is now. That would create a meaningful set of skills as a pre-requisite for level 2 training.

I am disappointed that more dentists have not voiced their thoughts. I know you have worked hard to get this far with these changes and have done it without much input from us. I'm confident because of many conversations that this is a good reflection of what would be very helpful, well accepted and make sense.

We are at a time when we are ready to empower some really talented people (our dental assistants) to make an impact for improved delivery of dental care in Iowa.

I greatly appreciate your time and effort in this area.

Respectfully,

Steven G. Rabedeaux, DDS, MAGD

Braness, Christel [IDB]

From: McCollum, Phil [IDB]
Sent: Friday, April 10, 2015 12:13 PM
To: Braness, Christel [IDB]
Subject: FW: expanded functions

This is the only other one I have received.

PHIL McCOLLUM
ASSOCIATE DIRECTOR
OPERATIONS | SYSTEMS ADMINISTRATION
IOWA DENTAL BOARD
400 SW EIGHTH STREET, SUITE D | DES MOINES, IOWA 50309
OFFICE: 515-281-3739 | FAX: 515-281-7969
www.dentalboard.iowa.gov

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From: Iowa Dental Board [IDB]
Sent: Thursday, April 09, 2015 10:48 AM
To: McCollum, Phil [IDB]
Subject: FW: expanded functions

From: Dr. Robert Hurley [mailto:DrHurley@omnidentalcentre.com]
Sent: Wednesday, April 08, 2015 3:38 PM
To: Iowa Dental Board [IDB]
Subject: expanded functions

As a practicing dentist in Iowa for more than 30 plus years I very much appreciate the value of high functioning dental assistants.
When you can employ a talented and motivated auxiliary practicing dentistry becomes fun.

In review of current proposals with my friend Dr. Steve Rabedeaux I would give a few comments.

1. Remove the periodontal dressing requirement.
2. Separate the nitrous oxide monitoring from expanded functions. Treat it more like radiology is.
3. Allow denture polishing, adjustments, essex retainers and similar appliances to fall under level 1.

Thank you for your consideration,

Robert W. Hurley, DDS,MAGD

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Gerd W. Clabaugh, MPA
Director

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

April 10, 2015

Phil McCollum, Associate Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309 – 4687

RE: ARC 1940C -- Dental assistants—expanded function procedures, general and public health supervision, 20.2 to 20.16

Dear Mr. McCollum:

The Iowa Department of Public Health supports rules changes that will allow public health supervision for dental assistants. This addition will greatly benefit local public health agencies and their dental sealant programs.

We respectfully recommend changes to the proposed rules for public health supervision of a dental assistant as follows:

- The proposed rules indicate that a registered dental assistant must have 3 years of clinical practice experience prior to having a public health supervision agreement (650—20.2(153), within the new definition of public health supervision). We recommend changing this to 1 year, which is the same as the proposed requirement for a registered dental assistant with expanded functions.
- The proposed rules include some responsibilities for the written agreement that, although they are applicable to the services provided by a dental hygienist, we do not feel are applicable to those that will be provided by a dental assistant. We recommend deleting 20.16 (2) a.(2) "...Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of services;" and 20.16 (2) a.(3) "Specify a period of time in which an examination by a dentist must occur prior to providing further services;"
- We recommend adding to 20.16 (2) a." Specify the dentist and/or dental hygienist who will be assisted under public health supervision at each specified location."
- The proposed rules include some responsibilities that we feel will not be applicable to the services provided by a dental assistant, who will be assisting a dentist or dental hygienist providing specific services. We recommend deleting 20.16 (2) b.(3), "Provide to the patient, parent, or guardian a written plan for referral to a dentist;" "(4) Have each patient, parent, or guardian sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services;" and "(5) Specify a procedure for creating and maintaining dental records for the patients who are treated, including where these records are to be located."
- The proposed rules indicate that a copy of the agreement must be filed with the Iowa Dental Board and also indicates the agreement must be filed with the Iowa Department of Public Health. We recommend

this be clarified. Currently, public health supervision agreements for dental hygienists are on file with the Iowa Department of Public Health and not with the Iowa Dental Board.

- The proposed rules include an outdated name for the current bureau at the Iowa Department of Public Health which oversees oral health programs. We recommend changing the reference to the current bureau name, the Bureau of Oral and Health Delivery Systems.
- The proposed rules include requirements regarding annually providing the supervising dentist a report (20.16 (2) d). We recommend deleting this and adding to 20.16 (3): "The report must be filed with the Bureau of Oral and Health Delivery Systems of the Iowa Department of Public Health and with the supervising dentist..."
- The proposed rules include details regarding the reporting requirements each year which may not be applicable since the dental assistant will be assisting a dentist or dental hygienist who is providing specific services. We recommend, in addition to changing the name of the Iowa Department of Public Health bureau, and adding to share a report with the supervising dentist, adding to 20.16 (3): "...and shall include information related to the locations where services were provided and name(s) of the dentist(s) and/or dental hygienist(s) assisted so that..." and to delete "number of patients seen and services provided".

We are also concerned with the proposed wording defining the allowable public health sites as seen in 650 - 20.16 (1): "*Public health agencies defined.* For the purposes of this rule, public health agencies include programs operated by federal, state, or local public health departments."

In reality, public health activities in Iowa are not limited to specific "public health agencies" but through a variety of contractual agreements and memorandums of agreement. In such settings, of which many are non-profit local agencies not directly operated by public health departments, public health activities are taking place. One example is Community Action Agencies. These agencies, among others, field public health staff including dental hygienists working under public health supervision and would equally benefit from dental assisting resources.

We would recommend that the language as proposed be modified to reflect actual public health services as delivered in Iowa to include the following: *Public health agencies defined*. For the purposes of this rule, public health agencies include programs operated or *contractually affiliated* with federal, state, or local public health departments.

We feel this is a minor change, but more accurately reflects the practice of public health and will greatly benefit our programs and the families they serve in Iowa.

Thank you for your consideration.

Sincerely,

Bob Russell DDS, MPH

Bob Russell, DDS, MPH
Public Health Dental Director
Chief, Bureau of Oral and Health Delivery Systems

My name is Elizabeth Addison, I am a registered dental hygienist both living and working in Iowa. I am writing in response to the Iowa Dental Boards Notice of Intended Action to amend Chapter 20, “Dental Assistants,” Iowa Administrative Code. Specifically I am writing in support of permitting registered dental assistants to work under public health supervision in certain settings.

I currently practice under a public health supervision agreement and provide preventative dental services at WIC offices and schools. Working with children there would be so many positive impacts to having a dental assistant. Being able to have a dental assistant would allow me to be more time efficient thus making my services more cost effective to provide to the underserved community that so desperately needs them. I could spend my time more effectively if I had someone who could help with the tasks of tear down and set up, which includes disinfection. Maintaining a dry field while placing a dental sealant can often be a challenge without having an extra hand for retraction or suction. Being able to have a dental assistant sit chairside to help with “show tell do” would be so helpful and also give the child another person to potential connect with. All in all I feel this change will allow those of us already working under public health supervision agreements to provide our services more effectively and at times even more safely.

Thank-You

Elizabeth Addison RDH
Family Inc.
3501 Harry Langdon Blvd Suite 150
Council Bluffs, IA 51503
712-256-9566 EXT 220

R. Bruce Cochrane, D.D.S., P.C.
Practice Limited to Periodontics

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Carroll, Iowa 51401
712-792-6313

310 East Call St.
Algona, IA 50511
515-395-2340

RECEIVED
MAR 16 2015
IOWA DENTAL BOARD

March 10, 2015

Iowa Dental Board
400 SW 8th Street
Des Moines, Iowa 50309

Dear Board,

I am in receipt of Dr. Steve Rabedeaux's email with regards to his thoughts on expanded functions. I think the positions he is taking are well thought out and logical. I would like to voice my support for these concepts.

I appreciate your interest in this, thank you again.

Sincerely,

Bruce

R. Bruce Cochrane DDS
RBC/jmh

Cc; Steve Rabedeaux

www.doctorcochrane.com • rbrucecochrane@live.com

Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

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Executive Director
Cynthia C. Durley, M.Ed., MBA

April 20, 2015

Iowa Dental Board
Attention: Phil McCollum, Associate Director
400 S.W. Eighth Street, Suite D
Des Moines, IA 50309

Dear Distinguished Members of the Iowa Dental Board:

Please accept this letter from the Dental Assisting National Board, Inc. (DANB) in response to the request for written comments in connection with the Notice of Intended Action that will be considered at a public hearing on April 21, 2015, relating to regulations governing the practice of dental assistants and expanded function dental assistants.

DANB is the American Dental Association-recognized national certification board for dental assistants, administering the nationally recognized Certified Dental Assistant™ (CDA®) certification program. Under current Iowa regulations, current certification as a DANB CDA certificant allows a registered dental assistant in Iowa to qualify for expanded functions training; in addition, DANB's Radiation Health and Safety (RHS®) exam, a component of the CDA certification exam, meets the examination requirement for the Iowa dental radiography qualification. DANB's exams meet nationally accepted test development standards, and DANB's CDA and Certified Orthodontic Assistant (COA®) certification programs are accredited by the National Commission on Certifying Agencies (NCCA). DANB certifications and exams are currently recognized or required to meet dental assisting qualifications by 38 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs.

DANB's comments on the current proposed regulations will focus on two areas: (1) potential ways that DANB can assist the Iowa Dental Board in administering an entrance examination for those wishing to receive education as Level 2 expanded function providers, and (2) existing DANB exams covering expanded functions included in the proposal for Level 1 and Level 2 providers.

(1) DANB Exams: Entrance Examination Options

Section 20.4(4)c of the proposed new rules calls for registered dental assistants who are Certified Level 1 providers to successfully pass a board-approved entrance examination with a score of at least 75 percent before beginning training as a Level 2 provider.

DANB currently offers a number of examinations that might serve as the entrance examination for Level 2 provider education. DANB recommends that the Board consider two options:

(A) DANB's AMP exam
DANB's Anatomy, Morphology and Physiology (AMP) exam covers foundational knowledge in the areas of anatomy of the head, neck and oral cavity, tooth anatomy and morphology, tooth numbering systems, occlusion, and oral pathology. The AMP exam is a component of DANB's Certified Restorative Functions Dental Assistant (CRFDA®) certification (available since 2013) and DANB's National Entry Level Dental Assistant (NELDA™) certification, a new DANB certification program. The AMP exam provides a means for dental boards to measure the foundational knowledge that is essential for successful performance in a restorative functions training program.

444 N. Michigan Ave., Suite 900, Chicago, IL 60611-3985 • 1-800-367-3262 • Fax: 312-642-8507 • danbmail@danb.org • www.danb.org

DANB has not established any eligibility requirements for the AMP exam, though states that choose to recognize this exam may establish their own eligibility requirements. All DANB exams, including the AMP exam, are available on computer six days a week at more than 250 computerized testing centers nationwide, including three in Iowa. An exam blueprint for the 105-question DANB AMP exam can be found on page 2 of Attachment 1.

(B) DANB's State Basic Skills Exam
DANB currently administers a state basic dental assisting skills exam for the State of Oregon and can easily administer the same exam to candidates in Iowa, if the Iowa Dental Board chooses to recognize this exam as an entrance exam for Level 2 expanded function providers. We are providing the following brief summary and blueprint for the basic skills exam DANB delivers for Oregon:

Number of questions: 100-125
Time allotted: 90 minutes
Content:

ORB Content Area	***Percent on exam***
1. Infection control and microbiology	20-25%
2. Collection of clinical data	10-15%
3. Management of emergencies	15-20%
4. Occupational safety	10-15%
5. Legal issues	10-15%
6. Anatomy	10-15%
7. General procedures *(placing/removing rubber dams and taking impressions)*	5-10%

This exam is pass/fail, with the pass point set by the Oregon Board of Dentistry. I have also attached this information in a separate one-page document for ease of reference (see Attachment 2).

DANB administers a wide range of dental assisting competency examinations and may also be able to offer additional options to the Iowa Dental Board if options (A) and (B) described above are not in line with Iowa's needs. DANB encourages the Board to contact DANB staff to discuss further the Board's intentions for this entrance examination.

Important Note Regarding Establishing a Pass Point:
It is unclear from the proposal whether the Iowa Dental Board contemplates that it will accept only one entrance exam that all those desiring to receive training in Level 2 functions must pass, or whether the Board will accept multiple entrance exams. In either scenario, DANB would like to note that national (National Commission for Certifying Agencies [NCCA]) and international (International Organization for Standardization [ISO 17024]) psychometric (testing and measurement) standards strongly advise against establishing a specific pass point such as 75% for high-stakes exams, such as those required or recognized in professional credentialing regulations.

If one form of an exam administered by one agency or educational institution will be recognized in the regulations, and the exam form and its test questions never change, then perhaps a passing standard of 75% might be justified. It is much more likely that even if one exam is recognized/required to meet state regulations, the exam is updated periodically because of evolution of the concepts to be tested. When the same percentage correct pass point is required to be applied to all exams and forms of an exam, this penalizes those who are taking a form of an exam that contains more difficult questions (which can be determined objectively via statistical methods). It is even less desirable from a public safety standpoint, to pass another group of exam candidates who are given a form of an exam that contains easier questions and a ubiquitous 75% correct is required to pass. In cases such as these, some who would pass the easier exam at 75% would fail the harder exam at the same percentage correct. This is unfair to exam candidates and does not protect the public through the application of a stable minimum passing standard.

Likewise, if multiple exams administered by various schools or testing agencies will be recognized, then establishing a global pass point of 75% without considering the unique characteristics of each exam may have the effect of unfairly penalizing some candidates who take a more difficult exam and/or may allow candidates who have not achieved the desired level of competency to earn certification as a Level 2 provider and perform intraoral functions on patients, potentially compromising public protection.

Best practices for development of competency examinations dictate that the pass point be set using one of several nationally accepted standard setting methodologies. If this pass point were to also be informed by statistical data about item and exam performance, this would better ensure that candidates are being fairly evaluated and the public protected.

If the Board chooses to consider accepting one or both of the options DANB has described above as entrance exams for Level 2 provider education/training, DANB will provide additional information about how the pass point for each of these exams is set. DANB recommends that the Board require such information from any other exam providers that may request acceptance of an exam by the Iowa Dental Board. In the interim, to give the Board as much flexibility as necessary to recognize multiple exams using different scoring systems or rubrics, DANB recommends modifying section 20.4(4)c as follows:

Certified Level 2 provider. A registered dental assistant must become a certified Level 1 provider and successfully pass a board-approved entrance examination with ~~a score of at least 75 percent~~ a passing score approved by the board before beginning training as a certified Level 2 provider.

(2) DANB Exams: Expanded Functions

DANB has contacted the Iowa Dental Board on previous occasions to make the Board aware of expanded function exams that DANB offers that address expanded functions under consideration in Iowa. Because the current proposal is significantly different from prior proposals, DANB would like to present information to the Board about these exams once again.

In March 2013, DANB launched a Certified Restorative Functions Dental Assistant (CRFDA) certification program, consisting of six component exams:

- Anatomy, Morphology and Physiology (AMP)
- Impressions (IM)
- Isolation (IS)
- Sealants (SE)
- Temporaries (TMP)
- Restorative Functions (RF)

The following chart outlines the functions under consideration in Iowa, and the DANB CRFDA component exam that addresses each function:

Iowa Expanded Function	**DANB CRFDA Component Exam Addressing Function**
Level 1 procedures	
1. Taking occlusal registrations	IM
2. Placement and removal of gingival retraction	IS
3. Fabrication and removal of provisional restorations	TMP

Iowa Expanded Function	**DANB CRFDA Component Exam Addressing Function**
4. Applying cavity liners and bases, desensitizing agents, and bonding systems	RF
5. Placement and removal of dry socket medication	*See note**
6. Placement of periodontal dressings	*See note**
7. Testing pulp vitality	*See note**
8. Monitoring of nitrous oxide inhalation analgesia	*See note**
9. Taking final impressions	IM
10. Removal of adhesives (hand instrumentation only)	
11. Preliminary charting of existing dental restorations and teeth	AMP
Level 2 procedures	
1. Placement and shaping of amalgam following preparation of a tooth by a dentist	RF
2. Placement and shaping of composite following preparation of a tooth by a dentist	RF
3. Forming and placement of stainless steel crowns	RF
4. Taking records for the fabrication of dentures and partial dentures	*See note**
5. Tissue conditioning (soft reline only, where denture is not relieved or modified)	

**Note: DANB's General Chairside Assisting (GC) exam, a component of DANB's CDA certification exam, addresses this topic. Iowa expanded function candidates who have qualified for Level 1 training by earning DANB's CDA certification will already have been tested on knowledge related to this function*.

A full set of exam blueprints for the CRFDA component exams can be found in Attachment 1. In addition, I am attaching an overview of DANB's CRFDA certification program as Attachment 3.

DANB's AMP, IS, IM, TMP, and SE exams do not have any eligibility requirements, but candidates must meet eligibility requirements established by DANB to take the RF exam and earn CRFDA certification. If DANB's RF eligibility requirements are not aligned with Iowa's requirements to earn Level 1 or Level 2 certification, DANB would consider offering a state-specific equivalent of the RF exam with Iowa-established eligibility requirements to accommodate those candidates who do not meet the DANB RF eligibility requirements.

If the Iowa Board wishes to require a competency assessment exam for any of the functions covered on DANB's CRFDA component exams, DANB encourages the Board to contact DANB to discuss this further.

The Board may also wish to consider using DANB's CRFDA component exams to qualify candidates who move to Iowa from other states and who have performed expanded functions in states that have educational requirements differing from Iowa's requirements. Standardized testing such as that provided by DANB's certification exams and component exams can serve as an objective means of verifying the competency of expanded function dental assistants who have received expanded functions training and experience outside of Iowa.

Summary and Next Steps
DANB's mission is to promote the public good by providing credentialing services to the dental community and, in fulfilling that mission, DANB works closely with many state boards of dentistry to implement competency assessment programs for dental assistants. These programs may be based on recognition of DANB national exams, when appropriate, or on state-specific examination solutions, when necessary. I am providing an overview of services that DANB provides to state boards of dentistry as Attachment 4 for your reference.

DANB believes that it can be of service to the Iowa Dental Board in providing the Level 2 entrance exam contemplated by the current proposal, and in providing competency assessment instruments for dental assistants who perform expanded functions. DANB encourages the Iowa Dental Board to contact DANB staff to discuss further the ways in which DANB can assist in implementing the new dental assisting program proposed in Iowa.

To make arrangements to discuss any topic addressed in this letter with the appropriate DANB staff members, please contact me at klandsberg@danb.org or 1-800-367-3262, ext. 431.

Best regards,

Katherine Landsberg
Assistant Director, Government Relations

CC: Cynthia C. Durley, M.Ed, MBA, DANB Executive Director
Johnna Gueorguieva, Ph.D., DANB Senior Director, Credentialing and Client Services

Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

Exam Blueprints and Suggested References for Exam Preparation

for

Certified Restorative Functions Dental Assistant (CRFDA) component exams

Anatomy, Morphology and Physiology (AMP) Page 2
Impressions (IM) Page 4
Temporaries (TMP) Page 6
Isolation (IS) Page 8
Sealants (SE) Page 10
Restorative Functions (RF) Page 12

Effective 01/01/2014

Note that each state's dental board implements regulations and establishes rules for delegating legally allowable duties to dental assistants. Passing one or more of the CRFDA component exams or earning CRFDA certification only conveys authority to perform these duties in those states that recognize these exams or this certification as meeting state dental assisting requirements. This information is at www.danb.org/Meet-State-Requirements.aspx.

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Anatomy, Morphology and Physiology (AMP) Exam Blueprint

(15%) I. HEAD AND NECK

A. Circulatory system
B. Lymphatic system
C. Muscular system
D. Nervous system
E. Skeletal system
F. Salivary glands
G. Sinuses
H. Temporomandibular joints

(25%) II. ORAL CAVITY

A. Alveolar process
B. Frenum
C. Hard and soft palates
D. Landmarks (e.g., radiographic, bony, soft tissue)
E. Oral mucosa
F. Tongue

(20%) III. TOOTH ANATOMY, MORPHOLOGY, AND RELATED CHARACTERISTICS

A. Primary dentition
B. Permanent dentition
C. Anomalies (e.g., fusions, ankylosis, supernumerary)

(15%) IV. TOOTH NUMBERING SYSTEMS

A. Universal
   1. Primary
   2. Permanent
B. Palmer
   1. Primary
   2. Permanent

(15%) V. OCCLUSION

A. Purpose
B. Classification
C. Management
D. Pathology

(10%) VI. ORAL PATHOLOGY

A. Soft tissue
B. Hard tissue

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Dental Assisting National Board, Inc.

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Suggested References for Exam Preparation

for

Anatomy, Morphology and Physiology (AMP)

A component of the DANB Certified Preventive Functions Dental Assistant (CRFDA) Exam

Effective 01/01/2014

1. *Essentials of Dental Assisting*, 4th edition. Robinson, D. and Bird, D.
2. *Dental Assisting: A Comprehensive Approach*, 3rd edition. Phinney, D. and Halstead, J.
3. *Modern Dental Assisting*, 10th edition. Bird, D. and Robinson, D.
4. *Primary Preventive Dentistry*, 7th edition. Harris, N. O. and Garcia-Godoy, F.

Note that each state's dental board implements regulations and establishes rules for delegating legally allowable duties to dental assistants. Passing one or more of the CRFDA component exams or earning CRFDA certification only conveys authority to perform these duties in those states that recognize these exams or this certification as meeting state dental assisting requirements. This information is at www.danb.org/Meet-State-Requirements.aspx.

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Impressions (IM) Exam Blueprint

(15%) **I. PURPOSE OF IMPRESSIONS**

A. Preliminary
B. Final (including CAD/CAM)
C. Fixed and removable appliances/prosthetics

(55%) **II. TAKING IMPRESSIONS**

A. Trays
   1. Stock
   2. Custom
   3. Placement and removal
   4. Selection
B. Materials
   1. Irreversible hydrocolloids (i.e., alginate)
      a. Purpose/uses
      b. Characteristics
      c. Preparing/mixing
   2. Elastomerics
      a. Purpose/uses
      b. Types
         i. Polyether
         ii. Polyvinyl siloxane
         iii. Polysulfide
         iv. Silicone
      c. Characteristics
      d. Preparing/mixing
C. Special considerations in taking impressions
   1. Anatomy
   2. Pathology
D. Retraction methods

(10%) **III. PATIENT MANAGEMENT TECHNIQUES**

(10%) **IV. BITE/OCCLUSAL REGISTRATIONS**

(10%) **V. INFECTION CONTROL/OSHA PROTOCOL**

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Suggested References for Exam Preparation

for

Impressions (IM)

A component of the DANB Certified Preventive Functions Dental Assistant (CRFDA) Exam

Effective 01/01/2014

1. *Essentials of Dental Assisting*, 4th edition. Robinson, D. and Bird, D.
2. *Dental Assisting: A Comprehensive Approach*, 3rd edition. Phinney, D. and Halstead, J.
3. *Dental Materials: Clinical Applications for Dental Assistants and Dental Hygienists*, 2nd edition. Hatrick, C., Eakle, W. and Bird, W.
4. *Dental Materials: Properties and Manipulation*, 10th edition. Powers, J.M. and Wataha, J.C.
5. *Infection Control and Management of Hazardous Materials for the Dental Team*, 4th edition. Miller, C. and Palenik, C.
6. *Modern Dental Assisting*, 10th edition. Bird, D. and Robinson, D.
7. *Pearson's Comprehensive Dental Assisting*. Tyler, L.

Note that each state's dental board implements regulations and establishes rules for delegating legally allowable duties to dental assistants. Passing one or more of the CRFDA component exams or earning CRFDA certification only conveys authority to perform these duties in those states that recognize these exams or this certification as meeting state dental assisting requirements. This information is at www.danb.org/Meet-State-Requirements.aspx.

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Temporaries (TMP) Exam Blueprint

(65%) I. TEMPORARY/PROVISIONAL RESTORATIONS

- A. Purpose
- B. Materials
  1. Acrylic
  2. Composite
  3. Metal (e.g., aluminum, stainless steel)
  4. Intracoronal cement (e.g., zinc oxide-eugenol, glass ionomer)
- C. Types of restorations
  1. Direct
     - a. Onlay
     - b. Inlay
     - c. Sedative/endodontic
  2. Indirect
     - a. Crown
       - i. Custom
       - ii. Prefabricated (e.g., stainless steel, polycarbonate, aluminum)
     - b. Bridge
     - c. Veneers
- D. Techniques and considerations
  1. Fabrication
  2. Placement
  3. Removal
- E. Homecare instructions/patient education

(20%) II. TEMPORARY CEMENT

- A. Selection
- B. Removal/clean-up

(15%) III. INFECTION CONTROL/OSHA PROTOCOL

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Suggested References for Exam Preparation

for

Temporaries (TMP)

A component of the DANB Certified Preventive Functions Dental Assistant (CRFDA) Exam

Effective 01/01/2014

1. *Essentials of Dental Assisting*, 4th edition. Robinson, D. and Bird, D.
2. *Dental Assisting: A Comprehensive Approach*, 3rd edition. Phinney, D. and Halstead, J.
3. *Dental Materials: Clinical Applications for Dental Assistants and Dental Hygienists*, 2nd edition. Hatrick, C., Eakle, W. and Bird, W.
4. *Dental Materials: Properties and Manipulation*, 10th edition. Powers, J.M. and Wataha, J.C.
5. *Infection Control and Management of Hazardous Materials for the Dental Team*, 4th edition. Miller, C. and Palenik, C.
6. *Modern Dental Assisting*, 10th edition. Bird, D. and Robinson, D.

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Isolation (IS) Exam Blueprint

(20%) I. PURPOSE OF ISOLATION

A. Throat protection
B. Dental field isolation
   1. Vision
   2. Moisture control

(30%) II. TYPES OF ATTRIBUTES/USES OF VARIOUS ISOLATION SYSTEMS/ARMAMENTARIA

A. Matrices
   1. Sectional
   2. Retainer
B. Wedges
C. Dental dams and clamps
D. Retraction material
E. Additional methods (e.g., cotton/gauze, cheek protectors, suction devices)

(30%) III. PLACEMENT AND REMOVAL PROCEDURES

(10%) IV. SPECIAL HEALTH CONSIDERATIONS

(10%) V. INFECTION CONTROL/OSHA PROTOCOL

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Suggested References for Exam Preparation

for

Isolation (IS)

A component of the DANB Certified Preventive Functions Dental Assistant (CRFDA) Exam

Effective 01/01/2014

1. *Essentials of Dental Assisting*, 4th edition. Robinson, D. and Bird, D.
2. *Dental Assisting: A Comprehensive Approach*, 3rd edition. Phinney, D. and Halstead, J.
3. *Dental Materials: Clinical Applications for Dental Assistants and Dental Hygienists*, 2nd edition. Hatrick, C., Eakle, W. and Bird, W.
4. *Infection Control and Management of Hazardous Materials for the Dental Team*, 4th edition. Miller, C. and Palenik, C.
5. *Modern Dental Assisting*, 10th edition. Bird, D. and Robinson, D.
6. *Pearson's Comprehensive Dental Assisting*. Tyler, L.

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Sealants (SE) Exam Blueprint

(10%) **I. PURPOSE OF SEALANTS**
- A. Bacteria collection in pit and fissures
- B. Dental caries
- C. Patient education

(40%) **II. INDICATIONS AND CONTRAINDICATIONS FOR SEALANT APPLICATION**

(10%) **III. ACID ETCHING**

(40%) **IV. SEALANTS**
- A. Classification
  1. Methods of curing
  2. Filled or unfilled
  3. Color
- B. Application
  1. Preparation of tooth
  2. Armamentarium
  3. Post-operative care
- C. Infection control/OSHA protocol

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Suggested References for Exam Preparation

for

Sealants (SE)

A component of the DANB Certified Preventive Functions Dental Assistant (CPFDA) Exam

Effective 01/01/2014

1. *Clinical Practice of the Dental Hygienist*, 10th and 11th editions. Wilkins, E. M.
2. *Dental Assisting: A Comprehensive Approach*, 3rd and 4th editions. Phinney D., Halstead J.
3. Dental Materials: Clinical Applications for Dental Assistants and Dental Hygienists, 2nd edition. Hatrick, C., Eakle, W. and Bird, W.
4. *Essentials of Dental Assisting*, 4th and 5th editions. Robinson, D. and Bird, D.
5. *Essentials of Dental Hygiene: Clinical Skills*. Cooper, M.D. and Wiechmann L.
6. *Modern Dental Assisting*, 9th and 10th editions. Bird D., Robinson D.

Note that each state's dental board implements regulations and establishes rules for delegating legally allowable duties to dental assistants. Passing one or more of the CRFDA component exams or earning CRFDA certification only conveys authority to perform these duties in those states that recognize these exams or this certification as meeting state dental assisting requirements. This information is at www.danb.org/Meet-State-Requirements.aspx.

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Restorative Functions (RF) Exam Blueprint

(7%) I. CAVITY LINERS AND BASES
- A. Purpose
- B. Materials
- C. Application

(7%) II. CAVITY CLASSIFICATIONS

(20%) III. AMALGAM RESTORATIONS
- A. Place, contour, finish, adjust and polish
- B. Materials/physical properties (e.g., mercury)

(30%) IV. COMPOSITE, GLASS IONOMER AND COMPOMER RESTORATIONS
- A. Etch and bond
- B. Place, contour, cure, finish, adjust and polish
- C. Materials
  1. Classifications
  2. Physical properties
     - a. Shrinkage
     - b. Wear resistance
     - c. Polishability
  3. Composition
  4. Shade selection

(12%) V. STAINLESS STEEL CROWNS
- A. Size, fit and place (i.e., cement)
- B. Primary dentition
- C. Permanent dentition

(15%) VI. PROCEDURAL CONSIDERATIONS
- A. Moisture control
- B. Advantages/disadvantages
- C. Indications/contraindications
- D. Homecare instructions/patient education

(9%) VII. INFECTION CONTROL/OSHA PROTOCOL

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Suggested References for Exam Preparation

for

Restorative Functions (RF)

A component of the DANB Certified Preventive Functions Dental Assistant (CRFDA) Exam

Effective 01/01/2014

1. *Essentials of Dental Assisting*, 4th edition. Robinson, D. and Bird, D.
2. *Dental Assisting: A Comprehensive Approach*, 3rd edition. Phinney, D. and Halstead, J.
3. *Dental Materials: Clinical Applications for Dental Assistants and Dental Hygienists*, 2nd edition. Hatrick, C., Eakle, W. and Bird, W.
4. *Dental Materials: Properties and Manipulation*, 10th edition. Powers, J.M. and Wataha, J.C.
5. *Infection Control and Management of Hazardous Materials for the Dental Team*, 4th edition. Miller, C. and Palenik, C.
6. *Modern Dental Assisting*, 10th edition. Bird, D. and Robinson, D.

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Basic Dental Assistant Skills Exam Delivered by DANB for Oregon
Summary Information

Number of questions: 100-125

Time allotted: 90 minutes

Exam fee: $200 *(will increase to $250 after 1/1/16)*

Content:

Content Area	% on exam
1. Infection control and microbiology	20-25
2. Collection of clinical data	10-15
3. Management of emergencies	15-20
4. Occupational safety	10-15
5. Legal issues	10-15
6. Anatomy	10-15
7. General procedures *(placing/removing rubber dams and taking impressions)*	5-10

Scoring: This exam is pass/fail, with the pass point set by the Oregon Board of Dentistry

The exam is updated approximately every five years.

February 2015

Dental Assisting National Board, Inc.

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CRFDA®

Certified Restorative Functions Dental Assistant Certification Program Overview

DANB's Certified Restorative Functions Dental Assistant (CRFDA) component exams are an objective measure of knowledge-based competency in the critical restorative functions that qualified dental assistants regularly perform in states that allow such duties to be delegated.

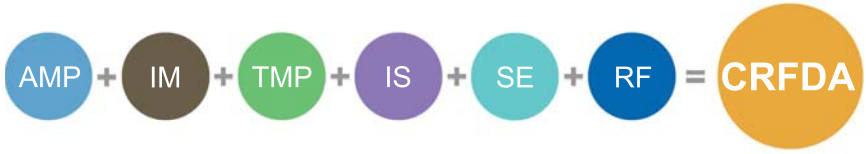
Component Exams

CRFDA certification consists of the following component exams:

- Anatomy, Morphology and Physiology (AMP) exam — 105 questions
- Impressions (IM) exam — 80 multiple-choice questions
- Temporaries (TMP) exam — 80 multiple-choice questions
- Sealants (SE) exam — 50 multiple-choice questions
- Isolation (IS) exam — 60 multiple-choice questions
- Restorative Functions (RF) exam — 105 multiple-choice questions

Candidates may take each component exam separately or in the following groupings. A candidate must pass all six component exams within a three-year period to earn DANB's CRFDA certification.

- Group 1 — Impressions (IM); Temporaries (TMP)
- Group 2 — Isolation (IS); Sealants (SE); Restorative Functions (RF)



Eligibility Requirements

There are no eligibility requirements to take five of the six components of the CRFDA certification program. However, a candidate must meet one of three eligibility pathways to quality to take the RF exam. All pathways require candidates to hold current DANB-accepted, hands-on CPR, BLS or ACLS certification. The eligibility pathways are as follows:

Pathway I	Current or former Certified Dental Assistant (CDA) certificants whose certification lapsed no more than 2 years ago
Pathway II	Commission on Dental Accreditation (CODA)-accredited dental assisting or dental hygiene program graduate
Pathway III	Successfully complete an Expanded Functions Dental Assisting or restorative course/program offered by an institution with a CODA-accredited dental assisting, dental hygiene or dental school program; Minimum of 3,500 hours work experience as a dental assistant accrued during the previous two to four years

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Exam Administration

DANB's CRFDA component exams are administered six days a week at more than 250 secure, proctored computerized testing centers nationwide.

Renewal

DANB CRFDA certification is valid for one year and must be renewed annually. To renew certification, certificants must:

- Annually complete 12 credits of continuing dental education meeting DANB requirements
- Maintain DANB-accepted, hands-on CPR, BLS or ACLS certification
- Submit the annual renewal fee (currently $60)

Former CRFDA certificants who do not renew their certification are no longer authorized to represent that they hold DANB's CRFDA certification and may not use the certification mark "CRFDA" following their names.

Background

Recognizing that many states are expanding the duties that may be delegated to qualified dental assistants in the areas of preventive and restorative functions, in February 2011, DANB's Board of Directors approved the development of the Certified Restorative Functions Dental Assistant (CRFDA) certification. DANB staff compiled and analyzed information about state requirements for delegating restorative functions to dental assistants and then used this information to propose functions to be tested on the CRFDA exam, the grouping of functions within individual component exams, and CRFDA certification program eligibility requirements.

Program Development and Launch

DANB held webinars and forums with representatives of its communities of interest in fall 2011. Proposals were developed and provided to DANB's Expanded Functions Dental Assistant (EFDA) Exam Committee, which made recommendations to DANB's Examination Programs Committee. DANB's Examination Programs Committee then made CRFDA program recommendations to DANB's Board of Directors, which approved the CRFDA program at the Board's February 2012 meeting.

The CRFDA component exams were pretested from August 1, 2012, through November 30, 2012. DANB's Board reviewed the DANB Examination Programs Committee's CRFDA pretest data and approved the committee's recommended passing standards. CRFDA component exam results, certificates and certifications, if earned, were mailed to pretest candidates at the end of January 2013. DANB officially launched the CRFDA certification program in April 2013, with the publication of the CRFDA exam application packet on its website. Administration of the CRFDA component exams began May 1, 2013.

About DANB

DANB is recognized by the American Dental Association as the national certification board for dental assistants. DANB's mission is to promote the public good by providing credentialing services to the dental community. For those dental assistants who meet the eligibility and exam requirements, DANB certification may be earned in the areas of Certified Dental Assistant™ (CDA®), Certified Orthodontic Assistant (COA®), Certified Preventive Functions Dental Assistant (CPFDA®) and Certified Restorative Functions Dental Assistant (CRFDA®). DANB will introduce a new entry-level certification, National Entry Level Dental Assistant (NELDA™), in early 2015. In addition to these national certifications, DANB offers certificates of knowledge-based competency in Radiation Health and Safety (RHS®); Infection Control (ICE®); Coronal Polish (CP); Sealants (SE); Topical Anesthetic (TA); Topical Fluoride (TF); Anatomy, Morphology and Physiology (AMP); Impressions (IM); Temporaries (TMP); and Isolation (IS).

DANB's CDA and COA certification programs are accredited by the National Commission for Certifying Agencies. Currently, there are more than 36,000 DANB certificants nationwide, and DANB certifications and certificates of knowledge-based competency are recognized or required in 38 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs. Passing DANB's exams demonstrates a dental assistant's competency in areas that are important to the health and safety of oral healthcare workers and patients alike.

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Dental Assisting National Board, Inc.
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DANB®
Overview of Services

About DANB
Mark of Dental Assisting Excellence™

Established in 1948, DANB is recognized by the American Dental Association (ADA) as the national certification board for dental assistants. DANB's mission is to promote the public good by providing credentialing services to the dental community. More than 36,000 dental assistants are currently DANB certified nationwide. In addition, nearly 190,000 dental assistants hold one or more of DANB's certificates of knowledge-based competency (marked with an asterisk* below). DANB, a nonprofit organization, is a member of the Institute for Credentialing Excellence and has earned and maintains accreditation for its eligible certification programs from the National Commission for Certifying Agencies (NCCA), which recognizes professional certification programs that meet rigorous NCCA standards.

DANB certifications and exams are currently recognized or required by 38 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs.

DANB Exams and Certifications
DANB offers five national certifications:

National Entry Level Dental Assistant (NELDA™)
Component exams:
Anatomy, Morphology and Physiology (AMP)*
Radiation Health and Safety (RHS®)*
Infection Control (ICE®)*

Certified Dental Assistant™ (CDA®)
Component exams:
General Chairside Assisting (GC)
Radiation Health and Safety (RHS®)*
Infection Control (ICE®)*

Certified Orthodontic Assistant (COA®)
Component exams:
Orthodontic Assisting (OA)
Infection Control (ICE®)*

Certified Preventive Functions Dental Assistant (CPFDA®)
Component exams:
Coronal Polish (CP)*
Sealants (SE)*
Topical Anesthetic (TA)*
Topical Fluoride (TF)*

Certified Restorative Functions Dental Assistant (CRFDA®)
Component exams:
Anatomy, Morphology and Physiology (AMP)*
Isolation (IS)*
Temporaries (TMP)*
Impressions (IM)*
Sealants (SE)*
Restorative Functions (RF)

Models for Using DANB Exams in Regulation of Dental Assistants

Dental Assistant Registration or Other Credentialing Conducted by State Regulatory Board
In states where the state board of dentistry is empowered by state law to register, license or otherwise credential dental assistants, DANB's national certification exams, or selected component exams, can fulfill the knowledge-based competency measurement requirement underlying state-specific credentialing. Rather than expending resources to develop a state-specific exam, a state regulatory agency can accept or require an existing DANB national exam or combination of DANB exams; doing so can eliminate exam development, administration, scoring and reporting costs and reduce lead time to implement a statewide dental assisting credentialing program. The modular format of DANB's certification exams — which consist of individual component exams covering specific functions or areas of knowledge — provides states with the flexibility to test only in the areas that are delegable to dental assistants under state law or rules. In addition to DANB's online credential verification tool, DANB provides periodic reporting of candidate exam results to state regulators free of charge at the interval requested by the state.

Dental Assistant Competency Measurement Without State Credentialing

In states where the state dental board is not empowered to register, license or otherwise credential dental assistants, regulation of dental assistants often takes the form of establishing parameters for delegation of duties to dental assistants, including outlining allowed and prohibited tasks, education requirements and competency testing requirements. DANB provides state regulators with a suite of independent, psychometrically sound standardized tests that allow for reliable measurement of knowledge-based competencies.

In such circumstances, it is often the employer dentist's responsibility to ensure that dental assistants have met the state's requirements, including passing any required examinations. DANB simplifies the employer's job by providing online and written credential verification at no cost.

Benefits of Partnering with DANB

- Recognizing or requiring existing DANB national exams eliminates exam development costs and allows for turnkey initiation of a state registration or competency measurement program for dental assistants
- There are no DANB-established eligibility prerequisites to take these component exams:

  For NELDA

  - Anatomy, Morphology and Physiology (also a component of CRFDA certification)
  - Radiation Health and Safety (also a component of CDA certification)
  - Infection Control (also a component of CDA and COA certification)

  For CDA:

  - Radiation Health and Safety
  - Infection Control

  For CPFDA:

  - Coronal Polish
  - Sealants (also a component of CRFDA certification)
  - Topical Fluoride
  - Topical Anesthetic

  For CRFDA:

  - Anatomy, Morphology and Physiology
  - Isolation
  - Impressions
  - Temporaries
  - Sealants

  In this way, DANB supports states in establishing any (or no) additional prerequisites to perform functions addressed by these DANB exams. States that do not allow all of the duties tested on the CPFDA or CRFDA certification exams can choose to recognize these national DANB certifications but require or recognize only those component exams that meet their state regulations.
- DANB exams are developed in accordance with nationally accepted psychometric standards, and its eligible certification programs are accredited by the NCCA, helping to ensure validity, reliability and legal defensibility
- DANB exams are available at more than 250 proctored, secure computerized testing sites nationwide (through Pearson VUE)
- DANB provides online credential verification for all DANB-administered credentials
- DANB reviews self-reported five-year criminal history and adverse regulatory actions for all DANB national exam candidates and certificants
- DANB monitors for and enforces against the unauthorized use of DANB credentials and notifies state regulatory boards of violations, when appropriate

Additional Services for State Regulators

- **Report Exam Results:** As noted above, DANB can provide state dental boards, free of charge, with periodic and/or custom reports of candidate performance on DANB exams
- **Collect Fees:** DANB can collect fees on the state's behalf and transfer the collected fees to the state
- **Issue State Certificates:** DANB can issue a state-specific certificate on the state's behalf to those who have passed the DANB-administered examinations required by the state
- **Develop State-Specific Exams:** When requested, DANB can develop state-specific exams, including jurisprudence exams; exam development costs are typically incorporated into the exam fee and passed on to the candidate, though some states may choose to subsidize these costs

For more information, please contact DANB's government relations staff at 1-800-367-3262, ext. 431, or klandsberg@danb.org.

McCollum, Phil [IDB]

From: hccmsdirector@frontiernet.net
Sent: Tuesday, April 21, 2015 12:05 PM
To: McCollum, Phil [IDB]
Subject: Comments re: Proposed Changes for Dental Assistants

We are in full support of Public Health Supervision for Dental Assistants working in School-based Sealant Programs. The limited services that would be provided by Dental Assistants in this setting do no warrant the strict rules under General Supervision. The Dental Assistants are working under the supervision of licensed Dentists. Dental Assistants are a vital part of fiscally responsible service provision. Thank you for your consideration.

Kim Fineran, BSN RN
HCCMS Project Director/PH Supervisor
Crawford County Home Health, Hospice & Public Health
712.263.3303

“Unless someone like you cares a whole awful lot, Nothing is going to get better. It's not.” Dr. Seuss

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McCollum, Phil [IDB]

From: Kim Howard <khoward@co.black-hawk.ia.us>
Sent: Tuesday, April 21, 2015 10:57 PM
To: McCollum, Phil [IDB]
Subject: Proposed rule change

Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309

April 17, 2015

A proposal has been submitted to the Iowa Dental Board to make changes in the section of the Iowa Administrative Code relating to supervision of dental assistants. The proposed changes would create rules regarding public health supervision of dental assistants that would restrict the services provided by the school-based dental program sponsored by Black Hawk County Health Department.

Children of many low-income families participate in this program. Because these families are often underserved and underinsured, their access to dental services is limited.

Please review the proposed requirement stating three years of experience is necessary prior to public health supervision. We feel this is excessive and 12 months or less would be more appropriate for the functions provided by a dental assistant. In addition, the proposed reporting requirements often duplicate the data that is already being submitted by the public health dental hygienist providing services in the school-based dental program.

Sincerely,

Joan Gilpin, RDH, MA
Tasha Andersen, RDA
Kimberly Howard, RDH

Kimberly Howard, RDH
I-Smile Coordinator
Black Hawk County Health Department
1407 Independence Ave., 5th Floor
Waterloo, IA 50703
Office: (319)291-2413
Cell: (319)415-5908
Secure Fax: (319)-291-2418
khoward@co.black-hawk.ia.us

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McCollum, Phil [IDB]

From: Iowa Dental Board [IDB]
Sent: Thursday, April 09, 2015 10:48 AM
To: McCollum, Phil [IDB]
Subject: FW: expanded functions

From: Dr. Robert Hurley [mailto:DrHurley@omnidentalcentre.com]
Sent: Wednesday, April 08, 2015 3:38 PM
To: Iowa Dental Board [IDB]
Subject: expanded functions

As a practicing dentist in Iowa for more than 30 plus years I very much appreciate the value of high functioning dental assistants.
When you can employ a talented and motivated auxiliary practicing dentistry becomes fun.

In review of current proposals with my friend Dr. Steve Rabedeaux I would give a few comments.

1. Remove the periodontal dressing requirement.
2. Separate the nitrous oxide monitoring from expanded functions. Treat it more like radiology is.
3. Allow denture polishing, adjustments, essex retainers and similar appliances to fall under level 1.

Thank you for your consideration,

Robert W. Hurley, DDS,MAGD

IDA
Iowa Dental Association

P.O. Box 31088
Johnston, IA 50131
(515) 331-2298 or (800) 828-2181
(515) 334-8007 (Fax)
info@iowadental.org (e-mail)

April 17, 2015

Mr. Phil McCollum, Associate Director
Iowa Dental Board
400 S.W. Eighth Street Suite D
Des Moines IA 50309-4687

Mr. McCollum:

Please accept the following comments on behalf of the leadership of the Iowa Dental Association related to ARC 1940C which is intended to clarify "general supervision requirements for dental assistants, add to the list of permissible services a dental assistant may perform under general supervision, increase the number of expanded function procedures which may be delegated to a registered dental assistant and set the education and training requirements for those procedures and permit registered dental assistants to work under public health supervision in certain settings."

IDA leadership supports the proposed clarification of "General Supervision" of RDAs.

IDA Leadership supports the proposal to allow RDAs to perform duties under "Public Health Supervision" by a dentist only…with the following recommendation:

- There should be a limit of no more than 2 RDAs that may be supervised at any one time by a "Public Health Supervision" supervising dentist.

For a significant amount of time, it has been the position of the IDA Leadership that properly trained registered dental assistants working under the appropriate supervision of a dentist should be able to perform a much more extensive list of expanded procedures properly delegated by the RDAs supervising dentist. As a result, the IDA Leadership is generally supportive of these proposed rule revisions substantially expanding the list of expanded procedures with the following comments and recommendations:

- A dentist supervising RDAs performing expanded procedures should be limited to supervising no more than 2 RDAs at any one time.

- The language in 20.4(4)c that…"A registered dental assistant must become a certified Level 1 provider…before beginning training as a certified Level 2 provider"…should be replaced with language allowing a dentist to delegate any Level 2 procedure to a RDA that has been properly trained and certified for that particular Level 2 expanded procedure without the requirement of being a certified Level 1 provider and/or certified Level 2 provider.

Dr. Bruce Cochrane, President ♦ Dr. Thomas Ludwig, President-Elect ♦ Dr. Thomas Peek, Vice-President ♦ Dr. Daniel Kegler, Immediate Past President
Mr. Larry Carl, CAE, Executive Director

IDA Leadership supports all proposed requirements as written in 20.16(2) a. b. c. and d.

IDA Leadership supports all the proposed language contained in 20.4(4) c.(3).

IDA Leadership supports adding use of a curing light and intraoral camera under general supervision.

Thank you for your consideration.

Lawrence F. Carl, CAE
Executive Director
Iowa Dental Association
8797 N.W. 54th Avenue Suite 100
Johnston IA 50131-9428
1-515-331-2298 Ext. 106
1-515-334-8007 fax
1-800-828-2181 Ext. 106
Larry.carl@iowadental.org

April 20, 2015

Phil McCollum, Associate Director, Iowa Dental Board
400 S.W. Eighth Street, Suite D, Des Moines, Iowa 50309
Via e-mail to phil.mccollum@iowa.gov

RE: Iowa Dental Hygienists' Association comments and suggested modifications to ARC 1940C

Dear Mr. McCollum,

The Iowa Dental Hygienists Association (IDHA) thanks the Iowa Dental Board for initiating rulemaking (ARC 1940 C) as it relates to the practice of a dental assistant in a public health setting. We believe this proposed rule will improve access to quality oral healthcare by ensuring that a dental assistant can assist a dental hygienist who is working in a public health setting. Dental hygienists today perform important oral health services to patients in public health settings, services in which having the assistance of a dental assistant improve the quality of care that is provided. These rule changes make it clear that a dental assistant can provide such assistance.

In reviewing the notice version of the rule, IDHA would suggest that the Dental Board make two changes in the final filed version of the rule. Those proposed changes are attached to this document. The first change we would suggest would be to 20.16(1) by adding "or affiliated with" to the definition of a public health agency. This language is an important addition because it better reflects how dental services in a public health setting are delivered in the state of Iowa, when delivered via a public health program.

Next, IDHA would suggest deleting subsections 3, 4, and 5 under 20.16(2)(b). These are responsibilities that a dental hygienist already performs under public health supervision, and it is unnecessary to place that same responsibility on a dental assistant.

We would encourage the Dental Board to strongly consider these suggested changes. IDHA believes these changes make a good rule even better.

Sincerely,

Nadine DeVoss, President
Iowa Dental Hygienists Association
20524 Greenview Rd.
Council Bluffs, IA 51503
nadine.devossrdh@gmail.com

Notice of Intended Action

ARC 1940C

DENTAL BOARD[650]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 147.76 and 272C.2, the Dental Board hereby gives Notice of Intended Action to amend Chapter 20, "Dental Assistants," Iowa Administrative Code.

The purposes of the proposed amendments are as follows: to clarify general supervision requirements for dental assistants, add to the list of permissible services a dental assistant may perform under general supervision, increase the number of expanded function procedures which may be delegated to a registered dental assistant and set the education and training requirements for those procedures, and permit registered dental assistants to work under public health supervision in certain settings.

Current rules regarding the general supervision of a dental assistant have consistently been interpreted to require that a dentist first examine the patient prior to delegating services to be provided by a dental assistant. These amendments clearly specify this requirement.

These amendments increase the number of services a dentist may delegate to a dental assistant under general supervision by adding the use of a curing light and intraoral camera.

Current rules authorize a licensed dentist to delegate 9 expanded function procedures to a properly trained registered dental assistant. These amendments would increase the number of procedures to 16 procedures, define the supervision requirements for the performing of all expanded functions, and set education and training requirements for all expanded functions.

Current rules authorize dental assistants to work under the personal, direct, or general supervision of a licensed dentist. These amendments would authorize an Iowa-licensed dentist to provide public health supervision to a registered dental assistant if the services are provided in a public or private school, public health agencies, hospitals, or the armed forces.

Any interested person may make written comments on the proposed amendments on or before April 21, 2015. Such written materials should be directed to Phil McCollum, Associate Director, Iowa Dental Board, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa 50309, or sent by e-mail to phil.mccollum@iowa.gov.

There will be a public hearing on April 21, 2015, at 2 p.m. in the Board office, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa, at which time persons may present their views orally or in writing.

The proposed amendments are subject to waiver or variance pursuant to 650—Chapter 7.

After analysis and review of this rule making, a positive impact on jobs has been found for dental assistants, who will now be able to perform more procedures and work in more settings.

These amendments are intended to implement Iowa Code sections 153.38 and 153.39.

The following amendments are proposed.

ITEM 1. Amend rule **650—20.2(153)**, definition of "General supervision," as follows:

"General supervision" means that a dentist has examined the patient and has delegated the services to be provided by a registered dental assistant, which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light and intraoral camera. The dentist need not be present in the facility while these services are being provided.

ITEM 2. Adopt the following **new** definition of "Public health supervision" in rule **650—20.2(153)**:

"Public health supervision" means all of the following:

1. The dentist authorizes and delegates the services provided by a registered dental assistant to a patient in a public health setting, with the exception that services may be rendered without the patient's first being examined by a licensed dentist;

2. The dentist is not required to provide future dental treatment to patients served under public health supervision;

3. The dentist and the registered dental assistant have entered into a written supervision agreement that details the responsibilities of each licensee/registrant, as specified in subrule 20.16(2); and

4. The registered dental assistant has an active Iowa registration and a minimum of three years of clinical practice experience.

ITEM 3. Rescind subrule **20.3(3)**.

ITEM 4. Renumber subrule **20.3(4)** as **20.3(3)**.

ITEM 5. Renumber rules **650—20.4(153)** to **650—20.14(153)** as **650—20.5(153)** to **650—20.15(153)**.

ITEM 6. Adopt the following **new** rule 650—20.4(153):

650—20.4(153) Expanded function requirements.

20.4(1) *Supervision requirements.* Registered dental assistants may only perform expanded function procedures which are delegated by and performed under the direct supervision of a dentist licensed pursuant to Iowa Code chapter 153. Dental assistant trainees are not eligible to perform expanded function procedures.

20.4(2) *Expanded function training required.* A registered dental assistant shall not perform any expanded function procedures listed in this chapter unless the assistant has successfully met the education and training requirements and is in compliance with the requirements of this chapter.

20.4(3) *Education and training requirements.* All expanded function training must be prior-approved by the board. The supervising dentist and the registered dental assistant shall be responsible for maintaining in each office of practice documentation of successful completion of the board-approved training.

a. Expanded function training for Level 1 procedures shall be eligible for board approval if the training is offered through a program accredited by the Commission on Dental Accreditation of the American Dental Association (ADA) or another program, which may include on-the-job training offered by a dentist licensed in Iowa. Training must consist of the following:

(1) An initial assessment to determine the base entry level of all participants in the program. At a minimum, all participants must meet at least one of the following requirements before beginning expanded function training:

1. Be a graduate of an ADA-accredited dental assistant program; or
2. Be currently certified by the Dental Assisting National Board (DANB); or
3. Have at least one year of clinical practice as a registered dental assistant; or
4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration;

(2) A didactic component;

(3) A laboratory component, if necessary;

(4) A clinical component, which may be obtained under the personal supervision of the participant's supervising dentist while the participant is concurrently enrolled in the training program; and

(5) A postcourse competency assessment at the conclusion of the training program.

b. Expanded function training for Level 2 procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or a program accredited by the Commission on Dental Accreditation of the American Dental Association.

20.4(4) *Expanded function providers.*

a. *Basic expanded function provider.* Registered dental assistants who do not wish to become certified as a Level 1 or Level 2 provider may perform select Level 1 expanded function procedures provided they have met the education and training requirements for those procedures. A dentist may delegate to a registered dental assistant only those Level 1 procedures for which the assistant has received the required expanded function training.

b. *Certified Level 1 provider.* Registered dental assistants must successfully complete training for all Level 1 expanded function procedures before becoming a certified Level 1 provider.

(1) A dentist may delegate any of the Level 1 expanded function procedures to dental assistants who are certified Level 1 providers.

(2) Level 1 procedures include:

1. Taking occlusal registrations;
2. Placement and removal of gingival retraction;
3. Fabrication and removal of provisional restorations;
4. Applying cavity liners and bases, desensitizing agents, and bonding systems;
5. Placement and removal of dry socket medication;
6. Placement of periodontal dressings;
7. Testing pulp vitality;
8. Monitoring of nitrous oxide inhalation analgesia;
9. Taking final impressions;
10. Removal of adhesives (hand instrumentation only); and
11. Preliminary charting of existing dental restorations and teeth.

c. *Certified Level 2 provider.* A registered dental assistant must become a certified Level 1 provider and successfully pass a board-approved entrance examination with a score of at least 75 percent before beginning training as a certified Level 2 provider. Registered dental assistants must successfully complete training for all Level 2 expanded function procedures before becoming certified Level 2 providers.

(1) A dentist may delegate any of the Level 1 or Level 2 expanded function procedures to a registered dental assistant who is a certified Level 2 provider.

(2) Level 2 procedures include:

1. Placement and shaping of amalgam following preparation of a tooth by a dentist;
2. Placement and shaping of composite following preparation of a tooth by a dentist;
3. Forming and placement of stainless steel crowns;
4. Taking records for the fabrication of dentures and partial dentures; and
5. Tissue conditioning (soft reline only, where denture is not relieved or modified).

These procedures refer to both primary and permanent teeth.

(3) Notwithstanding 650—paragraph 10.3(1)*"e"* and paragraph 20.3(2)*"e,"* for the purposes of this chapter, the removal of adhesives by hand instrumentation does not constitute the removal of "hard natural or synthetic material."

ITEM 7. Amend renumbered subparagraphs **20.5(1)"b"(1)** and **(2)** as follows:

(1) Reapplying for trainee status. A trainee may "start over" as a dental assistant trainee provided the trainee submits an application in compliance with subrule ~~20.6(1)~~ 20.7(1).

(2) Examination scores valid for three years. A "repeat" trainee is not required to retake an examination (jurisprudence, infection control/hazardous materials, radiography) if the trainee has successfully passed the examination within three years of the date of application. If a trainee has failed two or more examinations, the trainee must satisfy the remedial education requirements in subrule ~~20.10(1)~~ 20.11(1). The trainee status application will not be approved until the trainee successfully completes any required remedial education.

ITEM 8. Amend renumbered subrule 20.5(2) as follows:

20.5(2) *Registered dental assistant.* A registered dental assistant may perform under general supervision dental radiography, intraoral suctioning, use of a curing light and intraoral camera, and all extraoral duties that are assigned by the dentist and are consistent with these rules. During intraoral procedures, the registered dental assistant may, under direct supervision, assist the dentist in performing duties assigned by the dentist that are consistent with these rules. The registered dental assistant may take radiographs if qualified pursuant to 650—Chapter 22.

ITEM 9. Amend renumbered subparagraph **20.7(2)"b"(2)** as follows:

(2) Evidence of meeting the requirements specified in ~~20.6(2)*"a."*~~ 20.7(2)*"a."*

ITEM 10. Amend renumbered paragraph **20.11(1)"b"** as follows:

b. A dental assistant who fails the second examination will be required to complete the remedial education requirements set forth in subrule ~~20.10(2)~~ 20.11(2).

ITEM 11. Rescind rule **650—20.15(153)**.

ITEM 12. Adopt the following **new** rule 650—20.16(153):

650—20.16(153) Public health supervision allowed. A dentist may provide public health supervision to a registered dental assistant if the dentist has an active Iowa license and the services are provided in a public or private school, public health agencies, hospitals, or the armed forces.

20.16(1) *Public health agencies defined.* For the purposes of this rule, public health agencies include programs operated ~~by~~ or affiliated with federal, state, or local public health departments.

20.16(2) *Responsibilities.* When working together in a public health supervision relationship, a dentist and registered dental assistant shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the registered dental assistant;

(2) Have age- and procedure-specific standing orders for the performance of services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of services;

(3) Specify a period of time in which an examination by a dentist must occur prior to providing further services;

(4) Specify the location or locations where the services will be provided under public health supervision.

b. A registered dental assistant providing services under public health supervision may only provide services which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light and intraoral camera and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) ~~Provide to the patient, parent, or guardian a written plan for referral to a dentist;~~

~~(4) Have each patient, parent, or guardian sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and~~

~~(5) Specify a procedure for creating and maintaining dental records for the patients who are treated, including where these records are to be located.~~

c. The written agreement for public health supervision must be maintained by the dentist and the registered dental assistant and a copy filed with the board office within 30 days of the date on which the dentist and the registered dental assistant entered into the agreement. The dentist and registered dental assistant must review the agreement at least biennially.

d. The registered dental assistant shall file annually with the supervising dentist a report detailing the number of patients seen, the services provided to patients and the infection control protocols followed at each practice location.

e. A copy of the written agreement for public health supervision shall be filed with the Oral Health Bureau, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

20.16(3) *Reporting requirements.* Each registered dental assistant who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the oral health bureau of the Iowa department of public health on forms provided by the department and shall include information related to the number of patients seen and services provided so that the department may assess the impact of the program. The department will provide summary reports to the board on an annual basis.

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Gerd W. Clabaugh, MPA
Director

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

April 10, 2015

Phil McCollum, Associate Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309 – 4687

RE: ARC 1940C -- Dental assistants—expanded function procedures, general and public health supervision, 20.2 to 20.16

Dear Mr. McCollum:

The Iowa Department of Public Health supports rules changes that will allow public health supervision for dental assistants. This addition will greatly benefit local public health agencies and their dental sealant programs.

We respectfully recommend changes to the proposed rules for public health supervision of a dental assistant as follows:

- The proposed rules indicate that a registered dental assistant must have 3 years of clinical practice experience prior to having a public health supervision agreement (650—20.2(153), within the new definition of public health supervision). We recommend changing this to 1 year, which is the same as the proposed requirement for a registered dental assistant with expanded functions.
- The proposed rules include some responsibilities for the written agreement that, although they are applicable to the services provided by a dental hygienist, we do not feel are applicable to those that will be provided by a dental assistant. We recommend deleting 20.16 (2) a.(2) "…Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of services;" and 20.16 (2) a.(3) "Specify a period of time in which an examination by a dentist must occur prior to providing further services;"
- We recommend adding to 20.16 (2) a." Specify the dentist and/or dental hygienist who will be assisted under public health supervision at each specified location."
- The proposed rules include some responsibilities that we feel will not be applicable to the services provided by a dental assistant, who will be assisting a dentist or dental hygienist providing specific services. We recommend deleting 20.16 (2) b.(3), "Provide to the patient, parent, or guardian a written plan for referral to a dentist;" "(4) Have each patient, parent, or guardian sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services;" and "(5) Specify a procedure for creating and maintaining dental records for the patients who are treated, including where these records are to be located."
- The proposed rules indicate that a copy of the agreement must be filed with the Iowa Dental Board and also indicates the agreement must be filed with the Iowa Department of Public Health. We recommend

this be clarified. Currently, public health supervision agreements for dental hygienists are on file with the Iowa Department of Public Health and not with the Iowa Dental Board.

- The proposed rules include an outdated name for the current bureau at the Iowa Department of Public Health which oversees oral health programs. We recommend changing the reference to the current bureau name, the Bureau of Oral and Health Delivery Systems.
- The proposed rules include requirements regarding annually providing the supervising dentist a report (20.16 (2) d). We recommend deleting this and adding to 20.16 (3): "The report must be filed with the Bureau of Oral and Health Delivery Systems of the Iowa Department of Public Health and with the supervising dentist…"
- The proposed rules include details regarding the reporting requirements each year which may not be applicable since the dental assistant will be assisting a dentist or dental hygienist who is providing specific services. We recommend, in addition to changing the name of the Iowa Department of Public Health bureau, and adding to share a report with the supervising dentist, adding to 20.16 (3): "…and shall include information related to the locations where services were provided and name(s) of the dentist(s) and/or dental hygienist(s) assisted so that…" and to delete "number of patients seen and services provided".

We are also concerned with the proposed wording defining the allowable public health sites as seen in 650 - 20.16 (1): "*Public health agencies defined.* For the purposes of this rule, public health agencies include programs <u>operated by federal, state, or local public health departments</u>."

In reality, public health activities in Iowa are not limited to specific "public health agencies" but through a variety of contractual agreements and memorandums of agreement. In such settings, of which many are non-profit local agencies not directly operated by public health departments, public health activities are taking place. One example is Community Action Agencies. These agencies, among others, field public health staff including dental hygienists working under public health supervision and would equally benefit from dental assisting resources.

We would recommend that the language as proposed be modified to reflect actual public health services as delivered in Iowa to include the following: *Public health agencies defined*. For the purposes of this rule, public health agencies include programs operated or <u>*contractually affiliated*</u> with federal, state, or local public health departments.

We feel this is a minor change, but more accurately reflects the practice of public health and will greatly benefit our programs and the families they serve in Iowa.

Thank you for your consideration.

Sincerely,

Bob Russell, DDS, MPH
Public Health Dental Director
Chief, Bureau of Oral and Health Delivery Systems

McCollum, Phil [IDB]

From: Iowa Dental Board [IDB]
Sent: Tuesday, April 21, 2015 4:05 PM
To: McCollum, Phil [IDB]
Subject: FW: Dental Assistant Public Health Supervision Rules
Attachments: Stacy Jobes.vcf

From: Stacy Jobes [mailto:StacyJ@vnsia.org]
Sent: Tuesday, April 21, 2015 3:42 PM
To: Iowa Dental Board [IDB]
Subject: Dental Assistant Public Health Supervision Rules

April 21, 2015

Phil McCollum, Associate Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309 – 4687

RE: Dental Assistant Public Health Supervision Rules

Dear Mr. McCollum:

VNS of Iowa supports the use of public health supervision for dental assistants. Rule changes that allow a dental assistant to assist a dental hygienist in a local public health setting during the provision of dental sealants will greatly improve the oral health of children in our community.

VNS of Iowa supports dental assistants having one year of clinical practice experience prior to assisting under a public health supervision agreement with the agreement being on file with the Iowa Department of Public Health.

In terms of reporting, VNS of Iowa supports the dental assistant reporting the public health settings in which he or she assisted and reporting for which dental hygienist he or she assisted.

Thank you for your consideration and support of local public health efforts.

Stacy

Stacy Jobes
Maternal Child Health Director

VNS of Iowa
1111 9th Street, Suite 320
Des Moines, IA 50314

(515) 558-9618 Work
(515) 494-5827 Mobile
StacyJ@vnsia.org

McCollum, Phil [IDB]

From: Iowa Dental Board [IDB]
Sent: Tuesday, April 21, 2015 4:07 PM
To: McCollum, Phil [IDB]
Subject: FW: Dental Assistant Public Health Supervision

From: Lisa Koppin [mailto:lkoppin@NICAO-ONLINE.ORG]
Sent: Tuesday, April 21, 2015 12:53 PM
To: Iowa Dental Board [IDB]
Subject: Dental Assistant Public Health Supervision

I am writing from an MCH agency providing school-based sealant services in north central Iowa. I encourage your support of public health supervision for dental assistants. However, I do believe that the supervision requirements and guidelines need to be written specific to the dental assistant's role and not a repetition of what is required with the dental hygiene public health supervision.

Thank you for your consideration,

Lisa Koppin
Health Services Coordinator
North Iowa Community Action Organization
100 1st St. NW
Mason City, IA 50401
641-423-5044 extension 17

McCollum, Phil [IDB]

From: Jen Macke work <hccmsrdh@gmail.com>
Sent: Tuesday, April 21, 2015 10:37 PM
To: McCollum, Phil [IDB]
Subject: Public Health Supervision for Dental Assistants

To Whom It may Concern:

I believe that having a Public Health Supervision option for Dental Assistants would broaden the possibilities for the I-Smile program. Not only would we be able to afford more staffing with a dental assistant, but we would be able to have clerical help with a dental background that would double as our operatory staff. We currently do not have a dental assistant on staff, but would seriously consider it if this were to pass.

Please thoughtfully consider how this could benefit the public health settings and the children involved!

Thank You,
Jen Macke

McCollum, Phil [IDB]

From: Stuecker, Jill [IDB]
Sent: Tuesday, April 21, 2015 12:38 PM
To: McCollum, Phil [IDB]
Subject: FW: Notice of Intended Rules for Dental Assistants, Public Health Supervision and Expanded Functions

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From: Katie McBurney [mailto:kmcburney@marionph.org]
Sent: Tuesday, April 21, 2015 12:32 PM
To: Stuecker, Jill [IDB]; Braness, Christel [IDB]
Subject: FW: Notice of Intended Rules for Dental Assistants, Public Health Supervision and Expanded Functions

I wanted to resend this as it came back undeliverable when I tried to send to Mr. McCollum. If you could share my comment with the board it would be much appreciated. Thanks! Katie

---

From: Katie McBurney
Sent: Tuesday, April 21, 2015 12:25 PM
To: 'phil.mccollum@iowa.gov.'
Cc: 'IDB@iowa.gov'
Subject: Notice of Intended Rules for Dental Assistants, Public Health Supervision and Expanded Functions

Iowa Dental Board,

In response to the rules suggested for public health supervision of a dental assistant, I have a few minor recommendations. First, I would like to commend the board in recognizing the importance of a dental assistant in a public health setting and the need for rules to establish their presence. Currently our agency has been operating our school-based sealant program in the absence of a dental assistant and with passing of public health supervision rules for dental assistants, our program can only grow in effectiveness and efficiency. The few suggestions that I would hope you consider include the duplication of rules currently held under public health supervision of a dental hygienist. The following are already being provided to the patient under public health supervision of a hygienist. A dental assistant providing the following would be cumbersome and confusing to the patient and provider(s).

1. Stating that the services provided do not take place of a dentist examination
2. Providing a dentist referral to the patient receiving services
3. Maintaining a patient record

Another concern is related to the expanded functions of a dental assistant or dental hygienist. I notice a lack of language that requires or even recommends that expanded functions for dental assistants would be used to serve underserved clients. It was my understanding that expanded functions of dental assistants will function to serve more patients and assist with access to care in rural areas. I would recommend that the rules for offices that utilize expanded functions must implement requirements that their practice will take a certain percentage of underserved Iowans. If patients are unable to access care due to their insurance type, I do not see how expanded functions will better serve our rural, underserved Iowans.

Thank you for your considerations and all that you do to make Iowa the best in dental care!

Katie McBurney

Katie McBurney, RDH
I-Smile & *hawk-i* Coordinator
Marion County Public Health
2003 N. Lincoln St.
Knoxville IA 50138
Phone: 641-828-2238 ext. 226
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I-Smile™ ~ Healthy Mouths for Healthy Kids
www.ismiledentalhome.iowa.gov

Promoting and Protecting the Health of Marion County

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April 21, 2015

Phil McCollum, Associate Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

RE: Proposed Rules for Public Health Supervision of Dental Assistants

Dear Mr. McCollum:

I am pleased that rules have been drafted for the public health supervision of dental assistants. This will be greatly beneficial for our school-based sealant program in order to provide efficient, quality care. Following review of the proposed rules, I offer the following practical suggestions:

- The dental hygienist will have already acquired parent consent, provided a written plan for referral, as well as created and maintained a dental record in accordance with public health supervision rules. These actions would be duplicative, so therefore would not be applicable.

- As written, the reporting requirements, also present concern for duplication of the report the hygienist is already providing. Duplication should be avoided, whenever possible, in order to tell an accurate story and prevent unnecessary work.

In addition, please understand that some school-based sealant programs are operated by local non-profit agencies. Therefore, I suggest the definition of *public health agencies* for the purposes of this rule be broadened to allow for their inclusion.

Thank you for your consideration.

Sincerely,

Rachael Patterson-Rahn, RDH
I-Smile™ Coordinator

WARREN COUNTY
HEALTH SERVICES
COMMUNITIES OF CHOICE

DATE: April 21, 2015

To: Iowa Dental Board

This is in regards to the Notice of Intended Action for Iowa Administrative Code 650 – Chapter 20, 16(153), Public health supervision allowed for dental assistants.

Warren County Health Services is in support of public health supervision for dental assistants. This change would greatly impact our agency and our school dental sealant program.

Our school dental sealant program is currently in place serving Warren and Clarke counties. This program served over 200 students in the 2014-2015 school year. We were able to do this with the use of two dental hygienists, one applying sealants and the other providing suctioning and additional assistance to keep a dry field as four-handed is best practice for sealant application. This program is supported by a grant from the Iowa Department of Public Health and reimbursement from Medicaid students we provide services to. In order to keep this program alive to assist students in our area with dental services that may not be able to access on a regular basis, we need to sustain the program. By allowing dental assistants to have a public supervision agreement with a dentist, this would allow them to assist the dental hygienist and be a cost savings to us and would allow us to provide more services, purchase equipment, and expand our sealant program to other schools that may not have had it in the past.

We hope you consider the impact this will have on the children in Iowa our agency and so many others provide services to on a daily basis.

Thank you,

Sarah Petersen

Sarah Petersen, RDH
I-Smile Coordinator
Warren County Health Services
301 N. Buxton St. Ste 203
Indianola, IA 50125
Ph: (515)961-1074

I-Smile™

THE DENTAL PRACTICE, P.C. TDP

Steven G. Rabedeaux, DDS, MAGD

March 17, 2015

RECEIVED
MAR 19 2015
IOWA DENTAL BOARD

Iowa Dental Board
400 SW 8Th Street, Suite D
Des Moines, IA 50309

RE: EXPANDED FUCTION DENTAL ASSISTANT

Dear Iowa Dental Board,

I am most pleased with the proposed change in rules to allow expanded function training after 1 year for office trained assistants. That is very significant in rural areas where it is difficult to find trained assistants let alone those who have expanded function certification. Kudos!

Other thoughts about expanded function dental assisting as you consider a next level:

I question the importance of periodontal dressing training in level 1. I no longer use dressings for periodontal surgeries, as they are detrimental to healing. I am not aware of anyone who still does use them. This makes getting the clinical experiences to pass this area very challenging because the actual materials are not easily available and the usage is low or non-existent. Recommendation: Drop it.

The relevance is that the way the proposed rules read, all the areas in level 1 must be completed as a requirement to apply for level 2 training. The fabrication of provisional restorations, pulp testing, bite registration, final impressions, placing liners and adhesives and gingival isolation have transferable and relevant skills to the level 2 tasks. The other areas don't.

Further, monitoring of nitrous oxide is only meaningful in offices that have nitrous. That makes it nearly impossible for an assistant wishing to complete level 1 training in it's entirety to get the necessary clinical experiences needed for that task (let alone keep the skill current). Recommendation: Separate it.

A very useful task to consider would be the ability to adjust dentures with indicator pastes and indelible markers, provide soft tissue liners and replace them. With removable prosthetics, there is little or no chance for irreversible things to occur. This fits best under the level 1 group of expanded tasks. Consider an orthodontic office where a non-expanded function assistant is permitted to adjust retainers and active removable appliances on a daily basis. It is what they are trained to do. In some cases they fabricate

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them. And they should. They do it well. I noted this as a proposed group 2 task. That's excessive regulation.

I realize the board is looking to make this administratively simple. In the present form, it does not reflect current clinical practice. It will be difficult for many to complete the entire level 1 set. A practical solution would be to drop the periodontal pack entirely, move dry socket dressing to non expanded status, consider adding removable appliance/prosthetic adjustment and make nitrous oxide monitoring a separate certification just as radiography is now. That would create a meaningful set of skills as a pre-requisite for level 2 training.

I am disappointed that more dentists have not voiced their thoughts. I know you have worked hard to get this far with these changes and have done it without much input from us. I'm confident because of many conversations that this is a good reflection of what would be very helpful, well accepted and make sense.

We are at a time when we are ready to empower some really talented people (our dental assistants) to make an impact for improved delivery of dental care in Iowa.

I greatly appreciate your time and effort in this area.

Respectfully,

Steven G. Rabedeaux, DDS, MAGD

Dear Iowa Dental Board,

My name is Jessica Smith-Haight RDA I am currently a dental assistant for a public health agency in Creston which I assist a hygienist in the school based sealant program. I feel it is important to keeping dental assistants in public health, dental assistants help increase the retention rate in sealants because it is easier to keep the area dry with four handed dentistry. The amount of children we can serve in a school year is significantly higher when an assistant is present, it decrease set up time tear down time and the amount of time the child is in the chair. Please consider these issues when writing the new supervision agreement for dental assistants. Thanks for your time and consideration.

Sincerely,

Jessica Smith-Haight RDA

McCollum, Phil [IDB]

Subject: FW: ARC 1940C, Notice of Intended Action, expanded function

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From: Stephen R. Thies [mailto:srthis@QwestOffice.Net]
Sent: Saturday, April 18, 2015 2:15 PM
To: Iowa Dental Board [IDB]
Subject: ARC 1940C, Notice of Intended Action, expanded function

Iowa Dental Board,

Regarding the notice of intended action involving expanded functions, consider the following comments.

1. Tissue conditioning a denture with a soft reline material is a simple procedure and an easily reversed procedure. It is similar to taking alginate impression. This procedure should be included in the Level 1 list of expanded functions.
2. Denture relief and modification can be done by a trained dental assistant. Dental assistants relieve and modify orthodontic appliances. Denture modification is a similar procedure. Dental laboratory technicians routinely modify dentures. If the denture has been examined by the dentist and the area for modification has been determined by the dentist, then the dental assistant should be allowed to modify the denture. Denture relief and modification should be included as a Level 1 procedure.
3. Tissue conditioning a denture with soft reline material is commonly done in a denture that has been relieved and modified by a dentist. The procedure is qualified by the statement (…. where the denture is not relieved or modified). The qualifying statement is not necessary. If the intent is to prevent the assistant from relieving or modifying the denture, then the statement should read (… where the denture is not relieved or modified by a dental assistant.) However, please consider #2 and allow dental assistants to relieve and modify dentures as a Level 1 procedure.

In general the expanded function proposal is a good proposal and should be approved with the above stated additions.

Thank you,

Dr. Stephen Thies
Legislative chair
Iowa Academy of General Dentistry

EXPANDED FUNCTION TRAINING DISCUSSION

A. Discussion on Open Records Law
B. Discussion of Board Expectations Regarding Submitted Materials
C. Discussion Regarding Consistency Among Trainings
D. Discussion on Resubmission Criteria
E. Discussion on Fees to Review Material

Current Rules

650—20.15(153) Expanded function training approval. Expanded function training shall be eligible for board approval if the training is offered through a program accredited by the Commission on Dental Accreditation of the American Dental Association or another program prior-approved by the board, which may include on-the-job training offered by a dentist licensed in Iowa. Training must consist of the following:

1. An initial assessment to determine the base entry level of all participants in the program. At a minimum, participants must meet one of the following:
   - Be currently certified by the Dental Assisting National Board, or
   - Have two years of clinical dental assisting experience as a registered dental assistant, or
   - Have two years of clinical dental assisting experience as a dental assistant in a state that does not require registration;
2. A didactic component;
3. A laboratory component, if necessary;
4. A clinical component, which may be obtained under the personal supervision of the participant's supervising dentist while the participant is concurrently enrolled in the training program; and
5. A postcourse competency assessment at the conclusion of the training program.

Pending Rules

20.4(3) *Education and training requirements.* All expanded function training must be prior-approved by the board. The supervising dentist and the registered dental assistant shall be responsible for maintaining in each office of practice documentation of successful completion of the board-approved training.

a. Expanded function training for Level 1 procedures shall be eligible for board approval if the training is offered through a program accredited by the Commission on Dental Accreditation of the American Dental Association (ADA) or another program, which may include on-the-job training offered by a dentist licensed in Iowa. Training must consist of the following:

(1) An initial assessment to determine the base entry level of all participants in the program. At a minimum, all participants must meet at least one of the following requirements before beginning expanded function training:

1. Be a graduate of an ADA-accredited dental assistant program; or
2. Be currently certified by the Dental Assisting National Board (DANB); or
3. Have at least one year of clinical practice as a registered dental assistant; or
4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration;

(2) A didactic component;

(3) A laboratory component, if necessary;

(4) A clinical component, which may be obtained under the personal supervision of the participant's supervising dentist while the participant is concurrently enrolled in the training program; and

(5) A postcourse competency assessment at the conclusion of the training program.

b. Expanded function training for Level 2 procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or a program accredited by the Commission on Dental Accreditation of the American Dental Association.

20.4(4) *Expanded function providers.*

a. *Basic expanded function provider.* Registered dental assistants who do not wish to become certified as a Level 1 or Level 2 provider may perform select Level 1 expanded function procedures provided they have met the education and training requirements for those procedures. A dentist may delegate to a registered dental assistant only those Level 1 procedures for which the assistant has received the required expanded function training.

b. *Certified Level 1 provider.* Registered dental assistants must successfully complete training for all Level 1 expanded function procedures before becoming a certified Level 1 provider.

(1) A dentist may delegate any of the Level 1 expanded function procedures to dental assistants who are certified Level 1 providers.

(2) Level 1 procedures include:

1. Taking occlusal registrations;
2. Placement and removal of gingival retraction;
3. Fabrication and removal of provisional restorations;
4. Applying cavity liners and bases, desensitizing agents, and bonding systems;
5. Placement and removal of dry socket medication;
6. Placement of periodontal dressings;
7. Testing pulp vitality;
8. Monitoring of nitrous oxide inhalation analgesia;
9. Taking final impressions;
10. Removal of adhesives (hand instrumentation only); and
11. Preliminary charting of existing dental restorations and teeth.

c. *Certified Level 2 provider.* A registered dental assistant must become a certified Level 1 provider and successfully pass a board-approved entrance examination with a score of at least 75 percent before beginning training as a certified Level 2 provider. Registered dental assistants must successfully complete training for all Level 2 expanded function procedures before becoming certified Level 2 providers.

(1) A dentist may delegate any of the Level 1 or Level 2 expanded function procedures to a registered dental assistant who is a certified Level 2 provider.

(2) Level 2 procedures include:

1. Placement and shaping of amalgam following preparation of a tooth by a dentist;
2. Placement and shaping of composite following preparation of a tooth by a dentist;
3. Forming and placement of stainless steel crowns;
4. Taking records for the fabrication of dentures and partial dentures; and
5. Tissue conditioning (soft reline only, where denture is not relieved or modified).

These procedures refer to both primary and permanent teeth.

TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

March 31, 2015

The Honorable Paul Pate
Secretary of State of Iowa
State Capitol Building
LOCAL

Dear Mr. Secretary:

I hereby transmit:

House File 202, an Act relating to licensure of retired volunteer dentists and dental hygienists.

The above House File is hereby approved this date.

Sincerely,

Terry E. Branstad
Governor

cc: Secretary of the Senate
Clerk of the House

STATE CAPITOL DES MOINES, IOWA 50319 515.281.5211 FAX 515.725.3527 WWW.GOVERNOR.IOWA.GOV

House File 202

AN ACT

RELATING TO LICENSURE OF RETIRED VOLUNTEER DENTISTS AND DENTAL HYGIENISTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. 153.23 Retired volunteer license.

1. Upon application and qualification, the board may issue a retired volunteer license to a dentist or dental hygienist who has held an active license to practice dentistry or dental hygiene within the past five years, and who has retired from the practice of dentistry or dental hygiene, to enable the retired dentist or dental hygienist to provide volunteer dental or dental hygiene services. The board shall adopt rules to administer this section, including but not limited to rules providing eligibility requirements and services that may be performed pursuant to the license.

2. The board shall not charge an application or licensing fee for issuing or renewing a retired volunteer license. A retired volunteer license shall not be converted to a regular license with active or inactive status. A retired volunteer license shall not be considered to be an active license to practice dentistry or dental hygiene.

3. A person holding a retired volunteer license shall not charge a fee or receive compensation or remuneration in any form from any person or third-party payor including but not limited to an insurance company, health plan, or state or federal benefit program.

4. A person holding a retired volunteer license is subject to all rules and regulations governing the practice of dentistry or dental hygiene except those relating to the payment of fees, license renewal, and continuing education

requirements.

5. A dental hygienist holding a retired volunteer license shall abide by the permitted scope of practice of actively licensed dental hygienists described in section 153.15. However, a dental hygienist holding a retired volunteer license may perform screenings or educational programs without an actively licensed dentist present.

6. An applicant for a retired volunteer license who has surrendered, resigned, converted, or allowed a license to lapse or expire as the result of or in lieu of disciplinary action shall not be eligible for a retired volunteer license.

7. The board may waive the five-year requirement in subsection 1 if the applicant demonstrates that the applicant possesses sufficient knowledge and skills to practice safely and competently.

KRAIG PAULSEN
Speaker of the House

PAM JOCHUM
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 202, Eighty-sixth General Assembly.

CARMINE BOAL
Chief Clerk of the House

Approved March 31, 2015

TERRY E. BRANSTAD
Governor

IOWA DENTAL BOARD COMMITTEES

Updated 3/30/15

Dental Hygiene Committee (DHC)	Date Appointed
Mary Kelly, R.D.H., Chair	**2011**
Nancy Slach, R.D.H.	2012
Matthew McCullough, D.D.S.	2013
**mandated by statute*	

Anesthesia Credentials Committee (ACC)	Date Appointed
Kaaren Vargas, D.D.S., Chair (Board Member)	**2012**
John Frank, D.D.S.	2013
Richard Burton, D.D.S.	prior to 2012
Steven Clark, D.D.S.	prior to 2012
Kurt Westlund, D.D.S.	prior to 2004
Doulgas Horton, D.D.S.	prior to 2004
Gary Roth, D.D.S.	prior to 2004
**mandated by rule*	

Continuing Education Advisory Committee (CEAC)	Date Appointed
Lori Elmitt, Chair (Board Member)	***2012***
Steven Fuller, D.D.S. (Board Member)	2013
Marijo Beasler, R.D.H.	2009
George North, D.D.S.	prior to 2006
Jane Slach, R.D.A.	prior to 2006
Kristee Malmberg, R.D.A.	prior to 2006
Eileen Cacioppo, R.D.H.	prior to 2004
**mandated by rule*	

Iowa Practitioner Review Committee (IPRC)	Date Appointed
Richard Rips, D.D.S., Chair	**2011**
Gordon Anderson, II, IADC, Vice Chair	**2010**
DeeAnn Decker, IADC	2013
Sheila Rodgers, CADC, CCGC	2013
Jill Stuecker, Executive Director	2014
Vacancy (Psychiatrist or Psychologist)	
**mandated by rule*	

Licensure/Registration Committee (L&RC)	Date Appointed
Matthew McCullough, D.D.S., Chair	***2012***
Tom Jeneary, D.D.S.	2013
Diane Meier	2008
**mandated by rule*	

Budget Review Committee (BRC)	Date Appointed
Steven Fuller, D.D.S., Chair	***2012***
Tom Jeneary, D.D.S.	2013
Matthew McCullough, D.D.S.	2012
**created by Board*	

Dental Assistant Registration Committee (DARC)	Date Appointed
George North, D.D.S., Chair	***Est. 2003***
Tom Jeneary, D.D.S. (Board Member)	2013
Steven Fuller, D.D.S. (Board Member)	2011
Steven Bradley, D.D.S. (Board Member)	2010
Diane Meier (Board Member)	2008
Denise Bell, R.D.A.	2006
**created by Board*	

Executive Committee (EC)	Date Appointed
Steven Bradley, D.D.S., Chair	***2012***
Steven Fuller, D.D.S., Vice-Chair	2013
Matthew McCullough, D.D.S., Secretary	2013
Mary Kelly, R.D.H.	2012
**created by Board*	

IOWA DENTAL BOARD COMMITTEES

Updated 3/30/15

OWA DENTAL BOARD AD HOC COMMITTEES

Examination Review Committee (ERC)	***Date Appointed***
P.T. Grimes, D.D.S., Chair	***2008***
Steven Fuller, D.D.S. (Board Member)	2012
David Holmes, D.D.S.	prior to 2006
Michael Kanellis, D.D.S.	prior to 2006
Deena Kuempel, D.D.S.	prior to 2006
**ad hoc, created by Board*	

Expanded Functions Task Force	***Date Appointed***
Nancy Slach, R.D.H., Chair (Board Member)	***2013***
Tom Jeneary, D.D.S. (Board Member)	2013
Jane Slach, R.D.A.	2013
Elaine Peterson, R.D.A.	2013
Lynn Curry, D.D.S.	2013
Steven Thies, D.D.S.	2013
Michael Kanellis, D.D.S.	2013
**ad hoc, created by Board*	

Skilled Care Facility Task Force	***Date Appointed***
Michael Kanellis, D.D.S., Chair	***2013***
Steven Bradley, D.D.S. (Board Member)	2013
Mary Kelly, R.D.H. (Board member)	2013
Eileen Cacioppo, R.D.H.	2013
Howard Cowen, D.D.S.	2013
Lori Elmitt (Board Member)	2013
Jane Slach, R.D.A.	2013
Beth Jones	2013
Lynn Curry, D.D.S.	2013
Steven Thies, D.D.S.	2013
Maria Fuller, D.D.S.	2013
**ad hoc, created by Board*	

Dental Hygiene Committee Purpose Statement

The Dental Hygiene Committee is established in Iowa Code Section 153.33. The committee shall have the authority to adopt recommendations regarding the practice, discipline, education, examination, and licensure of dental hygienists and shall carry out duties as assigned by the board. The committee shall have no regulatory or disciplinary authority with regard to dentists, dental assistants, dental lab technicians, or any other auxiliary dental personnel (subsection 2).

The board shall ratify recommendations of the committee at the first meeting of the board following adoption of the recommendations by the committee, or at a meeting of the board specifically called for the purpose of board review and ratification of committee recommendations. The board shall decline to ratify committee recommendations only if the board makes a specific finding that a recommendation exceeds the jurisdiction or expands the scope of the committee beyond the authority granted in subsection 2, creates an undue financial impact on the board, or is not supported by the record (subsection 3).

Current Members	***Date Appointed***
Mary Kelly, R.D.H., Chair	***2011***
Nancy Slach, R.D.H.	2012
Matthew McCullough, D.D.S.	2013

Additional Information

Number of Members: 3, established in Iowa Code

Frequency of Meetings: Once per quarter, or as needed

Number of Vacancies: 1 vacancy effective May 1, 2015

Method of Appointment: The 2 dental hygienist members of the board are automatically members. The dentist member shall be elected to the committee annually by a majority vote of board members. The dentist member must have supervised and worked in collaboration with a dental hygienist for a period of at least 3 years immediately preceding election to the committee.

Term Limits: None

Mode of Meeting: Typically in person; teleconferences on occasion

Staff Coordinator: Christel Braness

**mandated by statute*

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Anesthesia Credentials Committee Purpose Statement

The Anesthesia Credentials Committee is established in Iowa Administrative Code 650--Chapter 29. The committee is tasked with reviewing requests related to the issuance and renewal of moderate sedation and general anesthesia permits.

Current Members	***Date Appointed***
Kaaren Vargas, D.D.S., Chair (Board Member)	***2012***
John Frank, D.D.S.	2013
Richard Burton, D.D.S.	prior to 2012
Steven Clark, D.D.S.	prior to 2012
Kurt Westlund, D.D.S.	prior to 2004
Doulgas Horton, D.D.S.	prior to 2004
Gary Roth, D.D.S.	prior to 2004

Additional Information

Number of Members: No fewer than 7. According to IAC 650--29.10 this committee shall be chaired by a member of the board and shall include at least 6 additional members who are licensed dentists. At least 4 committee members shall hold deep sedation/gederal anesthesia or moderate sedation permits.

Frequency of Meetings: Once per quarter, or more frequently as needed
Number of vacancies: 0
Method of Appointment: Apppinted by the board. The board chairperson shall appoint the committee chair.
Term Limits: None
Mode of Meeting: Typically by teleconference; occassionally in-person
Staff Coordinator: Christel Braness

**mandated by rule*

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Continuing Education Advisory Committee Purpose Statement

The Continuing Education Advisory Committee is a committee established in IAC 650--25.1 to review and make recommendations on post-approval requests for continuing education courses, or other continuing education-related issues, as requested.

Current Members	***Date Appointed***
Lori Elmitt, Chair (Board Member)	***2012***
Steven Fuller, D.D.S. (Board Member)	2013
Marijo Beasler, R.D.H.	2009
George North, D.D.S.	prior to 2006
Eileen Cacioppo, R.D.H.	prior to 2004
Jane Slach, R.D.A.	prior to 2006
Kristee Malmberg, R.D.A.	prior to 2006

Additional Information

Number of Members: 7. The committee is established in IAC 650--25.1. Must consist of 1 member of the board, 2 licensed dentists with expertise in the area of professional continuing education, 2 licensed dental hygienists with expertise in the area of professional continuing education, and 2 registered dental assistants with expertise in the area of professional continuing education.

Frequency of Meetings: Once every 6-8 weeks, or as needed
Number of Vacancies: 0
Method of Appointment: Apppinted by the board. The board chairperson shall appoint the committee chair.
Term Limits: None
Mode of Meeting: Typically by teleconference; occassionally in-person
Staff Coordinator: Christel Braness, Angela Davidson
**mandated by rule*

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Iowa Practitioner Review Committee Purpose Statement

The Iowa Practitioner Review Committee (IPRC) is established in Iowa Administrative Code 650--Chapter 35 to evaluate, assist, and monitor the recovery, rehabilitation, or maintenance of dentists, hygienists, or assistants who self-report impairments. The IPRC is both an advocate for the health of a practitioner and a means to protect the health and safety of the public.

Current Members	***Date Appointed***
Richard Rips, D.D.S., Chair	***2011***
Gordon Anderson, II, IADC, Chair	2010
DeeAnn Decker, International Alcohol and Drug Counselor	2013
Sheila Rodgers, Certified Alcohol and Drug Counselor, Certified Compulsive Gambling Counselor	2013
Jill Stuecker, Executive Director	2014
Vacancy: Psychiatrist or psychologist as desired by the committee	

Additional Information

Number of Members: Not specified in rule
Frequency of Meetings: Once per quarter
Number of Vacancies: 1, the committee wishes to have a psychiatrist or psychologist
Method of Appointment: The chairperson of the board shall appoint the members of the IPRC. Membership may include but is not limited to: Executive director of the board, 1 practitioner who has remained free of addition for no less than 2 years following successful completion of a board-approved recovery program, 1 physician/counselor with expertise in substance abuse/addition treatment program, 1 psychiatrist or psychologist, and 1 public member. The committee shall elect a chairperson and vice chairperson annually at the last meeting closest to April 30. They will both service 1 year terms beginning on May 1.

Term Limits: Committee members, except the executive director, shall be appointed for 3 year terms which begin on May 1 and terminate on April 30

Mode of Meeting: In-person
Staff coordinator: Angie Davidson
**mandated by rule*

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Licensure/Registration Committee Purpose Statement

The licensure/registration committee is responsible for reviewing and recommending appropriate action concerning applications for: Permanent licensure as a dentist in cases where former disciplinary action or criminal history has been reported and meets the criteria for review; Resident dental licenses or faculty permits in cases where the applicants are foreign trained; Reinstatement in cases where the practitioner has been out of practice for 5 or more years, to determine if additional examination(s) are required prior to reinstatement; Dental assistant registrations, radiography qualifications, reinstatements who have a criminal history; Dental assistant reinstatements for examination recommendations over five years, not covered in existing rules.

Current Members	***Date Appointed***
Matthew McCullough, D.D.S., Chair	***2012***
Tom Jeneary, D.D.S.	2013
Diane Meier	2008

Additional Information

Number of Members: 3. This committee requires appointments of board members due the confidential nature of the material (4 members could result in a tie, and 5 or more would establish a quorum of the board so it must be 3).

Frequency of Meetings: By email or as needed

Number of Vacancies: 1 on May 1, 2015

Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.

Term Limits: None

Mode of Meeting: By email or in person

Staff Coordinator: Janet Arjes, Christel Braness

**mandated by rule*

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Budget Review Committee Purpose Statement

The Budget Review Committee was established to review and discuss issues related to the board's annual budget.

Current Members	***Date Appointed***
Steven Fuller, D.D.S., Chair	***2012***
Matthew McCullough, D.D.S.	2012
Tom Jeneary, D.D.S.	2013

Additional Information

Number of Members: At board chairperson's descretion
Frequency of Meetings: As needed
Number of Vacancies: 0
Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.
Term Limits: None
Mode of Meeting: In person or by teleconference
Staff Coordinator: Jill Stuecker, Christel Braness
**created by Board*

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Dental Assistant Registration Committee Purpose Statement

The Dental Assistant Registration Committee was created by the board to review issues relating to dental assistants. The committee monitors policies around the registration and reinstatement process; testing; expanded functions and other issues as needed. The committee also reviews items as requested by the board.

Current Members	*Date Appointed*
George North, D.D.S., Chair	***Est. 2003***
Tom Jeneary, D.D.S. (Board Member)	2013
Steven Fuller, D.D.S. (Board Member)	2011
Steven Bradley, D.D.S. (Board Member)	2010
Diane Meier (Board Member)	2008
Denise Bell, R.D.A.	2006

Additional Information

Number of Members: At board chairperson's descretion
Frequency of Meetings: As needed
Number of vacancies: 0
Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.

Term Limits: None
Mode of Meeting: In person and by teleconference
Staff Coordinator: Janet Arjes
**created by Board*

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Executive Committee Purpose Statement

The Executive Committee is a subset of the board available to the executive director for support and guidance.

Current Members	***Date Appointed***
Steven Bradley, D.D.S., Chair	***2012***
Steven Fuller, D.D.S., Vice-Chair	2013
Matthew McCullough, D.D.S., Secretary	2013
Mary Kelly, R.D.H.	2012

Additional Information

Number of Members: At board chairperson's descretion. The executive committee should have at least a chair, vice-chair and secretary.
Frequency of Meetings: Once per quarter
Number of vacancies: 0
Method of Appointment: Appointed by board chairperson. Board chairperson serves as committee chair.
Term Limits: None
Mode of Meeting: In person or by phone as needed
Staff Coordinator: Jill Stuecker
**created by Board*

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Examination Review Committee Purpose Statement

The Examination Review Committee is an hoc committee established to review and discuss matters related to the licensing examinations accepted by the board.

Current Members	***Date Appointed***
P.T. Grimes, D.D.S., Chair	***2008***
Steven Fuller, D.D.S. (Board Member)	2012
David Holmes, D.D.S.	prior to 2006
Michael Kanellis, D.D.S.	prior to 2006
Deena Kuempel, D.D.S.	prior to 2006

Additional Information

Frequency of Meetings: Has not met in several years
Number of Members: At board chairperson's descretion
Number of vacancies: 0
Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.
Term Limits: None
Mode of Meeting:
Staff Coordinator: Phil McCollum

**ad hoc, created by Board*

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Expanded Functions Task Force Purpose Statement

THe Expanded Functions Task Force is an ad hoc committee tasked with making recommendations to the board about possible rule amendments related to expanded functions for RDAs and RDHs. The board also tasked the committee with reviewing requests for expanded functions course approval for recommendation to the board.

Current Members	***Date Appointed***
Nancy Slach, R.D.H., Chair (Board Member)	***2013***
Tom Jeneary, D.D.S. (Board Member)	2013
Jane Slach, R.D.A.	2013
Elaine Peterson, R.D.A.	2013
Lynn Curry, D.D.S.	2013
Steven Thies, D.D.S.	2013
Michael Kanellis, D.D.S.	2013

Additional Information

Number of Members: 7

Frequency of Meetings: As needed

Number of Vacancies: 0

Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.

Term Limits: None

Mode of Meeting: In person and by teleconference

Staff Coordinator: Janet Arjes, Christel Braness

**ad hoc, created by Board*

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Skilled Care Facility Task Force Purpose Statement

The Skilled Care Facility Task Force is an ad hoc task force created to discuss and review concerns related to dental health care access of residents of skilled care facilities. The task force was tasked with reviewing options related to these individuals and how to best address access to dental health care.

Current Members	***Date Appointed***
Michael Kanellis, D.D.S., Chair	***2013***
Steven Bradley, D.D.S. (Board Member)	2013
Mary Kelly, R.D.H. (Board member)	2013
Eileen Cacioppo, R.D.H.	2013
Howard Cowen, D.D.S.	2013
Lori Elmitt (Board Member)	2013
Jane Slach, R.D.A.	2013
Beth Jones	2013
Lynn Curry, D.D.S.	2013
Steven Thies, D.D.S.	2013
Maria Fuller, D.D.S.	2013

Additional Information

Number of Members: At board chairperson's descretion

Frequency of Meetings: Task Force has not met in approximately 1 year.

Number of Vacancies: 0

Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.

Term Limits: None

Mode of Meeting: Meet in person and by teleconference as appropriate

Staff Coordinator: Phil McCollum

**ad hoc, created by Board*

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***This is an external committee**

CRDTS Steering Committee	*Appointed:*	***CRDTS Examination Review Committees***	*Appointed:*
Steven Bradley, D.D.S.		Kaaren Vargas, D.D.S. - Dental Examinations	
		Mary Kelly, R.D.H. - Hygiene Examinations	

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AAFE
AMERICAN ACADEMY
OF FACIAL ESTHETICS

2120 South Green Road, Second Floor
South Euclid, OH 44121

800.952.0521 | WWW.FACIALESTHETICS.ORG

March 31, 2015

Dear Dr. Bradley,

I hope this letter finds you well.

By way of brief introduction to the rest of the Iowa Dental Board members, I am President of The American Academy of Facial Esthetics (AAFE). The American Academy of Facial Esthetics is an educational organization which focuses on teaching non-surgical minimally invasive procedures for both dental esthetic and dental pain therapeutic treatment in the oral and maxillofacial region. The AAFE presents over 100 courses a year in North America on the use of facial injectables such as Botox and dermal fillers for dental treatment as well as live patient and hands-on courses on frontline TMJ, headache, myofascial pain, dental implants, porcelain veneers, and other dental procedures. The American Academy of Facial Esthetics is also the fastest growing membership organization in dentistry with over 9000 members and we do have a number of members from your state.

A number of your fellow state boards around the country have used the AAFE as a resource to help educate state dental board members specifically in the area of facial injectables such as Botox and dermal fillers for dental esthetics and TMJ and facial pain treatment. Many dental board members are not familiar with this very rapidly growing area of dentistry. The use of Botox and dermal fillers by general dentists is now a normative dental procedure which is integrated into many dental treatment plans for both dental esthetic and dental therapeutic uses. The American Academy of Facial Esthetics has presented its live patient hands-on training at a number of large dental meetings including the Academy of General Dentistry Annual Session, the Chicago Dental Society Midwinter Meeting, the Hinman Dental Meeting, the Greater New York Dental Meeting, and at the American Dental Association Annual Session. Additionally, please see the enclosed document where you can see a list of over 50 dental universities and dental society continuing education programs that have included Botox and dermal fillers lectures and training in the last few years. The AAFE has already trained over 12,000 dental professionals from 48 states and 29 countries.

I know that the Iowa state dental board has been looking at the issue of Botox and dermal fillers in dentistry. With proper training, general dentists can very safely provide these services to their patients and have been doing so for the past few years in the

majority of states. I have personally worked with many state dental boards on this issue and nearly every state allows dentists to use these pharmaceuticals within the scope of dental practice. The enclosed articles will demonstrate the range of dental uses for Botox and dermal fillers.

The key point is that Botox and dermal fillers are pharmaceutical agents used in dental treatment, they are not treatment procedures. Botox and dermal fillers are equivalent to local anesthetics and antibiotics in their use in dentistry, they are not dental procedures but are used to accomplish dental treatment. There are now many uses for Botox and dermal fillers in dentistry for both dental esthetic and frontline TMJ and myofascial pain treatment. State board opinions, position statements, and administrative rules disallowing the specific use of Botox and dermal fillers by general dentists may directly conflict with the state dental practice act being that Botox and dermal fillers are simply drugs that are used for the broad range of dental procedures allowed by the definition of dentistry of the state dental practice act.

After working with so many state dental boards for a number of years, we all know that the primary purpose of the state dental board is to protect the public. This is important to us as well, which is why the American Academy of Facial Esthetics was created. It was important that we created an institution that was able to set standards for education in dental and facial esthetics and standardized protocols for the best therapeutic treatment outcomes – both these standards and protocols were previously lacking in dentistry. The American Academy of Facial Esthetics develops and advances interest in oral and facial esthetics and therapeutics through education, practice and research and adheres to the Requirements for Recognition of Dental Specialties guidelines of the American Dental Association.

Please let us know how else we may help you and the Iowa Dental Board. I am happy to answer any other questions that the dental board members have.

Sincerely Yours,

Louis Malcmacher DDS MAGD

Was Surgery Necessary?

Resolving One Patient's Pain After Radical Procedures Fail

Don't be fooled by what appears to be a simple temporomandibular disorder (TMD) or a facial esthetics case. When diagnosing orofacial pain and TMD, we need to consider a variety of factors in order to provide the highest quality frontline treatment to our patients.

Dental professionals may make the mistake of thinking that a patient's problem is limited to TMD and orofacial pain, when, in fact, the patient also may have obstructive sleep apnea. We can't treat the former issues without also addressing the latter. What's more, any treatments for these conditions also will directly affect the patient's facial esthetics, so you'll need to take this into consideration as well. Of course, if you want to make any kind of oral appliance for a patient, you'll also have to address occlusion issues.

As you can see from just this example, there is a lot to consider. You don't need to be an expert in all of these areas, however. You just need to be able to integrate all of these concerns into your treatment plan. This will ensure that your treatment of one condition won't exacerbate another.

Orofacial pain, dental sleep medicine, facial esthetics—these issues often are all interconnected. Consider how you treat these frontline cases, as well as when you should refer to other dental specialties and physicians.

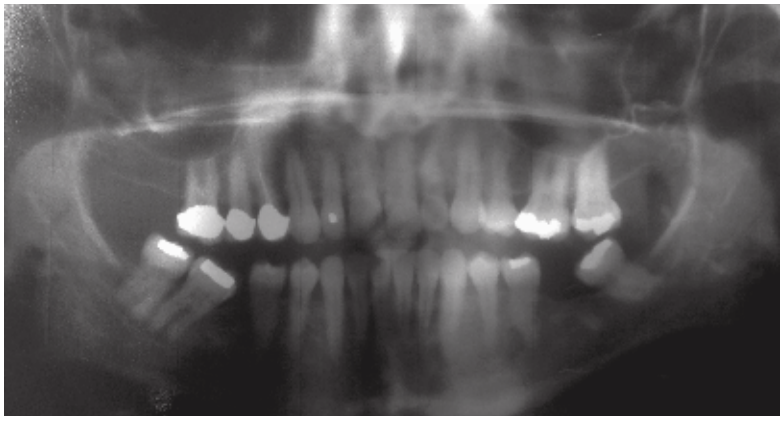

Figure 1. Panoramic radiograph taken in 2004, when the patient had constant orofacial pain.

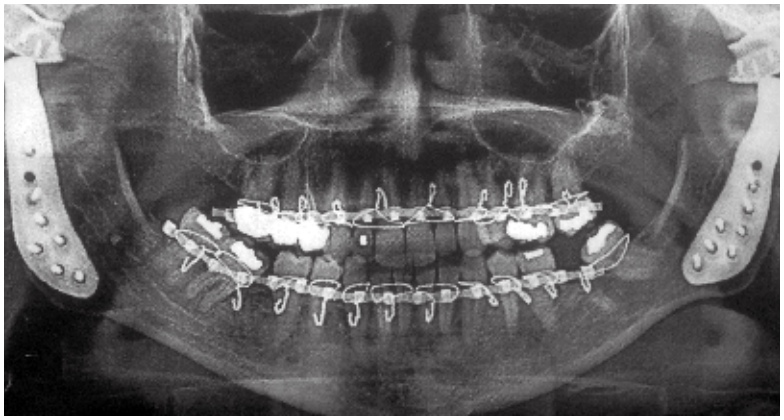

Figure 2. Panoramic radiograph taken after bilateral condylectomy procedure in 2013. Was this procedure necessary to resolve the patient's pain?

Trying everything

Allow me to share a truly fascinating case that my colleague, Rex Whiteman, DDS, a very talented Georgia dentist, recently shared with me. It involves a patient with a 15-year history of temporomandibular joint problems and head and neck pain. In Figure 1, you can see an X-ray of this patient from 2004.

The patient sought relief from several dentists and specialists, who attempted a number of orofacial pain treatments, including appliance therapy and medication. All of these treatments were designed to improve teeth- or joint-related conditions.

However, the patient reported that the pain just kept getting worse, and that she was experiencing a limited range of mandibular motion and crepitus in both temporomandibular joints. Hoping to remedy the situation, she went through surgical and invasive procedures, including bilateral open temporomandibular joint surgery in 2004 and a bilateral condylectomy in 2013 (Figure 2).

When I show these images to other colleagues, dentists like me who graduated in the '80s or earlier make the same comment: "I thought they stopped doing bilateral condylectomies in the 1980s."

These procedures are still performed in extreme cases, however, and the treating doctors felt this patient was just such a case. Based on her history, it seems the doctors were convinced that some sort of condylar degeneration was causing the pain.

So, what happened to her head and neck pain? Did it go away? The answer, unfortunately, is no. But, because the patient had undergone this radical treatment, she thought there was nothing else that could be done, and she resolved to live with the pain.

Finding relief

In 2013, the patient in question walked into Dr. Whiteman's office. At that time, her main complaints were ear, neck, shoulder, orofacial, and back pain. She also had limited ability to open her mouth, which was associated with her constant pain.

After reviewing and discussing her medical and treatment history (She was taking tramadol, a centrally acting opioid analgesic for moderate to severe pain.) he evaluated her head and neck muscles and found a number of trigger points that were radiating pain—exactly the pain she had always complained about. In fact, by palpating the trigger points, he could duplicate her pain.

Having been trained in frontline TMD, orofacial pain, and trigger point therapy, Dr. Whiteman discussed treatment options with his patient and suggested nonsurgical, minimally invasive trigger point injections with botulinum toxin (BOTOX®). The patient decided that she had nothing to lose and consented.

The dentist provided the BOTOX therapy, injecting six units into the orbicularis oculi muscles bilaterally, 10 units into the temporalis muscles bilaterally, 12 units into the masseter muscles bilaterally, five units into the splenius capitis muscles bilaterally, and 15 units into the trapezius muscles bilaterally.

The patient noted that she started to feel better while she was still in the office; subsequently, she enjoyed a resolution of approximately 85 to 95 percent of her pain within a week of the treatment. Dr. Whiteman asked if anybody had ever evaluated the muscles in her head and neck as a possible source of her pain, and the patient said she did not recall that occurring. All of the doctors she had seen had only been interested in the teeth, bones, and joints, she said.

Looking back

After her successful treatment, the patient turned to Dr. Whitman and asked the inevitable, but uncomfortable question: "Did I really need all of those surgeries?"

He answered diplomatically, "Listen, at this point I don't know. I wasn't there when you saw those dentists and specialists, and I'm sure that they knew what they were doing. I'm just happy that we were able to help resolve most of your pain, and now we know what to do in the future."

That is exactly how I would have answered this patient's question. We are in no position to judge past treatment decisions, because we don't know how the patient presented to his or her former doctors. However, what we can do with each case that comes before us is learn for the future. This dentist now knows how to resolve this patient's pain going forward, and that is a huge success for the patient. In addition to experiencing pain relief, it is also worth noting that she is pleased with the esthetic result of the treatment, specifically the slimmer jaw line that resulted from the masseter injections. As of press time, the patient was no longer experiencing pain, and her symptoms were completely resolved.

"We are in no position to judge past treatment decisions, because we don't know how the patient presented to his or her former doctors."

After my colleague shared this story with me, I asked to see the entire case file and found that the patient also had a long history of sleep apnea and had been wearing a continuous positive airway pressure (CPAP) machine for some time. This presents some additional questions since we know there is a deep comorbid relationship between bruxism, orofacial pain, and obstructive sleep apnea.

Was the patient's obstructive sleep apnea partially responsible for her orofacial pain problems? If so, to what degree? Some CPAP masks can put a tremendous amount of pressure on facial muscles, which could worsen existing orofacial pain. If this patient received the wrong kind of bruxism appliance—for example, a flat plane appliance that could make her muscular pain worse, not better—how much did that exacerbate her orofacial pain? If this patient's doctors would have taken all of these factors into consideration when developing her treatment plans, would she have resolved her pain years earlier? We will never know. What we do know is that dentists are able to successfully treat these types of patients with the appropriate training in frontline dental sleep medicine, bruxism, and orofacial pain therapy.

Today, we understand more about facial esthetics, orofacial pain, dental sleep medicine, and bruxism appliance therapy than ever before. It is time to start putting all of this knowledge together in order to better serve our patients. Only when we consider every potential consideration in evaluating our patients can we truly provide them with an integrative frontline treatment plan that really works. ◆

Louis Malcmacher, DDS, MAGD, is a practicing general dentist and an internationally known lecturer and author distinguished by his comprehensive and entertaining style. Dr. Malcmacher is the president of the American Academy of Facial Esthetics. Contact him at *impact@agd.org.*

The Hottest Topic in Dentistry

Botox and Dermal Fillers Offer Creative Treatment Options

It's interesting that when I give my most popular continuing education course, "The Hottest Topics in Dentistry," I talk about the full range of general dentistry—from what is new in restorative dentistry, crown and bridge, periodontics, endodontics, prosthodontics, implants, and the next generation no-prep veneers, to advanced practice management techniques. I also discuss Botox® and dermal fillers in dentistry, which is one of the hottest topics today. However, I always have to save that topic for later in the presentation, because if I talk about Botox first, many times that is all the dental audience wants to discuss. One of the reasons for this is because Botox and dermal fillers are new and exciting to dentistry. Additionally, once a dentist understands what Botox and dermal fillers actually do, their dental creativity immediately kicks in, and they have a whole new set of treatment options for their daily practice of dentistry.

There is no question that Botox and dermal fillers are well-known for the esthetic results they deliver in smoothing skin and replacing lost volume in the face, especially in the oral and peri-oral areas. Botulinum toxin (Botox and Dysport®) is essentially a muscle relaxer that will smooth wrinkled skin by dynamic movement of the underlying muscles. Dermal fillers, such as Juvéderm® and Restylane®, are volumizers—or plumpers—that fill out lips and static folds in the face caused by loss of collagen and fat. Once you have been trained in these procedures and thoroughly understand the anatomy, physiology, pharmacology, and related adverse reactions, you will find many, many therapeutic uses for both functional and dental esthetic purposes. Now that most states allow dentists to use botulinum toxin and dermal fillers for both dento-facial esthetic and therapeutic purposes, we are finding more and more treatment uses for Botox and dermal fillers in dentistry.

Figure 1. Preoperative smile; patient reports her front tooth is loose.

Figure 2. Tooth No. 9 has a horizontal fracture.

Figure 3. Successful implant integration replacing the left central incisor.

Figure 4. Insufficient interdental papilla creating black triangles.

Figure 5. Diode laser (Picasso® Lite) used to create space within the interdental papilla.

Figure 6. Dermal filler (Juvéderm® Ultra Plus XC) used to add volume and create proper contours of the interdental papilla.

Successful treatment outcomes

Here are but a few examples of dental esthetic and dental therapeutic uses for botulinum toxin and dermal fillers:

- TMD cases
- Bruxism and clenching cases
- Facial pain cases, including treating trigger points
- Treatment of angular chelitis
- Gummy smile cases
- Orthodontic relapse and depressed orthodontic appearance
- Reducing muscle hyperactivity for retention of removable prosthodontics
- Oral and maxillofacial esthetics to smooth skin
- Establishing esthetic dental lip lines and smile lines in esthetic dentistry cases as an alternative to gingivectomy, crown lengthening, and veneers
- Re-establishing lip volume for proper phonetics (in addition or as opposed to teeth lengthening with fixed or removable prosthodontics)
- Adding lip and perioral volume around the mouth for retention of removable prosthodontics
- Oral and maxillofacial esthetics, including lip augmentations and replacing volume in the intra-orally and extra-orally

TMJ and facial pain have haunted dental practitioners for years and are among the most frustrating of cases. Studies show that as many as 85 percent of TMJ and facial pain cases are mostly muscle-related. Dentists have previously concentrated their treatment on the occlusion and teeth first, and the muscles later. It is time to completely rethink this treatment progression. Now, using botulinum toxin therapeutically for facial pain and TMJ, it is possible to eliminate the pain coming from the muscle pathology first. Once we are able to see how much of a factor this pain is, we may go ahead and treat the occlusion or the actual joint much more easily and accurately than ever before.

Dealing with the 'black triangle'

Here is a perfect example of a new treatment option with a protocol developed by the faculty of the American Academy of Facial Esthetics (*www.facialesthetics.org)*. The dreaded "black triangle" usually tops the list of dentists' frustration after the preparation of crowns, bridges, and especially after implant and periodontal surgery. After treatment, the patient finally has a nice new tooth surrounded by one or two big black holes on either side of it, which the patient spits through or catches food in. While the patient should be thrilled that they don't have to wear a flipper or temporary anymore, they are disappointed at the esthetic results because of the lost tissue. What are our options? We can bond to adjacent teeth, we can redo the crown, remove the implant and try again with a new implant, or try a variety of other frustrating treatment options that are very aggressive and which may or may not work. The placement of dermal fillers in these areas to literally plump up papilla is a minimally invasive way to create proper and more pleasing gingival contours.

Let's take a look at the case above. Figure 1 shows the pre-op photo of a patient who has two all-ceramic crowns on teeth No. 8 and 9 and some veneers. The crown on tooth No. 9 is loose and the radiograph in figure 2 shows why—the tooth has fractured at the gumline. Figure 3 shows the new implant in place. The dreaded "black triangles" in figure 4 is one of the most challenging esthetic problems we deal with, for which there are very limited successful treatment options. Compare that to her original pre-op picture again in figure 1 and you can see why it bothers her. In addition to that, now food collects in these areas, and when she speaks, she finds herself, "spitting while I talk," something she has never done before. The patient loves and hates her new implant all at the same time. In figure 5, we treated her with a diode laser (Picasso® Lite, AMD Lasers) to loosen the gingival attachment and create space within the remaining papilla. Then we placed .15 mL of dermal filler (Juvéderm Ultra Plus XC, Allergan Corporation) into the papilla to rebuild it. Figure 6 shows the rebuilt gingival papilla, which fills up the black triangles and takes care of the patients' esthetic and functional concerns. The treatment appointment was approximately five minutes, and this outcome can be expected to last for eight months or longer—at which point the treatment will need to be repeated. This is a very minimally invasive approach to a very difficult dental situation, and it completely satisfies the needs of the patient and gives the dental operator a very successful treatment outcome.

Essential training

It is our legal and ethical duty to give patients all of the options available for their dental treatment. In this day and age, to do that, we need to get trained in the use of Botox and dermal fillers, as these are well-established viable dental treatment options. The treatments described in this article clearly fall under the definition of dentistry in nearly all of the state dental practice acts. Once dentists understand the use of botulinum toxin and dermal fillers in dentistry for dental therapeutic and dental esthetic cases and become proficient in their use through proper training, they will be able to offer these treatments in conjunction with, or in addition to, their current treatment options to patients. The American Academy of Facial Esthetics continues to develop successful proven techniques and trains dentists to integrate these procedures into dental esthetic and dental therapeutic treatment plans. Get trained today! ◆

Louis Malcmacher, DDS, MAGD, is a practicing general dentist and an internationally known lecturer and author known for his comprehensive and entertaining style. An evaluator emeritus for *Clinicians Report*, Dr. Malcmacher has served as a spokesman for the AGD and is the president of the American Academy of Facial Esthetics *(www.FacialEsthetics.org)*. You can contact him at *drlouis@FacialEsthetics.org*.

Dental education on Botox and dermal fillers for general dentists for therapeutic and esthetic purposes in the oral and maxillofacial areas 2008 – 2014

This partial list includes continuing education dental lectures and/or hands-on training programs that have been presented at the following dental universities (in residencies and continuing education courses for general dentists) and at the following dental associations and societies:

UCLA School of Dentistry
USC School of Dentistry
UCSF School of Dentistry
UMDNJ School of Dentistry
Loma Linda School of Dentistry
University of Washington School of Dentistry
University of Toronto School of Dentistry
University of Buffalo School of Dentistry
Iowa University Dental Society Meeting
Tufts University School of Dentistry
University of Michigan School of Dentistry
University of British Columbia School of Dentistry
Louisiana State University School of Dentistry
Nova Southeastern University School of Dentistry
University of Alabama School of Dentistry
American Dental Association Annual Meeting
American Academy of Facial Esthetics
Academy of General Dentistry
American Academy of Cosmetic Dentistry
California Dental Association Annual Meeting
Greater New York Dental Annual Meeting
Chicago Dental Society Annual Meeting
Northeastern Regional Dental Association
Kentucky Dental Association Annual Meeting
North California Academy of General Dentistry
Indiana Dental Association
Wisconsin Dental Association Annual Meeting
Quebec Dental Association Annual Meeting
Arizona Dental Association Annual Meeting
Texas Dental Association Meeting
Florida Dental Association Annual Meeting
Valley Forge Dental Association Meeting
Greater Long Island Dental Meeting
Hinman Dental Meeting
New Orleans Dental Conference
Dentaltown Annual Meeting
Sacramento District Dental Society
Maryland State Dental Association Meeting
Michigan Dental Association Meeting
Northern Virginia Dental Association Meeting
Buffalo Niagara Dental Annual Meeting
Oregon Dental Association Annual Meeting
Texas Academy of General Dentistry Annual Meeting
Ontario Academy of General Dentistry Annual Meeting
Alabama Academy of General Dentistry Annual Meeting
Pennsylvania Academy of General Dentistry
Illinois Academy of General Dentistry Annual Meeting
Beverly Hills Dental Study Club
Ohio Dental Association Annual Meeting
Maine Dental Association Annual Meeting
Detroit District Dental Society
Utah Academy of General Dentistry
Florida National Dental Congress
Yankee Dental Congress

The American Academy of Facial Esthetics trains dentists in the use of Botox and dermal fillers in the oral and maxillofacial areas for dental esthetic and dental therapeutic uses. In the last 3 years, The American Academy of Facial Esthetics has educated over 10000 healthcare professionals including over 8000 dental professionals including general dental and dental specialty offices from all 50 states and 36 countries through over 100 live patient training courses a year which has been become the model and standard for accepted dental education in these procedures.

HOUSE FILE 600
BY COMMITTEE ON HUMAN
RESOURCES

(SUCCESSOR TO HF 218)

A BILL FOR

1 An Act relating to telehealth and professional licensure,
2 insurance coverage, and reimbursement under the medical
3 assistance program.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. LEGISLATIVE FINDINGS. The general assembly
2 finds and recognizes all of the following:
3 1. Access to health care facilities and health care
4 professionals is critically important to the citizens of Iowa.
5 2. Telehealth uses electronic technology to overcome a
6 geographic distance between patients and health care providers
7 for the purpose of intervention, clinical management, or
8 assessing, monitoring, or educating patients.
9 3. The provision of telehealth results in demonstrated
10 cost-effectiveness, improvements in disease management,
11 and improved patient outcomes and studies by the American
12 telemedicine association and others have demonstrated
13 significant reductions in hospitalizations and otherwise
14 necessary medical care as a result of telehealth intervention.
15 4. Geography, weather, availability of specialists,
16 transportation, and other factors can create barriers to
17 accessing appropriate health care, including behavioral health
18 care, and one way to provide, ensure, or enhance access to
19 care given these barriers is through the appropriate use of
20 technology to allow health care consumers access to qualified
21 health care professionals.
22 5. Additionally, the utilization of telehealth will
23 further the maintenance and improvement of the physical
24 and economic health of patients in medically underserved
25 communities by retaining the source of health care in local
26 areas, strengthening the health infrastructure, and preserving
27 health-care-related jobs.
28 6. A need exists in this state to embrace efforts that
29 will encourage health insurers and health care professionals
30 to support the use of telehealth and that will also encourage
31 all state agencies to evaluate and amend their policies and
32 rules to remove any regulatory barriers prohibiting the use of
33 telehealth.
34 7. Recognition exists that the full potential of delivering
35 health care services through telehealth cannot be realized

without the assurance of payment and the resolution of existing legal and policy barriers to such payment.

8. The purpose of the Iowa telehealth Act is to provide a framework for health care professionals to utilize in providing telehealth to Iowans in a manner that provides efficient and effective access to quality health care.

Sec. 2. NEW SECTION. **147B.1 Title.**

This chapter shall be known and may be cited as the *"Iowa Telehealth Act"*.

Sec. 3. NEW SECTION. **147B.2 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Distant site"* means the site at which a health care professional delivering the service is located at the time the telehealth service is provided.

2. *"Health care professional"* means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession, or in an approved education or training program, as long as the person is operating within the person's professional scope of practice.

3. *"Remote patient monitoring"* means using telehealth to enable the health care professional to monitor and manage a patient's medical, functional, and environmental needs if such needs can be appropriately met through telehealth intervention.

4. *"Store-and-forward telehealth"* means the use of asynchronous communications between a patient and a health care professional or between a referring health care professional and a medical specialist at a distant site, supported by telecommunications technology for the purpose of diagnosis, consultation, treatment, or therapeutic assistance in the care of the patient, including the transferring of medical data from one site to another through the use of a camera or similar device that records or stores an image that is

sent or forwarded via telecommunications to another site for consultation.

5. *"Telehealth"* means the use of real-time, interactive audio or video telecommunications or electronic technology, remote patient monitoring, or store-and-forward telehealth by a health care professional to deliver health care services to a patient within the scope of practice of the health care professional, for the purposes of diagnosis, consultation, treatment, transfer of medical data, or exchange of medical education information. *"Telehealth"* does not include an audio-only telephone call, electronic mail message, or facsimile transmission.

Sec. 4. NEW SECTION. **147.163 Telehealth.**

1. A health care professional licensed by a board created under this chapter, as appropriate to the scope of practice of the profession, may employ the technology of telehealth by applying telehealth within the professional's scope of practice or by using telehealth technology under the direction and supervision of another health care professional who is using telehealth technology within the supervising professional's scope of practice. A health care professional's employment of telehealth acting under the direction and supervision of another health care professional who is using telehealth within that health care professional's scope of practice shall not be interpreted as practicing the supervising professional's health care profession without a license. However, any health care professional employing telehealth must hold a current valid license to practice the respective profession in the state and be trained, educated, and knowledgeable regarding the health care service provided and technology used and shall not perform duties for which the professional does not have sufficient training, education, and knowledge. Failure to have sufficient training, education, and knowledge is grounds for disciplinary action by the respective board.

2. The applicable board that exercises regulatory or

1 rulemaking authority over an affected profession under this
2 chapter, or the department in the absence of an applicable
3 board, shall adopt rules to administer this chapter.
4 3. The standard of care for a professional using telehealth
5 to provide health care services to a patient shall be the same
6 as the standard of care required of that professional for the
7 provision of in-person health care services to a patient.
8 4. The type of setting where telehealth is provided for the
9 patient or by the health care professional shall not be limited
10 if the delivery of health care services is appropriately
11 provided through telehealth.
12 5. This chapter shall not be construed to conflict with or
13 supersede provisions otherwise applicable to the licensure of
14 health care professionals.
15 6. This chapter shall not be construed to alter the scope
16 of practice of any health care professional, authorize the
17 delivery of health care services in a setting or manner not
18 otherwise authorized by law, or limit a patient's right to
19 choose in-person contact with a health care professional for
20 the delivery of health care services for which telehealth is
21 available.
22 7. If a health care professional provides services pursuant
23 to and in compliance with section 135.24 via telehealth in
24 accordance with this chapter, the provisions of section 135.24
25 including those relating to immunity from civil liability shall
26 apply to such health care professional.
27 Sec. 5. NEW SECTION. **514C.30 Telehealth.**
28 1. Notwithstanding the uniformity of treatment requirements
29 of section 514C.6, a contract, policy, or plan providing for
30 third-party payment or prepayment for health, medical, or
31 surgical coverage benefits may provide coverage for services
32 provided as telehealth if the services would be covered if
33 provided in-person. If coverage is provided for telehealth
34 under this section, coverage shall not require in-person
35 contact between a health care professional and a patient as a

prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided. If coverage is provided under this section, health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of coverage.

2. If health care coverage is provided for telehealth under this section, all of the following shall apply:

a. This section shall not be interpreted as preventing a third-party payment provider from imposing deductibles or copayment or coinsurance requirements for a health care service provided through telehealth if the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable to in-person consultation for the same health care service. A third-party payment provider shall not impose annual or lifetime maximums on coverage of telehealth unless the annual or lifetime maximum applies in the aggregate to all items and services under the contract, policy, or plan.

b. This section shall not be interpreted to require a third-party payment provider to provide reimbursement for a health care service that is not a covered benefit or to reimburse a health care professional who is not a covered provider under the contract, policy, or plan.

c. This section shall not be interpreted to preclude a third-party payment provider from performing utilization review to determine the appropriateness of telehealth in the delivery of health care services if the determination is made in the same manner as those regarding the same health care service when delivered in person.

d. This section shall not be interpreted to authorize a third-party payment provider to require the use of telehealth when the health care professional determines use of telehealth is not appropriate.

1 *e.* The provisions of this section shall apply to all of the
2 following classes of third-party payment provider contracts,
3 policies, or plans delivered, issued for delivery, continued,
4 or renewed in this state on or after January 1, 2016:
5 (1) Individual or group accident and sickness insurance
6 providing coverage on an expense-incurred basis.
7 (2) An individual or group hospital or medical service
8 contract issued pursuant to chapter 509, 514, or 514A.
9 (3) An individual or group health maintenance organization
10 contract regulated under chapter 514B.
11 (4) An individual or group Medicare supplemental policy,
12 unless coverage pursuant to such policy is preempted by federal
13 law.
14 (5) A plan established pursuant to chapter 509A for public
15 employees.
16 *f.* This section shall not apply to accident-only, specified
17 disease, short-term hospital or medical, hospital confinement
18 indemnity, credit, dental, vision, long-term care, basic
19 hospital, and medical-surgical expense coverage as defined
20 by the commissioner, disability income insurance coverage,
21 coverage issued as a supplement to liability insurance,
22 workers' compensation or similar insurance, or automobile
23 medical payment insurance.
24 3. The commissioner of insurance shall adopt rules pursuant
25 to chapter 17A as necessary to administer this section.
26 4. For the purposes of this section, *"health care*
27 *professional"* and *"telehealth"* mean as defined in section
28 147B.2, as enacted in this Act.
29 Sec. 6. MEDICAID PROGRAM —— REIMBURSEMENT FOR
30 TELEHEALTH. The department of human services shall adopt
31 rules to provide for coverage of telehealth under the
32 Medicaid program. The rules shall provide that in-person
33 contact between a health care professional and a patient
34 is not required as a prerequisite for payment for services
35 appropriately provided through telehealth in accordance

1 with generally accepted health care practices and standards
2 prevailing in the applicable professional community at
3 the time the services are provided. Health care services
4 provided through in-person consultations or through telehealth
5 shall be treated as equivalent services for the purposes
6 of reimbursement. As used in this section, "health care
7 professional" and "telehealth" mean as defined in section
8 147B.2, as enacted in this Act.
9 Sec. 7. STUDY ON USE OF TELEHEALTH. The department of
10 public health, in collaboration with the department of human
11 services, shall convene and conduct a study regarding options
12 for implementing telehealth and telehealth coverage and
13 reimbursement. The division of insurance of the department of
14 commerce shall be available for consultation as needed. The
15 department of public health shall submit a final report of its
16 findings and recommendations to the governor and the general
17 assembly by December 15, 2015.
18 EXPLANATION

19 **The inclusion of this explanation does not constitute agreement with**
20 **the explanation's substance by the members of the general assembly.**

21 This bill relates to telehealth and creates the Iowa
22 telehealth Act. The bill provides legislative findings
23 and purposes regarding the use of telehealth and provides
24 definitions.
25 The bill provides that a health care professional, as
26 appropriate to the scope of practice of the profession, may
27 employ the technology of telehealth by applying telehealth
28 within the professional's scope of practice or by employing
29 telehealth technology under the direction and supervision
30 of another health care professional who is using telehealth
31 technology within the supervising professional's scope
32 of practice. A health care professional's employment of
33 telehealth technology under the direction and supervision of
34 another health care professional who is acting within that
35 health care professional's scope of practice shall not be

1 interpreted as practicing the supervising professional's health
2 care profession without a license. A health care professional
3 employing telehealth technology must hold a current valid
4 license and must be trained, educated, and knowledgeable
5 regarding the health care service provided and technology
6 used and is prohibited from performing duties for which the
7 professional does not have sufficient training, education, and
8 knowledge. Failure to have sufficient training, education, and
9 knowledge is grounds for disciplinary action by the respective
10 board.
11 The bill directs the appropriate board that exercises
12 regulatory or rulemaking authority over a profession within
13 whose scope of practice telehealth may be employed or the
14 department, to adopt rules, to administer the requirements
15 relating to the provision of telehealth by such professionals.
16 The bill provides that the standard of care for a
17 professional, whether using telehealth or providing the care
18 in person, is the same. The type of setting where telehealth
19 is provided for the patient or by the health care professional
20 is not to be limited if the delivery of health care services
21 is appropriately provided through telehealth. The bill is not
22 to be construed to conflict with or supersede the provisions
23 of the health care professionals licensure or to alter the
24 scope of practice of any health care professional, authorize
25 the delivery of health care services in a setting or manner
26 not otherwise authorized by law, or limit a patient's right
27 to choose in-person contact with a health care professional
28 for the delivery of health care services for which telehealth
29 is available. The bill also provides that if a health care
30 professional provides services pursuant to and in compliance
31 with Code section 135.24 relating to the volunteer health
32 care provider program, via telehealth, the provisions of Code
33 section 135.24 including those relating to immunity from civil
34 liability shall apply to such health care professional.
35 The bill provides that a contract, policy, or plan providing

1 for third-party payment or prepayment for health, medical, or
2 surgical coverage benefits may cover telehealth. If telehealth
3 coverage is provided on or after January 1, 2016, the contract,
4 policy, or plan shall not deny coverage on the basis that the
5 services are provided via telehealth if the services would be
6 covered if provided in person and shall not require in-person
7 contact between a health care professional and a patient as a
8 prerequisite for payment for services appropriately provided
9 through telehealth in accordance with generally accepted health
10 care practices and standards prevailing in the applicable
11 professional community at the time the services are provided.
12 Health care services provided through in-person consultations
13 or through telehealth shall be treated as equivalent services
14 for the purposes of coverage.
15 The provision is not to be interpreted as preventing a
16 third-party payment provider from imposing deductibles or
17 copayment or coinsurance requirements for a health care service
18 provided through telehealth if the deductible, copayment, or
19 coinsurance does not exceed the deductible, copayment, or
20 coinsurance applicable to an in-person consultation for the
21 same health care service. The bill provides that a third-party
22 payment provider shall not impose annual or lifetime maximums
23 on coverage of telehealth unless the annual or lifetime maximum
24 applies in the aggregate to all items and services under the
25 contract, policy, or plan.
26 The bill provides that the Code section is not to be
27 interpreted to require a third-party payment provider to
28 provide reimbursement for a health care service that is not
29 a covered benefit or to reimburse a health care professional
30 who is not a covered provider under the contract, policy,
31 or plan; to preclude a third-party payment provider from
32 performing utilization review to determine the appropriateness
33 of telehealth in the delivery of health care services if the
34 determination is made in the same manner as those regarding
35 the same health care service when delivered in person; or to

1 authorize a third-party payment provider to require the use of
2 telehealth when the health care professional determines use of
3 telehealth is not appropriate.
4 The bill specifies the types of third-party payment provider
5 contracts, policies, or plans to which the bill applies and
6 those exempt from its application.
7 The commissioner of insurance is directed to adopt rules
8 pursuant to Code chapter 17A as necessary to administer the
9 provision.
10 The bill directs the department of human services to
11 adopt rules to provide for coverage of telehealth under the
12 Medicaid program. The rules are to provide that in-person
13 contact between a health care professional and a patient
14 is not required as a prerequisite for payment for services
15 appropriately provided through telehealth in accordance
16 with generally accepted health care practices and standards
17 prevailing in the applicable professional community at the
18 time the services are provided. Health care services provided
19 through in-person consultations or through telehealth are
20 to be treated as equivalent services for the purposes of
21 reimbursement.
22 The bill directs the department of public health, in
23 collaboration with the department of human services, to
24 convene and conduct a study regarding options for implementing
25 telehealth and telehealth coverage and reimbursement. The
26 division of insurance is required to be available for
27 consultation as needed. The department of public health
28 is directed to submit a final report of its findings and
29 recommendations to the governor and the general assembly by
30 December 15, 2015.

ARC 1769C

MEDICINE Board [653]
Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"b."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 147.76, the Board of Medicine hereby proposes to amend Chapter 13, "Standards of Practice and Principles of Medical Ethics," Iowa Administrative Code.

The purpose of Chapter 13 is to establish standards of medical practice for medical physicians and osteopathic physicians. The proposed rule establishes the standards of practice for physicians who use telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board approved this Notice of Intended Action during a regularly scheduled meeting on October 3, 2014.

Any interested person may present written comments on the proposed rule not later than 4:30 p.m. on January 15, 2015. Such written materials should be sent to Mark Bowden, Executive Director, Board of Medicine, 400 S.W. Eighth Street, Suite C, Des Moines, Iowa 50309-4686; or sent by e-mail to mark.bowden@iowa.gov.

There will be a public hearing on January 15, 2015, at 1:30 p.m. in the auditorium in the Wallace State Office Building, 502 East Ninth Street, Des Moines, Iowa, at which time persons may present their views either orally or in writing.

After analysis and review of this rule making, it has been determined that this rule could have a positive impact on jobs in Iowa. The new rule will facilitate the practice of medicine at more locations within the state.

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.

The following amendment is proposed.

Adopt the following **new** rule 653—13.11(147,148,272C):

653—13.11(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

1. The board recognizes that technological advances have made it possible for licensees in one location to provide medical care to patients in another location with or without an intervening health care provider.

2. Telemedicine is a useful tool that, if applied appropriately, can provide important benefits to patients, including increased access to health care, expanded utilization of specialty expertise,

rapid availability of patient records, and potential cost savings.

3. The board advises that licensees using telemedicine will be held to the same standards of care and professional ethics as licensees using traditional in-person medical care.

4. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may subject the licensee to potential discipline by the board.

13.11(1) *Definitions.* As used in this rule:

"Asynchronous store-and-forward transmission" means the transmission of a patient's health information from an originating site to a health care provider at a distant site without the presence of the patient.

"Board" means the Iowa board of medicine.

"In-person encounter" means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

"Licensee" means a medical physician or osteopathic physician licensed by the board.

"Telemedicine" means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes store-and-forward technologies, remote monitoring, and real-time interactive services, including tele-radiology, tele-pathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, e-mail messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

"Telemedicine technologies" means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

13.11(2) *Nationally recognized telemedicine guidelines.* A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The Board notes that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

13.11(3) *Iowa medical license required.* A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 653 – 9.

13.11(4) *Standards of care and professional ethics.* A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

13.11(5) *Scope of practice.* A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee's scope of practice, including the licensee's education, training, experience, ability, licensure, and certification.

13.11(6) *Identification of patient and physician.* A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

13.11(7) *Physician-patient relationship.*

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

(1) The person with a health-related matter seeks assistance from a licensee;

(2) The licensee agrees to undertake diagnosis and treatment of the person; and

(3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established:

(I) In-person Encounter: Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;

(2) Consultation with Another Licensee: Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient's care; or

(3) Telemedicine Encounter: Through telemedicine, if the standard of care does not require an in-person encounter, In accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

13.11(8) *Medical history and physical examination.* Generally, a licensee shall perform an in-person medical interview and a physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall ensure that the patient is interviewed to collect the patient's relevant medical history and that the patient receives a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire (i.e. a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) alone does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

13.11(9) *Nonphysician health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a, Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in-person or electronically to consult with nonphysician health care providers, particularly in the case of injury or an emergency.

13.11(10) *Informed consent.* A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

13.11(11) *Coordination of care.* A licensee who uses telemedicine shall (when medically appropriate) identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The

licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

13.11(12) *Follow-up care.* A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

13.11(13) *Emergency services.* A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

13.11(14) *Medical records.* A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

13.11(15) *Privacy and security.* A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols shall be established that address the following:

(1) Privacy;

(2) Health care personnel who will process messages;

(3) Hours of operation;

(4) Types of transactions that will be permitted electronically;

(5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;

(6) Archiving and retrieval; and

(7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

13.11(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

a. The technology and equipment utilized in the provision of telemedicine services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;

b. The technology and equipment utilized in the provision of telemedicine services must be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and

c. The technology and equipment utilized in the provision of telemedicine services must be compliant with the Health Insurance Portability and Accountability Act (HIPAA).

13.11(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

a. Types of services provided;

b. Contact information for the licensee;

c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;

d. Limitations in the drugs and services that can be provided via telemedicine;

e. Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;

f. Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);

g. Appropriate uses and limitations of the technologies, including in emergency situations;

h. Uses of and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;

i. To whom patient health information may be disclosed and for what purpose;

j. Rights of patients with respect to patient health information; and

k. Information collected and passive tracking mechanisms utilized.

13.11(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

a. To access, supplement and amend patient-provided personal health information;

b. To provide feedback regarding the quality of the telemedicine services provided; and

c. To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

13.11(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

13.11(20) *Circumstances where the standard of care may not require a licensee to personally examine a patient:* Under the following circumstances, whether such circumstances involve the use of telemedicine or not, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

a. Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;

b. Institutional settings, including writing initial admission orders for a newly hospitalized patient;

c. Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;

d. Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;

e. Situations in which the patient has been examined in-person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;

f. Emergency situations in which the life or health of the patient is in imminent danger;

g. Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;

h. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and

i. Licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

13.11(21) *Prescribing based solely on an internet request, internet questionnaire or a telephonic evaluation - prohibited.* Prescribing to a patient based solely on an internet request or internet questionnaire (i.e. a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subsection 13.11(20).

13.11(22) Nothing in this rule shall be interpreted to contradict or supersede the requirements established in rule 653—13.10(147,148,272C).

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Gerd W. Clabaugh, MPA
Interim Director

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Calendar Year 2014 Services Report
Public Health Supervision of Dental Hygienists

Total Number of Dental Hygienists with Supervision Agreement: 123 *(93 provided services)*
Total Number of Dentists with Supervision Agreement: 79

Service	Total Provided	Total Clients Age 0-20	Total Clients ≥ Age 21
Sealant	38,275	10,511	0
Prophylaxis	869	278	591
Open Mouth Screening	78,464	76,210	2,161
Fluoride Varnish Application	54,607	53,060	1,540
Individual Counselling/Education	54,406	51,153	3,253
Group/Classroom Education	1,549	27,305	799
Other	109	63	46

Referrals to Dentist(s)			
Clients Age 0-20		Clients ≥ Age 21	
Regular Care	Urgent Care	Regular Care	Urgent Care
42,898	8,868	796	296

Service	Total Services Per Public Health Setting								
	Schools	**Head Start Programs**	**Programs Affiliated with Early Childhood Iowa**	**Child Care Centers**	**Federally Qualified Health Centers**	**Free Clinics**	**Nursing Facilities**	**Federal Public Health Programs (eg WIC)**	**Local Public Health Programs**
Sealant	37,618	0	0	0	26	0	0	0	631
Prophylaxis	90	0	0	0	236	0	419	0	124
Open Mouth Screening	37,524	8,700	4,667	443	212	93	515	25,748	562
Fluoride Application	22,281	8,416	3,717	296	74	0	417	18,974	432
Individual Counseling	20,014	5,264	2,538	370	254	360	422	24,783	401
Group Education	651	335	484	33	0	0	17	22	7
Other (x-rays)	0	0	0	0	51	0	0	51	7

Hygienists Who Submitted 2014 Services Report(s)

	LAST NAME	FIRST
1.	Ackerman	Mariah
2.	Addison	Elizabeth
3.	Badger	Jenifer
4.	Bammert	Sonja
5.	Beem	Carla
6.	Bolic	Samira
7.	Borsdorf	Sarah
8.	Boswell	Briana
9.	Chamberlin	Stephanie
10.	Christensen	Dana
11.	Clemen	Laura
12.	Davidson	Sharon
13.	DeWitt	Jason
14.	Diers	Lisa
15.	Doore	Dawn
16.	Eckenrod	Katrina
17.	Ericson	Dawn
18.	Forseen	Tammy
19.	Funk	Peggy
20.	Gannon	Tisha
21.	Gilpin	Joan
22.	Goetsch	Amy
23.	Halfwassen	Angela
24.	Henke	Cynthia
25.	Hetzler	Rikki
26.	Honsey	Kari
27.	Householder	Elizabeth
28.	Howard	Kim
29.	Hrubes	Marie
30.	Hunziker	Amy
31.	Jamrok	Diane
32.	Janssen	Denise
33.	Kapparos	Robyn
34.	Kelly	Mary
35.	Kemp	Patricia
36.	Kennedy	Rhonda
37.	Ketelsen	Mary Jo
38.	Keune	Susan
39.	Kimpson	Stacy
40.	Kirchner	Lisa

41. Macke	Jennifer
42. Marchese	Kristin
43. McBurney	Katie
44. McGill	Stephanie
45. McManus	Shannon
46. McNeme	Mary Katherine
47. Medinger	Lacey
48. Meyers	Linda
49. Miller	Ashley
50. Milonas	Susan
51. Mondloch	Cora
52. Moreno	Katherine
53. Mortensen	Peggy
54. Mueller	Melissa
55. Mumm	Katie
56. Nicola	Kimberly
57. Nolte	Karen
58. Otto	Tiffany
59. Padgett	April
60. Patterson-Rahn	Rachael
61. Paulsen	Amy
62. Petersen	Sarah
63. Pettit	Angela
64. Piper	Renee
65. Rausch	Angela
66. Ruge	Ashley
67. Schuler	Deb
68. Schulte	Michele
69. Sisomphane	Stacey
70. Smit	Kristina
71. Sodawasser	Sara
72. Steinbach	Sherry
73. Steiner	Pamela
74. Strong	Celeste
75. Tello	Jennifer
76. Temple	Sheila
77. Terrell	Marlena
78. Thompson	Tamara
79. Thorsteinson	Katherine
80. Timmerman	Susan
81. Tosh	Eileen
82. Van Marel	Tanya
83. Van Zuiden	Elizabeth

84. Vignovich	Tracey
85. Weed	Tara
86. Weiland	Angela
87. White	MaryAnn
88. Wieck	Carolyn
89. Wilson	Cynthia
90. Winker	Sue
91. Wolterman	Courtney
92. Zern	Mary Jo
93. Zwack	Jacquie

Hygienists Who Responded: Did not provide services in 2014; keep agreement active

LAST NAME	FIRST
1. Bertsch	Jane
2. DeBuhr	Penny
3. Evans	Lori
4. Friemdann	Angela
5. Gerlock	Sherry
6. Grisanti	Sharon
7. Leitru	Kathleen
8. Lindeman	Cydney
9. McLaughlin	Melinda
10. Payne	Traci
11. Speer	Colleen
12. Throgmartin	Amy
13. Trewet	Tama

Hygienists Who Responded: Did not provide services in 2014; inactivate agreement

LAST NAME	FIRST
1. Chickering	Stephanie
2. Hillis	Janet
3. Hyland	Susan
4. Jochim	Donna
5. Peterson	Paula
6. Reynolds	Kimberly
7. Wenthe	Jody

Hygienists who did not respond to email requests from IDPH for 2014 Services Report(s)

LAST NAME	FIRST	Notes
Balman	Ann Marie	Also no response in 2013
Elliott	Amanda	
Gramlich	Stephanie	
Harshman	Susan	Also no response in 2012, 2013
Johnson	Christi	
Kumm	Nicole	
Maestre	Catherine	
Onnen	Natalya	
Ross	Theresa	Also no response in 2012, 2013
Sheridan	Charlene	