



**Scott Walker, Governor**  
**Dave Ross, Secretary**

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**DENTISTRY EXAMINING BOARD**  
**Room 121A, 1400 E. Washington Avenue, Madison**  
**Contact: Brittany Lewin (608) 266-2112**  
**July 6, 2016**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a description of the actions of the Board.*

**AGENDA**

**8:30 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

**A. Pledge of Allegiance**

**B. Adoption of Agenda (1-3)**

**C. Approval of Minutes – May 4, 2016 (4-6)**

**D. Administrative Updates**

- 1) Staff Updates
- 2) Open Records Law

**E. Legislative/Administrative Rule Matters – Discussion and Consideration (8-17)**

- 1) Adoption Order for DE 10 Relating to Mobile Dentistry
- 2) Proposals for Amending DE 2, 3 Relating to Dentist Licensure and Practice of Dental Hygiene
- 3) Update on Pending and Possible Rulemaking Projects

**F. Informational Items**

- 1) American Board of Dental Examiners, Inc. Letter **(18-24)**
- 2) American Dental Hygienists' Association Standards for Clinical Dental Hygiene Practice **(25-62)**

**G. Speaking Engagement(s), Travel, or Public Relation Request(s)**

- 1) CRDTS Annual Meeting

**H. Items Added After Preparation of Agenda**

- 1) Introductions, Announcements and Recognition
- 2) Election of Board Officers
- 3) Appointment of Board Liaison(s)

- 4) Administrative Updates
- 5) Education and Examination Matters
- 6) Credentialing Matters
- 7) Practice Matters
- 8) Legislative/Administrative Rule Matters
- 9) Liaison Report(s)
- 10) Informational Item(s)
- 11) Disciplinary Matters
- 12) Presentations of Petition(s) for Summary Suspension
- 13) Petitions for Designation of Hearing Examiner
- 14) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 15) Presentation of Proposed Final Decision(s) and Order(s)
- 16) Presentation of Interim Orders
- 17) Petitions for Re-Hearing
- 18) Petitions for Assessments
- 19) Petitions to Vacate Orders
- 20) Requests for Disciplinary Proceeding Presentations
- 21) Motions
- 22) Petitions
- 23) Appearances from Requests Received or Renewed
- 24) Speaking Engagement(s), Travel, or Public Relation Request(s)

**I. Public Comments**

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (Wis. Stat. s. 19.85(1)(a),); to consider licensure or certification of individuals (Wis. Stat s. 19.85(1)(b), Stats.; to consider closing disciplinary investigations with administrative warnings (Wis. Stat. s. 19.85 (1)(b), and 440.205,); to consider individual histories or disciplinary data (Wis. Stat. s. 19.85 (1)(f),); and to confer with legal counsel (Wis. Stat. s. 19.85(1)(g),).**

**J. APPEARANCE – DLSC Attorney Cody Wagner and Patrick Crawford – Review of Administrative Warning WARN00000479, DLSC Case Number 15 DEN 031 (63-66)**

**K. Credentialing Matters**

- 1) Application Review of Scott Ferguson, D.D.S. **(67-92)**

**L. Monitoring Matters**

- 1) Paul Ganshert, D.D.S. **(93)**

**M. Deliberation on Division of Legal Services and Compliance (DLSC) Matters**

**1) Administrative Warnings**

- a) 15 DEN 009 – D.A.H. **(94-95)**
- b) 15 DEN 063 – S.K.S. **(96-97)**

**2) Proposed Stipulations, Final Decisions and Orders**

- a) 14 DEN 098 – Donald A. Kraut, D.D.S. **(98-111)**
- b) 15 DEN 028 – Douglas L. Cook, D.D.S. **(112-119)**

- c) 15 DEN 092 – Kirk D. Almendinger, D.D.S. **(120-126)**
- 3) **Case Closures**
  - a) 15 DEN 090 **(127-131)**
  - b) 16 DEN 031 **(132-134)**

**N. Order Fixing Costs in the Matter of Disciplinary Proceedings Against Dennis A. Butler, D.D.S. – Discussion and Consideration (135-143)**

**O. Consulting with Legal Counsel**

**P. Deliberation of Items Received After Preparation of the Agenda**

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) Disciplinary Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP)
- 6) Petition(s) for Summary Suspensions
- 7) Petitions for Designation of Hearing Examiner
- 8) Proposed Stipulations, Final Decisions and Orders
- 9) Administrative Warnings
- 10) Review of Administrative Warning
- 11) Proposed Final Decisions and Orders
- 12) Matters Relating to Costs/Orders Fixing Costs
- 13) Case Closings
- 14) Proposed Interim Orders
- 15) Petitions for Assessments and Evaluations
- 16) Petitions to Vacate Orders
- 17) Remedial Education Cases
- 18) Motions
- 19) Petitions for Re-Hearing
- 20) Appearances from Requests Received or Renewed

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

**Q. Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate**

**R. Open Session Items Noticed Above not Completed in the Initial Open Session**

**S. Board Member Training**

**ADJOURNMENT**

**NEXT MEETING DATE SEPTEMBER 7, 2016**

**DENTISTRY EXAMINING BOARD  
MEETING MINUTES  
May 4, 2016**

**PRESENT:** Debra Beres, RDH; Mark Braden, DDS; Eileen Donohoo, RDH; Leonardo Huck, DDS; Lyndsay Knoell, DDS; Timothy McConville, DDS; Wendy Pietz, DDS; Carrie Stempski, RDH; Beth Welter, DDS

**STAFF:** Brittany Lewin, Executive Director; Nifty Lynn Dio, Bureau Assistant; and other department staff

**CALL TO ORDER**

Lyndsay Knoell, Chair, called the meeting to order at 8:30 a.m. A quorum of nine (9) members was confirmed.

**ADOPTION OF AGENDA**

**MOTION:** Debra Beres moved, seconded by Eileen Donohoo, to adopt the agenda as published. Motion carried unanimously.

**APPROVAL OF MINUTES**

**MOTION:** Debra Beres moved, seconded by Leonardo Huck, to approve the minutes of March 2, 2016 as published. Motion carried unanimously.

**LEGISLATIVE/ADMINISTRATIVE RULE MATTERS**

**2015 Act 269 Relating to Prescribing Controlled Substances Guidelines**

**MOTION:** Leonardo Huck moved, seconded by Carrie Stempski, to authorize the Wendy Pietz to communicate with the Medical Examining Board and Board of Nursing regarding guidelines for prescribing controlled substances. Motion carried unanimously.

**Update on Legislation and Pending and Possible Rulemaking Projects**

**MOTION:** Debra Beres moved, seconded by Eileen Donohoo, to request DSPS staff draft a scope statement revising DE 5 and 6 relating to standards of conduct and unprofessional advertising and to authorize the Chair to approve for submission to the Governor's Office and publication and to authorize the Chair to approve the scope for implementation no less than 10 days after publication. Motion carried unanimously.

**CLOSED SESSION**

**MOTION:** Debra Beres moved, seconded by Mark Braden, to convene to closed session to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85 (1)(b), and 440.205, Stats.); to consider individual histories or disciplinary data (s. 19.85 (1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.). Lyndsay

Knoell, Chair, read the language of the motion. The vote of each member was ascertained by voice vote. Roll Call Vote: Debra Beres – yes; Mark Braden – yes; Eileen Donohoo – yes; Leonardo Huck – yes; Lyndsay Knoell – yes; Timothy McConville – yes; Wendy Pietz – yes; Carrie Stempski – yes; Beth Welter – yes. Motion carried unanimously.

The Board convened into Closed Session at 10:01 a.m.

### **RECONVENE TO OPEN SESSION**

**MOTION:** Debra Beres moved, seconded by Eileen Donohoo, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened into Open Session at 10:53 a.m.

### **VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION**

**MOTION:** Eileen Donohoo moved, seconded by Debra Beres, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

### **Proposed Stipulations, Final Decisions and Orders**

#### ***15 DEN 015 – Eugene Darkow, D.D.S.***

**MOTION:** Debra Beres moved, seconded by Timothy McConville, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Eugene Darkow, DLSC Case No. 15 DEN 015. Motion carried unanimously.

#### ***15 DEN 070 – James Caple, D.D.S.***

**MOTION:** Debra Beres moved, seconded by Carrie Stempski, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against James Caple, DLSC Case No. 15 DEN 070. Motion carried unanimously.

#### ***15 DEN 080 – Leland Judd, D.D.S.***

**MOTION:** Mark Braden moved, seconded by Beth Welter, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Leland Judd, DLSC Case No. 15 DEN 080. Motion carried unanimously.

### **Case Closures**

#### ***15 DEN 103***

**MOTION:** Timothy McConville moved, seconded by Eileen Donohoo, to close DLSC Case No. 15 DEN 103, against A.P., for No Violation. Motion carried unanimously.

### **ADJOURNMENT**

**MOTION:** Eileen Donohoo moved, seconded by Debra Beres, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 11:10 a.m.

DRAFT

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Sharon Henes Administrative Rules Coordinator		<b>2) Date When Request Submitted:</b> 23 June 2016	
		Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Dentistry Examining Board			
<b>4) Meeting Date:</b>  6 July 2016	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Legislation and Rule Matters – Discussion and Consideration 1. Adoption Order for DE 10 Relating to Mobile Dentistry 2. Proposals for Amending DE 2, 3 Relating to Dentist Licensure and Practice of Dental Hygiene 3. Update of Pending and Possible Rulemaking Projects	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>			
<b>11) Authorization</b>			
<i>Sharon Henes</i>		<i>23 June 2016</i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN  
DENTISTRY EXAMINING BOARD

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IN THE MATTER OF RULE-MAKING	:	ORDER OF THE
PROCEEDINGS BEFORE THE	:	DENTISTRY EXAMINING BOARD
DENTISTRY EXAMINING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE 15-095)

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ORDER

An order of the Dentistry Examining Board to create DE 10 relating to mobile dentistry.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:** ss. 447.058 and 447.07, Stats.

**Statutory authority:** ss. 15.08 (5) (b) and 447.02 (2) (f), (g) and (h), Stats.

**Explanation of agency authority:**

Each examining board shall promulgate rules for its own guidance and for the guidance of the profession to which it pertains, and define and enforce professional conduct and unethical practices not inconsistent with the law relating to the particular profession. s. 15.08(5)(b)

The examining board shall promulgate rules specifying: a requirement that a mobile dentistry program registrant establish procedures for a patient treated in the mobile dentistry program to access his or her patient records; standards of conduct for the operation of a mobile dentistry program in this state, the provision of dental services through a mobile dentistry program and the use of portable dental equipment; and a definition of “mobile dentistry program: and the activities that constitute the operation of a mobile dentistry program for purposes of the registration requirement under s. 447.058. ss. 447.02(2)(f), (g) and (h), Stats.

**Related statute or rule:** n/a

**Plain language analysis:**

This rule implements 2013 Act 244 by creating DE 10.

DE 10.01 defines mobile dentistry program as a program which uses portable equipment or supplies in a location that is not a dental or hospital facility or is a self-contained facility that moves.

DE 10.02 creates the registration requirements. A program is excluded from registration if it meets one of the following: dental or dental hygiene care provided within a 30 mile radius of a main or satellite facility provided the care is billed by that facility and necessary follow-up care is being provided by the dentist or dental hygienist; the care is being provided to no more than 2 per day to a new or established patient of record of a main or satellite dental facility; and the Department of Health conducting screenings as part of the Centers for Disease Control and Prevention surveys. The first two exceptions allow for a dentist or dental hygienist to make “house calls” and the last recognizes the unique nature of the survey screenings.

An applicant would be required to fill out an application, pay a fee, and provide a list of all employees or contractors who are providing dental or dental hygiene care and their Wisconsin dentist or dental hygienist license number. A renewal requires a renewal form and fee and a current list of their employees or contractors. If a person owns or operates more than one mobile dentistry program, a registration is required for each program.

DE 10.03 requires access to patient records. Each patient is to be provided with the name and contact information of the program and the registration number. At the time of providing services, the program is required to provide the patient with a written description of the services provided, the provider’s name and license number and the findings and recommendations. Mobile dentistry records are subject to the same rules governing a dentist or dental hygienist working in a dental facility. A mobile dentistry program is required to provide access to patient records.

DE 10.04 requires a mobile dentistry program to have a written protocol for follow-up care in a dental facility that is permanently established within a 60 mile radius of where the mobile dentistry services were provided. The protocol must include a written agreement with at least one provider for emergency treatment.

DE 10.045 requires a mobile dentistry program registrant to fail to update the department within 30 days of new employees, contractors, or volunteers providing dental or dental hygienist services in Wisconsin.

DE 10.05 lists unprofessional conduct as a violation of the standards of conduct all licensed dentists and dental hygienists are required to maintain or the specific mobile dentistry access to patient records, written protocols or notification of new employees, contractors or volunteers.

**Summary of, and comparison with, existing or proposed federal regulation:** None

**Comparison with rules in adjacent states:**

**Illinois:** Illinois defines mobile dental vans and portable dental units as any self-contained or portable dental unit in which dentistry is practiced that can be moved, towed, or transported from one location to another in order to establish a location where dental services can be provided. A dentist providing services through a mobile dental van or portable dental unit is to provide to the patient or the patient’s parent or guardian, in writing, the dentist’s name, license number, address, and information on how the patient or the patient’s parent or guardian may obtain the patient’s dental records.

**Iowa:** Iowa does not require the registration of mobile dentistry programs.

**Michigan:** Michigan defines mobile dentistry as a self-contained, intact facility in which dentistry or dental hygiene is practiced that may be transported from one location to another or a site used on a temporary basis to provide dental services using portable equipment. An application shall include: a list of each dentist, dental hygienist and dental assistant who will provide care including each individual's name, address, telephone number and license number; a written plan and procedure for providing emergency follow-up care to each patient; a signed memorandum of agreement between the operator and at least one dentist who can arrange for or provide follow-up services at a site within a reasonable distance for the patient; if provides only preventative services, a signed memorandum of agreement for referral for comprehensive dental services between the operator and at least 1 dentist; and proof of general liability insurance covering the mobile dental facility. If an operator has a memorandum of agreement due to its status as a state of Michigan designated or funded oral health prevention program with oversight from the department of community health, the operator is exempt from any requirement concerning a memorandum of agreement. The patient shall be provided a copy of a written treatment plan which shall address comprehensive services to be provided either at the mobile dental facility or through a dentist under a memorandum of agreement with the operator of the mobile dental facility. If the operator is unable to make arrangements for continued treatment, he or she shall place written documentation of the attempts in the patient record and make the documentation available to the department upon request. The operator shall provide access to records upon request.

**Minnesota:** Minnesota does not require the registration of mobile dentistry programs.

### **Summary of factual data and analytical methodologies:**

The Board formed a committee which looked at the proposals from stakeholders as well as reviewing other states' laws. The committee and Board spent considerable time discussing issues relating to the definition of mobile dentistry programs and protocols for follow-up care balancing the accessibility of the programs to operate in the state with the safety of the public.

### **Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:**

The rules were posted for economic comments for 14 days. One comment was received requesting an exemption from the rule for mobile dentistry programs receiving partial funding from the state. The Board invited Matt Crespín of Children's Health Alliance of Wisconsin to a meeting to discuss his economic concerns. Mr. Crespín focused on exempting his programs and not on the economic impact on mobile dentistry programs in general. The Board decided not to make changes to the rule to mitigate the economic impact to programs receiving state funds.

Throughout the rule promulgation process, the Board solicited comments from stakeholders. A main concern of all stakeholders is for patients treated by a mobile dentistry program to obtain follow-up care. The Board considered many alternatives to reach this objective with a goal for

the rule to not be a burden on small businesses. Requiring a mobile dentistry program to have protocols for follow-up care, including a written agreement for emergency care meets the objective of protecting public health but not burdening businesses.

**Fiscal Estimate and Economic Impact Analysis:**

The Fiscal Estimate and Economic Impact Analysis is attached.

**Effect on small business:**

These proposed rules may have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. and were submitted to the Small Business Regulatory Review Board for a determination on whether the rules will have a significant economic impact on a substantial number of small businesses. The Department’s Regulatory Review Coordinator may be contacted by email at Jeffrey.Weigand@wisconsin.gov, or by calling (608) 267-2435

The Small Business Regulatory Review Board determined the rules will not have a significant economic impact on a substantial number of small businesses.

**Agency contact person:**

Sharon Henes, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Board Services, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, Wisconsin 53708; telephone 608-261-2377; email at Sharon.Henes@wisconsin.gov.

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TEXT OF RULE

SECTION 1. Chapter DE 10 is created to read:

CHAPTER DE 10  
MOBILE DENTISTRY

**DE 10.01 Definitions.** In this chapter:

- (1) “Mobile dentistry program” means a program providing dental hygiene as defined by s. 447.01 (3), Stats. or dentistry as defined by s. 447.01 (8), Stats., excluding a health practitioner practicing within the scope of a license not governed by ch. 447, Stats., in one of the following:
1. Using portable equipment or supplies that are transported to any location that is not an intact dental or hospital facility.
  2. In a self-contained, intact facility that can be moved.
- (2) “Mobile dentistry program registrant” means a person registered under s. 447.058, Stats.

**DE 10.02 Mobile dentistry program registration.** (1) REGISTRATION REQUIRED. (a) No person may own or operate a mobile dentistry program in this state unless the person is registered under this section. A person that wishes to own or operate more than one mobile

dentistry program in this state shall apply for a separate registration under this section for each mobile dentistry program the person owns or operates.

(b) A program providing dental or dental hygiene care is not required to register if one of the following requirements is satisfied:

1. The dental or dental hygiene care is provided within a 50 mile radius of their main or satellite facility and all of the following:
  - a. The care is billed by the main or satellite dental facility.
  - b. The dentist or dental hygienist provides any necessary follow-up care to the patient.
2. The dental or dental hygiene care is being provided to a new or established patient of record of the main or satellite dental facility and no more than 2 patients per day are being treated using portable equipment or a self-contained, intact facility that can be moved.
3. Department of health services screening assessments conducted as part of the Wisconsin Oral Health surveillance program.

(2) **REGISTRATION.** An applicant for registration to own or operate a mobile dentistry program shall submit all of the following:

- (a) An application for registration on a form provided by the department. The application shall include the person's name and tax identification number, the person's business address and telephone and any other information the department or the examining board requires.
- (b) The fee specified in s. 440.05 (1), Stats.
- (c) A list of all employees, contractors, or volunteers who are providing dental or dental hygiene care in Wisconsin. The list shall include the Wisconsin license number for each person providing dental or dental hygiene care.

(3) **RENEWAL.** A mobile dentistry program registrant renewing a registration shall submit all of the following:

- (a) A renewal form provided by the department.
- (b) The renewal fee as determined by the department under s. 440.03 (9) (a), Stats.
- (c) A list of all employees, contractors or volunteers who are providing dental or dental hygiene care in Wisconsin. The list shall include the Wisconsin license number for each person providing dental care.

**DE 10.03 Access to patient records.** The mobile dentistry program registrant shall do all of the following:

- (1) Provide each patient with the name and contact information of the mobile dentistry program and mobile dentistry program's registration number providing services.
- (2) At the time of providing services, give each patient a written description of the dental services provided for that patient, any provider's name and license number, and the findings and recommendations.
- (3) Maintain patient dental records in accordance with ch. DE 8.
- (4) Provide access to dental records in accordance with s. 146.83, Stats.

**DE 10.04 Protocol for follow-up care.** (1) There shall be a written protocol for follow-up care, for patients treated in the mobile dental program, in a dental facility that is permanently established within 60 mile radius of where services were provided.

(2) There shall be an agreement with at least one provider for emergency treatment.

**DE 10.045 Notification to department.** The mobile dentistry program shall notify the department within 30 days of new employees, contractors or volunteers providing dental or dental hygiene services in Wisconsin.

**DE 10.05 Standards of conduct.** Unprofessional conduct by a mobile dentistry program registrant includes any of the following:

- (1) Violating any provision under ss. DE 10.03, 10.04 or 10.045.
- (2) Engaging in unprofessional conduct under s. DE 5.02.

SECTION 2. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the third month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)  
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Dated \_\_\_\_\_

Agency \_\_\_\_\_

Board Member  
Dentistry Examining Board

## Chapter DE 2

### LICENSURE

DE 2.01	Application for license.
DE 2.015	Faculty license.
DE 2.02	Duration of license.
DE 2.03	Biennial renewal.
DE 2.04	Endorsement.

DE 2.05	Examination passing score.
DE 2.06	Unauthorized assistance.
DE 2.07	Examination review.
DE 2.08	Claim of examination error.
DE 2.09	Failure and reexamination.

**Note:** Chapter DE 2 as it existed on February 28, 1982, was repealed and a new chapter DE 2 was created effective March 1, 1982.

**DE 2.01 Application for license. (1)** An applicant for license as a dentist shall submit all of the following to the board:

- (a) An application on a form approved by the board.
- (c) The fee authorized by s. 440.05 (1), Stats.
- (d) Evidence of successful completion of an examination on provisions in ch. 447, Stats., and chs. DE 1 to 9.
- (e) Evidence satisfactory to the board of having graduated from an accredited dental school.
- (f) Verification from the commission on national examinations of the American dental association or other board-approved professional testing services of successful completion of an examination.

(g) Verification from the central regional dental testing service or other board-approved testing services of successful completion of an examination in clinical and laboratory demonstrations taken within the 5-year period immediately preceding application. In this paragraph, “successful completion” means an applicant has passed all parts of the examination in no more than 3 attempts on any one part, as required in s. DE 2.09.

**Note:** Application forms are available upon request to the board office at 1400 East Washington Avenue, P. O. Box 8935, Madison, Wisconsin 53708.

**(1m)** An applicant for a license as a dentist who is a graduate of a foreign dental school shall submit all of the following to the board:

- (a) Evidence satisfactory to the board of having graduated from a foreign dental school.
- (b) The information required in sub. (1) (a) to (d), (f) and (g).
- (d) Evidence of one of the following:
  1. Verification of having been awarded a DDS or DMD degree from an accredited dental school.
  2. Verification of having received a dental diploma, degree or certificate from a full time, undergraduate supplemental dental education program of at least two academic years at an accredited dental school. The program must provide didactic and clinical education to the level of a DDS or DMD graduate.

**(2)** An applicant for license as a dental hygienist shall meet requirements in sub. (1) (a) through (d) and shall also submit to the board:

- (a) Verification from the commission on national examinations of the American dental association or other board-approved professional testing service of successful completion of an examination on the basic principles of the practice of dental hygiene; and
- (b) Verification from the central regional dental hygiene testing service or other board-approved testing service of successful completion of an examination in clinical and laboratory demonstrations taken within the 5-year period immediately preceding application.

**History:** Cr. Register, February, 1982, No. 314, eff. 3-1-82; am. (1) (g), Register, May, 1984, No. 341, eff. 6-1-84; am. (1) (e), Register, March, 1988, No. 387, eff. 4-1-88; am. (1) (e) and (2) (intro.), Register, June, 1995, No. 474, eff. 7-1-95; am. (1) (intro.), (a), (c), (e), (f) and r. (1) (b), Register, April, 1999, No. 520, eff. 5-1-99; am. (1) (g), Register, June, 2001, No. 546, eff. 7-1-01; CR 09-007: am. (1) (e), cr.

(1m) Register October 2009 No. 646, eff. 11-1-09; CR 15-013: r. (1m) (e), cr. (1m) (d) Register October 2015 No. 717, eff. 10-1-15.

**DE 2.015 Faculty license. (1)** The board shall grant a license to practice dentistry to an applicant who is licensed in good standing to practice dentistry in another jurisdiction approved by the board upon presentation of the license and who does all of the following:

- (a) Submits an application on a form provided by the board.
- (b) Pays the fee specified in s. 440.05 (2), Stats.
- (c) Submits a written certification from an accredited post-doctoral dental residency training program or accredited school of dentistry in this state that the applicant has been offered employment as a full-time faculty member in that program or at that school of dentistry.
- (d) Submits to an initial interview and any other interview that the board may require that demonstrates, to the board’s satisfaction, that the applicant is competent to practice dentistry.
- (e) Discloses all discipline which has ever been taken against the applicant in any jurisdiction.

**(2)** A license granted under sub. (1) authorizes the license holder to do all of the following:

(a) Practice dentistry only within the primary educational facility affiliated with an accredited post-doctoral dental residency training program or accredited school of dentistry in this state.

(b) Perform dental procedures that are incident to instruction while at a site affiliated with an accredited post-doctoral dental residency training program or accredited school of dentistry located in this state.

**(3)** A license granted under sub. (1) shall not be transferable to another accredited school of dentistry in this state or accredited post-doctoral dental residency training program without prior approval by the board.

**(4)** A license granted under sub. (1) is no longer in effect if the license holder ceases to be employed as a full-time faculty member at an accredited post-doctoral dental residency training program or accredited school of dentistry in this state. The license holder shall notify the board in writing within 30 days of the date on which his or her employment as a licensed faculty member under sub. (1) is terminated.

**Note:** Application forms are available upon request to the Dentistry Examining Board, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

**History:** CR 02-139: cr. Register December 2003 No. 576, eff. 1-1-04; CR 11-034: am. (1) (c), (2) (a), (b), (3), (4) Register July 2012 No. 679, eff. 8-1-12.

**DE 2.02 Duration of license. (1)** Every person granted a license as a dentist shall be deemed licensed for the current biennial license period.

**(2)** Every person granted a license as a dental hygienist shall be deemed licensed for the current biennial license period.

**(3)** Licensees shall qualify biennially for renewal of license. **History:** Cr. Register, February, 1982, No. 314, eff. 3-1-82; am. (2), Register, June, 1995, No. 474, eff. 7-1-95; am. Register, April, 1999, No. 520, eff. 5-1-99.

**DE 2.03 Biennial renewal. (1)** REQUIREMENTS FOR RENEWAL; DENTISTS. To renew a license a dentist shall, by October

1 of the odd-numbered year following initial licensure and every 2 years thereafter, file with the board all of the following:

(a) An application for renewal on a form prescribed by the department.

(b) The fee authorized by s. 440.08 (2), Stats.

(c) Evidence satisfactory to the board that the licensee has current proficiency in cardiopulmonary resuscitation, including the use of an automated external defibrillator, achieved through instruction provided by an individual, organization, or institution of higher education approved by the Wisconsin department of health services.

(d) Except as provided in sub. (4), evidence satisfactory to the board of successful completion of the continuing education credit hours required under ch. DE 13.

**(2) REQUIREMENTS FOR RENEWAL; DENTAL HYGIENISTS.** A dental hygienist shall by October 1 of the odd-numbered year following initial licensure and every 2 years thereafter, meet the requirements for renewal specified in sub. (1) (a) to (d).

**(3) FAILURE TO MEET REQUIREMENTS.** A dentist or dental hygienist who fails to meet the requirements under subs. (1) (a) to (d) and (2) by the renewal date shall cease and desist from dental or dental hygiene practice.

**(4) NEW LICENSEES.** Dentists and dental hygienists are not required to satisfy the continuing education requirements under sub. (1) (d) for the first renewal period following the issuance of their initial licenses.

**(5) REQUIREMENTS FOR LATE RENEWAL; REINSTATEMENT.** (a) A dentist or dental hygienist who files an application for renewal of a license within 5 years after the renewal date may renew his or her license by filing with the board all of the following:

1. An application for renewal on a form prescribed by the department.

2. The fee authorized by s. 440.08 (2), Stats., plus the applicable late renewal fee authorized by s. 440.08 (3), Stats.

3. Evidence satisfactory to the board that the licensee has current proficiency in cardiopulmonary resuscitation, including the use of an automated external defibrillator, achieved through instruction provided by an individual, organization, or institution of higher education approved by the department of health services.

4. Except as provided under sub. (4), evidence satisfactory to the board of successful completion of the continuing education credit hours required under ch. DE 13.

(b) A dentist or dental hygienist who files an application for renewal more than 5 years after the renewal date may be reinstated by filing with the board an application and fees as specified in subs. (1) and (2) and verification of successful completion of examinations or education, or both, as the board may prescribe.

**(6) REINSTATEMENT FOLLOWING DISCIPLINARY ACTION.** A dentist or dental hygienist applying for licensure following disciplinary action by the board, pursuant to s. 447.07, Stats., may be reinstated by filing with the board:

(a) An application as specified in s. DE 2.01;

(b) The fee authorized by s. 440.05 (1), Stats.;

(c) Verification of successful completion of examinations as the board may prescribe; and,

(d) Evidence satisfactory to the board, either orally or in writing as the board deems necessary, that reinstatement to practice will not constitute a danger to the public or a patient.

**(7) DISPLAY OF LICENSE.** The license and certificate of registration shall be displayed in a prominent place by every person licensed and currently registered by the board.

**History:** Cr. Register, February, 1982, No. 314, eff. 3-1-82; correction in (6) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1986, No. 364; am. (1) (intro.), (b), (2), (5) (a) (intro.), 2., (b), (6) (intro.) and (7), r. (4), Register, June, 1995, No. 474, eff. 7-1-95; am. (1) (intro.), (2), Register, June, 1996, No. 486, eff. 7-1-96; am. (1) (b), (5) (a) 2. and (6) (b), Register, April, 1999, No. 520, eff. 5-1-99; CR 11-033; am.

(1) (intro.), (a), cr. (1) (d), am. (2), (3), cr. (4), am. (5) (a) (intro.), 1., cr. (5) (a) 4. Register July 2012 No. 679, eff. 8-1-12.; CR 11-035; am. (1) (intro.), (a), cr. (1) (c), am. (5) (a) (intro.), 1., cr. (5) (a) 3. Register July 2012 No. 679, eff. 8-1-12.

**DE 2.04 Endorsement.** (1) The board may grant a license as a dentist to an applicant who holds a valid license issued by the proper authorities of any other jurisdiction of the United States or Canada upon payment of the fee authorized by s. 440.05 (2), Stats., and submission of evidence satisfactory to the board that all of the following conditions are met:

(a) The applicant has graduated from an accredited school of dentistry or the applicant has graduated from a foreign dental school and has successfully completed an accredited postgraduate program in advanced education in general dentistry or an accredited general dental practice residency.

(b) The applicant submits a certificate from each jurisdiction in which the applicant is or has ever been licensed stating that no disciplinary action is pending against the applicant or the license, and detailing all discipline, if any, which has ever been imposed against the applicant or the license.

(c) The applicant has not failed the central regional dental testing service clinical and laboratory demonstration examination, or any other dental licensing examination, within the previous 3 years.

(d) The applicant has been engaged in the active practice of dentistry, as defined in s. DE 1.02 (2), in one or more jurisdictions in which the applicant has a current license in good standing, for at least 48 of the 60 months preceding the application for licensure in Wisconsin.

(e) The applicant has successfully completed a clinical and laboratory demonstration licensing examination on a human subject which, in the board's judgment, is substantially equivalent to the clinical and laboratory demonstration examination administered by the central regional dental testing service, or, alternatively, has successfully completed a board specialty certification examination in a dental specialty recognized by the American Dental Association.

(f) The applicant has successfully completed a jurisprudence examination on the provisions of Wisconsin statutes and administrative rules relating to dentistry and dental hygiene.

(g) The applicant possesses a current certificate of proficiency in cardiopulmonary resuscitation from a course provider approved by the Wisconsin department of health services.

(h) The applicant has disclosed all discipline which has ever been taken against the applicant in any jurisdiction shown in reports from the national practitioner data bank and the American Association of Dental Boards.

(i) The applicant has presented satisfactory responses during any personal interview with the board which may be required to resolve conflicts between the licensing standards and the applicant's application.

**(2)** The board may grant a license as a dental hygienist to an applicant who holds a license issued by the proper authorities of any other jurisdiction of the United States or Canada upon payment of the fee authorized by s. 440.05 (2), Stats., and submission of evidence satisfactory to the board that all of the following conditions are met:

(a) The applicant has graduated from a school of dental hygiene accredited by the Commission on Dental Accreditation of the American Dental Association.

(b) The applicant submits a license from each jurisdiction in which the applicant is or has ever been licensed stating that no disciplinary action is pending against the applicant or the license, and detailing all discipline, if any, which has ever been imposed against the applicant or the license.

(c) The applicant has not failed the central regional dental testing service clinical and laboratory demonstration examination, or

any other dental hygiene licensing examination, within the previous 3 years.

(d) The applicant has successfully completed a clinical and laboratory demonstration examination on a human subject which, in the board's judgment, is substantially equivalent to the clinical and laboratory demonstration examination administered by the central regional dental testing service.

(e) The applicant has successfully completed a jurisprudence examination on the provisions of Wisconsin statutes and administrative rules relating to dentistry and dental hygiene.

(f) The applicant has been engaged in the active practice of dental hygiene, as defined in s. DE 1.02 (1), in a jurisdiction in which the applicant has a current license in good standing.

(g) The applicant possesses a current certificate of proficiency in cardiopulmonary resuscitation from a course provider approved by the Wisconsin department of health services.

(h) The applicant has disclosed all discipline which has ever been taken against the applicant in any jurisdiction shown in reports from the national practitioner data bank and the American Association of Dental Boards.

(i) The applicant has presented satisfactory responses during any personal interview with the board which may be required to resolve conflicts between the licensing standards and the applicant's application.

**History:** Cr. Register, February, 1982, No. 314, eff. 3-1-82; renum. (1) (c) and (d), (2) (c) and (d) to be (1) (d) and (f), (2) (d) and (e) and am. (1) (f), (2) (d) and (e), am. (1) (e), cr. (1) (c) and (2) (c), Register, August, 1987, No. 380, 9-1-87; am. (1) and (2), cr. (1) (g) to (i) and (2) (f) to (i), Register, August, 1991, No. 428, eff. 9-1-91; emerg. r. and recr. (1) (ed), eff. 3-18-97; am. (1) (intro.), (c) (e), (2) (intro.), (c) and (d), Register, April, 1999, No. 520, eff. 5-1-99; CR 09-007: am. (1) (a) Register October 2009 No. 646, eff. 11-1-09; CR 11-034: am. (1) (e) Register July 2012 No. 679, eff. 8-1-12; CR 11-035: am. (1) (g), (h), (2) (a), (g), (h) Register July 2012 No. 679, eff. 8-1-12.

**DE 2.05 Examination passing score.** The score required to pass an examination shall be based on the board's determination of the level of examination performance required for minimum acceptable competence in the profession. The board shall make the determination after consultation with subject matter experts who have reviewed a representative sample of the examination questions and available candidate performance statistics, and shall set the passing score for the examination at that point which represents minimum acceptable competence in the profession.

**History:** Cr. Register, April, 1999, No. 520, eff. 5-1-99.

**DE 2.06 Unauthorized assistance.** An applicant may not give or receive unauthorized assistance during the examination. The action taken by the board when unauthorized assistance occurs shall be related to the seriousness of the offense. These actions may include withholding the score of the applicant, entering a failing grade for the applicant, and suspending the ability of the applicant to sit for the next scheduled examination after the examination in which the unauthorized assistance occurred.

**History:** Cr. Register, April, 1999, No. 520, eff. 5-1-99.

**DE 2.07 Examination review. (1)** An applicant who fails an examination administered by the board may request a review of that examination by filing a written request to the board within 30 days after the date on which the examination results were mailed to the applicant.

**(2)** An examination review shall be conducted under the following conditions:

(a) The time for review shall be limited to one hour.

(b) The examination shall be reviewed only by the applicant and in the presence of a proctor.

(c) The proctor may not respond to inquiries by the applicant regarding allegations of examination error.

(d) Any comments or claims of error regarding specific questions or procedures in the examination may be placed in writing by the applicant on the form provided for this purpose. The request shall be reviewed by the board in consultation with a subject matter expert. The applicant shall be notified in writing of the board's decision.

(e) An applicant shall be permitted only one review of the failed examination each time it is taken and failed.

**Note:** The board office is located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

**History:** Cr. Register, April, 1999, No. 520, eff. 5-1-99.

**DE 2.08 Claim of examination error. (1)** An applicant wishing to claim an error on an examination administered by the board must file a written request for board review in the board office within 30 days after the date the examination was reviewed. The request shall include all of the following:

(a) The applicant's name and address.

(b) The type of license applied for.

(c) A description of the perceived error, including reference text citations or other supporting evidence for the applicant's claim.

**(2)** The request shall be reviewed by the board in consultation with a subject matter expert. The applicant shall be notified in writing of the board's decision.

**Note:** The board office is located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

**History:** Cr. Register, April, 1999, No. 520, eff. 5-1-99.

**DE 2.09 Failure and reexamination.** An applicant who fails to achieve a passing grade on the board-approved examination in clinical and laboratory demonstrations may apply for reexamination on forms provided by the board and shall pay the appropriate fee for each reexamination as required in s. 440.05, Stats. If the applicant fails to achieve a passing grade on any part of the second reexamination, the applicant may not be admitted to any further examination until the applicant reapplies for licensure and presents evidence satisfactory to the board of further professional training or education as the board may prescribe following its evaluation of the applicant's specific case.

**History:** Cr. Register, June, 2001, No. 546, eff. 7-1-01.

## Chapter DE 3

### PRACTICE OF DENTAL HYGIENE

DE 3.01 Supervision.  
 DE 3.02 Practice of dental hygiene defined.  
 DE 3.03 Prohibited practices.

DE 3.04 Oral systemic premedications and subgingival sustained release chemotherapeutic agents.

**Note:** Chapter DE 3 as it existed on February 28, 1982 was repealed and a new chapter DE 3 was created effective March 1, 1982.

**DE 3.01 Supervision.** A dental hygienist shall practice under the supervision of a licensed dentist in a dental facility or a facility specified in s. 447.06 (2), Stats., if applicable.

**History:** Cr. Register, February, 1982, No. 314, eff. 3-1-82; correction made under s. 13.93 (2m) (b) 7., Stats., Register August 2006 No. 608.

**DE 3.02 Practice of dental hygiene defined.**

(1) Those practices a dental hygienist may perform while a dentist is present in the dental facility include:

- (a) Performing complete prophylaxis which may include:
  1. Removing calcareous deposits, accretions and stains from the surface of teeth;
  2. Performing deep periodontal scaling, including root planing;
  3. Polishing natural and restored tooth surfaces.
- (b) Placing temporary restorations in teeth in emergency situations.

(c) Placing in an oral cavity:

1. Rubber dams; and
2. Periodontal surgical dressings.

(d) Removing from an oral cavity:

1. Rubber dams;
2. Periodontal surgical dressings; and
3. Sutures.

(e) Removing excess cement from teeth, inlays, crowns, bridges and fixed orthodontic appliances.

(2) Those practices a dental hygienist may perform whether or not a dentist is present in the dental facility include:

- (a) Preparing specimens for dietary or salivary analysis;
- (b) Taking impressions for and fabricating study casts and opposing casts;

(c) Making and processing dental radiograph exposures;

(d) Conducting a preliminary examination of the oral cavity and surrounding structures which may include preparing case histories and recording clinical findings for the dentist to review;

(e) Providing prevention measures, including application of fluorides and other topical agents approved by the American dental association for the prevention of oral disease.

(3) A dental hygienist shall report clinical findings made in the practice of dental hygiene to the supervising dentist.

**History:** Cr. Register, February, 1982, No. 314, eff. 3-1-82.

**DE 3.03 Prohibited practices.** A dental hygienist may not:

(1) Administer or prescribe, either narcotic or analgesics or systemic-affecting nonnarcotic drugs, or anesthetics except as provided under ch. DE 15.

(2) Place or adjust dental appliances.

(3) Diagnose any condition of the hard or soft tissues of the oral cavity or prescribe treatment to modify normal or pathological conditions of the tissues.

(4) Place and carve restorations, except as specified in s. DE 3.02 (1) (b).

**History:** Cr. Register, February, 1982, No. 314, eff. 3-1-82; CR 15-056: am. (1) Register February 2016 No. 722, eff. 3-1-16.

**DE 3.04 Oral systemic premedications and subgingival sustained release chemotherapeutic agents.**

(1) "Oral systemic premedications" means antibiotics that are administered orally to patients prior to providing dental or dental hygiene services in order to mitigate against the risk of patients developing a bacterial infection.

(2) "Subgingival sustained release chemotherapeutic agents" means medications that are applied under the gum tissue in periodontal pockets to treat periodontal or gum disease.

(3) A dentist may delegate to a dental hygienist the administration of oral systemic premedications and subgingival sustained release chemotherapeutic agents to patients only if all of the following conditions are met:

(a) The administration is performed pursuant to a treatment plan for the patient approved by a dentist.

(b) A dentist remains on the premises in which the administration is performed and is available to the patient throughout the completion of the appointment.

**History:** Cr. Register, September, 2000, No. 537, eff. 10-1-00.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Nifty Lynn Dio, Bureau Assistant On behalf of Brittany Lewin, Executive Director		<b>2) Date When Request Submitted:</b>  06/29/2016  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Dentistry Examining Board			
<b>4) Meeting Date:</b>  07/06/2016	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Informational Items: American Board of Dental Examiners, Inc. Letter	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A	
<b>10) Describe the issue and action that should be addressed:</b>  Letter from ADEX for the Board's information.			
<b>11) Authorization</b>			
<b>Nifty Lynn Dio</b>		<b>06/29/2016</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			



**AMERICAN BOARD OF DENTAL EXAMINERS, INC.**

**Stanwood Kanna, D.D.S., President**  
**William Pappas, D.D.S., Vice-President**  
**Jeffery Hartsog, D.M.D., Secretary**  
**Conrad McVea, III, D.D.S., Treasurer**  
**Bruce Barrette, D.D.S., Past President**

June 5, 2016

Dear State Board of Dentistry,

In recent years there has been a strong move to create a uniform national dental and dental hygiene licensure examination driven by the American Board of Dental Examiners (ADEX), an exam development corporation and the Regional Testing Agencies that administer the ADEX developed dental licensure examination. Currently there are 41 States, 3 US Jurisdictions and the Country of Jamaica that accept the ADEX dental licensure examination for initial licensure. This is by far the most widely accepted initial dental licensure examination in the country.

The ADEX has committed itself to designing the most comprehensive, current and ethical clinical licensure examination in dentistry. As dentistry changes in its delivery and scope so must the licensure examination. Test design and guidelines of test development are uniform in order to be valid and reliable. The challenge with dental examinations in the past has been with its delivery or administration. Having a unique and critical component of the examination that necessitates clinical performance standards on patients has been in the past more focused on student (candidate) orientation than patient centered resulting in ethical challenges. The ADEX through its newly developed Patient Centered Curriculum Integrated Format has now addressed this concern by focusing the exam format to taking care of the needs of the patient. The result has been rewarding to both the patient and the candidate.

As you familiarize yourself with this new PC-CIF format be assured that ADEX in conjunction with educators, examiners and those testing agencies that deliver the ADEX exam are constantly working to provide your state with the most comprehensive, widely accepted, valid, reliable and ethical initial licensure exam in dentistry and dental hygiene. Please do not hesitate to contact ADEX or myself if you have any questions.

Sincerely,

Stanwood H. Kanna DDS, President  
American Board of Dental Examiners, Inc. (ADEX)

Enclosures



## The Patient Centered Curriculum Integrated Format (PC CIF)

This new format of the ADEX CIF examination was originally called the “Buffalo Format” because it was developed in conjunction with the University at Buffalo and the New York Board of Dentistry and was successfully piloted at the University at Buffalo in 2015. In 2016 the PC CIF is currently being offered to all dental schools that would like to host this format

The PC CIF is a modification of the Curriculum Integrated (CIF) Format that focuses on patient care needs, rather than the candidate’s examination. The examination itself is the identical ADEX Licensing Examination for initial licensure in dentistry. That is the content, criteria, scoring, and performance parameters are identical no matter which format is being administered.

The American Board of Dental Examiners, Inc. (ADEX) and its testing agencies have introduced an examination format for candidates at dental schools, which is designed to focus on patient needs to enhance the patient experience in the sections of the examination that evaluate the care provided by the candidate during the examination process.

As context for this approach, the American Dental Association (ADA) has adopted a policy that the only acceptable examination format that includes providing patient treatment is the Curriculum Integrated Format with the adoption of ADA resolution 20 H– 2005, and defined the Curriculum Integrated Format in ADA resolution 1H-2007 which is included as Appendix A.

The ADEX examination was in compliance with the 2005 resolution and substantially in compliance with the 2007 resolution. However, ADEX and its testing agencies wanted to comply with all provisions of the ADA definition, as well as adopting an examination format that would fulfill all of the ethical concerns identified in the ADA paper entitled, *Ethical Considerations When Using Patients in the Examination Process*, which had been recently revised in May, 2013. For readers interested in the full text of this document, please see the attached document.

As part of the validity argument for continuing to use the scores and decisions from this new approach, the ADEX examination content, criteria, scoring, and performance parameters remain identical to the previous examination. However, **the new examination administration format now allows the dental school to ensure that the care provided in the examination process is done on a patient of record, and provided within an appropriately sequenced treatment plan as defined by the dental school.** The examination assessments are given multiple times within the school year, to allow for candidate remediation and retake prior to graduation as well as patient scheduling and treatment plans concerns.

Equally important, is that follow-up patient care required as a result of candidate performance is completed under the supervision of the dental school faculty, utilizing the treatment protocols and philosophy of the host dental school. Finally, the patient care provided by the dental student, during the examination process, can also be independently evaluated by the dental school faculty to fulfill the CODA required competencies, if necessary. Patient informed consent is completed for both the dental school and the testing agency throughout the process.

Keeping in mind the technical and legal requirements for licensure examinations, **this format was developed in collaboration with educators, examiners, and representatives from organized dentistry.** The goal was to balance the responsibilities of maintaining the independence of the licensure process with a focus within the examination on the needs of the patient in a continuing effort to develop the most ethical examination process possible when patient care is a component.

The administrative format differences in the PC CIF Format are:

1. Calibrated school faculty may assist candidates in selection of patients of record at the school, for the ADEX Restorative and Periodontal examinations that meet the requirements set by ADEX for the examination process. The faculty's role is to validate that the patient's proposed care is appropriate to be provided under the school's treatment planning protocols.
2. The examiners have final determination about what lesions/cases are accepted for the examination and which are not. The patient's medical status and blood pressure are always evaluated at the time of care. Additionally, the proposed care is also evaluated to validate the treatment being provided meets examination requirements.
3. Faculty and the school's protocols have the final determination *if* care will be provided. The institutional treatment protocols of the dental school will determine the timing of care and the type of care provided. For example a dental school's proposed care based on the extent of caries is preserved; so that re-mineralization and the depth of caries prior to treatment is a school decision.
4. The faculty may also evaluate the treatment provided to the patients and this may or may not be incorporated as part of a school student competency program.
5. Faculty may also enter treatment provided into the school database as it occurs during the examination as dictated by school protocol.
6. The schools faculty will determine, schedule, and supervise any patient follow-up care that may be required.
7. Candidates who are unsuccessful will have their performance explained to them by their faculty and the faculty will supervise any required patient care.
8. The exam scheduling allows for multiple school visits and candidates challenging only those parts of the examination for which they have treatment-planned patients. In this respect the examination process is scheduled over multiple visits allowing the candidate to focus on the patient's needs rather than a single examination date.

Therefore, the school may wish to have several smaller PC CIF examinations at regular intervals rather than one large Perio/Restorative Examination as in the past. This is arranged between the school and the testing agency when scheduling the examination series. The school is usually allowed to schedule the candidates and their patients for each of these smaller exams. Candidates will challenge the procedures for which the school has approved the proposed patient treatment initially, but may take any one (or more) procedures not taken the first time at a later exam. Failing procedures can also be taken at a subsequent session.

The following information is intended to assist dental licensure candidates, as well as examiners and educators involved in the testing process, in recognizing ethical considerations when patients are part of the clinical licensure process.

**Background:** Dental licensure is intended to ensure that only qualified individuals are licensed to provide dental treatment to the public. Most licensing jurisdictions have three general requirements: an educational requirement-graduation from a dental education program accredited by the Commission on Dental Accreditation; a written (theoretical) examination-to determine whether the applicant has achieved the theoretical bases at a level of competence that protects the health, welfare and safety of the public; and a clinical examination in which a candidate demonstrates the clinical knowledge, skills and abilities necessary to safely practice dentistry.

Anecdotal information and experiences reported in the literature by licensees and educators have raised ethical considerations when human subjects/patients are used in the examination process.<sup>1-6</sup> While others disagree, it is recognized that the profession must ensure that the welfare of patients is safeguarded in every step of the clinical licensure examination process.<sup>7</sup>

The licensure examination process is evolving. Many clinical examination agencies continue to monitor developments for applicability and affordability of alternatives to human subjects/patients in providing valid and reliable assessment of clinical competence.

The ADA has voiced its position regarding the use of human subjects/patients in clinical examinations through a series of resolutions culminating with the adoption of the 2005 House of Delegates' Resolution 20H-2005.<sup>8-10</sup> This resolution reaffirms ADA support for the elimination of human subjects/patients in the clinical licensure examination process while giving exception to a more recent methodology for testing known as the curriculum-integrated format (CIF). The 2006 ADA House of Delegates directed the ADA Council on Dental Education and Licensure to develop a definition of CIF and present it to the 2007 House of Delegates. The 2007 House adopted the following definition (1H:2007):

**Curriculum Integrated Format:** An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

Given that currently there are no new technologies that completely eliminate the use of human subjects/patients in the clinical examination processes, the ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA)<sup>11</sup> called on major stakeholders, including the ADA's Council on Dental Education and Licensure (CDEL), to provide input for the development of a statement that would identify key ethical considerations and provide guidance to help ensure the welfare of the patient remains paramount.

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**Ethical Considerations When Using Human Subjects/Patients in the Examination Process**

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1. Soliciting and Selecting Patients: The ADA Principles of Ethics and Code of Professional Conduct<sup>12</sup> (ADA Code), Section 3, Principle: Beneficence states that the "dentist's primary obligation is service to the patient" and to provide "competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration given to the needs, desires and values of the patient." The current examination processes require candidates to perform restorative and periodontal treatments on patients. In light of the principle stated above, this may create an ethical dilemma for the candidate when seeking patients to sit for the exam. Candidates should refrain from the following:
  1. Reimbursements between candidates and patients in excess of that which would be considered reasonable (remuneration for travel, lodging and meals).
  2. Remuneration for acquiring patients between licensure applicants.
  3. Utilizing patient brokering companies.
  4. Delaying treatment beyond that which would be considered acceptable in a typical treatment plan (e.g. delaying treatment of a carious lesion for 24 months).
  
2. Patient Involvement and Consent: The ADA Code, Section 1, Principle: Patient Autonomy states that "the dentist's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient's needs, desires and abilities." Candidates and dental examiners support patient involvement in the clinical examination process by having a written consent form that minimally contains the following basic elements:
  1. A statement that the patient is a participant in a clinical licensure examination, that the candidate is not a licensed dentist, a description of the procedures to be followed and an explanation that the care received might not be complete.
  2. A description of any reasonably foreseeable risks or discomforts to the patient.
  3. A description of any benefits to the patient or to others which may reasonably be expected as a result of participation.
  4. A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the patient.
  5. An explanation of whom to contact for answers to pertinent questions about the care received.
  6. A statement that participation is voluntary and that the patient may discontinue participation at any time without penalty or loss of benefits to which the patient is otherwise entitled.

3. Patient Care: The ADA Code, Section 3, Principle: Beneficence states that the dentist has a “duty to promote the patient’s welfare.” Candidates can do this by ensuring that the interests of their patient are of primary importance while taking the exam. Examiners contribute to this by ensuring that candidates are adequately monitored during the exam process such that the following treatment does not occur:
  1. Unnecessary treatment of incipient caries.
  2. Unnecessary patient discomfort.
  3. Unnecessarily delaying examination and treatment during the test.
  
4. Follow-Up Treatment: The ADA Code, Section 2, Principle: Nonmaleficence states that “professionals have a duty to protect the patient from harm.” To ensure that the patient’s oral health is not jeopardized in the event that he/she requires follow-up care, candidates and dental examiners should make certain that the patient receives the following:
  1. A clear explanation of what treatment was performed as well as what follow-up care may be necessary.
  2. Contact information for pain management.
  3. Complete referral information for patients in need of additional dental care.
  4. Complete follow-up care ensured by the mechanism established by the testing agency to address care given during the examination that may need additional attention.

Sources:

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11. CEBJA is the ADA agency responsible for providing guidance and advice and for formulating and disseminating materials on ethical and professional conduct in the practice and promotion of dentistry.
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October 2008

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Nifty Lynn Dio, Bureau Assistant On behalf of Brittany Lewin, Executive Director		<b>2) Date When Request Submitted:</b>  06/29/2016  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Dentistry Examining Board			
<b>4) Meeting Date:</b>  07/06/2016	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Informational Item <b>American Dental Hygienists' Association Standards for Clinical Dental Hygiene Practice</b>	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A	
<b>10) Describe the issue and action that should be addressed:</b>  Wisconsin Dental Hygienists' Association Advocacy Chair Linda Jorgenson, RDH, BS, RF, submitted the attachment information for the Board's reference.			
<b>11) Authorization</b>			
<b>Nifty Lynn Dio</b>		<b>06/29/16</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

# Standards for Clinical Dental Hygiene Practice



American  
Dental  
Hygienists'  
Association

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**REVISED STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE – 2016**



## **REVISED STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE – 2016**

### **HISTORY**

One hallmark of a true profession is its willingness to assume responsibility for the quality of care that its members provide. In 1985, the American Dental Hygienists' Association (ADHA) took a major step toward fulfillment of that responsibility with the development of Applied Standards of Clinical Dental Hygiene Practice.<sup>1</sup> This document is the third revision<sup>2</sup> to build on those Standards and promote dental hygiene practice based on current and relevant scientific evidence.

### **INTRODUCTION**

The Standards for Clinical Dental Hygiene Practice outlined in this document guide the individual dental hygienist's practice. Dental hygienists remain individually accountable to the standards set by the discipline and by applicable federal, state, and local statutes and regulations that define and guide professional practice.<sup>3</sup> These Standards should not be considered as a substitute for professional clinical judgment. In addition, they should not be confused with the Accreditation Standards for Dental Hygiene Education Programs, which are chiefly concerned with the structure and operation of dental hygiene education programs.<sup>4</sup>

Dental hygienists are valued members of the health care workforce. They have the knowledge, skills, and professional responsibility to provide oral health promotion and health protection strategies for all individuals as well as groups. As licensed professionals, they are accountable for the care and services they provide.

These Standards promote the knowledge, values, practices, and behaviors that support and enhance oral health with the ultimate goal of improving overall health. The primary purpose of the Standards for Clinical Dental Hygiene Practice is to assist dental hygiene clinicians in the provider-patient relationship. In addition, dental hygienists in other professional roles such as educator, researcher, entrepreneur, public health professional, and administrator — as well as those employed in corporate settings — can use these Standards to facilitate the implementation of collaborative, patient-centered care in interprofessional teams of health professionals. This collaboration can occur in a variety of practice settings including community and public health centers, hospitals, school-based programs, long-term care facilities, outreach, and home care programs. The secondary purpose of these Standards is to educate other health care providers, policymakers, and the public about the clinical practice of dental hygiene. The purpose of medical and dental science is to enhance the health of individuals as well as populations. Dental hygienists use scientific evidence in the decision-making process impacting their patient care. The dental hygienist is expected to respect the diverse values, beliefs, and cultures present in individuals and communities. When providing dental hygiene care, dental hygienists must support the right of the individual to have access to the necessary information and provide opportunities for dialogue to allow

the individual patient to make informed care decisions without coercion. Facilitating effective communication might require an interpreter and/or translator based on the patient and practitioner's need to communicate. Dental hygienists must realize and establish their professional responsibility in accordance with the rights of individuals and groups. In addition, when participating in activities where decisions are made that have an impact on health, dental hygienists are obligated to assure that ethical and legal issues are addressed as part of the decision-making process. Dental hygienists are bound by the Code of Ethics of the American Dental Hygienists' Association.<sup>3</sup>

The Standards for Clinical Dental Hygiene Practice provide a framework for clinical practice that focuses on the provision of patient-centered comprehensive care. The Standards describe a competent level of dental hygiene care<sup>1,2,4-7</sup> as demonstrated by the critical thinking model known as the dental hygiene process of care.<sup>7</sup> As evidenced by ADHA policy<sup>6</sup> and various dental hygiene textbooks,<sup>8-10</sup> the six components of the dental hygiene process of care include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation (Appendix A). The dental hygiene process encompasses all significant actions taken by dental hygienists and forms the foundation of clinical decision-making.

## **DEFINITION OF DENTAL HYGIENE PRACTICE**

Dental hygiene is the science and practice of recognition, prevention and treatment of oral diseases and conditions as an integral component of total health.<sup>11</sup> The dental hygienist is a primary care oral health professional who has graduated from

an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene to provide education, assessment, research, administrative, diagnostic, preventive and therapeutic services that support overall health through the promotion of optimal oral health.<sup>12</sup> In practice, dental hygienists integrate multiple roles to prevent oral diseases and promote health (Appendix B).

Dental hygienists work in partnership with all members of the dental team. Dentists and dental hygienists practice together as colleagues, each offering professional expertise for the goal of providing optimum oral health care to the public. The distinct roles of the dental hygienist and dentist complement and augment the effectiveness of each professional and contribute to a collaborative environment. Dental hygienists are viewed as experts in their field; are consulted about appropriate dental hygiene interventions; are expected to make clinical dental hygiene decisions; and are expected to plan, implement, and evaluate the dental hygiene component of the overall care plan.<sup>7-10</sup> All states define their specific dental hygiene practice scope and licensure requirements.

## **EDUCATIONAL PREPARATION**

The registered dental hygienist (RDH) or licensed dental hygienist (LDH) is educationally prepared for practice upon graduation from an accredited dental hygiene program (associate, post-degree certificate, or baccalaureate) within an institution of higher education and qualified by successful completion of a national written board examination and state or regional clinical examination for licensure.

In 1986, ADHA declared its intent to establish the baccalaureate degree as the minimum entry level for dental hygiene practice (Appendix C).<sup>7,13-14</sup>

## **PRACTICE SETTINGS**

Dental hygienists can apply their professional knowledge and skills in a variety of work settings as clinicians, educators, researchers, administrators, entrepreneurs, and public health professionals, and as employees in corporate settings. The private dental office continues to be the primary place of employment for dental hygienists. However, never before has there been more opportunity for professional growth. Clinical dental hygienists may be employed in a variety of health care settings including, but not limited to, private dental offices, schools, public health clinics, hospitals, managed care organizations, correctional institutions, or nursing homes.<sup>6</sup>

One example of an innovative, interprofessional practice model was tested by Patricia Braun, MD, MPH, associate professor, Pediatrics and Family Medicine at the University of Colorado Anschutz School of Medicine. This project co-located a dental hygienist in the pediatrician's office. Co-locating dental hygienists into medical practices is a feasible and innovative way to provide oral health care, especially for those who have limited access to preventive oral health services.<sup>14</sup>

Another innovative model exists in Oregon, where expanded practice dental hygienists (EPDHs) do not need a collaborative agreement with a dentist to initiate dental hygiene care for populations that qualify as having limited access to care; however, some aspects do require a collaborative agreement.<sup>15</sup>

EPDHs in Oregon are able to work in a variety of settings,<sup>16</sup> such as nursing homes, schools, and as private business owners.<sup>14</sup>

## **PROFESSIONAL RESPONSIBILITIES AND CONSIDERATIONS**

Dental hygienists are responsible and accountable for their dental hygiene practice, conduct, and decision-making. Throughout their professional career in any practice setting, a dental hygienist is expected to:

- Understand and adhere to the ADHA Code of Ethics.
- Maintain a current license to practice, including certifications as appropriate.
- Demonstrate respect for the knowledge, expertise, and contributions of dentists, dental hygienists, dental assistants, dental office staff, and other health care professionals.
- Articulate the roles and responsibilities of the dental hygienist to the patient, interprofessional team members, referring providers, and others.
- Apply problem-solving processes in decision-making and evaluate these processes.
- Demonstrate professional behavior.
- Maintain compliance with established infection control standards following the most current guidelines to reduce the risks of health-care-associated infections in patients, and illnesses and injuries in health care personnel.
- Incorporate cultural competence<sup>17</sup> in all professional interactions.
- Access and utilize current, valid, and reliable evidence in clinical decision-making through analyzing and interpreting the literature and other resources.
- Maintain awareness of changing trends in dental hygiene, health, and society that impact dental hygiene care.

- Support the dental hygiene profession through ADHA membership.
- Interact with peers and colleagues to create an environment that supports collegiality and teamwork.
- Prevent situations where patient safety and well-being could potentially be compromised.
- Contribute to a safe, supportive, and professional work environment.
- Participate in activities to enhance and maintain continued competence and address professional issues as determined by appropriate self-assessment.
- Commit to lifelong learning to maintain competence in an evolving health care system.

### **DENTAL HYGIENE PROCESS OF CARE**

The purpose of the dental hygiene process of care is to provide a framework where the individualized needs of the patient can be met; and to identify the causative or influencing factors of a condition that can be reduced, eliminated, or prevented by the dental hygienist.<sup>8-10</sup> There are six components to the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation and evaluation, and documentation; see Appendix A).<sup>7-10, 18</sup>

The dental hygiene diagnosis is a key component of the process and involves assessment of the data collected, consultation with the dentist and other health care providers, and informed decision-making. The dental hygiene diagnosis and care plan are incorporated into the comprehensive plan that includes restorative, cosmetic, and oral health needs that the patient values. All components of the

process of care are interrelated and depend upon ongoing assessments and evaluation of treatment outcomes to determine the need for change in the care plan. These Standards follow the dental hygiene process of care to provide a structure for clinical practice that focuses on the provision of patient-centered comprehensive care.

## **STANDARDS OF PRACTICE**

### **Standard 1: Assessment**

The ADHA definition of assessment: The collection and analysis of systematic and oral health data in order to identify client needs.<sup>19</sup>

#### **I. Health History**

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

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

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

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

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

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

**Pharmacologic history** includes the list of medications, including dose and frequency, that the patient is currently taking. This includes but is not limited to

any over-the-counter (OTC) drugs or products such as herbs, vitamins, nutritional supplements, and probiotics. The practitioner should confirm any past history of an allergic or adverse reaction to any products.

## II. Clinical Assessment

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

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

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

- E. Mobility and fremitus
- F. Presence, location, and extent of furcation involvement

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

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

### III. Risk Assessment<sup>20-21</sup>

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

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

1. Domestic violence
2. Physical, emotional, or sexual abuse
3. Behavioral
4. Psychiatric
5. Special needs
6. Literacy
7. Economic
8. Stress
9. Neglect

### **Standard 2: Dental Hygiene Diagnosis**

ADHA defines dental hygiene diagnosis as the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene care plan.<sup>22</sup>

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

- I. Analyze and interpret all assessment data.

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

### **Standard 3: Planning**

Planning is the establishment of realistic goals and the selection of dental hygiene interventions that can move the client closer to optimal oral health.<sup>24</sup> The interventions should support overall patient goals and oral health outcomes.

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

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

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

#### **Standard 4: Implementation**

Implementation is the act of carrying out the dental hygiene plan of care.<sup>24</sup> Care should be delivered in a manner that minimizes risk; optimizes oral health; and recognizes issues related to patient comfort including pain, fear, and/or anxiety.

Through the presentation of the dental hygiene care plan, the dental hygienist has the opportunity to create and sustain a therapeutic and ethically sound relationship with the patient.

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

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

### **Standard 5: Evaluation**

Evaluation is the measurement of the extent to which the client has achieved the goals specified in the dental hygiene care plan. The dental hygienist uses evidence-based decisions to continue, discontinue, or modify the care plan based on the ongoing reassessments and subsequent diagnoses.<sup>25</sup> The evaluation process

includes reviewing and interpreting the results of the dental hygiene care provided and may include outcome measures that are physiologic (improved health), functional, and psychosocial (quality of life, improved patient perception of care). Evaluation occurs throughout the process as well as at the completion of care.

- I. Use measurable assessment criteria to evaluate the tangible outcomes of dental hygiene care (e.g., probing, biofilm control, bleeding points, retention of sealants, etc.).
- II. Communicate to the patient, dentist, and other health/dental care providers the outcomes of dental hygiene care.
- III. Evaluate patient satisfaction of the care provided through oral and written questionnaires.
- IV. Collaborate to determine the need for additional diagnostics, treatment, referral, education, and continuing care based on treatment outcomes and self-care behaviors.
- V. Self-assess the effectiveness of the process of providing care, identifying strengths and areas for improvement. Develop a plan to improve areas of weakness.<sup>26</sup>

### **Standard 6: Documentation**

The primary goals of good documentation are to maintain continuity of care, provide a means of communication between/among treating providers, and to minimize the risk of exposure to malpractice claims. Dental hygiene records are considered legal documents and as such should include the complete and accurate recording of all collected data, treatment planned and provided, recommendations

(both oral and written), referrals, prescriptions, patient/client comments and related communication, treatment outcomes and patient satisfaction, and other information relevant to patient care and treatment.

- I. Document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation) including the purpose of the patient's visit in the patient's own words. Documentation should be detailed and comprehensive; e.g., thoroughness of assessment (soft-tissue examination, oral cancer screening, periodontal probing, tooth mobility) and reasons for referrals (and to whom and follow-up). Treatment plans should be consistent with the dental hygiene diagnosis and include no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.<sup>26</sup>
- II. Objectively record all information and interactions between the patient and the practice (e.g., telephone calls, emergencies, prescriptions) including patient failure to return for treatment or follow through with recommendations.
- III. Record legible, concise, and accurate information. For example, include dates and signatures, record clinical information so that subsequent providers can understand it, and ensure that all components of the patient record are current and accurately labeled and that common terminology and abbreviations are standard or universal.
- IV. Recognize ethical and legal responsibilities of recordkeeping including guidelines outlined in state regulations and statutes.
- V. Ensure compliance with the federal Health Information Portability and Accountability Act (HIPAA). Electronic communications must meet HIPAA standards in order to protect confidentiality and prevent changing entries at a later date.

- VI. Respect and protect the confidentiality of patient information.

### **SUMMARY**

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

### **KEY TERMS**

**Client:** The concept of client refers to the potential or actual recipients of *dental hygiene* care, and includes persons, families, groups and communities of all ages, genders, socio-cultural and economic states.<sup>29</sup>

**Cultural Competence:** the awareness of cultural difference among all populations, respect of those differences and application of that knowledge to professional practice.<sup>17</sup>

**Dental Hygiene Care Plan:** an organized presentation or list of interventions to promote the health or prevent disease of the patient's oral condition. The plan is designed by the dental hygienist and consists of services that the dental hygienist is educated and licensed to provide.<sup>5, 7</sup>

**Evidence-Based Practice:** the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual clients. The practice of evidence-based dental hygiene requires the integration of individual clinical expertise and client preferences with the best available external clinical evidence from systematic research.<sup>30</sup>

**Intervention:** dental hygiene services rendered to clients as identified in the dental hygiene care plan. These services may be clinical, educational, or health promotion related.<sup>29</sup>

**Interprofessional Team:** a group of health care professionals and their patients who work together to achieve shared goals. The team can consist of the dental hygienist, dentist, physician, nutritionist, smoking cessation counselor, nurse practitioner, etc.<sup>31</sup>

**Outcome:** result derived from a specific intervention or treatment.

**Patient:** the potential or actual recipient of dental hygiene care, including persons, families, groups, and communities of all ages, genders, and socio-cultural and economic states.<sup>22</sup>

**Patient-Centered:** approaching services from the perspective that the client is the main focus of attention, interest, and activity. The client's values, beliefs, and needs are of utmost importance in providing evidence-based care.<sup>32</sup>

**Risk Assessment:** an assessment based on characteristics, behaviors, or exposures that are associated with a particular disease; e.g., smoking, diabetes, or poor oral hygiene.<sup>21</sup>

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## RESOURCES

The following websites can provide evidence upon which to base clinical decisions in compliance with the Commission on Dental Accreditation (CODA) Accreditation Standards for Dental Hygiene Education Programs.

ADHA Policy Manual. Glossary, 18-96. American Dental Hygienists' Association

[Internet]. 2016 [cited 2016 March 28]. Available from:

[https://www.adha.org/resources-docs/7614\\_Policy\\_Manual.pdf](https://www.adha.org/resources-docs/7614_Policy_Manual.pdf)

American Academy of Public Health Dentistry: <http://www.aaphd.org/>.

American Academy of Pediatric Dentistry: <http://www.aapd.org/>.

American Academy of Periodontology: <http://perio.org/>.

American Dental Association: <http://www.ada.org/>.

Commission on Dental Accreditation. Accreditation Standards for Dental Hygiene Education Programs. American Dental Association [Internet]. 2016 January [cited 2016 March 3]. Available [http://www.ada.org/~media/CODA/Files/2016\\_dh.ashx](http://www.ada.org/~media/CODA/Files/2016_dh.ashx)

American Diabetes Association: <http://www.diabetes.org/>.

American Heart Association: <http://www.americanheart.org/>.

Association of State and Territorial Dental Directors: <http://www.astdd.org/>.

Canadian Dental Hygienists' Association: [www.cdha.org](http://www.cdha.org).

Centers for Disease Control and Prevention (caries, mineralization strategies, and

health protection goals): <http://www.cdc.gov/>

<http://www.cdc.gov/osi/goals/goals.html>

<http://www.cdc.gov/niosh/homepage.html>

CDC Guidelines for Infection Control in Dental healthcare Settings. Centers for Disease Control and Prevention [Internet]. 2003. [cited 2016 March 28]. Available from;

<http://www.cdc.gov/OralHealth/infectioncontrol/guidelines/index.htm>

Center for Evidence-Based Dentistry: <http://www.cebd.org/>.

Clinical Trials: <http://www.clinicaltrials.gov/>.

The Cochrane Collaboration: <http://www.cochrane.org/>.

Forrest JL, Miller SA. An Evidence-Based Decision-Making Model for Dental Hygiene Education, Research and Practice. *J Dent Hyg.* 2001; 75(1): 50-63.

Health Insurance Portability and Accountability Act (HIPAA): <http://www.hipaa.org/>.

National Guideline Clearing House: <http://www.guidelines.gov/>.

Nunn ME. Understanding the Etiology of Periodontitis: An Overview of Periodontal Risk Factors. *Periodontol* 2000. 2003; 32: 11-23.

Occupational Safety and Health Administration:

<http://www.osha.gov/SLTC/dentistry/index.html>.

The Organization for Safety and Asepsis Procedures (OSAP): <http://www.osap.org/>.

Special Care Dentistry: <http://www.scdonline.org/>.

The Selection of Patients for Dental Radiograph Examinations. American Dental Association and the US Department of Health and Human Services [Internet]

Revised 2012 [cited 2016 March 28]. Available from:

[http://www.fda.gov/downloads/Radiation-](http://www.fda.gov/downloads/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/UCM329746.pdf)

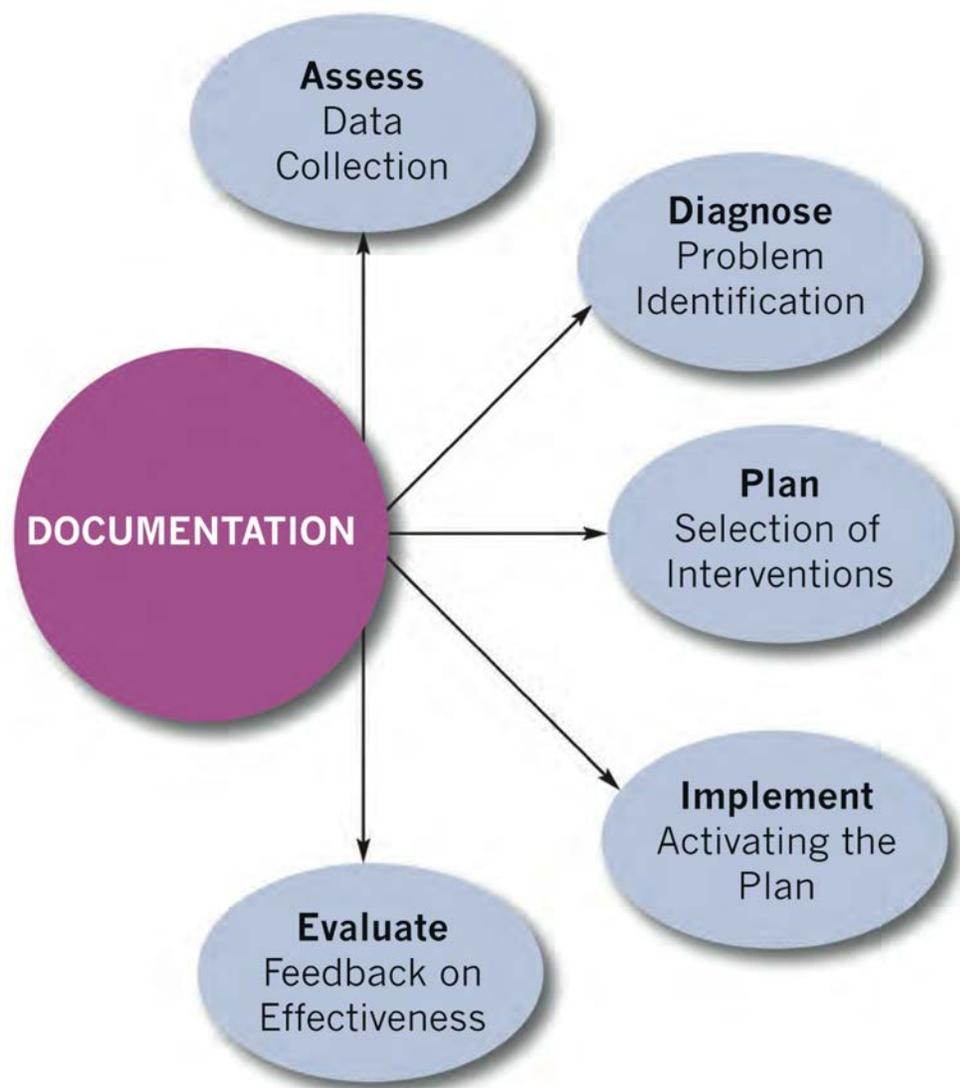
[EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/Medical X-Rays/UCM329746.pdf](http://www.fda.gov/downloads/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/UCM329746.pdf)

Comprehensive Periodontal Therapy: A Statement by the American Academy of Periodontology. *J Periodontol.* 2011; 82(7): 943-949.

## Appendix A

### Dental Hygiene Process of Care <sup>7</sup>

There are six components to the dental hygiene process of care. These include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation. The six components provide a framework for patient care activities.



Adapted from: Wilkins EM. Clinical Practice of the Dental Hygienist. 12th ed.

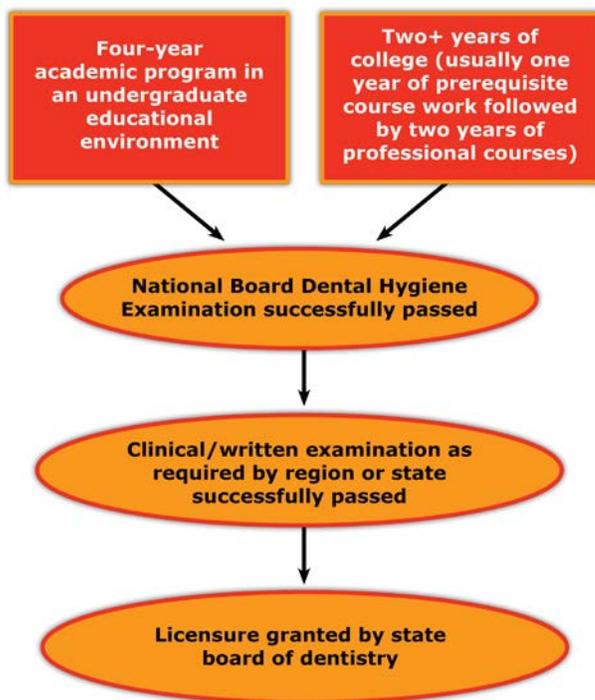
Philadelphia, PA: Wolters Kluwer. 2017. pp. 12-14.

## Appendix B

### Professional Roles of the Dental Hygienist<sup>33</sup>

<b>Overview</b> The dental hygienist plays an integral role in assisting individuals and groups in achieving and maintaining optimal oral health. Dental hygienists provide educational, clinical and consultative services to individuals and populations of all ages in a variety of settings and capacities. The professional roles of the dental hygienist are outlined below.						
Clinician	Corporate	Public Health	Researcher	Educator	Administrator	Entrepreneur
<p>Dental hygienists in a clinical role assess, diagnose, plan, implement, evaluate and document treatment for prevention, intervention and control of oral diseases, while practicing in collaboration with other health professionals. Examples of clinical employment settings include:</p> <ul style="list-style-type: none"> <li>• Private dental practices</li> <li>• Community clinics</li> <li>• Hospitals</li> <li>• University dental clinics</li> <li>• Prison facilities</li> <li>• Nursing homes</li> <li>• Schools</li> </ul>	<p>Corporate dental hygienists are employed by companies that support the oral health industry through the sale of products and services. Leaders throughout the dental industry often employ dental hygienists due to their clinical experience and understanding of dental practice. Examples of corporate positions include:</p> <ul style="list-style-type: none"> <li>• Sales representatives</li> <li>• Product researchers</li> <li>• Corporate educators</li> <li>• Corporate administrators</li> </ul>	<p>Community health programs are typically funded by government or nonprofi tani zt i o s. These positions often offer an opportunity to provide care to those who otherwise would not have access to dental care. Examples of positions for dental hygienists in public health settings include:</p> <p><i>Clinician</i></p> <ul style="list-style-type: none"> <li>• Rural or inner city community clinics</li> <li>• Indian Health Service</li> <li>• Head Start programs</li> <li>• School sealant programs</li> </ul> <p><i>Administrator</i></p> <ul style="list-style-type: none"> <li>• State public health officer</li> <li>• Community clinic administrator</li> </ul>	<p>Research conducted by dental hygienists can be either qualitative or quantitative. Quantitative research involves conducting surveys and analyzing the results, while qualitative research may involve testing a new procedure, product or theory for accuracy, effectiveness, etc. Examples of employment settings for dental hygienist researchers include:</p> <ul style="list-style-type: none"> <li>• Colleges and universities</li> <li>• Corporations</li> <li>• Governmental agencies</li> <li>• Nonprofi tani zt i o s</li> </ul>	<p>Dental hygiene educators are in great demand. Colleges and universities throughout the U.S. require dental hygiene instructors who use educational theory and methodology to educate competent oral health professionals. Corporations also employ educators who provide continuing education to licensed dental hygienists. Examples of dental hygiene educators include:</p> <ul style="list-style-type: none"> <li>• Clinical instructors</li> <li>• Classroom instructors</li> <li>• Program directors</li> <li>• Corporate educators</li> </ul>	<p>Dental hygienists in administrative positions apply organizational skills, communicate objectives, identify and manage resources, and evaluate and modify programs of health, education and health care. Examples of administrative positions held by dental hygienists include:</p> <ul style="list-style-type: none"> <li>• Clinical director, statewide school sealant program</li> <li>• Program director, dental hygiene educational program</li> <li>• Executive director, state association staff</li> <li>• Research administrator, university</li> <li>• Director, corporate sales</li> </ul>	<p>By using imagination and creativity to initiate or finance new commercial enterprises, dental hygienists have become successful entrepreneurs in a variety of businesses. Some examples of business opportunities developed by dental hygienists include:</p> <ul style="list-style-type: none"> <li>• Practice management company</li> <li>• Product development and sales</li> <li>• Employment service</li> <li>• CE provider or meeting planner</li> <li>• Consulting business</li> <li>• Founder of a nonprofit</li> <li>• Independent clinical practice</li> <li>• Professional speaker / writer</li> </ul>

## Appendix C



### Educational Path for Entry into the Profession

Dental hygienists must complete an accredited educational program to qualify for licensure in a particular state or region. Dental hygienists are licensed with the credential of Registered Dental Hygienist (RDH) or Licensed Dental Hygienist (LDH) following completion of an academic

program that includes didactic and clinical requirements.

### Professional Specialization

Dental hygienists can further their academic credentials after earning a certificate, associate, and/or baccalaureate degree. A dental hygienist can continue his or her educational advancement by enrolling in a variety of master's-level programs, which provides eligibility for a doctoral-level degree.



## **Development and Validation Process for the Standards for Clinical Dental Hygiene Practice**

In 2003, the ADHA Board of Trustees approved the establishment of a task force to define and develop standards for clinical dental hygiene practice. The previous standards of practice document created by ADHA had been published in 1985 and was no longer being distributed due to the significant changes in dental hygiene practice; therefore, the association did not have document accurately reflecting the nature of clinical dental hygiene practice. A series of task force meetings occurred by phone, electronically and in-person from 2004 to 2008 in order to create and revise the draft standards document.

As part of the validation process, in November 2005, a survey was distributed to all ADHA council members, 50 participants in the ADHA Constituent Officers Workshop, and a 50-member random selection of the ADHA membership to provide feedback regarding the draft Standards of Practice that had been created by the task force. The data collected from these audiences was collated, analyzed and reviewed by the task force in making subsequent modifications.

During the 2006 ADHA Annual Session, the chair of the task force presented the draft Standards document to the membership, responded to questions, and requested written and oral feedback regarding the direction of the document. The Standards were also posted on the ADHA website prior to the annual meeting and for a period following in order to solicit feedback from the membership and other communities of interest. In the fall of 2006, the task force met and considered the

comments from all respondents and made additional revisions to the document. The task force also reviewed clinical standards of practice documents from other professions as a point of comparison.

In 2007, the revised Standards were shared during the ADHA Annual Session with the draft document posted online and open for comments from the communities of interest. Following the annual meeting, the draft document was also broadly distributed to the communities of interest, which included a pool of approximately 200 organizations.

Following the collection of feedback from all interested parties, the task force considered all feedback and met by conference call in order to finalize the document. The final document was submitted to the ADHA Board of Trustees in March 2008 for their consideration and adoption.

In September 2014, the Standards for Clinical Dental Hygiene Practice policies and references were updated and the document was reprinted. It was determined at the 2015 Annual Session that the Standards would need to be revised since at least three years had passed since the last full revision of the document. A new task force was appointed by ADHA President Jill Rethman, RDH, BA, for the revision of the Standards.

2016 Task Force Membership:

Christine Nathe, RDH, MS, New Mexico, Chair

Carol Jahn, RDH, MS, Illinois

Deborah Lyle, RDH, BS, MS, New Jersey

JoAnn Gurenlian, RDH, MS, PhD, New Jersey

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ADHA Board of Trustee Advisor:

Sharlee Burch, RDH, MPH, EdD, Kentucky

DENTAL HYGIENE PROCESS OF CARE • ASSESSMENT • DENTAL  
HYGIENE DIAGNOSIS • PLANNING • IMPLEMENTATION • EVAL-  
UATION • DOCUMENTATION • EVIDENCE-BASED PRACTICE •  
PATIENT-CENTERED • DENTAL HYGIENE CARE PLAN • INTERPRO-  
FESSIONAL COLLABORATION • CRITICAL THINKING • EVIDENCE-  
BASED DECISION MAKING • CULTURAL COMPETENCE • DIRECT  
ACCESS • DENTAL HYGIENE PROCESS OF CARE • ASSESSMENT •  
DENTAL HYGIENE DIAGNOSIS • PLANNING • IMPLEMENTATION •  
EVALUATION • DOCUMENTATION • EVIDENCE-BASED PRACTICE  
• PATIENT-CENTERED • DENTAL HYGIENE CARE PLAN • INTERPRO-  
FESSIONAL COLLABORATION • CRITICAL THINKING • EVIDENCE-  
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