THE MARYLAND STATE BOARD OF DENTAL EXAMINERS

SUMMER 2009 Newsletter
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The President's Message

Change, Commitment, Consistency

It is said that the only individual that likes change is a wet baby. It is also said that if you aren't changing then you are not growing and things that aren't growing are dead.

Both of the above statements apply to individuals, the nation, the State and especially the Dental Board. There has been a tremendous amount of change at the Board and we are still growing. In the past year we lost employees in key positions, hired a new Executive Director, a new Compliance Officer, and had the largest number of new appointees to the Board in recent memory. Nevertheless, we have remained committed to our core mission to protect the public. For the first time in the last 7 years we now have a full compliment of investigators. The new compliance officer has brought a sense of efficiency and accountability to the discipline unit. Despite the change in executive directors they have all been helping the Board move forward by increasing the Board's online capabilities and continuing to look for new ways to make the Internet work for our licensees as well as the public. Each in his own way has worked with all units within the Board to ensure that the employees have what they need and are working as efficiently as possible.

Despite the conclusion of the term for some of the most knowledgeable and hard working Board members, the remaining members have made a special effort to help bring the newest members up to speed as rapidly as possible. The commitment to the task and the energy the new members have brought with them has helped the Board maintain its consistency. The new members need to be applauded for how quickly they have become knowledgeable and efficient.

I am confident that due to the commitment of the Board's staff and Board members we will stay true to our mission to protect the public and help the profession maintain the highest standards.

Wishing you the best in 2009

J. Timothy Modic, DDS, FAGD
Immediate Past President

Thanks to the following individuals for their contributions to the newsletter:

Murray Sherman, Legal Assistant
Richard Bloom, Board Counsel
Leslie Grant, DDS, Compliance Officer
Sharon Gregg-Jones, Fiscal Analyst
Desiree DeVoe, Dental Compliance Secretary
Gloria Byrd, Case Manager
Deborah Welch, Licensing Coordinator
Tim Modic, DDS, Immediate Past President
Jane Casper, RDH, MA, Board President
Barbara Merritt, RDH, Board Member
Zeno St. Cyr II, MPH, Consumer Board Member
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MARYLAND STATE BOARD OF DENTAL EXAMINERS 2009 ON-LINE LICENSE RENEWAL

DENTIST AND DENTAL HYGIENIST
MAY 1, 2009 TO JUNE 30, 2009
DEBORAH A. WELCH, LICENSING UNIT COORDINATOR

The Maryland State Board of Dental Examiners will be utilizing an on-line renewal system for the 2009 license renewal. Renewing your license on-line using your credit card is secure and efficient. We have essentially eliminated paperwork!

Upon completion of your on-line renewal application, the Dental Board mails your renewal license within 24 to 36 hours.

2009 ON-LINE RENEWAL INSTRUCTIONS WERE MAILED ON APRIL 24, 2009.

From the Licensing Staff...

The Licensing Unit is committed to providing excellent customer service to all licensees and the public. In an effort to function more efficiently, we introduced the online system in 2006 to streamline the renewal process. The 2009 on-line renewals process was very well received by our licensees. The Licensing Unit has worked extremely hard to recognize and implement licensure procedures that will be more customer friendly.

- Deborah A. Welch
Licensing Unit Supervisor/Coordinator

Licensing Staff: Sandra Sage, *Dental Hygienist Coordinator*
Patsy Sherwood, *Dental Assistant Coordinator*
Rona Melton, *Verifications Coordinator*

A BRAND NEW MEDICAID

- *Increased reimbursement rates*
- *Simplified credentialing*
- *Claims processing made easy*
- *Only one insurance company*
- *Case management services*

Beginning July 1, 2009 there will be a new and improved Maryland Medicaid system. The cumbersome process of credentialing will be a thing of the past and the claims process will be simplified. Add that to the increase in reimbursement rates and hopefully this will result in many more Maryland dentists becoming participating providers. Doral Dental has been chosen as the new dental vendor for Maryland. Instead of seven different insurance companies to deal with, there is only ONE! Please consider helping the underserved children in Maryland by becoming a Medicaid dental provider!

Jane S. Casper, RDH, MA
MSBDE Board President

BOARD STAFF PARTICIPATE IN AFGHANISTAN FOCUSED GIVING PROJECT

The Howard S. Bell Task Force Medical Hospital sponsored a Department of Health and Mental Hygiene gift giving drive in July 2008 to benefit the people of Afghanistan. The project focuses primarily on communities in remote villages and refugee camps where resources, if any, are limited. Basic amenities in these areas are often unavailable.

Through their kind generosity and enthusiasm, Maryland State Board of Dental Examiners staff members from each division, Administration, Compliance, and Licensing, donated brand new clothing items, shoes, kites, soccer balls, games, toys, and books. More than one hundred dollars was collected for the purchase of school supplies and teacher's kits. All contributions and purchases were made according to culturally sensitive guidelines.

Members of the Board expressed their appreciation to all staff for their willingness to extend "gift giving diplomacy" to the citizens of Afghanistan. Congratulations to the staff for a job well done!

Leslie E. Grant, D.D.S.
Dental Compliance Officer

Go to the address below to access the regulations of references mentioned in this newsletter
www.dhmh.md.gov/dental/

Medical Records – Retention, Storage and Disposal

Subtitles 3 and 4 of Title 4 of the Health General Article, Md. Code Ann., Health Gen., ("H.G.") §§ 4-301 et seq. entitled *Confidentiality of Medical Records* and §§ 4-401 et seq. entitled *Personal Medical Records,* and the concomitant Code of Maryland Regulations (COMAR) Title 10.01.16. et seq. primarily regulates the retention, storage and disposal of medical records by health care facilities and providers. Broadly defined, a medical record includes information transmitted in any form, if the information is identified with a particular patient and relates to the health care of that patient. H.G. § 4-301(g).[1]

The following is a summary highlighting various aspects of the statutory and regulatory requirements:

OWNERSHIP – Medical records are the personal property of the entity providing the healthcare. Upon request, patients may receive copies, but the original records remain with the provider. COMAR 10.01.16.04.C.

RETENTION - Medical records for all patients shall be maintained for a minimum of 5 years after the record is made or until the patient is 21 years of age, whichever is longer. COMAR 10.01.16.04.B. [2]

RETENTION SCHEDULE AND STORAGE – Health care providers shall develop and maintain a records retention schedule. COMAR 10.01.16.04.A; Records shall be maintained in accordance with that schedule. COMAR 10.01.16.05.A ; and are to be stored pursuant to COMAR 10.01.16.04.D, E, F, and G.

DISPOSAL OF MEDICAL RECORDS - The provider shall ensure confidentiality during the disposal process. The procedures for disposing of paper records, electronic records and for other types of media differ. Consult COMAR 10.01.16.05.C for the procedures applicable to your practice.

1 88 Opinions of the Attorney General, ___ 2003 [Opinion No. 03-022 (December 18, 2003)

2 Note that HIPAA's 6 year retention requirement controls only health plans, claims clearinghouses and providers that transmit information in electronic form.

EARLY DESTRUCTION – COMAR 10.01.16.07 establishes the prerequisites for early destruction of Medical Records that have not met the retention requirements of COMAR 10.01.16.04.

DESTRUCTION OF RECORDS – A provider may not destroy, alter, obliterate, or otherwise obscure a medical record. H.G. § 4-401.

CIVIL PENALTIES – In addition to any other penalties that my be provided for under Title 4, Subtitle 4 – *Personal Medical Records* – a health care provider may be found liable in court for actual damages and may be subject to an array of administrative fines assessed by the Board. H.G. § 4-403(g) and COMAR 10.01.16.09.

PREDETERMINATION OF INSURANCE BENEFITS

Dr. James Goldsmith

The Board receives a number of complaints from patients that dental work is performed and subsequently, insurance benefits are found to be less than the patient anticipated or are denied completely. The Board recognizes that knowing one's benefits is ultimately the responsibility of the patient; however, misunderstanding can usually be averted if the dentist submits a plan of proposed treatment to the insurance company for a predetermination of benefits prior to the commencement of treatment.

Go to the address below to access the regulations of references mentioned in this newsletter

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THE MARYLAND STATE BOARD OF DENTAL EXAMINERS

AND ITS RESPONSIBILITY TO REPORT ADVERSE ACTIONS TO THE NATIONAL PRACTITIONER DATA BANK- HEALTHCARE AND PROTECTION DATA BANK

The National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) are information clearinghouses created by Congress to improve health care quality and reduce health care fraud and abuse in the United States. The NPDB receives and discloses information related to professional competence and conduct of physicians, dentists, and other health care practitioners. The Healthcare Integrity and Protection Data Bank (HIPDB) receives and discloses information related to final adverse actions against health care practitioners, providers, and suppliers. Collectively, the NPDB and HIPDB are referred to as "the Data Banks."

The Board has been reporting adverse actions to the NPDB since 1990, and HIPDB since 1996. These reports include voluntary license surrender, and Final Board Orders and Consent Orders each of which may include, but are not limited to revocation, suspension, reprimand and or probation and which often will include any number of compliance conditions. The denial of an initial license and Publicly Available Negative Action of Finding are reported to HIPDB only. The Board is mandated to provide all adverse action reports to the data banks within thirty (30) days of its action.

The information reported by the Board may be retrieved by other State Boards, insurance carriers, and hospitals when rendering a decision on initial licenses, renewal of license, or credentialing. This reporting may hinder a licensee from maintaining or receiving malpractice insurance, as well as denial, revocation, or acceptance by carriers of certain insurances. The licensees, however, have the right to provide a statement in response to the Board's report. When the statement is processed, it is sent to all queriers who received a copy of the initial report, and is included with the report when it is released to future queriers.

CHANGING ADDRESSES.

The law requires that dentists and dental hygienists shall notify the Board in writing within 60 days of any change of address. This is very important since the Board is required only to attempt to contact you at the address you have on record.

The Board is authorized to proceed with its duties, including discipline, with or without your participation. Failure to notify the Board of an address change may result in your failure to receive a renewal notice, which in turn may lead to disciplinary action for practicing on an expired license.

In addition, untimely notification will result in an address fine fee of $10.

In addition to reporting, the Board uses the resources of the NPDB-HIPDB during the initial licensure process, as well as the investigatory process. Therefore, licensees must keep in mind that any adverse actions from other State Boards may be considered in determining whether a licensee may obtain a license or certificate to practice in this State. The Board's ultimate goal is to assure that all licensees are practicing in a professional and competent manner, in order to protect and provide quality care to the citizens of Maryland.

Submitted By: Gloria T. Byrd, *Case Manager*

Expanding Pathways to Licensure:

IS PATIENT SAFETY JEOPARDIZED? A CONSUMER'S PERSPECTIVE

By: Zeno W. St. Cyr, II, M.P.H.
Consumer Board Member

INTRODUCTION

I am pleased to offer a consumer's perspective on this timely and important topic – expanding pathways to licensure and its potential effects on patient safety. One may ask, why have some states now augmented their traditional licensure model? That is, graduate from dental or dental hygiene school, pass a state licensing exam, then begin practicing. Moreover, why are we seeing an increase in novel models for delivery of dental health care services, some of which appear to mirror the evolution in primary medical care delivery? Minnesota, for example, is examining an Oral Health Practitioner model for dental health delivery. Several states, including Maine, have an Independent Practice Dental Hygienist model. And Alaska has implemented the Dental Health Aide program.

At the heart of this matter is dental access to care. The statistics are staggering.

For every child without medical insurance, there are 2.6 children without dental insurance (equivalent to 23 million children without dental insurance).[1] For every adult without medical insurance, there are three adults without dental insurance (85 million uninsured adults).[2]

1 Vargas CM, Isman RE, Crall JJ. Comparison of Children's Medical and Dental Insurance Coverage by Socioeconomic Characteristics. US 1995. J Public Health Dent. 2002 Winter;62(1):38-44

2 National Center for Health Statistics (NCHS), National Health Interview Survey (NHIS) 1995. Data tabulated by the Office of Analysis, Epidemiology, and Health Promotion. NCHS, CDC 2000.

Disparities in oral health for underserved: [3]

- Poor children suffer 2x the decay, and are 3x more likely to have unmet oral health needs.
- <20% of Medicaid children receive preventive dental services.
- 25% of poor children never visit a dentist before kindergarten.
- Uninsured children are 2.5 times less likely to receive dental care as insured children
- 14.2% of uninsured vs. 6.6% insured reported no dental visit in the last five years.

As we debate the dental paradigms of the future, quite possibly no topic engenders more passion and a disparate array of opinions than how to address dental access to care.

IMPORTANCE OF PUBLIC PROTECTION

At the outset, I stress that patient safety must remain in the forefront of any discussion of dental licensure. Whether current or former members of state Boards of Dentistry, dental practitioners, dental or dental hygiene school educators, professional associations, or other dental communities of interest, we must be united in insisting that public protection guides any policy decisions made with regard to licensing dental professionals.

This importance cannot be minimized because the public depends on government, and by extension the state boards, to assure that any individual licensed to practice dentistry has sufficiently demonstrated the competency to practice independently.

Most consumers are not interested in what school or even in what country a dentist or hygienist was trained. But the public does want assurances that when they sit in a dental operatory, their problem will be appropriately addressed. In truth, the public is largely clueless about the licensing process. Some may know that a test is given to candidates for licensure, but most have no idea who administers the test or what the licensing exam entails.

3 Crall et. al. Disparities in Children's Oral Health and Access to Dental Care. JAMA 2000; 284(20): 2625-31.

THE DENTAL CARE ACCESS DILEMMA

In April 2003, U.S. Surgeon General Richard Carmona issued a **National Call to Action to Promote Oral Health** to draw attention to the glaring dental health needs in this country. Dr. Carmona, in the preface of his Call to Action, references the Surgeon General's report, **Oral Health in America**, issued three years earlier, in May of 2000, which first highlighted the need for improvements in dental health. The report stated:

> The great and enduring strength of American democracy lies in its commitment to the care and well-being of its citizens. The nation's long-term investment in science and technology has paid off in ever-expanding ways to promote health and prevent disease. We can be proud that these advances have added years to the average life span and enhanced the quality of life. But an "average" is necessarily derived from all values along a continuum and it is here that we come to recognize gaps in health and well-being. Not all Americans are benefiting equally from improvements in health and health care. America's continued growth in diversity has resulted in a society with broad educational, cultural, language, and economic differences that hinder the ability of some individuals and groups from realizing the gains in health enjoyed by many.
>
> These health disparities were highlighted in the year 2000 Surgeon General's report: Oral Health in America where it was reported that no less than a "silent epidemic of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups." The report also highlighted the disabling oral and craniofacial aspects of birth defects.

The report was a wake-up call, raising a powerful voice against the silence. It called upon policymakers, community leaders, private industry, health professionals, the media, and the public to affirm that oral health is essential to general health and well-being and to take action. No one should suffer from oral diseases or conditions that can be effectively prevented and treated. No schoolchild should suffer the stigma of craniofacial birth defects nor be found unable to concentrate because of the pain of untreated oral infections. No rural inhabitant, no homebound adult, no inner city dweller should experience poor oral health because of barriers to access to care and shortages of resources and personnel.

Herein lies the dilemma for both the dental community and government. It is good that groups such as ADA and ADHA, many of the dental and dental hygiene schools, and other dental communities of interest are grappling with how to address access to dental health. It is also admirable that many of Maryland's dentists and hygienists provide pro-bono dental care to the needy. But it simply is far too little to significantly impact the dental access problem.

GOVERNMENT'S INHERENT RESPONSIBILITY

We must recognize that an inherent function of government is to provide for its citizens. And while government has a far from perfect model for providing medical care to its special populations, including the elderly and the indigent, a similar model for dental care is all but non-existent. Federal funding through the State Children's Health Insurance Program (SCHIP) has helped some States provide dental health services to the needy. But in an environment of rising health care costs and strained budgets, state policy-makers and their Federal counterparts continue to struggle to find ways to address the growing need for dental health services.

EXPANDING PATHWAYS AND PATIENT SAFETY

California and Minnesota have begun looking beyond their borders for answers. California enacted legislation

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allowing the state to partner with De La Salle, a dental school in Mexico to grant licenses to graduates that agree to practice in underserved areas of the state. A dental school in India also seeks such a partnership with California.

The Minnesota Board can now examine credentials of international dental school graduates to determine if their training is at least equal to that provided by U.S. dental schools, for the purpose of allowing some to take the state licensing examination.

In addition, Florida's Department of Health published a Notice of Proposed Rule for the purpose of evaluating foreign dental schools and certifying those schools that provide dental education and training comparable to accredited U.S. schools.

Increasingly, the international arena is being used to recruit faculty, particularly at dental schools. This poses a different set of challenges for licensure and, potentially, patient safety.

A great concern to dental patient safety advocates is the candidate who repeatedly fails the licensing examination and then opts to seek licensure through a Post Graduate Year One (PGY-1) residency program. Although some states have considered PGY-1 as an alternative licensure pathway, New York is the only state that currently mandates the PGY-1 pathway for licensure of dentists. While this pathway does not currently affect dental hygiene, many wonder whether it may only be a matter of time before PGY-1 also looms in the future of the profession.

Today, State Boards of Dentistry and dental and dental hygiene schools are being drawn into the dental care and licensing debates. None are immune to political pressures as the search for answers continues. State Boards find themselves dealing with licensing issues that could impact both dental care access and/or patient safety. Pressure has come from politicians, dental and hygiene school Deans, dental associations, and students on an array of items that include relaxing licensing exam standards, changing requirements to make it easier to license by credentials, creating new license categories to accommodate practitioners recruited to the state, supporting expanded functions for dental hygienists and dental assistants, and in some cases, agreeing to support entirely new categories of dental professionals.

CONCLUSION

Clearly, there are no easy or quick answers to solving the access to dental care problems in this country. Neither dental or dental hygiene schools nor the dental profession are currently capable of addressing this country's huge need for dental health services. Faced with shortages in dental professionals and overwhelming need, particularly by special populations, some states are now considering or have already changed the current paradigm for licensing dental professionals and delivering dental health services. However, any discussion about expanding pathways for licensing dental professionals must be thoughtful… yet careful.

There's a very important reason why independent testing is required for licensure. Licensure examinations help protect the profession and, more importantly, help to protect the public. The dental licensing exam is a critical precursor to licensure. It is a tool to aid in protecting the public as one measure of the competency of hygienists to practice…and dentists to practice independently.

Our nation's 35th President, John F. Kennedy, said in his inaugural speech on January 20, 1963, "If a free society cannot help the many who are poor, it cannot save the few who are rich."

As policy-makers continue to struggle to find ways to provide adequate dental care to its citizens, dental communities of interest must unite with state policymakers in ensuring that any solutions considered or implemented have public protection at its centerpiece.

Go to the address below to access the regulations of references mentioned in this newsletter
www.dhmh.md.gov/dental/

Guidelines

FOR EMPLOYED AND TEMPORARY DENTAL HYGIENISTS WORKING UNDER GENERAL SUPERVISION IN PRIVATE DENTAL OFFICE

By Barbara L. Merritt, RDH

General supervision, as defined in the Maryland dental laws, means supervision of a dental hygienist by a dentist in a private dental office where the dentist may or may not be present when the dental hygienist performs the dental hygiene procedures.

Requirements of the hygienist and supervising dentist:

- The supervising dentist must be actively licensed in Maryland and is responsible for ensuring that all of the criteria for the dental hygienist are met.
- The dental hygienist must be actively licensed in Maryland and have a minimum of 1,500 hours of dental hygiene clinical practice in direct patient care.

An agreement between the supervising dentist and the dental hygienist setting forth the terms and conditions under which the dental hygienist may practice must exist. Office safety protocol to be implemented without the presence of a supervising dentist in the event of a staff exposure/incident, fire or medical emergency must exist. The written agreement, including the statement "the dental hygienist may provide dental hygiene services without the supervising dentist on the premises" must be signed by both the dentist and dental hygienist.

General supervision does not apply to patients:

- who have not been examined by a supervising dentist in the same private dental office within 7 months
- without a written prescription written by the supervising dentist, documented in the patients' records, for dental hygiene services
- without their consent.

This article is provided for general information purposes and does not include all of the legal requirements of general supervision of a dental hygienist.

Please note that during the 2009 legislative session the Maryland General Assembly passed Senate Bill 602 and House Bill 576, signed into law by Governor O'Malley as Chapters 565 and 566 respectively. The bills titled *"Dental Hygienists – Expanded Functions"* will allow a dental hygienist to perform manual curettage in conjunction with scaling and root planing without a dentist on the premises, once the dental hygienist meets certain enumerated education, training, evaluation, and examination requirements established by the Board. In addition, the bills allow a dental hygienist to administer local anesthesia by infiltration for the purpose of anesthetizing soft tissue to facilitate the performance of dental hygiene procedures, but not as a medical specialty, provided that the dentist is physically on the premises and prescribes the administration of local anesthesia by the dental hygienist. Again, as with manual curettage, the dental hygienist must first meet all education, training, evaluation and examination requirements established by the Board and pass a written and clinical examination as required by the Board. The dental hygienist must obtain the educational requirements for the administration of local anesthesia from an accredited dental hygiene program.

Note that a dental hygienist is not allowed to perform manual curettage in conjunction with scaling and root planing, or administer local anesthesia until the Board has promulgated the regulations and the dental hygienist has met all of the legal requirements established by the Board. Failure to do so may result in disciplinary action against both the dental hygienist and the supervising dentist.

You may access a copy of Senate Bill 602 or House Bill 576 by going to the Maryland General Assembly's website at www.mlis.state.md.us. Scroll down to Bill Number, type HB 576 or SB 602 and click Submit Query. Note the EXPLANATION on the bottom of the first page. CAPITALS INDICATE MATTER ADDED TO EXISTING LAW; [Brackets] indicate language deleted from existing law; underlining indicates amendments to the bill; and ~~strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

MARYLAND STATE BOARD OF DENTAL EXAMINERS

DISCIPLINARY ACTIONS TAKEN
MAY 2008 - APRIL 2009

LICENSEE NAME AND NUMBER	SUMMARY OF ACTION TAKEN
Javette Mullen, DRT, Certificate #12780	*Consented to a Reprimand effective May 7, 2008 with conditions for practicing dental radiation technology on an expired certificate.*
Denise Nadeau, DDS, Lic. # 12166	*Interim Consent Order in which the respondent is prohibited from practicing dentistry in the State of Maryland pending resolution of the matter. Maryland action resulting from disciplinary actions taken in Maine. Interim Consent Order effective May 7, 2008.*
Neil Whittaker, DDS, Lic. # 12504	*Amended Consent Order effective May 21, 2008.*
Edward Silverman, DDS, Lic. # 13021	*Order of Termination of Probation effective May 21, 2008.*
Maria Sevilla-Guevara, DDS, Lic. # 12374	*Order of Termination of Probation effective May 21, 2008.*
Azad Ally, DDS, No License #	*Final Order denying licensure in Maryland executed on August 20, 2008.*
Sharon Keister, DDS, Lic. # 8840	*Letter of Surrender executed August 20, 2008. Licensee surrendered license effective December 31, 2007.*
Maxine Clark, DDS, Lic. # 8300	*Order of Termination of Probation effective September 17, 2008.*
Deborah Tabb, DDS, Lic. # 8164	*Amended Final Order effective September 3, 2008, vacated by the Circuit Court for Montgomery County on December 1, 2008.*
Patrick Madden, DDS, Lic. # 7561	*Order of Termination of Probation effective October 1, 2008.*
Michael Baylin, DDS, Lic. # 4133	*Order of Termination of Probation effective October 3, 2008.*
Suzanne Fohl, DDS, Lic. # 11531	*Order of Termination of Probation effective October 17, 2008.*
Paul Vidzuinas, DDS, Lic. # 8250	*Order of Satisfaction of Consent Order effective October 15, 2008.*
Stephen Gentile, DMD, Lic. # 10473	*Order of Satisfaction effective October 15, 2008.*

LICENSEE NAME AND NUMBER	SUMMARY OF ACTION TAKEN
Benham Manesh, DDS, Lic. # 11469	*Final Order effective October 29, 2008 with Reprimand and 24 months probation for practicing dentistry in a professionally incompetent manner.*
Ronald Gravitz, DMD, Lic. # 6317	*Order of Termination of Probation effective December 20, 2008*
Elena Madariaga, RDH, Lic. # 12208	*Order of Termination of Probation effective December 20, 2008.*
Adly Wilson, DDS, Lic. # 11917	*Order of Termination of Probation effective December 17, 2008.*
Donald Parker, DDS, Lic. # 4871	*Order of Termination of Probation effective December 17, 2008.*
Daniel Placido, DDS, Lic. # 3286	*Order of Termination of Probation effective January 1, 2009.*
Freda Goldberg, RDH, Lic. # 239	*Order of Termination of Probation effective January 21, 2009.*
Mark A. Pitts, DDS, Lic. # 11347	*License Summarily Suspended effective February 10, 2009. Suspension lifted effective February 24, 2009.*
Jonathan Cole, DMD, Lic. # 8545	*Pre-Charge Consent Order effective March 4, 2009 with probationary period consistent with the period of probation in the state of Pennsylvania. Pennsylvania order effective August 11, 2006.*
Matthew Michie, DDS, Lic. # 5897	*Pre-Charge Consent Order effective March 18, 2009 with Reprimand for failure to comply with Centers for Disease Control guidelines.*
Cheryl Stende, RDH, Lic. # 2726	*Consent Order effective April 15, 2009 granting license to practice dental hygiene with conditions, Reprimand and two-years probation for practicing on an expired dental hygiene license.*

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www.dhmh.md.gov/dental/

Bulletin

MARYLAND STATE BOARD OF DENTAL EXAMINERS NEW CONTINUING EDUCATION REQUIREMENTS

DENTISTS AND DENTAL HYGIENISTS ABUSE AND NEGLECT

To: All Maryland Licensed dentists and dental hygienists

(Authority: Annotated Code of Maryland, Health Occupations Article, § 4-205 (a)(5) and the Code of Maryland Regulations, Title 10, Subtitle 44, Chapter 22, Continuing Education)

The Maryland State Board of Dental Examiners and its licensees are committed to ensuring that Maryland's citizens receive quality dental care and enjoy good health in safe surroundings. As a part of that commitment the Board is concerned that many of the States' most vulnerable citizens have or will become the victims of domestic abuse and neglect. The Board therefore strongly believes that each Maryland dentist and dental hygienist should receive formal training, in the form of continuing education, in the area of abuse and neglect.

Effective January 26, 2009 the regulations dealing with continuing education were amended. **The new regulations mandate that each Maryland dentist and dental hygienist complete a Board-approved 2 hour continuing education course in abuse and neglect relating to Maryland law during every other renewal cycle. The course will help licensees recognize and treat abuse and neglect, and emphasize the importance of reporting abuse and neglect to the proper authorities.**

The regulation will first affect dentists and dental hygienists scheduled to renew their licenses during the June 30, 2011 renewal cycle. Generally, the period to complete continuing education for those scheduled to renew their licenses during the June 30, 2011 cycle would commence on January 1, 2009 and end on December 31, 2010, providing the licensee with a 24 month period in which to complete the continuing education. That rule holds true with the exception of the course in abuse and neglect. As a result of the Board's desire that its licensees gain an increased awareness of this problem, the period to complete the course will be less than the usual 24 month period for those who must renew their licenses by June 30, 2011. That is, those dentists and dental hygienists scheduled to renew their licenses during the June 30, 2011 cycle will still be required to complete the 2 hour Board-approved course on or before December 31, 2010.

The 30 hours of continuing education presently required to renew a dental or dental hygiene license will not be increased as a result of this regulation. Prior to this change the Board would accept up to 15 hours of continuing education credits for self-study activities, including internet courses. The allowance has been increased to 17 hours for all dentists and all dental hygienists during all renewal periods. It is hoped that this will aid those who wish to complete the course on-line. Please keep in mind that the course must be Board-approved.

Dentists who have questions should call Ms. Deborah Welch, Dentist Licensing Coordinator at 410-402-8511. Dental Hygienists with questions should call Ms. Sandra Sage, Dental Hygienist Coordinator at 410-402-8510.

The Board appreciates your understanding and cooperation.

Respectfully,

J. Timothy Modic, D.D.S.
Immediate Past President

Go to the address below to access the regulations of references mentioned in this newsletter
www.dhmh.md.gov/dental/

Bulletin

MARYLAND STATE BOARD OF DENTAL EXAMINERS

DENTAL RADIATION TECHNOLOGISTS

NEW REQUIREMENTS FOR INITIAL CERTIFICATION, RENEWAL, LATE RENEWAL, AND REINSTATEMENT

To: All Maryland licensed dentists and certified dental radiation technologists.

(Authority: Annotated Code of Maryland, Health Occupations Article, § 4-505, and the Code of Maryland Regulations, Title 10, Subtitle 44, Chapter 19, Dental Radiation Technologist)

The Maryland State Board of Dental Examiners is committed to ensuring that Maryland's citizens receive quality dental care and that its licensees and certificate holders are qualified and competently trained to provide dental services.

Effective January 26, 2009 the regulations dealing with dental radiation technologists were amended.

This Bulletin is intended to discuss only the recent changes to the law.

A dental radiation technologist seeking renewal of their certificate in 2011 or thereafter must complete, in addition to other requirements contained in the regulations, a 2-hour Board approved course on infection control. A dental radiation technologist who fails to complete the 2-hour Board-approved course will not be permitted to renew his or her certificate.

A dental radiation technologist seeking to renew their certificate within 30 days of its expiration in 2011 or thereafter must complete, in addition to other requirements contained in the regulations, a 2-hour Board-approved course on infection control. A dental radiation technologist who fails to complete the 2-hour Board-approved course will not be permitted to renew his or her certificate.

A dental radiation technologist holding an expired certificate to practice dental radiation technology in 2011 or thereafter must complete, in addition to other requirements contained in the regulations, a 2-hour Board-approved course on infection control. A dental radiation technologist who fails to complete the 2-hour Board-approved course will not be permitted to reinstate their certificate.

To new applicants: In addition to other requirements contained in the regulations, to qualify to be certified as a dental radiation technologist, an applicant shall be an individual who:

1. Is 18 years old or older;
2. Is of good moral character; and
3. Holds a high school degree or its equivalent.

An applicant for a dental radiation technologist certificate who does not meet the Board's qualifications may be denied a certificate.

Please note that only dentists, dental hygienists, and dental radiation technologists certified by the Maryland State Board of Dental Examiners are permitted to practice dental radiation technology in Maryland. A dental assistant, regardless of education, experience, or certification elsewhere, may not place or expose radiographs in Maryland without first being certified by the State Dental Board. (A limited exception exists for an individual enrolled in an educational program recognized by the State Dental Board for dental hygiene or dental assisting, who places or exposes dental radiographs pursuant to the educational program.)

In addition, a licensed dentist who employs an individual to practice dental radiation technology or who supervises an individual to practice dental radiation technology who is not certified by the Board is guilty of unprofessional conduct and may be subject to disciplinary action under Health Occupations Article, § 4-315, Annotated Code of Maryland.

The dental laws change over time. You are responsible for keeping yourself apprised of the current law.

Dentists and dental radiation technologists who have questions should call Ms. Patsy Sherwood, Office Services Clerk at 410-402-8509.

The Board appreciates your understanding and cooperation.

Respectfully,

J. Timothy Modic, D.D.S.
Immediate Past President

Access to Dental Care

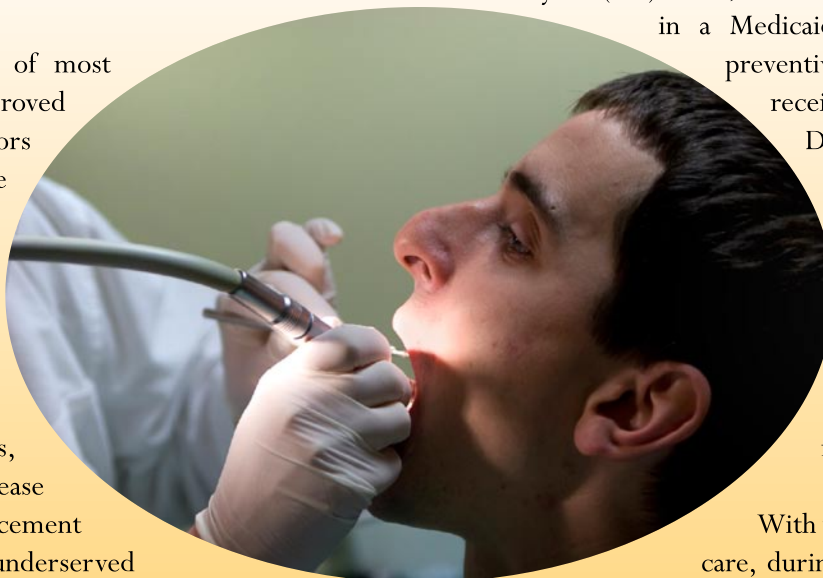
The issue of "Access to Dental Care" in our State and in our nation has received increased attention in recent years primarily because of:

1) The 2000 Surgeon General's "Report on Oral Health in America"

2) The Institute of Medicine's 2003 publication "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" and

3) The death of a twelve year old Prince George's County child from a brain infection caused by an untreated abscessed tooth.

Broadly defined, access to care may be considered to incorporate the ability to routinely identify and utilize a dental home without encumbering hardship. Barriers to access may include: lack of insurance, geographic isolation, age, lack of transportation, poverty, disability, multiple/rare medical conditions, limited oral health literacy, cultural beliefs, and anxiety.



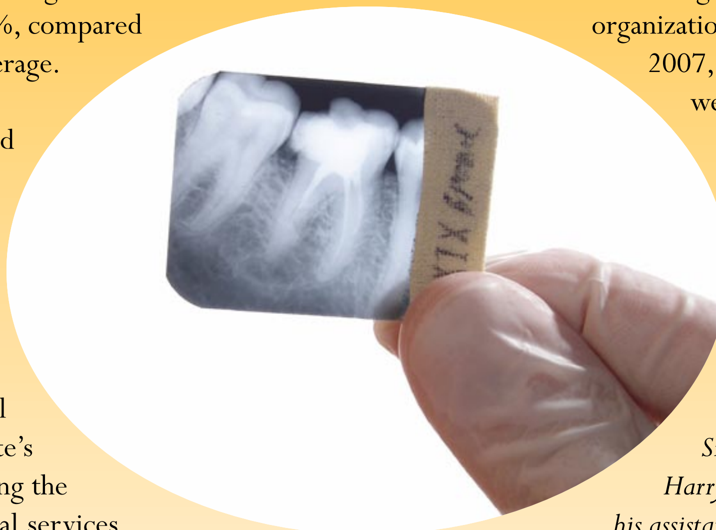
Overall, the oral health of most Americans has improved significantly. Fewer seniors are edentulous and more young adults have never experienced tooth decay. Unfortunately however, achieving optimum oral health is a challenge for some of our citizens. High care rates, untreated periodontal disease and lack of tooth replacement disproportionately affect underserved individuals. For instance, approximately 80% of dental care is found in only 25% of the population.

Recently, in March of 2009, the American Dental Association convened its first "Access to Care Summit". In attendance at the three day meeting were nearly 150 participants representing stakeholder groups such as dental advocacy groups, dental leadership, governmental groups, dental specialty and special interests groups, and policymakers. The conference addressed key overall themes including: working toward incorporating cultural competency into provision of services, addressing inequities in health and health care delivery, coordination of care, and ethical provision of evidence based best practices service delivery. It was generally recognized that the dental public health infrastructure has substantially diminished in the past twenty years, contributing to inadequate access to care for vulnerable persons. Ongoing work subsequent to the meeting will continue to provide and initiate action plans for dental workforce development, reorganization of dental delivery systems, oral health literacy, financing, and dental/medical collaboration.

At the local level here in Maryland, there are 4,033 dentists with active licenses, 3,206 of whom are general dentists, and 118 are pediatric dentists. As of July, 2008, 18.4% of active dentists were listed in the Health Choice directory. Of these, 16.6% provided services in at least one dental encounter. Medicaid statistics for Maryland indicate that for calendar year (CY) 2007, of the 216,885 children enrolled in a Medicaid MCO, 45.2% received preventive services and 19.3% received restorative treatment. During that same time frame, dental utilization rates for the 19,968 adult (21+) pregnant women enrolled in the program equaled 18.0%, and of the 138,212 adults overall, services were rendered to 13.2%.

With respect to children in foster care, during CY 2007, 44.4% of the 13,910 children in care experienced at least one dental encounter, 43.1% received preventive/diagnostic services, and 30.6% received restorative treatment. Also in CY 2007, 3,213 children participated in the Rare and Expensive Case Management (REM) program. Of these children 28.5% experienced at least one dental encounter, with 27.8% receiving preventive/ diagnostic services and

20.3% receiving restorative care. When compared to National participation, Maryland's young citizens utilized services at a rate of 30.67%, compared to the 33.04% national average.



The vision of the Maryland State Board of Dental Examiners is *"a state that provides citizens qualified dental care to further the good health and well-being of the citizens of Maryland."* In keeping with our goal of protecting our State's residents, and in recognizing the tremendous need for dental services throughout Maryland's borders, the Board, nearly fifteen years ago, as part of the disciplinary process, began requiring pro bono dental services. In essence, practitioners who have been sanctioned for reasons other than standard of care violations are required to provide a designated number of hours of donated dental services to selected pre-approved sites. Presently there are eighteen locations including local, state, federal, and non-profit organizations throughout the state. In CY 2007, approximately 1700 hours of service were rendered. The Board takes great pleasure in contributing our part to the health, well being and smiles of our fellow Marylanders.

Leslie E. Grant, DDS
Dental Compliance Officer

Sincere appreciation is extended to Dr. Harry Goodman, DHMH Dental Director for his assistance with Health Choice information.

DENTAL BOARD ELECTIONS

Last year Governor O'Malley signed into law Senate Bill 764 and House Bill 811 (Chapters 211 and 212 of the 2008 Laws of Maryland) directing that the State Board of Dental Examiners hold elections for dentist and dental hygienist vacancies on the Board. The elections were previously conducted by the Maryland State Dental Association and the Maryland Dental Society for dentists, and the Maryland Dental Hygienists' Association for dental hygienists.

On April 1, 2009 and April 15, 2009 the elections for dentists and dental hygienists respectively, were held at the Rice Auditorium on the Spring Grove Hospital campus in close proximity to the Board's offices. There is one dentist vacancy and two dental hygienist vacancies. The Board is pleased to state that the elections went very smoothly, and the results have been forwarded to the Governor in accordance with the dental laws.

The Board wishes to thank all of those dentists and dental hygienists who participated in the election process. The results of the election may be found on the Board's website at www.dhmh.md.gov/dental.

THE MARYLAND STATE BOARD OF DENTAL EXAMINERS

SUMMER 2009 NEWSLETTER

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