Minnesota Council of Health Boards

Legislative Review of Health Occupation Program

Licensure of Denturists

Review of Legislative Request:
Health Occupation Review

Licensure of Denturists
(HF105 / SF 179)

Application submitted by:

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Review Panel for the Council of Health Boards:

- Dr. Judith Sperling, Board of Podiatric Medicine
- Keith Hovland, Executive Director, Board of Podiatric Medicine
- Marshall Shragg, Executive Director, Board of Dentistry
- Tom Hiendlmayr, Minnesota Department of Health
- Gerald McCoy, Board of Dentistry

Staff to the Subcommittee:

Cindy Greenlaw Benton
Health-Related Licensing Boards
Administrative Services Unit

Public meeting dates:

November 6, 2003 November 19, 2003

Review Comments:

The subcommittee of the Council of Health Boards was charged with the responsibility of reviewing the application to license denturists in Minnesota. This proposal is advocated for, and represented by, a private citizen. This subcommittee has assessed the degree to which the responses to the Council's questions supported the application for establishing licensure. The panel reviewed the application through means of a ratings worksheet. Ratings were based upon the materials provided with the application, with limited reliance on knowledge of, or assumptions about, the professions by the subcommittee. The worksheets contained 60 items in the general topic areas: Description of the Occupation; Safety and Efficacy; Government and Private Sector Recognition; Education and Training; Practice Model & Viability of Profession; and Regulatory Framework. The proposal submitted by the proponent for Denturist Licensure was reviewed according to these 60 items for thoroughness of response and provision of information.

The Council reviewed the proposal with a view toward providing the Legislature with an objective evaluation of information regarding the proposal and to describe what areas, if any, were supportive of licensure of the occupation, and which were not. The subcommittee also reviewed this proposal with a view to inquiring into whether there is unquestionably a basis for regulating the profession and whether denturity and its practice is clearly defined and without grey areas. The subcommittee met to review the worksheets and to discuss the proposal on November 6, 2003. The subcommittee met a second time to further discuss the proposal on November 19, 2003.

In general, this subcommittee found that, as presented, the responses given to the questionnaire did not fully respond to concerns regarding licensure in several important aspects, and in some instances, substantial need for additional information was identified. These areas include: Description of the Occupation (and implications for scope of practice issues); Education and Training; and Practice Model & Viability of Profession.

Although the proposal reviewed by this committee did not contain detailed information regarding some of the particulars of the proposal, the preparation and submission of this proposal and legislative response served to call attention to the important issue of access to oral health care, and the financial barriers that may prevent citizens from obtaining needed care.

A primary impetus and justification for the licensure of dentists as described by its proponent was improved access to denture care and lower cost of dentures. No studies were submitted, however, which indicated whether access and cost were affected by the licensure of denturists in those jurisdictions that regulate denturists, nor the extent to which access and cost have been affected.

Additional research is suggested, which would inquire into areas for which insufficient information was provided by the proponent of this proposal.

A. Description of the Occupation

The scope of practice anticipated by licensure was not fully specified. The draft legislation provides for preparation of full and partial dentures, as well as construction and alterations. Due to conflicting information received by the subcommittee, the subcommittee was unsure whether a dentist would in all instances be consulted and would initially make a determination of the need, type, and nature of denture work required.

The proposal indicates that denturists would have their own place of business, and not be under the supervision of dentists; the rationale underlying denturism as an independent function rather than one subject to supervision by a dentist was not clearly expressed. The general work setting in which denturists would perform their work was also not fully described.

The respondent to the questionnaire asserts that access to dentures will be improved in that providers of denture care other than dentists will be available, and that dentures will thus be provided at a lower price than currently available. However, the subcommittee found no substantiation for this assertion.

No description of a current model of access to care, and how it would change if this proposal were enacted, was provided. Minnesota-specific information regarding the potential need for services and utilization by public was not provided.

B. Scope of Practice

No clear scope of practice or description of practice was delineated, nor was a clear description of the type of work that would be beyond the scope of practice given. Additional research might into the similarity or differences of work done by denturists compared with work performed by dentists, dental hygienists, dental technicians, and dental assistants might be useful to the Legislature. The portion of the bill regarding examination and referral (Sec. 6 [150B.05]) provides for an examination of the oral cavity of the patient by a denturist "before making and fitting a denture"; in the event that this examination provides reasonable cause to believe there is an abnormality or disease process requiring medical or dental treatment, the denturist is to immediately refer the patient to a dentist or physician. (In such a case, it is assumed the denturist would take no further action until a written statement that a denture would pose no threat to the patient's health was provided by a physician or dentist).

According to legislation, the practice of denturism includes each of the following:

- Making dentures
- Placing dentures
- Constructing dentures
- Altering dentures
- Reproducing dentures
- Repairing dentures
- Taking impressions
- Furnishing or supplying a denture
- Advising the use of a denture

Under the terms of the draft legislation, then, an examination by a dentist is required only before making and fitting a denture, but not for the numerous other activities included within the scope of practice of denturism. Even if "reasonable cause" of an abnormality or disease were found, an examination by a dentist would not be required – such an examination could be done by a physician. (H.F. No. 105, Article 1, Section 6.) It thus appears that a patient could receive dentures without being required to have ever seen a dentist. The subcommittee could not reconcile this proposed legislative language with the statement contained within the proponent's statement that, "A denturist would need a certificate of good oral health from a dentist".

The proposal also appears to permit prescription authority and fabrication without supervision of dentist. No rationale for permitting prescription privileges to denturists was submitted.

C. Government and Private Sector Recognition

Specific research or additional information regarding level / type of regulation in those states or provinces that regulate the practice and a discussion of the rationale for why the occupation has been prohibited in some states would be useful in evaluating this proposal.

The question of whether third-party reimbursement (insurance) for denturist services occurs in states in which denturists are regulated was not fully addressed.

The subcommittee was not provided sufficient information to determine whether the cost of regulation would be efficacious, in that the number of prospective denturists in Minnesota is unknown, and no projection was made of the number of denturists of the number of edentulous persons who could benefit from the services of a denturist. In conjunction with this matter, the pool from which practitioners would come was not clearly identified.

D. Education and Training

Overall, the subcommittee was unable to discern a standard or proposed standard for education of denturists in the current proposal, or whether completion of any particular educational program would be required. Licensure by reciprocity would be permitted under this proposed legislation; however, reciprocity is not a currently approved means of entering into other related professions regulated by the Board of Dentistry in the Dental Practice Act.

Training and education of current lab technicians is not described within the proposal; nor is the interaction of lab technicians and denturity explained.

A State examination would be required, however, Minnesota currently has no state examination, and the proposal has not clearly identified a standard examination that would be acceptable for Minnesota denturist practitioners, or what organization, if any, would develop such an examination. Similarly, no accrediting organization or system to evaluate competency was identified.

No requirement for continuing education for denturists was identified by the proponent, nor within the proposed legislation. The proposal appears to anticipate that denturists could be involved in activities during which a medical emergency could arise; continuing education in regard to such matters is regularly required of health professionals.

E. Practice Model & Viability of Profession

The proposal has not addressed the question of to what extent the occupation has made efforts to develop practice guidelines and treatment protocols for clinical care; and does not indicate whether the occupation encourages the use of peer review meetings and outcomes and treatment measures as feedback for individual practitioners.

The proposal also has not addressed the occupation's commitment and progress, if any, in ensuring that care provided by its members is culturally appropriate; nor presented objective research or other information indicating the occupation's record in terms of patient satisfaction.

F. Regulatory Framework

The subcommittee did not receive sufficient information to determine the cost of regulation or the size of the group that would be regulated, and thus cannot determine whether regulation would be cost effective. The proposal has not addressed the viability of the occupation nor identified the current number of practitioners. The anticipated supply of practitioners and demand for practitioners is similarly not addressed. Overall, the rationale justifying regulation is not adequately addressed.

The subcommittee was also not provided Minnesota-specific information regarding the potential need for services, nor does the information provided indicate that there is a ready population of denturists available in Minnesota.

The proposal as submitted creates a new chapter in Minnesota law for licensure of denturists. Minnesota Chapter 150A already provides regulatory authority for dentistry and affiliated dental professions (e.g., dental technicians, dental hygienists, dental assistants). The question of whether a separate new chapter in Minnesota law providing for denturist licensure is the most appropriate regulatory scheme (rather than inclusion in an already existing chapter), is worthy of additional review.

The committee also noted that this proposal creates an advisory committee of four denturists; this structure could potentially create a redundancy of regulatory authority and activity in that the proposal also currently provides for regulatory activities to be conducted through the Board of Dentistry.

cc: Senator Becky Lourey
Senator Sheila Kiscaden
Senator Linda Berglin
Representative Lynda Boudreau
Representative Jim Abler
Representative Michael Paymar
Committee Member Wil Wilson
Health Licensing Boards:
Dentistry Executive Director Marshall Shragg
Human Resources Officer Cindy Greeenlaw Benton
Nursing Home Examiner Executive Director Randy Snyder

KEY: ~~stricken~~ = old language to be removed
underscored = new language to be added

NOTE: If you cannot see any difference in the key above, you **need to** change the display of stricken and/or underscored language.

Authors and Status ■ List versions

H.F No. 105, as introduced: 83rd Legislative Session (2003-2004) Posted on Jan 16, 2003

A bill for an act

relating to health occupations; requiring the commissioner of health to license denturists; permitting the practice of denturism in this state; establishing licensure and examination requirements; establishing a denture technology advisory council; creating fees; authorizing rulemaking; providing a penalty; amending Minnesota Statutes 2002, sections 116J.70, subdivision 2a; 144.335, subdivision 1; 150A.05, subdivision 2; 319B.40; proposing coding for new law as Minnesota Statutes, chapter 150B.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

DENTURIST LICENSURE

Section 1. [INTENT.]

The legislature's intent in establishing a licensure system for denturists is to help assure the public's health, provide a mechanism for consumer protection, and offer cost-effective alternatives for denture care services and products to individual consumers and the state.

Sec. 2. [150B.01] [DEFINITIONS.]

Subdivision 1. [APPLICATION.] The definitions in this section apply to this chapter.

Subd. 2. [ADVISORY COUNCIL.] "Advisory council" means the denture technology advisory council.

Subd. 3. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 4. [DENTURE.] "Denture" means a removable full or partial upper or lower dental appliance to be worn in the mouth to replace missing natural teeth.

Subd. 5. [DENTURIST.] "Denturist" means a person who engages in the practice of denturism and is licensed under this chapter.

Subd. 6. [PRACTICE OF DENTURISM.] "Practice of denturism" means:

(1) making, placing, constructing, altering, reproducing, or repairing a denture; and

(2) taking impressions and furnishing or supplying a denture directly to a person, or advising the use of the denture, and maintaining a facility for these purposes.

Sec. 3. [150B.02] [PRACTICE OF DENTURISM PERMITTED.]

The practice of denturism is permitted in this state, if

the services are provided in conformance with the requirements of this chapter.

Sec. 4. [150B.03] [LICENSURE; PROTECTED TITLES AND RESTRICTIONS ON USE.]

Subdivision 1. [LICENSURE REQUIRED.] No person may engage in the practice of denturism unless the person is licensed as a denturist under this chapter.

Subd. 2. [PROTECTED TITLES.] No person may hold himself or herself out to the public as a denturist, use the title "licensed denturist" or "denturist," or use any other titles, words, letters, abbreviations, or insignia indicating or implying that the person is licensed under this chapter or eligible for licensure under this chapter, unless the person has been licensed as a denturist under this chapter.

Subd. 3. [PENALTY.] A person who violates any provision of this section is guilty of a misdemeanor.

Sec. 5. [150B.04] [EXCLUSIONS FROM CHAPTER.]

Nothing in this chapter prohibits or restricts:

(1) the practice of a health-related occupation by a person who is licensed, registered, or certified in Minnesota and who is practicing within the scope of practice of that occupation;

(2) the practice of denturism by a person employed in the service of the federal government while performing duties incident to that employment;

(3) the practice of denturism by a student enrolled in a school approved by the commissioner, if the denturism services provided by a student are provided according to a course of instruction or an assignment from an instructor, and under the supervision of an instructor; or

(4) work performed by dental laboratories and dental technicians under the written prescription of a dentist.

Sec. 6. [150B.05] [EXAMINATION AND REFERRAL REQUIREMENTS.]

Before making and fitting a denture, a denturist shall examine the oral cavity of the patient to receive the denture. If the denturist's examination gives the denturist reasonable cause to believe that there is an abnormality or disease process in the oral cavity that requires medical or dental treatment, the denturist shall immediately refer the patient to a dentist or physician. If the patient is referred to a dentist or physician, the denturist shall take no further action to manufacture or place a denture until the patient has been examined by a dentist or physician and the dentist or physician provides a written statement that a denture will pose no threat to the patient's health. If the denturist's examination reveals the patient's need for tissue or teeth modifications to assure proper fit of a full or partial denture, the denturist shall refer the patient to a dentist and shall assure that the modification has been completed before taking an impression to complete the denture.

Sec. 7. [150B.06] [DUTIES OF COMMISSIONER.]

To regulate denturists, the commissioner shall exercise the following powers and duties:

(1) establish qualifications for persons applying for licensure;

(2) prescribe, administer, and determine the requirements for examinations and establish what constitutes a passing grade for licensure;

(3) adopt rules necessary to implement this chapter;

(4) evaluate schools, and designate those schools from which graduation will be accepted as proof of an applicant's

completion of the course work requirements for licensure;

(5) discipline applicants and persons licensed under this chapter who violate a ground for disciplinary action;

(6) issue licenses for the practice of denturism;

(7) administer oaths and subpoena witnesses to carry out the activities authorized under this chapter;

(8) establish forms and procedures necessary to implement this chapter; and

(9) hire staff as needed to implement this chapter and act on behalf of the commissioner and the advisory council.

Sec. 8. [150B.07] [DENTURE TECHNOLOGY ADVISORY COUNCIL.]

Subdivision 1. [ESTABLISHMENT; MEMBERSHIP.] (a) The commissioner shall appoint seven persons to a denture technology advisory council. The advisory council shall consist of:

(1) four persons who are licensed denturists under this chapter. The initial appointees need not be licensed denturists but must have at least five years of experience in the practice of denturism or in a related field;

(2) two persons who are public members, as defined in section 214.02, and who are not affiliated with any health care occupation or facility. At least one of the public members must be over 65 years of age and must represent senior citizens; and

(3) one person who is a dentist licensed in Minnesota.

(b) No person may serve more than two consecutive terms on the advisory council.

Subd. 2. [ORGANIZATION.] The advisory council shall be organized and administered under section 15.059.

Subd. 3. [DUTIES.] At the commissioner's request, the advisory council shall:

(1) advise the commissioner regarding licensure qualifications for denturists;

(2) advise the commissioner regarding requirements for examinations, what constitutes a passing grade on an examination, and prescribing and administering examinations;

(3) advise the commissioner regarding rules that are necessary to implement this chapter;

(4) review reports of investigations related to individuals and make recommendations to the commissioner as to whether licensure should be denied or disciplinary action should be taken; and

(5) perform other duties for advisory councils authorized by chapter 214, as directed by the commissioner.

Sec. 9. [150B.08] [LICENSURE FEES.]

Subdivision 1. [FEES.] The following denturist license fees shall be paid to the commissioner:

(1) application fee, $.....;

(2) examination fee, $.....;

(3) licensure fee, $.....;

(4) license renewal fee, $.....;

(5) inactive license fee, $.....; and

(6) inactive license renewal fee, $.....

Subd. 2. [NONREFUNDABLE; WHERE DEPOSITED.] All fees collected are nonrefundable and must be deposited in the state government special revenue fund.

Sec. 10. [150B.09] [REQUIREMENTS FOR LICENSURE.]

Subdivision 1. [GENERAL REQUIREMENTS FOR LICENSURE.] The commissioner shall issue a license to practice denturism to an applicant who:

(1) submits a completed application to the commissioner on a form provided by the commissioner;

(2) submits the fees required under section 150B.08;

(3) documents successful completion of formal training lasting at least two years with a major course of study in the practice of denturism, at a school approved by the commissioner. The formal training must include special training in oral pathology specified by the commissioner; and

(4) passes a written examination and practical examination approved by the commissioner.

Subd. 2. [LICENSURE BY RECIPROCITY.] The commissioner shall issue a license by reciprocity to practice denturism to an applicant who is currently licensed or registered to practice denturism in another state that the commissioner determines has substantially equivalent licensure or registration standards to those in this state, and who:

(1) submits a completed application to the commissioner on a form provided by the commissioner;

(2) submits the fees required under section 150B.08;

(3) provides proof of having successfully passed a written examination and practical examination for denturism in the state where the applicant is licensed or registered, if the commissioner determines that the examinations are substantially equivalent to those in this state; and

(4) submits an affidavit from the agency that licenses or registers denturists in the state where the applicant is licensed or registered, attesting to the fact that the applicant is currently licensed or registered in that state.

Subd. 3. [LICENSURE BY EQUIVALENCY DURING TRANSITION PERIOD.] Between July 1, 2003, and June 30, 2005, the commissioner shall issue a license by equivalency to an applicant who:

(1) submits a completed application to the commissioner on a form provided by the commissioner;

(2) submits the fees required under section 150B.08;

(3) submits three affidavits from persons other than family members attesting that the applicant has been employed in the practice of denturism for at least five years, or submits documentation of at least 4,000 hours of practical experience in the practice of denturism;

(4) documents successful completion of a training course approved by the commissioner, or successful completion of an equivalent course approved by the commissioner; and

(5) passes a written examination and practical examination approved by the commissioner.

Subd. 4. [CONTENT OF LICENSE.] A license must list all addresses where the licensed denturist will engage in the practice of denturism.

Subd. 5. [LICENSE RENEWAL.] The commissioner shall establish by rule the requirements for license renewal. The requirements for license renewal shall not be more stringent than the requirements for licensure established in this chapter.

Sec. 11. [150B.10] [LICENSURE EXAMINATION.]

Subdivision 1. [EXAMINATION ADMINISTRATION.] The commissioner shall prescribe and administer the written and practical examinations for licensure under this chapter. The commissioner may hire denturists licensed under this chapter to prepare, administer, and grade the examinations, or may contract with regional examiners to prepare, administer, and grade the examinations.

Subd. 2. [REQUIREMENTS FOR EXAMINATIONS.] The examinations must determine the qualifications, fitness, and ability of the

applicant to practice denturism. The examinations must include a written examination and a practical examination involving a demonstration of skills. The written examination must cover the following subjects: head and oral anatomy and physiology, oral pathology, partial denture construction and design, microbiology, clinical dental technology, dental laboratory technology, clinical jurisprudence, asepsis, medical emergencies, and cardiopulmonary resuscitation. Examinations must be held at least annually. The first examination must be administered no later than December 31, 2003.

Subd. 3. [FAILURE OF WRITTEN OR PRACTICAL EXAMINATION.] Upon payment of an appropriate fee, an applicant who fails either the written or practical examination may take again the portion of the examination that the applicant failed.

Sec. 12. [150B.11] [INACTIVE LICENSE.]

Subdivision 1. [GENERAL.] A licensed denturist may place his or her license on inactive status. A person whose license is on inactive status shall not engage in the practice of denturism in this state without first reactivating the license. An inactive license must be renewed according to a schedule established by the commissioner. Failure to renew an inactive license shall result in cancellation of the inactive license.

Subd. 2. [CHANGE TO ACTIVE STATUS.] The commissioner shall by rule establish requirements under which a person whose license is on inactive status may change the license to active status.

Subd. 3. [DISCIPLINARY ACTION.] If a disciplinary proceeding has been initiated to suspend or revoke a person's inactive license, the license shall remain inactive until the proceedings are completed.

Sec. 13. [150B.12] [GROUNDS FOR DISCIPLINARY ACTION; DISCIPLINARY ACTIONS; SUSPENSION.]

Subdivision 1. [GROUNDS FOR DENIAL OF LICENSURE OR DISCIPLINE.] The commissioner may refuse to grant a license, may approve licensure with conditions, or may discipline a denturist licensed under this chapter using any disciplinary actions listed in subdivision 2 on proof that the individual has:

(1) intentionally submitted false or misleading information to the commissioner or the advisory council;

(2) failed, within 30 days, to provide information in response to a written request by the commissioner or advisory council;

(3) engaged in the practice of denturism in an incompetent manner or in a manner that falls below the community standard of care;

(4) violated any provision of this chapter;

(5) failed to perform the practice of denturism with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or due to other physical or mental impairment;

(6) been convicted of violating any state or federal law, rule, or regulation which directly relates to the practice of denturism;

(7) aided or abetted another person in violating any provision of this chapter;

(8) been disciplined for conduct in the practice of an occupation by the state of Minnesota, another jurisdiction, or a national professional association, if any of the grounds for discipline are the same or substantially equivalent to those in this chapter;

(9) not cooperated with the commissioner or advisory

council in an investigation of allegations of a ground for disciplinary action;

(10) advertised in a manner that is false or misleading;

(11) engaged in dishonest, unethical, or unprofessional conduct in connection with the practice of denturism that is likely to deceive, defraud, or harm the public;

(12) demonstrated a willful or careless disregard for the health, welfare, or safety of a patient;

(13) performed medical diagnosis, practiced dentistry, or provided treatment, other than the practice of denturism, without being licensed to do so under the laws of this state;

(14) paid or promised to pay a commission or part of a fee to any person who contacts the denturist for consultation or sends patients to the denturist for treatment;

(15) engaged in an incentive payment arrangement, other than that prohibited by clause (14), that promotes overutilization of the practice of denturism, whereby the referring person or person who controls the availability of denturist services to a patient profits unreasonably as a result of patient treatment;

(16) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(17) obtained money, property, or services from a patient through the use of undue influence, high-pressure sales tactics, harassment, duress, deception, or fraud;

(18) performed services for a patient who had no possibility of benefitting from the services;

(19) failed to refer a patient to a dentist or physician for examination or services as required under section 150B.05, or otherwise violated section 150B.05;

(20) engaged in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(21) violated a federal or state court order, including a conciliation court judgment, or a disciplinary order issued by the commissioner, related to the person's practice of denturism; or

(22) any other just cause related to the practice of denturism.

Subd. 2. [FORMS OF DISCIPLINARY ACTION.] When the commissioner finds that an applicant or a licensed denturist has engaged in a ground for disciplinary action under this chapter, the commissioner may take one or more of the following actions:

(1) refuse to grant a license;

(2) revoke the license;

(3) suspend the license;

(4) impose limitations or conditions on the license;

(5) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the denturist of any economic advantage gained by the violation charged or to reimburse the commissioner for all costs of the investigation and proceeding; including, but not limited to, the amount paid by the commissioner for services from the office of administrative hearings, attorney fees, court reports, witnesses, reproduction of records, advisory council members' per diem compensation, staff time, and expense incurred by advisory council members and department staff;

(6) order the denturist to provide uncompensated professional service under supervision at a designated clinic or other health care institution;

(7) censure or reprimand the denturist; or

(8) any other action justified by the case.

Subd. 3. [DISCOVERY; SUBPOENAS.] In all matters relating to the commissioner's investigation and enforcement activities related to denturists, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary materials. Any person failing or refusing to appear or testify regarding any matter about which the person may be lawfully questioned or failing to produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the commissioner or by a subpoena of the commissioner to do so may, upon application by the commissioner to the district court in any district, be ordered to comply with the order or subpoena. The commissioner may administer oaths to witnesses or take their affirmation. Depositions may be taken within or outside the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon a person it names anywhere within the state by any officer authorized to serve subpoenas or other process in civil actions in the same manner as prescribed by law for service of process issued out of the district court of this state.

Subd. 4. [TEMPORARY SUSPENSION.] In addition to any other remedy provided by law, the commissioner may, without a hearing, temporarily suspend the right of a denturist to practice if the commissioner finds that the denturist has violated a statute or rule that the commissioner has authority to enforce and that continued practice by the denturist would create a serious risk of harm to others. The suspension takes effect upon service of a written order on the denturist specifying the statute or rule violated. The order remains in effect until the commissioner issues a final order in the matter after a hearing or upon agreement between the commissioner and the denturist. Service of the order is effective if the order is served on the denturist or the denturist's attorney either personally or by first class mail. Within ten days of service of the order, the commissioner shall hold a hearing on the sole issue of whether there is a reasonable basis to continue, modify, or lift the suspension. Evidence presented by the commissioner or denturist must be by affidavit only. The denturist or the denturist's attorney of record may appear for oral argument. Within five working days after the hearing, the commissioner shall issue an order and, if the suspension is continued, schedule a contested case hearing within 45 days after issuance of the order. The administrative law judge shall issue a report within 30 days after closing of the contested case hearing record. The commissioner shall issue a final order within 30 days after receipt of that report, the hearing record, and any exceptions to the report filed by the parties.

Subd. 5. [AUTOMATIC SUSPENSION.] A denturist's right to practice is automatically suspended if (1) a guardian is appointed for a denturist, by order of a district court under sections 525.54 to 525.61, or (2) the denturist is committed by order of a district court under chapter 253B. The right to practice remains suspended until the denturist is restored to

capacity by a court and, upon petition by the denturist, the suspension is terminated by the commissioner after a hearing or upon agreement between the commissioner and the denturist.

Sec. 14. [150B.13] [ADDITIONAL REMEDIES.]

Subdivision 1. [CEASE AND DESIST.] (a) The commissioner may issue a cease and desist order to stop a person from violating or threatening to violate a statute, rule, or order which the commissioner has issued or has authority to enforce. The cease and desist order must state the reason for its issuance and give notice of the person's right to request a hearing under sections 14.57 to 14.62. If, within 15 days of service of the order, the subject of the order fails to request a hearing in writing, the order is the final order of the commissioner and is not reviewable by a court or agency.

(b) A hearing must be initiated by the commissioner not later than 30 days from the date of the commissioner's receipt of a written hearing request. Within 30 days of receipt of the administrative law judge's report, and any written agreement or exceptions filed by the parties, the commissioner shall issue a final order modifying, vacating, or making permanent the cease and desist order as the facts require. The final order remains in effect until modified or vacated by the commissioner.

(c) When a request for a stay of a cease and desist order accompanies a timely hearing request, the commissioner may, in the commissioner's discretion, grant the stay. If the commissioner does not grant a requested stay, the commissioner shall refer the request to the office of administrative hearings within three working days of receipt of the request. Within ten days after receiving the request from the commissioner, an administrative law judge shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five working days of receiving the administrative law judge's recommendation.

(d) In the event of noncompliance with a cease and desist order, the commissioner may institute a proceeding in district court to obtain injunctive relief or other appropriate relief, including a civil penalty payable to the commissioner not exceeding $10,000 for each separate violation.

Subd. 2. [INJUNCTIVE RELIEF.] In addition to any other remedy provided by law, including the issuance of a cease and desist order under subdivision 1, the commissioner may in the commissioner's own name bring an action in district court for injunctive relief to restrain a denturist from a violation or threatened violation of any statute, rule, or order which the commissioner has authority to administer, enforce, or issue.

Subd. 3. [ADDITIONAL POWERS.] The issuance of a cease and desist order or injunctive relief granted under this section does not relieve a denturist from criminal prosecution by a competent authority or from disciplinary action by the commissioner.

Sec. 15. [150B.14] [REPORTING OBLIGATIONS.]

Subdivision 1. [PERMISSION TO REPORT.] A person who has knowledge of any conduct constituting grounds for disciplinary action relating to the practice of denturism under this chapter may report the violation to the commissioner.

Subd. 2. [INSTITUTIONS.] A state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the commissioner any action taken by the agency,

institution, or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition a denturist's privilege to practice or treat patients or clients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action for conduct that might constitute grounds for disciplinary action by the commissioner under this chapter. The institution, organization, or governmental entity shall also report the resignation of any denturists before the conclusion of any disciplinary action proceeding for conduct that might constitute grounds for disciplinary action under this chapter, or before the commencement of formal charges but after the denturist had knowledge that formal charges were contemplated or were being prepared.

Subd. 3. [PROFESSIONAL SOCIETIES.] A state or local professional society for denturists shall report to the commissioner any termination, revocation, or suspension of membership or any other disciplinary action taken against a denturist. If the society has received a complaint that might be grounds for discipline under this chapter against a member on which it has not taken any disciplinary action, the society shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the commissioner.

Subd. 4. [LICENSED PROFESSIONALS.] A licensed health professional shall report to the commissioner personal knowledge of any conduct that the licensed health professional reasonably believes constitutes grounds for disciplinary action under this chapter by a denturist, including conduct indicating that the denturist may be medically incompetent, or may be medically or physically unable to engage safely in the provision of services. If the information was obtained in the course of a client relationship, the client is a denturist, and the treating individual successfully counsels the denturist to limit or withdraw from practice to the extent required by the impairment, the commissioner may deem this limitation of or withdrawal from practice to be sufficient disciplinary action.

Subd. 5. [INSURERS.] (a) Each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to denturists or the medical joint underwriting association under chapter 62F, shall submit to the commissioner quarterly reports concerning the denturists against whom malpractice settlements and awards have been made. The report must contain at least the following information:

(1) the total number of malpractice settlements or awards made;

(2) the date the malpractice settlements or awards were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made;

(4) the dollar amount of each settlement or award;

(5) the address of the practice of the denturist against whom an award was made or with whom a settlement was made; and

(6) the name of the denturist against whom an award was made or with whom a settlement was made.

(b) The insurance company shall, in addition to the above information, submit to the commissioner any information, records, and files, including clients' charts and records, it possesses that tend to substantiate a charge that a denturist may have engaged in conduct violating this chapter.

Subd. 6. [SELF REPORTING.] A denturist shall report to the commissioner any personal action that would require that a report be filed with the commissioner by any person, health care facility, business, or organization under subdivisions 2 to 5. The denturist shall also report the revocation, suspension, restriction, limitation, or other disciplinary action in this state and report the filing of charges regarding the denturist's license or right of practice in another state or jurisdiction.

Subd. 7. [DEADLINES; FORMS.] Reports required by subdivisions 2 to 6 must be submitted no later than 30 days after the reporter learns of the occurrence of the reportable event or transaction. The commissioner may provide forms for the submission of the reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting.

Sec. 16. [150B.15] [INVESTIGATIONS; PROFESSIONAL COOPERATION; EXCHANGING INFORMATION.]

Subdivision 1. [COOPERATION.] A denturist who is the subject of an investigation, or who is questioned in connection with an investigation, by or on behalf of the commissioner, shall cooperate fully with the investigation. Cooperation includes responding fully to any question raised by or on behalf of the commissioner relating to the subject of the investigation whether tape recorded or not. Challenges to requests of the commissioner may be brought before the appropriate agency or court.

Subd. 2. [EXCHANGING INFORMATION.] (a) The commissioner shall establish internal operating procedures for:

(1) exchanging information with state boards; agencies, including the office of ombudsman for mental health and mental retardation; health-related and law enforcement facilities; departments responsible for licensing health-related occupations, facilities, and programs; and law enforcement personnel in this and other states; and

(2) coordinating investigations involving matters within the jurisdiction of more than one regulatory agency.

(b) The procedures for exchanging information must provide for forwarding to an entity described in paragraph (a), clause (1), any information or evidence, including the results of investigations, that is relevant to matters within the regulatory jurisdiction of that entity. The data have the same classification in the possession of the agency receiving the data as they have in the possession of the agency providing the data.

(c) The commissioner shall establish procedures for exchanging information with other states regarding disciplinary action against denturists.

(d) The commissioner shall forward to another governmental agency any complaints received by the commissioner that do not relate to the commissioner's jurisdiction but that relate to matters within the jurisdiction of the other governmental agency. The agency to which a complaint is forwarded shall advise the commissioner of the disposition of the complaint. A complaint or other information received by another governmental agency relating to a statute or rule that the commissioner is empowered to enforce must be forwarded to the commissioner to be processed according to this section.

(e) The commissioner shall furnish to a person who made a complaint regarding a denturist a description of the actions of the commissioner relating to the complaint.

ARTICLE 2
CONFORMING AMENDMENTS

Section 1. Minnesota Statutes 2002, section 116J.70, subdivision 2a, is amended to read:

Subd. 2a. [LICENSE; EXCEPTIONS.] "Business license" or "license" does not include the following:

(1) any occupational license or registration issued by a licensing board listed in section 214.01 or any occupational registration issued by the commissioner of health pursuant to section 214.13;

(2) any license issued by a county, home rule charter city, statutory city, township, or other political subdivision;

(3) any license required to practice the following occupation regulated by the following sections:

(i) abstracters regulated pursuant to chapter 386;

(ii) accountants regulated pursuant to chapter 326A;

(iii) adjusters regulated pursuant to chapter 72B;

(iv) architects regulated pursuant to chapter 326;

(v) assessors regulated pursuant to chapter 270;

(vi) athletic trainers regulated pursuant to chapter 148;

(vii) attorneys regulated pursuant to chapter 481;

(viii) auctioneers regulated pursuant to chapter 330;

(ix) barbers regulated pursuant to chapter 154;

(x) beauticians regulated pursuant to chapter 155A;

(xi) boiler operators regulated pursuant to chapter 183;

(xii) chiropractors regulated pursuant to chapter 148;

(xiii) collection agencies regulated pursuant to chapter 332;

(xiv) cosmetologists regulated pursuant to chapter 155A;

(xv) dentists, registered dental assistants, and dental hygienists regulated pursuant to chapter 150A;

(xvi) denturists regulated pursuant to chapter 150B;

(xvii) detectives regulated pursuant to chapter 326;

~~(xvii)~~ (xviii) electricians regulated pursuant to chapter 326;

~~(xviii)~~ (xix) mortuary science practitioners regulated pursuant to chapter 149A;

~~(xix)~~ (xx) engineers regulated pursuant to chapter 326;

~~(xx)~~ (xxi) insurance brokers and salespersons regulated pursuant to chapter 60A;

~~(xxi)~~ (xxii) certified interior designers regulated pursuant to chapter 326;

~~(xxii)~~ (xxiii) midwives regulated pursuant to chapter 147D;

~~(xxiii)~~ (xxiv) nursing home administrators regulated pursuant to chapter 144A;

~~(xxiv)~~ (xxv) optometrists regulated pursuant to chapter 148;

~~(xxv)~~ (xxvi) osteopathic physicians regulated pursuant to chapter 147;

~~(xxvi)~~ (xxvii) pharmacists regulated pursuant to chapter 151;

~~(xxvii)~~ (xxviii) physical therapists regulated pursuant to chapter 148;

~~(xxviii)~~ (xxix) physician assistants regulated pursuant to chapter 147A;

~~(xxix)~~ (xxx) physicians and surgeons regulated pursuant to chapter 147;

~~(xxx)~~ (xxxi) plumbers regulated pursuant to chapter 326;

~~(xxxi)~~ (xxxii) podiatrists regulated pursuant to chapter 153;

~~(xxxiii)~~ (xxxiii) practical nurses regulated pursuant to chapter 148;

~~(xxxiii)~~ (xxxiv) professional fund raisers regulated pursuant to chapter 309;

~~(xxxiv)~~ (xxxv) psychologists regulated pursuant to chapter 148;

~~(xxxv)~~ (xxxvi) real estate brokers, salespersons, and others regulated pursuant to chapters 82 and 83;

~~(xxxvi)~~ (xxxvii) registered nurses regulated pursuant to chapter 148;

~~(xxxvii)~~ (xxxviii) securities brokers, dealers, agents, and investment advisers regulated pursuant to chapter 80A;

~~(xxxviii)~~ (xxxix) steamfitters regulated pursuant to chapter 326;

~~(xxxix)~~ (xl) teachers and supervisory and support personnel regulated pursuant to chapter 125;

~~(xl)~~ (xli) veterinarians regulated pursuant to chapter 156;

~~(xli)~~ (xlii) water conditioning contractors and installers regulated pursuant to chapter 326;

~~(xlii)~~ (xliii) water well contractors regulated pursuant to chapter 103I;

~~(xliii)~~ (xliv) water and waste treatment operators regulated pursuant to chapter 115;

~~(xliv)~~ (xlv) motor carriers regulated pursuant to chapter 221;

~~(xlv)~~ (xlvi) professional firms regulated under chapter 319B;

~~(xlvi)~~ (xlvii) real estate appraisers regulated pursuant to chapter 82B; or

~~(xlvii)~~ (xlviii) residential building contractors, residential remodelers, residential roofers, manufactured home installers, and specialty contractors regulated pursuant to chapter 326;

(4) any driver's license required pursuant to chapter 171;

(5) any aircraft license required pursuant to chapter 360;

(6) any watercraft license required pursuant to chapter 86B;

(7) any license, permit, registration, certification, or other approval pertaining to a regulatory or management program related to the protection, conservation, or use of or interference with the resources of land, air, or water, which is required to be obtained from a state agency or instrumentality; and

(8) any pollution control rule or standard established by the pollution control agency or any health rule or standard established by the commissioner of health or any licensing rule or standard established by the commissioner of human services.

Sec. 2. Minnesota Statutes 2002, section 144.335, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For the purposes of this section, the following terms have the meanings given them:

(a) "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting pursuant to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services pursuant to sections 144.341 to

144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(b) "Provider" means (1) any person who furnishes health care services and is regulated to furnish the services pursuant to chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 150A, 150B, 151, 153, or 153A, or Minnesota Rules, chapter 4666; (2) a home care provider licensed under section 144A.46; (3) a health care facility licensed pursuant to this chapter or chapter 144A; (4) a physician assistant registered under chapter 147A; and (5) an unlicensed mental health practitioner regulated pursuant to sections 148B.60 to 148B.71.

(c) "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

Sec. 3. Minnesota Statutes 2002, section 150A.05, subdivision 2, is amended to read:

Subd. 2. [EXEMPTIONS AND EXCEPTIONS OF CERTAIN PRACTICES AND OPERATIONS.] Sections 150A.01 to 150A.12 do not apply to:

(1) the practice of dentistry or dental hygiene in any branch of the armed services of the United States, the United States Public Health Service, or the United States Veterans Administration;

(2) the practice of dentistry, dental hygiene, or dental assisting by undergraduate dental students, dental hygiene students, and dental assisting students of the University of Minnesota, schools of dental hygiene, or schools of dental assisting approved by the board, when acting under the direction and supervision of a licensed dentist or a licensed dental hygienist acting as an instructor;

(3) the practice of dentistry by licensed dentists of other states or countries while appearing as clinicians under the auspices of a duly approved dental school or college, or a reputable dental society, or a reputable dental study club composed of dentists;

(4) the actions of persons while they are taking examinations for licensure or registration administered or approved by the board pursuant to sections 150A.03, subdivision 1, and 150A.06, subdivisions 1, 2, and 2a;

(5) the practice of dentistry by dentists and dental hygienists licensed by other states during their functioning as examiners responsible for conducting licensure or registration examinations administered by regional and national testing agencies with whom the board is authorized to affiliate and participate under section 150A.03, subdivision 1, and the practice of dentistry by the regional and national testing agencies during their administering examinations pursuant to section 150A.03, subdivision 1;

(6) the use of X-rays or other diagnostic imaging modalities for making radiographs or other similar records in a hospital under the supervision of a physician or dentist or by a person who is credentialed to use diagnostic imaging modalities or X-ray machines for dental treatment, roentgenograms, or dental diagnostic purposes by a credentialing agency other than the board of dentistry; ~~or~~

(7) the service, other than service performed directly upon the person of a patient, of constructing, altering, repairing, or duplicating any denture, partial denture, crown, bridge, splint, orthodontic, prosthetic, or other dental appliance, when performed according to a written work order from a licensed

dentist in accordance with section 150A.10, subdivision 3; or

(8) services that are included within the practice of denturism, as defined in section 150B.01, and that are provided by denturists licensed under chapter 150B.

Sec. 4. Minnesota Statutes 2002, section 319B.40, is amended to read:

319B.40 [PROFESSIONAL HEALTH SERVICES.]

(a) Individuals who furnish professional services pursuant to a license, registration, or certificate issued by the state of Minnesota to practice medicine pursuant to sections 147.01 to 147.22, as a physician assistant pursuant to sections 147A.01 to 147A.27, chiropractic pursuant to sections 148.01 to 148.106, registered nursing pursuant to sections 148.171 to 148.285, optometry pursuant to sections 148.52 to 148.62, psychology pursuant to sections 148.88 to 148.98, social work pursuant to sections 148B.18 to 148B.289, dentistry pursuant to sections 150A.01 to 150A.12, pharmacy pursuant to sections 151.01 to 151.40, or podiatric medicine pursuant to sections 153.01 to 153.26 are specifically authorized to practice any of these categories of services in combination if the individuals are organized under this chapter.

(b) Denturists licensed pursuant to chapter 150B are authorized to provide professional services in combination with dentists licensed pursuant to sections 150A.01 to 150A.12 if the individuals providing the services are organized under this chapter and if the combination does not impede the independent professional judgment of either party.

(c) This authorization does not authorize an individual to practice any profession, or furnish a professional service, for which the individual is not licensed, registered, or certified, but otherwise applies regardless of any contrary provision of a licensing statute or rules adopted pursuant to that statute, related to practicing and organizing in combination with other health services professionals.

Thom L. Jordan
1387 Eleanor Ave.
St. Paul, MN 55116
Phone: 651-699-1923

September 10, 2003

Mr. Randy Snyder, Executive Director
Minnesota Council of Health Boards
Board of Examiners for Nursing Home Administrators
2829 University Ave. S.E., Suite 440
Minneapolis, MN 55414

Re: S.F. No. 179/H.F. No. 105 -- Licensure of Denturists in Minnesota

Dear Mr. Snyder:

I am an individual citizen presenting this report on behalf of denturists.

I have been licensed by the Department of Commerce, starting June 1947 and renewed until 1999, in health insurance.

I am pleased to present the answers requested by the Council of Health Boards for the Council's consideration and judgment. The Council's report should be sent to the Health and Family Security Committee of the Minnesota Senate and to the Health and Human Services Policy Committee in the Minnesota House of Representatives to hopefully be used when this bill is considered again next session.

I attended four Senate hearings with Senator Kiscaden, who is the author of S.F. No. 179. The first hearing was with the Health and Family Security Committee. The second hearing, on the first engrossment, was with the State and Local Government Operations Committee. The third hearing, on the second engrossment, was with the Finance Committee. The fourth hearing, on the third engrossment, was with the Health and Human Services and Corrections Budget Division Committee. The bill was eventually included in the Senate Health and Human Services omnibus bill, which passed the Senate floor on a 38 to 27 nonpartisan vote.

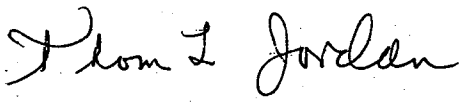
May I take this opportunity to express my gratitude to Senator Sheila Kiscaden who presented it to the four above-named Senate committees. I am also grateful to all these committee chairpersons in the Senate for passing this denturist bill.

There are 600,000 seniors age 65 and over in Minnesota who would greatly benefit by the passage of this bill licensing denturists in Minnesota.

My career has been in the health area since 1947, and I am much aware that seniors in Minnesota do not have any state or federal programs for dental care, with the exception of Medicaid, those incarcerated, and those veterans who apply to the county veterans' service office for dental benefits. These three groups should save Minnesota thousands of dollars in the years to come when legislation is passed licensing denturists. All citizens in Minnesota could save many dollars on the purchase of upper or lower false teeth from a licensed denturist.

Sincerely,

Thom L. Jordan



Questions Relating to Description of the Occupation

1. What is the occupational group proposed for regulation?

   A "denturist" under this new legislation. It would be a new licensed occupation in Minnesota.

2. What does the occupation do and how does it provide care? How does the occupation describe itself in terms of the types of care it provides, and the types of care that are beyond its professional scope?

   The practice of denturitry involves taking impressions of the upper and lower jaws, fabricating the dentures to complement the patient's facial features, and fitting the fabricated denture in the patient's mouth. It also involves, in most states and foreign countries that recognize denturists, the examination of the oral cavity to determine that no abnormalities exist and the mouth is fit for dentures.

3. Is the occupation a "complete system" that includes a range of modalities and therapies? If not, is it a modality that could be provided by members of different occupations?

   A "denturist" practice is very limited to the making of false teeth. A dentist would handle all other areas regarding the patient's mouth and teeth problems.

4. Are practitioners of the occupation typically responsible for making a diagnosis? If not, are they responsible for making an evaluation or identification of a problem?

   Under the proposed legislation, a patient would need a certificate of good oral health from a dentist. If a denturist found any oral problems, he would refer the patient to a dentist.

5. Are practitioners of the occupation responsible for writing, interpreting, or otherwise contributing to the establishment of the service or treatment plan? If yes, describe the responsibilities. If not, identify who is responsible.

   A denturist would need a certificate of good oral health from a dentist. Normally, a denturist prepares a written statement as to the "work to be done and the cost for the patient of the false teeth the denturist would make."

6. What services provided by the occupation are typically unsupervised?

   A denturist should have his own place of business and laboratory and not be under the supervision of a dentist. He may very well work with a dentist on special consultations.

7. What are typical work settings?

(1) **Denture Arts**
1131 Yellowstone Ave.
Pocatello, ID

(2) **Harris' Denture Studio**
1156 N. Arthur Ave.
Pocatello, ID

(3) **Main West Denture Clinic**
507 Main Ave. W.
Twin Falls, ID

(4) **Barnes Mini-Cassia Denture Center**
1100 Elba Ave.
Burley, ID

8. How long has the occupation been in existence?

ARIZONA	IDAHO	MAINE	MONTANA	OREGON	WASHINGTON
1978 By Legislation	1982 By Initiative 1983 By Legislation	1977 By Legislation Amended 1994	1984 By Initiative 1995 By Legislation	1978 By Initiative	1994 By Initiative 1995 By Legislature

(*See* Attachment #i)

9. Is it found only in the United States? If not, what is its current international status?

Denturists are in many countries, provinces and territories throughout most of the free world; including Australia, Canada, Denmark, Finland, Holland, Jordan, the Netherlands, Finland, Poland, Spain, Sweden, Switzerland, Tasmania, and the United Kingdom.

10. What is the philosophy behind the occupation? What ethics, concepts, or values help define the occupation? Has a "Code of Ethics" been developed by the occupation?

Based on a five-year study, the Federal Trade Commission reported that the "unmet needs for denture care among the edentulous population are so pervasive as to present a serious public health problem." The report went on to show that "approximately 13 million people need to have at least one full denture constructed . . . . **To date, in twenty-five years of practice in the U.S., there has not been one successful malpractice claim against a denturist.** Furthermore, there has never been one case of evidence in the United States where a denturist has ever posed a threat to or has ever harmed a denture patient."

11. Does the occupation identify itself more in terms of an "acute care" (sickness) model or in terms of a "health promotion/disease prevention" (wellness) model?

Denturists would refer these cases to a dentist or a doctor.

12. How is the occupation different from or similar to other health occupations, systems, and modalities?

A denturist works in a laboratory making a set of upper or lower false teeth. This may be similar to the person who manufactures artificial limbs.

13. What processes and guidelines exist for inter-professional referral, comanagement and collaboration?

In the state of Oregon, nine of ten denturists report that they had a positive business relationship with at least some of the dentists. Also, 78 percent of the denturists had a "good" or "excellent" relationship with a dentist. Canadians have good dentist and denturist relationships with 30-year cooperation.

14. How many individuals practice the occupation in Minnesota? How many of these would be subject to regulation?

Currently, none. All future licensed denturists would be subject to regulation by the state of Minnesota.

15. Is the workforce growing? If so, at what rate? What are the estimated demand requirements and workforce supply for the occupation?

	ARIZONA	IDAHO	MAINE	MONTANA	OREGON	WASHINGTON
Numbers of Denturists	12	29	15	13	130	103

(*See* Attachment #i)

Questions Relating to Safety and Efficacy

16. What evidence exists to demonstrate the efficacy of the services provided by the occupation?

Efficacy can be related to the dental laboratories that currently operate throughout Minnesota. They do provide false teeth to dentists.

17. How does the occupation measure the safety and efficacy of the services it provides?

To date in 25 years of practice in the U.S., there has not been one successful malpractice claim against a denturist.

18. What are the findings of studies (U.S. and international) that have been done on safety and risk of harm to patients/clients from the care approaches, treatments, and modalities used by members of the occupation?

A scientific study conducted in 1984 on denture wearing and oral cancer found no evidence that denture wearing, even wearing ill-fitting dentures, is a significant factor in oral cancer. The study was conducted on 400 patients with oral carcinoma seen in the Oral Medicine Clinic, University of California, San Francisco, between 1968 and 1982. This study included recorded data on tumor site and stage, smoking habits, and dental/denture status. "When denture and nondenture wearers were compared, there was no apparent risk relationship in regard to tobacco use, tumor state, or delay in diagnosis." This study also concluded that "denture wearing in a population of oral cancer patients does not appear to be associated statistically with an increased risk of the development of a malignance." The study concludes that there is no correlation between the wearing of dentures and any specific cancer sites. Furthermore, there is no difference between denture wearers and control groups in the occurrence of oral cancer.

19. Describe and document consequences to the consumer that result from incompetent or unethical practice or omission of appropriate practice. Include information on the consequences in each of the following areas:

(A) Emotional consequences
(B) Financial consequences
(C) Physical consequences
(D) Social consequences

From *Denturist and Dentures*, Van den Eeden Report

(A) Page 13 –
Dear Sir:
I discovered your site while looking for help as I need personalized dentures and filled with hope I am asking for our direction. As I continue my search I've learned more about this much needed service for people like me, I understand that currently this profession must settle for now anyway to stay in the basement. **I am**

so sorry as there are so many patients such as I who are without hope, who've been denied and yet in my heart I know that I can have dentures redone using my existing lower denture as a "tray" for the outer edges of my gum. I have 4 posterior titanium implants with a bar screwed down to all four. I wear an overdenture over this apparatus. I've had these for 9 years. Overtime my gums receded and now I am perceived by dentists as I've reached bottom. To much of a challenge, they don't want to tie up their time with me. And yet it would not really take that long and it would add at least 6 more years to my life so I could enjoy my grandchildren looking presentable, (I am 62 years old a pleasant looking person & proud).
I am looking for a "lab tech" in central Florida but by myself I find it difficult.

(B) Page 16 –
I need help! I had **upper dentures made in January 2001**. They were never correct from the moments they put them in my mouth. They worked on them till sometime in August or Sept. 2001 then decided to **make a second pair**. The second pair were not correct either! The dentist said that's my mouth and that's all they could do for me. I've have gone to the BBB and Assoc. of Dentist and Doctors and that's going to take forever! I need help now, 11 months later and too late. I'm stressed out, depressed, can't eat, laugh, sneeze, they fall out of my mouth! I won't go anywhere I'm not working. The **cost of the dentures was around $3,000.00**. I don't even know if I have any money for another pair.

(C) Page 12 –
I've been cruising around your site, and more than anything, I would LOVE to have the name of a denturist in my area, Pennsylvania.
I'm desperate....and am willing to travel to wherever the BEST practicing denturist does business.
Background (horror story) - About 10 years ago, my dentist put in a temporary bridge, and I started having much pain in my upper posterior area where the temporary was located.

(D) Page 17 –
As of today I have still gotten no results and the dentures still don't fit right. I have no money to get a proper pair made? **Do you know of anyone, anyone that might be able to help me?**

20. Describe any complaints filed with state law enforcement authorities, courts, departmental agencies, occupational boards, or occupational associations that have been lodged against practitioners of the occupation in Minnesota within the past five years.

Because denturists are not licensed in Minnesota there are no complaints.

21. What are the findings of studies (U.S. and international) that have been done on efficacy and effectiveness of the care approaches, treatments, and modalities used by members of the occupation?

The most current and thorough study is by the Legislative Research Commission of Kentucky. A copy is attached.

22. Where does the occupation or field recognize gaps in its members' knowledge and perhaps even competency? What is the occupation's research agenda?

The legislation will require an examination to be licensed. In addition, a denturist would need a certain number of hours working in dental laboratory for experience.

23. How is the occupation working internally and with other occupations to support the safe development of new and unconventional practices?

There are a number of places for safe development:

The denturists have their own professional association.

The denturist colleges and dental universities in the U.S. are developing many new materials and technical systems that affect both dentist and denturist regarding false teeth.

The industry that manufactures dental material is constantly upgrading its products.

Questions Relating to Government and Private Sector Recognition

24. Describe the proposed minimum qualifications for entry into the occupation. Include a description of any levels of specialization within the occupation and the qualifications for each. How are the specialties taught and tested?

S.F. No. 179 amended into S.F. No. 1532
Section 9 (S.F. No. 179) states:

"Requirement for a Licensure"

(1) submits a completed application to the board;
(2) submits the fees required;
(3) documents successful completion of formal training lasting at least two years with a major course of study in the practice of denturism, at a school approved by the board (of Dentistry); and
(4) passes a written examination and practical examination approved by the board.

There are colleges in the U.S. that teach denturism. (*See* attachments #iii and #iv)

25. Is the occupation affirmatively regulated in any states (or provinces)? For each state that regulates the occupation, provide the name of the agency that provides the regulation, the type/level of regulation, the legislative scope of practice (including supervisory and disclosure requirements), and regulatory requirements such as continuing education, licensing fees, and disciplinary processes. If the occupation is regulated by a board, provide information on the board structure, including the size of the board and board membership eligibility requirements.

	ARIZONA	IDAHO	MAINE	MONTANA	OREGON	WASHINGTON
Regulating Authority	Board of Dental Examiners	Board of Denturitry	Dental Examiners	Dental Board	State Advisory Council on Denture Technology	Board of Denture Technology

(*See* Attachment #i)

26. Does any state or province prohibit the practice of the occupation? If so, provide summary language of each such statute.

Canada has legally recognized denturitry since denturists were licensed in British Columbia in 1958. The first attempts as legislation to enable denturists to deal directly with the public came in 1955 but were limited in scope to the repair of broken dentures. Public sentiment was the driving force behind the legislation to legalize denturitry, led by consumer advocates with support from the media. Even before the consumer push for legislation in British Columbia, denturists were practicing illegally. This was accomplished by practicing without publicly advertising services, to avoid the charges of practicing dentistry without a license.

Other Canadian provinces shortly followed suit: Alberta, 1961; Manitoba, 1970; Quebec, Nova Scotia, and Ontario, 1973; and New Brunswick, 1978. By 1979, there were only two provinces in Canada that prohibited denturist's services. The Denturist Association of Canada states that as of September 1999, denturists have been recognized by legislation in every jurisdiction in Canada except for Prince Edward Island. The dentists and denturists in Canada work closely together to provide denture services to the public. Thirteen percent (13%) of Canadian denturists' patients are referred by dentists, and the public has been generally supportive of denturitry.

Even though Kentucky law explicitly prohibits the practice of denturitry, denturists have operated in Kentucky for more than 25 years and continue to operate.

ADAC – American Denturist Advocacy Council
We currently have 21 states represented in the ADAC.

If 21 states are members of ADAC and only six states have current legislation licensing denturist, the 15 states that have denturist practicing denturitry without a state licensing law. As to the other 29 states (29 + 21) there is no record of their laws available.

27. How do the rest of the states/provinces treat the occupation from a regulatory and legislative standpoint? For example, is the occupation statutorily ignored but permitted to be provided as long as practitioners do not cross over the line into the medical practice act? Is licensure nominally available but technically impossible to obtain? Have any states enacted innovative legislation or developed new policies that recognize emerging occupations in some novel way?

DENTURITRY IN OTHER STATES

In the United States, dentures are still provided almost exclusively through dentists. Most dentists make impressions in their offices and then send them with instructions to a dental laboratory where a dental laboratory technician actually fabricates the dentures.

Other States

In addition to these six states, there are other states that have provisions for various auxiliary dental personnel to perform denture-related functions. In Colorado, current law provides that certain tasks related to denturitry may be performed by auxiliary personnel under the dentist's direct supervision; that is, the dentist must authorize the procedures but need not be present.

The state of Florida allows dentists to delegate the task of taking preliminary impressions to auxiliary personnel, but the final impressions and any other denture fitting procedures are reserved for the dentist. In 1996, Florida introduced legislation to legitimize and regulate the practice of denturitry in that state. Although it was placed on the calendar, the bill died when the legislature adjourned without taking action.

Other states have tried to legalize denturitry and have failed in those attempts. Most recently, Mississippi introduced legislation to license denturists in the 1999 General Assembly. The title of the introduced bill was the "Mississippi Freedom of Choice Dentures Act." This title seems to reflect the trend in legislative attempts to legalize the profession of denturitry. This attempt failed in committee.

Arizona has only 12 denturists. The Board of Dentists are not granting new licenses since the original 30 licenses. Maine passed a law in 1977 but 20 years passed before denturists could be licensed.

28. Are there pivotal opinions issued by state attorneys general or case law decisions that control the provision of care from members of the occupation?

There has been no reference to attorney general or case law in any of the current publications.

Back in 1980, a Federal Trade Commission staff report on regulations surrounding denture-making concluded that activities by the dental associations and state boards in restricting the activities of denturists might violate antitrust laws. The report recommended further investigation, but no such investigation was ever conducted.

29. If this occupation is regulated in other jurisdictions, is there third-party reimbursement for the services provided by the occupation in those jurisdictions?

There is no third-party involvement. It is between dentist and denturist as to the jurisdiction of the making of false teeth.

30. Is malpractice insurance widely available to members of the occupation? What information is available about members of the occupation from malpractice monitoring services?

Yes, malpractice insurance can be purchased from:

Arthur Platt Agent
Sebrite Financial Corporation
5421 Feltl Road
Minnetonka, MN 55347
Phone (952) 563-1234

This agency has an association group liability policy of $1 million that a denturist can purchase for a premium of $300. In the five years Mr. Platt has had this policy, he has never had a claim. (Please call him for current update and verification.)

31. What are the (estimated) utilization rates for the occupation? How many client/patient visits are made to members of the occupation per defined time period?

There is no way of knowing because there is no denturist in Minnesota. The number of licensed denturists in the U.S. is between 12 in Arizona and 130 in Oregon.

32. Do hospitals, clinics, and other health care institutions recognize members of the occupation with admitting or other privileges?

Currently, they do not because there are no licensed denturists in Minnesota. There is a community dentistry, Apple Tree Dental, in Minneapolis staffed by dentist.

33. Are jobs are available for members of the occupation?

With legislation licensing a denturist, then it is very possible those employees currently working in a dental laboratory could establish their own denturist office.

34. Is the occupation affiliated with an association which enacts and enforces standards? If so, explain the enforcement mechanism.

There is a national denturist association. It has no enforcement power. Denturists would be under proposed legislation under the jurisdiction of the state of Minnesota.

35. Describe the extent to which the proposed regulation will affect the cost of the services provided by practitioners.

The president of the denturist association and the owner of a Seattle clinic said that area dentists charge anywhere from $1,350 to $4,800 for a full set of dentures since the false teeth are **created in dental labs for only about $250** a set.

Some maintain that consumers have saved millions of dollars from the purchase of dentures in states that have regulated denturism. A study by the Oregon State Denturists Association compared the average cost of a full set of dentures purchased in Oregon and found that the dentists surveyed charged an average of **$1,248** while the denturists in the study charged an average of **$585**.

There are many more examples of the savings to the 600,000 senior citizens in Minnesota at age 65 and over. The savings on an upper or lower set of false teeth is from two-thirds to one-half less than from a dentist.

36. Describe the overall cost-effectiveness and economic impact of the proposed regulation, including indirect costs to consumers.

Age is a primary factor. In the U.S., 23 percent of the population aged 65 to 74 is edentulous and of the 75 or older group the rate climbs to nearly 27 percent. A recent poll of 46 states conducted by the Centers for Disease Control and Prevention found that 44 percent of Kentuckians 65 or older were edentulous.

Denturists will save each state hundreds of thousands, if not millions, of dollars each year in Medicaid denture expenses. It has been proven that denturists charge one-third to one-half of what dentists charge and therefore have a positive effect on the state's fiscal budget.

Medicaid does pay for false teeth.

A county veteran service officer is allowed up to $1,000 each year for a veteran to have dental work done. One year's expense can cover to removing teeth. The veteran then

would need to wait a year to get false teeth with a second state payment of up to $1,000. Denturists would save the state money.

People incarcerated can currently get false teeth at state expense. Denturists would be a savings to the state of Minnesota.

In Canada, the health care system, which includes dentistry, has a large savings with false teeth from denturists.

Questions Relating to Education and Training

37. Are education, clinical training, or apprenticeships available to train would-be members of the occupation? What is the range of opportunities? How many programs are offered?

Bates Technical College – Tacoma, WA (*See* attachment #iv)
Mills Grae University – Cottondale, FL (*See* attachment #iii)
N. Alberta Institute of Technology – Edmonton, AB (*See* attachment #ii)
George Brown College of Applied Arts and Technology – Toronto, ON
College Edouard-Montpetit – Longueuil, QC
Vancouver Community College – Vancouver, BC
(*See* also attachment #v)

Apprenticeship would come from working in a dental laboratory.

The Minnesota State Colleges and Universities, 500 Welles Fargo Bldg., St. Paul. Currently, they have a four-year dental hygienist course at Mankato.

There are 19 two-year courses for dental hygienist and assistance in Minnesota today.

There is a class at Century College in orthodontics and prosthetics.

38. For each opportunity (degree program, apprenticeship, etc.), what are the prerequisites, requirements, supervision, and financial costs?

The colleges would set the prerequisites. The cost of a denturist setting up a practice and the college cost are a fraction of those for a dentist.

(*See* also #37 and attachments #ii, #iii, #iv, and #v)

39. What are the didactic and clinical components of the training opportunities? For any clinical practicum, what is the level of supervision, length of program, and level of patient/client base (primary care, specialty, acute, average)?

The educational requirement for a denturist is not so much a medical field of study but being a skilled craftsman making false teeth. Laboratory work is where the skills are developed.

In an orthopedic shop, artificial limbs are made. (*See* also #37 and attachments #ii, #iii, and #iv)

40. How are students tested for competence during and at completion of all didactic and clinical programs?

Most colleges require a student to maintain a "B" average in order to graduate. This should be the case for colleges teaching denturism. The state of Minnesota requires passing an examination in order to receive a license.

41. Are educational opportunities standardized across the states for the occupation? For example, do faculty members in different institutions rely on standard curricula established by the occupation? If so, how were curricula standardized? What agency or institution oversees maintenance of standards?

The "dental colleges" in the U.S. have many meetings and conventions attended by their faculty and dentists where new ideas on false teeth are discussed. The American Dental Association has state and national conventions where manufacturers and their sales staff display "new" products which would be available to denturists for the making of false teeth. The dental industry would set the standard for false teeth.

42. For apprenticeship models, describe the components, competency assessment, and supervision and mentoring elements.

A denturist would obtain apprenticeship experience working in a dental laboratory making false teeth. The employer would be a supervisor for excellent work.

43. Are there accepted national or regional standards of education and training for competent practice of the occupation? (An indication of such standards is the existence of a national or regionally psychometrically valid and reliable test for measuring achievement of minimum entry-level skill and knowledge.)

There are 24 state denturist associations which provide standards for competency. The national association is in Harrisburg, PA. These organizations are interested in a post-college educational program for a denturist to continue a life-long opportunity of studying denturism.

44. Does the occupation have standard tests individuals can take to demonstrate their knowledge, skills, and judgment in the occupation?

Each state licencing board requires a test in order to obtain a license. Minnesota would follow the pattern of testing in other states and Canada.

45. Are individuals sufficiently educated and trained to be competent to practice the occupation? How is competence determined?

There are standards that an individual must meet in order to be licensed in Minnesota. The state will require a passing grade in their test plus other requirements, such as experience.

46. Are specialties in the occupation offered? How are these taught and tested?

There does not seem to be any specialty except if someone should teach denturism in a college.

47. What does the occupation propose as a vehicle to ensure continued competency?

Lifelong learning is important in his job of making false teeth. A denturist could attend the many conventions, classes, and association meetings. He has the opportunity for continued competency. This way it is in his best interest to learn of new material and new ways to make false teeth in order to keep in practice as a denturist.

48. What efforts has the occupation made to develop practice guidelines and treatment protocols for clinical care? Does the occupation encourage the use of peer review meetings and outcomes and treatment measures as feedback for individual practitioners?

Denturists are the only health care professionals in the United States who are completely trained both clinically and technically to perform all phases of the denture care delivery system from start to finish. They are thoroughly trained in all the operative clinical procedures and the laboratory procedures pertaining to fitting, designing, construction, and delivery of removable complete dentures and removable partial dentures. Denturists by far have superior training when it comes to removable prosthodontics. Denturists also have from equivalent to more thorough training in the sciences relating to clinical denture care. A few of these subjects are Microbiology and Immunology, Head and Neck Anatomy, Physiology, Oral Pathology, Radiology, Radiographic Interpretation, Pharmacology, Temporo Mandibular Disorders, and Cardiopulmonary Resuscitation. Yes, there are meetings of state and national denturist groups.

49. What guidelines has the occupation developed and encouraged for work in interprofessional teams and consulting and referral arrangements? Does the occupation provide, through initial and continuing education, information about other health care occupations so that members of the occupation can make informed decisions about collaboration and referrals?

Dental colleges in the United States are the principal source of scientific advances in "false teeth." If a manufacturer develops a new material for making false teeth, their sales force will market the new product to dental laboratories and denturists both. Like a dentist, a denturist would attend conventions where new products are displayed.

50. What is the occupation's record in terms of patient satisfaction and provider/patient relationships? What commitment has the occupation made to ensure that care provided by its members is culturally appropriate?

The denturist profession's has an unprecedented track record. The truth remains that denturists:

1. Have come from the upper ranks of the denture craftsmen;
2. Are highly trained health care professionals;
3. Have an impeccable safety record;
4. Produce a better end product;
5. Have been known to satisfy their patients at a much higher standard; and
6. Can deliver dentures to the public at half the cost of what dentists charge.

51. How does the occupation support and encourage new modalities and therapies within the occupation? How is the occupation incorporating new technologies and communications capacities into its practice?

The manufacturing of dental products is a huge industry both domestically and internationally. At the many conventions, manufacturers like to display the new products to make false teeth. Patterson Dental Supply, Inc. of Eagan, MN, is an international provider of dental products for making false teeth.

52. Describe the extent to which the proposed regulation will affect the cost of the services provided by the practitioners.

A denturist charges from one-half to two-thirds of a dentist's cost for false teeth.

53. What is the expected impact of the proposed regulation on the existing supply of practitioners?

Currently there are not any denturists in Minnesota. It would be years before the professional of denturist would make much of an impact. Currently false teeth are supplied by a dentist.

54. What percentage of current practitioners will be able to meet the proposed eligibility criteria?

With no denturist licensed in Minnesota, it is possible that someone currently working in a dental laboratory could apply to be a licensed denturist in Minnesota.

55. Will individuals who are not able to meet the proposed eligibility criteria be able to continue to provide services under a different but related occupational title?

Yes, an individual who does not get licensed by the state of Minnesota could still find employment in a dental laboratory where he would be doing work for a dentist making false teeth.

56. Under the proposal, will current practitioners be "grandparented?" If current practitioners would be grandparented, describe how long and under what conditions.

S.F. No. 179, section 10, subdivision 2, state licensure by reciprocity. Subdivision 3 provides licensure by equivalency during a transition period.

57. What groups, including national and state professional and trade associations, are working on behalf of the occupation? What are their membership numbers and criteria for membership? What are their goals and current policy agendas? Provide the address of each. Here is a list of associations:

* Arizona Denturist Society
Phoenix, AZ

California Denturist Society
Lancaster, CA

Connecticut Denturist Society
Milford, CT

Florida Denturist Society
North Miami Beach, FL

Indiana Denturist Association
Terre Haute, IN

Kentucky Association of Denturists
Louisville, KY

Louisiana Denturist Organization
Pearl River, LA

* Denturist Association of Maine
Hartland, ME

Massachusetts Denturitry Society
Templeton, MA

* Montana Denturitry Medicine Association
West Billings, MT

Denturist Society of New Jersey
Flanders, NJ

* Oregon State Denturist Association
Portland, OR

Pennsylvania Denturist Society
Harrisburg, PA

Tennessee Denturist Society
Collegedale, TN

Wanda Anderson, Executive Director
National Denturist Association
Poulsbo, WA

* State licensing laws in effect, plus Idaho. List is not current or complete. There are 24 state associations.

58. Identify any existing governmental agencies that can protect consumers who utilize the services of the occupation.

In the pending legislation, S.F. No. 179, section 1, subdivision 2, "advisory council" means the denture technology advisory council. As originally introduced in S.F. No. 179, the regulatory authority for licensing denturists was to be the Commissioner of Health. In later engrossments of the bill, this authority was changed to the Board of Dentistry. Section 7 of the bill lists the duties of the Board.

59. Describe why existing remedies are inadequate to prevent or readdress the kinds of harm that could result from nonregulation.

Minnesota does not currently license denturists. There are not any denturists practicing in Minnesota. I did hear that one person is working on an Indian reservation for Indians, but I do not have any further information.

60. In which of the ways described below should the occupation be regulated? Explain the rationale.

A. By a new independent board?

See answer to #58.

B. By an existing board where the board is renamed and reorganized to include a significant number of board members representing the newly credentialed occupation?

See answer to #58. This is an area that needs to be addressed by the Legislature. Would a dentist or denturist manage the newly created board? In Maine a law was passed 20 years ago for a denturist law under the control of the dentist board. For 20 years they did not license a denturist. In the United States, 44 states have restricted the practice of denturism by the Dental Association, including Minnesota.

C. By an existing board where the board membership is changed to include one or more board members representing the newly credentialed occupation?

Only if new legislation had one or more denturists on the Board of Dentistry. The concern of having the regulator be the Board of Dentistry continues to be whether the Board would maintain a "bias" against denturists.

D. By an existing board where the board forms a separate advisory committee with members from the newly credentialed occupation, as well as public members, to advise the board?

A separate committee could still be controlled by dentists. It is not my position to get into any thought or discussion on dentists. I have five false teeth in an upper plate. I had my two front teeth capped. They were pulled by the United States Army Air Force because I flew as an engineer on a B-24 bomber in World War II. Dentists are not now or have ever been supporting a movement to license denturists. The medical world is changing, especially the dental profession with implants. They are not now in these days heavy into making false teeth. The St. Paul telephone directory lists only six prosthodontists with a St. Paul phone number of "651." Who knows if those dentists are now into crowns and bridges anyway.

A Study of Denturitry

Directed by the 1998 General Assembly

Research Report No. 292

LEGISLATIVE RESEARCH COMMISSION
Frankfort, Kentucky
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CHAPTER I

INTRODUCTION

There are over 50 million people in the United States who are missing all of their permanent teeth, a condition known as edentulism.[1] Most of these people have dentures or will receive dentures, but many do not. Those that are without dentures do not have them for a variety of reasons, but two primary reasons are availability of denture services and cost. In an effort to reduce cost and increase the supply of denture providers, six states and Canada have legalized "denturists," non-dentists who provide dentures directly to the public. Other states, including Kentucky, have attempted to recognize denturists but such efforts have failed. The 1998 Kentucky General Assembly enacted SB 65 which directed a study of the denturitry issue, and this report is the product of that study.

Study Methodology

This study provides information that may be useful in determining whether denturists should be legally recognized and allowed to practice independently in Kentucky.

Occupational regulation invokes the police power of the state to restrict the people who can perform certain functions, in order to protect the public health, safety, or welfare. To explore the impact on the public health of allowing denturists to practice, researchers for this study looked at the public health risks presented and at the actual incidence of public harm documented in other jurisdictions where the practice of denturitry is allowed. An extensive literature search was conducted via the internet. A particular effort was made to identify research conducted by organizations with no vested interest in dentistry or denturitry. Input was requested and received

from various professional organizations representing proponents and opponents of denturitry. Inquiries were made of officials from other states and Canada that recognize denturists. Some of the research reports referenced in this study are dated, but they are used as sources because no subsequent research was found to dispute or update the data.

Chapter II looks at the historical background and evolution of the practice of dentistry and the emergence of denturitry. In Chapter III, denturitry laws enacted in other states are examined, and Chapter IV covers past attempts to legalize denturists in Kentucky. Relevant economic issues are explored in Chapter V, and public health issues are covered in Chapter VI. The final chapter, Chapter VII, summarizes the issues and looks at policy options that are available to the 2000 General Assembly to address the matter.

CHAPTER II

EVOLUTION OF DENTAL PRACTICE

Occupational Regulation

The emergence and evolution of an occupational group follows a standard pattern regardless of the nature of the occupation. (The term "occupation" is used generically in this study in reference to both occupational and professional groups.) Understanding this process may be helpful in understanding the denturitry issue. First, the need for the occupation must be recognized. Then, individuals who have demonstrated some ability in performing the activities, generally through experience, find themselves in demand. Next, a body of knowledge is created and formal education programs developed to prepare persons to engage in the occupation. Finally, the practitioners within the occupation organize and seek government sanctions to permit exclusively their group to engage in the occupation and to prevent others from doing so in order to protect the public.

Generally, the "scope of practice" for the occupation is defined in very broad terms. If the occupational group is the first within its field to seek regulation, the scope of practice usually includes any activity that might fall within that field. A broad scope of practice is not problematic as long as practitioners can keep pace with the evolution of the occupation. Often, when knowledge grows to the point where a practitioner cannot keep pace with changes, two things can happen. First, specialists within the occupation may begin to emerge, and second, auxiliary personnel not members of the original occupation may begin to perform discreet sets of tasks within the established scope of practice. These are usually tasks that practitioners do not have time to perform, or do not desire to perform and they normally require less knowledge and/or skill. Preparation for these emerging, task-oriented groups is usually less stringent and

often outside the formal education paradigm recognized by the regulated practitioners and specialists.

These new occupations are usually accepted and even encouraged by the original practitioners if they meet a demand that the practitioners cannot meet, and if the original practitioners retain control over the full "scope of practice." In many cases, the emerging group will ultimately want to practice independently which usually precipitates scope of practice disputes. There have been many long, hard-fought battles in most occupational fields for independent practice, and these will continue as long as occupations continue to evolve.

The practice of medicine is a good example of how this evolutionary process works. Doctors have been practicing medicine since recorded time. An early doctor learned by apprenticing with another doctor who had acquired the skills also by apprenticeship. Over the years a scientific body of knowledge developed which in turn led to the establishment of medical schools. It was not until the mid 1800's, however, that formally trained doctors organized to have states regulate the practice of medicine to keep untrained, incompetent persons from practicing. In regulating physicians, the scope of practice for medicine was defined broadly. The current definition of medicine in Kentucky law still reflects the breadth and depth of the scope of practice:

> Practice of medicine and osteopathy means the diagnosis, treatment, or correction of *any and all human conditions*, ailments, diseases, injuries or infirmities by any and all means, methods, devices, or instrumentalities. (emphasis added) [KRS 311.550]

Since the initial licensure of physicians, many ancillary medical occupations have emerged and each has had to define its scope of practice within the broad definition of medicine. These groups include podiatrists, chiropractors, optometrists, nurses, physician assistants, nurse

practitioners, nurse anesthetists, nurse midwives, emergency medical technicians, and a burgeoning number of practitioners in behavioral medicine. Some of these have acquired the ability to practice independently, while others have not.

Dentistry

Dentistry itself is an occupation that has emerged from medicine even though the practice of dentistry may indeed be as old as humanity. Cro-Magnon skulls show evidence of tooth decay, and the earliest recorded reference to oral disease is from an ancient Sumerian text that describes "tooth worms" as a cause of dental decay. As early as 700 BCE the Etruscans were able to make dental appliances. They consisted of wide bands of pure gold that were soldered together to fit over natural teeth and a substitute tooth made of ivory or bone inserted into place.[2]

During the Renaissance in Europe, dentistry was not considered a separate area of practice. It was the province of physicians and surgeons and remained so until the "Father of Dentistry," Pierre Fauchard, wrote a comprehensive work in the 18th century detailing the practice of dentistry. It was within this document, *Le Chirugien Dentiste*, that the term dentist was applied to those medical professionals that dealt almost exclusively with teeth. Fauchard wrote that surgeons did not wish to practice dentistry and that the technical training required to fill and replace teeth was not to their tastes.[3] Dentistry then became a specialty of medicine.

During this period, medicine was self-regulated by professional associations that functioned as guilds. The power of these groups to control the practice of medicine fluctuated with political and social circumstances. After the French Revolution, for example, controls over all medical professions were removed and anyone who wished to practice could do so. This

resulted in egregious harm to the public, and Napoleon Bonaparte in 1802 imposed controls to resolve the problem including making the practice of dentistry in France a specialty of surgery.[4]

As in Europe, surgeons originally pulled teeth in the United States, but as medicine evolved, most surgeons turned to other procedures while a few specialized in tooth extraction. In the mid-1800's, this latter group split from the physicians and surgeons and formed the practice of dentistry. By 1889, Charles Gordon organized a dental congress in the United States and during this time, porcelain dentures became available in America.[5] The first government regulation of dentistry did not occur until the 1920's.

The scope of practice for dentists is therefore a sub-set of medicine and the overlap from time to time still causes problems. For example, in 1998 the Tennessee Board of Dentistry promulgated a regulation allowing oral surgeons to perform elective cosmetic surgery. The rationale behind this move was that oral surgeons were trained in facial reconstructive surgery and therefore competent to perform these expanded functions. The Tennessee Medical Association objected and filed suit to stop implementation of the regulation on the grounds only a graduate of a medical school with a license to practice medicine was competent to perform plastic surgery.

Denturitry

With the continuing evolution of dentistry, dentists have gravitated more to procedures for saving and restoring natural teeth than pulling teeth and making dentures. Technological advancements have given dentists new methods and materials to fill, cap, and bond teeth, and even dental implants as an alternative to dentures. While retaining the production of dentures as part of the practice of dentistry, dentists began to delegate certain functions such as the actual fabrication of the dentures to trained specialists. As the population of this country aged and the

need for dentures increased, the practice of denturitry emerged. The practice of denturitry involves taking impressions of the upper and lower jaws, fabricating the dentures to complement the patient's facial features, and fitting the fabricated denture in the patient's mouth. It also involves, in most states and foreign countries that recognize denturists, the examination of the oral cavity to determine that no abnormalities exist and the mouth is fit for dentures.

In other countries, notably Australia, Denmark, Finland, Iraq, Israel, and Switzerland, dentures are legally available through the services of denturists. In Denmark, denturists were never prohibited from providing services directly to the public and were formally licensed in 1976. According to the World Health Organization's Division of Non communicable Diseases/Oral Health, in 1987, 60% of the world's population age 65-74 were edentulous. In 1990-91 there were 800 licensed dental laboratory technicians registered worldwide and of that number 650 of them served the public as denturists.[6]

The Canadian Experience

Canada has legally recognized denturitry since denturists were licensed in British Columbia in 1958.[7] The first attempts at legislation to enable denturists to deal directly with the public came in 1955 but were limited in scope to the repair of broken dentures. Public sentiment was the driving force behind the legislation to legalize denturitry, led by consumer advocates with support from the media.[8] Even before the consumer push for legislation in British Columbia, denturists were practicing illegally. This was accomplished by practicing without publicly advertising services, to avoid the charges of practicing dentistry without a license.

Other Canadian provinces shortly followed suit: Alberta, 1961; Manitoba, 1970; Quebec, Nova Scotia, and Ontario, 1973; and New Brunswick, 1978.[9] By 1979, there were only two provinces in Canada that prohibited denturist's services. The Denturist Association of Canada states that as of September 1999, denturists have been recognized by legislation in every

jurisdiction in Canada except for Prince Edward Island. The dentists and denturists in Canada work closely together to provide denture services to the public. Thirteen percent (13%) of Canadian denturists' patients are referred by dentists, and the public has been generally supportive of denturitry.[10]

In the beginning of legalized denturitry in Canada, denturists were grandfathered in by examination. This was done so that people who were trained and/or practiced denturitry prior to the enactment of the law could be licensed.[11] This practice was discontinued in 1981. To be a certified denturist in Canada, applicants must now submit academic credentials and proof of graduation. In the academic year 1974-1975, the only education program for denturists was a five semester program at George Brown College of Applied Arts and Technology in Toronto. Today, there are five colleges of denturitry operating in Canada.[12]

CHAPTER III

DENTURITRY IN OTHER STATES

In the United States, dentures are still provided almost exclusively through dentists. Most dentists make impressions in their offices and then send them with instructions to a dental laboratory where a dental laboratory technician actually fabricates the dentures. A dental laboratory technician receives certification based upon training or practical experience in either a licensed dentist's office or in a commercial dental laboratory, or by having a degree from a two year course of study. The dentist later fits the finished product but may send it back to the lab for further alterations. By contrast, denturists deal directly with the patient by making the impressions, fabricating the dentures, and providing alterations after the fittings.

There are six states that currently allow the practice of denturitry in the United States: Arizona, Idaho, Maine, Montana, Oregon, and Washington. A breakdown of major provision of denturitry laws in these states contained in Table 1.

Authorization

Maine enacted the first denturitry law in 1977. Two states, Arizona and Oregon, followed suit in 1978. Denturitry laws were then enacted in Idaho in 1982 and Montana in 1984. The most recently enacted law was in Washington in 1994. In four of the six states that have enacted denturitry laws, public initiative or referendum has been the medium through which it has been accomplished, indicating a similar grass roots consumer support that drove the legalization in Canada.

TABLE 1
STATE DENTURITRY LAWS*

	ARIZONA	IDAHO	MAINE	MONTANA	OREGON	WASHINGTON
Date Authorized	1978 By Legislation	1982 By Initiative 1983 By Legislation	1977 By Legislation Amended 1994	1984 By Initiative 1985 By Legislation	1978 By Initiative	1994 By Initiative 1995 By Legislature
Required Supervision	In dentist's office; under gen'l superv'n; initial & final OK by dentist	None	None	None	None	None
Oral Health Certificate Required	No	No	Yes–by DDS <30 days	No	Yes–by MD or DDS**	No
Range of Services	Make/repair full & partial	Make/repair full; repair partial only	Make/repair full only	Make/repair full & partial	Make/repair full & partial	Make/repair full & partial
Type of Regulation	Certification	Licensure	Licensure	Licensure	Licensure	Licensure
Regulating Authority	Board of Dental Examiners	Board of Denturitry	Dental Examiners	Dental Board	State Advisory Council on Denture Technology	Board of Denture Technology
Composition of Authority	6 dentists 2 hygienists	3 denturists 2 lay members	5 dentists 1 hygienist 1 lay member	6 dentists 1 denturist 1 hygienist 2 lay members	1 dentist 4 denturists 2 lay members	1 dentist 4 denturists 2 lay members
Required Training	2 yr degree exam	2 yr degree exam 2 yr internship	2 yr degree exam	2 yr degree exam 1 yr internship	2 yr degree exam 2 yr internship	2 yr degree exam
Continuing Education Required	None	12 hrs/yr	20 hrs/2 yrs	36 hrs/3 yrs	30 hrs/3 yrs	None
"Grandfather" Clause (original)	None	5 yrs experience	10 yrs experience;	5 years practical experience	4,000 hrs practical experience	graduate of denturism program;exam
Number of Denturists	12	29	15	13	130	103

** Statute analysis and table preparation completed by LRC staff.*

*** No oral health certificate required if the denturist has completed additional training in oral pathology*

Supervision

Only one state that has legalized denturitry requires supervision by a dentist. In Arizona, the denturist must practice in a dentist's office under the general supervision of the dentist. The dentist must give the initial okay for denture procedures to be done by the denturist and must give the final authorization for the completed procedures. In the remaining states where denturitry is legal, there is no requirement for any type of supervision of the denturist by a dentist.

Oral Health Certificate

Maine and Oregon both require that a patient present an oral health certificate obtained from a dentist or a physician to the denturist before the denturist can provide services to the patient. Generally an oral health certificate is valid for one year from the examination date. In Maine, a patient must have an oral examination by a dentist within thirty days of using the services of a denturist. Oregon requires that patients have an oral examination by a dentist or a physician before denture services are obtained through a denturist. However, if a denturist has proof of additional training in oral pathology, the oral health certificate requirement does not apply. The supervision requirement in Arizona makes the requirement of an oral health certificate redundant, but the remaining states of Idaho, Montana and Washington have no oral health certificate requirement.

Range of Services

Four states--Arizona, Montana, Oregon, and Washington--have the same requirements for the types of services that a denturist can provide to the public. They all allow for the construction and repair of full and partial dentures. In Idaho, the denturist can make and repair

full dentures, but may only repair partials. In Maine, the statutory definition of the practice of denturitry allows the denturist to make and repair full dentures only.

Type of Regulation

Arizona is the only state that certifies denturists rather than licensing them. However, the term *certification* used in the Arizona statutes may be misleading since denturists are specifically told that to practice their trade they must be certified; hence the model becomes in actuality a licensing model. In all the remaining states that have legalized the practice of denturitry, the regulatory model used is licensing.

Regulating Authority and Composition

In Arizona the regulating authority is the State Dental Board composed of six dentists, two dental hygienists, and three lay members. Idaho has a Board of Denturitry composed of three denturists and two lay members. Maine is regulated by the Dental Examiners Board consisting of five dentists, one dental hygienist, and one lay member. In Montana denturists operate under the auspices of the Dental Board, which consists of six dentists, one denturist, one dental hygienist, and two lay members. Oregon has a State Advisory Council on Denture Technology as the regulatory authority. It consists of one dentist, four denturists, and two lay members. Washington has a Board of Denture Technology comprised of one dentist, four denturists, and two lay members.

There is some disparity between the memberships of the boards regulating the practice of denturitry in the states where the practice is legal. Arizona and Maine have no denturists as board members but include dental hygienists, and Idaho operates the Board of Denturitry without the benefit of dentist members or dental hygienist members. All boards include lay members.

Required Training

The educational requirements for licensing are fairly consistent throughout the six states where denturitry is a legal practice. All six states require a minimum of a two year degree plus an examination for licensing or certification. In addition to those requirements, Idaho and Oregon require a two year internship with a licensed denturist and Montana requires a one year internship.

Continuing Education

Arizona and Washington are the only states that do not require continuing education for denturists. Idaho requires proof of 12 hours of continuing education each year. Maine requires proof of twenty hours of continuing education every two years. Montana denturists must have 36 hours of continuing education within a three year period and Oregon requires denturists to show proof of 30 hours within three years. Thus, Idaho and Montana have the highest continuing education requirements of all six states where denturitry is a legalized practice.

Grandfather Clause

Five states allow for the grandfathering in of denturists. Arizona is the only state with no provision for grandfathering. Idaho requires five years experience. Maine allows denturists to be licensed with ten years experience. Montana requires five years practical experience. Oregon requires 4,000 hours and Washington requires graduation from a formal "denturism program" and successfully passing a board-approved written and clinical examination.

Other States

In addition to these six states, there are other states that have provisions for various auxiliary dental personnel to perform denture related functions. In Colorado, current law provides that certain tasks related to denturitry may be performed by auxiliary personnel under the dentist's direct supervision; that is, the dentist must authorize the procedures but need not be present on the premises while the procedures are performed. Furthermore, the dentist must certify the oral fitness of the patient before the auxiliary personnel proceed with any work pertaining to dentures. (Colo. Rev. Stat. sec.12-35-109, 1999)

The state of Florida allows dentists to delegate the task of taking preliminary impressions to auxiliary personnel, but the final impressions and any other denture fitting procedures are reserved for the dentist.[13] In 1996, Florida introduced legislation to legitimize and regulate the practice of denturitry in that state. Although it was placed on the calendar, the bill died when the legislature adjourned without taking action [14]

Other states have tried to legalize denturitry and have failed in those attempts. Most recently, Mississippi introduced legislation to license denturists in the 1999 General Assembly. The title of the introduced bill was the "Mississippi Freedom of Choice Dentures Act." This title seems to reflect the trend in legislative attempts to legalize the profession of denturitry. This attempt failed in committee.[15]

CHAPTER IV

DENTURITRY IN KENTUCKY

Legislative History

The first attempt to license denturists in Kentucky was HB 336, introduced in the 1978 General Assembly. While this bill did not pass, it marked the beginning of a twenty year period during which unsuccessful attempts would be made to recognize denturists during each legislative session. These attempts took the form of denturitry bills, denturitry amendments, and study resolutions. Bills included HB 541 in 1980, HB 563 in 1982, SB 355 in 1986, HB 130 in 1988, HB 421 in 1992, HB's 805 and 827 in 1994, HB 86 in 1996, and HB 182 in 1998. These bills ranged from the establishment of a comprehensive regulatory process to license denturists to very brief, simple bills which merely defined denturitry and exempted it from the practice of dentistry. All of these bills failed, as did amendment attempts.

In 1986 Senate Bill 46, a bill to license professional geologists, passed both houses with the house committee substitute. The committee substitute created a new section of KRS Chapter 411 which prohibited a person from being prosecuted or enjoined from performing acts he or she is authorized to perform, even if the acts are included in the practice of another profession. Denturitry opponents realized that this provision could be interpreted as indirectly authorizing denturitry, or at the very least removing it from any enforcement jurisdiction. The opponents prevailed on the Governor to veto the bill, and she did so, and the veto was not overridden.[16]

Study Resolutions

In addition to the attempts to license denturists, there have been several resolutions to study the subject. House Concurrent Resolution 130, introduced in the 1988 session, directed the Legislative Research Commission to "conduct a study of the practice of denturists and dental laboratories and examine the merits and risks to the general public of them either to continue to be regulated by the board of dentistry, to establish their own licensure board, or to be regulated in a different manner." HCR 82 was introduced in the 1996 session directing the Interim Joint Committee on Licensing and Occupations to conduct a similar study. Neither of these resolutions passed, but the 1998 General Assembly enacted SB 65, which became the authority for this study.[17]

Current Kentucky Law

Current Kentucky law specifically prohibits the practice of denturitry. Any person who:

> ..takes impressions of the human teeth or jaws to be used directly in the fabrication of any intraoral appliance, or shall construct, supply, reproduce or repair any prosthetic denture, bridge, artificial restoration, appliance or other structure to be used or worn as a substitute for natural teeth, except upon the written laboratory procedure work order of a licensed dentist and constructed upon or by the use of casts or models made from an impression taken by a licensed dentist, or who shall advertise, offer, sell or deliver any such substitute or the services rendered in the construction, reproduction, supply or repair thereof to any person other than a licensed dentist..." [KRS 313.010(2)]

is considered as "practicing dentistry."

In 1974, this statute was amended to include the definition of a dental laboratory technician, substantially legitimizing the profession and providing for its regulation in the

Commonwealth. (1974 Acts ch. 303, sec. 1) In order to qualify for a certificate of authority from the Board of Dentistry in Kentucky as a dental laboratory technician, one must complete two years of training or acquire two years of practical experience in dental laboratory technology by employment in either a dentist's office or commercial dental laboratory, or have a degree in dental laboratory technology from an accredited school with a two year course of study.

Even though Kentucky law explicitly prohibits the practice of denturitry, denturists have operated in Kentucky for more than twenty-five years and continue to operate. The Kentucky Board of Dentistry has successfully prosecuted denturists for practicing dentistry without a license. The more prominent denturists have continued to practice by employing a licensed dentist to perform the denture functions still reserved for dentists. Other denturists continue to operate illegally, and for this reason the total number of denturists in Kentucky is not known.

CHAPTER V

ECONOMIC ISSUES

Overview

Edentulism results from oral diseases, such as dental caries (cavities) and periodontal disease. But edentulism also reflects attitudes toward oral health, availability and accessibility of dental care, the prevailing standard of care, and availability of health insurance. [18] Other factors that play a role in the prevalence of edentulism are education level, income, residency (urban/rural), and age.

Age is a primary factor. In the United States, 23% of the population aged 65 to 74 is edentulous and of the 75 or older group the rate climbs to nearly 27%. A recent poll of 46 states conducted by the Centers for Disease Control and Prevention found that 44% of Kentuckians 65 or older were edentulous. Kentucky had the second highest rate, ranking behind only West Virginia with 46%. Hawaii had the lowest rate at 13.9%. [19]

The high incidence of edentulism in the 65 and older age range can be partially attributed to the fact that preventative tooth loss measures now in place were not available to that age group in their younger years. Also, a generally held misconception years ago was that tooth loss was an inevitable consequence of the aging process, and dentists were more apt to remove teeth than to restore them.[20] The prevalence of edentulism among persons age 65 and over will probably continue to decline in succeeding generations.[21] However, the United States is an aging population so the number of edentulous people in the 65 or older age range will likely rise in the foreseeable future.[22]

Cost of Dentures

A Federal Trade Commission Report cites several issues to be addressed in researching the unmet dental needs of the population. This report was drafted by the San Francisco office in 1978 and issued by the full commission in 1984. While it is more than 20 years old, it remains the most comprehensive treatment of denturitry issues yet produced. Among the issues contained in this report are certain barriers to obtaining denture care, and price is one of the primary barriers. This report concludes that one of the major reasons for failure to obtain denture care is the high cost of that care, especially for the elderly.[23] Denturists believe that they can competently provide dentures directly to the public for up to half the price charged by a dentist. Denturists maintain that their overhead is lower than dental office practice overhead and that they do not sacrifice quality to keep their prices low.

The effect of the legalization of denturitry upon the cost of dentures to the public can be reviewed in the light of the Canadian experience, since denturitry has been legal in that country for a little over 40 years. Although the cost of dental services responds to overall inflation, the consumer in Canada continues to realize approximately a 50 percent savings in the cost of dentures from a denturist as compared to the cost from a dentist.[24]

Another example of economic impact is seen in the state of Oregon, where a review of dental insurance data shows that the costs of dentures, which had been rising at the same rate as other dental services, had a much lower rate of increase after passage of the denturitry initiative.[25]

A study conducted in the State of Michigan by the Office of Health and Medical Affairs found that after comparing the cost of obtaining dentures from a denturist in Oregon, Idaho, and Canada with the cost of obtaining dentures from a dentist in Michigan, dentures obtained from a

denturist cost about half of those provided by a dentist in that state. This study also notes that the evidence that denturists provide dentures at a lower cost is important when the "side effects" of state regulation of dental personnel and dental care are considered such as the issue of dentist supervision and dental auxiliary personnel:

> Dr. John E. Kuchman, an associate professor at the University of California at Davis and a consultant on dental care economics to the Federal Trade Commission, has examined the implications of denturist competition. Dr. Kushman's research found that denturists offer lower prices and concludes that 'the economic advantages of introducing competition are great, and significant impairments in quality would be required to offset them.' Dr. Kushman notes that such impairments in quality have not been documented. He dismisses denturists working under the supervision of a dentist as not providing the greatest consumer benefit, since the denturist can be considered another office dental auxiliary.[26]

Insurance Coverage

The Centers for Disease Control and Prevention found that in 1997 edentulism was more prevalent among those persons without dental insurance (27.0%) than among those who had dental insurance (18.3%).[27] In a note to the study by the Center for Disease Control and Prevention the editor states:

> ...the higher prevalence of total tooth loss among persons without dental insurance than among those with dental insurance may, in part, result from reduced use of preventive and restorative dental services. however, dental insurance in the Untied States is almost entirely employment-based, and Medicare does not cover most dental procedures; therefore, relatively few persons aged >65 years have dental insurance.[28]

A special commission of the American Dental Association also noted that : "there are members of the edentulous public who have gained only limited access or no access to the

denture care they desire or need. The cost of denture care places this health service beyond the reach of many individuals of low and low-middle income."[29]

Opponents of legalized denturitry note that Kentucky has two dental schools and a relatively good per capita rate of dentists in its urban areas. They maintain that the competitive market already operates to keep down the price of dentures and that dentures also are available through low-priced services and pro bono programs operated by dentists. Proponents argue that any advantages gained by competition between dentists are nonexistent outside of the state's largest cities. The FTC report notes that "while the emerging advertising of low-priced denture services will have an important impact on the accessibility of denture care, it is likely to be engaged in by too few dentists in too few locations to potentially reach the 13 million Americans who presently have unmet needs for denture care."[30]

Government Savings

Obtaining dentures through the services of denturists could have an economic impact on the state budget since under the current Medicaid program complete upper and lower dentures are an allowable expense. [KRS 205.560(1)] A study by the state of Michigan found that in the fiscal year 1983-84 Michigan Medicaid paid $4.1 million for upper and lower dentures. Even though the projected cost for the fiscal year 1984-85 was $3.4 million due to reduced number of Medicaid eligible people, the study indicates the overall savings to the state of Michigan could amount to as much as $1 million if dentures were available through denturists.[31]

A study by the Washington State Health Coordinating Council of the bill to certify denturists in that state shows that the Medicaid program in that state would be impacted by the legalization of denturitry by a savings of up to 50% of Medicaid expenditures for dentures. "In fiscal year 1985 the state purchased 5,694 complete dentures at a cost of $1,752,320. The state

paid $513,926 for partials, $14,267 for adjustments, $73,227 for repairs, and $204,798 for duplicates."[32] This made the Medicaid expenditures for Washington slightly over $2 million. The study says that "Dealing directly with denturists and their laboratories could save the state close to a million dollars per year."[33]

CHAPTER VI

PUBLIC HEALTH ISSUES

Overview

Advances in medical science and technology are allowing people to keep their natural teeth longer. Fluoridated water supplies, fluoride in toothpaste, and fluoride treatments in schools are examples of interventions that have been highly successful. There is even a vaccine in trial stages that causes the body to produce high levels of an enzyme in saliva that destroys caries, the bacteria that causes cavities.

But there is still that group of people who have not had the advantage of these breakthroughs and who have lost or will lose their natural teeth. Some of these with sufficient means can still benefit from modern medical advances such as dental implants, but the remainder will need dentures if they are to realize a satisfactory quality of life.

Losing one's natural teeth can have a significant impact on both the physical and psychological health of the edentulous person. People may face traumatic experiences when they lose their teeth, such as rejection in the job market where personal appearance can be crucial in obtaining employment. "Tooth loss is associated with advancing age. The loss of one's teeth can precipitate an emotional crisis. The belief that tooth loss will result in a decrease of family love and affection is widespread."[34] In a report that charted behavioral changes in a six year period after good dentures were obtained by a group of 64 patients of various ages, it was discovered that obtaining dentures, "...has had an identifiable impact on the several behavioral variables for which changes were predicted before the study began. There has been general improvement in self-image, confidence, and relaxation...."[35]

While the cultural context of wearing dentures is cosmetic, there are some definite effects on physical health as well, especially for the elderly edentulous. Their food choices may be dictated by the fact that they have either no natural teeth or ill fitting dentures. Poor nutrition may in turn result in a myriad of nutrition-related health problems. In addition, the simple pleasure of eating may be diminished.

In regard to public health issues, opponents of denturitry maintain that if dentures are provided directly by denturists, consumers may be injured by ill-fitting dentures, unsanitary facilities will spread diseases, and the rate of edentulism will increase.[36] These issues are explored in the following sections.

Competency

Public health and safety are always the key issues in whether the denturitry should be regulated at all. The first public health question is whether denturists are competent to perform the functions they seek to perform. Opponents of denturitry claim "...denturists know nothing about the practice of dentistry nor the treatment of patients and have no training in the provision of health services."[37] Proponents of denturitry maintain that they are competent by virtue of either formal training or years of experience, some of which have been in a clinical setting with a dentist, or both. Proponents further contend that the only way they can prove their competency is to be given an opportunity to practice.

There is no formal training program for denturitry in Kentucky. Kentucky schools do offer training in dental hygiene and dental assisting, and the Lexington Community College offers a two-year program in dental lab technology. The absence of formal programs in denturitry is not unusual, however, since Kentucky does not officially recognize denturists.

Denturitry proponents point out that there were no programs in Canada prior to the legalizing of denturitry, and now there are five programs. For example, the George Brown College of Applied Arts and Technology in Toronto, Canada offers a six semester degree program in denturitry that includes on-campus classes as well as courses available through distance learning. The George Brown program is flexible and will give credit for community college dental technology courses as well as credit for actual practice experience.

Analysis of Risks

To fully understand the other public health issues with respect to denturitry, one must first look at the functions involved in the practice of denturitry. There are four basic functions:

1. Examination of the oral cavity to determine suitability for dentures;
2. Making of impressions from which the dentures will be fabricated;
3. Fabrication of the dentures; and
4. Fitting and adjustment of the finished dentures.

What public health risks are involved in denturists performing these functions? The third function, fabrication of dentures, does not involve patient contact so there is essentially no health risk. In addition, it is a technical function that is currently performed by dental lab technicians and denturists and, therefore, is not an issue.

The second function, making impressions, does involve patient contact and working in the oral cavity. There is some risk of spreading infectious disease when performing this function unless sanitation standards are applied and enforced. There does not appear, under normal circumstances, to be any health risk related to the actual making of impressions. This is a

technical procedure that dentists currently are required to perform but frequently delegate to auxiliary personnel.

Function four, the fitting and adjustment, does pose some public health risks. Opponents contend that ill fitting dentures may lead to oral cancer and that only dentists are trained and qualified to perform this function. Denturists argue that since they are the ones who actually make the dentures, they are just as competent as dentists to fit and adjust them. They also contend that the fit is usually better because the fitting is done where the dentures are made and adjustments can be made immediately, saving the patient time and money.

There is also a potential health risk posed by a denturist performing the first function, the initial examination of the oral cavity. Before dentures are made and fitted, an examination must be conducted to determine that the oral cavity is fit to receive dentures. Teeth or pieces of teeth, bone protrusions in the jaw or gums, and sores or lesions are examples of the abnormalities that would make the oral cavity unfit for dentures. Dentists argue that their education and training makes them the only group within the dental field competent to perform an oral examination. Denturists counter that they are competent to perform this function through education and experience. Some denturists have completed denturitry programs that cover mouth, neck, and jaw pathology. Others claim that years of experience, including experience working with a dentist, have prepared them to detect abnormalities. They say that they may not be able to identify the specific pathology present but they are competent to detect abnormalities and will make necessary referrals to dentists for proper treatment.

Oral Health

While there is some public health risk involved in the practice of denturitry, a review of the actual documented incidence of public harm may be useful. There are three public health issues that need to be examined:

1. The spread of infectious diseases through improper procedures or unsanitary facilities;
2. An increase in the incidence of oral cancer due to insufficient or improper diagnostic screening; and
3. An increase in the incidence of oral cancer due to ill-fitting dentures.

With regard to the spread of infectious diseases, denturitry opponents point to incidents where inspectors of the Board of Dentistry have observed sanitation violations. In one case a practitioner was observed not wearing latex gloves, and in another case an improper appliance was used to sterilize molds for making impressions. Proponents contend that they observe general sanitation standards and that the citations for violations have been infrequent and relatively minor. They also point out that since denturists are not now regulated, they are not always aware of specific sanitation protocols and they would not object to appropriate standards and training being required of them. According to the FTC report, there has been no increase in the spread of infectious disease attributable to the practice of denturitry in the United States or Canada.[38]

The issue of regular diagnostic examinations for denture wearers is another issue that has public health impact. An argument for opponents of denturitry is that the rate of undetected oral cancer will rise with the legalization of denturitry. They state that patients using the services of a denturist will not have proper access to diagnosis and treatment for oral cancers. Proponents of denturitry maintain that with legalization, a higher level of oral health may actually be attained. They reason that the more mouths that are seen by denturists, the more referrals they can make to

dentists of patients exhibiting potential pathological conditions and with this cooperative approach help protect the public's oral health.

The final public health issue is the link between oral cancer and the practice of denturitry. Opponents argue that legalizing denturists will result in more ill-fitting dentures and an increase in oral cancer. The relationship of dentures to oral cancer is based on the hypothesis that chronic physical irritation of the oral mucosa (caused by ill-fitting dentures) is a contributing factor in the incidence of oral cancers.

A scientific study conducted in 1984 on denture wearing and oral cancer found no evidence that denture wearing, even wearing ill fitting dentures, is a significant factor in oral cancer.[39] The study was conducted on 400 patients with oral carcinoma seen in the Oral Medicine Clinic, University of California, San Francisco, between 1968 and 1982. This study included recorded data on tumor site and stage, smoking habits, and dental/denture status. "When denture and non denture wearers were compared, there was no apparent risk relationship in regard to tobacco use, tumor state, or delay in diagnosis."[40] This study also concluded that "denture wearing in a population of oral cancer patients does not appear to be associated statistically with an increased risk of the development of a malignancy."[41] The study concludes that there is no correlation between the wearing of dentures and any specific cancer sites. Furthermore, there is no difference between denture wearers and control groups in the occurrence of oral cancer.[42]

Similar results have been observed in certain denturitry jurisdictions. In Alberta, Canada, where denturitry has been legal since 1961, there was no increase in the rate of oral cancer over the next 15 years.[43] According to the FTC report, there has been no increase in the incidence of oral cancer in the United States or Canada associated with the practice of denturitry.[44] In

addition, anecdotal evidence indicates there is no significant difference in the rates of oral cancer when comparing denturitry states that require a certificate of oral health with those that do not.

CHAPTER VII

POLICY OPTIONS

Summary

Denturitry is a technical occupation that has evolved from the practice of dentistry. Six states, Canada, and most western European countries allow denturists to practice independently. Attempts to legalize denturists in Kentucky have been made every legislative session since 1978, but none have been successful. The concern expressed by opponents of denturitry is that denturists are not sufficiently educated to practice independently and that allowing them to do so would be harmful to the public health. Competency of denturists and standards of practice do raise issues for consideration. Available research on the public health issues suggests that health risks are minimal and the actual incidence of health problems is not significantly different between states that allow denturists and states that do not. In regard to economic issues, there is some evidence that legalizing denturists does increase the availability of denture services and reduce the cost.

Policy Options

There are three basic policy options that might be considered by the 2000 General Assembly. The first option is not to license denturists; the option that has been exercised by previous General Assemblies whenever the issue has been before them. This option preserves the status quo, which is that all denture work is performed as part of the practice of dentistry and under the aegis of a dentist. The argument for this approach is that it protects the public from any health risks that might be posed by the independent practice of denturists.

The argument against this option is that the public will not realize the benefits that the denturitry proponents contend will be available. The cost of dentures will not decline. Dentures will not be made for more edentulous citizens. And fewer citizens will have oral examinations, possibly resulting in oral pathology going undetected. The major drawback to this argument, however, is that the question of whether denturists are qualified to independently practice denturitry is still not resolved and the issue will continue to arise regularly as a legislative issue.

The second option is to license denturists. The pros and cons of this option are obviously the reverse of those of the first option. Arguments for licensing would be that more denture services would be available. The cost of dentures would decline and more oral pathology would be detected and patients referred to a dentist. The argument against licensing is that the public could be exposed to a greater health risk.

The third option would be to establish a "pilot project" through which qualified denturists would be licensed for a set period of time and would be allowed to practice under controlled and monitored circumstances. This option would allow denturists to prove their competence but at the same time provide public protections to minimize any potential health risks. To assure a successful outcome, the pilot project would need to be carefully structured. Practice standards, including sanitation standards, would need to be established, and denturists would need to report regularly on their activities. A complaint process would need to be put into place and complaints investigated.

An oversight committee would need to be created to work with the Board of Dentistry to monitor the pilot project. The oversight committee membership should reflect equal representation of dentists and denturists, but should also contain persons not aligned with either group to give representation to consumer interests and provide objectivity.

Denturists contend that they are sufficiently trained and competent to practice independently. Opponents contend they are not. The pilot project approach would provide the opportunity for denturists to prove their claim, but to do so under controlled circumstances designed to protect the public. With a pilot project in place and operating for a period of three to six years, sufficient objective data should be generated to allow a future General Assembly to make an informed decision on permanent licensure.

TABLE 1
STATE DENTURITRY LAWS*

	ARIZONA	IDAHO	MAINE	MONTANA	OREGON	WASHINGTON
Date Authorized	1978 By Legislation	1982 By Initiative 1983 By Legislation	1977 By Legislation Amended 1994	1984 By Initiative 1985 By Legislation	1978 By Initiative	1994 By Initiative 1995 By Legislature
Required Supervision	In dentist's office; under gen'l superv'n; initial & final OK by dentist	None	None	None	None	None
Oral Health Certificate Required	No	No	Yes--by DDS <30 days	No	Yes--by MD or DDS**	No
Range of Services	Make/repair full & partial	Make/repair full; repair partial only	Make/repair full only	Make/repair full & partial	Make/repair full & partial	Make/repair full & partial
Type of Regulation	Certification	Licensure	Licensure	Licensure	Licensure	Licensure
Regulating Authority	Board of Dental Examiners	Board of Denturitry	Dental Examiners	Dental Board	State Advisory Council on Denture Technology	Board of Denture Technology
Composition of Authority	6 dentists 2 hygienists	3 denturists 2 lay members	5 dentists 1 hygienist 1 lay member	6 dentists 1 denturist 1 hygienist 2 lay members	1 dentist 4 denturists 2 lay members	1 dentist 4 denturists 2 lay members
Required Training	2 yr degree exam	2 yr degree exam 2 yr internship	2 yr degree exam	2 yr degree exam 1 yr internship	2 yr degree exam 2 yr internship	2 yr degree exam
Continuing Education Required	None	12 hrs/yr	20 hrs/2 yrs	36 hrs/3 yrs	30 hrs/3 yrs	None
"Grandfather " Clause (original)	None	5 yrs experience	10 yrs experience;	5 years practical experience	4,000 hrs practical experience	graduate of denturism program;exam
Number of Denturists	12	29	15	13	130	103

** Statute analysis and table preparation completed by LRC staff.*

*** No oral health certificate required if the denturist has completed additional training in oral pathology*

ttachment #ii

Denturist Curriculums

(Two examples:)

Northern Alberta's Curriculum

Semester: 1

Course ID	Name	Hours
DNT121	Dental Anatomy	36
DNT131	Introduction to Complete Dentures	153
DNT141	Introduction to Partial Denture Fabrication	119
DNT171	Microbiology and Dental Asepsis	51
HSC102	Human Workplace Relations	51
MLT181	Foundations of Oral Pathology	51
Electives		
PLE125	Physical and Leisure Education (optional)	12

Semester: 2

Course ID	Name	Hours
DET231	Advanced Complete Denture Design	180
DET241	Introduction to Partial Denture Design	126
DET261	Introduction to Clinical Prosthodontics	85
DET281	Dental Radiology For The Denturist	34
MLT274	Oral Pathology	68
Electives		
PLE260	Physical and Leisure Education (optional)	12

Semester: 3

Course ID	Name	Hours
DET331	Applied Prosthodontics I	204
DET341	Applied Removable Partial Denture Design	85
DET361	Patient Treatment I	204
DET371	Jurisprudence and Ethics	18

Semester: 4

Course ID	Name	Hours
DET431	Applied Prosthodontics II	204
DET461	Patient Treatment II	221
DET471	Introduction to Osseointegration and Implant Overdentures	17
DET481	Practice Management	17

Mills Grae's Curriculum

SECOND YEAR, FALL TERM			HOURS	CREDITS
ANATOMY	621	MEDICAL TERMINOLOGY	40	04
ANATOMY	622	HUMAN ANATOMY	40	04
ANATOMY	623	DENTAL ANATOMY	40	04
BIOCHEM	621	BIOCHEMISTRY	40	04
MICROBIO	621	MICROBIOLOGY/IMMUNOLOGY	60	06
ORALDX	621	CARDIOPULMONARY RESUSCITATION	10	01
RPCLINIC	721	REMOVABLE PROSTHETICS	80	02
SECOND YEAR, WINTER TERM				
ANATOMY	624	HEAD & NECK ANATOMY	60	06
BIOCHEM	622	BIOCHEMISTRY	40	04
DENTUR	621	OCCLUSION	40	04
ORALDX	622	HEAD & NECK DX SYSTEM	20	02
PHYSIOL	621	PHYSIOLOGY	40	04
RADIOL	621	PRINCIPLES OF RADIOLOGY	30	03
RPCLINIC	722	REMOVABLE PROSTHETICS	80	02
SECOND YEAR, SPRING TERM				
BIOCHEM	623	NUTRITION	40	04
DENTUR	622	PERIODONTOLOGY	20	02
ORALDX	623	MEDICAL EMERGENCIES	20	02
ORALDX	624	ORAL DIAGNOSIS	70	07
PHYSIOL	622	PHYSIOLOGY	40	04
RADIOL	622	RADIOGRAPHIC INTERPRETATION	40	04
RPCLINIC	723	REMOVABLE PROSTHETICS	80	02
THIRD YEAR, FALL TERM				
DENTUR	631	PRACTICE MANAGEMENT	40	04
PATHOL	631	GENERAL PATHOLOGY	80	08
PHARM	631	PHARMACOLOGY	40	04
PUBLICH	631	GERONTOLOGY	20	02
PUBLICH	632	PUBLIC HEALTH	50	05
RPCLINIC	731	REMOVABLE PROSTHETICS	80	02
THIRD YEAR, WINTER TERM				
DENTUR	632	ETHICS & JURISPRUDENCE	20	02
ELECT	63X	ELECTIVE	50	05
ELECT	63X	ELECTIVE	40	04
PATHOL	632	SYSTEMIC PATHOLOGY	40	04
PHARM	632	PHARMACOLOGY	40	04
PUBLICH	633	PUBLIC HEALTH	40	04
RPCLINIC	732	REMOVABLE PROSTHETICS	80	02

THIRD YEAR, SPRING TERM

DENTUR	633	IMPLANTOLOGY	40	04
DENTUR	634	PAIN MANAGEMENT	40	04
DENTUR	635	SLEEP DISORDERS	40	04
ELECT	63X	ELECTIVE	30	03
PATHOL	633	CLINICAL DIAGNOSTIC PATHOLOGY	80	08
RPCLINIC	733	REMOVABLE PROSTHETICS	80	02

FOURTH YEAR, FALL TERM

DENTUR	641	TEMPOROMANDIBULAR JOINT	80	08
PATHOLO	641	CLINICAL DIAGNOSTIC PATHOLOGY	120	12
PHARM	641	CLINICAL PHARMACOLOGY	40	04
RPCLINIC	741	REMOVABLE PROSTHETICS	80	02

FOURTH YEAR, WINTER TERM

RPCLINIC	742	DENTURITRY PRACTICE RESIDENCY	520	13

FOURTH YEAR, SPRING TERM

RPCLINIC	743	DENTURITRY PRACTICE RESIDENCY	520	13

ELECTIVE COURSES

ELECT	631	SPORTS MEDICINE	50	05
ELECT	632	PHYSICAL FITNESS	50	05
ELECT	633	SPORTS NUTRITION	40	04
ELECT	634	DISTANCE RUNNING	40	04
ELECT	635	BITEMARK IDENTIFICATION	30	03
ELECT	636	MEDICAL MALPRACTICE	30	03
ELECT	63X	TO BE DEVELOPED UPON DEMAND		

CURRICULUM SUMMARY	HOURS	CREDITS
FIRST YEAR, PREREQUISITES	860	47
SECOND YEAR	930	75
THIRD YEAR	930	75
FOURTH YEAR	1,360	52
TOTAL CURRICULUM	4,080	249

Part 3
Questionnaire on New or Expanded Regulation

Instructions

The following sections contain questions relating to proposals for new or expanded regulation of a health occupation. Prepare your response to the questions as follows:

- Prepare a separate document with your answers to the questions
- Include the questions with your answers so there is no confusion about which questions you are answering
- Attach the document to a cover letter with the information described in Part 2

For guidance on how to answer the questions, refer to the following:

- The background information provided in Part 1 of this document
- The background information provided below on each category of questions
- The Credentialing Policy Guidelines contained in Part 4 of this document

Submit the completed document to:

Randy Snyder, Executive Director
Board of Examiners of Nursing Home Administrators
University Park Plaza, Suite 440
2829 University Avenue SE
Minneapolis MN 55414

If you have questions, you can contact Mr. Snyder by telephone or e-mail as follows:

Telephone: 612-617-2117
E-Mail: Randy.Snyder@state.mn.us

A. Description of the Occupation

Background Information

Just what is the occupation all about? A basic description or definition of the occupation is primary. Before exploring the details of educational opportunities, regulatory schemes and costs, one needs to know what the occupation aims to do. Such basic descriptions are important to all audiences, from consumers to insurers to legislators to other health care occupations. It is only with sufficient descriptive information about an emerging occupation that these audiences can begin to understand appreciate a new occupation.

The description should clearly state the occupation's approach to health and the types of services it offers to the public. It should include the range of care provided and acknowledgement of what types of conditions are *not* in the expertise of practitioners. Audiences also want to know how the occupation sees itself relative to other health care occupations.

The descriptions should also include reliable estimates of the size of the occupation and workforce growth trends over time. Such estimates are invaluable to understanding whether the occupation has sufficient membership numbers to competently and proactively "grow" the occupation.

Questions Relating to Description of the Occupation

1. What is the occupational group proposed for regulation?
2. What does the occupation do and how does it provide care? How does the occupation describe itself in terms of the types of care it provides, and the types of care that are beyond its professional scope?
3. Is the occupation a "complete system" that includes a range of modalities and therapies? If not, is it a modality that could be provided by members of different occupations?
4. Are practitioners of the occupation typically responsible for making a diagnosis? If not, are they responsible for making an evaluation or identification of a problem?
5. Are practitioners of the occupation responsible for writing, interpreting, or otherwise contributing to the establishment of the service or treatment plan? If yes, describe the responsibilities. If not, identify who is responsible.
6. What services provided by the occupation are typically unsupervised?
7. What are typical work settings?
8. How long has the occupation been in existence?
9. Is it found only in the United States? If not, what is its current international status?

10. What is the philosophy behind the occupation? What ethics, concepts, or values help define the occupation? Has a "Code of Ethics" been developed by the occupation?
11. Does the occupation identify itself more in terms of an "acute care" (sickness) model or in terms of a "health promotion/disease prevention" (wellness) model?
12. How is the occupation different from or similar to other health occupations, systems and modalities?
13. What processes and guidelines exist for inter-professional referral, co-management and collaboration?
14. How many individuals practice the occupation in Minnesota? How many of these would be subject to regulation?
15. Is the workforce growing? If so, at what rate? What are the estimated demand requirements and workforce supply for the occupation?

B. Safety and Efficacy

Background Information

High on the list of criteria to consider when evaluating an emerging occupation is the evidence regarding safety and efficacy of the services provided. It is worth separating these two concepts—safety and efficacy—because different audiences ascribe different levels of importance to them.

Safety issues deal with the potential risk of harm to patients and clients. Some occupations have broader diagnostic scopes of practice than others, carrying with it greater potential risk of harm. Some occupations employ treatment modalities or therapies that carry higher potential risks than others. Modalities on the relatively higher end of the continuum usually include invasive techniques such as surgery and controlled substances such as pharmaceutical drugs that are either injected or ingested. At the other end of the safety continuum might be less- or non-invasive techniques or use of non-controlled substances. Lines are not brightly painted between high- and low-risk modalities. For example, apparently "non-invasive" psychotherapy and counseling treatments may carry significant risk of harm to patients.

Safety issues are of concern to all interested parties, but to varying degrees. Because regulation is a state police power, grounded in a need to protect the public, state legislators are keenly interested in the level to which an occupation's services put the public at harm. If the risk is relatively high, legislatures are more likely to infringe on an individual's desire to provide services by insisting that members of the occupation be regulated. If risk of harm is relatively low, legislatures may decline to regulate the occupation and permit it to operate as any business might.

Efficacy concerns go beyond safety to measure the effectiveness of an occupation, treatment, or modality. Is the treatment likely to cure the illness or prevent the disease? Will it promote self-healing? Does it work? Reasons for the public to seek out complementary and alternative health care include trying something else after initial allopathic efforts have failed. Members of the occupation and other health care practitioners also need to know about effectiveness to provide good care and referrals as appropriate.

The biomedical research world has developed excellent research protocols over the past several decades. Randomized controlled trials, now the gold standard in the allopathic fields, can measure the safety and efficacy of specific medical interventions extremely effectively. For many new treatment modalities and some emerging occupations, using these research protocols is appropriate. For many emerging occupations in complementary and alternative health, however, the current gold standard in biomedical research may not always provide meaningful results. Therefore some have suggested

looking to alternative types of evidence, including empirical, qualitative, and anecdotal data. Others have recommended that other measures, such as intra- and inter-professional peer review, practice guidelines, and educational standards and competency assessments can help fill the gap in evidentiary knowledge about an occupation.

Questions Relating to Safety and Efficacy

16. What evidence exists to demonstrate the efficacy of the services provided by the occupation?
17. How does the occupation measure the safety and efficacy of the services it provides?
18. What are the findings of studies (US and international) that have been done on safety and risk of harm to patients/clients from the care approaches, treatments, and modalities used by members of the occupation?
19. Describe and document consequences to the consumer that result from incompetent or unethical practice or omission of appropriate practice. Include information on the consequences in each of the following areas:
    A. Emotional consequences
    B. Financial consequences
    C. Physical consequences
    D. Social consequences
20. Describe any complaints filed with state law enforcement authorities, courts, departmental agencies, occupational boards, or occupational associations that have been lodged against practitioners of the occupation in Minnesota within the past five years.
21. What are the findings of studies (US and international) that have been done on efficacy and effectiveness of the care approaches, treatments, and modalities used by members of the occupation?
22. Where does the occupation or field recognize gaps in its members' knowledge and perhaps even competency? What is the occupation's research agenda?
23. How is the occupation working internally and with other occupations to support the safe development of new and unconventional practices?

C. Government and Private Sector Recognition

Background Information

Consumers, regulators, and insurers want to know if other people are seeing members of the occupation for health care, if other states are regulating them, if other insurers are paying for or reimbursing for their services.

One of the primary forms of recognition comes from state governments through regulation. If an occupation is regulated, it may be regulated in a number of ways. States may also choose to prohibit the practice of a particular occupation or to ignore it completely. If an occupation is not proactively regulated by the state, providers of health care may be found to be engaged in unauthorized practice in violation of the state's regulatory laws.

For many emerging occupations, securing regulation (especially licensure) in all the states has become a goal because of the associated benefits—such as reimbursement from federal programs or insurers—that often come with licensure. They may also argue that regulation can improve access to providers and better protect the public from harm. For occupations that are regulated, their board structures, regulatory financing and scope of practice are critical items of information. Other occupations have declined to seek regulation, basing their decision on the low potential risk of harm to the public, evidence that regulation can negatively affect access to care, and the capacity of the market to weed out the lower qualified members of the occupation.

Reimbursement recognition is another major aspect of an occupation that decision-makers need to learn. Consumers want to know whether their health plan (whether private or government-based such as Medicare or Medicaid) will reimburse a provider for services they render. Insurers want to know if government plans or other insurers reimburse for the services of an occupation new to them.

The question of whether members of an emerging occupation can and do obtain malpractice insurance should be included in any evaluation of the occupation. This information is not only an indication of another level of recognition, it also helps consumers understand what recourse they might have should something go wrong. In addition, legislators are often very curious about the availability of malpractice insurance (and whether the occupation is availing itself of it) when considering the consumer protection aspects of regulation.

The number of patient or client visits to members of an emerging occupation can give interested audiences a useful snapshot picture. Utilization rates combined with costs of

services can tell practitioners about career and market opportunities. Utilization rates combined with numbers of other health care providers in a given geographic area can help inform policy makers dealing with access issues.

Other aspects of recognition may include hospital and clinic privileges as well as the job opportunities available to members of the occupation.

A final aspect of recognition is non-governmental credentialing organizations. The idea behind credentialing organizations is to provide information to potential clients, patients, employers, health plans, and third-party payers about health care providers. The *existence* of these organizations is one indicator that the occupation has grown to a level that calls for and supports such activity. However, it is the *quality* of the services offered by these organizations that matters the most for many key actors, including insurers. They need to know, for example, that credentialing standards used by the organizations are comparable to, if not the same as, nationally recognized standards.

Questions Relating to Government and Private Sector Recognition

24. Describe the proposed minimum qualifications for entry into the occupation. Include a description of any levels of specialization within the occupation and the qualifications for each. How are the specialties taught and tested?
25. Is the occupation affirmatively regulated in any states (or provinces)? For each state that regulates the occupation, provide the name of the agency that provides the regulation, the type/level of regulation, the legislative scope of practice (including supervisory and disclosure requirements), and regulatory requirements such as continuing education, licensing fees, and disciplinary processes. If the occupation is regulated by a board, provide information on the board structure, including the size of the board and board membership eligibility requirements.
26. Does any state or province prohibit the practice of the occupation? If so, provide summary language of each such statute.
27. How do the rest of the states/provinces treat the occupation from a regulatory and legislative standpoint? For example, is the occupation statutorily ignored but permitted to be provided as long as practitioners do not cross over the line into the medical practice act? Is licensure nominally available but technically impossible to obtain? Have any states enacted innovative legislation or developed new policies that recognize emerging occupations in some novel way?
28. Are there pivotal opinions issued by state attorneys general or case law decisions that control the provision of care from members of the occupation?
29. If this occupation is regulated in other jurisdictions, is there third-party reimbursement for the services provided by the occupation in those jurisdictions?
30. Is malpractice insurance widely available to members of the occupation? What information is available about members of the occupation from malpractice monitoring services?

31. What are the (estimated) utilization rates for the occupation? How many client/patient visits are made to members of the occupation per defined time period?
32. Do hospitals, clinics, and other health care institutions recognize members of the occupation with admitting or other privileges?
33. Are jobs available for members of the occupation?
34. Is the occupation affiliated with an association which enacts and enforces standards? If so, explain the enforcement mechanism.
35. Describe the extent to which the proposed regulation will affect the cost of the services provided by practitioners.
36. Describe the over-all cost-effectiveness and economic impact of the proposed regulation, including indirect costs to consumers.

D. Education and Training

Background Information

Questions regarding the education and training of members of an occupation are often high on the list of inquiries from consumers, legislators, other health care practitioners, and would-be members of the occupation. What does it take to become a member of the occupation?

Most mainstream health occupations (and many of the complementary, alternative, and on-allopathic fields) rely on traditional education routes, such as university, professional school, and clinical practice to prepare entering practitioners. Other preparatory models include apprenticeships, oral tradition, and novel non-linear, non-degree based approaches. Regardless of the particular track one follows to enter an occupation, the occupation should be able to demonstrate (through clearly described methods) that its members are *competent* to provide the care they offer when they enter the occupation.

Education programs also often provide the grounds for developing an occupation's research capacity. Science-based research on the safety and efficacy of treatments and modalities, on policy directions, and on public health impacts can often more easily be accomplished in the institutional setting than in the individual's office or practice setting. And budding researchers can be properly trained, supported, and mentored by more learned members of the occupation.

Finally, education and training programs can serve as leverage points in the ongoing evolution of health care generally and an occupation specifically. Inter-professional training for successful team or collaborative work, new technologies and practice goals such as culturally competent care are just a few examples of the opportunities for health care improvement educational institutions can offer.

Questions Relating to Education and Training

37. Are education, clinical training or apprenticeships available to train would-be members of the occupation? What is the range of opportunities? How many programs are offered?
38. For each opportunity (degree program, apprenticeship, etc.), what are the pre-requisites, requirements, supervision, and financial costs?
39. What are the didactic and clinical components of the training opportunities? For any clinical practicum, what is the level of supervision, length of program, and level of patient/client base (primary care, specialty, acute, average)?
40. How are students tested for competence during and at completion of all didactic

and clinical programs?

41. Are educational opportunities standardized across the states for the occupation? For example, do faculty members in different institutions rely on standard curricula established by the occupation? If so how were curricula standardized? What agency or institution oversees maintenance of standards?
42. For apprenticeship models, describe the components, competency assessment, and supervision and mentoring elements.
43. Are there accepted national or regional standards of education and training for competent practice of the occupation? (An indication of such standards is the existence of a national or regional psychometrically valid and reliable test for measuring achievement of minimum entry-level skill and knowledge.)
44. Does the occupation have standard tests individuals can take to demonstrate their knowledge, skills, and judgment in the occupation?
45. Are individuals sufficiently educated and trained to be competent to practice the occupation? How is competence determined?
46. Are specialties in the occupation offered? How are these taught and tested?
47. What does the occupation propose as a vehicle to ensure continued competency?

E. Practice Model and Viability of Occupation

Background Information

The continually changing nature of health care challenges health care occupations to adapt and evolve. Just a few of the changes include technological developments, research findings, new financing and delivery models, changing demographics, and new and changing occupations. The ability of an occupation to understand and adapt to change is an indication of its viability. An occupation's role in leading positive change is an indication of its strength in defining and improving health care.

One of the more promising developments in health car is attention to quality improvement. Another leading edge activity in health care includes efforts to work meaningfully in teams of health care providers. Closely related are efforts to develop strong and reliable systems for consultation, collaboration, and referral between health care practitioners.

To continue to grow, all occupations must find ways to support the development of new techniques and modalities while maintaining safeguards for the public. Occupations must also seek to understand and use technological inventions and developments, including those found in information technology and "high-tech" communications. Professional efforts to improve provider/patient relationships are also indicators of the long-term viability of the occupation.

Questions Relating to Practice Model and Viability of Occupation

48. What efforts has the occupation made to develop practice guidelines and treatment protocols for clinical care? Does the occupation encourage the use of peer review meetings and outcomes and treatment measures as feedback for individual practitioners?
49. What guidelines has the occupation developed and encouraged for work in interprofessional teams and consulting and referral arrangements? Does the occupation provide, through initial and continuing education, information about other health care occupations so that members of the occupation can make informed decisions about collaboration and referrals?
50. What is the occupation's record in terms of patient satisfaction and provider/patient relationships? What commitment has the occupation made to ensure that care provided by its members is culturally appropriate?
51. How does the occupation support and encourage new modalities and therapies within the occupation? How is the occupation incorporating new technologies

and communications capacities into its practice?

52. Describe the extent to which the proposed regulation will affect the cost of the services provided by the practitioners.
53. What is the expected impact of the proposed regulation on the existing supply of practitioners?
54. What percentage of current practitioners will be able to meet the proposed eligibility criteria?
55. Will individuals who are not able to meet the proposed eligibility criteria be able to continue to provide services under a different but related occupational title?
56. Under the proposal, will current practitioners be "grandparented"? If current practitioners would be grandparented, describe how long and under what conditions.
57. What groups, including national and state professional and trade associations, are working on behalf of the occupation? What are their membership numbers and criteria for membership? What are their goals and current policy agendas? Provide the address of each.

F. Regulatory Framework

Background Information

Health occupation regulation should be efficient and cost-effective. It should provide regulated persons and the public with readily accessible and understandable information and procedures. It should also provide fair representation of both regulated practitioners and the public.

When a state agency is given authority to regulate an occupation, the authority is usually to provide credentialing of members of the occupation. Credentialing means an administrative process under which a government agency reviews evidence of qualifications and issues a credential after determining than a person is entitled to use a restricted occupational title (registration) or to practice a restricted occupation (licensing).

Regardless of how the occupation is credentialed, there are a number of options for the organization and administration of the regulatory system.

Questions Relating to Regulatory Framework

58. Identify any existing governmental agencies that can protect consumers who utilize the services of the occupation.
59. Describe why existing remedies are inadequate to prevent or readdress the kinds of harm that could result from non-regulation.
60. In which of the ways described below should the occupation be regulated? Explain the rationale.
    A. By a new independent board?
    B. By an existing board where the board is renamed and reorganized to include a significant number of board members representing the newly credentialed occupation?
    C. By an existing board where the board membership is changed to include one or more board members representing the newly credentialed occupation?
    D. By an existing board where the board forms a separate advisory committee with members from the newly credentialed occupation, as well as public members, to advise the board?
    E. By the Department of Health, using an advisory committee comprised of members of the public and the newly credentialed occupation?

Ratings Worksheet

The following questions are provided to the Occupation. Respond to questions as information supports proposal, does not support or you require more information to make a decision.	**Proposal Supports**	**Not supported**	**Neutral or Not Sure or Need More Information**

A. Description of the Occupation			
1. What is the occupational group proposed for regulation?			
2. What does the occupation do and how does it provide care? How does the occupation describe itself in terms of the types of care it provides, and the types of care that are beyond its professional scope?			
3. Is the occupation a "complete system" that includes a range of modalities and therapies? If not, is it a modality that could be provided by members of different occupations?			
4. Are practitioners of the occupation typically responsible for making a diagnosis? If not, are they responsible for making an evaluation or identification of a problem?			
5. Are practitioners of the occupation responsible for writing, interpreting, or otherwise contributing to the establishment of the service or treatment plan? If yes, describe the responsibilities. If not, identify who is responsible.			
6. What services provided by the occupation are typically unsupervised?			
7. What are typical work settings?			
8. How long has the occupation been in existence?			
9. Is it found only in the United States? If not, what is its current international status?			
10. What is the philosophy behind the occupation? What ethics, concepts, or values help define the occupation? Has a "Code of Ethics" been developed by the occupation?			
11. Does the occupation identify itself more in terms of an "acute care" (sickness) model or in terms of a "health promotion/disease prevention" (wellness) model?			
12. How is the occupation different from or similar to other health occupations, systems and modalities?			
13. What processes and guidelines exist for inter-professional referral, co-management and collaboration?			
14. How many individuals practice the occupation in Minnesota? How many of these would be subject to regulation?			
15. Is the workforce growing? If so, at what rate? What are the estimated demand requirements and workforce supply for the occupation?			

Summary of Section A. Are there remaining questions that need to be addressed further by the occupation or addressed by the legislature?

The following questions are provided to the Occupation. Respond to questions as information supports proposal, does not support or you require more information to make a decision.	**Proposal Supports**	**Not supported**	**Neutral or Not Sure or Need More Information**

B. Safety and Efficacy			
16. What evidence exists to demonstrate the efficacy of the services provided by the occupation?			
17. How does the occupation measure the safety and efficacy of the services it provides?			
18. What are the findings of studies (US and international) that have been done on safety and risk of harm to patients/clients from the care approaches, treatments, and modalities used by members of the occupation?			
19. Describe and document consequences to the consumer that result from incompetence or unethical practice or omission of appropriate practice. Include information on the consequences in each of the following areas: A. emotional consequences B. Financial consequences C. Physical consequences D. Social consequences			
20. Describe any complaints filed with state law enforcement authorities, courts, departmental agencies, occupational boards, or occupational associations that have been lodged against practitioners of the occupation in Minnesota within the past five years.			
21. What are the findings of studies (US and international) that have been done on efficacy and effectiveness of the care approaches, treatments, and modalities used by members of the occupation?			
22. Where does the occupation or field recognize gaps in its members' knowledge and perhaps even competency? What is the occupation's research agenda?			
23. How is the occupation working internally and with other occupations to support the safe development of new and unconventional practices?			

Summary of Section B. Are there remaining questions that need to be addressed further by the occupation or addressed by the legislature?

The following questions are provided to the Occupation. Respond to questions as information supports proposal, does not support or you require more information to make a decision.	**Proposal Supports**	**Not supported**	**Neutral or Not Sure or Need More Information**
C. Government and Private Sector Recognition			
24. Describe the proposed minimum qualifications for entry into the occupation. Include a description of any levels of specialization within the occupation and the qualifications for each. How are the specialties taught and tested?			
25. Is the occupation affirmatively regulated in any states (or provinces)? For each state that regulates the occupation, provide the name of the agency that provides the regulation, the type/level of regulation, the legislative scope of practice (including supervisory and disclosure requirements), and regulatory requirements such as continuing education, licensing fees, and disciplinary processes. If the occupation is regulated by a board, provide information on the board structure, including the size of the board and board membership eligibility requirements.			
26. Does any state or province prohibit the practice of the occupation? If so, provide summary language of each such statute.			
27. How do the rest of the states/provinces treat the occupation from a regulatory and legislative standpoint? For example, is the occupation statutorily ignored but permitted to be provided as long as practitioners do not cross over the line into the medical practice act? Is licensure nominally available but technically impossible to obtain? Have any states enacted innovative legislation or developed new politics that recognize emerging occupations in some novel way?			
28. Are there pivotal opinions issued by state attorneys general or case law decisions that control the provision of care from members of the occupation?			
29. If this occupation is regulated in other jurisdictions, is there third-party reimbursement for the services provided by the occupation in those jurisdictions?			
30. Is malpractice insurance widely available to members of the occupation? What information is available about members of the occupation from malpractice monitoring services?			
31. What are the (estimated) utilization rates for the occupation? How many client/patient visits are made to members of the occupation per defined time period?			
32. Do hospitals, clinics, and other health care institutions recognize members of the occupation with admitting or other privileges?			
33. Are jobs available for members of the occupation?			
34. Is the occupation affiliated with an association which enacts and enforces standards? If so, explain the enforcement mechanisms.			
35. Describe the extent to which the proposed regulation will affect the cost of the services provided by the practitioners.			
36. Described the over-all cost-effectiveness and economic impact of the proposed regulation, including indirect costs to consumers.			

Summary of Section C. Are there remaining questions that need to be addressed further by the occupation or addressed by the legislature?

The following questions are provided to the Occupation. Respond to questions as information supports proposal, does not support or you require more information to make a decision.	**Proposal Supports**	**Not supported**	**Neutral or Not Sure or Need More Information**

D. Education and Training			
37. Are education, clinical training or apprenticeships available to train would-be members of the occupation? What is the range of opportunities? How many programs are offered?			
38. For each opportunity (degree program, apprenticeship, etc.), what are the prerequisites, requirements, supervision, and financial costs?			
39. What are the didactic and clinical components of the training opportunities? For any clinical practicum, what is the level of supervision, length of program, and level of patient/client base (primary care, specialty, acute, average)?			
40. How are students tested for competence during and at completion of all didactic and clinical programs?			
41. Are educational opportunities standardized across the states for the occupation? For example, do faculty members in different institutions rely on standard curricula established by the occupation? If so, how were curricula standardized? What agency or institution oversees maintenance of standards?			
42. For apprenticeship models, describe the components, competency assessment, and supervision and mentoring elements.			
43. Are there accepted national or regional standards of education and training for competent practice of the occupation? (An indication of such standards is the existence of a national or regional psychometrically valid and reliable test for measuring achievement of minimum entry-level skill and knowledge.)			
44. Does the occupation have standard tests individuals can take to demonstrate their knowledge, skills, and judgment in the occupation?			
44. Are individuals sufficiently prepared to be competent to provide the care they will provide? How is competence determined?			
45. Are individuals sufficiently educated and trained to be competent to practice the occupation? How is competence determined?			
46. Are specialties in the occupation offered? How are these taught and tested?			
47. What does the occupation propose as a vehicle to ensure continued competency?			

Summary of Section D. Are there remaining questions that need to be addressed further by the occupation or addressed by the legislature?

The following questions are provided to the Occupation. Respond to questions as information supports proposal, does not support or you require more information to make a decision.	**Proposal Supports**	**Not supported**	**Neutral or Not Sure or Need More Information**

E. Practice Model & Viability of Profession			
48. What efforts has the occupation made to develop practice guidelines and treatment protocols for clinical care? Does the occupation encourage the use of peer review meetings and outcomes and treatment measures as feedback for individual practitioners?			
49. What guidelines has the occupation developed and encouraged for work in inter-professional teams and consulting and referral arrangements? Does the occupation provide, through initial and continuing education, information about other health care occupations so that members of the occupation can make informed decisions about collaboration and referrals?			
50. What is the occupation's record in terms of patient satisfaction and provider/patient relationships? What commitment has the occupation made to ensure that care provided by its members is culturally appropriate?			
51. How does the occupation support and encourage new modalities and therapies within the occupation? How is the occupation incorporating new technologies and communications capacities into its practice?			
52. Describe the extent to which the proposed regulation will affect the cost of the services provided by the practitioners.			
53. What is the expected impact of the proposed regulation on the existing supply of practitioners?			
54. What percentage of current practitioners will be able to meet the proposed eligibility criteria?			
55. Will individuals who are not able to meet the proposed eligibility criteria be able to continue to provide services under a different but related occupational title?			
56. Under the proposal, will current practitioners be "grand-parented"? If current practitioners would be grand-parented, describe how long and under what conditions.			
57. What groups, including national and state professional and trade associations, are working for the occupation? What are their membership numbers and criteria for membership? What are their goals and current policy agendas? Provide the address of each.			

Summary of Section E. Are there remaining questions that need to be addressed further by the occupation or addressed by the legislature?

The following questions are provided to the Occupation. Respond to questions as information supports proposal, does not support or you require more information to make a decision.	**Proposal Supports**	**Not supported**	**Neutral or Not Sure or Need More Information**

F. Regulatory Framework			
58. Identify any existing governmental agencies that can protect consumers that utilize the services of the occupation.			
59. Describe why existing remedies are inadequate to prevent or address the kinds of harm that could result from non-regulation.			
60. In which of the ways described below should the occupation be regulated? Explain the rationale. A. By a new independent board? B. By an existing board where the board is renamed and reorganized to include a significant number of board members representing the newly credentialed occupation? C. By an existing board where the board membership is changed to include one or more board members representing the newly credentialed occupation? D. By an existing board where the board forms a separate advisory committee with members from the newly credentialed occupation, as well as public members, to advise the board? E. By the Department of Health, using an advisory committee comprised of members of the public and the newly credentialed occupation?			

Summary of Section F. Are there remaining questions that need to be addressed further by the occupation or addressed by the legislature?