



Dora
Department of Regulatory Agencies

Office of Policy, Research and Regulatory Reform

2013 Sunset Review: State Board of Dental Examiners

October 15, 2013





Executive Director's Office

Barbara J. Kelley
Executive Director

John W. Hickenlooper
Governor

October 15, 2013

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the State Board of Dental Examiners (Board). I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2014 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...

The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination....

The report discusses the question of whether there is a need for the regulation provided under Article 35 of Title 12, C.R.S. The report also discusses the effectiveness of the Board and staff in carrying out the intent of the statutes and makes recommendations for statutory changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Barbara J. Kelley
Executive Director





John W. Hickenlooper
Governor

Barbara J. Kelley
Executive Director

2013 Sunset Review: State Board of Dental Examiners

Summary

What Is Regulated?

Dentists and dental hygienists are health care practitioners focused on patients' oral health. Dentists clean and remove decay from teeth, extract teeth, perform root canals, place crowns and dental implants, fill cavities, fit dentures and braces, administer anesthesia, and prescribe medications. Dental hygienists provide preventative dental care, which includes cleaning teeth and applying sealants and fluoride treatments; examine patients for oral disease; and educate patients about oral hygiene.

Why Is It Regulated?

Regulation ensures that dentists and dental hygienists meet minimum standards of competence.

Who Is Regulated?

In September 2013, there were 4,948 active dentists and 4,482 active dental hygienists.

How Is It Regulated?

The State Board of Dental Examiners (Board), housed in the Division of Professions and Occupations of the Department of Regulatory Agencies, regulates dentists and dental hygienists in Colorado. Applicants for a dental or dental hygiene license must have graduated from an accredited school of dentistry or dental hygiene and pass both a national written examination and an examination designed to evaluate clinical competence.

What Does It Cost?

The fiscal year 11-12 expenditure to oversee this program was \$916,971, and there were 3.6 full-time equivalent employees associated with this program.

What Disciplinary Activity Is There?

From fiscal year 07-08 through fiscal year 11-12, the Board issued 365 disciplinary actions, including license suspensions, revocations, stipulations, letters of admonition, and cease and desist orders.

Key Recommendations

Continue the State Board of Dental Examiners for nine years, until 2023.

By assuring that dentists and dental hygienists meet minimum standards for licensure, the Board assures that new licensees possess basic professional competency when they enter the marketplace. During the five year sunset review period, the Board also took a total of 365 disciplinary actions against individuals who violated the Dental Practice Law. These actions ensure that incompetent or unsafe practitioners are either removed from practice or are subject to supervision or license restrictions that ensure public safety. Through its licensing, rulemaking, and enforcement activities, the Board protects the public health, safety and welfare.

Revise the clinical examination requirement to allow the Board to accept other methods of evaluating clinical competency.

In order to qualify for a license in Colorado, both dental and dental hygiene applicants must pass an examination designed to test their clinical skills and knowledge. The notion that a clinical examination can be something other than a one-time, high-stakes examination performed on a real patient is gaining broader acceptance and the definition of what constitutes a clinical examination will undoubtedly continue to evolve. Accordingly, the General Assembly should expand the law to allow the Board, at its discretion, to accept alternate methods of evaluating clinical competency, including residency and portfolio models.

Establish that a dentist or dental hygienist's failure to properly address his or her own physical or mental condition is grounds for discipline, and authorize the Board to enter into confidential agreements with licensees to address their respective conditions.

Under current law, the Board may take disciplinary action against a licensee who has a physical or mental condition which renders him or her unable to treat patients with reasonable skill and safety. Simply having such a condition should not be grounds for discipline, but failing to limit one's practice to accommodate such a condition should be. The General Assembly should clarify the grounds for discipline accordingly, and grant the Board the authority to enter into confidential agreements with licensees having such conditions.

Major Contacts Made During This Review

American Board of Dental Examiners
Central Regional Dental Testing Services, Inc.
Colorado Dental Association
Colorado Dental Hygienists' Association
Colorado Department of Public Health and Environment,
Oral Health Unit
Colorado Division of Professions and Occupations
Colorado Northwest Community College
Comfort Dental
Community College of Denver
Concorde Career College
Dental Assisting National Board, Inc.

National Association of Dental Laboratories
North East Regional Board of Dental Examiners, Inc.
Oral Health Colorado
Pacific Dental
Peer Assistance Services, Inc.
Perfect Teeth
Pueblo Community College
Society of Oral and Maxillofacial Surgeons
Southern Regional Testing Agency
State Board of Dental Examiners
University of Colorado School of Dental Medicine
Western Regional Examining Board

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are Prepared by:
Colorado Department of Regulatory Agencies
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Table of Contents

Background	1
Introduction	1
Types of Regulation	2
Sunset Process	4
Methodology	5
Profile of the Professions.....	5
Legal Framework	8
History of Regulation.....	8
Colorado Dental Practice Law.....	9
Program Description and Administration.....	21
Licensing	23
Examinations	24
Complaints/Disciplinary Actions	31
Peer Assistance Program	35
Analysis and Recommendations	36
Recommendation 1 – Continue the State Board of Dental Examiners for nine years, until 2023.....	36
Recommendation 2 – Change the name of the Board to the “Colorado Dental Board.”	37
Recommendation 3 – Revise the clinical examination requirement to allow the Board to accept other methods of evaluating clinical competency.	38
Recommendation 4 – Repeal the requirement that the Board promulgate rules establishing the number of times a dentist can take a clinical examination.....	40
Recommendation 5 – Repeal the requirement that accredited dental hygiene programs be two years in length.....	41
Recommendation 6 – Establish that a dentist or dental hygienist's failure to properly address his or her own physical or mental condition is grounds for discipline, and authorize the Board to enter into confidential agreements with licensees to address their respective conditions.....	42

<i>Recommendation 7 – Add a cross-reference to Colorado's provider network statute to section 12-35-116.5(1), C.R.S.....</i>	<i>44</i>
<i>Recommendation 8 – Give the Board the ability to suspend a licensee for failing to comply with a Board order.....</i>	<i>44</i>
<i>Recommendation 9 – Establish that failing to follow generally accepted standards for infection control is grounds for discipline.</i>	<i>45</i>
<i>Recommendation 10 – Grant the Board fining authority and direct the Board to promulgate rules establishing a uniform system and schedule of fines.</i>	<i>46</i>
<i>Recommendation 11 – Repeal the jurisprudence examination requirement.</i>	<i>47</i>
<i>Recommendation 12 – Repeal the requirement that applicants for a dental license by examination submit verification of all health care licenses.</i>	<i>48</i>
<i>Recommendation 13 – Create an inactive status for dental hygienists and allow retired dental hygienists to provide no-cost care to low-income patients.</i>	<i>49</i>
<i>Recommendation 14 – Repeal the requirement that letters of admonition be sent by certified mail.</i>	<i>49</i>
<i>Recommendation 15 – Establish failure to respond to a complaint as grounds for discipline.</i>	<i>50</i>
<i>Recommendation 16 – Repeal the provision disqualifying people with past felony convictions or Board discipline from serving on the Board.....</i>	<i>50</i>
<i>Recommendation 17 – Clarify that Board members may continue to serve until a replacement is appointed.</i>	<i>51</i>
<i>Recommendation 18 – Make technical changes to the Dental Practice Law.</i>	<i>51</i>

Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria¹ and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

¹ Criteria may be found at § 24-34-104, C.R.S.

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- Whether the agency through its licensing or certification process imposes any disqualifications on applicants based on past criminal history and, if so, whether the disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subparagraph (i) of paragraph (a) of subsection (8) of this section shall include data on the number of licenses or certifications that were denied, revoked, or suspended based on a disqualification and the basis for the disqualification; and
 - Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.colorado.gov/opr.

The regulatory functions of the State Board of Dental Examiners (Board) as enumerated in Article 35 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2014, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA to conduct an analysis and evaluation of the administration of the Board pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation of dentists and dental hygienists should be continued for the protection of the public and to evaluate the performance of the Board and staff of the Division of Professions and Occupations (Division). During this review, the Board and the Division must demonstrate that the regulation serves to protect the public health, safety or welfare, and that the regulation is the least restrictive regulation consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, DORA staff attended Board meetings, interviewed Division staff, reviewed Board records and minutes including complaint and disciplinary actions, interviewed officials with state and national professional associations, interviewed health care providers, reviewed Colorado statutes and Board rules, and reviewed the laws of other states.

Profile of the Professions

Dentists are health care practitioners focused on patients' oral health. They diagnose and treat problems with the teeth and gums and promote good oral hygiene. Dentists clean and remove decay from teeth, extract teeth, perform root canals, place crowns and dental implants, fill cavities, repair fractured teeth, and fit dentures and braces. Dentists also interpret X-rays, administer anesthesia to prevent patients from feeling pain during dental procedures, and prescribe analgesics, antibiotics or other medications.

All 50 states require dentists to be licensed. In order to qualify for a license, typically candidates must complete a four-year dental education program accredited by the Commission on Dental Accreditation (CODA), pass the national written licensing examination administered by the Joint Commission on National Dental Examinations (JCNDE), and demonstrate clinical competence.

There are 65 accredited dental education programs in the United States, including the University of Colorado, Denver's School of Dental Medicine. Accredited programs confer either a Doctorate of Dental Surgery (DDS) or Doctorate of Dental Medicine (DMD) degree.

The most typical method for demonstrating clinical competence is by passing a clinical examination where the candidate performs basic dental procedures on a patient. The candidate's work is then evaluated by several dentists. Currently, there are four different clinical examinations. While some states enumerate which clinical examination applicants for a license must take, many states, including Colorado, accept a passing score on any regional or state examination. A few states, including California and New York, allow candidates to demonstrate clinical competency by completing a post-graduate year of supervised clinical practice or by presenting a portfolio of clinical cases for review.

While most dentists are general practitioners and handle a wide variety of cases, dentists may choose to specialize in one of the following nine specialties:²

- Dental public health specialists promote good dental health in specified populations.
- Endodontists perform root-canal therapy, wherein dentists remove nerves and blood supply from injured or infected teeth.
- Oral pathologists diagnose diseases such as oral cancer.
- Oral and maxillofacial radiologists use imaging technology to diagnose diseases of the neck and head.
- Oral and maxillofacial surgeons operate on the mouth, jaws, teeth, neck, and head.
- Orthodontists straighten the teeth with braces or other appliances.
- Pediatric dentists provide dental services to children.
- Periodontists treat the gums and bone supporting the teeth.
- Prosthodontists replace missing teeth with fixtures, such as crowns, bridges, or dentures.

Most specialists must complete two to four years of additional education in their specialty area after dental school.

Dentists may work in their own practices, either as solo practitioners or in partnership with other dentists; as salaried associate dentists in large group practices; or, less commonly, in public health settings. In May 2010, the median annual wage for dentists was \$146,920.³ Earnings vary considerably according to a practitioner's years of experience, geographic location, and specialty area.

Dental hygienists provide preventative dental care, which includes cleaning teeth and applying sealants and fluoride treatments; examine patients for oral disease; and educate patients about oral hygiene.

As with dentists, all 50 states require dental hygienists to be licensed. Although licensing requirements vary from state to state, typically candidates must possess an associates' degree from a CODA-accredited dental hygiene program, pass the national written licensing examination administered by the JCNDE, and pass a patient-based clinical examination.

There are 336 accredited dental hygiene programs in the United States, four of which are located in Colorado.

² Bureau of Labor Statistics. *Occupational Outlook Handbook, 2012-13 Edition: Dentists*. Retrieved on September 18, 2013 from <http://www.bls.gov/ooh/healthcare/dentists.htm#tab-2>

³ Bureau of Labor Statistics. *Occupational Outlook Handbook, 2012-13 Edition: Dentists*. Retrieved on September 18, 2013 from <http://www.bls.gov/ooh/healthcare/dentists.htm#tab-5>

As with dentistry, there are numerous testing agencies that conduct patient-based clinical examinations for dental hygienists. Colorado accepts a passing score on any regional or state examination.

The level of supervision under which dental hygienists practice varies considerably from state to state, which affects the settings in which they may work. Dental hygienists typically work closely with dentists in dental offices. They may also work in public health settings. A few states, including Colorado, permit dental hygienists to practice independently.

In May 2010, the median wage for dental hygienists was \$68,250. Most dental hygienists—62 percent—worked part-time in 2010.⁴

The United States Bureau of Labor Statistics (BLS) projects that from now until 2020, employment opportunities for dentists and dental hygienists will grow much faster than the average for all occupations: 21 percent faster than average for dentists⁵ and 38 percent for dental hygienists.⁶

The BLS bases this projected increase on numerous factors. First, baby boomers are more likely than previous generations to keep their teeth as they age, meaning that they will require more dental care to maintain their oral health. Second, as research continues to establish the link between oral health and overall health, the demand for dental services will likely grow. Third, the popularity of cosmetic dental procedures, such as teeth-whitening treatments, will likely continue to grow as such procedures become less time-consuming and invasive.

⁴ Bureau of Labor Statistics. *Occupational Outlook Handbook, 2012-13 Edition: Dental Hygienists*. Retrieved on September 18, 2013 from <http://www.bls.gov/ooh/healthcare/dental-hygienists.htm#tab-5>

⁵ Bureau of Labor Statistics. *Occupational Outlook Handbook, 2012-13 Edition: Dentists*. Retrieved on September 18, 2013 from <http://www.bls.gov/ooh/healthcare/dentists.htm#tab-6>

⁶ Bureau of Labor Statistics. *Occupational Outlook Handbook, 2012-13 Edition: Dental Hygienists*. Retrieved on September 18, 2013 from <http://www.bls.gov/ooh/healthcare/dental-hygienists.htm#tab-6>

Legal Framework

History of Regulation

The General Assembly established the regulation of dentists in Colorado on March 15, 1889, when it created the five-member State Board of Dental Examiners (Board), and established a fine of up \$500 for practicing dentistry without a license.

In 1891, a requirement was added that dentists had to graduate from a United States or foreign school of dentistry. Through the first quarter of the 20th century, there was no restriction on who could extract teeth.

In 1919, the General Assembly defined the practice of dentistry and established a dental hygiene license.

In 1929, the Colorado Supreme Court ruled against the corporate practice of dentistry. In 1935, the General Assembly responded to this decision by allowing the practice of dentistry in a partnership. In 1961, the General Assembly added statutory language that granted dentists the right to prescribe drugs and administer general and local anesthesia.

In 1971, the statute defined dental “auxiliaries” as any person not a dentist or dental hygienist licensed in Colorado who may be assigned or delegated to perform dental tasks or procedure. Accordingly, dentists were also granted authority to delegate tasks.

An important change came in 1979, when the General Assembly amended the statute to allow dental hygienists to practice in various settings without the personal direction of a dentist.

Following the 1985 sunset review of the Board, the General Assembly made several changes to the law. The 1986 legislation increased the total number of Board members from eight to nine and changed the Board composition from five dentists, two dental hygienists and one public member to four dentists, two dental hygienists and three public members. The bill also empowered the Board to determine, by rule, the minimum training and equipment requirements for the administration of anesthesia and certain forms of sedation.

Following the 1995 sunset review of the Board, the General Assembly passed Senate Bill 96-087. The bill added another dentist member to the Board, bringing the total number of Board members to 10; created a process for licensure by endorsement; and granted the Board authority to issue confidential letters of concern to licensees. The bill also updated the list of tasks that cannot be delegated to dental auxiliaries, expanded the grounds for discipline against dentists and hygienists, and created a “retired” license status for dentists and hygienists.

The General Assembly passed House Bill 1102 in 2004. Among other changes, the bill increased the Board size from 10 to 13 members by adding seats for two dentists and one dental hygienist; granted the Board the authority to convene panels to consider licensing and disciplinary matters; and expanded the list of clinical examinations accepted for licensure.

Senate Bill 212, passed in 2006, gave dental hygienists the ability to enter into agreements with dentists for the shared lease or rental of equipment or office space.

With the passage of House Bill 1134 in 2007, the General Assembly permitted non-profit organizations to own and operate dental or dental hygiene practices, provided such practices served low-income populations and met other specific requirements.

In 2009, the General Assembly passed two bills amending the dental law. House Bill 1128 created a licensing process for dentists practicing solely in academic settings. Senate Bill 129 added “dental hygiene diagnosis” to the scope of practice of dental hygienists.

Colorado Dental Practice Law

The laws governing the regulation of dentists and dental hygienists in Colorado are housed within Article 35 of Title 12, Colorado Revised Statutes (C.R.S.), and are known collectively as the “Dental Practice Law of Colorado”⁷ (Law).

The State Board of Dental Examiners (Board) is vested with the authority to regulate dentists and dental hygienists in Colorado.⁸ The Board is composed of 13 Governor-appointed members: seven dentists, three dental hygienists, and three public members.⁹ When considering Board appointments, the Governor must take into account the geographical, political, urban, and rural balance among Board members.¹⁰

All Board members must be legal residents of Colorado. The dentist and dental hygienist members must hold a current Colorado license and have been actively engaged in clinical practice for at least five years immediately preceding appointment to the Board.¹¹ The Law bars anyone who has been convicted of a felony or a violation of any law governing the practice of dentistry from serving on the Board.¹²

Every year, the Board elects from among its members a chairperson and a vice-chairperson. The Board must meet at least quarterly.¹³

⁷ § 12-35-101, C.R.S.

⁸ § 12-35-104(1)(a), C.R.S.

⁹ § 12-35-104(1)(b), C.R.S.

¹⁰ § 12-35-104(1)(a), C.R.S.

¹¹ § 12-35-105(1), C.R.S.

¹² § 12-35-105(2), C.R.S.

¹³ § 12-35-104(2), C.R.S.

The powers and duties of the Board include:¹⁴

- Conducting examinations to assure the qualifications of applicants for dentist and dental hygienist licenses;
- Granting, issuing, and renewing licenses;
- Promulgating rules as necessary;
- Conducting hearings to take disciplinary action against people who violate the Law;
- Conducting investigations and inspections; and
- Issuing anesthesia permits to licensed dentists.

To facilitate the licensure process, the Board may establish a subcommittee of at least six Board members to address licensing functions.¹⁵ The Board is not authorized to arbitrate fee disputes.¹⁶

Scope of Practice

The Law defines “dentistry” as:¹⁷

the evaluation, diagnosis, prevention, or treatment, including nonsurgical, surgical, or related procedures, of diseases, disorders, or conditions of the oral cavity, maxillofacial area, or the adjacent and associated structures and the impact of the disease, disorder, or condition on the human body so long as a dentist is practicing within the scope of his or her education, training, and experience and in accordance with applicable law.

The law further includes the following within the practice of dentistry:¹⁸

- Performing, or attempting or professing to perform, any dental operation, oral surgery, or dental diagnostic or therapeutic services of any kind;
- Serving as a proprietor of a place where dental operation, oral surgery, or dental diagnostic or therapeutic services are performed;
- Taking impressions of the human teeth, jaws, maxillofacial area, or adjacent and associated structures, performing any phase of any operation incident to the replacement of a part of a tooth, or supplying artificial substitutes for the natural teeth, jaws, or adjacent and associated structures;
- Furnishing, constructing, or repairing any prosthetic denture, bridge, or other structure to be worn in the human mouth or upon the jaws, maxillofacial area, or adjacent and associated structures or placing, adjusting, or attempting or professing to adjust such an appliance or structure;
- Professing to the public to furnish, supply, construct, reproduce, or repair any prosthetic denture, bridge, appliance, or other structure;

¹⁴ § 12-35-107(1), C.R.S.

¹⁵ § 12-35-107(3), C.R.S.

¹⁶ § 12-35-108, C.R.S.

¹⁷ § 12-35-103(5), C.R.S.

¹⁸ § 12-35-113(1), C.R.S.

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- Examining, diagnosing, planning treatment of, or treating natural or artificial structures or conditions associated with, adjacent to, or functionally related to the oral cavity, jaws, maxillofacial area, or adjacent and associated structures and their impact on the human body;
 - Extracting, or attempting to extract, human teeth or correcting, or attempting to correct, malformations of human teeth or jaws;
 - Repairing or filling cavities in human teeth;
 - Prescribing dental X-rays or giving, or professing to give, interpretations or readings of such dental X-rays, computerized tomography (CT) scans, or other diagnostic methodologies;
 - Representing oneself as practicing dentistry, by using the words "dentist" or "dental surgeon," or by using the letters "D.D.S.," "D.M.D.," "D.D.S./M.D.," or "D.M.D./M.D.";
 - Stating, permitting to be stated, or professing by any means or method whatsoever that a person can perform or will attempt to perform dental operations or render a diagnosis;
 - Prescribing such drugs or medications and administering such general or local anesthetics, anesthesia, or analgesia as may be necessary for the proper practice of dentistry;
 - Prescribing, inducing, and setting dosage levels for inhalation analgesia; and
 - Giving or professing to give interpretations or readings of dental charts or records or giving treatment plans or interpretations of treatment plans derived from examinations and patient records.

The Law defines “dental hygiene” as:¹⁹

the delivery of preventive, educational, and clinical services supporting total health for the control of oral disease and the promotion of oral health provided by a dental hygienist within the scope of his or her education, training, and experience and in accordance with applicable law.

Dental hygienists may perform the following tasks independently (without dentist supervision), provided such tasks are within the scope of their education, training, and experience:²⁰

- Removing deposits, accretions, and stains from all surfaces of the tooth and smoothing and polishing natural and restored tooth surfaces, including root planing;
- Removing granulation and degenerated tissue from the gingival wall of the periodontal pocket;
- Providing preventive measures including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease;

¹⁹ § 12-35-103(4), C.R.S.

²⁰ § 12-35-124(1), C.R.S.

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- Gathering and assembling information including:
 - Fact-finding and patient history;
 - Preparation of study casts for the purpose of fabricating a permanent record of the patient's present condition;
 - Extra- and intra-oral inspection;
 - Dental and periodontal charting; and
 - Taking X-rays;
 - Administering topical anesthetic to patients in the course of providing dental care;
 - Performing dental hygiene assessment, dental hygiene diagnosis, and dental hygiene treatment planning for dental hygiene services and identifying dental abnormalities for immediate referral to a dentist; and
 - Administering fluoride, fluoride varnish, and antimicrobial solutions for mouth rinsing.

There are additional tasks dental hygienists may perform under indirect dentist supervision. Under indirect supervision, the dentist does not need to be on the premises where these procedures are being performed: rather, the procedures must be performed with the dentist's prior knowledge and consent.²¹ The additional tasks that dental hygienists may perform under indirect supervision include:

- Performing gingival curettage that includes the incidental removal of live epithelial tissue;²²
- Administering local anesthetic,²³ provided they have completed the additional didactic and clinical training specified in rule;²⁴ and
- Any dental task or procedure that is assigned by a licensed dentist and does not require the professional skill of a licensed dentist.²⁵

Although Colorado law does not require dental assistants to meet specific qualifications, it does define the tasks dental assistants may perform. Under indirect supervision, dental assistants may.²⁶

- Smooth and polish natural and restored tooth surfaces;
- Provide preventative measures, including the application of fluoride and other topical agents;
- Gather and assemble information, including fact-finding and patient history, performing oral inspections and dental and periodontal charting;
- Administer topical anesthetics to patients; and
- Repair dentures pursuant to a laboratory work order signed by a licensed dentist.²⁷

²¹ § 12-35-103(10)(a), C.R.S.

²² § 12-35-125(1)(b), C.R.S.

²³ § 12-35-125(1)(f), C.R.S.

²⁴ 3 CCR 709-1, Rule XIV (H).

²⁵ § 12-35-128(2), C.R.S.

²⁶ § 12-35-128(3)(b), C.R.S.

²⁷ § 12-35-128(4), C.R.S.

Under direct supervision—in which the dentist is actually present on the premises where the task is being performed²⁸—dental assistants may also:²⁹

- Administer nitrous oxide to a patient, and monitor its use; and
- Perform tasks needed for the fabrication of complete or partial dentures.

In the case of tasks related to denture fabrication, the Law prohibits dentists from using more dental assistants than they can reasonably supervise and holds dentists personally liable for the patient care provided by dental assistants under their supervision.³⁰

All unlicensed personnel (including dental assistants) who expose patients to ionizing radiation—i.e., those who take X-rays—must complete at least eight hours of instruction as specified in rule. Licensed dentists or hygienists must ensure that unlicensed personnel complete the training within three months of hire.³¹

Although the Law gives dentists considerable latitude in delegating dental tasks, the licensed dentist maintains sole responsibility for dental diagnosis, treatment planning, and prescription of therapeutic measures. Further, prescriptive authority, and any procedure involving surgery or that will contribute to or result in irremediable alteration of the oral anatomy, may not be delegated to anyone other than a licensed dentist.³²

Licensing

Colorado has a mandatory practice act, meaning that in order to practice dentistry or dental hygiene, a person must be licensed, except that dental assistants may perform certain procedures as defined by law.³³

Applicants may apply for licensure by examination or by endorsement.

To qualify for a dentist license, applicants must submit an application, pay a fee, and:³⁴

- Be at least 21 years old;
- Have graduated from an accredited dental school;
- Submit proof of having passed:³⁵
 - The examination administered by the Joint Commission on National Dental Examinations (JCNDE);
 - A jurisprudence examination designed to test applicants' knowledge of the Law; and
 - An examination designed to test clinical skills and knowledge;

²⁸ § 12-35-103(6), C.R.S.

²⁹ § 12-35-128(3)(c) and (d) C.R.S.

³⁰ § 12-35-128(3)(d)(III) C.R.S.

³¹ 3 CCR 709-1, Rule X.

³² § 12-35-128(1), C.R.S.

³³ § 12-35-112, C.R.S.

³⁴ § 12-35-117(1), C.R.S.

³⁵ § 12-35-119(1), C.R.S.

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- Provide information on any pending or final disciplinary actions taken against them in other states and any acts they have committed which would be grounds for disciplinary action under Colorado law;
 - Provide verification of licensure from other jurisdictions where they hold or have held a dental or other health care license; and
 - Meet any more stringent criteria established by the Board.

Applicants for license by endorsement must meet all of the qualifications above, and provide proof that they hold a current license in another state and that they are professionally competent. The ways that applicants may prove competency include documenting active clinical practice or teaching in an accredited dental school.³⁶

Dentists who practice dentistry in the course of employment at an accredited dental school may apply for an academic license. Applicants for an academic license must provide proof that they graduated from a United States or foreign dental school and are employed by an accredited Colorado dental school, and pass the jurisprudence examination.³⁷ Holders of academic licenses may practice dentistry only in the performance of their official duties as employees of the dental school.³⁸

To qualify for a dental hygienist license, applicants must submit an application, pay a fee, and:³⁹

- Have graduated from an accredited school of dental hygiene that was at least two academic years long;
- Provide information on any acts they have committed which would be grounds for disciplinary action under Colorado law; and
- Submit proof of having passed:⁴⁰
 - The examination administered by the JCNDE;
 - A jurisprudence examination; and
 - An examination designed to test clinical skills and knowledge.

Applicants for license by endorsement must meet all of the qualifications above, provide verification of licensure from any other jurisdiction where they are licensed, and document that they have maintained professional competency by teaching, clinical practice, or other means determined by the Board.⁴¹

³⁶ § 12-35-120(2), C.R.S.

³⁷ § 12-35-117.5(2), C.R.S.

³⁸ § 12-35-117.5(4), C.R.S.

³⁹ § 12-35-126(1), C.R.S.

⁴⁰ § 12-35-127(1), C.R.S.

⁴¹ § 12-35-127(3)(b)(III)(A), C.R.S.

Dentists who no longer wish to practice in Colorado may apply to have their licenses transferred to either inactive⁴² or retired⁴³ status. Dentists in inactive status cannot practice in Colorado at all,⁴⁴ while dentists in retired status may provide dental services to the indigent on a limited basis, as long as they do not charge a fee for their services.⁴⁵

Dental hygienists may also apply for retired status,⁴⁶ but may not practice while their licenses are in retired status.⁴⁷

As a condition of active licensure, dentists must maintain commercial professional liability insurance coverage in a minimum indemnity amount of \$500,000 per incident and \$1.5 million aggregate per year.⁴⁸ Dental hygienists must hold coverage either on their own or through their supervising dentist in the amount of at least \$50,000 per incident and \$300,000 aggregate per year.⁴⁹

People exempt from the licensing requirement include:⁵⁰

- Licensed physicians, unless the physician practices dentistry as a specialty;
- Anesthetists or registered nurses administering anesthetic for a dental operation under the direct supervision of a dentist;
- Graduate dentists, dental surgeons or dental hygienists practicing in their official duties in the United States armed forces, public health service, Coast Guard, or Veterans Administration;
- Instructors, students, or residents participating in accredited schools of dentistry, dental hygiene, dental assisting, or in advanced dental education programs;
- Dentists or dental hygienists licensed in other states or countries appearing in programs of dental education or research or providing service on a volunteer basis, so long as such practice is limited to no more than five consecutive days in a 12-month period;
- Any person or entity filling a licensed dentist's laboratory work order for the construction, reproduction, or repair of prosthetic dentures, bridges, plates, or appliances;
- People working under the direct or indirect supervision of a licensed dentist when authorized by the Law or Board rules; and
- Examiners representing a Board-approved testing agency during the administration of an examination.

⁴² § 12-35-122(1), C.R.S.

⁴³ § 12-35-123(1), C.R.S.

⁴⁴ § 12-35-122(1)(a), C.R.S.

⁴⁵ § 12-35-123(6), C.R.S.

⁴⁶ § 12-35-123(1), C.R.S.

⁴⁷ 3 CCR 709-1, Rule III A (6).

⁴⁸ § 13-64-301, C.R.S.

⁴⁹ § 12-35-127(4), C.R.S.

⁵⁰ § 12-35-115(1), C.R.S.

Anesthesia

A basic dental license allows dentists to administer local anesthesia, provide analgesics such as ibuprofen, prescribe and administer medications to relieve patients' pain or anxiety, and administer nitrous oxide.⁵¹ Dentists who wish to perform minimal, moderate or deep sedation/general anesthesia must apply to the Board and document specific additional education and experience.⁵²

Under Board rule, neither the medications used nor the route of administration determines the level of anesthesia administered. Rather, the level of anesthesia may be determined by the patient's level of consciousness and responsiveness, and the anesthesia's effect on the patient's airway and respiratory and cardiovascular function.⁵³

Board Rule defines minimal sedation as:⁵⁴

A minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.

To obtain minimal sedation privileges, a dentist must complete either a residency in minimal sedation recognized by the Commission on Dental Accreditation (CODA) or 16 hours of Board-approved coursework in minimal sedation.⁵⁵

Board Rule defines moderate sedation as:⁵⁶

A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

To obtain moderate sedation privileges, dentists must complete either a CODA-recognized residency in moderate sedation or take 60 hours of Board-approved coursework in moderate sedation and submit documentation for 20 sedation cases.⁵⁷

⁵¹ 3 CCR 709-1, Rule XIV, E. 1.

⁵² 3 CCR 709-1, Rule XIV, F.

⁵³ 3 CCR 709-1, Rule XIV, B.

⁵⁴ 3 CCR 709-1, Rule XIV, C. 4.

⁵⁵ 3 CCR 709-1, Rule XIV, I.

⁵⁶ 3 CCR 709-1, Rule XIV, C. 5.

⁵⁷ 3 CCR 709-1, Rule XIV, J. 2.

Board Rule defines deep sedation as:⁵⁸

A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

Board Rule defines general anesthesia as:⁵⁹

A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

To obtain a deep sedation/general anesthesia permit, dentists must complete either a residency program in general anesthesia or a post-doctoral training program that provides comprehensive training commensurate with American Dental Association guidelines.⁶⁰

Within 90 days of applying for moderate sedation privileges or a deep sedation/general anesthesia permit, the applicant must retain a Colorado-licensed anesthesiologist, certified nurse anesthetist, or dentist with a deep sedation/general anesthesia permit to conduct a clinical, on-site inspection of the applicant's office. During the inspection, the inspector must ensure that the office has adequate office equipment, records, and emergency procedures, and observe at least one case where the dentist administers anesthesia at the level commensurate with that of the permit for which he or she is applying.⁶¹

Minimal sedation privileges, moderate sedation privileges, and deep sedation/general anesthesia permits are valid for five years and must be renewed.⁶²

⁵⁸ 3 CCR 709-1, Rule XIV, C. 6.

⁵⁹ 3 CCR 709-1, Rule XIV, C. 6.

⁶⁰ 3 CCR 709-1, Rule XIV, K.

⁶¹ 3 CCR 709-1, Rule XIV, L.

⁶² 3 CCR 709-1, Rule XIV, F3, 4 and 5.

With additional training, dental hygienists may administer local anesthetic under a dentist's indirect supervision. To qualify for local anesthesia privileges, dental hygienists must complete 12 hours of didactic training in areas specified in rule and complete 12 hours of clinical training wherein they administer at least six infiltration and six block injections.⁶³ Local anesthesia privileges are issued once and remain active as long as the dental hygienist maintains an active license.⁶⁴

Provided they have completed the appropriate training, dental hygienists may administer nitrous oxide under the direct supervision of a licensed dentist. The supervising dentist is responsible for ensuring that the training is sufficient.⁶⁵ A separate permit or privilege is not required.

Practice Ownership

Only a Colorado-licensed dentist may own a dental practice in Colorado, and only Colorado-licensed dentists or dental hygienists may own a dental hygiene practice,⁶⁶ with a few notable exceptions.

A non-profit organization may own a dental or dental hygiene practice if the organization meets the federal definition of a community health center or if at least 50 percent of the patients served by the practice are low-income. Cities, counties, special districts, and other political subdivisions of the state may also own dental or dental hygiene practices.⁶⁷

The Law establishes that it is grounds for discipline for a dentist or dental hygienist to practice as a partner, agent, or employee of or in joint venture with, any unlicensed person, or any partnership, association, or corporation. However, licensed dentists and dental hygienists may form business partnerships with unlicensed people by participating in provider networks.⁶⁸

In all of these cases, the practice ownership must not affect the exercise of independent professional judgment of the dentists or dental hygienists providing patient care.⁶⁹

⁶³ 3 CCR 709-1, Rule XIV, H.

⁶⁴ 3 CCR 709-1, Rule XIV, F.

⁶⁵ 3 CCR 709-1, Rule XIV, G.

⁶⁶ § 12-35-116.5(1), C.R.S.

⁶⁷ §§ 12-35-116.5(1)(c), C.R.S.

⁶⁸ § 6-18-303(2), C.R.S.

⁶⁹ §§ 12-35-116.5(1)(c(III)) and 6-18-303(2)(a), (b), and (c), C.R.S.

Enforcement and Disciplinary Actions

The Board may take disciplinary action against the license of any dentist or dental hygienist who has violated the Law. Grounds for discipline include:⁷⁰

- Using fraud, misrepresentation, or deception in applying for, renewing, or seeking reinstatement of a license;
- Having been convicted of a felony or any crime that would constitute a violation of the Law;
- Administering, dispensing, or prescribing any habit-forming drug or any controlled substance other than in the course of legitimate professional practice;
- Habitually abusing or excessively using any habit-forming drug or any controlled substance or alcohol;
- Having a physical or mental disability that renders the licensee unable to perform dental or dental hygiene services with reasonable skill and with safety to the patient;
- Advertising in a manner that is misleading, deceptive, or false;
- Refusing to make patient records available to a patient pursuant to a written authorization-request;
- Engaging in false billing, including performing one dental or dental hygiene service and billing for another, billing for any service not rendered, and committing a fraudulent insurance act;
- Failure of a dental hygienist to refer a patient to a dentist when he or she detects a condition that requires care beyond the dental hygiene scope of practice;
- Ordering or performing, without clinical justification, any service, X-ray, or treatment that is contrary to recognized standards of the practice of dentistry or dental hygiene;
- Failing to adequately supervise unlicensed persons;
- Engaging in any conduct that constitutes a crime, where the conduct relates to the licensee's practice as a dentist or dental hygienist; and
- Practicing outside the scope of dental or dental hygiene practice.

Anyone may file a complaint against a dentist or dental hygienist. Complaints must be submitted in writing.⁷¹

The Board is split into two panels of six members each for the purpose of reviewing complaints.⁷² The Board chair may elect to participate on either panel. Each panel acts as both an inquiry and a hearing panel: a complaint referred to one panel for investigation is heard by the other panel if it is referred for a formal hearing.⁷³

⁷⁰ § 12-35-129(1), C.R.S.

⁷¹ § 12-35-129(6), C.R.S.

⁷² § 12-35-129(12)(a), C.R.S.

⁷³ § 12-35-129(12)(b), C.R.S.

If the Board finds that a dentist or dental hygienist has violated the Law, it may suspend, revoke, or censure the license, issue a letter of admonition, or place the licensee on probation.⁷⁴ Disciplinary orders that allow licensees to continue to practice may impose restrictions on the license or require licensees to undergo examinations evaluating their physical and mental health, attend therapy, obtain additional education or training, or submit to practice monitoring.⁷⁵

If an investigation reveals conduct on the part of a dentist or dental hygienist that does not warrant formal disciplinary action but might lead to serious consequences if not corrected, the Board issues a confidential letter of concern.⁷⁶

Peer Assistance Program

All Colorado-licensed dentists are entitled to use the services of a peer assistance program selected by the Board. Administered by a non-profit organization, the peer assistance program educates dentists on recognizing and preventing physical, emotional, and psychological problems; evaluates and offers assistance to dentists experiencing such problems; and monitors dentists who have been referred for treatment.⁷⁷

Dentists may enroll in the program directly or the Board may refer dentists to the program in lieu of taking disciplinary action. Board-referred participants must enter into a written agreement with the program that outlines the specific requirements for successful completion of the program. The agreement must also include a provision stating that failing to comply with the terms of the agreement will result in disciplinary action.⁷⁸

The program is funded by a fee that is included in the renewal fee for licensed dentists. The fee is capped at \$100 per year per licensee.⁷⁹

⁷⁴ § 12-35-129(1), C.R.S.

⁷⁵ § 12-35-129(7)(g), C.R.S.

⁷⁶ § 12-35-129(7)(f), C.R.S.

⁷⁷ § 12-35-138(1)(b), C.R.S.

⁷⁸ § 12-35-138(2)(a), C.R.S.

⁷⁹ § 12-35-138(1)(a), C.R.S.

Program Description and Administration

The State Board of Dental Examiners (Board) is vested with the authority to regulate dentists and dental hygienists in Colorado. Article 35 of Title 12, Colorado Revised Statutes (C.R.S.), which creates the Board and establishes its powers and responsibilities, is known as the Dental Practice Law (Law).

The 13-member Board meets quarterly. Board meetings typically address rulemaking, general policy matters and issues relevant to the professions of dentistry and dental hygiene. The Board is divided into two panels of six members each (with the Board chair serving on either panel) to address disciplinary matters. The panels—Panel A and Panel B—meet about every five weeks.

The Division of Professions and Occupations within the Colorado Department of Regulatory Agencies (Division and DORA, respectively) provides administrative and managerial support to the Board.

Table 1 illustrates, for the five fiscal years indicated, the expenditures and staff associated with the Board.

Table 1
Agency Fiscal Information

Fiscal Year	Total Program Expenditure	FTE
07-08	\$982,438	3.55
08-09	\$1,174,277	3.55
09-10	\$1,101,973	3.60
10-11	\$1,016,488	3.60
11-12	\$916,971	3.60

According to Division staff, the increase in program expenditures from fiscal year 07-08 to 08-09 corresponds with an increase in legal services costs related to clearing a backlog of cases. As the cases were resolved, program expenditures gradually decreased.

On July 1, 2013, there were 3.2 full-time equivalent employees (FTE) allocated to the Board, including:

- General Professional VI (Program Director) = 0.45 FTE: Manages the day-to-day operations of the program, advises and assists the Board, and implements Board decisions.
- General Professional III = 0.6 FTE: Processes disciplinary actions, monitors licensee compliance, and reports disciplinary actions to appropriate agencies.
- Technician IV = 0.15 FTE: Processes initial decisions, administers public notices for rulemaking, and arranges travel for Board members and staff.
- Technician III = 1.0 FTE: Processes complaints and drafts enforcement correspondence.
- Administrative Assistant III = 1.0 FTE: Handles incoming calls, handles licensing applications involving “yes” answers to screening questions (concerning drugs/convictions/discipline in another state, and so on), processes anesthesia applications, coordinates Board meetings, and drafts Board minutes.

This number does not include employees in the centralized offices of the Division, which provide management, licensing, administrative, technical, and investigative support to the Board. However, the cost of those employees is reflected in the Total Program Expenditures.

Table 2 shows the fees the Board charges for licenses and permits.

**Table 2
State Board of Dental Examiners Fees**

Type of Fee	Dentist	Dental Hygienist
Original License (any method)*	\$405	\$150
Renewal—Active License	\$412	\$86
Renewal—Inactive License	\$394	Not applicable
Renewal—Retired License	\$28	\$28
Late Fee (for renewals after the expiration date)	\$15	\$15
Reinstatement	\$427	\$101
Reinstatement—Academic License	\$395	Not applicable
Status Change to Retired	\$20	\$20
Reactivation	\$322	Not applicable
Deep Sedation/General Anesthesia Permit	\$75	Not applicable
Duplicate Computer License	\$5	\$5

*Includes academic licenses

The Board currently charges no fees for minimal or moderate sedation privileges for dentists or local anesthesia permits for dental hygienists—even though there are costs associated with issuing these privileges/permits—because the statute does not explicitly allow the Board to collect such fees.

The renewal, reinstatement, and original license fees for dentists include an \$80 surcharge to fund the peer assistance program.

Pursuant to section 24-34-105, Colorado Revised Statutes, fees are subject to change every July 1.

Licensing

There are two routes to licensure in Colorado: by examination and by endorsement. Applicants must complete the appropriate application and submit it with all supporting documentation to the Division's Office of Licensing. A licensing specialist reviews the application and notifies the applicant of any deficiencies. Once the application is complete, a licensing specialist evaluates the application to ensure the applicant meets the requirements. If requirements are met, the license is issued. If not, the licensing specialist notifies the applicant in writing, and the application is kept on file for one year.

Table 3 illustrates, for the five fiscal years indicated, the number of new dentist and dental hygienist licenses issued.

**Table 3
New Licenses**

Fiscal Year	Dentists	Academic Dentists*	Dental Hygienists
07-08	266	--	236
08-09	252	--	240
09-10	270	4	217
10-11	249	3	264
11-12	268	1	252

*The Division began issuing academic licenses in 2009.

The number of new licenses issued for both dentists and dental hygienists has remained relatively stable over the past five years.

Table 4 illustrates the total number of licensed dentists and dental hygienists for the five fiscal years indicated.

**Table 4
Total Number of Licensees**

Fiscal Year	Dentists	Dental Hygienists
07-08	4,600	3,774
08-09	4,880	4,072
09-10	4,677	4,042
10-11	4,982	4,297
11-12	4,861	4,245

The total numbers of both dentists and dental hygienists have remained stable over the five-year reporting period.

Dental and dental hygiene licenses must be renewed every two years. They expire on the last day of February of even-numbered years.

Table 5 shows the total number of licensed dentists and dental hygienists, as well as the number of anesthesia permit/privilege holders, as of July 2013.

Table 5
Number of Licenses and Permit/Privilege Holders, July 2013

	Dentists	Dental Hygienists
Active licenses	4,833	4,378
Inactive licenses	28	Not applicable
Retired licenses	228	111
Academic licenses	12	Not applicable
Minimal sedation privileges	146	Not applicable
Moderate sedation privileges	164	Not applicable
Deep sedation/ general anesthesia permits	136	Not applicable
Local anesthesia permits	Not applicable	3,353

About 76 percent of dental hygienists hold local anesthesia permits. A comparatively small number of dentists—about nine percent—hold advanced anesthesia privileges.

Examinations

National Board Examinations

In order to qualify for a license, prospective dentists must pass a national written examination developed by the Joint Commission on National Dental Examinations (JCNDE). The National Board Dental Examination (NBDE) is computer-based and consists of two parts.

Part I has 400 multiple choice items, with 100 questions for each of these four disciplines: Anatomic Sciences, Biochemistry-Physiology, Microbiology-Pathology, and Dental Anatomy and Occlusion.⁸⁰ Part I costs \$355⁸¹ and candidates have seven hours to complete it.⁸²

⁸⁰ *NBDE Part I Guide*, Joint Commission on National Dental Examinations (2012), p. 19.

⁸¹ *NBDE Part I Guide*, Joint Commission on National Dental Examinations (2012), p. 7.

⁸² *NBDE Part I Guide*, Joint Commission on National Dental Examinations (2012), p. 8.

In order to be eligible to sit for Part I of the NBDE, a person must be a current student in or graduate of an accredited dental school. Students who are enrolled in or graduates of non-accredited schools may qualify to sit for Part I if they provide additional documentation.⁸³

Part II has a discipline-based component and a case-based component. The discipline-based component consists of 400 questions covering the following disciplines:⁸⁴

- Endodontics
- Operative Dentistry
- Oral and Maxillofacial Surgery / Pain Control
- Oral Diagnosis
- Orthodontics / Pediatric Dentistry
- Patient Management
- Periodontics
- Pharmacology
- Prosthodontics

The case-based component presents specific cases where the candidate must evaluate numerous aspects of a patient's care. This component includes a total of 100 questions, with about 10 to 15 questions about each case. The questions may relate to any of the basic sciences and clinical disciplines.⁸⁵

Part II costs \$400 and is administered over a two-day period: candidates have seven hours to complete the discipline-based component and three-and-a-half hours to complete the case-based component.⁸⁶

In order to be eligible to sit for the NBDE Part II, candidates must have passed Part I.⁸⁷

Prometric administers both parts of the NBDE at many test locations nationwide. There are four testing sites in Colorado: Colorado Springs, Grand Junction, Greenwood Village, and Longmont.

⁸³ *NBDE Part I Guide*, Joint Commission on National Dental Examinations (2012), pp. 3-4.

⁸⁴ *NBDE Part II Guide*, Joint Commission on National Dental Examinations (2012), p. 21.

⁸⁵ *NBDE Part II Guide*, Joint Commission on National Dental Examinations (2012), p. 21.

⁸⁶ *NBDE Part II Guide*, Joint Commission on National Dental Examinations (2012), p. 9.

⁸⁷ *NBDE Part II Guide*, Joint Commission on National Dental Examinations (2012), p. 4.

Table 6 indicates the number of NBDE examinations administered to first-time test takers and the corresponding pass rates for the five fiscal years indicated. Pass rates specific to Colorado candidates were not available.

Table 6
Written Dental Examinations for First-Time Test Takers

Calendar Year	Written Examinations	Pass Rate (%)
National Board Dental Examination: Part I		
2008	4,697	92.6
2009	4,881	94.7
2010	4,923	94.7
2011	5,068	95.5
2012	Not available	93.9
National Board Dental Examination: Part II		
2008	4,721	94.7
2009	4,726	86.3
2010	4,945	89.4
2011	5,312	94.9
2012	Not available	94.4

Although NBDE administrators were able to provide the 2012 pass rates, they declined to provide the number of test-takers. The number of test-takers and the official 2012 pass rates will be published in the NBDE Technical Report in April 2014.

The pass rates for both examinations are consistently high, averaging about 94 percent for Part I and 92 percent for Part II over the five-year reporting period.

Dental hygienists must also pass a national written examination administered by the JCNDE. The National Board Dental Hygiene Examination (NBDHE) is a multiple-choice, computer-based examination consisting of two components:⁸⁸

- Component A includes 200 items addressing three major areas: Scientific Basis for Dental Hygiene Practice (60 items), Provision of Clinical Dental Hygiene Services (116 items), and Community Health/Research Principles (24 items).⁸⁹
- Component B includes 150 case-based questions about 12 to 15 dental hygiene patient cases.⁹⁰

Candidates have three-and-a-half hours to complete Component A and four hours to complete Component B.⁹¹

⁸⁸ *NBDHE Guide*, Joint Commission on National Dental Examinations (2012), p. 19.

⁸⁹ *NBDHE Guide*, Joint Commission on National Dental Examinations (2012), pp. 20-22.

⁹⁰ *NBDHE Guide*, Joint Commission on National Dental Examinations (2012), p. 19.

⁹¹ *NBDHE Guide*, Joint Commission on National Dental Examinations (2012), p. 9.

The examination costs \$390.⁹² Pearson Vue administers the NBDHE at many locations nationwide, including three in Colorado, located in Greenwood Village, Pueblo, and Westminster.

Table 7 indicates the number of NBDHE examinations administered to first-time test takers and the corresponding pass rates for the five fiscal years indicated. Pass rates specific to Colorado candidates were not available.

Table 7
Examinations for Colorado Dental Hygienist Applicants

Calendar Year	Written Examinations	Pass Rate (%)
2008	6,770	95.0
2009	6,708	95.8
2010	6,828	96.2
2011	6,968	94.8
2012	Not available	95.8

Although NBDHE administrators were able to provide the 2012 pass rates, they declined to provide the number of test-takers. The number of test-takers and the official 2012 pass rates will be published in the NBDHE Technical Report in April 2014.

As with the dental examination, the pass rates for the NBDHE is consistently high, averaging 95.5 percent over the five-year reporting period.

Clinical Examinations

In addition to taking a national examination to qualify for a license, Colorado requires prospective dentists to pass an examination designed to test their clinical skills and knowledge.

Historically, five regional testing agencies comprised of state boards of dentistry have developed and administered separate but substantially similar examinations. Those regional testing agencies include:

- Central Regional Dental Testing Services, Inc. (CRDTS);
- Council of Interstate Testing Agencies, Inc. (CITA);
- North East Regional Board of Dental Examiners, Inc. (NERB);
- Southern Regional Testing Agency (SRTA); and
- Western Regional Examining Board (WREB).

A few states—including California, Delaware, Florida, and Nevada—independently developed and administered their own clinical examinations.

⁹² *NBDHE Guide*, Joint Commission on National Dental Examinations (2012), p. 8.

Growing national interest in developing a single, uniform clinical examination led to the formation, in 2004, of the American Board of Dental Examiners (ADEX). The ADEX examination has replaced some, but not all, of the regional and state examinations. At this writing, 30 jurisdictions (29 states and the District of Columbia) were members of ADEX and 41 jurisdictions accepted the ADEX examination for licensure.

ADEX is solely a test development organization, not an examination administration entity, so regional testing agencies administer the examination. As of July 2013, NERB, SRTA, Nevada, and Florida administer the ADEX examination; CRDTS, WREB, and CITA administer their own unique but similar examinations; and Delaware is the last state to develop and administer its own examination. Colorado accepts any of these examinations for licensure.

Most clinical examinations include sections addressing endodontics, periodontics, prosthodontics, and restorative dentistry. Typically, a portion of the examination must be performed on a mannequin and a portion must be performed on a patient. Candidates are responsible for locating patients who meet the eligibility criteria for the examination. Successful patient selection is considered part of the examination.

Generally, to qualify to sit for a clinical examination, a person must be a current student in or recent graduate of an accredited dental school.

Table 8 includes the basic content and cost for each clinical examination Colorado accepts for licensure.

**Table 8
Content of Dental Clinical Examinations**

Examination	Content Areas					Cost
	Endodontics	Periodontics	Prosthodontics	Restorative	Diagnosis and Treatment Planning	
American Board of Dental Examiners (ADEX)	M	P	M	P	C	\$2,085 to \$2,175*
Central Regional Dental Testing Services, Inc. (CRDTS)	M	P	M	P	--	\$2,095
Council of Interstate Testing Agencies, Inc. (CITA)	M	P	M	P	--	\$2,100
Delaware	--	P	--	P	C	\$250
Western Regional Examining Board (WREB)	M	C, P	C	P	C	\$2,360
Legend: C=Computer-based M=Mannequin-based P=Patient-based *The cost of the examination varies somewhat by jurisdiction.						

For all examinations except Delaware, the cost of the examination includes malpractice or liability insurance coverage for the duration of the examination. Delaware requires candidates to secure such insurance themselves.

Candidates may schedule to take any computer-based segments of the examinations at their convenience through the testing administration agency. The actual hands-on, clinical examination may be offered in either a traditional or curriculum-integrated format. In the traditional format, which is offered by all testing agencies, the entire examination takes place over a two- to three-day period that is determined far in advance. In the curriculum-integrated format, offered by some testing agencies, the separate sections of the examination are administered to dental students sequentially over the course of their studies.

For all examinations, candidates must pass each individual section of the examination to receive an overall passing score. Consequently, a high score on the periodontal examination cannot be used to bolster a poor score on the endodontics examination. For the patient- and mannequin-based portions of the examination, a panel of three examiners typically evaluates the work performed by the candidate using the following four categories: satisfactory, minimally acceptable, marginally substandard, and critical deficiency. The specific guidelines for examiners vary somewhat from one examination to the next.

Testing agencies track and report the pass rates for their respective examinations in different ways: some report a median pass rate, others use an average; some report aggregate, overall pass rates, and others report pass rates for each individual section of the examination (e.g., endodontics). Because of this wide variation, it is difficult to provide a side-by-side comparison of the pass rates. Generally speaking, however, the pass rates for dental clinical examinations are quite high, averaging about 90 percent.

Dental hygienists also must pass a clinical examination to qualify for Colorado licensure. ADEX, CRDTS, CITA, and WREB offer substantially similar examinations, and California and Delaware develop and administer their own state examinations. As with dentistry, Colorado accepts a passing score on any of these examinations.

All dental hygiene clinical examinations consist primarily of a comprehensive patient-based examination. Candidates are evaluated in areas including assessment, periodontal probing, calculus removal and tissue management. Candidates are responsible for locating patients who meet the eligibility criteria for the examination. Successful patient selection is considered part of the examination.

The ADEX and WREB examinations also include a computer-based didactic component.

Candidates may schedule to take any computer-based segments of the examinations at their convenience through the testing administration agency. All patient-based clinical examinations take place on a single day scheduled far in advance.

Generally, the cost for dental hygiene clinical examination administered by a regional testing agency is between \$950 and \$1,000.

As with the dental clinical examinations, regional testing agencies track and report pass rates for their respective dental hygiene examinations differently, making it difficult to create a side-by-side comparison of pass rates. The pass rates for the examinations average in the 80 percent range.

Complaints/Disciplinary Actions

Anyone, including patients, other health professionals, and insurance providers, can file a complaint against a licensed dentist or dental hygienist, or anyone who may have violated the Law. The Board may also initiate complaints.

The panels of the Board review complaints to determine whether there is a violation of the Law. The panels may refer complaints to the Division's Office of Investigations, to the Attorney General's Office or the Expedited Settlement Program, the Division's in-house complaint resolution program.

Table 9 illustrates the number and types of complaints received by the Board for the five fiscal years indicated.

Table 9
Total Number of Complaints Received and Handled

Fiscal Year	Dentists	Dental Hygienists	Unlicensed	Total
07-08	268	21	12	301
08-09	251	35	5	291
09-10	361*	36	5	402
10-11	226	12	4	242
11-12	261**	29	5	295

*Includes 3 academic dentists

**Includes 1 academic dentist

Division staff attribute the increase in the number of complaints in fiscal year 09-10 to a period at the end of the previous fiscal year when one employee had to cover the duties of two positions. This resulted in some complaints being processed and reported in fiscal year 09-10 instead of 08-09.

Table 10 shows, for the five fiscal years indicated, the nature of the complaints filed against licensed dentists.

Table 10
Nature of Complaints against Licensed Dentists

Nature of Complaints	FY 07-08	FY 08-09	FY 09-10	FY 10-11	FY 11-12
Practicing without a license	8	16	49	4	10
Standard of practice	240	196	252	166	192
Sexual misconduct	0	0	0	1	0
Substance abuse	18	2	16	4	6
Felony conviction	5	0	1	0	1
Aiding and abetting the unlicensed practice of dentistry or dental hygiene	8	12	16	3	29
Advertising – misleading, deceptive, or false	3	2	1	4	0
Failure to report discipline/malpractice settlement	1	1	2	0	8
Failure to supervise unlicensed person	2	2	4	0	3
Violating or attempting to violate the law	11	15	16	8	0
Physical or mental disability – unsafe to practice	7	2	6	2	3
Patient records release	7	3	4	1	0
Willfully attempting to deceive the Board on application or otherwise	2	5	1	0	0
Fee-splitting with unlicensed person	2	1	0	0	1
Discipline in another state/territory/country	2	0	1	0	0
Recordkeeping	9	0	0	0	0
Anesthesia administration/delegation	4	2	6	5	1
Joint venture with someone who does not possess a license	0	1	0	0	0
Pediatric case management	0	2	2	1	0
Names and status under which dental practice may be conducted	0	0	5	0	1
Failure to maintain malpractice insurance coverage	0	0	1	0	0
Failure to comply with X-ray minimum standards for qualifications/training for unlicensed person	0	0	1	0	0
Failure to change address with the Board	0	0	0	2	0
TOTAL	329	262	384	201	255

The overwhelming majority of complaints—over 70 percent of all complaints received over the five year period—related to standard of practice.

Practicing without a license is the second most common basis for complaints, comprising six percent of complaints. Division staff attribute the elevated number of complaints in this category for fiscal year 09-10 to a high number of reinstatement applicants who disclosed they had practiced on a lapsed license.

Table 11 shows, for the five fiscal years indicated, the nature of the complaints filed against licensed dental hygienists.

**Table 11
Nature of Complaints against Dental Hygienists**

Nature of Complaints	FY 07-08	FY 08-09	FY 09-10	FY 10-11	FY 11-12
Practicing without a license	14	29	16	9	21
Standard of practice	2	11	10	3	4
Scope of practice	0	0	1	0	0
Substance abuse	3	1	8	1	2
Felony conviction	3	0	4	1	0
Violating or attempting to violate the law	5	2	12	2	2
Administration of nitrous oxide/local anesthesia	2	2	1	1	1
Physical or mental disability – unsafe to practice	0	0	1	1	1
Names and status under which dental practice may be conducted	0	0	0	0	1
Willfully attempting to deceive the Board on application or otherwise	0	0	0	0	1
TOTAL	29	45	53	18	33

About 50 percent of all complaints received against dental hygienists for the five-year review period related to unlicensed practice. About 17 percent related to standard of practice.

If a complaint reveals no violation of the Law, the Board can either dismiss it outright or via a confidential letter of concern. If a complaint does reveal a possible violation, the Board may direct the Division to investigate further. Once it has enough information, the Board may take disciplinary action against the license. Potential disciplinary actions against dentists and dental hygienists include letters of admonition, probation, suspension, and revocation. The Board may also compel unlicensed people to cease the unlawful practice of dentistry or dental hygiene by issuing cease and desist orders.

Table 12 shows, for the five fiscal years indicated, the total number of final actions taken against dentists, dental hygienists, and unlicensed individuals.

**Table 12
Final Actions Taken Against Dentists and Hygienists**

Type of Action	FY 07-08			FY 08-09			FY 09-10			FY 10-11			FY 11-12		
	DEN	DH	U												
Revocations	2	0	0	2	0	0	1	1	0	4	2	0	4	0	0
Suspensions	4	1	0	6	2	0	9	1	0	14	1	0	4	0	0
Stipulations	29	1	0	35	2	0	21	6	0	36	3	0	21	6	0
Letters of Admonition	6	5	0	20	5	0	12	11	0	19	3	0	17	6	0
Other (Cease and Desist Orders, Citations)	8	1	4	3	0	0	2	0	2	1	1	2	17	0	1
TOTAL DISCIPLINARY ACTIONS	61			75			66			86			76		
Dismissals	117	1	7	96	3	5	136	4	1	116	7	4	93	4	4
Letters of Concern	63	7	0	77	23	0	106	10	0	55	9	0	48	0	2
TOTAL DISMISSALS	195			204			257			191			151		

Key: DEN=Dentists, DH=Dental Hygienists, and U=unlicensed individuals

From fiscal year 08-09 to 09-10, there was a significant increase in the number of letters of concern issued to dentists and dental hygienists. This corresponds with the increase in the number of complaints against both dentists and hygienists regarding reinstatement applicants practicing on lapsed licenses.

In fiscal year 12-13, the Board denied the license application of one applicant based on criminal history. The Board had revoked the person's license in 2008 due to two convictions of driving while ability impaired.

Since 2008, the Board has suspended two dentists due to felony convictions: one was convicted of a Class-4 felony for possession of controlled substances and the other was convicted of vehicular homicide. The Board also accepted the voluntary permanent license relinquishment by a person who had been on Board probation due to a driving under the influence conviction. The person was facing numerous pending charges at the time of the relinquishment.

Peer Assistance Program

All Colorado-licensed dentists are entitled to use the services of a peer assistance program selected by the Board. The Board currently contracts with Peer Assistance Services, Inc. (PAS), to administer the program, which provides evaluation, assessment and treatment monitoring and referral services for dentists with substance abuse, mental health, or related problems. Family members, friends, or colleagues may refer dentists to the program.

Anyone applying for, renewing, or reinstating a dental license pays an \$80 surcharge that is used to support the program. The annual budget for PAS is \$192,540.

Dentists may enroll in the program directly, or the Board may refer dentists to the program in lieu of taking disciplinary action. Dentists must undergo a comprehensive assessment to determine whether they are eligible to participate. If so, PAS staff then develops a contract that includes an individualized treatment and rehabilitation plan.

There is no fee for evaluations, assessments, referrals or treatment monitoring. Participating dentists are responsible for paying any fees for treatment, therapy, and testing.

In July 2013, there were a total of 18 dentists under contract with PAS, including 7 Board-ordered and 11 voluntary participants.

Analysis and Recommendations

Recommendation 1 – Continue the State Board of Dental Examiners for nine years, until 2023.

The State Board of Dental Examiners, housed within the Division of Professions and Occupations of the Department of Regulatory Agencies (Division and DORA, respectively) is vested with the authority to regulate dentists and dental hygienists in Colorado.

The central question of a sunset review is whether such regulation is necessary to protect the public health, safety, and welfare.

Dentists diagnose and treat problems with the teeth and gums. They clean, repair, restore, and extract teeth, perform root canals, place implants, and fit dentures and braces. Dentists also interpret X-rays, administer anesthesia to prevent patients from feeling pain during dental procedures, and prescribe analgesics, antibiotics or other medications.

Dental hygienists clean teeth, provide preventative dental care, and educate patients about oral hygiene.

The professions of dentistry, and to a lesser degree, dental hygiene, require extensive knowledge of anatomy and physiology as well as considerable manual dexterity. The substandard practice of either profession poses risks to patients: if a dental hygienist fails to clean a patient's teeth properly or to recognize symptoms of decay, the patient might develop more serious oral health problems. A dentist improperly preparing a tooth during a restoration could lead to the loss of a tooth or to permanent nerve damage.

In July 2013, there were 4,833 dentists and 4,378 dental hygienists in Colorado.

By assuring that dentists and dental hygienists meet minimum standards for licensure—i.e., graduate from an accredited education program, pass a national didactic examination and pass an examination testing clinical skills—the Board assures that new licensees possess basic professional competency when they enter the marketplace.

The Board also protects the public by enumerating which tasks may be delegated to unlicensed personnel and by promulgating rules establishing additional education and training requirements for licensees seeking anesthesia permits or privileges.

Over the past five years, the Board has reviewed an average of 306 complaints against dentists and dental hygienists per year. The majority of these complaints relate to substandard practice, meaning that to evaluate them requires the professional expertise of the Board. During that five year period, the Board took a total of 365 disciplinary actions against individuals who violated the Dental Practice Law (Law), including 16 revocations. The Board also placed probationary conditions on 160 licensees. These activities assure that incompetent or unsafe practitioners are either removed from practice or are subject to supervision or license restrictions that ensure public safety.

Through its licensing, rulemaking, and enforcement activities the Board protects the public health, safety and welfare. For these reasons, the Board should be continued for nine years, until 2023. This nine-year extension is appropriate given the scope of the recommendations in this report.

Recommendation 2 – Change the name of the Board to the “Colorado Dental Board.”

In the past, states—including Colorado—developed and administered their own licensing examinations, and it was typical for board members to examine candidates for licensure personally.

This is no longer the case, and has not been for some time. The Joint Commission for National Dental Examinations (JCNDE) develops the written licensing examinations for dentists and dental hygienists and national testing agencies administer those examinations. Multiple regional testing agencies develop and administer the clinical examinations. Although Board members can, and a few do, serve as examiners for the clinical examinations, dentists and dental hygienists who are not Board members also serve as examiners.

The Board also has the ability to appoint examination proctors, defined as:⁹³

a licensed dentist or dental hygienist, who shall have at least five years' clinical experience and who is appointed by the board to supervise and administer written and clinical examinations in the field in which the dentist or dental hygienist is licensed to practice[.]

Since the regional testing agencies have been conducting the clinical examinations, the Board has been phasing out the process of appointing examination proctors and does so rarely, and only then at the specific request of testing agencies. Generally speaking, testing agencies recruit, select and train examiners independently, and the Board refers dentists or dental hygienists who wish to serve as examiners directly to testing agencies.

⁹³ §12-35-103(7), C.R.S.

Because the Board is no longer the sole entity examining candidates for licensure, the name of the Board should be changed to the “Colorado Dental Board,” all references to Board members personally conducting examinations should be repealed, and the definition of “examination proctor” should be repealed.

Recommendation 3 – Revise the clinical examination requirement to allow the Board to accept other methods of evaluating clinical competency.

In order to qualify for a license in Colorado, both dental and dental hygiene applicants must pass an examination designed to test their clinical skills and knowledge.

Which clinical examination is accepted for licensure has evolved considerably over the past 50 years. Until the 1960s, each state conducted its own clinical examination and required anyone seeking a license to pass that examination. Under that regime, if a candidate who had passed Colorado’s clinical examination moved to Nebraska, he or she would have to take and pass Nebraska’s clinical examination to qualify for a license there.

A desire to make testing standards more uniform and to allow more mobility for dentists and dental hygienists led, in the 1960s and 1970s, to 45 state boards of dentistry grouping into four regional testing agencies:⁹⁴

- Central Regional Dental Testing Services, Inc. (CRDTS), of which Colorado is a member;
- North East Regional Board of Dental Examiners, Inc. (NERB);
- Southern Regional Testing Agency (SRTA); and
- Western Regional Examining Board (WREB).

The regional testing agencies allowed candidates to pool their resources: instead of states having to conduct occupational analyses, develop psychometrically sound examinations, and administer the examinations independently, the testing agencies could do so on behalf of their member boards. Dental and dental hygiene applicants also benefited. Now, if a candidate took the CRDTS examination, he or she knew it would be accepted for licensure in all of the CRDTS member states.

Candidates moving to a state that was a member of another regional testing agency, however, would still have to take the regional examination accepted by that state. Until 2004, the Board would only accept clinical examinations administered by a testing agency of which Colorado is a member, i.e., CRDTS.

⁹⁴ California, Florida, Hawaii, Indiana, and Nevada remained independent.

In 2004, the General Assembly amended the Dental Practice Law (Law) to accept any examination administered by either a regional testing agency composed of at least four states or another state.⁹⁵ In other words, Colorado currently accepts a passing score on any examination administered by a regional testing agency or an independent state. This includes the examination developed by the American Board of Dental Examiners (of which Colorado is a participating member), which is administered by regional testing agencies.

Many other states have a similar policy of accepting any examinations administered by a regional testing agency or independent state.

Regardless of the history described above, the examinations themselves share some basic traits: they are one-time, high-stakes examinations that require candidates to treat real patients. No other health care profession requires this kind of examination. Since the late 1990s, state boards have investigated, and in some cases adopted, alternative methods of evaluating prospective dentists and dental hygienists' clinical competency.

Alternative methods include:

- A yearlong **post-graduate residency** in an accredited doctoral program (typically called a PGY-1). In 2003, New York mandated PGY-1 in lieu of a clinical examination. Washington, Minnesota, California, and Connecticut currently accept (but do not mandate) PGY-1 in lieu of a clinical examination.
- A **portfolio** method, wherein students in their final year of dental school build a portfolio of completed clinical experiences demonstrating competency in defined areas. California passed legislation enabling the portfolio method in 2010 and is in the process of implementing the program.
- A **computer- or mannequin-based clinical examination** that does not involve any treatment of actual patients, such as the objective structured clinical examination (OSCE) offered by the National Dental Examining Board of Canada. Minnesota currently accepts the OSCE for licensure.

The notion that a clinical examination can be something other than a one-time, high-stakes examination performed on a real patient is gaining broader acceptance, and the definition of what constitutes a clinical examination will undoubtedly continue to evolve. Colorado should revise its statute accordingly to accommodate these changes.

By expanding the list of clinical examinations accepted for licensure in 2004, Colorado reduced barriers to licensure for dentists and dental hygienists. Reducing such barriers can have a positive effect for Coloradans by increasing access to dental services.

In this spirit, Colorado should make two changes to the provision regarding the clinical examination for dentists and dental hygienists.

⁹⁵ §§ 12-35-119(1)(c) and 127(1)(b), C.R.S.

First, the General Assembly should repeal the requirement that the clinical examination must be administered by a regional testing agency composed of at least four states, or by another state. The four-state threshold is arbitrary and does not in itself assure the quality or validity of an examination. Further, if the membership of a regional testing agency were to fall below the four-state requirement, there is nothing preventing member states from independently administering the same examination.

Because the limitation on how many states must comprise a regional testing agency serves no meaningful purpose, and it is not Colorado's intent to accept only state-administered examinations, the entire limitation on which entities' clinical examinations the Board will accept should be repealed.

Second, in light of the evolution in how states are evaluating the clinical competency of prospective dentists and dental hygienists, the General Assembly should expand the law to allow the Board, at its discretion, to accept alternate methods of evaluating clinical competency, including residency and portfolio models.

Doing so would accommodate emerging alternative methods for assuring dental and dental hygiene applicants' clinical competency. These changes would be consistent with Colorado's history of increasing Coloradans' access to professional services by removing barriers to licensure and with the first sunset criterion that regulation should be the least restrictive consistent with the public interest.

Recommendation 4 – Repeal the requirement that the Board promulgate rules establishing the number of times a dentist can take a clinical examination.

Section 12-35-119(3), Colorado Revised Statutes (C.R.S.), directs the Board to promulgate rules establishing:

The maximum number of times and maximum time period within which an applicant will be allowed to retake only the failed parts of the examination designed to test clinical skills and knowledge; and

The maximum number of times an applicant may fail to successfully complete the examination designed to test clinical skills and knowledge before the Board requires such applicant to take specified remedial measures as a prerequisite to retaking the examination.

In accordance with these provisions, the Board promulgated Rule III(B)(c), which establishes that dental applicants may take the clinical examination three times without having to meet any additional training requirements. If an applicant fails on the third attempt, the applicant must submit a remedial training plan to the Board before applying to take it a fourth time. The Board may approve or deny the applicant's bid to take the examination a fourth time, or any subsequent attempts.

This limitation made sense in the past, when applicants for a Colorado dental license were obligated to pass a Colorado-specific clinical examination developed and administered by the Board. Currently, however, the Board accepts for licensure any one of four different clinical examinations, all of which are administered by discrete, independent testing agencies. Candidates no longer have to apply to the Board to take a clinical examination; rather, they apply directly to the appropriate testing agency. Each testing agency maintains its own retake policy.

In this testing environment, it is not possible for the Board to monitor the number of times a candidate has taken a clinical examination or to enforce the provisions of Rule III(B)(c).

For these reasons, the General Assembly should repeal the requirement that the Board promulgate rules addressing clinical examination retakes.

Recommendation 5 – Repeal the requirement that accredited dental hygiene programs be two years in length.

Section 12-35-126(1)(b), C.R.S., requires applicants for a dental hygiene license to provide proof that they graduated from an accredited dental hygiene program of at least two academic years in length.

The Commission on Dental Accreditation (CODA) accredits dental hygiene education programs. Current CODA standards for such programs require that the curriculum be at least two academic years of full-time instruction *or its equivalent*⁹⁶ (emphasis added). This flexibility allows programs to offer an accelerated or intensive curriculum that allows graduation in less than two years. Therefore, it would be possible for an accredited program to be shorter than two academic years, and that graduates of such programs might find themselves ineligible for licensure based upon a strict interpretation of this provision.

Because the Board entrusts CODA with the responsibility for accrediting dental hygiene programs, the Law should not include provisions that might conflict with CODA's accreditation standards. For example, the Law does not state how long an accredited dental program must be in order for its graduates to qualify for a license: it simply states that such program must be accredited.

To align the Law with CODA's accreditation standards and to make the language for dental hygiene parallel to that of dentistry, the requirement that accredited programs must be at least two academic years should be repealed.

⁹⁶ *Accreditation Standards for Dental Hygiene Accreditation Programs*, Commission on Dental Accreditation (January 2013), p. 15.

Recommendation 6 – Establish that a dentist or dental hygienist's failure to properly address his or her own physical or mental condition is grounds for discipline, and authorize the Board to enter into confidential agreements with licensees to address their respective conditions.

One of the Board's central responsibilities is to take disciplinary action against dentists or dental hygienists who pose a threat to the patients under their care. The Board may take disciplinary action against any dentist or dental hygienist who has:⁹⁷

Such physical or mental disability as to render the licensee unable to perform dental or dental hygiene services with reasonable skill and with safety to the patient[.]

Having such a condition may also affect an applicant's ability to be licensed as a dentist or dental hygienist. The application for initial licensure asks:⁹⁸

In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a dentist (or dental hygienist) safely and competently including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder?

Further, at each two-year renewal, dentists and dental hygienists must attest that they are in compliance with the law, so in effect they are attesting that they do not have such a physical or mental condition. If they have acquired such a condition since the last renewal, they must disclose such to the Board.

The intent of these provisions is clear: to protect the public from unsafe practitioners. But in many cases, licensees with such conditions could continue to practice safely, under certain defined circumstances. For example, a dentist with a hand injury could continue to diagnose and evaluate patients, but would have to delegate tasks requiring manual dexterity to another practitioner. A dental hygienist with bipolar disorder might be able to treat patients safely provided he or she takes the proper medication.

Under the current system, licensees with such conditions could enter into an agreement or practice limitation with the Board in order to continue practicing via a public disciplinary order. Section 12-35-129(7)(g), C.R.S., allows the Board to include in any disciplinary order terms that assure the licensee is safe to practice. Such terms could include requiring a licensee to undergo a physical or mental examination; to complete therapy, training, or education; or to enter into a period of supervised practice. The Board can also restrict the scope of the licensee's practice to ensure that he or she does not practice beyond the limits of his or her capabilities.

⁹⁷ § 12-35-129(1)(j), C.R.S.

⁹⁸ Colorado Division of Professions and Occupations, *Application for Original License—Dentist* (October 2012), p. 3 and *Application for Original License—Dental Hygienist* (August 2012), p. 4.

These orders provide a mechanism for these licensees to continue to practice, but are troubling philosophically. The orders are considered discipline, and become part of the licensee's permanent record. Being injured in a car accident, suffering a stroke, or receiving a diagnosis of bipolar disorder is fundamentally different from committing an act that constitutes grounds for discipline under the Law. While these conditions might temporarily or permanently affect a dentist or dental hygienist's ability to treat patients, it seems unjust for a dentist who successfully manages bipolar disorder with medication to be included in the same category as a dentist who has defrauded a patient. Not only does this stigmatize the person with the condition, it can affect his or her ability to participate in provider networks and can increase malpractice insurance rates.

Current law presents dentists and dental hygienists who have a physical or mental condition that might affect their practice with a stark choice: violate the law by continuing to practice, stop practicing entirely, or enter into a public disciplinary order.

During the 2010 legislative session, the General Assembly passed House Bill 10-1260 (HB 1260), which contains a provision allowing the Medical Board to enter into confidential agreements with physicians with physical or mental conditions that might affect their practice. These agreements establish the measures that physicians must adhere to in order to practice safely.

The legislation made another important change: previously, a physician would be subject to discipline simply for having a physical or mental condition that might affect his or her practice. Under HB 1260, the Medical Board may discipline a physician if he or she fails to:⁹⁹

Notify the board...of a physical or mental illness or condition that impacts the licensee's ability to perform a medical service with reasonable skill and with safety to patients, failing to act within the limitations created by a physical or mental illness or condition that renders the licensee unable to perform a service with reasonable skill and with safety to the patient, or failing to comply with the limitations agreed to under a confidential agreement [.]

Simply having a physical or mental condition or illness is no longer a reason to impose discipline. As long as the physician notifies the Medical Board of his or her condition or illness, enters into a confidential agreement outlining the measures he or she must take to assure safe practice, and adheres to the agreement, there is no violation of the Medical Practice Act. Consequently, these agreements do not constitute discipline and do not appear to be reportable to the National Practitioner Data Bank. If a physician fails to meet the requirements or stay within the limitations enumerated in the agreement, the Medical Board may then take disciplinary action. This assures adequate public protection. Further, under HB 1260, licensees who are subject to discipline due to habitual or excessive use or abuse of alcohol, a habit-forming drug, or a controlled substance are not eligible to enter into confidential agreements.

⁹⁹ House Bill 10-1260, § 29.

Since HB 1260 passed, the General Assembly has passed similar legislation for acupuncturists,¹⁰⁰ physical therapists,¹⁰¹ mental health professionals,¹⁰² pharmacists,¹⁰³ and massage therapists.¹⁰⁴

The General Assembly should enact a similar provision for dentists and dental hygienists by granting the Board the authority to enter into confidential agreements with licensees. The General Assembly should also repeal the current provision located at section 12-35-129(1)(j), C.R.S., and, to assure public protection, establish failure to properly address the licensee's own physical or mental condition as grounds for discipline.

Recommendation 7 – Add a cross-reference to Colorado's provider network statute to section 12-35-116.5(1), C.R.S.

Colorado's provider network statute, located in section 6-18-301, *et seq.*, C.R.S., allows dentists and dental hygienists to own a dental or dental hygiene practice by participating in a provider network. However, section 12-35-116.5(1), C.R.S., which establishes who may own a Colorado dental or dental hygiene practice, does not make any reference to the provider network statute.

Section 12-35-116.5(1), C.R.S., should be updated to add a cross-reference to section 6-18-301, C.R.S., which governs provider networks. This change would provide a complete picture of the ownership scenarios currently permissible under Colorado law.

Recommendation 8 – Give the Board the ability to suspend a licensee for failing to comply with a Board order.

Among the ways the Board may resolve a complaint is placing a licensee on probation. In those instances, the dentist or dental hygienist complained against agrees to settle the complaint by voluntarily entering into a probationary agreement, or stipulation, with the Board. Stipulations establish the terms licensees must meet in order to have their licenses restored to active, unrestricted status.

Occasionally, licensees who have signed stipulations fail to meet the agreed-upon terms, for example, they fail to submit practice monitor reports or complete continuing education within a specified time period. From July 2011 to August 2013, the Board entered into stipulations with 50 licensees. Of those, 12 licensees—roughly 24 percent—failed to meet the terms of the stipulation.

In these cases, the Board has three options: to summarily suspend the licensee, seek an injunction, or initiate a new complaint against the licensee for violating a Board order.

¹⁰⁰ § 12-29.5-108.5(1), C.R.S.

¹⁰¹ § 12-41-118.5, C.R.S.

¹⁰² § 12-43-221.5, C.R.S.

¹⁰³ § 12-42.5-134, C.R.S.

¹⁰⁴ § 12-35.5-116.5, C.R.S.

All of these approaches have drawbacks. The Board may seek summary suspensions and injunctions only if the licensee poses an imminent threat to the health and safety of patients under his or her care. By imposing conditions on the licensee, the Board has determined that the licensee is to some degree unsafe to practice, but licensees on probation typically do not pose the level of threat that would justify a summary suspension or injunction. Also, these processes are time-consuming and can be expensive.

The other option is to initiate a complaint against a licensee for violating a Board order. This option takes time, during which the licensee may continue to practice.

Any time the Board places a licensee on probation, it has determined that the licensee requires additional education, practice monitoring or other measures to practice safely. When a licensee on probation continues to practice in violation of a stipulation, it places the public at risk.

The Board of Veterinary Medicine has another option for handling licensees who fail to meet the terms of their stipulations. Under section 12-64-111(11), C.R.S., the board may suspend the license of a veterinarian who fails to comply with a board order. The board may impose the license suspension until the licensee complies with the order.

Since this provision was added in 2011, staff for the Board of Veterinary Medicine reports a higher rate of compliance with probationary agreements. In most cases, the suspension does not actually occur. Rather, the knowledge that failure to comply with the stipulation could lead to suspension encourages licensees to stay in compliance.

Therefore, the General Assembly should add a provision allowing the Board to suspend the licenses of dentists or dental hygienists who fail to comply with a Board order.

Recommendation 9 – Establish that failing to follow generally accepted standards for infection control is grounds for discipline.

In the practice of dentistry or dental hygiene, it is essential that licensees follow proper infection control procedures. The “Guidelines for Infection Control in Dental Health-Care Settings,” published by the federal Centers for Disease Control and Prevention, are generally accepted as setting the standards for infection control procedures.

A high-profile case that occurred last year underscores the importance of maintaining proper infection control in a dental office. In that case, an oral surgeon re-used sedation syringes on patients over a 12-year period.¹⁰⁵ Thousands of the surgeon’s former patients had to undergo testing for possible exposure to infection.

¹⁰⁵ Michael Booth and Joey Bunch, “Highlands Ranch, Denver dentist may have contaminated patients for 12 years,” *The Denver Post*, July 12, 2012.

Incidents like these are clearly violations of the Law and constitute grossly negligent practice or practice that fails to meet generally accepted standards, which is grounds for disciplinary action under section 12-35-129(1)(k), C.R.S. Board Rule XVI specifically states that failure to maintain infection control might violate that provision.

However, because of the potentially far-reaching consequences of failing to maintain proper infection control, it should be established as its own separate statutory provision.

For these reasons, the General Assembly should establish as grounds for discipline failing to follow generally accepted standards for infection control.

Recommendation 10 – Grant the Board fining authority and direct the Board to promulgate rules establishing a uniform system and schedule of fines.

When determining the appropriate disciplinary action to take against a dentist or dental hygienist who has violated the Law, the Board has numerous options to choose from: a letter of admonition, which is a reprimand that imposes no conditions on the licensee; probation, which places conditions on the license and establishes the terms the licensee must meet for the restriction to be lifted; and suspension or revocation, which remove licensees from practice temporarily or permanently. The Board does not, however, have the ability to levy a fine against a licensee.

Fining can be a useful deterrent for administrative violations, such as practicing on a lapsed license, but could be effective in other situations as well.

The Board sometimes grapples with cases wherein a licensee is technically competent but engages in unethical behavior: for example, where a licensee performs unnecessary tests in order to collect insurance reimbursements. In this scenario, a letter of admonition seems too lenient, revocation too severe, and probation inappropriate because the licensee's professional competence is not in question.

When a licensee breaks the law for financial gain, it seems appropriate for the discipline to impose financial consequences. The Board currently has the option to suspend a licensee, which has fiscal consequences, but also might curtail patients' access to care during the suspension period.

Fines could serve as a powerful deterrent for licensees considering breaking the law to enrich themselves, and as a meaningful disciplinary action against those who do so.

Other health care boards within the Division currently have the ability to assess fines against licensees:

- The Medical Board may fine licensees up to \$5,000 per violation.¹⁰⁶
- The Board of Pharmacy may fine a licensee from \$500 up to \$5,000 for each violation.¹⁰⁷
- The Board of Chiropractic Examiners may assess a fine of \$1,000 or more for a first violation, up to \$3,000 for a second violation, and up to \$5,000 for a third or subsequent violation.¹⁰⁸
- The Board of Veterinary Medicine may fine licensees from \$100 up to \$1,000 per violation.¹⁰⁹
- The Physical Therapy Board may assess fines of up to \$1,000.¹¹⁰
- The Board of Nursing may assess fines of no less than \$250 up to \$1,000 per violation.¹¹¹

Other programs within the Division report that the ability to levy fines expedites the settlement of cases because licensees are more likely to agree to a fine than to a suspension.

Fining authority would give the Board a targeted way to discipline licensees who violate the law to increase profits, expedite the settling of such cases, and, unlike a suspension, keep the licensee in practice, thereby assuring access to care for the licensee's patients.

Therefore, the General Assembly should grant the Board fining authority and direct the Board to promulgate rules establishing a uniform system and schedule of fines that it may impose on licensees.

Recommendation 11 – Repeal the jurisprudence examination requirement.

To be eligible for a license, applicants for both dental¹¹² and dental hygiene¹¹³ licenses must pass a jurisprudence examination. This examination consists of 40 true-or-false questions about the Law and Board rules and policies. It is a take-home, open-book examination. Division staff estimate that 98 percent of applicants pass the examination on the first attempt.

¹⁰⁶ § 12-36-118(5)(g)(III), C.R.S.

¹⁰⁷ § 12-42.5-124(5)(a)(I), C.R.S.

¹⁰⁸ § 12-33-117(1.5), C.R.S.

¹⁰⁹ § 12-64-111(4), C.R.S.

¹¹⁰ § 12-41-122, C.R.S.

¹¹¹ § 12-38-116.5(4)(c)(III), C.R.S.

¹¹² § 12-35-119(1)(b), C.R.S.

¹¹³ § 12-35-127(1)(c), C.R.S.

The majority of professions within the Division—including physicians, nurses, veterinarians, chiropractors, physical therapists, and respiratory therapists—have no such requirement. This does not mean, however, that those professions have no obligation to know and comply with their respective practice acts. All regulated professionals have an ongoing obligation to know the laws and rules applicable to the profession, not just at the time of initial licensure, but over the course of their careers.

The jurisprudence examination poses a burden for applicants, who by the time they apply for a license have already passed two high-stakes examinations, and for Division staff, who must continually update and manually grade the examinations.

It is the dentist's or dental hygienist's ongoing professional commitment to knowing and complying with the applicable statutes and rules that protects the public, not the passage of a one-time, take-home, open-book jurisprudence examination. The examination serves as an administrative hurdle rather than a meaningful assessment of a licensee's readiness for licensure.

Therefore, the General Assembly should repeal this requirement.

Recommendation 12 – Repeal the requirement that applicants for a dental license by examination submit verification of all health care licenses.

Section 12-35-117(1)(d), C.R.S., requires applicants for a dental license by examination to provide “verification of licensure from other jurisdictions where the applicant holds or has held a dental or other health care license.”

Verifications are typically required when a person is applying for a license by endorsement, not examination. The statutes regulating most health care professions—including dental hygienists, physicians, nurses, chiropractors, physical therapists, optometrists, and podiatrists—do not require applicants to submit any license verification when applying for license by examination. The dental statute requires dental applicants to submit verification not only of any dental licenses they may have held, but all health care licenses.

This places an administrative burden on the applicant, who must contact other jurisdictions and sometimes pay a fee to obtain verifications, and for the licensing specialists within the Division, who must track and file the verifications. More importantly, it is unclear how this practice protects the public. There is no evidence that this additional level of scrutiny for dental applicants is necessary.

Therefore, this provision should be repealed.

Recommendation 13 – Create an inactive status for dental hygienists and allow retired dental hygienists to provide no-cost care to low-income patients.

The Law allows dentists who are no longer practicing to apply for retired or inactive status. To qualify for either status, a dentist must submit an affidavit stating he or she will not practice after a certain date and pay a fee. Dentists in retired or inactive status wishing to return to active status may apply to the Board, pay any applicable fees, and comply with the financial responsibility requirements.

Currently, inactive status is unavailable to dental hygienists, and although both dentists and hygienists are eligible for retired status, only retired dentists may provide free care to low-income populations. Retired dental hygienists are barred from doing so.

The General Assembly should revise the Law to create an inactive status for dental hygienists, and to allow retired dental hygienists to provide free care to low-income populations, as retired dentists can, and grant them similar immunity.

Making these changes would introduce parity between dentists and dental hygienists and benefit the public by allowing retired dental hygienists to care for low-income patients.

Recommendation 14 – Repeal the requirement that letters of admonition be sent by certified mail.

Section 12-35-129(1), C.R.S., requires the Board to send letters of admonition via certified mail. While this delivery method allows Division staff to verify that a delivery attempt was made, it does not guarantee that the addressee actually receives the letter. The addressee can decline to sign for or pick up the letter, and then claim he or she never received it. This defeats the purpose of sending the letter by certified mail.

Certified mail also costs more than first-class mail.

The General Assembly should repeal the requirement that letters of admonition be sent by certified mail, requiring instead that such letters be sent via first-class mail. Section 12-35-111(1), C.R.S., requires that dentists report changes of address to the Division within thirty days of the change. If the change is made in a timely manner, it is very unlikely that the licensee would not receive a properly addressed letter of admonition.

Requiring that letters of admonition be sent via first-class mail would save money and streamline the administrative process for letters of admonition without compromising the Board's enforcement authority. Therefore, the General Assembly should repeal the requirement that letters of admonition be sent by certified mail.

Recommendation 15 – Establish failure to respond to a complaint as grounds for discipline.

When the Board receives a complaint against a dentist or dental hygienist, it sends a copy of the complaint to the licensee, who has 30 days to respond to the complaint in writing. Not only does failing to respond to a complaint create an administrative delay and hinder the investigative process, it also poses a potential threat to the public: each day that an unsafe dentist or dental hygienist continues to work puts the public at risk. While there may be extenuating circumstances that prevent a licensee from responding promptly, the Board should have the authority to discipline a licensee for failing to respond.

From July 2011 to August 2013, there were 21 cases where licensees failed to respond to a complaint.

Other health professionals—including physicians,¹¹⁴ nurses,¹¹⁵ chiropractors,¹¹⁶ and physical therapists¹¹⁷—are subject to discipline for failing to respond to a complaint.

Therefore, the General Assembly should establish as grounds for discipline failure to respond to a complaint.

Recommendation 16 – Repeal the provision disqualifying people with past felony convictions or Board discipline from serving on the Board.

Section 12-35-105(2), C.R.S., expressly forbids from serving on the Board people who have been convicted of either 1) a felony, or 2) the Law or any other law governing the practice of dentistry.

This specific prohibition is unusual among the Division’s health care boards: only the Nursing Home Administrators Board has a similar provision.

This blanket prohibition could automatically disqualify someone who is otherwise well-qualified to serve on the Board, such as someone who had successfully completed Board probation 15 years ago.

When applying for a position on any state board or commission, a person is required to disclose any criminal history and must agree to submit to a criminal history check by the Colorado Bureau of Investigation. In reviewing a person’s application for a Board position, the Governor may decide he or she does not wish to appoint the person based on his or her history. The Governor should have maximum flexibility in evaluating potential Board members. Section 12-35-105(2), C.R.S., is unusual and automatically eliminates otherwise qualified individuals from Board service.

Therefore, the General Assembly should repeal this provision.

¹¹⁴ § 12-36-117(1)(gg), C.R.S.

¹¹⁵ § 12-38-117(1)(u), C.R.S.

¹¹⁶ § 12-33-117(1)(ff), C.R.S.

¹¹⁷ § 12-41-115(1)(w), C.R.S.

Recommendation 17 – Clarify that Board members may continue to serve until a replacement is appointed.

Section 12-35-104(1)(a), C.R.S., establishes the composition of the Board and allows each Board member to serve two consecutive four-year terms. There is no provision, however, allowing Board members to continue to serve until a replacement is appointed. This could affect the Board's ability to convene a quorum and potentially delay Board business.

The statutes for many other boards within the Division, including the Board of Accountancy,¹¹⁸ the State Board of Licensure for Architects, Professional Engineers and Professional Land Surveyors¹¹⁹ the Medical Board,¹²⁰ and the Board of Psychologist Examiners¹²¹ include provisions allowing board members to continue to serve until a replacement is appointed.

The General Assembly should add similar language to the Law. Allowing a Board member to continue to serve until his or her replacement is appointed assures the Board is able to fulfill its statutory responsibilities without interruption.

Recommendation 18 – Make technical changes to the Dental Practice Law.

As with any law that has been in existence for many decades, the Law contains instances of obsolete, duplicative and confusing language. Further, reorganizing some portions of the statute would improve its clarity and readability. The Law should be revised to reflect current terminology and administrative practices and reorganized to group like subjects together. These changes are technical in nature, meaning that they have no substantive impact on the practice of dentistry or dental hygiene.

The General Assembly should make the following technical changes:

- **Section 12-35-101, C.R.S.** Change name of statute to “Dental Practice Act” to be congruent with other programs within the Division.
- **Section 12-35-103(8), C.R.S.** Repeal the definition of “inactive license” as it is only used in section 12-35-122, C.R.S.
- **Section 12-35-103(12), C.R.S.** Repeal “and shall be null and void upon the failure of the licensee to file an application for renewal and to the pay the fee as required by section 12-35-121.” Section 12-35-121 addresses the issue of renewals.
- **Sections 12-35-103(13) and (15), C.R.S.** Repeal the terms “license certificate” and “renewal certificate,” as they are obsolete.
- **Sections 12-35-104(1)(a) and (b), C.R.S.** Update (a) to reflect the current composition of the Board and repeal (b), because it is obsolete.

¹¹⁸ § 12-2-103(1), C.R.S.

¹¹⁹ § 12-25-106(5), C.R.S.

¹²⁰ § 12-36-103(3), C.R.S.

¹²¹ § 12-43-302(4)(1a), C.R.S.

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- **Section 12-35-104(4)(a), C.R.S.** Repeal “including the issuing of permits for administering anesthesia and the regulation of such administration of anesthesia” because those functions are included under “all functions of the Board.”
 - **Sections 12-35-107(1)(b)(I), (II), (III) and (IV), C.R.S.** Repeal the list of specific topics that must be addressed in rule because rules addressing these topics have been promulgated.
 - **Section 12-35-107(1)(h)(I), C.R.S., and throughout the Law.** Update the anesthesia terminology to reflect the current terminology in Board Rule XIV, and clarify that in addition to issuing permits for deep sedation/general anesthesia, the Board issues minimal or moderate sedation permits to dentists and local anesthesia permits to dental hygienists, and may collect fees for such privileges and permits.
 - **Section 12-35-110(2), C.R.S.** Update this to reflect that the name of the referenced association has changed to the “American Association of Dental Boards,” and add “or a successor association” to accommodate any future name changes.
 - **Section 12-35-113(1)(c), C.R.S.** Update the final citation in this paragraph to section 12-35-128(3)(b)(III), C.R.S.
 - **Section 12-35-113(1)(n), C.R.S.** Update the final citation in this paragraph to section 12-35-128(3)(b), C.R.S.
 - **Section 12-35-115(1)(b), C.R.S.** Repeal “under the direct supervision of a licensed dentist,” because such supervision is not required under the Nurse Practice Act.
 - **Section 12-35-115(1)(d), C.R.S.** Strike “of the American Dental Association” (ADA) because CODA is no longer affiliated directly with the ADA.
 - **Section 12-35-117, C.R.S.** Add a new provision that clarifies that applicants must meet the financial responsibility standards established in section 13-64-301(1), C.R.S.
 - **Section 12-35-118, C.R.S.** The license requirements for foreign graduates are no different than those for applicants for licensure by examination. Having a separate section that lists identical requirements is confusing. Therefore, this section should be repealed.
 - **Section 12-35-119, C.R.S.** Change the title to “Examination—how conducted—license issued to successful applicants” to better reflect the substance of the section.
 - **Section 12-35-119(2), C.R.S.** Revise this section to reflect that examination results will be retained for one, not two, years. This is consistent with current administrative practice and with other Division-regulated professions.
 - **Section 12-35-121, C.R.S.** Revise this to state, “The director may establish renewal fees and delinquency fees for late renewal and fees for reinstatement,” to clarify that the delinquency fees are charged due to late renewal, not reinstatement.
 - **Section 12-35-123(5), C.R.S.** Repeal the statement, “pursuant to section 12-35-117,” because it is unnecessary and references dentists only.

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- **Sections 12-35-124 and 125, C.R.S.**
 - Rather than restating all of the tasks that constitute the unsupervised practice of dental hygiene, section 12-35-125, C.R.S., should simply refer to the previous section (12-35-124, C.R.S.), then list only those tasks which go beyond the list in section 12-35-124, C.R.S.
 - Repeal references to the practice of dental hygiene by dentists because the dentistry scope of practice encompasses dental hygiene.
 - Repeal the language in section 12-35-125(2), C.R.S., regarding the administration of local anesthetic because section 12-35-125(1)(f), C.R.S., already establishes such administration may be performed under indirect supervision.
 - **Section 12-35-126(4), C.R.S.** Repeal this section, because it is duplicative with section 12-35-121, C.R.S.
 - **Section 12-35-127, C.R.S.** Both licensure by examination and by endorsement are addressed in this section. For the purpose of increasing clarity and readability, this should be split into two sections, one addressing examination, and the other addressing endorsement.
 - **Section 12-35-127(2), C.R.S.** Revise this section to reflect that examination results will be retained for one, not two, years. This is consistent with current administrative practice and with other Division-regulated professions.
 - **Section 12-35-128(2), C.R.S.** The phrase “on the premises” should be repealed, because it contradicts the definition of “indirect supervision” in section 12-35-103(10)(a), C.R.S.
 - **Section 12-35-128(3)(b), C.R.S.** The words “direct or” should be stricken, because the tasks in the subsequent list may be performed under indirect supervision.
 - **Section 12-35-128(4), C.R.S.** This provision should be added to the list of tasks that may be done under indirect supervision at section 12-35-128(3)(b), C.R.S.
 - **Section 12-35-129, C.R.S.** This section is very long and covers a variety of topics. To clarify and improve the readability of this section, it should be split into seven separate sections with the following headings:
 - Panels
 - Denials
 - Grounds for discipline
 - Disciplinary actions
 - Mental/physical evaluations
 - Disciplinary proceedings
 - Cease and desist orders
 - Injunctive proceedings
 - **Section 12-35-129(1)(hh), C.R.S.** Since section 12-35-127(4), C.R.S., also requires dental hygienists to meet financial responsibility requirements, that provision should be referenced here.
 - **Section 12-35-131, C.R.S.** Add dental hygiene to this section, which prohibits the use of a forged or invalid diploma.
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