VIRGINIA BOARD OF DENTISTRY

AGENDA

September 15-16, 2016

Department of Health Professions

Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center, - Henrico, Virginia 23233

PAGE

September 15, 2016

9:00 a.m. **Formal Hearings**

September 16, 2016

Board Business

9:00 a.m. **Call to Order – Dr. Rizkalla, Vice-President**

Evacuation Announcement – Ms. Reen

9:05 **Public Hearing on Proposed Regulations to Require Capnography for Monitoring Sedation and Anesthesia** **P1**

Public Comment

Approval of Minutes

- June 9, 2016 Formal Hearing **P11**
- June 10, 2016 Business Meeting **P14**
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- August 2, 2016 Telephone Conference Call **P25**
- August 12, 2016 New Board Member Orientation **P27**

DHP Director's Report – Dr. Brown

Liaison/Committee Reports

- BHP - Dr. Watkins
  August 18, 2016 Minutes **P29**
- AADB – Dr. Rizkalla
  - Membership
  - 133rd Annual Meeting **P34**
  - ADA Forum Invitation **P35**
- ADEX – Dr. Rizkalla
  August 2016 Annual Meeting Report **P37**
- SRTA– Dr. Watkins
  August 2016 Annual Meeting Report **P40**

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VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Dentistry**

Meeting: Public hearing

Edit meeting Cancel this meeting

Meeting Details	
Date / Time	9/16/2016 9:05 am
Location	Perimeter Building, 9960 Mayland Drive, 2nd Floor, Board Room 4, Richmond, VA 23233
Board Website	http://www.dhp.virginia.gov
Agenda document	not available

Disability Friendly? Yes **Deaf interpreter available upon request?** Yes

Purpose of the meeting

The Board will take public comment on proposed regulations to require capnography for monitoring sedation and anesthesia.

Meeting Scope

[ ] General business

[ ] Discuss particular regulations / chapters

[X] Public hearing to discuss a proposed change

This meeting is a public hearing to discuss the following proposed change(s)

Requirement for capnography for monitoring anesthesia or sedation

Contact Information	
Name / Title:	Sandra Reen / *Executive Director*
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Project 4438

BOARD OF DENTISTRY

Requirement for capnography for monitoring anesthesia or sedation

18VAC60-21-291. Requirements for administration of conscious/moderate sedation.

A. Delegation of administration.

1. A dentist who does not hold a permit to administer conscious/moderate sedation shall only use the services of a qualified dentist or an anesthesiologist to administer such sedation in a dental office. In a licensed outpatient surgery center, a dentist who does not hold a permit to administer conscious/moderate sedation shall use either a qualified dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer such sedation.

2. A dentist who holds a permit may administer or use the services of the following personnel to administer conscious/moderate sedation:

a. A dentist with the training required by 18VAC60-21-290 D 2 to administer by an enteral method;

b. A dentist with the training required by 18VAC60-21-290 D 1 to administer by any method;

c. An anesthesiologist;

d. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1; or

e. A registered nurse upon his direct instruction and under the immediate supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1.

3. If minimal sedation is self-administered by or to a patient 13 years of age or older before arrival at the dental office, the dentist may only use the personnel listed in subdivision 2 of this subsection to administer local anesthesia. No sedating medication shall be prescribed for or administered to a patient 12 years of age or younger prior to his arrival at the dentist office or treatment facility.

4. Preceding the administration of conscious/moderate sedation, a permitted dentist may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

a. A dental hygienist with the training required by 18VAC60-25-100 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

b. A dental hygienist, dental assistant, registered nurse, or licensed practical nurse to administer Schedule VI topical oral anesthetics.

5. A dentist who delegates administration of conscious/moderate sedation shall ensure that:

a. All equipment required in subsection B of this section is present, in good working order, and immediately available to the areas where patients will be sedated and treated and will recover; and

b. Qualified staff is on site to monitor patients in accordance with requirements of subsection D of this section.

B. Equipment requirements. A dentist who administers conscious/moderate sedation shall have available the following equipment in sizes for adults or children as appropriate for the

patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

3. Endotracheal tubes with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway;

4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades;

5. Pulse oximetry;

6. Blood pressure monitoring equipment;

7. Pharmacologic antagonist agents;

8. Source of delivery of oxygen under controlled positive pressure;

9. Mechanical (hand) respiratory bag;

10. Appropriate emergency drugs for patient resuscitation;

11. Electrocardiographic monitor if a patient is receiving parenteral administration of sedation or if the dentist is using titration;

12. Defibrillator;

13. Suction apparatus;

14. Temperature measuring device;

15. Throat pack; ~~and~~

16. Precordial or pretracheal stethoscope; and

17. Capnograph/end tidal CO2 monitor.

C. Required staffing. At a minimum, there shall be a two person treatment team for conscious/moderate sedation. The team shall include the operating dentist and a second person to monitor the patient as provided in 18VAC60-21-260 K and assist the operating dentist as provided in 18VAC60-21-260 J, both of whom shall be in the operatory with the patient throughout the dental procedure. If the second person is a dentist, an anesthesiologist, or a certified registered nurse anesthetist who administers the drugs as permitted in 18VAC60-21-291 A, such person may monitor the patient.

D. Monitoring requirements.

1. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility and prior to discharge.

2. Blood pressure, oxygen saturation, and pulse shall be monitored continually during the administration and recorded every five minutes.

3. Monitoring of the patient under conscious/moderate sedation is to begin prior to administration of sedation or, if pre-medication is self-administered by the patient, immediately upon the patient's arrival at the dental facility and shall take place continuously during the dental procedure and recovery from sedation. The person who administers the sedation or another licensed practitioner qualified to administer the same level of sedation must remain on the premises of the dental facility until the patient is evaluated and is discharged.

E. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge and vital signs have been taken and recorded.

2. Post-operative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number.

3. The patient shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

F. Emergency management. The dentist shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway, and cardiopulmonary resuscitation.

18VAC60-21-301. Requirements for administration of deep sedation or general anesthesia.

A. Preoperative requirements. Prior to the appointment for treatment under deep sedation or general anesthesia the patient shall:

1. Be informed about the personnel and procedures used to deliver the sedative or anesthetic drugs to assure informed consent as required by 18VAC60-21-260 F.

2. Have a physical evaluation as required by 18VAC60-21-260 C.

3. Be given preoperative verbal and written instructions including any dietary or medication restrictions.

B. Delegation of administration.

1. A dentist who does not meet the requirements of 18VAC60-21-300 shall only use the services of a dentist who does meet those requirements or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a dentist shall use either a dentist who meets the requirements of 18VAC60-20-300, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist who meets the requirements of 18VAC60-20-300 may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

a. A dentist with the training required by 18VAC60-21-300 C;

b. An anesthesiologist; or

c. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-300 C.

3. Preceding the administration of deep sedation or general anesthesia, a dentist who meets the requirements of 18VAC60-20-300 may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

a. A dental hygienist with the training required by 18VAC60-25-100 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

b. A dental hygienist, dental assistant, registered nurse, or licensed practical nurse to administer Schedule VI topical oral anesthetics.

C. Equipment requirements. A dentist who administers deep sedation or general anesthesia shall have available the following equipment in sizes appropriate for the patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

3. Endotracheal tubes with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway;

4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades;

5. Source of delivery of oxygen under controlled positive pressure;

6. Mechanical (hand) respiratory bag;

7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;

8. Appropriate emergency drugs for patient resuscitation;

9. EKG monitoring equipment;

10. Temperature measuring devices;

11. Pharmacologic antagonist agents;

12. External defibrillator (manual or automatic);

13. ~~For intubated patients, an End-Tidal CO^2 monitor~~ Capnograph/end tidal CO2 monitor;

14. Suction apparatus;

15. Throat pack; and

16. Precordial or pretracheal stethoscope.

D. Required staffing. At a minimum, there shall be a three-person treatment team for deep sedation or general anesthesia. The team shall include the operating dentist, a second person to monitor the patient as provided in 18VAC60-21-260 K, and a third person to assist the operating dentist as provided in 18VAC60-21-260 J, all of whom shall be in the operatory with the patient during the dental procedure. If a second dentist, an anesthesiologist, or a certified registered nurse anesthetist administers the drugs as permitted in 18VAC60-21-301 B, such person may serve as the second person to monitor the patient.

E. Monitoring requirements.

1. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility to include: temperature, blood pressure, pulse, oxygen saturation, and respiration.

2. The patient's vital signs and EKG readings shall be monitored, recorded every five minutes, and reported to the treating dentist throughout the administration of controlled drugs and recovery. When depolarizing medications are administered, temperature shall be monitored constantly.

3. Monitoring of the patient undergoing deep sedation or general anesthesia is to begin prior to the administration of any drugs and shall take place continuously during administration, the dental procedure, and recovery from anesthesia. The person who administers the anesthesia or another licensed practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

F. Emergency management.

1. A secured intravenous line must be established and maintained throughout the procedure.

2. The dentist shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway, and cardiopulmonary resuscitation.

G. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge and vital signs have been taken and recorded.

2. Post-operative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number for the dental practice.

3. The patient shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
June 9, 2016

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 1:08 p.m., on June 9, 2016 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Charles E. Gaskins, III, D.D.S., President

MEMBERS PRESENT:
John M. Alexander, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Carol R. Russek, J.D., Citizen Member
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT: Tonya A. Parris-Wilkins, D.D.S.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Donna M. Lee, Discipline Case Manager

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
James E. Schliessmann, Senior Assistant Attorney General
Shevaun Roukous, Adjudication Specialist
Andrea Pegram, Court Reporter

ESTABLISHMENT OF A QUORUM: With nine members present, a quorum was established.

Kimberly D. Johnson, R.D.H. Reinstatement Case Nos.: 171896 and 159434

Ms. Johnson was present without legal counsel in accordance with the Notice of the Board dated May 19, 2016.

Dr. Gaskins swore in the witnesses.

Ms. Johnson made an opening statement, and she did not have any exhibits to present to the Board.

Following Mr. Schliessmann' s opening statement and presentation of Commonwealth's Exhibits 1-5, Ms. Johnson objected to the statements made by Mr. Schliessmann pertaining to the Virginia Alcohol Safety Action Program ("VASAP"). Dr. Gaskins overruled Ms. Johnson's objection, and admitted into evidence Commonwealth's Exhibits 1 through 5. Dr. Gaskins informed Ms. Johnson she could address her concerns about VASAP in her testimony to the Board.

Mr. Schliessmann informed the Board that Commonwealth's Exhibit 2, which is the mandatory suspension Order entered April 29, 2015, was missing Page 2 that contains Dr. Brown's signature when the exhibit packet was mailed to Ms. Johnson and the Board members. Mr. Schliessmann requested that Page 2 of the April 29, 2015 Order be admitted into evidence. Dr. Gaskins admitted Page 2 of the April 29, 2015 Order into evidence.

Ms. Reen stated that also in Commonwealth's Exhibit 2, the bate-stamped pages 5 and 6 are placed in the wrong order in the exhibit in that page 6 is before page 5.

Mr. Schliessmann stated that by letter dated June 2, 2016, he informed Ms. Reen and Ms. Johnson that he intended to amend the language in allegation number 2(a) of the Statement of Allegations in the Notice of Formal Hearing dated May 19, 2016. Mr. Schliessmann requested that the Board enter into evidence his letter that shows the amended language for allegation Number 2(a). Dr. Gaskins admitted into evidence the letter dated June 2, 2016 from Mr. Schliessmann to amend the Formal Hearing Notice.

Ms. Johnson testified on her own behalf.

Testifying on behalf of the Commonwealth was John W. Turner, DHP Senior Investigator.

Closed Meeting: Dr. Rizkalla moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Ms. Johnson. Additionally, he moved that Board staff, Ms. Reen, Ms. Lee, and Board counsel, Mr. Rutkowski attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Rizkalla moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted

from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision: Dr. Rizkalla moved to accept the Findings of Facts and Conclusion of Law as presented by the Commonwealth, amended by the Board, and read by Mr. Rutkowski. The motion was seconded and passed.

Mr. Rutkowski reported that the Board denied Ms. Johnson's application for reinstatement of her license to practice dental hygiene in the Commonwealth of Virginia.

Dr. Rizkalla moved to adopt the decision as read by Mr. Rutkowski. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 3:08 p.m.

_____ _____

Charles E. Gaskins, III, D.D.S., President Sandra K. Reen, Executive Director

_____ _____

Date Date

VIRGINIA BOARD OF DENTISTRY
MINUTES
June 10, 2016

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:03 a.m. on June 10, 2016, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

PRESIDING: Charles E. Gaskins III, D.D.S., President

BOARD MEMBERS PRESENT:
John M. Alexander, D.D.S
Tonya A. Parris-Wilkins, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Carol R. Russek, J.D., Citizen Member
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Donna Lee, Discipline Case Manager for the Board

OTHERS PRESENT: David E. Brown, D.C., DHP Director

ESTABLISHMENT OF A QUORUM: All members of the Board were present.

Ms. Reen read the emergency evacuation procedures.

Dr. Gaskins explained the parameters for public comment and opened the public comment period.

PUBLIC COMMENT: **Dr. Richard Taliaferro, DDS**, President of the Virginia Dental Association, commended the Board for attending dental association meetings around the state to inform dentists about regulatory changes. He also expressed appreciation for the Board's response to concerns about the regulations governing the administration of nitrous oxide analgesia and asked the Board to make the regulations and requirements appropriate to the degree of risk.

APPROVAL OF Minutes: Dr. Gaskins asked if there were any corrections to the March 10, 2016 Formal Hearing minutes; March 11, 2016 Business Meeting

minutes; and April 27, 2016 Nitrous Subcommittee Meeting minutes. These minutes were approved as published.

DHP DIRECTOR'S REPORT:

Dr. Brown reported on DHP's staff training held on May 24-25, 2016, noting that Secretary Hazel gave a presentation and staff rated the training as 4.4 out of a scale of 5. He stated that DHP and other state agencies are participating in launching a new webpage on opioid abuse, Virginia Aware, on July 1, 2016. He welcomed any suggestions for a section on dentists and good links for pain management that could be made available on the webpage.

Dr. Brown addressed the Board's authority to recover disciplinary costs, commenting that the law is permissive and allows for discretion on assessing these cost. He then posed questions about the Board's practice of assessing costs for every respondent. He asked about fairness for dental hygienists whose income is typically less than a dentist's; the impact on a licensee who is not working; when respondents are notified of the assessment; and if a monetary penalty loses impact when it is significantly less than the administrative costs being assessed. Dr. Brown said he wanted to make the Board aware of his questions since some of the current Board members were not part of the Board when this law was instituted.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Watkins stated he did not have anything to report.

AADB. Dr. Parris-Wilkins referenced her report and stated that there are a lot of topics that boards are concerned about across the country so the meeting was very enlightening and at times contentious. Ms. Palmatier said she didn't have any additional comments.

ADEX. Dr. Rizkalla gave a presentation on the five agencies administering licensure exams and the test development agency, ADEX, noting that licensure portability is an important matter to dental professionals. He stated that CDCA and CITA administer the ADEX dental exam, while CRDTS, SRTA, and WREB administer their own exams. Then he addressed the letters sent by the ADA and ADEA to state dental boards indicating any state dental board that accepts fewer than all of the available clinical licensure examinations is acting arbitrarily and speciously in an anticompetitive manner. Dr. Rizkalla said Virginia accepts all testing exams so no immediate action was needed, but the Board should be aware of the national issues.

Ms. Swecker asked what steps had been taken for members of the Virginia Board to examine for CITA. Ms. Reen stated she is obtaining information from the agency.

Ms. Reen said the Board may want to consider rejoining the AADB, if it wants to have a voice in the national discussion of licensure examinations. She explained the Board could join; then pay for designated board members individually to have voting privileges. She suggested that the Exam Committee could be convened to make recommendations on rejoining and on establishing a position on clinical examinations. Several Board members expressed an interest that the Board should join AADB in order to have a voice in the upcoming matters that will be addressed by AADB. Dr. Brown said he would consider requests to send more than two Board members to the meetings to facilitate participation. He also suggested delegating discussion of Board participation to the Board president, Ms. Reen, and him to discuss finances to determine how many Board members can join AADB annually.

Ms. Swecker moved that the Board rejoin AADB with the Board delegating to the president of the Board in consultation with Ms. Reen and Dr. Brown to review the finances to determine how many Board members can join AADB annually. The motion was seconded and passed.

Regulatory-Legislative Committee. Ms. Swain stated that the Committee met on May 6, 2016, and reviewed the minutes with the Board. She stated that the next meeting is scheduled for October 14, 2016.

Nitrous Subcommittee Meeting. Dr. Gaskins stated that the meeting held on April 27, 2016 was very productive, and that any proposed changes to the legislation would need to be voted on today by the Board so that it possibly can be a fast-track action.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported that the regulatory action requiring capnography for monitoring anesthesia or sedation, and the regulations addressing the qualifications for restricted or temporary licenses are at the Governor's Office for review.

Board Action on the Monitoring of Nitrous Oxide and Minimal Sedation. Ms. Yeatts reviewed the changes recommended by the Nitrous Subcommittee to establish a new section of regulation which addresses the administration of only nitrous oxide and to modify the provisions for the administration of minimal sedation in the following sections:

- 18VAC60-21-10(D) – Add definitions for the terms "analgesia" and "inhalation analgesia" and modify the definition of the term "minimal sedation."
- 18VAC60-21-260(D)(2) – Amend to add Body Mass Index (BMI).
- 18VAC60-21-279 – Add this section to address administration of only inhalation analgesia (nitrous oxide).
- 18VAC60-21-280(A)(2) – Amend to replace the words "nitrous oxide" with the words "minimal sedation."
- 18VAC60-21-280(C)(1)(d) - Amend to replace the word "indirect" with "direct."
  The Board decided to replace the words "under direct supervision" with the words "with the dentist present in the operatory."

Ms. Yeatts then recommended amending 18VAC60-21-279(D) to add blood pressure monitoring equipment because blood pressure is a required vital sign. The Board agreed.

Dr. Wyman moved to adopt the proposed regulations as a fast-track action. The motion was seconded and passed.

Board Action on Public Participation Guidelines. Ms. Yeatts stated that 18VAC60-11-50(A)(ii) was added to conform to an amendment made to the language in the Code of Virginia. Ms. Swain moved to advance the amendment to 18VAC60-11-50 by fast-track action. The motion was seconded and passed.

Board Action on HB319 – Volunteer Hours to Count Toward CE Requirement. Ms. Yeatts presented the amendments to Chapter 21 and Chapter 25 recommended by the Regulatory-Legislative Committee. The Board discussed the ratio of CE credit to number of volunteer hours without changing the Committee's recommendation. What constitutes a "free clinic" was questioned because some clinics charge an administrative or "sliding scale" fee. Mr. Rutkowski was asked to research this matter and to report his findings at the Board's September meeting.

Dr. Alexander moved that the Board adopt the amendments to Chapter 21 and Chapter 25 as presented by Ms. Yeatts for fast-track action. The motion was seconded and passed.

Board Discussion on SB712 – Remote Supervision of Dental Hygienists. Ms. Yeatts reviewed the draft regulations recommended by the Regulatory-Legislative Committee. There was a question about whether a dental hygienist employed by a facility might practice under remote supervision. Ms. Reen noted that the legislation requires a dental hygienist to be employed by a dentist in order to practice under the new provisions for remote supervision.

Ms. Yeatts said SB712 becomes effective July 1, 2016, so the Board will adopt regulations for emergency enactment at its September Board meeting.

HB310. Ms. Reen noted that this bill addressing mobile dental clinics will also be addressed at the September Board meeting.

BOARD DISCUSSION/ACTION:

Review and Discussion of Public Comment Topics. Dr. Gaskins reported that Dr. Taliaferro's comments were addressed in the regulatory proposal for monitoring Nitrous Oxide and minimal sedation which was adopted earlier in the meeting.

Dr. Gaskins said the following letters were received as information:

- ADEA Letter to State Board.
- ADEA Letter to Maryland State Board of Dental Examiners
- JCNDE Letter to State Board
- ADEX Letter to State Board

Guidance Document Addressing Failure to Report to the PMP. Ms. Reen informed the Board that the guidance document is a proposal to guide staff in addressing PMP reports of dentists that failed to submit required dispensing reports. Ms. Swain moved to adopt the Guidance Document. The motion was seconded and passed.

ADA Sedation and Anesthesia Guidelines. Ms. Reen asked the Board if it wished to make further comment on these guidelines. Dr. Rizkalla moved that the Executive Director send a letter in support of the information provided and include information on the Board's regulatory action on Nitrous Oxide. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported that from February, 2016, through May 24, 2016, the Board received 139 cases and closed 151. She said, in the first quarter of 2016 (January 1 – March 31, 2016):

- A total of 74 patient care cases were received and 66 were closed for a 89% clearance rate;
- The current pending caseload older than 250 days is 31% and the goal is 20%; and
- 84% of the patient care cases were closed within 250 days and the goal is 90%.

Ms. Palmatier reported on the number of sedation and anesthesia permit holders, noting that there are 442 Permit Holder Locations with some locations having multiple permit holders and some permit holders having multiple locations. She said in the 19 months

since the sedation inspection program began, 52 permit holder locations with approximately 100 permit holders have been inspected.
Ms. Palmatier explained there is a high number of cases that need to be scheduled for informal conferences. She requested that the Board approve adding the following tentative dates to its schedule for informal conferences: July 22, 2016; August 19, 2016; October 28, 2016; and December 16, 2016. She also asked that she be allowed to use any three Board members available on those dates instead of the established special conference committees. Following discussion of using another day of the week and scheduling Thursday afternoon through Friday, the Board agreed to add the requested dates to the schedule and approved using any Board members that are available.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

2017 Proposed Calendar. Ms. Reen stated the calendar is presented for adoption so that room reservations can be made. She added that, once Board appointments are made, adjustments in committee assignments may be needed so she recommended addressing any date changes at the September meeting. Dr. Watkins moved to adopt the 2017 meeting calendar. The motion was seconded and passed.

Guidance Document Addressing Auditing Continuing Education (CE). Ms. Reen reviewed that the Board voted in March to institute an annual random audit; then granted her permission to work on a guidance document for discussion of implementation. She then addressed the following issues:

- **Exemptions and extensions of time to complete CE** – Ms. Reen explained that in practice, licensees are requesting exemptions because that is the option in the regulations and the Board is only granting extensions. Ms. Yeatts added that the Virginia Code is worded exemptions or extensions. After further discussion, the Board agreed by consensus to amend the regulations to add "extensions" by fast track action.
- **Random sample size** – Ms. Reen reviewed the Raosoft Sample Size Calculator, noting that the number to be audited was based on the Board's total number of licensees; to keep the sample size low, even though that meant oral and maxillofacial surgeons and sedation and anesthesia permit holders would be counted more than once, and that inactive licensees are included. She noted that Dr. Carter recommended the figures for the margin of error, confidence level and response distribution, and that she supported using the total count methodology.
- **Deciding annually the scope of audit** – Ms. Reen asked the Board to determine each year the scope of the audit to be

conducted to prevent audit activity from adversely affecting performance on meeting goals for standard of care cases. Board members asked about an audit every two years.

- **Auditing selected licenses** – Ms. Reen explained that the Board currently audits licensees who fail to attest to completing CE on their renewal forms. She asked if the Board wanted to also audit licensees who are under a board order to complete CE in addition to the required 15 hours annually or who have been given extensions for completing CE. Dr. Brown stated that the Board should be consistent with all other boards in DHP and do only a random audit. He added that other boards use temporary staff to conduct audits. Several board members supported auditing the selected licensees as addressed in the draft guidance document.

The Board agreed to Dr. Brown's proposal to edit the Scope of Audits section of the guidance document to read as follows:

> The Board shall conduct an audit of compliance with CE requirements on a random sample of licensees selected from MLO by the DHP IT Department. The sample size shall be determined using both the online Sample Size Calculator by Raosoft (or equivalent algorithm) and the total number of licensees. The Board may also audit the following:
>
> - Active licensees who have completed the terms of a CCA or a Board Order which required completion of CE in addition to the 15 hour requirement per year;
> - Active licensees who failed to respond, or responded "no", to the CE renewal question on the annual renewal form, and/or requested an exemption after license renewal;
> - Active licensees who were granted an extension to meet their CE requirement.

Dr. Rizkalla moved to amend the previous action taken by the Board on March 11, 2016, to change from collecting every year a random sample for CE audit to a biennial CE audit. The motion was seconded and passed.

Dr. Wyman moved to amend the regulations to grant an exemption up to one year prior to the renewal date. The motion was seconded and passed.

Ms. Reen recommended moving her last two items on the Agenda to the September meeting so the disciplinary matter that had been scheduled for 12:30 p.m. could be addressed. All agreed.

Dr. Gaskins noted that the terms of five members are expiring and that at least four of the five were not seeking another term. He, Ms. Swain, Ms. Swecker, Dr. Rolon, and Dr. Watkins all expressed appreciation for the support and guidance they have received and for the great learning experience serving as a Board member has given them.

Dr. Gaskins stated that he had appointed Dr. Rolon and Ms. Swain to the Nominating Committee, and that they will meet today so that a report can be presented to the Board in September.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 1:38 p.m.

_____
Charles E. Gaskins III, D.D.S., President

_____
Sandra K. Reen, Executive Director

_____
Date

_____
Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 1:50 p.m., on June 10, 2016, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 4, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Tammy K. Swecker, R.D.H., Secretary-Treasurer

MEMBERS PRESENT:
Tonya A. Parris-Wilkins, D.D.S.
Evelyn M. Rolon, D.M.D.
Carol R. Russek, J.D.
Melanie C. Swain, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
John M. Alexander, D.D.S.
Charles E. Gaskins, III, D.D.S.
A. Rizkalla, D.D.S.

QUORUM: With seven members present, a quorum was established.

STAFF PRESENT: Sandra K. Reen, Executive Director

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General, Board Counsel
Wayne T. Halbleib, Senior Assistant Attorney General
Tammie Jones, Adjudication Specialist

Donald Kern, D.D.S. Case Nos.: 148950 and 148993 The Board received information from Mr. Halbleib regarding a Consent Order signed by Dr. Kern as a settlement proposal for the resolution of his case in lieu of proceeding with the scheduled Formal Hearing.

Closed Meeting: Dr. Watkins moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Donald Kern. Additionally, Dr. Watkins moved that Ms. Reen and Mr. Rutkowski attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Watkins moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION: The Board adopted Ms. Russek's motion to offer a counter proposal with findings that § 54.1-2406(4) of the Code of Virginia was violated as addressed in the allegations.

ADJOURNMENT: With all business concluded, the Board adjourned at 2:30 p.m.

Tammy K. Swecker, R.D.H., Chair

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION – TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:33 p.m., on June 30, 2016, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 1, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Charles E. Gaskins, III, D.D.S., President

MEMBERS PRESENT:
Melanie C. Swain, R.D.H.
Tonya A. Parris-Wilkins, D.D.S.
Evelyn M. Rolon, D.M.D.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
John M. Alexander, D.D.S.
A. Rizkalla, D.D.S.
Carol R. Russek, J.D.
Tammy K. Swecker, R.D.H.

QUORUM: With six members present, a quorum was established.

STAFF PRESENT:
Kelley W. Palmatier, Deputy Executive Director
Donna Lee, Discipline Case Manager

Mesfin W. Zelleke, D.D.S.
Case No.: 155676

The Board received information from Ms. Palmatier regarding the expert opinion obtained on behalf of the Board for the possible resolution of this case in lieu of proceeding with a formal hearing.

DECISION: Dr. Watkins moved that the Board accept the opinion of the expert regarding the standard of care, dismiss the case and not proceed with a formal hearing. Following a second, a roll call vote was taken. The motion passed.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:55 p.m.

Charles E. Gaskins, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:18 p.m., on August 2, 2016, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: A. Rizkalla, D.D.S., President

MEMBERS PRESENT: John M. Alexander, D.D.S.
Patricia B. Bonwell, R.D.H., PhD.
Nathaniel C. Bryant, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Tammy C. Ridout, R.D.H.
Carol R. Russek, J.D.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT: Tonya A. Parris-Wilkins, D.D.S.

QUORUM: With nine members present, a quorum was established.

STAFF PRESENT: Sandra K. Reen, Executive Director
Lori Pound, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT: James E. Rutkowski, Assistant Attorney General, Board Counsel
Wayne T. Halbleib, Senior Assistant Attorney General

Ms. Reen explained to the new Board members the purpose and procedures of the telephone conference call and the responsibility of the Board when rendering a decision.

Edward A. Longwe, D.D.S.
Case No.: 172776

The Board received information from Mr. Halbleib in order to determine if Dr. Longwe's practice of dentistry constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.

Closed Meeting: Dr. Alexander moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Edward A. Longwe. Additionally, Dr. Alexander moved that Ms. Reen, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Alexander moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which

only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION: Dr. Wyman moved that the Board summarily suspend Dr. Longwe's license to practice dentistry in the Commonwealth of Virginia in that his practice of dentistry constitutes a substantial danger to public health and safety; schedule him for a formal hearing; and, offer a consent order for the revocation of his license to practice dentistry in lieu of proceeding with a formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 6:15 p.m.

A. Rizkalla, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

BOARD OF DENTISTRY
NEW MEMBER ORIENTATION

Friday, August 12, 2016

Department of Health Professions
9960 Mayland Drive, Suite 200
Henrico, Virginia

CALL TO ORDER: The meeting was called to order at 1:15 p.m.

PRESIDING: Al Rizkalla, D.D.S., President

MEMBERS PRESENT: Patricia B. Bonwell, R.D.H., Ph.D
Nathaniel C. Bryant, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Tammy C. Ridout, R.D.H.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager

OTHER: James E. Rutkowski, Assistant Attorney General, Board Counsel

ORIENTATION: Dr. Rizkalla welcomed all new Board Members. Dr. Rizkalla reviewed the Board's bylaws and the Code of Conduct for all members.

Mr. Rutkowski explained his role with the Board and discussed the powers and duties of health regulatory boards, the Administrative Process Act, the Freedom of Information Act, and the Conflict of Interest provisions.

Ms. Reen went over the laws, regulations and policies in the Board Member's notebook. She then explained the Board's three areas of work; licensure, regulation, and discipline. She gave an overview of the Board's structure, staffing, and memberships in AADB, SRTA and ADEX.

Ms. Vu reviewed the state's policies on travel and per diems then provided the conflict of interest training information to complete online and ask to be notified upon completion.

Ms. Palmatier explained the disciplinary case process and the Probable Cause Review form and discussed the information needed to close a case and to move a case forward for issuance of an advisory letter, confidential consent agreement, pre-hearing consent order and notice for an informal conference. She also reviewed the guide for case reviews, probable cause decisions

and disciplinary action. She encouraged members to use it to help work through cases and to call staff with any questions about a case.

ADJOURNMENT The training was adjourned at 4:35 p.m.

Al Rizkalla, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

Virginia Department of Health Professions

DRAFT

Board of Health Professions
Full Board Meeting

August 18, 2016
11:00 a.m. - Board Room 2
9960 Mayland Dr, Henrico, VA 23233

In Attendance	Barbara Allison-Bryan, MD, Board of Medicine
	CHAIRMAN: Robert J. Catron, Citizen Member
	Helene D. Clayton-Jeter, OD, Board of Optometry
	Kevin Doyle, Ed.D., LPC, LSATP, Board of Counseling
	Yvonne Haynes, LCSW, Board of Social Work
	Mark Johnson, DVM, Board of Veterinary Medicine
	Allen R. Jones, Jr., DPT, PT
	Robert H. Logan, III, Ph.D., Citizen Member
	Ryan Logan, Board of Pharmacy
	Martha S. Perry, MS, Citizen Member
	Jacquelyn M. Tyler, RN, Citizen Member
	Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language Pathology
	James D. Watkins, DDS, Board of Dentistry
	James Wells, RPH, Citizen Member
Absent	Trula E. Minton, MS, RN, Board of Nursing
DHP Staff	David E. Brown, D.C., Director DHP
	Elizabeth A. Carter, Ph.D., Executive Director BHP
	Charles Giles, Budget Manager
	Elaine Yeatts, Senior Policy Analyst DHP
	Laura L. Jackson, Operations Manager BHP
Observers	Dr. William Ward, Virginia Chiropractic Association
	Laura McHale, Keeney Group/VCA

Call to Order

Acting Chair Mr. Catron **Time** 11:05 a.m.

Quorum Established

Public Comment

Comment Dr. William Ward, Virginia Chiropractic Association

Discussion

Dr. Ward thanked the Board for its work on the Chiropractor review and extended his wishes that the committee agree with the addition of this item to the scope of practice.

Approval of Minutes

Presenter Mr. Catron

Discussion

The May 5, 2016 10:00 a.m. Full Board meeting minutes were approved with one amendment: remove the DHP logo from the Telehealth Review update report, and properly seconded. All members in favor, none opposed.

Directors Report

Presenter Dr. Brown

Discussion

Dr. Brown provided an update on the agency's internal training activities and plans for the fall board member training day. In addition, he mentioned the agency's continued efforts in activities related to reduction of opiate abuse. DHP will be submitting three (3) bills this year to the General Assembly. DHP Boards are reviewing statutes and making revisions as necessary. The Board of Medicine is hosting a website for the Prescription Drug Task Force which will go live in early September.

Legislative and Regulatory Report

Presenter Ms. Yeatts

Discussion

Ms. Yeatts advised the Board that *18VAC 75-30-10 et seq.*, regulations governing standards for dietitians and nutritionists require appeal because the language is now incorporated into statute.

Motion

A motion was made to repeal *18VAC 75-30-10 et seq.*, regulations governing standards for dietitians and nutritionists. The motion was properly seconded by Dr. Watkins. All members were in favor, none opposed.

Discussion

Ms. Yeatts advised the Board that *18VAC 75-11-10 et seq.* needs to be amended to include a requirement for the Board to afford interested persons an opportunity to present their views and be accompanied by and represented by counsel or other representative in the promulgation of any regulatory action. This amendment reflects statutory update.

Motion

A motion was made to amend *18VAC 75-11-10 et seq.* The motion was properly seconded by Dr. Logan, III. All members were in favor, none opposed.

DHP Budget Review

Presenter Mr. Giles

Discussion

Mr. Giles provided an overview of DHPs FY17 budget. He stated that DHP is a non-general fund agency and that revenue is generated by issuing licensees and not tax dollars. 83% of the agency's revenue is budgeted based on then number of renewals forecasted for a given fiscal year. The remaining 17% of revenue is budgeted based on historical data.

Lunch Break

Presenter Mr. Catron

Mr. Catron announced a lunch break at 11:55 a.m. The meeting reconvened at 12:14 p.m.

Executive Directors Report

Presenter Dr. Carter

Agency Performance

Dr. Carter reviewed the agencies performance measures in relation to clearance rate, age of pending caseload and time to disposition.

Board Budget

Dr. Carter stated that the Board utilized 95.57% of its yearly budget. Staff turnover in early FY2016 accounted for the 4.43% difference.

Healthcare Workforce Data Center

Dr. Carter provided an update on the Data Center. The latest Dentist and Dental Hygienist reports will be presented to the Board of Dentistry in September. She will also be presenting at the Council on Licensure, Enforcement and Regulation annual conference in September. The presentation will focus on Virginia's minimum data set standard approach as a model for other states' professional licensing boards.

Regulatory Research Committee Report

Presenter Mr. Wells

Chair

Mr. Wells updated the Board on the progress that was made regarding the Chiropractor/CLD review at the August 18, 2016 10:00 a.m. Regulatory Research Committee meeting. The Committee concluded the following: (1) It affirms that health care providers should be allowed to practice to the highest level of their education and training. (2) Chiropractors licensed by the Virginia Board of Medicine who successfully complete the Federal Motor Carrier Safety Administration Medical Examiner training and testing do have the requisite education and training. (3) Virginia's chiropractor scope of practice statutory language is dated and does not reflect current circumstances. The General Assembly may wish to consider a comprehensive scope of practice update to avoid single-issue amendments in the future. Board staff will create a letter in response to Delegate Orrock's original request by November 1, 2016.

Motion

A motion was made to create a response letter to Delegate Orrock to include the three items as discussed. The motion was properly seconded by Dr. Allison-Bryan. All in favor, none opposed.

Board Reports

Presenter Mr. Catron

Board of Physical Therapy

Dr. Jones stated reported that the new Board of Physical Therapy's Executive Director has been hired and will begin August 25. He thanked Ms. Russell for her service.

Board of Medicine

Dr. Allison-Bryan reported on the Board of Medicine's Legislative Committee's recommendation not to participate in the Interstate Medical Licensure Compact in its current form. Dr. Allison-Bryan stated that the purpose of the Compact was three-fold: 1) promote access to underserved states, 2) avoid duplication of the licensing work by boards, and 3) preempt a need for the federal government to issue a national license. She advised there were several factors discussed at length that were not consistent with the Board's current operations, including language that conflicts with Virginia laws and regulations. She also stated that the Board of Medicine is looking into decreasing the current licensing fee.

Board of Social Work

Ms. Haynes stated that the Board of Social Work completed fast track regulations to lessen the burden for future licensure by endorsement applicants.

Board of Audiology & Speech-Language Pathology

Ms. Verdun reported that regulations are being refined to stream line the language for SLP Assistants.

Board of Counseling

Dr. Doyle reported that the Board has scheduled a Supervisor Summit and Education Summit for September 9, 2016. In a matter of three hours after posting the invitation, 150 people had signed-up to attend. At this time, there will additional summits scheduled, as this is too many people to attend at one time.

Board of Pharmacy

Mr. Logan stated that the Board of Pharmacy's Regulatory Advisory Panel is reviewing regulations for processors of cannabidiol oil and THC-A oil to treat epilepsy patients who experience seizures. This work is extensive and ongoing at this time.

New Business

Presenter Mr. Catron

There was no new business to discuss.

Adjourned

Adjourned 12:48 p.m.

Acting Chair Robert Catron

Signature: _____ Date: ____/____/____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ Date: ____/____/____

Highlights of the 133rd Annual Meeting
AMERICAN ASSOCIATION OF DENTAL BOARDS
Sheraton Denver Downtown Hotel

Dates and Location: Tuesday-Wednesday, October 18-19, 2016, Sheraton Denver Downtown Hotel, Denver, CO. (See "Registration and Housing Information" for details.)

Schedule:

Tuesday, October 18, 2016

11:00 am – 12:30 pm	Registration
12:30 pm – 5:00 pm	Program/General Assembly
6:00 pm - 7:30 pm	President's Reception

Wednesday,October 19, 2016

7:00 am – 8:00 am	Registration
7:00 am – 8:00 am	Liaison Meeting
7:00 am – 8:00 am	New Member Orientation
7:00 am – 8:00 am	Program Committee Meeting
8:00 am – 12:00 pm	Program/Business Session
12:00 pm – 1:30 pm	Banquet Luncheon
1:30 pm – 5:00 pm	Program/General Assembly

Program Highlights: The goal of the 133rd AADB Annual Meeting is to provide information that is useful at the state level. The program has not been finalized at this time but the central theme will be the subject of license portability. The program details will be posted on the AADB website as soon as they are finalized.

Business Sessions: These sessions involve state boards' as well as individual members' positions on national issues which will allow the AADB to express its members' views at the national level. Therefore, the Board of Directors encourages boards and individual members to present resolutions on appropriate topics. Any member may submit a resolution for consideration during the 133rd Annual Meeting. A resolution either directs the Association to take a specific action or provides a statement of philosophy that can be used to represent a member's opinion at the national level. Resolutions should be submitted to the Central Office by August 1, 2016. Each resolution should be accompanied by a concise background statement. Rationale should appear only in the background statement; the resolution should be limited to the action or proposed statement.

Social Functions:

- ·President's Reception, 6:00 pm – 7:30 pm, Tuesday, October 18, 2016
- ·Banquet Luncheon, 12:00 noon – 1:30 pm, Wednesday, October 19, 2016. The "Citizen of the Year" will be recognized at this time.

Nominations for "Citizen of the Year": At each Annual Meeting, an AADB member is honored as "Citizen of the Year". This award is intended to honor a member who has made exceptional contributions to the public through dentistry and other types of public service. Nominations for "Citizen of the Year" will be accepted until August 1, 2016. Each nomination should include the name, address, email address and telephone number of the nominee and a description of his or her contribution.

ADA American Dental Association®
America's leading advocate for oral health

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Chicago, Illinois 60611-2637

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Date: August 31, 2016

To: Colorado Board of Dental Examiners
Connecticut Department of Public Health – Practitioner Licensing and Investigations Section
Iowa Dental Board
Kentucky Board of Dentistry
Minnesota Board of Dentistry
Virginia Board of Dentistry
Wisconsin Dentistry Examining Board

From: Dr. David M. Waldschmidt, Director, Department of Testing Services

Subject: Invitation to Attend ADA 2016 OSCE Development Forum

Dear Dr. Rizkalla, Board President, Virginia Board of Dentistry,

The Department of Testing Services (DTS) is a department within the American Dental Association (ADA) that provides psychometric and test development services for high-stakes examination programs within the dental and dental hygiene professions. DTS has been asked by the ADA's Council on Dental Education and Licensure (CDEL) to investigate the feasibility of developing a non-patient based, objective structured clinical examination (OSCE) for licensure purposes. Your dental board is invited to participate in a forum to solicit feedback on this topic.

The 2016 ADA OSCE Development Forum will include a brief presentation by DTS on the comparability of current clinical licensure examinations, and the anticipated characteristics of an OSCE capable of addressing core clinical examination licensure requirements. This presentation will be followed by a facilitated discussion led by Dr. Anthony Ziebert, SVP of the ADA's Division of Education and Professional Affairs. Feedback collected will be used to inform CDEL's recommendation to pursue an OSCE, as well as the construction and characteristics of the OSCE that could be developed.

To facilitate your board's participation, the forum will be held in Denver, Colorado, directly following the American Association of Dental Board's (AADB's) annual meeting. Details are provided below. Appetizers, beer, and wine will be provided.

Event:	**ADA 2016 OSCE Development Forum**
Date:	**Wednesday, October 19, 2016**
Time:	**5:00 pm – 6:30 pm**
Location:	**Tower Court B of the Sheraton Hotel Denver Downtown, Denver, CO**

We would appreciate receiving your response by September 31, 2016. At this time, attendance at the forum has been restricted to a select group of forward-thinking dental boards who might be amenable to such an examination. Your board's participation in this forum is important, and will be used to help inform the future of dental licensure in the US and its jurisdictions.

If you have any questions, please contact Betsey Palmer via email at palmerbe@ada.org.

Sincerely,

David M. Waldschmidt, Ph.D.
Director, ADA Department of Testing Services

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cc: ADA Board of Trustees and Officers
ADA Licensure Task Force
ADA state societies corresponding to invited dental boards
Cecile A. Feldman, D.M.D., M.B.A., Chair, ADEA Board of Directors
Daniel J. Gesek, Jr., DMD, Chair, CDEL
Karen M. Hart, Director, CDEL and Education Operations
Jane Jasek, Manager, Dental Education and Licensure Matters, CDEL
Nancy Honeycutt, Executive Director, American Student Dental Association (ASDA)
Kathleen T. O'Loughlin, DMD, MPH, ADA Executive Director
Jill M. Price, DMD, Vice Chair, CDEL
Sohaib Soliman, President, ASDA
Richard W. Valachovic, D.M.D., MPH, President and CEO, ADEA
Anthony J. Ziebert, DDS, MS, Senior Vice President, Education and Professional Affairs

2016-2017 All current officers were re-elected.

Changes to the ADEX Examination:

- Endodontics: Increased the allowable size of the posterior access opening for 2017.
- Periodontics: Second submission of another patient will no longer be allowed.
- Restorative: Indirect pulp cap will be allowed 2017.
- Restorative: There will be "ONE" posterior composite restoration. (i.e. box vs. slot prep)

Changes to the ADEX Dental Hygiene Examination:

- Case selection will consist of one primary quadrant with 6 teeth and 2 posterior teeth in a secondary quadrant all of which, the candidate may utilize to select surfaces.
- The 2018 examination will be stopped after pre-treatment if it is determined that adequate number of points to pass has not been accrued to have a chance to pass.
- A process for the submission of a second case selection is being investigated for implementation in 2018

Presentations to the House of Representatives:

Dr. Joseph Gambacorta, Assistant Dean of Clinical Affairs, University of Buffalo- School of Dental Medicine:

"THE ROLE OF THE PATIENT CENTERED CIF IN A NATIONASL EXAM FOR DENTISTRY"

Dr. David Perkins, CDCA (Commission on Dental Competency Assessment)

"ADA LICENSURE TASK FORCE- THE DENTAL EXAMINATIONS ARE NOT THE SAME"

Respectfully submitted,

A.Rizkalla, DDS

ADEX
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Highlights of the 12th Annual American Board of Dental Examiners, Inc. (ADEX)
House of Representatives
August 7, 2016
Rosemont, IL

The following are highlights of the 12th Annual ADEX House of Representatives:

There were 50 out of 58 Jurisdiction, District Hygiene and District Consumer Representatives present.

2016 – 2017 Officers were elected: Dr. Stanwood Kanna, HI, President; Dr. William Pappas, NV, Vice-President; Dr. Jeffery Hartsog, MS, Secretary; Dr. Conrad "Chip" McVea, III, LA, Treasurer. Dr. Bruce Barrette, WI, remains as Immediate Past President.

District 5 elected Dr. Eleanore Awadalla, OH, to the ADEX Board of Directors.

District 8 re-elected Dr. David Perkins, CT, to the ADEX Board of Directors.

District 9 elected Dr. Russell Chin, RI, to the ADEX Board of Directors.

District 10 elected Dr. Mina Paul, MA, to the ADEX Board of Directors.

ADEX Board of Directors

- Framework for a major review on the ADEX Bylaws announced.
- ADEX Strategic Plan reviewed.

Changes to the ADEX Dental Examination:

- Scoring – No changes.
- Endodontics
  - Increased the allowable size of the posterior access opening for 2017.
  - Approved new prototype Acadental molar for use in examination starting in 2018 or later depending on its availability.
- Periodontics – No changes. The committee is working on developing a prototype patient-based periodontics exam that test for the critical aspects of the National Occupational Analysis (NOA).
- Restorative
  - Approved the indirect pulp cap protocol beginning in 2017.
  - In 2018 there will be one posterior composite restoration.
- Prosthodontics – No change to current exam. Committee finalized new proposed criteria.

P.O. Box 50718 • Mesa, AZ 85208
Telephone (503) 724-1104
ADEXOFFICE@aol.com
www.adexexams.org

Changes to the ADEX Dental Hygiene Examination:

- The 2017 scoring changes will undergo an equating study before they are implemented.
- The Case Selection will consist of one primary quadrant with 6 natural teeth and 2 posterior teeth in a secondary quadrant all of which the candidate may utilize to select surfaces.
- The 2018 examination will be stopped after pre-treatment if it is determined that an adequate number of points to pass the examination has not been accrued to have a chance to pass.
- A process for the submission of a second Case Selection is being investigated for implementation in 2018.

ADEX House of Representatives:

- Approved the Dental and Dental Hygiene Examinations as recommended by the Examination Committees and the Board of Directors.

Presentations to the House of Representatives:

Dr. Joseph Gambacorta, Asst. Dean of Clinical Affairs, Univ. of Buffalo - School of Dental Medicine

"The Role of the Patient Centered CIF in a National Exam for Dentistry."

Dr. David Perkins, Chairman, The Commission on Dental Competency (CDCA)

"ADA Licensure Task Force – The Dental Examinations Are Not the Same."

****

13th Annual ADEX House of Representatives Meeting is scheduled on Sunday, August 13, 2017, Doubletree Hotel, Rosemont, IL.

August 9, 2016

REPORT OF THE 41st ANNUAL SRTA MEETING HELD IN HILTON HEAD, SC: AUG. 4th – 6th, 2016

This meeting was held at the Marriott Resort & Spa.

I serve on the Dental Calibration committee, which met on Thursday morning from 8am until 5pm.
This committee:

1. Defined or confirmed common errors as assigned by examiners at previous exam sites.
2. Grouped manikins by errors to be used for calibrations.
3. Determined the number of manikins to be used per calibration session.
4. Encoded manikin information such that randomization can occur at each exam site.
5. Determined that manikin calibration will be combined with a PowerPoint presentation as needed for examiner calibration.
6. Reviewed and revised the PowerPoint presentations for dental examiner calibration.

This committee did not complete its tasks by 5pm; so we met again on Friday morning at 6:30am for an hour and again on Friday afternoon at 6pm for another hour.

The committee will meet again in November in either Charlotte, NC or Atlanta, GA in order to finalize the calibration exercises for the 2017 Exam cycle.

On Friday, I was the representative on the Dental Examination committee.
This Committee:

1. Discussed allowing the dental candidates the option to choose two of four procedures on the restorative section. However, when it was pointed out that some states require an anterior Class III and some states require an amalgam restoration; this subject was tabled until more state specific information could be acquired.
2. Discussed having pre-approval of patient lesions by "SRTA calibrated" faculty members at each school (as a couple of other regional boards have implemented). However, this was tabled too because our psychometrician felt this could possibly create a problem if examiners denied a pre-approved lesion at the exam site.
3. Authorized the use of D-3 students as assistants during the exam.
4. Denied a request to allow candidates to do "indirect pulp caps" (leave a little decay in a tooth to prevent a pulp exposure). It was felt that candidates should NOT be choosing such deep lesions.
5. Determined that the SAC should NOT be called to review FAILED manikin procedures as our psychometrician felt that this unfairly gives the candidate an immediate appeal to his manikin that other candidates do NOT get.
6. Special intra-oral cameras were purchased by SRTA so that we may take pictures of failed cases to show to faculty at the schools as well as use in examiner calibration exercises.

7. Reviewed and revised scoring criteria for each section of the SRTA dental exam.
8. Will require that stints be made by all candidates for grading purposes for the PROSTH section of the exam.
9. Reviewed changes recommended by the Dental Calibration committee.
10. Accepted that examiners may dress in business casual for the PIE I (manikin-only) exam as NO candidate contact is made.
11. Discussed changes in the Examiners' training manual for 2017.
12. Proposed another meeting in November in Charlotte or Atlanta in conjunction with the dental Calibration committee prior to the 2017 exam cycle.

Lastly, I serve as the Virginia representative on the SRTA Board of Directors.
We met from 5pm until 6pm to review preliminary reports from the committees that met on yesterday and today. These reports will be made at the General Session on Saturday.

THE GENERAL SESSION WAS HELD ON SATURDAY, AUGUST 6th

PLEASE SEE ATTACHED COPIES OF REPORTS GIVEN AT THIS SESSION.

Officers elected for 2017-2018 are: President-Elect=Dr. Susan King (KY); Treasurer=Dr. Bob Hall (VA); Secretary=Dianne Gary, RDH (KY).

THE 2017 MEETING WILL BE HELD AT THE HILTON MYRTLE BEACH, SC. (DATES: Aug 3rd-5th).

SRTA IS APPROACHING OTHER STATES TO ADMINISTER THE SRTA EXAM. (no candidates from VCU are taking the dental or the dental hygiene exam with SRTA in 2017)!

There was a little controversy at this session as a few of the Alabama members felt that last year's meeting did NOT allow an opportunity to discuss the decision by the SRTA Board of Directors to withdraw from ADEX. President Marc Muncy reminded the membership that it was a BOARD DECISION to withdraw that could have been overruled by a two-thirds vote of the general assembly; however NO ONE brought that action to the floor for a vote last year. He further pointed out that the action to withdraw was "intentionally" held until AFTER the 2015 general session in case such reversal by the general assembly did happen. After some discussion by a number of delegates, No motion was presented regarding this issue.

Meeting adjourned at 11:30am.

New president for 2016-17 is Michelle Bedell, DMD of SC. She held a brief session with the Board of Directors after the meeting to confirm her first telephone conference call of the Board on Monday, September 19th at 7pm EST.

THANK YOU TO THE BOARD OF DENTISTRY AND DR. BROWN FOR ALLOWING ME TO REPRESENT YOU AT THIS MEETING.

The Bylaw Committee report to the 2016 SRTA membership is as follows:

1. At the General Assembly meeting last year (2015) an interim policy involving internationally trained dental candidates was omitted from the bylaw report. To correct this oversight the policy was again introduced and voted on by the Board of Directors as an interim policy for this year. It is now being brought before the members of the General Assembly to be voted on for inclusion as a permanent part of the SRTA Bylaws. The interim policy reads as follows:

   Article VIII – Examinations – Candidates and Examiners
   Section 5 – International Candidates

   An internationally trained dentist may take the SRTA dental examination upon satisfaction of the following requirements:
   1. Present a certified copy of a degree or certificate with an English translation from the candidate's college or university of training, and
   2. Present a letter from the state board of dentistry that is willing to license the candidate, requesting SRTA to administer the examination, and
   3. Payment of all fees required to take the examination.

   The Bylaw Committee and the Board of Directors have approved this interim policy and recommend an affirmative vote for its addition to the SRTA Bylaws.

2. The Bylaw Committee is recommending a change to the duties of the Board of Directors. Section 4 – Duties – Item I of Article V requires the Board of Directors in conjunction with the Dental Examination and Dental Hygiene Examination Committees to develop the examination schedule each year. Since the SRTA office staff performs this duty each year and is able to make speedy changes when needed, the Bylaw Committee acting upon the suggestion of our Executive Director is making the recommendation that this entire section be removed from the bylaws.

3. The next two recommendations are also suggestions from our Executive Director and involve the additions to (1) Article VIII, Section 1 – titled

Dental Students - Item D and (2) Article VIII, Section 2 - titled Dentists - Item C. These additions are being made in order to accommodate candidates utilizing the CSE format examination and will read as follows:

1. D. A candidate may apply to retake each failed or incomplete section of the examination during the following available examination period. A candidate may attempt each examination section up to three (3) times during the eighteen (18) months after the date he or she took the first section of the Traditional or PIE (Progressive Integrated Examination) Series, or 24 months after the date of the first section of the CSE (Curriculum Sequenced Examination). After three failures of any one section, the entire examination must be retaken.

2. C. A candidate may apply to retake each failed or incomplete section of the examination during the following available examination period. A candidate may attempt each examination section up to three (3) times during the eighteen (18) months after the date he or she took the first section of the Traditional or PIE (Progressive Integrated Examination) Series, or 24 months after the date of the first section of the CSE (Curriculum Sequenced Examination). After three failures of any one section, the entire examination must be retaken.

This concludes the Bylaw Committee report for 2016.

Submitted by David G. Edwards, DDS
Chairman of the Bylaw Committee

Calibration and Dental Examination Committees

August 4-5, 2016

The Calibration committee met all day on Thursday and again Friday morning.

The committee made some changes to the manikin scoring criteria. Using the new criteria, the committee evaluated 30 endo and 30 pros manikins to develop a hands-on examiner calibration.

Two sets were developed that include 6 pros and 6 endo models per set. The examiners will grade them on the kindle. Discrepancies in scoring will be discussed as a group.

The committee reviewed the current patient based calibration slides and made recommendations for changes.

The Dental Examination Committee and Calibration met on Friday with the Dental Educators, Allison Pinion from Bright Link and Dr. Chad Buckendahl.

During the Dental Exam Committee meeting the following were voted on:

Provisional Acceptance process which would allow faculty to approve lesions prior to the exam. The faculty would need to be calibrated. The committee voted to have Administration first consult with SRTA's attorney and Dr. Chad Buckendahl before contacting one of SRTA's schools to set up a pilot program.

Allow the candidate to choose two out of 4 restorative procedures. Further investigation is needed. Some State Boards require an anterior and posterior restoration for licensure. Allowing candidates to choose 2 posterior procedures could limit their mobility.

Candidates will be allowed to use D3 students as chair side assistants.

Changes were made to the patient based scoring criteria.

It was voted on that stints for the pros will be mandatory for grading purposes by all 3 examiners in 2017. **The Board of Directors voted not to accept this action as presented. They voted to make the following change: Candidates will be required to make stints prior to starting the Fixed Prosthodontic procedures. The Board of Directors has directed the Exam Committee to consult with Dr. Chad Buckendahl for his opinion on examiners using the stints to score, mandatory or optional.**

Dr. George Martin was unanimously voted as chair of the committee.

Dr. Chad Buckendahl entered the meeting late afternoon. He was asked about provisional acceptance and he expressed concerns allowing faculty to preapprove candidate lesions. He also stated that if two examiners agreed scoring that a third is not necessary. However he expressed that it would be a good idea to allow the computer to call for a third examiner occasionally to gather needed data on examiners.

Dr. Chad Buckendahl also expressed concerns about SAC being called for failures on the typodonts.

DENTAL HYGIENE EXAMINATION COMMITTEE

REPORT TO THE BOARD OF DIRECTORS: AUGUST 5, 2016

The Dental Hygiene Examination Committee met on Friday, August 5, 2016 at the Marriott Hilton Head Resort in Hilton Head, SC.

Members:	State:
Sherie Barbare, Chair	South Carolina
Jennifer Lamb	Arkansas
Mary Warner	Tennessee
Mary Beth Shea	West Virginia
Sandra Kay Alexander	Alabama

The committee discussed the current year examination criteria, pass rates, and the examiner survey results. Educators left after the discussion of examination statistics and criteria for a break out session led by Marlene Fullilove, SRTA Examiner from Tennessee and former adjunct faculty at the University of Tennessee in Memphis. The DHEC wants to express its gratitude to all the educators for their presence and valuable contribution to the meeting discussions.

Recommended changes to the dental hygiene criteria for 2017, as well as changes voted on in 2016 that were not implemented are attached to this report.

Tanya Riffe was elected as the new Board of Directors representative by unanimous vote.

Respectfully submitted,

Sherie Barbare, DHEC Chair

ATTACHMENT: MOTIONS

DHEC REPORT TO THE BOARD OF DIRECTORS

2015 Motion*:

#1	Move radiographs to patient eligibility. If non-diagnostic and verified by CFM, patient dismissed and candidate fails. No points attached to radiographs.
#2	Eliminate restriction on surfaces that can be assigned that are terminal surfaces (distal with no adjacent surface)
#3	Examiner #1 lists 15 surfaces for verification. Twelve will be assigned, if verified. Eliminate having candidates list surfaces.
#4	Changed terminology of "Initial Case Presentation" to "Patient Eligibility"
#5	Eliminate 15 point deduction for 4 or more surfaces of remaining calculus
#6	Eliminate scoring of radiographs

***2015 Motions that were approved by the DHEC, but not implemented in 2016. These motions are in addition to the 2016 motions for the 2017 dental hygiene examination.**

2016 Motions:

#1	Increase patient treatment time from 1.5 hours to 2 hours.
#2	Replace the term "qualifying calculus" to "moderate to heavy: easily explorer detectable calculus"
#3	Case Selection will consist of 2 quadrants (primary & secondary) • Both quadrants must have a molar • At least one molar must have a proximal contact
#4	Dismiss patient if not enough verified calculus to pass
#5	Eliminate facial surfaces from detection exercise (assign four teeth so there will still be twelve surfaces)
#6	Eliminate minor tissue trauma

2017 Proposed Points:

	# of Opportunities	Points	Total
Calculus Requirements Met	**1**	**7**	**7**
Calculus Detection	**12**	**1**	**12**
Perio	**6**	**1**	**6**
Removal of verified Calculus	**12**	**6**	**72**
Plaque/Stain/Remaining calculus on unassigned surfaces	**1**	**3**	**3**
		TOTAL:	**100**

Strategic Planning Committee 2016 Report

The Strategic Planning Committee held two conference calls and has one more meeting scheduled July 19 prior to the SRTA 2016 annual meeting. The committee has continued its work on ideas and suggestions both old and new.

Newsletter

The newsletter was designed and the office is ready to receive information for publication. The content of the newsletter will include new examiner introductions and information that SRTA members would like to share. The newsletter is meant to be concise and informative.

Website

The website is being completed. An online calibration test containing 50 questions about exam procedures is being finalized. Exam logistics and online reimbursement items are running smoothly.

Orientation

The committee is continually establishing a network of specified presenters to visit schools and state boards to share SRTA's mission.

Liaisons

The liaison list is currently being updated. Liaisons are important to keeping the lines of communication open with the institutions that we serve.

Portability

Discussions were held concerning portability. The committee was interested in obtaining hard numbers about how many dental students are affected by the limitations on movement. A survey idea was presented with a bank of questions being prepared and possibly sent to Junior and senior dental students.

Survey

Questions have been reviewed and are ready to be sent out via Survey Monkey.

Marketing

Ideas were discussed about who and how to approach regarding acceptance of the SRTA exam. What process does each state have to navigate in order to accept SRTA? Do we have membership resources that can communicate with those states who do not accept our exam? Need to determine which states to approach first.

My appreciation is extended to all of our committee members for all of their work while serving on this committee. Thank you so very much!

Michelle Bedell, DMD
Chair, Strategic Planning

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of August 12, 2016)

Board	Board of Dentistry	
Chapter		**Action / Stage Information**
[18 VAC 60 - 11]	Public Participation Guidelines	Conforming to Code [Action 4577] Fast-Track - *At Secretary's Office*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Requirement for capnography for monitoring anesthesia or sedation [Action 4411] Proposed - *Register Date: 8/22/16* *Comment period from 8/22/16 to 10/21/16* *Public Hearing: 9/16/16*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Qualifications for restricted or temporary licenses [Action 4504] Fast-Track - *Register Date: 7/25/16* *Effective: 9/8/16*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Credit for volunteer hours and extension of time for CE [Action 4597] Fast-Track - *DPB Review in progress* [Stage 7617]
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Administration of nitrous oxide only [Action 4598] Fast-Track - *DPB Review in progress* [Stage 7618]

UNAPPROVED

BOARD OF DENTISTRY
MINUTES OF REGULATORY–LEGISLATIVE COMMITTEE
Friday, May 6, 2016

TIME AND PLACE:	The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order on May 6, 2016 at 9:00 a.m. at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 3, Henrico, Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., Chair
COMMITTEE MEMBERS PRESENT:	John M. Alexander, D.D.S. Tonya A. Parris-Wilkins, D.D.S. Bruce S. Wyman, D.M.D.
OTHER BOARD MEMBERS PRESENT:	Charles E. Gaskins, III, D.D.S., Ex-Officio Al Rizkalla, D.D.S. Carol Russek, J.D., Citizen Member Tammy K. Swecker, R.D.H.
ESTABLISHMENT OF QUORUM:	All members of the Committee were present.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Executive Director Huong Q. Vu, Operations Manager Elaine Yeatts, DHP Policy Analyst
OTHER PRESENT:	James E. Rutkowski, Assistant Attorney General
PUBLIC COMMENT:	None
APPROVAL OF MINUTES:	Ms. Swain asked if Committee members had reviewed the February 12, 2016 minutes. Two grammatical corrections were agreed to by consensus and the minutes were approved as amended.
STATUS REPORT ON LEGISLATION AND REGULATORY ACTIONS:	Ms. Yeatts reported that the Board has two regulatory actions at the Secretary's office for review: one to require capnography equipment for monitoring anesthesia or sedation; and the other to amend 18VAC60-21-230 to be consistent with statutory requirements for a faculty license.
RECOMMENDATION ON PUBLIC PARTICIPATION GUIDELINES (PPG):	Ms. Yeatts advised that section 18VAC60-11-50 of the Board's regulations for public participation need to be amended to include a Code change which permits a person to be accompanied or represented by counsel at public comment opportunities. She asked the Committee to

advance this recommendation to the Board for adoption as a fast track action. Dr. Wyman moved to accept Ms. Yeatts' request. The motion was seconded and passed.

RECOMMENDATION ON THE AMENDMENT TO ALLOW VOLUNTEER HOURS TO COUNT TOWARD CE REQUIREMENTS (HB319):

Ms. Yeatts stated that HB319, as passed by the 2016 General Assembly, requires the Board to amend its regulations to provide continuing education credit (CE) to licensees who volunteer at a local health department or a free clinic. She offered proposed language to amend 18VAC60-21-250.5 and 18VAC60-25-190.3 and asked the Committee to recommend the number of hours that could be earned for what amount of service.

Discussion followed about the maximum number of hours that could be earned for volunteer activities and the number of volunteer hours needed to earn one hour of CE. Points of discussion included the purpose of CE is to address clinical competence; voluntary practice does not address competence; reasonable credit should be allowed to promote volunteer services; and volunteer hours must be documented by the host/sponsor for the volunteer activity to count toward the Board's CE requirement. Following consideration of several proposals, Dr. Wyman moved to recommend a maximum of two CE credits per renewal year. The motion was seconded and passed. Dr. Wyman moved to recommend requiring three documented volunteer hours for one hour of credit. The motion was seconded and passed.

RECOMMENDATION ON EXPANDING THE EXEMPTION FOR REGISTRATION REQUIREMENTS TO MOBILE DENTAL CLINICS OPERATED BY THE FEDERALLY QUALIFIED HEALTH CENTERS, AND FREE HEALTH CLINICS OR HEALTH SAFETY NET CLINICS (HB310):

Ms. Yeatts stated that HB310, as passed by the 2016 General Assembly, expands the exemptions for registration requirements to include mobile dental clinics operated by federally qualified health centers, free health clinics, and health safety net clinics. She reviewed her proposal to amend 18VAC60-21-430, which can be done as an exempt action and asked the Committee to advance the recommendation to the Board for adoption.

The fifth exemption for clinics serving non-ambulatory people was discussed as having the potential for abuse and inconsistency with standards for practice. Ms. Yeatts said the Board cannot delete or edit this provision because it is the language passed by the General Assembly. The 30 mile radius was questioned and Ms. Yeatts again explained that it could not be changed because it is established as law. Dr.

Wyman move to recommend the proposal as presented to the Board for adoption as an exempt action. The motion was seconded and passed.

RECOMMENDATION ON THE REQUIREMENTS OF THE REMOTE SUPERVISION OF DENTAL HYGIENISTS TO IMPLEMENT SB712:

Ms. Yeatts stated that SB712, as passed by the 2016 General Assembly, allows dental hygienists who are employed by a dentist to practice under remote supervision in free clinics and federally qualified health centers. She added that the required emergency regulations must be in effect within 280 days of enactment. She said the statute is very detailed and will be the primary reference so the proposed regulations include only the provisions needed to acknowledge the new practice model. She also offered a proposed guidance document which addresses the provisions for remote supervision in a question and answer format. She then reviewed the proposed regulatory language which includes:

- adding the definition of "remote supervision" to 18VAC60-21-10 and 18VAC60-25-10; and
- adding references to the Code in 18VAC60-21-140.C and in 18VAC60-25-60 to include the remote supervision as an option in the provisions for delegation to dental hygienists.

She added that questions had been raised about having an exemption from the mobile clinic registration requirement for dental hygienists to practice under remote supervision. She said this is not a required change but, for purposes of discussion, she added language in 18VAC60-21-430.

Discussion followed with agreement that:

- the definition of "remote supervision" in the Code for the Virginia Department of Health model should also be included in the definitions section to avoid confusion about the two meanings of the term; and
- the new recordkeeping requirements for dental hygienists practicing under remote supervision should be added in18VAC60-25-110.

The consultation requirement for a dental hygienist to provide hygiene services to patients with periodontal disease raised concerns. Addressing the level of disease that would require consultation was considered but not pursued based on advice of counsel. The limitation that only dental hygienists employed by a dentist can practice under the new definition and the ratio of dentist to dental hygienist were discussed without any action taken.

A motion made by Dr. Wyman to strike the proposed exemption for mobile clinic registration in 18VAC60-21-430 was seconded. In discussion, it was agreed that the new exemptions added by passage of HB 310 addresses the settings where dental hygienists might practice under remote supervision so the proposed exemption was not needed. The motion passed.

Ms. Yeatts reviewed the draft guidance document she prepared, *Guidance for Practice of a Dental Hygienist under Remote Supervision.* Ms. Reen asked that it clearly reference section F of §54.1-2722 since it only addresses the private practice model. It was agreed to present this draft at the June Board meeting for discussion.

Dr. Alexander moved to advance the emergency regulations as amended to the Board for discussion at the June meeting and adoption at its September meeting. The motion was seconded and passed.

NEXT MEETING: Ms. Swain reminded the Committee that it is scheduled to meet on Friday, October 14, 2016.

ADJOURNMENT: With all business concluded, Ms. Swain adjourned the meeting at 11:06 a.m.

Melanie C. Swain, R.D.H., Chair

Sandra K. Reen, Executive Director

Date

Date

Agenda Item: Board Action on Regulations for Remote Supervision

Included in your agenda package are:

A copy of the SB712 of the 2016 General Assembly

A copy of DRAFT regulations recommended by the Regulation Committee

A copy of DRAFT guidance (questions and answers) for implementation of remote supervision

Staff Note:

The 2nd enactment of SB712 requires adoption of emergency regulations.

Board action:

Adoption of draft regulations as an emergency action.

Adoption of draft guidance document.

CHAPTER 497

An Act to amend and reenact §§ 54.1-2722 and 54.1-2724 of the Code of Virginia, relating to dental hygienists; practicing under remote supervision.

[S 712]

Approved March 25, 2016

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2722 and 54.1-2724 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2722. License; application; qualifications; practice of dental hygiene.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of a dental hygiene program accredited by the Commission on Dental Accreditation and offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

~~For the purposes of this section, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have done an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.~~

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. *For the purposes of this subsection, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.*

Notwithstanding any provision of law, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the Commonwealth under the remote supervision of a dentist employed by the Department of Health. A dental hygienist providing such services shall practice pursuant to a protocol adopted by the Commissioner of Health on September 23, 2010, having been developed jointly by (i) the medical directors of the Cumberland Plateau, Southside, and Lenowisco Health Districts; (ii) dental hygienists employed by the Department of Health; (iii) the Director of the Dental Health Division of the

Department of Health; (iv) one representative of the Virginia Dental Association; and (v) one representative of the Virginia Dental Hygienists' Association. Such protocol shall be adopted by the Board as regulations.

~~F.~~ A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of the Commonwealth, shall be prepared and submitted by the Department of Health to the Virginia Secretary of Health and Human Resources annually. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

F. For the purposes of this subsection, "remote supervision" means that a dentist is accessible and available for communication and consultation with a dental hygienist employed by such dentist during the delivery of dental hygiene services but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

Notwithstanding any other provision of law, a dental hygienist may practice dental hygiene under the remote supervision of a dentist who holds an active, unrestricted license by the Board and who has a dental office physically located in the Commonwealth. No dental hygienist shall practice under remote supervision unless he has (i) completed a continuing education course offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of clinical experience. A dental hygienist practicing under remote supervision shall have professional liability insurance with policy limits acceptable to the supervising dentist. A dental hygienist shall only practice under remote supervision at a community health center, charitable safety net facility, free clinic, long-term care facility, elementary or secondary school, Head Start program, or women, infants, and children program.

A dental hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine pursuant to subsection V of §54.1-3408, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation. No dental hygienist practicing under remote supervision shall administer local anesthetic or nitrous oxide.

Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal or written permission of any dentist who has treated the patient in the previous 12 months and can be identified by the patient.

After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision shall consult with the supervising dentist prior to providing further dental hygiene services if such patient is medically compromised or has periodontal disease.

A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a treatment plan for the patient and either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient. The supervising dentist shall review a patient's records at least once every 10 months.

Nothing in this subsection shall prevent a dental hygienist from practicing dental hygiene under general supervision whether as an employee or as a volunteer.

§ 54.1-2724. Limitations on the employment of dental hygienists.

The Board shall determine by regulation ~~how many~~ *the total number of* dental hygienists, *including dental hygienists under general supervision and dental hygienists under remote supervision, who* may work at one time for a dentist. *No dentist shall employ more than two dental hygienists who practice under remote supervision at one time.* The State Board of Health may employ the necessary number of hygienists in public school dental clinics, subject to regulations of the Board.

2. That the Board of Dentistry shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

Project 4680 - none

BOARD OF DENTISTRY

Remote supervision

Part I

General Provisions

18VAC60-21-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2700 of the Code of Virginia:

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"AAOMS" means the American Association of Oral and Maxillofacial Surgeons.

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, his facility, his partner or associate, or any dentist affiliated with the dentist or his facility by any means or method for the purpose of inducing purchase, sale, or use of dental methods, services, treatments, operations, procedures, or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures, or products.

"CODA" means the Commission on Dental Accreditation of the American Dental Association.

"Code" means the Code of Virginia.

"Dental assistant I" means any unlicensed person under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-21-150 and 18VAC60-21-160.

"Mobile dental facility" means a self-contained unit in which dentistry is practiced that is not confined to a single building and can be transported from one location to another.

"Nonsurgical laser" means a laser that is not capable of cutting or removing hard tissue, soft tissue, or tooth structure.

"Portable dental operation" means a nonfacility in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions.

"Radiographs" means intraoral and extraoral radiographic images of hard and soft tissues used for purposes of diagnosis.

C. The following words and terms relating to supervision as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Direct supervision" means that the dentist examines the patient and records diagnostic findings prior to delegating restorative or prosthetic treatment and related services to a dental assistant II for completion the same day or at a later date. The dentist prepares the tooth or teeth to be restored and remains immediately available in the office to the dental assistant II for guidance or assistance during the delivery of treatment and related services. The dentist examines the patient to evaluate the treatment and services before the patient is dismissed.

"Direction" means the level of supervision (i.e., immediate, direct, indirect, or general) that a dentist is required to exercise with a dental hygienist, a dental assistant I, or a dental assistant II or that a dental hygienist is required to exercise with a dental assistant to direct and oversee the delivery of treatment and related services.

"General supervision" means that a dentist completes a periodic comprehensive examination of the patient and issues a written order for hygiene treatment that states the specific services to be provided by a dental hygienist during one or more subsequent appointments when the dentist may or may not be present. Issuance of the order authorizes the dental hygienist to supervise a dental assistant performing duties delegable to dental assistants I.

"Immediate supervision" means the dentist is in the operatory to supervise the administration of sedation or provision of treatment.

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, or (iii) preparing the patient for dismissal following treatment.

"Remote supervision" means that a dentist is accessible and available for communication and consultation with a dental hygienist employed by such dentist during the delivery of dental hygiene services but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided. For the purpose of practice by a public health dental hygienist, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

D. The following words and terms relating to sedation or anesthesia as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Conscious/moderate sedation" or "moderate sedation" means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. 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.

"Enteral" means any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).

"General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator 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.

"Inhalation" means a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

"Local anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes "anxiolysis" (the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of

consciousness) and includes "inhalation analgesia" (the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness).

"Moderate sedation" (see the definition of conscious/moderate sedation).

"Monitoring" means to observe, interpret, assess, and record appropriate physiologic functions of the body during sedative procedures and general anesthesia appropriate to the level of sedation as provided in Part VI (18VAC60-21-260 et seq.) of this chapter.

"Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular).

"Titration" means the incremental increase in drug dosage to a level that provides the optimal therapeutic effect of sedation.

"Topical oral anesthetic" means any drug, available in creams, ointments, aerosols, sprays, lotions, or jellies, that can be used orally for the purpose of rendering the oral cavity insensitive to pain without affecting consciousness.

Part III

Direction and Delegation of Duties

18VAC60-21-110. Utilization of dental hygienists and dental assistants II.

A. A dentist may utilize up to a total of four dental hygienists or dental assistants II in any combination practicing under direction at one and the same time. In addition, a dentist may permit through issuance of written orders for services, additional dental hygienists to practice under general supervision in a free clinic or a public health program, or on a voluntary basis.

B. In accordance with § 54.1-2724 of the Code, no dentist shall employ more than two dental hygienists who practice under remote supervision at one time.

18VAC60-21-140. Delegation to dental hygienists.

A. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:

1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers, with any sedation or anesthesia administered.

2. Performing an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets, or other abnormal conditions for assisting the dentist in the diagnosis.

3. Administering nitrous oxide or local anesthesia by dental hygienists qualified in accordance with the requirements of 18VAC60-25-100.

B. The following duties shall only be delegated to dental hygienists and may be performed under indirect supervision or may be delegated by written order in accordance with §§ 54.1-2722 D and 54.1-3408 J of the Code to be performed under general supervision:

1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers with or without topical oral anesthetics.

2. Polishing of natural and restored teeth using air polishers.

3. Performing a clinical examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets, or other abnormal conditions for further evaluation and diagnosis by the dentist.

4. Subgingival irrigation or subgingival application of topical Schedule VI medicinal agents pursuant to § 54.1-3408 J of the Code.

5. Duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist, with the exception of those listed as nondelegable in 18VAC60-21-130, those restricted to indirect supervision in subsection A of this section, and those restricted to delegation to dental assistants II in 18VAC60-21-150.

C. Delegation of duties to a dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 F of the Code. However, delegation of duties to a public health dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 E of the Code.

Part I

General Provisions

18VAC60-25-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2700 of the Code of Virginia:

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Active practice" means clinical practice as a dental hygienist for at least 600 hours per year.

"ADA" means the American Dental Association.

"Analgesia" means the diminution or elimination of pain in the conscious patient.

"CDAC" means the Commission on Dental Accreditation of Canada.

"CODA" means the Commission on Dental Accreditation of the American Dental Association.

"Code" means the Code of Virginia.

"Dental assistant I" means any unlicensed person under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered to perform reversible, intraoral procedures as specified in 18VAC60-21-150 and 18VAC60-21-160.

"Direction" means the level of supervision (i.e., direct, indirect, or general) that a dentist is required to exercise with a dental hygienist or that a dental hygienist is required to exercise with a dental assistant to direct and oversee the delivery of treatment and related services.

"General supervision" means that a dentist completes a periodic comprehensive examination of the patient and issues a written order for hygiene treatment that states the specific services to be provided by a dental hygienist during one or more subsequent appointments when the dentist may or may not be present. Issuance of the order authorizes the dental hygienist to supervise a dental assistant performing duties delegable to dental assistants I.

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, or (iii) preparing the patient for dismissal following treatment.

"Inhalation" means a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness.

"Local anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

"Monitoring" means to observe, interpret, assess, and record appropriate physiologic functions of the body during sedative procedures and general anesthesia appropriate to the level of sedation as provided in Part VI (18VAC60-21-260 et seq.) of Regulations Governing the Practice of Dentistry.

"Nonsurgical laser" means a laser that is not capable of cutting or removing hard tissue, soft tissue, or tooth structure.

"Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular).

"Remote supervision" means that a dentist is accessible and available for communication and consultation with a dental hygienist employed by such dentist during the delivery of dental hygiene services but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist

and may not be present with the dental hygienist when dental hygiene services are being provided. For the purpose of practice by a public health dental hygienist, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

"Topical oral anesthetic" means any drug, available in creams, ointments, aerosols, sprays, lotions, or jellies, that can be used orally for the purpose of rendering the oral cavity insensitive to pain without affecting consciousness.

18VAC60-25-60. Delegation of services to a dental hygienist.

A. In all instances and on the basis of his diagnosis, a licensed dentist assumes ultimate responsibility for determining with the patient or his representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with this chapter, Part III (18VAC60-21-110 et seq.) of the Regulations Governing the Practice of Dentistry, and the Code.

B. Dental hygienists shall engage in their respective duties only while in the employment of a licensed dentist or governmental agency or when volunteering services as provided in 18VAC60-25-50.

C. Duties that are delegated to a dental hygienist under general supervision shall only be performed if the following requirements are met:

1. The treatment to be provided shall be ordered by a dentist licensed in Virginia and shall be entered in writing in the record. The services noted on the original order shall be rendered within a specified time period, not to exceed 10 months from the date the

dentist last performed a periodic examination of the patient. Upon expiration of the order, the dentist shall have examined the patient before writing a new order for treatment under general supervision.

2. The dental hygienist shall consent in writing to providing services under general supervision.

3. The patient or a responsible adult shall be informed prior to the appointment that a dentist may not be present, that only topical oral anesthetics can be administered to manage pain, and that only those services prescribed by the dentist will be provided.

4. Written basic emergency procedures shall be established and in place, and the hygienist shall be capable of implementing those procedures.

D. An order for treatment under general supervision shall not preclude the use of another level of supervision when, in the professional judgment of the dentist, such level of supervision is necessary to meet the individual needs of the patient.

E. Delegation of duties to a dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 F of the Code. However, delegation of duties to a public health dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 E of the Code.

Part III

Standards of Conduct

18VAC60-25-110. Patient records; confidentiality.

A. A dental hygienist shall be responsible for accurate and complete information in patient records for those services provided by a hygienist or a dental assistant under direction to include the following:

1. Patient's name on each page in the patient record;

2. A health history taken at the initial appointment, which is updated when local anesthesia or nitrous oxide/inhalation analgesia is to be administered and when medically indicated and at least annually;

3. Options discussed and oral or written consent for any treatment rendered with the exception of prophylaxis;

4. List of drugs administered and the route of administration, quantity, dose, and strength;

5. Radiographs, digital images, and photographs clearly labeled with the patient's name, date taken, and teeth identified;

6. A notation or documentation of an order required for treatment of a patient by a dental hygienist practicing under general supervision as required in 18VAC60-25-60 C; and

7. Notation of each treatment rendered, date of treatment, and the identity of the dentist and the dental hygienist providing service.

B. A dental hygienist shall comply with the provisions of § 32.1-127.1:03 of the Code related to the confidentiality and disclosure of patient records. A dental hygienist shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the hygienist shall not be considered negligent or willful.

C. A dental hygienist practicing under remote supervision shall document in the patient record that he has obtained (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal or written

permission of any dentist who has treated the patient in the previous 12 months and can be identified by the patient.

Guidance for Practice of a Dental Hygienist under Remote Supervision

References from § 54.1-2722 of the Code of Virginia

1. **What is meant by "remote supervision"**

   "Remote supervision" means that a dentist is accessible and available for communication and consultation with a dental hygienist employed by such dentist during the delivery of dental hygiene services but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

2. **Who can employ a dental hygienist to practice dental hygiene under the remote supervision?**

   A dentist who holds an active, unrestricted license by the Virginia Board of Dentistry and who has a dental office physically located in the Commonwealth.

3. **What qualifications are necessary for a dental hygienist to practice under remote supervision?**

   The hygienist must have (i) completed a continuing education course offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of clinical experience.

4. **Are there other requirements for practice under remote supervision?**

   A dental hygienist practicing under remote supervision shall have professional liability insurance with policy limits acceptable to the supervising dentist.

5. **In what settings can a dental hygienist practice under remote supervision?**

   A hygienist can only practice dental hygiene under remote supervision at a community health center, charitable safety net facility, free clinic, long-term care facility, elementary or secondary school, Head Start program, or women, infants, and children program.

6. **What tasks can a dental hygienist practicing under remote supervision perform?**

   A hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer topical oral fluorides under an oral or

written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine pursuant to subsection V of §**54.1-3408**, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation.

7. **Is the dental hygienist allowed to administer local anesthetic or nitrous oxide?**

   No, a dental hygienist practicing under remote supervision is not allowed administer local anesthetic or nitrous oxide.

8. **What disclosures and permissions are required?**

   Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal or written permission of any dentist who has treated the patient in the previous 12 months and can be identified by the patient.

9. **How is the dental hygienist required to involve the dentist when practicing under remote supervision?**

   a) After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision shall consult with the supervising dentist prior to providing further dental hygiene services if such patient is medically compromised or has periodontal disease.
   b) A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a treatment plan for the patient and either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient.
   c) The supervising dentist shall review a patient's records at least once every 10 months.

10. **Is a dental hygienist who practicing under remote supervision allowed to also practice dental hygiene under general supervision whether as an employee or as a volunteer?**

    Yes, the requirements of § 54.1-2722 F do not prevent practice under general supervision.

11. **Are the requirements for remote supervision different for a public health dental hygienist employed by the Virginia Department of Health?**

    Yes, remote supervision in a public health setting is defined in § 54.1-2722 E:

E. *For the purposes of this subsection, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.*

Notwithstanding any provision of law, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the Commonwealth under the remote supervision of a dentist employed by the Department of Health. A dental hygienist providing such services shall practice pursuant to a protocol adopted by the Commissioner of Health on September 23, 2010, having been developed jointly by (i) the medical directors of the Cumberland Plateau, Southside, and Lenowisco Health Districts; (ii) dental hygienists employed by the Department of Health; (iii) the Director of the Dental Health Division of the Department of Health; (iv) one representative of the Virginia Dental Association; and (v) one representative of the Virginia Dental Hygienists' Association. Such protocol shall be adopted by the Board as regulations.

Agenda Item: Board Action on Regulations for Mobile Dental Clinics

Included in your agenda package are:

A copy of the HB310 of the 2016 General Assembly

A copy of regulations recommended by the Regulation Committee

Staff Note:

This action will conform 18VAC60-21-430 to changes in the Code and is, therefore, an exempt action.

Board action:

Adoption of amendment to section 430 of the regulations as an exempt action.

CHAPTER 78

An Act to amend and reenact § 54.1-2708.3 of the Code of Virginia, relating to mobile dental clinics; exemption from registration requirements.

[H 310]

Approved March 1, 2016

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2708.3 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2708.3. Regulation of mobile dental clinics.

No person shall operate a mobile dental clinic or other portable dental operation without first registering such mobile dental clinic or other portable dental operation with the Board, except that *the following shall be exempt from such registration requirement: (i)* mobile dental clinics or other portable dental operations operated by federal, state, or local government agencies or other entities identified by the Board in regulations ~~shall be exempt from such registration requirement~~*; (ii) mobile dental clinics operated by federally qualified health centers with a dental component that provides dental services via mobile model to adults and children within 30 miles of the federally qualified health center; (iii) mobile dental clinics operated by free health clinics or health safety net clinics that have been granted tax-exempt status pursuant to § 501(c)(3) of the Internal Revenue Code that provide dental services via mobile model to adults and children within 30 miles of the free health clinic or health safety net clinic; and (iv) mobile dental clinics that provide dental services via mobile model to individuals who are not ambulatory and who reside in long-term care facilities, assisted living facilities, adult care homes, or private homes.*

The Board shall promulgate regulations for mobile dental clinics and other portable dental operations to ensure that patient safety is protected, appropriate dental services are rendered, and needed follow-up care is provided. Such regulations shall include, but not be limited to, requirements for the registration of mobile dental clinics, locations where services may be provided, requirements for reporting by providers, and other requirements necessary to provide accountability for services rendered.

Project 4841 - none

BOARD OF DENTISTRY

Mobile dental clinics

18VAC60-21-430. Exemptions from requirement for registration.

The following shall be exempt from requirements for registration as a mobile dental clinic or portable dental operation:

1. All federal, state, or local governmental agencies; ~~and~~

2. Dental treatment that is provided without charge to patients or to any third party payer;

3. Clinics operated by federally qualified health centers with a dental component that provides dental services via mobile model to adults and children within 30 miles of the federally qualified health center;

4. Clinics operated by free health clinics or health safety net clinics that have been granted tax-exempt status pursuant to § 501(c)(3) of the Internal Revenue Code that provide dental services via mobile model to adults and children within 30 miles of the free health clinic or health safety net clinic; and

5. Clinics that provide dental services via mobile model to individuals who are not ambulatory and who reside in long-term care facilities, assisted living facilities, adult care homes, or private homes.

Agenda Item: Petition for rulemaking

Included in your package are:

A copy of the petition received from Dr. Deborah Blanchard

Copies of comments on the petition

A copy of applicable regulations

Board action:

The Board may reject the petition's request. If rejected, the Board must state their reasons for denying the petition.

OR

The Board may initiate rulemaking by adoption of an amendment by publication of a Notice of Regulatory Action.

OR

The Board may adopt a proposed amendment by a fast-track action.

COMMONWEALTH OF VIRGINIA
Board of Dentistry

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
(804) 527-4428 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,) Blanchard, Deborah R., DDS		
Street Address 1128 E Bay Shore Drive	Area Code and Telephone Number 757-321-1300	
City Virginia Beach	State VA	Zip Code 23451
Email Address (optional) drb@baycolonydentistry.com	Fax (optional) 757-321-0778	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

Deletion of Requirement for Dentists to Display Current Registration with the federal Drug Enforcement Administration (DEA Registration) with a Current Active Dental License in each Dental Practice Setting Where It Is Conspicuous and Readable by Patients as required by 18VAC60-21-30 Paragraph C - Posting requirements.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Change the wording to:

C. A dentist who administers, prescribes or dispenses Schedules II through V controlled substances shall *retain on the dental practice premises* his current registration with the federal Drug Enforcement Administration ~~with his current active license~~.

Rationale: To decrease the opportunity for individuals (patients, vendors, service workers, subcontractors) to easily obtain a dentist's DEA Registration number and use it to create false prescriptions. Public display of the federal Drug Enforcement Administration registration is not a recommended practice by the federal Drug Enforcement Agency Office of Diversion Control.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

Legal authority of the board to take the action requested is promulgated in the Code of Virginia 54.1-2400, paragraph 6.

54.1-2400 General powers and duties of health regulatory boards.

6. To promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title.

Signature: Deborah R Blanchard, DDS, MSD Date: 10 June 2016

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter **Regulations Governing the Practice of Dentistry [18 VAC 60 - 21]**

All comments for this forum

Back to List of Comments

Commenter: Kimberlyn R. Atherton, DDS * 7/15/16 11:54 am

Posting my DEA in a public place makes it easy for those seeking opioids to forge prescriptions.

Commenter: Heath Cash, D.D.S. * 7/15/16 12:07 pm

Eliminate requirement to publicly post DEA license

Please consider changing the requirement for dentists to post their DEA license in a public location. Doing so only makes it easier for those seeking to forge prescriptions.

Commenter: Dag Zapatero, DDS * 7/15/16 12:16 pm

Why make it easier for addicts to gain access to our DEA numbers?

I am in agreement with Dr. Blanchard's request. There is no logical reason for dentist in the Commonwealth to post their DEA license in view of the public. Having it available for insception and certifing that its valid should be enough safeguard patients. If a doctor has multiple offices it should be enough that it just remain in one location and it be made available upon request, or that he/she be required to log into the DEA website to download a fresh copy.

Commenter: James Willis, DDS * 7/15/16 12:16 pm

Stop Making us Post DEA Info

Please consider changing the requirement for dentists to post their DEA license in a public location. Doing so only makes it easier for those seeking to forge prescriptions.

Commenter: Barrett W. R. Peters, DDS, MSD * 7/15/16 12:31 pm

DEA Certificate Posting

To Whom It May Concern:

Please remove the requirement for posting DEA Certificate as its public display creates an opportunity for a DEA number to be in an inappropriate way during a time in which our country is grappling with a prescription drug abuse crisis.

Commenter: Dr. Austin Westover * 7/15/16 12:33 pm

Remove req to display DEA license

I support removing the requirement to post one's DEA license. There is no public benefit and does increase the chances of having one's information stolen.

Commenter: Ralph J Rutledge Jr DDS * 7/15/16 12:40 pm

Posting DEA # Deletion

The posting for the public to see the # is a bad idea ."Here it is now copy it and get some drugs illegally". Finally some common sense creeps into the system! Pass this ASAP.

Commenter: Dr B Robert Meer, Elden Family Dental * 7/15/16 12:40 pm

DEA Registration Posting Requirement

Please eliminate this posting requirement. It will contribute to people illegally obtaining various prescriptions. We are already accountable for any prescriptions we write.

Commenter: Mark Huie DDS, MS * 7/15/16 12:46 pm

DEA certification posting requirement

Please consider and remove the current policy having us to post DEA cert. It makes it too easy for abusers.

Commenter: Jason Dulac DDS, railroad dental associates * 7/15/16 12:59 pm

I support removing the posting requirement

I was surprised by this requirement when it came out and do not believe it to be good practice to post our Dea certificate. I support removal of the requirement to post the Dea certificate.

Commenter: John W Pash DDS. ADA. VDA. NVDS * 7/15/16 1:14 pm

Removing DEA & Va prescribing certificate from office display

This is an excellent issue. This issue should have should have settled before now. Anything we can do to prevent our patients from being tempted to steal access to drug purchase for illegal use should be implemented . My vote

is yes.over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Daniel G Stockburger, DDS * 7/15/16 1:31 pm

Support removal of DEA posting req.

This would help decrease unauthorized accessibility to my DEA number. Currently anyone could take a picture on their phone of my registration and falsify prescriptions.

Commenter: Thomas S Cooke. DDS * 7/15/16 1:37 pm

DEA license display

I agree with the petitioner especially with the change in opiod perscription rules.

Commenter: William B Perkinson III * 7/15/16 3:06 pm

Dea posting

I agree the dea certificate should not be posted. There is no benefit to public safety, and drug seekers could use this information to obtain drugs.

Commenter: michael fabio * 7/15/16 3:43 pm

posting a copy of a dentist's registration issued by the DEA

I believe we should eliminate the requirement for posting a copy of a dentist's registration issued by the Drug Enforcement Administration to avoid an opportunity for individuals to use the number for illegal purposes.

this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Tony M Chehade DDS * 7/15/16 4:03 pm

Posting DEA certificate

I am against the idea of having to post the DEA certificate in public view. Having the number available to the public is not a safe practice and should only be available to the people/ agencies that need it.

Commenter: Robert Morrison DMD, Morrison Dental Group * 7/15/16 4:12 pm

A Prudent Rule Change

This would be a prudent rule change in a time we are being challenged by government, our profession and our patients to be part of the solution in reducing prescription drug abuse. This change removes one more temptation.

Commenter: Dina Bambrey, D.M.D. * 7/15/16 5:54 pm

Let's enact the rule change for our DEA licenses!

I agree and wholeheartedly support a change to the legislation that will allow us NOT to have to post our DEA information. It is a security risk to us and the public in the growing epidemic of illegal prescription drug abuse.

Commenter: Atkins, Maestrello, Miller ans Associates * 7/15/16 9:17 pm

Remove the requirement for posting our DEA license

Please remove the requirement for posting our DEA license in plain sight, it makes practioners vulernable for idenity theft.

Commenter: Kenneth Stoner * 7/16/16 6:37 am

posting is dangerous

Patients should not be able to get your DEA number off the wall and then pretend to be a staff member and call themselves in a Rx. Maybe redact the number and post the certificate as a compromise.

Commenter: Sheila R Field * 7/16/16 7:33 am

DEA License Protection

It is wise to protect our practitioners from thieves. It's bad enough our patients steal our numbers from the prescriptions we give to them. The requirement to post our DEA License lacks common sense.

Commenter: Dr. Don Cherry * 7/16/16 9:19 am

Eliminate DEA posting

Eliminate DEA posting.

Commenter: David Black, VDA Board of Directors, Piedmont Component * 7/16/16 11:20 am

Posting DEA Permit

With the statewide push to combat opiate abuse, the easier an addict can get information that will help them obtain more drugs illegally, the more chances there are for abuse. I believe the problem is more basic than reading a number off a certificate, but as long as we have the certificate available for proper authorities, that should be sufficient. I can't remember any time in my 40+ years in practice that someone questioned if I could prescribe drugs to them and wanted to see my certificate.

Commenter: Henry Botuck, DDS * 7/16/16 4:50 pm

Posting DEA license

Let's not make it too easy to give addicts access to our DEA numbers. They may get it anyway, but there is no sense in just handing it too them.

Commenter: Marshall Bonnie * 7/17/16 3:19 pm

Posting of DEA number

I believe there are abundant and prudent reasons for eliminating the mandatory posting of DEA license number. I do realize that the number is freely shown on written prescriptions so the rationale for not posting is somewhat compromised. If there are valid and evidence-supported reasons for posting this information I am certainly willing to consider them.

Thank you,

M. Bonnie

Commenter: Katie Lee, DDS * 7/17/16 3:46 pm

DEA posting requirement

Please consider eliminating the requirement for posting a copy of a dentist's DEA registration. This country is facing a prescription opioid crisis, and elimating the requirement will make it more difficult for individuals to use the number for illegal purposes.

Commenter: Fred N. Kessler, DDS * 7/17/16 7:28 pm

Posting of DEA Regestration

I urge the Board to eliminate the posting of DEA registrations.

Commenter: Richard L Taliaferro, DDS, President , Virginia Dental Association * 7/17/16 8:02 pm

Posting of DEA Certificate

I believe that the posting of our DEA Certificate does allow addicts to potentially use the information to fruadulently obtain drugs. In addition to potentially contributing to more opioid abuse, it could contrbute to our personal information being stolen. If we must post our DEA license, I would propose that we be allowed to make copies and post the copied certificate with the DEA number blacked out.

Commenter: Vince Dougherty * 7/17/16 8:17 pm

no need to post DEA drug license

I believe there is no reason to post our drug license in our office. It only opens up the possibility of faudulent use. This possibility is small but why open up any possibility to fraud. To my knowledge there has not been a patient that has stood in front of my license to verify it. I can not think of any benefit in posting it where aii can see.

Commenter: Guy Levy * 7/18/16 9:01 am

DEA Posting

I support eliminating the requirement to post the DEA license and make it available upon request, in order to avoid possible fraudulent use of the DEA number. Thank you for your consideration.

Commenter: flavio nasr * 7/18/16 9:39 am

DEA license

Removing the requirement to post the DEA license is something that makes total sense in the current environment of our society.

Commenter: Harlan Hendricks, DDS * 7/18/16 10:10 am

DEA License Posting Requirement

Please examine eliminating the requirement for dentists in the Commonwealth to display their DEA licenses. With the prescription opioid epidemic in this country, easier access to a DEA license increases the potential for patients to use this number for illegal purposes and abuse. Thank you for your consideration.

Commenter: Carolyn C Herring * 7/18/16 1:05 pm

5408860531

Displaying the certificate without our DEA number visible makes perfect sense.

Commenter: Rod Rogge * 7/18/16 1:34 pm

7573337444

Years ago, the military required that I use both my DEA and social security numbers on prescriptions. An enlisted man was able to find my numbers without me writing a prescription for him, and he used those numbers to acquire a surprising amount of narcotics in military and civilian pharmacies before he was caught. He also used the information to steal my identity, producing over a year of legal hassles and severe inconvenience. If anything, we should use a secure network to pharmacies, eliminating paper prescriptions, and keeping the public from having access to this information. At least we now have the prescription registry, so that we can track abusers before they use us to get more narcotics.

Commenter: Les Davenport * 7/18/16 10:35 pm

One step further

Dr Bonnie made a great point. Our written prescriptions have the DEA number clearly printed on them, apparently a requirement in Virginia statutes. Any public posting of the complete DEA number opens the door for fraudulent activity and abuse of controlled substances as well as the "system." We should be seeking revision of the pharmaceutical regulations as well as the requirement for posting the DEA certificate. We have seen the change in credit card receipts to only display the last four numbers. Why wouldn't this serve a similar purpose with the DEA number?

Commenter: Dr. Neelam Dube * 7/19/16 10:55 am

DEA license posting

I agree with the petitioner and urge the Board to eliminate the posting of DEA registrations.

Commenter: Mary Ann Choby DMD * 7/19/16 11:10 am

DEA available to the public

Please eliminate the DEA number available to the public. Just recently, on the front page of the the ADA newsletter , there is a comment by the ADA President that focuses on prescribing opioids safely and effectively. This month's ADA journal presents a paper concerning opioids prescription abuse. Our concern is not only are we reducing the number of prescriptions of opioids, but we need to protect our right of privacy to our DEA number.

Commenter: Michael Gazori, DDS * 7/19/16 4:29 pm

DEA License posting

I am not sure I understand the rationale for requiring the posting of the DEA license. With prescription abuse seemingly at an all-time high, it would make it even easier for unscrupulous, clever people to abuse the system. Requiring the posting of the DEA license with the DEA number makes no sense.

Commenter: Benita Miller, D.D.S. * 7/21/16 1:53 am

Eliminate requirement to publicly post copy of DEA registration

I appreciate Dr. Blanchard's petition and urge the Board to eliminate the requirement to publicly post a copy of our DEA registration. Espeically considering the drug crisis in America, there is nothing to gain and everything to lose by posting this registration. Keeping a copy of the registration on file should be more than adequate for proper record keeping and will certainly reduce opportunities for information theft and fraudulent use of that information.

Commenter: Kirk M. Norbo, D.M.D. * 7/21/16 5:30 pm

DEA license posting

Please support this petition to eliminate the requirement to post DEA licenses. In today's world, this policy is obsolete and could even be considered negligent.

Commenter: Erika C Mason DDS * 7/22/16 10:03 am

DEA License Display

I agree with the resolution to do away with the Displaying of our DEA license - and we might really consider how our # is diplayed on our prescription pads -- to be changed like they have done to CC #'s.

Commenter: Allen A. Zarrinfar * 7/22/16 12:52 pm

No need to post registration

I agree with the petition. There is no rational to post the registration while there is potentional for fradulant use.

Commenter: Steven Forte D.D.S. * 7/26/16 1:08 pm

DEA license

I support eliminating the requirement to post our DEA license. Thank you.

Commenter: Carmen A. Cote, DDS * 8/2/16 3:37 pm

Posting the DEA number in our offices

I understand the board is trying to make the patients feel safer when a dentist holds a certificate that allow him/her to prescribe medications. But the board has forgotten about the risks for a dentist when there are hundreds of patients looking for narcotics and will do anything illegal to get them. Please do not make this easy for the drug addicts.

Commenter: Cynthia Southern, DDS * 8/5/16 10:26 am

Posting DEA license

I agree that we should not have to post our DEA license. We should not make it easy for the drug abuse to continue.

Commenter: Gregory Engel * 8/7/16 10:02 am

Please remove DEA posting requirement

I see little benefit in a mandatory posting of the provider's DEA license. Prescription opiod abuse is a significant concern. Computer programs can make forgeries much easier once specific information is obtained. Why make it easier for this to occur? Each provider has earned their

priveledge to prescribe scheduled medications. Why allow potential tainting of their good name by making it easier for ill intended use? Please promptly remove this requirement.

Commenter: barclay weisberg * 8/9/16 1:01 pm

7576506534

I see little benefit in the posting of a provider's DEA license. Prescription opiod abuse is a significant issue but this does nothing to help resolve the situation. Computer programs can make forgeries much easier if specific information is obtained (like aproviders DEA#). Why make it easier for this to occur? Each provider has earned their priveledge to prescribe scheduled medications. Why allow potential tainting of their good name by making it easier for ill intended use? Please remove this requirement.

Commenter: Hosek Dentistry * 8/9/16 2:33 pm

Remove requirment to post DEA license.

The current requirement to post our DEA license is archaic and counterproductive. The world has changed. It is completely illogical to assist any individual desiring to pursue illegal activities with prescription drugs. There is ample evidence in any legal dental office to provide the public with proper verification such as state license to practice and degrees obtained. Any attempt to keep this requirement is only seeing a tree and not the forest.

Commenter: Michael Hutchings, DDS * 8/9/16 2:43 pm

Public Display of DEA Number

There is potentail for abuse if the DEA number is displayed in public. Suggest either dropping the requirement for public display of the DEA registration form, or remove the provider number from the front of the form.

Commenter: Les Richmond * 8/9/16 9:56 pm

posting DEA licence

I think the idea needs to be thought thru again.. It seems like publically posting the licence doesn't really

accomplish anything and may actually enable some fraud. Please consider just posting it on an inside

office wall not readily accessible to the casual public. Thank you.

Commenter: Dwight Bradshaw, DDS * 8/9/16 10:08 pm

DEA posting requirement

I support the removal of the DEA posting requirement.

Commenter: Richard A. Arnaudin * 8/9/16 10:26 pm

Remove requirement to post DEA number

Commenter: Robert Feild, Feild Dentistery a division of atlantic dental care PLC 8/10/16 5:57 am

DEA posting

I am in favor of the petition.

Commenter: Jeffrey R. Bek, DDS * 8/10/16 9:10 am

Posting of DEA registration

Requiring that a provider's DEA registration ber posted for public view is unnecessary and may provide an opportunity for unauthorized use by individual's attempting to illegally obtain controlled substances. The posting of a provider's license to practice is adequate for public reassurance, posting the DEA registration accomplishes no additional purpose.

Commenter: David T. Marshall, DDS * 8/10/16 11:40 am

Displaying DEA Lisc Numbers

Please consider removing the requirement of having to display our DEA License numbers in our offices to help lower the risk of substance abuse in the public.

Commenter: Dr. Steven A. Carroll * 8/10/16 7:03 pm

DEA postings

Please remove the regulation to display DEA numbers in our offices to prevent fraudulent use of our DEA numbers. Thank you for your consideration.

* Nonregistered public user

18VAC60-21-30. Posting Requirements.

A. A dentist who is practicing under a firm name or who is practicing as an employee of another dentist is required by § 54.1-2720 of the Code to conspicuously display his name at the entrance of the office. The employing dentist, firm, or company must enable compliance by designating a space at the entrance of the office for the name to be displayed.

B. In accordance with § 54.1-2721 of the Code a dentist shall display his dental license where it is conspicuous and readable by patients in each dental practice setting. If a licensee practices in more than one office, a duplicate license obtained from the board may be displayed.

C. A dentist who administers, prescribes, or dispenses Schedules II through V controlled substances shall display his current registration with the federal Drug Enforcement Administration with his current active license.

D. A dentist who administers conscious/moderate sedation, deep sedation, or general anesthesia in a dental office shall display his sedation or anesthesia permit issued by the board or certificate issued by AAOMS.

Practitioner's Manual - SECTION II

View New Web Browser Security Requirements

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Title 21 USC Codified CSA

SECTION II – GENERAL REQUIREMENTS

Schedules of Controlled Substances

The drugs and other substances that are considered controlled substances under the CSA are divided into five schedules. A complete list of the schedules is published annually on an updated basis in the DEA regulations, Title 21 of the Code of Federal Regulations, Sections 1308.11 through 1308.15. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States and their relative abuse potential and likelihood of causing dependence when abused. Some examples of the drugs in each schedule are outlined below.

IMPORTANT NOTE:

All drugs listed in Schedule I have no currently accepted medical use in treatment in the United States and therefore may not be prescribed, administered, or dispensed for medical use. In contrast, drugs listed in Schedules II through V all have some accepted medical use and therefore may be prescribed, administered, or dispensed for medical use.

Schedule I Substances

Substances in this schedule have no currently accepted medical use in treatment in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

Some examples of substances listed in Schedule I are: heroin; lysergic acid diethylamide (LSD); marijuana (cannabis); peyote; methaqualone; and methylene-dimethoxy-methamphetamine ("ecstasy").

The CSA allows for bona fide research with controlled substances in Schedule I, provided that the FDA has determined the researcher to be qualified and competent, and provided further that the FDA has determined the research protocol to be meritorious. Researchers who meet these criteria must obtain a separate registration to conduct research with a Schedule I controlled substance.

Schedule II Substances

Substances in this schedule have a high potential for abuse with severe psychological or physical dependence.

Examples of single entity Schedule II narcotics include morphine, codeine, and opium. Other Schedule II narcotic substances and their common name brand products include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®), and fentanyl (Sublimaze® or Duragesic®).

Examples of Schedule II stimulants include amphetamine (Dexedrine® or Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®). Other Schedule II substances include: cocaine, amobarbital, glutethimide, and pentobarbital.

Schedule III Substances

Substances in this schedule have a potential for abuse less than substances in Schedules I or II.

Examples of Schedule III narcotics include combination products containing less than 15 milligrams of hydrocodone per dosage unit (i.e., Vicodin®) and products containing not more than 90 milligrams of codeine per dosage unit (i.e., Tylenol with codeine®).

Examples of Schedule III non-narcotics include benzphetamine (Didrex®), phendimetrazine, dronabinol (Marinol®), ketamine, and anabolic steroids such as oxandrolone (Oxandrin®).

Schedule IV Substances

Substances in this schedule have a lower potential for abuse relative to substances in Schedule III.

Examples of a Schedule IV narcotics include propoxyphene (Darvon® and Darvocet-N 100®).

Other Schedule IV substances include alprazolam (Xanax®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

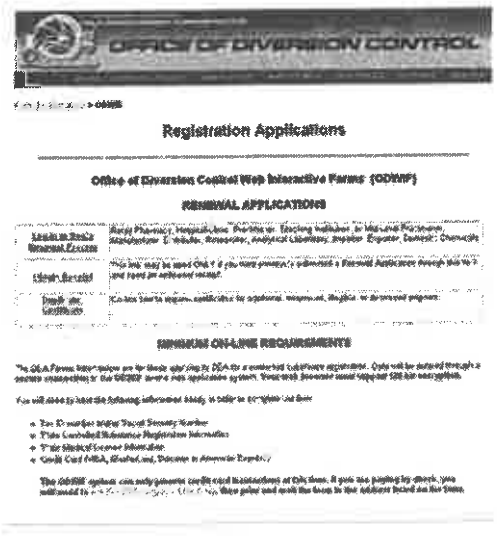
Schedule V Substances

Substances in this schedule have a lower potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotic and stimulant drugs. These are generally used for antitussive, antidiarrheal and analgesic purposes.

Examples include cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC®, and Phenergan with Codeine®).

Registration Requirements

Under the CSA, the term "practitioner"is defined as a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which the practitioner practices or performs research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research. Every person or entity that handles controlled substances **must** be registered with DEA or be exempt by regulation from registration.



Change of Business Address

A practitioner who moves to a new physical location must request a modification of registration. A modification of registration can be requested online at www.DEAdiversion.usdoj.gov or in writing to the DEA field office responsible for that state. If the change in address involves a change in state, the proper state issued license and controlled substances registration must be obtained prior to the approval of modification of the federal registration. If the modification is approved, DEA will issue a new certificate of registration and,If requested, new Schedule II order forms (DEA Form-222, Official Order Form). A Renewal Application for Registration (DEA Form-224a) will only be sent to the registered address on file with DEA. It will not be forwarded.

Termination of Registration

Any practitioner desiring to discontinue business activities with respect to controlled substances must notify the nearest DEA field office (see Appendix E) in writing. Along with the notification of termination of registration, the practitioner should send the DEA Certificate of Registration and any unused Official Order Forms (DEA Form-222) to the nearest DEA field office.

Denial, Suspension or Revocation of Registration

Under the CSA, DEA has the authority to deny, suspend, or revoke a DEA registration upon a finding that the registrant has:

1. Materially falsified any application filed
2. Been convicted of a felony relating to a controlled substance or a List I chemical
3. Had their state license or registration suspended, revoked, or denied
4. Committed an act which would render the DEA registration inconsistent with the public interest
5. Been excluded from participation in a Medicaid or Medicare program

In determining the public interest, the CSA states the following factors are to be considered:

1. The recommendation of the appropriate state licensing board or professional disciplinary authority
2. The applicant's experience in dispensing or conducting research with respect to controlled substances
3. The applicant's conviction record under federal or state laws relating to the manufacture, distribution, or dispensing of controlled substances
4. Compliance with applicable state, federal, or local laws relating to controlled substances
5. Such other conduct which may threaten the public health and safety

Practitioner's Use of a Hospital's DEA Registration Number

Practitioners (e.g., intern, resident, staff physician, mid-level practitioner) who are agents or employees of a hospital or other institution may, when acting in the usual course of business or employment, administer, dispense, or prescribe controlled substances under the registration of the hospital or other institution in which they are employed, provided that:

1. The dispensing, administering, or prescribing is in the usual course of professional practice
2. Practitioners are authorized to do so by the state in which they practice
3. The hospital or institution has verified that the practitioner is permitted to dispense, administer or prescribe controlled substances within the state
4. The practitioner acts only within the scope of employment in the hospital or institution
5. The hospital or institution authorizes the practitioner to dispense or prescribe under its registration and assigns a specific internal code number for each practitioner so authorized (See example of a specific internal code number below):

A current list of internal codes and the corresponding individual practitioners is to be maintained by the hospital or other institution. This list is to be made available at all times to other registrants and law enforcement agencies upon request for the purpose of verifying the authority of the prescribing individual practitioner.

Inappropriate Use of the DEA Registration Number

DEA strongly opposes the use of a DEA registration number for any purpose other than the one for which it was intended, to provide certification of DEA registration in transactions involving controlled substances. The use of DEA registration numbers as an identification number is not an appropriate use and could lead to a weakening of the registration system.

The Centers for Medicare and Medicaid Services has developed a National Provider Identification (NPI) number unique to each healthcare provider. The Final Rule for establishment of the NPI system was published in the Federal Register (FR 3434, Vol. 69, No. 15) by the Department of Health and Human Services on January 23, 2004. The effective date of this Final Rule was May 23, 2005; all covered entities must begin using the NPI in standard transactions by May 23, 2007.

Exemption of Federal Government Practitioners from Registration

The DEA registration grants practitioners federal authority to handle controlled substances. However, the DEA registered practitioner may only engage in those activities that are authorized under state law for the jurisdiction in which the practice is located. When federal law or regulations differ from state law or regulations, the practitioner is required to abide by the more stringent aspects of both the federal and state requirements. In many cases, state law is more stringent than federal law, and must be complied with in addition to federal law. Practitioners should be certain they understand their state as well as DEA controlled substance regulations.

Application for Registration

To obtain a DEA registration, a practitioner must apply using a DEA Form 224. Applicants may submit the form by hard copy or online. Complete instructions accompany the form. To obtain the application, DEA may be contacted at:

- www.DEAdiversion.usdoj.gov (DEA Diversion Internet Web Site)
- any DEA field office (see listing in Appendix E of this manual)
- DEA Headquarters' Registration Section in Washington, D.C. at 1-800-882-9539 (Registration Call Center)

The DEA Form-224 may be completed online or in hard copy and mailed to:

Drug Enforcement Administration
Attn: ODR
P.O. Box 2639
Washington, D.C. 22152-2639

A sample DEA Form 224 – New Application for Registration, is located at **Appendix H**, DEA Forms.

Certificate of Registration

The DEA Certificate of Registration (DEA Form 223) must be maintained at the registered location in a readily retrievable manner and kept available for official inspection.

The CSA requires that a separate registration be obtained for each principal place of business or professional practice where controlled substances are manufactured, distributed, or dispensed. DEA has historically provided an exception that a practitioner who is registered at one location, but also practices at other locations, is not required to register separately for any other location at which controlled substances are only prescribed. If the practitioner maintains supplies of controlled substances, administers, or directly dispenses controlled substances at the separate location the practitioner must obtain a separate DEA registration for that location. The exception applies only to a secondary location within the same state in which the practitioner maintains his/her registration. DEA individual practitioner registrations are based on state authority to dispense or conduct research with respect to controlled substances. Since a DEA registration is based on a state license, it cannot authorize controlled substance dispensing outside that state. Hence, the separate registration exception applies only to locations within the same state in which practitioners have their DEA registrations.

A duplicate Certificate of Registration may be requested online. It appears on DEA's website, www.DEAdiversion.usdoj.gov, as follows:

Registration Renewals

Practitioner registrations must be renewed every three years. Renewal registrations use DEA Form 224a, Renewal Application for DEA Registration (see example at Appendix H, DEA Forms). The cost of the registration is indicated on the application form.

A renewal application is sent to the registrant approximately 45 days before the registration expiration date. The renewal application is sent to the address listed on the current registration certificate. If the renewal form is not received within 30 days before the expiration date of the current registration, the practitioner should contact the DEA registration office for their state, or DEA Headquarters at 1-800-882-9539, and request a renewal registration form.

The registration renewal application may be completed online at www.DEAdiversion.usdoj.gov, or in hard copy and mailed to:

Drug Enforcement Administration
Attn: ODR
P.O. Box 2639
Washington, D.C. 22152-2639

The requirement of registration is waived for any official of the U.S. Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, or Bureau of Prisons who is authorized to prescribe, dispense, or administer, but not to procure or purchase controlled substances in the course of his/her official duties. Such officials shall follow procedures set forth in Title 21, CFR § 1306 regarding prescriptions, but shall state the branch of service or agency (e.g., "U.S. Army" or "Public Health Service") and the service identification number of the issuing official in lieu of the registration number required on prescription forms. The service identification number for a Public Health Service employee is his/her Social Security identification number.

If Federal Government practitioners wish to maintain a DEA registration for a private practice, which would include prescribing for private patients, they must be fully licensed to handle controlled substances by the state in which they are located. Under these circumstances, the Federal Government practitioner will not be eligible for the fee exemption and must pay a fee for the registration.

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OFFICE OF DIVERSION CONTROL

U.S. DEPARTMENT OF JUSTICE • DRUG ENFORCEMENT ADMINISTRATION
Office of Diversion Control • 8701 Morrissette Drive • Springfield, VA 22152 • 1-800-882-9539

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AUDITING CONTINUING EDUCATION
Adoption of Revised Guidance Document 60-5
September 16, 2016 Board Meeting

Background
At the Board's June 10, 2016 meeting, the Board discussed and revised this guidance document but did not address a motion to adopt it as revised. The sections which were revised are highlighted for review.

Authority
Requirements for continuing education in 18VAC60-21-250. E. and 18VAC60-25-190.D.
Dentist and dental hygienist licensees are required to verify compliance with continuing education requirements on their annual renewal applications. Following a renewal period, the board may conduct an audit of licensees to verify compliance. Licensees selected for audit must provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

Action needed
Adopt the revised guidance document.

Virginia Board of Dentistry

Policy on Auditing Continuing Education and Sanctioning for Failure to Meet the Requirements

Excerpts of Applicable Law, Regulation and Guidance

- The Board shall promulgate regulations requiring continuing education (CE) for any dental license or reinstatement and may grant extensions or exemptions, §54.1-2709.E.
- The Board shall promulgate regulations requiring continuing education for any dental hygiene license or reinstatement and may grant extensions or exemptions, §54.1-2729.
- Dentists and dental hygienists are required to:
  - complete a minimum of 15 hours of approved continuing education and
  - maintain the required documentation of completion for a minimum of four years following each renewal. 18VAC60-21-250 and 18VAC60-25-190.
- The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted prior to renewal of the license. 18VAC60-21-250 and 18VAC60-25-190.
- Failure to comply with continuing education requirements may subject the licensee to disciplinary action, 18 VAC 60-20-21-250.I and 18VAC60-25-190.D.
- Confidential Consent Agreements may be used to address continuing education, Guidance Document: 60-1

Extension and Exemption Requests

- The president of the Board may grant an extension request for up to one year for completion of continuing education upon receipt of a written request with an explanation which is submitted prior to the renewal date.
- The president of the Board may grant an exemption request for up to one year for all or part of the required 15 hours upon receipt of a written request with supporting documents which is submitted prior to the renewal date.

Initiation of a CE Audit

After the completion of the April 1st to March 31st renewal cycle in an odd numbered year, the Executive Director shall report to the Board the current operational issues, staffing, and disciplinary caseload for consideration by the Board in deciding the scope of the audit to be conducted that year.

Scope of Audits

The Board shall biennially conduct an audit of compliance with CE requirements on a random sample of licensees selected from MLO by the DHP IT Department. The sample size shall be determined using both the online Sample Size Calculator by Raosoft (or equivalent algorithm) and the total number of licensees. The Board may also audit the following:

- Active licensees who have completed the terms of a CCA or a Board Order which required completion of CE in addition to the 15 hours requirement per year;
- Active licensees who failed to respond, or responded "no", to the CE renewal question on the annual renewal form, and/or requested an exemption after license renewal;

- Active licensees who were granted an extension to meet their CE requirement.

Auditing CE

- Selected licensees will be notified by email to submit the necessary documentation to verify CE completion. A second notice will be sent by USPS if there is no response.
- Documentation submitted to verify CE completion will be reviewed by Board staff for compliance with the regulations.
- Licensees who have met the CE requirements will be sent a thank you letter.
- Licensees who have not complied with the audit notification or CE requirements will be referred for possible disciplinary action.

A. Guideline for Offering a Confidential Consent Agreement (CCA)

1. The executive director or designee shall review the documentation received for probable cause and shall only offer a CCA for a first offense when:
    - there is only one finding of probable cause and that finding is that the licensee is unable to document completion of from 1 to 5 hours of acceptable continuing education (CE).
    - there are findings of probable cause for violations in addition to missing CE consistent with Guidance Document 60-1, Policy on CCAs/Confidential Consent Agreements.
2. The offered CCA shall include a finding that a violation occurred and shall request the licensee's agreement to obtain the missing hours within 45 days and to henceforth comply with the CE requirements. The CCA shall state that the hours obtained pursuant to the CCA shall not count toward the next license renewal.

B. Guidelines for Imposing Disciplinary Sanctions

1. In addition to a notice of an informal conference, a licensee shall be offered a Pre-Hearing Consent Order (PHCO) when the licensee:
    - falsely certified completion of the required CE for license renewal.
    - is unable to document completion of from 1 to 5 hours of acceptable CE in a subsequent audit.
    - is unable to document completion of from 6 to 15 hours of acceptable CE.
2. In cases where there are findings of probable cause for violations in addition to missing CE, a PHCO may be offered with a notice of an informal conference.
3. The following sanctioning guidelines shall be included in the PHCO:
    a. For falsely certifying completion for renewal – Reprimand and $1000 monetary penalty.
    b. For missing 1 to 5 hours – Subsequent Offenses – Reprimand, obtain the missing hours within 30 days and a $250 monetary penalty for each missing hour.
    c. For missing 6 to 15 hours – First offense - Reprimand and obtain the missing hours within 45 days.
    d. For missing 6 to 15 hours – Subsequent offenses – Reprimand, obtain the missing hours within 45 days and a $500 monetary penalty for each missing hour.

Standards for Professional Conduct in the Practice of Dentistry

Amending Guidance Document 60-15

Background:

This guidance document needs to be amended as highlighted on page 3 to be consistent with the regulatory requirement for maintaining patient records for not less than six years:

18VAC60-21-90. Patient information and records.

A. A dentist shall maintain complete, legible, and accurate patient records for not less than six years from the last date of service for purposes of review by the board with the following exceptions:

1. Records of a minor child shall be maintained until the child reaches the age of 18 years or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative pursuant to § 54.1-2405 of the Code; or

3. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

Adoption is recommended.

Standards for Professional Conduct In The Practice of Dentistry

Preamble

The Standards for Professional Conduct for licensees of the Virginia Board of Dentistry establishes a set of principles to govern the conduct of licensees in the profession of dentistry. Licensees must respect that the practice of dentistry is a privilege which requires a high position of trust within society. The Board maintains that adherence to these standards will safeguard patients, uphold the laws and regulations governing practice and maintain the public trust. The standards are an expression of types of conduct that are either required or encouraged and that are either prohibited or discouraged to provide further guidance on the requirements for practice set out in the Code of Virginia and the Regulations Governing the Practice of Dentistry and Dental Hygiene.

Scope of Practice

- Keep knowledge and skills current. The privilege, professional status, and a license to practice derive from the knowledge, skill, and experience needed to safely serve the public and patients.
- Seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing the knowledge and skills of those who have special skills, knowledge and experience, or advanced training.
- Do not prescribe treatment or use diagnostic techniques or diagnose, cure, or alleviate diseases, infections or other conditions that are not within the scope of the practice of dentistry or that are not based upon accepted scientific knowledge or research.
- Do not treat or prescribe for yourself.

Treating or Prescribing for Family

- Only treat and prescribe based on a bona-fide practitioner-patient relationship, and prescribe by criteria set forth in §54.1-3303 of the Code of Virginia.
- Do not prescribe to a family member a controlled substance or a medicine outside the scope of dentistry.
- When treating a family member or a patient maintain a patient record documenting a bona-fide practitioner-patient relationship.

Staff Supervision

- Protect the health of patients by only assigning to qualified auxiliaries those duties which can be legally delegated.
- Prescribe and supervise the patient care provided by all auxiliary personnel in accordance with the correct type of supervision.
- Maintain documentation that staff has current licenses, certificates for radiology, up-to-date vaccinations, CPR training, HIPPA training, and OSHA training in personnel files.
- Display documents that are required to be posted in the patient receiving area so that all patients might see and read them.

- Be responsible for the professional behavior of staff towards patients and the public at all times.
- Avoid unprofessional behavior with staff
- Provide staff with a safe environment at all times.
- Provide staff with opportunities for continuing education that will keep treatment and services up-to-date and allow staff to meet continuing education requirements
- Supervise staff in dispensing, mixing and following the instruction for materials to be used during treatment.
- Instruct the staff to inform the dentist of any event in the office concerning the welfare of the patient regarding exposures or blood borne pathogens

Practitioner-Patient Communications

- Before performing any dental procedure, accurately inform the patient or the guardian of a minor patient of the diagnoses, prognosis and the benefits, risks, and treatment alternatives to include the consequences of doing nothing.
- Inform the patient of proposed treatment and any reasonable alternatives, in understandable terms to allow the patient to become involved in treatment decisions.
- Acquire informed consent of a patient prior to performing any treatment.
- Refrain from harming the patient and from recommending and performing unnecessary dental services or procedures.
- Specialists must inform the patient that there is a need for continuing care when they complete their specialized care and refer patients to a general dentist or another specialist to continue their care.
- Immediately inform any patient who may have been exposed to blood or other infectious material in the dental office or during a procedure about the need for post exposure evaluation and follow up and to immediately refer the patient to a qualified health care professional
- Do not represent the care being provided in a false or misleading manner
- Inform the patient orally and note in the record any deviation in a procedure due to the dentist's discretion or a situation that arises during treatment that could delay completion of treatment or affect the prognosis for the condition being treated.
- Inform the patient about the materials used for any restoration or procedure such as crowns, bridges, restorative materials, ingestibles, and topicals as to risks, alternatives, benefits, and costs, as well as describing the materials, procedures, or special circumstances in the patient's notes.
- Refrain from removing amalgam restorations from a non-allergic patient for the alleged purpose of removing toxic substances from the body. The same applies to removing any other dental materials.

Patient of Record

- A patient becomes a patient of record when the patient is seated in the dental chair and examination and diagnosis of the oral cavity is initiated.
- In §54.1-2405(B) of the Code of Virginia, "current patient" means a patient who has had a patient encounter with the provider or his professional practice during the two-year period immediately preceding the date of the record transfer.

Patient Records

- Maintain treatment records that are timely, accurate, legible and complete.
- Note all procedures performed as well as substances and materials used.
- Note all drugs with strength and quantity administered and dispensed.
- Safeguard the confidentiality of patient records.
- Upon request of a patient or an authorized dental practitioner, provide any information that will be beneficial for the welfare and future treatment of that patient.
- On request of the patient or the patient's new dentist timely furnish gratuitously or at a reasonable cost, legible copies of all dental and financial records and readable copies of x-rays. This obligation exists whether or not the patient's account is paid in full.
- Comply with §32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.
- Post information concerning the time frame for record retention and destruction in the patient receiving area so that all patients might see and read it.
- Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.
- Maintain records for not less than ~~three~~ six years from the last date of treatment as required by the Board of Dentistry and maintain records for longer periods of time to meet contractual obligations or requirements of federal law.
- When closing, selling or relocating a practice, meet the requirements of §54.1-2405 of the Code of Virginia for giving notice and providing records.

Financial Transactions

- Do not accept or tender "rebates" or split fees with other health professionals.
- Maintain a listing of customary fees and represent all fees being charged clearly and accurately.
- Do not use a different fee without providing the patient or third party payers a reasonable explanation which is recorded in the record.
- Return fees to the patient or third party payers in a timely manner if a procedure is not completed or the method of treatment is changed.
- Do not accept a third party payment in full without disclosing to the third party that the patient's payment portion will not be collected.
- Do not increase fees charged to a patient who is covered by a dental benefit plan.
- Do not incorrectly describe a dental procedure in order to receive a greater payment or reimbursement or incorrectly make a non-covered procedure appear to be a covered procedure on a claim form.
- Do not certify in a patient's record or on a third party claim that a procedure is completed when it is not completed.
- Do not use inaccurate dates that are to benefit the patient; false or misleading codes; change the procedure code to justify a false procedure; falsify a claim not having done the procedure, or expand the claim.
- Avoid exploiting the trust a patient has in the professional relationship when promoting or selling a product by: advising the patient or buyer if there is a financial incentive for the dentist to recommend the product; providing the patient with written information

about the product's contents and intended use as well as any directions and cautions that apply to its use; and, informing the patient if the product is available elsewhere.
- Do not misrepresent a product's value or necessity or the dentist's professional expertise in recommending products or procedures.

Relationships with Practitioners
- Upon completion of their care, specialists or consulting dentists are to refer back to the referring dentist, or if none, to the dentist of record for future care unless the patient expresses a different preference.
- A dentist who is rendering a second opinion regarding a diagnosis or treatment plan should not have a vested interest in the patient's case and should not seek to secure the patient for treatment unless selected by the patient for care.

Practitioner Responsibility
- Once a course of treatment is undertaken, the dentist shall not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Emergency care must be provided during the notice period to make sure that the patient's oral health is not jeopardized or to stabilize the patient's condition.
- Only prescribe, dispense, and utilize those devices, drugs, dental materials and other agents accepted for dental treatment.
- Make reasonable arrangements for the emergency care of patients of record.
- Exercise reasonable discretion in the selection of patients. Dentists may not refuse patients because of the patient's race, creed, color, sex, or national origin.
- Do not refuse to treat a patient because the individual has AIDS, is HIV positive, or has had hepatitis. Use a proper protocol in the office to protect the public and staff.
- Follow the rules and regulations of HIPAA, OSHA, FDA, and the laws governing health practitioners in the Code of Virginia.
- Follow the applicable CDC infection control guidelines and recommendations.
- Be knowledgeable in providing emergency care and have an acceptable emergency plan with delegated duties to the staff in written form, maintain accurate records and be current in basic CPR.
- Avoid interpersonal relationships with patients and staff that could impair professional judgment or risk the possibility of exploiting the veracity and confidence placed in the doctor-patient relationship.

Advertising Ethics
- Do not hold out as exclusive any devise agent, method, or technique if that representation would be false or misleading in any material respect to the public or patients.
- When you advertise, fees must be included stating the cost of all related procedures, services and products which to a substantial likelihood are necessary for the completion of the service as it would be understood by an ordinarily prudent person.
- Disclose the complete name of a specialty board or other organization which conferred certification or another form of credential.
- Do not claim to be a specialist or claim to be superior in any dental specialty or procedure unless you have attained proper credentials from an advanced postgraduate education

program accredited by the Commission on Dental Accreditation of the American Dental Association.

Reports and Investigations

- Cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board and timely provide information and records as requested.
- Allow staff to cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board.
- Report the adverse reaction of a drug or dental device to the appropriate medical and dental community and in the case of a serious event to the Food and Drug Administration or Board of Dentistry.
- Provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.
- Become familiar with the special signs of child abuse and report suspected cases to the proper authorities.
- Report to the Board of Dentistry instances of gross or continually faulty treatment by other dentists.

Notice

This guidance document does not address every law and regulation which governs the practice of dentistry. To fully understand your legal responsibilities you should periodically review the laws, regulations, notices and guidance documents provided on the Board of Dentistry webpage, www.dhp.virginia.gov/dentistry.

Adopted: December 4, 2009
Revised: March 13, 2015

PROPOSED REVISION

Virginia Board of Dentistry

Policy on Recovery of Disciplinary Costs

Applicable Law and Regulations

- §54.1-2708.2 of the Code of Virginia.
  The Board of Dentistry (the Board) may recover from any licensee against whom disciplinary action has been imposed reasonable administrative costs associated with investigating and monitoring such licensee and confirming compliance with any terms and conditions imposed upon the licensee as set forth in the order imposing disciplinary action. Such recovery shall not exceed a total of $5,000. All administrative costs recovered pursuant to this section shall be paid by the licensee to the Board. Such administrative costs shall be deposited into the account of the Board and shall not constitute a fine or penalty.

- 18VAC60-20-18 of the Regulations Governing Dental Practice. The Board may assess:
  - the hourly costs to investigate the case,
  - the costs for hiring an expert witness, and
  - the costs of monitoring a licensee's compliance with the specific terms and conditions imposed

  up to $5,000, consistent with the Board's published guidance document on costs. The costs being imposed on a licensee shall be included in the order agreed to by the parties or issued by the Board.

Policy

In addition to the sanctions to be imposed which might include a monetary penalty, the Board will specify the costs to be recovered from a licensee in each pre-hearing consent order offered and in each order entered following an administrative proceeding. The amount to be recovered will be calculated using the assessment of costs specified below and will be recorded on a Disciplinary Cost Recovery Worksheet (the worksheet). All applicable costs will be assessed as set forth in this guidance document. Board staff shall complete the worksheet and assure that the cost to be assessed is included in Board orders. The completed worksheets shall be maintained in the case file. Assessed costs shall be paid within 45 days of the effective date of the Order.

Assessment of Costs

Based on the expenditures incurred in the state's fiscal year which ended on June 30, ~~2015~~ 2016, the following costs will be used to calculate the amount of funds to be specified in a board order for recovery from a licensee being disciplined by the Board:

- ~~$109~~ **107** per hour for an investigation multiplied by the number of hours the DHP Enforcement Division reports having expended to investigate and report case findings to the Board.
- ~~$118~~ **114** per hour for an inspection conducted during the course of an investigation, multiplied by the number of hours the DHP Enforcement Division reports having expended to inspect the dental practice and report case findings to the Board.
- If applicable, the amount billed by an expert upon acceptance by the Board of his expert report.
- The applicable administrative costs for monitoring compliance with an order as follows:

PROPOSED REVISION

o	$ ~~128.75~~	**123.50**	Base cost to open, review and close a compliance case
o	~~71.75~~	**68.75**	For each continuing education course ordered
o	~~19.00~~	**18.25**	For each monetary penalty and cost assessment payment
o	~~19.00~~	**18.25**	For each practice inspection ordered
o	~~38.00~~	**36.50**	For each records audit ordered
o	~~114.00~~	**109.50**	For passing a clinical examination
o	~~105.50~~	**101.00**	For each practice restriction ordered
o	~~86.50~~	**82.75**	For each report required.

Inspection Fee

In addition to the assessment of administrative costs addressed above, a licensee shall be charged $350 for each Board-ordered inspection of his practice as permitted by 18VAC60-20-30 of the *Regulations Governing Dental Practice.*

DHP	
Various Cost Per Hour	
FY17 Rates for Billing Purposes	
Enforcement Hour	$ 107
Sr. Inspectors	114
Pharmacy Inspectors	139
Sandy Reen	129
Huong Vu	73

FY16 cost used to compile cost per hour rates

Virginia Board of Dentistry
Calculation of Costs for Recovery
Based on FY16 Expenditures

COMPLIANCE WITH SANCTIONS	Compliance Case Manager (CCM)		Executive Director (ED)		Combined Costs	FY16 PROPOSED CHARGE
Base cost to open, review and close a compliance case ($ per hr * 1.25 hrs) - CCM ($ per hr * .25 hr) - ED	73.00	**$91.25**	129.00	**$32.25**	$123.50	**$123.50**
For each continuing education course order ($ per hr * .5 hr) - CCM ($ per hr * .25 hr) - ED	73.00	**$36.50**	129.00	**$32.25**	$68.75	**$68.75**
For each moneytary penalty and cost assessment payment ($ per hr * .25 hr) - CCM only	73.00	**$18.25**				**$18.25**
For each practice inspection ordered ($ per hr * .25 hr) - CCM only	73.00	**$18.25**				**$18.25**
For each records audit ordered ($ per hr *.5 hr) - CCM only	73.00	**$36.50**				**$36.50**
For passing a clinical examination ($ per hr * 1.5 hr) - CCM only	73.00	**$109.50**				**$109.50**
For each practice restriction ordered ($ per hr * .5 hr) - CCM ($ per hr * .5 hr) - ED	73.00	**$36.50**	129.00	**$64.50**	$101.00	**$101.00**
For each report required ($ per hr * .25 hr) - CCM ($ per hr * .5 hr) - ED	73.00	**$18.25**	129.00	**$64.50**	$82.75	**$82.75**

Virginia Board of Dentistry

Disciplinary Cost Recovery Worksheet

Case # _____ **Order Entered:** _____

Licensee: _____

Investigation Cost/hr	Enforcement Hour (# of hour x 107)		Sr. Inspectors Hour (# of hour x 114)	
# of Hours		$0.00		$0.00
# of Hours		$0.00		$0.00
Record Duplication		$0.00		$0.00
Expert Witness		$0.00		$0.00
Other		$0.00		$0.00
Total	**$0.00**		**$0.00**	
Grand Total	**$0.00**			

Monitoring Cost/hr	Enter Each Cost That Applies (# of unit x cost per unit)	
Base Administrative Cost - $123.50/case		$123.50
Continuing Education - $68.75/course		$0.00
Monetary Penalty - $18.25/payment		$0.00
Administrative Cost - $18.25/payment		$0.00
Practice Inspection - $18.25/inspection		$0.00
Clinical Exam - $109.50		$0.00
Record Audits - $36.50/audit		$0.00
Practice Restriction - $101.00/restriction		$0.00
Reporting Requirement - $82.75/report		$0.00
Total	**$123.50**	

Total for costs : **$123.50**

Maximum recovery is $5,000

Status Report on Examining for CITA

Background

The Board, at its March 2016 meeting, directed Ms. Reen, to consult with CITA (Council of Interstate Testing Agencies) about complying with Virginia's State Travel Regulations and Board Counsel to determine if Board members can serve as examiners for CITA.

Applicable State Policies

CITA should be handled in the same manner the Board of Dentistry (BOD) handles SRTA in regards to BOD board members serving as examiners. Here are the guidelines to consider from the Department of Accounts and the Office of the Governor:

- CITA is considered an exempt organization so the following Comptroller requirements must be met:
  - Reimbursement must comply with the funding organization's (CITA) travel policy.
  - If any of the travel expenses estimated for a travel event exceed any of the guidelines established in Virginia State Travel Regulations, the Office of the Secretary must approve the travel in advance.
  - The exempt organization is allowed to pay expenses directly for the traveler (such as lodging and airfare) and may directly reimburse the traveler for out-of-pocket expenses based on the exempt organization's travel policy.
  - Documentation of the actual reimbursement must be retained within the appropriate records retention requirements.
- Governor's Executive Order Number Two states:
  - Part II – Definitions
    - "Anything of value" means:
      - 18. An honorarium or compensation for services
    - "Gift" does not mean:
      - 8. Payment or reimbursement of reasonable legitimate travel and related expenses incurred by an officer or employee in order to engage in an activity that serves a legitimate public purpose.
- All M&IE rates are governed by the U.S. General Service Administration rates. M&IE must be reduced travel days and for the applicable meal when meals are provided at no cost during an overnight travel period.

DHP has never allowed board members to accept what is considered remuneration or compensation for services. If any of the expense reimbursements in CITA's travel policy are compensation for services, then Executive Order Number Two considers that a gift. DHP can ask for an advisory opinion from the Virginia Conflict of Interest and Ethics Advisory Council regarding questions addressing the potential or actual receipt of gifts and activities that may result in, or create an appearance of, impropriety.

Information Provided for Review and Discussion

- CITA Policy for Acceptance of Examiners
- CITA Expense Reimbursement Form
- CITA Travel Reimbursement Policy

Council of Interstate Testing Agencies
Policy for Acceptance of Examiners

1. Must have a current unrestricted license to practice dentistry or dental hygiene in the member states of CITA or other regional state or regional licensing jurisdiction.

2. Must have been licensed to practice dentistry or dental hygiene for a minimum of five (5) years.

3. Must be in good standing with all jurisdictions wherein practitioner is currently or has ever been licensed to practice dentistry or dental hygiene, and must never have been the subject of a disciplinary action, reprimand, or other formal action of any kind whatsoever in any licensing jurisdiction.

4. Must be approved by the chief of the examination and/or examination committee assignment.

5. Must complete all online calibration exercises at least two (2) weeks prior to the beginning of each examination cycle.

6. Must attend and successfully complete all refresher calibration sessions held prior to each clinical licensure examination to which assigned and successfully complete a Qualifying Test with an 80% or better.

7. Must provide verification of professional malpractice insurance. If malpractice insurance is not currently secured, the CITA office is able to provide insurance for the purposes of examinations for a minimal fee.

8. Licensed dentists who have met all other criteria required to become an examiner at a CITA test site and who are employed as faculty more than eight (8) hours a week at a dental school, dental program and/or dental school out-reach clinic where students will be serving rotations, and/or providing services; many not serve as a CITA Dental Examiner in the state which they are employed.

9. Licensed dental hygienists who have met all other criteria required to become an examiner at a CITA test site and who are employed as faculty more than eight (8) hours a week at a dental/hygiene school, dental/hygiene program and/or dental/hygiene school out-reach clinic where students will be serving rotations, and/or providing services; many not serve as a CITA Dental Examiner in the state which they are employed.

CITA

2016 EXPENSE REIMBURSEMENT
EXAMINER
CITA BOARD OF DIRECTOR

Name		**Purpose**	☐ Meeting ☐ Exam
Address ☐ Check if new address	Address:	**Event Date(s):**	
	Address:	**Location:**	---
	City: State: -- Zip:		

New Examiners must complete a W-9 prior to receiving payment.

Travel Expenses (based on policy)		Amount
Total Airfare Max. $550 ($650 to/from Puerto Rico) includes airfare, luggage fees, early check in fees and upgrade fees		$
Total Personal Auto Mileage Max $500 (.54 cents/mile)	Total miles: _____	$
Total Reimbursable Lodging (excluding incidentals)		$
Other Expenses (Max $150 for Taxi, Parking, Bellman)		$
Other approved expenses not listed above		$
Rental Car (must be approved prior to travel)		$
Expense Per Diem		
Travel Day to Exam/Meeting (if travel is >150 miles)	___ ½ Day @ $175	$
Calibration Day (Chief/CFE, Patient, Hygiene only)	___ ½ Day @ $175	$
Exam/Meeting Day(s)	___ ½ Day @ $175 ___ Full Day(s) @ $350 each day	$
Travel Day after Exam/Meeting (if travel is >150 miles)	___ ½ Day @ $175	$
	Total	$0.00
Signature:	**Date:**	
CITA OFFICE USE ONLY		
	Deductions made by CITA	$ ( )
	Additions made by CITA	$
	Total amount due	$
Reviewed By:	**Date:**	

This is a fillable form. Email completed form to Sarah Stiegler at the CITA office sstiegler@citaexam.com. Scanned receipts MUST accompany the complete form. No more than $25.00 maybe submitted without receipts.

OR

Sign and date the form and submit it to the CITA office:

CITA—Attn: Sarah Stiegler

1003 High House Road, Suite 101, Cary, NC 27513

THIS FORM MUST BE SUBMITTED TO CITA WITHIN 30 DAYS OF YOUR TRAVEL.

REQUESTS SUBMITTED AFTER 30 DAYS MAY BE DENIED PAYMENT.

Please note that payments may take up to 15 business days during peak exam times.

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Council of Interstate Testing Agencies Inc. (CITA)
2016 Exam Year Travel Reimbursement Policy

The Council of Interstate Testing Agencies Inc. (CITA) reimburses travelers to cover the major portion of expenses related to authorize CITA business.

Approved Examination Contracted Personnel include Exam Site Administrator (ESA), Co-ESA and IT Coordinators. All travel approvals are given when assigned to an exam and/or by the CITA Office Manager. Travel days are not available for Co-ESA and Exam staff.

I. Expense Per Diem Guidelines

CITA compensations for Examiners and Examination Contracted Staff are divided into several categories depending on the services provided by that individual.

1. Expense per diems for Examination Contracted Personnel are included on the Administrative Exam Personnel and IT expense voucher. Exam Staff expense per diem is included on their expense voucher.

2. All Examiners are expected to travel to the examination site on calibration day so that they arrive in time for their published calibration time and schedule. "Departure sites" will be defined as the Examiner's city of residence, unless approved in advance by CITA.

3. Out of Town Examiners combined travel (over 150 miles to the exam site) and calibration will be reimbursed an expense per diem of **$350** for calibration day (½ day for travel and ½ day for calibration). Examiners will be will be paid a per diem travel day at a rate of **$175** to travel home from the exam.

4. Local Examiners (travel less than 150 miles to the exam site) will receive a reimbursement of **$175** as an expense per diem for local travel to the exam site and calibration. There will be no travel per diem allowed for travel home from the exam.

5. Examiners will receive an expense per diem of $350 for each full day they examine. When an exam is scheduled as a half day (Exam ends before 12:30 pm), Examiners, Examination Contracted Personnel and all other contracted Exam Staff, will be paid at the ½ day rate as listed on their expense voucher. If traveling more than 150 miles home from the exam, then a full day per diem will be paid which includes a travel day home. Exam schedules are finalized at least 45 day before the exam. If the exam schedule changes from a full day to a ½ day and it is less than 45 days before the exam, then the ½ day exam will be paid as a full day. If travel is by air then an additional travel day will be paid if scheduled flight is the following day.

Examiner Category	Calibration	Exam Day(s)	Travel Day(s)
Local Examiner MAX Two full day exam = $875	½ day ($175)	$350/Full exam day $175/1/2 exam day	NA
Examiner-traveling more than 150 miles to exam site MAX Two full day exam = $1,225	½ day ($175)	$350/Full exam day $175/1/2 exam	½ day ($175) to and from exam

6. As a standard operating procedure, additional consideration will be made for Essential Exam Personnel such as the Chief Examiner, Grading Room Calibrators, designated CITA Staff, ESA and IT Coordinators who would by nature of their service to CITA may be required to arrive at examination sites up to one day before calibration.

7. ESA, Co-ESA and IT Coordinators, when travel has been approved, will be reimbursed for travel expenses per the travel expense guidelines articulated for examiners.

8. Prior to making travel plans an Examiner and/or Examination Contracted Personnel may submit a Travel Variance form if there is compelling need to deviate from the travel policy. Compelling considerations may be due to extenuating travel distances and/or to attend meetings called by CITA prior to the examination. **Requests should be submitted in writing PRIOR to making travel plans for potential approval of an Early Arrival Date or other variance from the expense policy.**

II. Board of Director Per Diem Guidelines

9. CITA will compensate members of the Board of Directors a **$350 full day** expense per diem **or $175 for a half day (4 hours or less)** to attend CITA Board of Director meetings, or to attend state, regional or national meetings on behalf of CITA. CITA will compensate **$175** as an expense per diem per travel day is travel is over 150 miles. When travel is on the same day as the exam or meeting, a full day expense per diem will be paid for that day.

10. Board of Director Members shall be paid a **$350 full day** expense per diem **or $175 for a half day (4 hours or less)** to participate in and/or provide administrative oversight of the CITA examination or office operations. CITA will compensate **$175** as an expense per diem per travel day if travel is over 150 miles. When travel is on the same day as the exam or meeting, a full day Expense Per Diem will be paid for that day.

III. Travel Expense Guidelines

12. If traveling by air, flights are required to be booked prior to 30-days of travel. CITA will reimburse for luggage fees, early check in fees, upgrade fees AND a coach airfare booked from home base to point of meeting/examination site up to $550.00 and $650.00 for travel to and from continental US. CITA will routinely consider an Early Arrival Date for all Examination Participants who must fly into Puerto Rico for an examination or out of Puerto Rico for an examination. (Fees higher than this will need to be pre-approved by the President or Office Manager).

13. As stated in #12, CITA is now including luggage fees, early check in fees or upgrade fees in the maximum amount reimbursed for flight.

14. If traveling by personal automobile, CITA will reimburse for mileage at the rate of **$.575 per mile** traveled **up to a maximum of $500** if this is your primary form of transportation to the exam site (subject to change per Federal Reimbursement Rates). Changed to new IRS rate of $.54 per mile 2/22/2016.

15. **CITA will reimburse up to a combined $150 for taxi fares, bellman, airport or hotel parking fees, tolls, ext.**

16. CITA does **NOT** reimburse for fuel expenses nor does it reimburse for rental cars used within the state or territory where the examination/meeting is being held UNLESS receiving prior approval from the CITA Office Manager or President.

17. CITA will not reimburse for meals. As of 2016, this is included in the expense per diem for all Examiners and Examination Contracted Personnel.

18. Hotel rooms will be reimbursed by CITA starting the evening of calibration for all Examiners and approved Examination Contracted Personnel through the last night of the exam. Exam Staff may also be pre-approved for a hotel night if they travel over 50 miles to the exam. For example, a traditional DDS exam would include 3 hotel nights. Additional nights are at examiners own expense unless pre-approved by the CITA Office Manager or President prior to travel.

19. CITA will reserve blocks of rooms for meetings and examinations; however, it will be the responsibility of each individual to pay for their room and file an expense reimbursement. CITA will reimburse individuals up to the contracted hotel room charges including room tax. CITA is often able to negotiate discounted hotel room rates but to do so normally must execute contracts at an early date and must guarantee use of such rooms. Therefore, CITA reserves the right to require individuals to stay in the specific CITA designated hotels. **CITA does NOT reimburse for incidentals (i.e. laundry service, room service, movies, internet, etc.)**

IV. Reimbursement Process

20. Individuals are required to complete a CITA Expense Reimbursement Form. Receipts for all expenses, (Do NOT submit receipts for meals), must be attached to the form to receive reimbursement. This includes hotel bills, automobile rental receipts if pre-approved, parking receipts, airline ticket stubs, and taxi receipts. The one exception is for tips for hotel bellmen, which are exempt from the receipt requirement up to the amount of $10 per occurrence. CITA will reimburse up to a total of $25.00 without a receipt. To receive reimbursement for expenses, all reimbursement forms are required to be submitted to the CITA office within 30-days from date of expenses. Expense forms and legible copies of receipts or original receipts must be sent either via the US Postal Service or scanned in and sent by email to ***Sarah Stiegler*** at (***sstiegler@citaexam.com***). **Faxed expense forms will not be processed in 2016.** In the extreme circumstance that a receipt has been lost, CITA *may* permit the reimbursement of the expense upon completion of an affidavit from the submitting party and approval of the current Office Manager.

21. All reimbursements will be made after the travel has occurred.

22. A W-9 is required from each contractor before the first reimbursement will be processed. The IRS Requires that CITA report reimbursement for expense per diems paid to individuals during the year if the total exceeds $600. Individuals who have received reimbursement for expense per diems in excess of $600 will be sent a 1099 Form at the conclusion of the tax year. Therefore, it is important that you maintain your receipts for individual tax purposes.

Disciplinary Board Report for September 16, 2016

Today's report reviews the 2016 calendar year case activity then addresses the Board's disciplinary case actions for the fourth quarter of fiscal year 2016 which includes the dates of April 1, 2016 through June 30, 2016.

Calendar Year 2016

The table below includes all cases that have received Board action since January 1, 2016 through August 25, 2016.

Calendar 2016	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
January	24	2	3	5
February	42	39	5	44
March	44	50	5	55
April	32	12	2	14
May	36	30	8	38
June	28	31	6	37
July	29	47	3	50
August 25th	18	20	10	30
September				
October				
November				
December				
Totals	**253**	**231**	**42**	**273**

Q4 FY 2016

For the fourth quarter of 2016, the Board received a total of 65 patient care cases. The Board closed a total of 66 patient care cases for a 102% clearance rate, which is down from 89% in Q3 of 2016. The current pending caseload older than 250 days is 29%, which is down from 31% in Q3 of 2016. The Board's goal is 20%. In Q4 of 2016, 75% of the patient care cases were closed within 250 days, as compared to 84% in Q3 of 2016. The Board's goal is 90% of patient care cases closed within 250 days.[1]

License Suspensions

Between May 25, 2016 and August 25, 2016, the Board has summarily suspended one dental license.

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[1] The Agency's Key Performance Measures.

- DHP's goal is to maintain a 100% clearance rate of allegations of misconduct through the end of FY 2016.
- The goal is to maintain the percentage of open patient care cases older than 250 business days at no more than 20% through the end of FY 2016.
- The goal is to resolve 90% of patient care cases within 250 business days through the end of FY 2016.

Board Ordered Continuing Education

The Board has recently seen an uptick in the number of Respondents who have requested modifications of the terms in their Board Orders regarding continuing education. Respondents have requested the ability to take the required continuing education through the Internet. The Board historically has mandated any continuing education course required by an Order to be taken face-to-face, interactive sessions (i.e., no home study, journal, or Internet courses). Upon presentation of these requests for modification, the Special Conference Committees that originally heard the informal conference have decided to deny the requests on the basis that the requirement of the continuing education being face-to-face, interactive sessions is part of the sanction.

Board Member concerns

Board staff would like to know if the Board members have any concerns about the way discipline matters are being handled? How is the probable cause review process working? Is there anything that could be done differently? Any concerns about informal conferences?

Comments Requested: ADA Sedation and Anesthesia Guidelines

Background:

At the June, 2016 Board meeting, the ADA Request for Comments on its Sedation & Anesthesia Guidelines was reviewed and the Board authorized its Executive Director to submit comments. The comments the Board submitted in June, 2016 to the ADA Council on Dental Education and Licensure on the ADA Sedation and Anesthesia Guidelines are provided as information.

No action is required.

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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June 30, 2016

Dr. Daniel J. Gesek, Jr., Chair
Council on Dental Education and Licensure
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Via email, care of: JasekJ@ada.org

Dear Dr. Gesek:

The Virginia Board of Dentistry (the Board) appreciates this opportunity to comment on the Council's proposed revisions to the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists and the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. These guidelines are an invaluable resource for the Board. In addition, the Guidelines for Teaching are incorporated by reference in the Board's Regulations Governing the Practice of Dentistry as Virginia's education standard for issuance of conscious/moderate sedation permits and deep sedation and general anesthesia permits.

We support, and are especially appreciative of, the Council's proposed language in:

- Lines 468 – 472 and 595 - 598 to require monitoring end-tidal CO2 for moderate sedation and for deep sedation and general anesthesia.
- Lines 1362 - 1365 to require 60 hours of instruction plus 20 patient experiences for moderate sedation courses regardless of the route of administration.
- Lines 1366 – 1372 to require certification of the competence of each participant, additional experience to achieve competence, and the maintenance of records of instruction and clinical experiences to capture the number of patients managed by each participant.
- Lines 402 – 409 and 523 – 530 to include an assessment of Body Mass Index (BMI) as a part of a pre-procedural workup.

The Board also wants to inform the Council of three changes it has advanced in our sedation and anesthesia regulations which are germane to the Council's proposed amendments. The first one is to separate the administration of only nitrous oxide from the provisions for minimal sedation

into a new section on the administration of inhalation analgesia. This action will facilitate having a clear delineation in equipment and monitoring requirements between inhalation analgesia alone, and minimal sedation with or without nitrous oxide. The second change is to limit intraoperative monitoring to continuous visual observation of responsiveness, color, and respiration for both inhalation analgesia and minimal sedation with or without nitrous oxide. The third change is to require the recording of patients' height and weight and, if appropriate, Body Mass Index (BMI).

The Board commends the Council's commitment to patient safety and its thoughtful and well-reasoned development of both guidelines. The proposed changes are needed to foster a common understanding of the steps needed to promote both the well-being of patients, and the competence of dentists.

The Board looks forward to learning of the Council's success in advancing its proposals. Please contact me at sandra.reen@dhp.virginia.gov if you have any questions about these comments.

Sincerely,

Sandra K Reen

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

Virginia Board of Dentistry
June 10, 2016

Review of the Alternatives Recommended by Commenters on the NOIRA to Require a Periodic Jurisprudence Examination

Notable Quotes

"We are kept abreast of any changes in the regulations and laws via email and mail." Pg 7 of 13
"The laws governing Dentistry have not changed much if at all in the 15 years I have had my license…" Pg 6 of 10
"Our elected officials should really focus their attention to other areas." Pg 8 of 10
"My concern is the frequency which dentists would have to take this exam relative to the infrequent changes made by the Board." Pg 7 of 12
"It seems we now get email updates about regulation changes that we never got in the past. I feel more up to date than I ever have in the past. Is this not working?" Pg 9 of 12
"If the VDA would keep us informed/up to date via emails we would not need this." Pg 4 of 11
"Presently, I would have to STOP my practice in order to read (and understand) ALL of the continually generated "regulations" to practice dentistry in VA." Pg 7 of 11

Alternatives

- Regular E-mails (frequently, monthly, quarterly, yearly)
  - Notice of changes in laws and regulations
  - Board actions , recurring violations
  - Layman's terms, clear, easy to understand, readability
  - Request a response
- Require an Exam for Initial Licensure, Violators, Re-entry
- Online CE course
  - Review of recent changes
  - Violations/common infractions/trends
  - Module to review
  - Add as a CE requirement
- A short written or online test at renewal
- Comprehensive guidance documents
- Friendly well organized meeting annually
- Positive education campaign

Excerpt from the 9/18/2015

Ms. Reen reported:

- The proposal advanced by the Ad Hoc Committee on Disciplinary Findings to amend the Sanction Reference Points guidance document to add a financial gain factor to the offense scoring tables will be presented at the December meeting. She added that Mr. Kauder of Visual Research has evaluated the effect of adding this offence and will present his findings at the Board's December meeting.
- There were several misstatements about the work of the Board in the VDA President's Message in the latest Virginia Dental Journal. The misstatements were:
  1. *Only 3 – 5% of licensees violate the laws and regulations dentists.* She said that in the last five years 8,358 dentists have held an active dental license and 1,472 of those dentists have had at least one case before the Board. This means that 17.6% of the dentists licensed in this five year snapshot were or are currently being investigated by the Board for possible violations of the laws and regulations which govern dental practice in Virginia.
  2. *The Board only communicates to interested third parties about changes.* The Board's Public Participation e-mail list of 167 individuals and organizations includes numerous dentists and dental organizations. BRIEFS which addresses the policy actions of the Board is sent to every licensee with an email address on record.
  3. *The Board used to publish a quarterly newsletter.* Looking back to 1988, the records indicate that a year or more passed between bulletins until 2010. Beginning in 2010, BRIEFS has been issued twice a year with the exception that only one was issued in 2014.

She also noted that Dr. Link encouraged VDA members to contact Board members to address their issues. Ms. Reen said that Board members are public officials who can hear comments from the public, but she went on to caution that questions should be referred to her since she is the spokesperson for the Board.

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File a Complaint
Administrative Proceedings Division

Virginia Board of Dentistry News and Information

- Newsletters
- Other Board News
- Case Decsions

Newsletters

Click on the link below to view the Virginia Board of Dentistry Newsletter.

- February 2016 Briefs
- August 2015 Briefs
- February 2015 Briefs
- February 2014 Briefs
- August 2013 Briefs
- February 2013 Briefs
- August 2012 Briefs
- January 2012 Briefs
- August 2011 Briefs
- January 2011 Briefs
- August 2010 Briefs
- March 2010 Briefs
- August 2007
- May 2006
- Winter 2003/2004

- Spring 2003
- Winter/Spring 2002 (PDF format)
- Summer 2002

Other Board News

Sedation and Anesthesia Permits and Inspections Q and A

Questions and answers regarding Sedation and Anesthesia Permits and Inspections (pdf)

Extension of renewal requirements for deployed military and spouses

Virginia law allows active duty service people or their spouses who are deployed outside the U.S. to have an extension of time for any requirement or fee pertaining to renewal until 60 days after the person's return from deployment. The extension cannot last beyond 5 years past the expiration date for the license. For more information, please read attached policy (pdf) and contact the applicable board for your license.

Address of record

The Department of Health Professions (DHP) is required to collect an official address of record from each health professional. This address is used by DHP for agency purposes and may be provided as public information. DHP is also required to give health professionals the opportunity to provide an alternate address for dissemination to the public. **If no second (public) address is provided, the official address of record is given to the public.** An individual is not required to submit a place of residence for either the official address of record or the public address. A post office box or a practice location is acceptable. Changes to either address are required within 30 days of any change and may be made at any time by accessing your licensure information through the online system or by written notification to the Board.

Advertising

Advertising: Are you in Compliance

Recordkeeping - Beyond the Regulatory Requirement

Recordkeeping - Beyond the Regulatory Requirement - a Power Point presentation, is posted as a resource for licensees who wish to evaluate their recordkeeping practices.

Duty to Report Adult or Child Abuse, Neglect or Exploitation

By law, the persons licensed as health care practitioners have a duty to report to the Virginia Department of Social Services or the local departments of social services any known or suspected incidences of abuse, neglect, or exploitation of children or elderly and incapacitated adults. Contact information and a copy of the law may be obtained at: Legal Requirements to Report Child Abuse and Adult Abuse

Board Case Decisions

Recent Case Decisions

- January 1, 2002 to December 31, 2002
- January 1, 2003 to December 31, 2003
- January 1, 2004 to December 31, 2004
- January 1, 2005 to December 31, 2005

To view the PDF files on this page you'll need the free Adobe Acrobat Reader
For the other files you'll need Microsoft Word or the free viewer.

Board of Dentistry
Charles E. Gaskins III, DDS President
Sandra Reen, Executive Director
Email: denbd@dhp.virginia.gov

Virginia Board of Dentistry
September 16, 2016

IMPLEMENTATION OF THE FOUR CHAPTERS

POSTING REQUIREMENTS

1. **Use of wallet size for display**
2. **Objections to displaying DEA permit because the information can be taken used fraudulently**
3. **Volunteer exemption not referenced in the regulations**

- **§ 54.1-2721. Display of license.**
  Every person practicing dentistry in this Commonwealth shall display his license in his office in plain view of patients. Any person practicing dentistry without having his license on display shall be subject to disciplinary action by the Board.
  The provisions of this section shall not apply to any dentist while he is serving as a volunteer providing dental services in an underserved area of the Commonwealth under the auspices of a Virginia charitable corporation granted tax-exempt status under § 501 (c) (3) of the internal Revenue Code and operating as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services.
- **18VAC60-21-30. Posting requirements.**
  A. A dentist who is practicing under a firm name or who is practicing as an employee of another dentist is required by § 54.1-2720 of the Code to conspicuously display his name at the entrance of the office. The employing dentist, firm, or company must enable compliance by designating a space at the entrance of the office for the name to be displayed.
  B. In accordance with § 54.1-2721 of the Code a dentist shall display his dental license where it is conspicuous and readable by patients in each dental practice setting. If a licensee practices in more than one office, a duplicate license obtained from the board may be displayed.
  C. A dentist who administers, prescribes, or dispense Schedules II through V controlled substances shall display his current registration with the federal Drug Enforcement Administration with his current active license.
  D. A dentist who administers conscious/moderate sedation, deep sedation, or general anesthesia in a dental office shall display his sedation or anesthesia permit issued by the board or certificate issued by AAOMS.
- **Action on applications for registration: revocation or suspension of registration**
  § 1301.35 Certificate of registration; denial of registration.
  (c) The Certificate of Registration (DEA Form 223) shall contain the name, address, and registration number of the registrant, the activity authorized by the registration, the schedules and/or Administration Controlled Substances Code Number (as set forth in **part 1308** of this chapter) of this controlled substances which the registrant is authorized to handle, the amount of fee paid (or exemption), and the expiration date of the registration. The registrant shall maintain the certificate of registration at the registered location in a readily retrievable manner and shall permit inspection of the certificate by any official, agent or employee of the Administration or of any Federal, State, or local agency engaged in enforcement of laws relating to controlled substances. [62 FR 13954, Mar. 24, 1997]

MAINTAINING A SAFE AND SANITARY PRACTICE

1. **Reference the CDC Guidelines or a similar resource to give licensees specific information on requirements**

- **§ 54.1-2706. Revocation or suspension; other sanctions.**
  The Board may refuse to admit a candidate to any examination, refuse to issue a license to any applicant, suspend for a stated period or indefinitely, or revoke any license or censure or reprimand any licensee or place him on probation for such time as it may designate for any of the following causes:
  11. Practicing or causing others to practice in a manner as to be a danger to the health and welfare of his patients and the public;
- **18VAC60-21-60. General responsibilities to patients.**
  A. A dentist is responsible for conducting his practice in a manner that safeguards the safety, health, and welfare of his patients and the public by:

1. Maintaining a safe and sanitary practice, including containing or isolating pets away from the treatment areas of the dental practice. An exception shall be made for a service dog trained to accompany its owner or handler for the purpose of carrying items, retrieving objects, pulling a wheelchair, alerting the owner or handler to medical conditions, or other such activities of service or support necessary to mitigate a disability.

- **Centers for Disease Control - Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care**

  This document summarizes current infection prevention recommendations and includes a checklist that can be used to evaluate compliance. The information presented here is based primarily upon the previously published 2003 guideline (see below) and represents infection prevention expectations for safe care in dental settings.

  The Summary includes additional topics and information relevant to dental infection prevention and control published by CDC since 2003 including:

  - Infection prevention program administrative measures,
  - Infection prevention education and training,
  - Respiratory hygiene and cough etiquette,
  - Updated safe injection practices, and
  - Administrative measures for instrument processing.

  The Summary is intended for use by anyone needing information about basic infection prevention measures in dental health care settings, but is not a replacement for the more extensive guidelines. Readers are urged to consult the full guidelines for additional background, rationale, and scientific evidence behind each recommendation.

  Resources:

  Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care[PDF-1MB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care.pdf)
  Infection Prevention Checklist for Dental Settings (Print-Friendly)[PDF-825 KB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care-checklist.pdf)
  Infection Prevention Checklist for Dental Settings (Fillable Form)[PDF-884 KB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/dentaleditable_tag508.pdf)
  Recommendations from the Guidelines for Infection Control in Dental Health-Care Settings, 2003[PDF-766 KB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/recommendations-excerpt.pdf)

REPORTIABLE EVENTS

1. Is a report required when there is an emergency treatment event related to local anesthesia?
2. Should there be an "or" between sedation and anesthesia in the last line?

- **18VAC60-21-100. Reportable events during or following treatment or the administration of sedation or anesthesia.**

  The treating dentist shall submit a written report to the board within 15 calendar days following an unexpected patient event that occurred intra-operatively or during the first 24 hours immediately following the patient's departure from his facility, resulting in either a physical injury or a respiratory, cardiovascular, or neurological complication that was related to the dental treatment or service provided and that necessitated admission of the patient to a hospital or in a patient death. Any emergency treatment of a patient by a hospital that is related to sedation anesthesia shall also be reported.

DELEGATION TO DENTAL HYGIENISTS

1. **Use of the term "gingival curettage"** - refer to "incidental removal of soft tissue that may occur during root instrumentation" and not to gingival curettage as a stand-alone procedure
2. **Explain the term "nonsurgical laser"** – is laser diode more accurate
3. **Are there education requirements for using a laser?**

- **§ 54.1-2722. License; application; qualifications; practice of dental hygiene.**
D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.
- **§ 54.1-2706. Revocation or suspension; other sanctions.**
The Board may refuse to admit a candidate to any examination, refuse to issue a license to any applicant, suspend for a stated period or indefinitely, or revoke any license or censure or reprimand any licensee or place him on probation for such time as it may designate for any of the following causes:
12. Practicing outside the scope of the dentist's or dental hygienist's education, training, and experience;
- **18VAC60-21-130. Nondelegable duties; dentists.**
Only licensed dentists shall perform the following duties:
2. Performing surgical or cutting procedures on hard or soft tissue except a dental hygienist performing gingival curettage as provided in 18VAC60-21-140;
- **18VAC60-21-140. Delegation to dental hygienists.**
A. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:
1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers, with any sedation or anesthesia administered.
B. The following duties shall only be delegated to dental hygienists and may be performed under indirect supervision or may be delegated by written order in accordance with §§ 54.1-2722 D and 54.1-3408 J of the Code to be performed under general supervision:
1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers with or without topical oral anesthetics.
- **18VAC60-25-40. Scope of practice.**
C. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:
1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and non-surgical lasers with any sedation or anesthesia administered.
D. The following duties shall only be delegated to dental hygienists and may be performed under indirect supervision or may be delegated by written order in accordance with § 54.1-2722 D of the Code to be performed under general supervision:
1. Scaling, root planning, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and non-surgical lasers with or without topical oral anesthestics.

Addition to Implementation of the Four Chapters discussion document

DENTAL HYGIENISTS TREATING PATIENTS UNDER SEDATION AND GENERAL ANESTHESIA

1. **Address the inconsistency between the regulations governing dental hygiene treatment as highlighted below, the treatment team provisions for conscious/moderate sedation and Guidance Document 60-4.**

18VAC60-21-140. Delegation to dental hygienists.

A. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:

1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers, with any sedation or anesthesia administered.
2. Performing an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets, or other abnormal conditions for assisting the dentist in the diagnosis.
3. Administering nitrous oxide or local anesthesia by dental hygienists qualified in accordance with the requirements of 18VAC60-25-100.

18VAC60-25-40 Scope of Practice.

C. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:

1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and non-surgical lasers with any sedation or anesthesia administered.

18VAC60-21-291. Requirements for administration of conscious/moderate sedation.

C. Required staffing. At a minimum, there shall be a two person treatment team for conscious/moderate sedation. The team shall include the operating dentist and a second person to monitor the patient as provided in 18VAC60-21-260 K and assist the operating dentist as provided in 18VAC60-21-260 J, both of whom shall be in the operatory with the patient throughout the dental procedure. If the second person is a dentist, an anesthesiologist, or a certified registered nurse anesthetist who administers the drugs as permitted in 18VAC60-21-291 A, such person may monitor the patient.

18VAC60-21-301. Requirements for administration of deep sedation or general anesthesia.

D. Required staffing. At a minimum, there shall be a three-person treatment team for deep sedation or general anesthesia. The team shall include the operating dentist, a second person to monitor the patient as provided in 18VAC60-21-260 K, and a third person to assist the operating dentist as provided in 18VAC60-21-260 J, all of whom shall be in the operatory with the patient during the dental procedure. If a second dentist, an anesthesiologist, or a certified registered nurse anesthetist administers the drugs as permitted in 18VAC60-21-301 B, such person may serve as the second person to monitor the patient.

Excerpt from Guidance Document 60-4 Q & A on Analgesia, Sedation and Anesthesia Practice
WHAT REGULATIONS APPLY WHEN A PATIENT WANTS SEDATION FOR SCALING AND ROOT PLANING TREATMENT BY A DENTAL HYGIENIST? DOES THE DDS WHO HOLDS A CONSCIOUS/MODERATE SEDATION PERMIT HAVE TO STAY IN THE TREATMENT ROOM AFTER PROVIDING THE SEDATION WHILE THE RDH TREATS THE PATIENT?

The treatment team for conscious/moderate sedation must include the operating dentist. There is no statute or regulation which permits a dental hygienist to treat patients under conscious/moderate sedation, deep sedation or general anesthesia with or without a dentist present during treatment. See the staffing requirements in section 18VAC60-21-291.C and 301.D.

ADA American Dental Association®
America's leading advocate for oral health

Statement on Lasers in Dentistry

From the ADA Council on Scientific Affairs

Introduction

Applications for and research on lasers in dentistry continues to expand since their introduction to the dental profession. Dental laser systems are cleared for marketing in the United States via the Food and Drug Administration (FDA) Premarket Notification [510(k)] process. The primary purpose of this Statement is to provide comments and a science-based perspective on several increasingly popular uses for dental lasers. These topics include: Sulcular Debridement (sometimes termed Laser Curettage), Laser-Assisted New Attachment Procedure (LANAP), Reduction of Bacteria Levels in periodontal pockets (sometimes termed Pocket Sterilization), Laser-facilitated Wound Healing, Laser Root Planing, Aid in the Diagnosis of Caries (Laser Fluorescence), and other Hard Tissue Applications including endodontics. The statement also provides a brief overview of the FDA's 510(k) process and educational options for dental laser systems.

FDA 510(k) Clearance

All dental lasers currently available on the U.S. market have been issued 510(k) clearances by the FDA. 510(k) submissions are reviewed and processed by the Center for Devices and Radiological Health (CDRH) in the FDA. The review team determines if the product under review meets relevant criteria for "substantial equivalence" to a predicate device (the term "predicate" is used to describe any device that is marketed for the same use as the new device, even if the actual technologies are not the same).

The FDA includes in its review dental laser system specifications and safety mechanisms in relationship to already cleared devices. For new indications for use the FDA may request additional safety and effectiveness data in support of the clearance

for market. Given the many factors that are appropriate to evaluate when using lasers in biological systems, the Council feels that the 510(k) process alone is not inherently sufficient to scientifically demonstrate safety, efficacy, or effectiveness for marketed dental laser applications in all cases. Properly designed preclinical and clinical studies are often needed to demonstrate safety, efficacy and clinical effectiveness for specific products and uses.

The number and type of studies necessary to obtain 510(k) clearance varies widely for the various types of devices used in dentistry. The Council encourages dental practitioners to cautiously consider claims of safety and efficacy that are purely based on the product having been cleared for market by the FDA through the 510(k) process. It is appropriate and prudent for the practitioner to request detailed information from the manufacturer about the scientific evidence that forms the basis for the marketed use. This information will help the dentist to discuss the benefits and risks of the treatment options with patients. Another source of information for clinicians to learn more about the available evidence on a specific topic or clinical question is the ADA's Evidence-Based Dentistry Web page (http://ebd.ada.org) developed by the ADA Center for Evidence-Based Dentistry.

There are currently more than twenty cleared indications for use for dental lasers in the United States. Dental lasers obtaining 510(k) clearance may be labeled, promoted, and advertised by the manufacturer for only those specific indications for use for which the devices have been cleared for marketing. Dental laser manufacturers must seek FDA 510(k) clearance for each laser product and each specific indication for use. Not every laser is cleared for every conceivable use. Therefore, FDA marketing clearances apply to certain products that are specific to the manufacturer and product. For any specific laser device, the specific indications for use, as marketing clearances, can be found in the professional information section of the operator's manual for the device.

Additional uses for dental lasers are considered "off label use." Within the scope of a license to practice, dentists may choose to use lasers or other products "off label." Practitioners should consider off label use in light of possible benefits and risks, patient needs, and the available scientific evidence. The Council recommends that dentists read and understand the specific indications for use for each device. Practitioners may also access the FDA Web site

(http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm), call the FDA or consult with the manufacturer for specific and up-to-date information about cleared indications for use.

Laser Education

It is the position of the Council that practitioners obtain proper training on the use of dental laser devices, and that dentists use the devices within their licensed scope of practice, training and experience. Guidance for the profession for safe dental laser use is provided by American National Standards Institute Standard Z136.1 Safe Use of Lasers and Z136.3 Safe Use of Lasers in Health Care Facilities. Specific training is also available from manufacturers, and via independent providers of continuing education, including professional organizations and academic institutions. Continuing education programs/presenters should address and disclose possible conflicts of interest. At the present time, the ADA's Commission on Dental Accreditation does not include laser education in its accreditation standards for dental education programs. However, proposed educational standards are available (e.g., Curriculum Guidelines and Standards for Dental Laser Education1).

Sulcular Debridement (Curettage)

The dental literature indicates that when used as an adjunct to meticulous root planing, mechanical or chemical curettage (i.e., the intentional removal of the epithelial lining of the sulcus) offers no consistent benefit beyond scaling and root planing alone with respect to gain of the periodontal attachment. As such, curettage was deemed several years ago to be of no known clinical value. Accordingly, the ADA code for curettage was omitted from the CDT-4 code listing. There is little convincing clinical evidence that adjunctive laser curettage produces a result superior to adjunctive mechanical or chemical curettage, or even scaling and root planing alone. Current evidence suggests that therapies intended to arrest and control periodontitis depend primarily on effective root debridement.

Laser-Assisted New Attachment Procedure

A 2007 publication compared the probing depth, attachment gain, and type of attachment from traditional mechanical therapy of advanced chronic periodontitis vs. traditional mechanical therapy that included two intrasulcular applications of Nd: YAG; one aimed at removing the sulcular epithelium and another said to "seal" the pocket.2 In this study, histology was performed on 6 pairs of single-rooted teeth at 3 months. Laser-treated pockets tended to show greater probing depth reductions and clinical attachment gains than non-lased pockets. Based on measurements from notches placed in periodontally involved root surfaces before treatment, lased teeth showed evidence of new cementum while 5 of the 6 control teeth showed a long junctional epithelial attachment. This study concluded that the Laser Assisted New Attachment ProcedureTM (LANAP) can be associated with cementum-mediated new connective-tissue attachment and apparent periodontal regeneration of diseased root surfaces in humans.

Although the Council is optimistic regarding the potential for lasers to enhance effectiveness in treating periodontitis, dentists should note that this study provides no more than pilot validation for this treatment concept. The study was not blinded, and the sample size was small thereby limiting extrapolation of the results to the general population. Further, pre-treatment notches in the teeth were difficult to place, hard to know exactly where they were placed and are difficult to clearly detect on histological specimens. Moreover, the advanced periodontal destruction initially present in these 6 test teeth make it difficult to extrapolate these results to cases of early and moderate chronic periodontitis, where the anatomic environment, laser energy distribution and clinical outcome may differ substantially. It is also unclear what laser-based "sealing" of a treated periodontal sulcus is and, if real, what benefits it might provide. Additional clinical data from properly designed clinical trials with adequate sample sizes are still required before it can be known to what extent LANAP is safe and effective across the spectrum of patients with chronic periodontitis. The Council therefore cautions clinicians to weigh the available evidence for LANAP when considering the options available for treatment of the periodontal diseases.

Reduction of Bacteria Level

Lasers, as a group, have inconsistently demonstrated the ability to reduce microorganisms within a periodontal pocket. It appears from the literature that mechanical root debridement remains a priority to attain improvements in clinical

attachment levels. However, limited new data suggest that clinical outcomes may be enhanced by the adjunctive use (following root debridement) of a bactericidal irrigant activated by a cold laser.3

Laser Wound Healing

Methods using low-powered lasers to improve wound healing have been noted for many years but the reported results have been mixed. While the risk of thermal damage from low-powered lasers appears minimal, the Council considers the application of laser energy purely for the purpose of improved wound healing to be controversial and not well supported by clinical studies.

Laser Root Planing

Erbium lasers show potential for effective root debridement. The Er:YAG laser has been shown, in vitro, to remove calculus4 and to negate endotoxin.5 Clinical data also exist that suggest the Er:YAG laser can result in a superior calculated clinical attachment gain compared with mechanical scaling and root planing alone.6 The Council views such developments as encouraging. Additional well-designed comparative studies would be helpful to clinicians in confirming these results.

Aid in the Diagnosis of Caries

Laser fluorescence may be a useful adjunct in the detection of early enamel caries.7 The level of energy used in this application poses little risk to the patient and offers potential benefits. Presently, one product available commercially in the United States is based on this laser technology, using a diode laser at 655-nm wavelength. Other adjunctive caries detection products available in the United States do not use laser technology.

Hard Tissue Applications

The vast majority of the lasers cleared for market since the last Council Statement on Lasers in 1998 that are intended for hard tissue applications, such as the ablation of caries, enamel, and dentin, are either the Er:YAG (2.94 μm) or the Er,Cr:YSGG (2.78 μm) laser. In general, the Council believes these applications to be reasonable based

upon supporting in vitro and in vivo studies. Some clinical studies exist that report equivalency to traditional hard tissue removal methods.8 However other studies question the reliability of bonding to dentin surfaces prepared with an Er,Cr:YSGG laser9 or suggest that Er:YAG laser-cut preparations in enamel and dentin are equivalent to air-abrasion preparations with respect to resin bond strengths.10 The ability to perform cavity preparations with the Er:YAG and Er,Cr:YSGG lasers without local anesthetic, where possible and where appropriate, is viewed positively by the Council. The shallow penetration of the Er: YAG and Er, Cr: YSGG lasers reduce the thermal risk to the pulp in comparison to other more penetrating laser wavelengths. While the Council acknowledges that the Er:YAG and Er, Cr:YSGG lasers represent an alternative method of removing enamel, dentin and caries, clinicians are encouraged to be cautious and to be aware of the benefits and risks involved in the removal of hard tissue and caries using lasers and traditional cavity preparation methods.

Endodontics

The primary goal for endodontic therapy is cleansing, shaping and sealing the root canal system. Lasers are cleared for pulpotomy, blood flow measurements, apicoectomy, and illumination of the endodontic orifice and for softening gutta percha. Currently, there are no devices that can accurately measure the pulpal blood flow. Lasers used as an adjunct have been shown to aid in the cleansing of the root canal space. In vitro evidence indicates that lasers are equivalent to conventional rotary instrumentation for shaping the coronal and middle thirds, but inferior for shaping the apical 1/3 of the root canal system. There is no evidence that lasers provide a superior seal or higher clinical success rate than conventional instrumentation.

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graduated. She has published articles in both Access and RDH magazines and lectures on dental lasers, contemporary periodontal therapies, and the dental treatment for patients with AD/HD. She currently resides in San Antonio with her husband and two young babies who keep her very busy. Lisa practices clinical dental hygiene at Dominion Dental Spa, the office of Dr. Tiffini Stratton, DDS.

COMMON DENTAL HYGIENE PROCEDURES WITH LASERS

Lasers can be used in every specialty of dentistry and for a wide range of procedures. Since this article is focusing on laser use specific to dental hygiene, I am going to focus on soft tissue procedures. Dental hygienists all over the world use lasers for various procedures, depending on their state's/country's laws.1,11,15

- Pit and fissure sealants — The laser light disinfects the grooves to prevent contamination, which aids in sealant placement.
- Adjunct to scaling and root planing procedures — Laser light helps decontaminate pockets, decreasing the numbers of periodontal pathogens and removing diseased or granulation tissue. The laser light is effective in eliminating dark-pigmented bacteria, which is the primary bacteria we are trying to eliminate in periodontal disease.
- Aphthous ulcer treatment — This is achieved by a process known as biostimulation. You do not make direct contact with your target tissue when you biostimulate. The laser fiber is held a couple of millimeters away from the ulcer on the tissue. You direct the laser energy at the ulcer and the patient will start to feel immediate pain relief. The ulcer will heal almost overnight and some research claims if you biostimulate an area one time, another ulcer will never appear in that area again. It is thought the laser energy increases collagen growth, and osteoblastic and fibroblastic activity. This leads to rapid wound healing and anti-inflammatory effects in the tissue.

- Whitening — Laser photons initiate a photochemical activator and increase the enamel response to hydrogen peroxide.2
- Decay prevention — Lasers are thought to increase the enamel uptake of fluoride ions.3,20 This is not FDA approved as of yet for caries prevention.14 It is believed the laser will help fuse the inorganic components of enamel and vaporize the organic components, thus producing a less porous surface that is more resistant to demineralization.

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UNAPPROVED - DRAFT

BOARD OF DENTISTRY
MINUTES of the NOMINATING COMMITTEE MEETING

Friday, June 10, 2016

Perimeter Center
9960 Mayland Drive, Suite 200
Richmond, VA 23233
Board Room 4

CALL TO ORDER:	The meeting was called to order at 3:30 p.m.
PRESIDING:	Melanie C. Swain, R.D.H., Chair
MEMBERS PRESENT:	Evelyn Rolon, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director for the Board
QUORUM:	All members were present.
NOMINATIONS:	The Committee reviewed and discussed possible candidates and agreed by consensus to nominate Dr. Rizkalla for president, Dr. Alexander for vice-president and Dr. Parris-Wilkins for secretary-treasurer.
ADJOURNMENT:	With all business concluded, the Committee adjourned at 3:50 p.m.

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Melanie C. Swain, R.D.H., Chair Sandra K. Reen, Executive Director

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Date Date