VIRGINIA BOARD OF DENTISTRY

AGENDAS

September 17-18, 2015

Department of Health Professions

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

PAGE

September 17, 2015

10:00 a.m. **Formal Hearing**

September 18, 2015

Board Business

9:00 a.m. **Call to Order – Ms. Swain, President**

Evacuation Announcement – Ms. Reen

Public Comment

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Election of Officers

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VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
June 11, 2015

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 1:30 p.m., on June 11, 2015 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Melanie C. Swain, R.D.H., President

MEMBERS PRESENT:
John M. Alexander, D.D.S.
Sharon W. Barnes, Citizen Member
Surya P. Dhakar, D.D.S.
Al Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBERS EXCUSED:
Charles E. Gaskins, III, D.D.S.
Bruce S. Wyman, D.M.D.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Huong Q. Vu, Operations Manager

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
James E Schliessmann, Assistant Attorney General
Tiffany A. Laney, Adjudication Specialist
Holly M. Bush, Court Reporter, Farnsworth & Taylor Reporting.

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

Robert S. Kidder, D.D.S.
Case No.: 155322 and 161450

Dr. Kidder was present without legal counsel in accordance with the Notice of the Board dated May 11, 2015.

Ms. Swain swore in the witnesses.

Following Dr. Kidder's opening statement, Ms. Swain admitted into evidence Respondent's Exhibits A.

Following Ms. Wolf's opening statement, Ms. Swain admitted into evidence Commonwealth's Exhibits 1 through 6.

Testifying on behalf of the Commonwealth were Marcella Luna, DHP Senior Investigator and Phillip Powers, US Probation Officer.

Dr. Kidder testified on his own behalf.

Closed Meeting: Dr. Watkins 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 Dr. Kidder. Additionally, he moved that Board staff, Ms. Reen, Ms. Vu, 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. 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.

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

Decision: Dr. Watkins 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.

Dr. Watkins moved to deny Dr. Kidder's reinstatement application to practice in the Commonwealth of Virginia. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: The Board adjourned at 3:20 p.m.

Melanie C. Swain, R.D.H., President	Sandra K. Reen, Executive Director
Date	Date

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES
June 12, 2015

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:00 a.m. on June 12, 2015, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

PRESIDING: Melanie C. Swain, R.D.H., President

BOARD MEMBERS PRESENT:
John M. Alexander, D.D.S
Sharon W. Barnes, Citizen Member
Surya P. Dhakar, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

BOARD MEMBERS ABSENT:
Charles E. Gaskins, III, 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
Huong Vu, Operations Manager for the Board

OTHERS PRESENT:
David E. Brown, D.C., DHP Director
James E. Rutkowski, Assistant Attorney General

ESTABLISHMENT OF A QUORUM: With eight members of the Board present, a quorum was established.

Ms. Reen read the emergency evacuation procedures.

Ms. Swain gave greetings then explained the parameters for public comment and opened the public comment period.

PUBLIC COMMENT: **Dr. Michael Link, VDA President**, stated that the VDA Board of Directors voted unanimously to oppose the NOIRA for requiring passage of a law exam indicating that it was viewed as a punitive measure. He recommended more communication from the Board

to licensees and commented that the sedation inspection guidelines do not protect the public.

APPROVAL OF MINUTES:

Ms. Swain asked if there are any corrections to the minutes as listed on the agenda. No corrections were offered and the minutes were adopted as present.

DHP DIRECTOR'S REPORT:

Dr. Brown --

- Noted that the Task Force on Prescription Drug and Heroin Abuse continues to meet and develop recommendations to reduce deaths that result from drug abuse.
- Stated that in July the Prescription Monitoring Program (PMP) will begin phasing in the registration of pharmacists and prescribers of Schedule II, III and IV controlled substances.
- Encouraged participation in the Board Development Day on September 28, 2015.
- Reported that he is proposing legislation to change the composition of boards in DHP and wants to propose having an additional citizen member on the Board of Dentistry. He asked if the Board would want to replace a dentist to keep the membership at ten or add an eleventh slot for a new citizen member. By consensus, the Board supported adding an eleventh slot for another citizen member.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Watkins stated that the BHP meeting minutes are provided and he is available to answer any questions. Ms. Reen noted that the BHP discussed the Board of Dentistry's request for consideration of investigating the veracity of electronic records. She added that a summer intern is researching this topic and will present his findings at the BHP's August 6, 2015 meeting.

AADB. Ms. Swain stated that she, Dr. Gaskins and Ms. Palmatier attended the AADB Mid-Year meeting in April 2015. She added that her report is included in the agenda and noted that the substance abuse discussion was an eye opener.

Ms. Palmatier noted that her report is also included in the agenda and added that the NC Board indicates that it will not change its processes very much as a result of the Supreme Court decision issued in their case with the Federal Trade Commission.

ADEX. Drs. Rolon and Rizkalla said there was nothing new to report.

SRTA. Dr. Watkins stated that issues with the acceptance of the ADEX exam will be addressed at SRTA's annual meeting in August 2015. Ms. Swecker reported that SRTA did not administer the ADEX Dental Hygiene Exam in 2015. Ms. Swain noted that Dr. Watkins, Ms. Swecker and Dr. Rizkalla plan to attend the annual meeting.

CTel Executive Telehealth Summit 2015. Ms. Barnes thanked the Board for the opportunity to attend. She then noted the following topics were discussed:

- In Idaho's rural areas telemedicine is saving money and providing better care.
- Establishing a physician-patient relationship through an examination by tablet, phone app, or web camera.
- Doctors in one state treating patient in another state.
- Whether dentistry is ready for teledentistry.

Ad Hoc Committee on Disciplinary Findings. Dr. Watkins said the committee is recommending some amendments to the Sanction Reference Points guidance document and asked Ms. Reen to address her follow-up on the recommendations. Ms. Reen reported that she has talked to Mr. Kauder of Visual Research to determine if adding another 20 point offence score for "financial or other material gain" will affect the delineation of the offense scoring ranges. She added that Mr. Kauder has agreed to evaluate the effect and that she hoped to have the findings for the Board's September meeting.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported that the Periodic Review to reorganize Chapter 20 into four new chapters has been at the Governor's office for more than 170 days and that the NOIRA for a law exam is pending approval by the Governor to publish.

Response to Petition for Rulemaking from Dr. Sood. Ms. Yeatts stated that the petition requests acceptance of the dental programs accredited by Commission on Dental Accreditation of Canada (CDAC) since there is an existing reciprocal agreement between CDAC and Commission on Dental Accreditation of American Dental Association (CODA) to bilaterally recognize programs that are accredited by either of these commissions. She noted that the Board may accept the petitioner's request for amendments to regulations

and initiate rulemaking by adoption of a NOIRA or the Board may reject it and state its reasons for denying the petition. She said the regulations that would need to be amended are 18VAC60-20-60 and 18VAC60-20-71. Dr. Watkins moved to accept dental programs accredited by CDAC. The motion was second and passed. Dr. Watkins moved to initiate rulemaking by fast-track action. The motion was seconded and passed.

Mr. Rutkowski agreed to advise Ms. Reen if dental programs accredited by CDAC can be deemed equivalent to programs accredited by CODA now or if it is necessary to wait for the regulatory language to be changed.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics. No discussion occurred.

Written comments from Ms. Quitter and from Dr. Mayberry. Ms. Reen noted that the issue addressed in these comments is restricting the placement of implants to oral surgeons. Dr. Alexander commented that restricting implant placement to only Oral Surgeons is not ideal since there are others who are qualified to do so. He added that he agreed with Dr. Mayberry about taking a weekend course is not sufficient training. Discussions followed about having Ms. Quitter submit a complaint; interest in knowing if other boards have regulatory restrictions; and, the high rate of failure on implants performed by general dentists in disciplinary cases. It was agreed to accept these comments as information and to have staff acknowledge the comments and recommend that Ms. Quitter file a complaint.

Requiring Capnography for Sedation and General Anesthesia. Ms. Reen stated that Dr. Alexander is requesting discussion of amending the current regulations (18VAC60-20-110 and 120) to add capnography to the requirements for administering sedation. She added that the Board's options are to pursue this matter as fast-track, to assign this matter to the Regulatory-Legislative Committee, or to authorize the regulatory process. She then turned the discussion over to Dr. Alexander who stated that it is a patient safety and standard of care issue. He then read the definition of capnography as a method by which the exhaled CO2 can be measured. He added that this method indicates the oxygen level sooner than pulse oximeter. He then moved to amend the regulations to include capnography by fast-track action. The motion was seconded and passed.

Proposed Legislation on Fee Splitting. Ms. Reen stated that Dr. Gaskins is requesting that the fee splitting legislative proposal that

was not approved by the Governor for the 2015 General Assembly be advanced again. Ms. Yeatts noted that when the proposed legislation was last presented, comments received were mixed and it was not widely supported by dentists. She added that legislation must meet the Governor's criteria as being essential for public safety or agency efficiency. Dr. Rizkalla moved to resubmit the proposed legislation. The motion was seconded and passed.

Comments Requested: ADA Sedation and Anesthesia Guidelines. Ms. Reen stated that at its December 2014 meeting, the Board authorized the submission of comments on these guidelines and initial comments were submitted in January 2015. She said the ADA has opened another comment period on the guidelines which closes on June 29, 2015 and added that the drafts circulated for comment include changes in the provisions for children age twelve and under and the requirements for moderate sedation competency courses which the Board had addressed in its comments. She advised that the Board might submit additional comments or take no action. Discussion followed about the meaning of the word "managed" as used in the teaching guidelines for a moderate sedation course and the importance of insuring that the students have direct clinical experience. Ms. Reen indicated that the Board could develop its own education requirements instead of using the ADA's Guidelines or it could issue guidance on its interpretation of the ADA's guidelines. Dr. Alexander suggested that the Board submit comments on the clinical component then, once the final guidelines are in place, the Board can issue its own guidance. By consensus, the Board agreed to submit comments and authorized Ms. Swain to review and approve the comments which will be drafted by Dr. Alexander, Dr. Rizkalla and Board staff.

Policy Strategies to Increase Access to Dental Treatment. Ms. Reen stated that the minutes and transcript of the Open Forum on Policy Strategies to Increase access to Dental Treatment are included in the agenda for discussion of the next steps to be taken. She added that written comments received after the forum and applicable laws and regulations are also included to facilitate the discussion. She said there was considerable support for expanding the options for dental hygienists to practice under remote supervision of dentists and support for adjusting the education and endorsement requirements for DA II registration. Dr. Brown commented that the Open Forum was successful and showed there was a need to address access to dental care. He noted that patient harm was not raised as an issue in expanding the options for dental hygienists to practice under remote supervision. Discussion followed about expanding remote supervision to free clinics and settings serving children and the elderly. The Regulatory-

Legislative Committee was asked to work on a proposal to expand the use of remote supervision for these populations and to review the education requirements for dental assistants II.

Nominating Committee. Ms. Swain reviewed the provisions of the Standard Code of Parliamentary Procedures for nominating committees. She asked anyone interested in serving as an officer to let Ms. Reen know by July 15, 2015. She explained that she will appoint members who are not interested in serving as officers to the nominating committee which will meet prior to the September board meeting.

BOARD COUNSEL REPORT:

Mr. Rutkowski said he recently advised DHP that Board members serving as examiners can be directly reimbursed by SRTA for travel expenses then explained they cannot receive SRTA's per diem/honorarium for serving as an examiner. In addition, he explained that board members should never do research in relation to a disciplinary proceeding and should rely on the information in the case record to make decisions.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported that from January 1, 2015 through June 11, 2015 332 cases were received; 399 cases were closed with no violation; and 61 cases were closed with violations. She noted that 61 patient care cases were received and 64 cases were closed achieving a 105% clearance rate for the third quarter; the pending caseload older that 250 days was 33%; and 75% of cases were closed within 250 days. She added that the license of one dentist and one hygienist had recently been mandatorily suspended. She also reported that 116 sedation permit inspections had been completed since November 2014. Ms. Palmatier said Drug Control Act and recordkeeping violations are recurring findings and that approximately 73% of the case decisions have resulted in advisory letters.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Registration of dentists to dispense drugs. Ms. Reen reported that 4067 of the 6600 dentists with active licenses have completed the waiver form and she is working with PMP staff to advise the remaining dentists that they must submit a waiver or register to report dispensing. Anyone who does not respond will be reported to the Board for consideration of disciplinary action.

Wage position. Ms. Reen reported that a part time position has been approved to hire a dentist to assist in case reviews.

2016 Proposed Calendar. Ms. Reen stated that the 2016 proposed calendar is presented for adoption by the Board. She said the Committee Meeting days are reserved for Regulatory-Legislative or Examination Committee meetings. The Board agreed by consensus to change a committee meeting date from August 5, 2016 to August 12, 2016. Dr. Watkins moved to adopt the 2016 calendar as amended. The motion was seconded and passed.

Revenues, Expenditures & Cash Balance Analysis. Ms. Reen said as a result of the analysis the Board, at its September meeting, will need to act on a one-time renewal fee decrease, stating that DHP's budget manager will present his recommendations for the decrease in September. Ms. Yeatts added that the one-time reduction will be done as an exempt action and will be published for 30 days and be in effect for the 2016 renewal notices.

Auditing Continuing Education (CE). Ms. Reen asked the Board to consider if and how it would like to address licensees' compliance with the CE requirements. She explained the Board's practice has been to have respondents appearing for an informal conference bring their CE documentation for the previous three renewal years for review by the Board. She added that the Board is now piloting standardized forms for the letters, notices, and orders that are prepared by the Administrative Proceeding Division of DHP and she has been notified that the request for CE documents could no longer be addressed in its notices for informal conferences because the request is not germane to the subject complaint or proceeding and could be addressed in another manner. Ms. Reen suggested that the Board suspend auditing until Board staff can research how other boards within DHP and other boards of dentistry are conducting audits. Ms. Reen agreed to provide information at the December 2015 meeting.

Open Forum on Policy Strategies to Address Teledentistry. Ms. Reen stated that the draft announcement and attachments are presented for consideration. She noted that currently there are no strategies listed in this draft such as were included in the access forum announcement. She asked the Board if it wishes to proceed with the forum. Dr. Watkins moved to accept the draft as presented and to proceed with the forum. The motion was seconded passed.

SPECIAL SESSION:

PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	John M. Alexander, D.D.S. Sharon W. Barnes Surya P. Dhakar, D.D.S. Al Rizkalla, D.D.S. Evelyn M. Rolon, D.M.D. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S.
MEMBERS ABSENT:	Charles E. Gaskins, III, D.D.S. Bruce S. Wyman, D.M.D.
QUORUM:	With eight members present, a quorum was established.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley Palmatier, Deputy Executive Director Huong Vu, Operations Manager Emily Tatum, Adjudication Specialist
OTHERS PRESENT:	James E. Rutkowski, Assistant Attorney General, Board Counsel Corie E. Tillman Wolf, Assistant Attorney General
Len Futerman, DDS Case No.: 162249	The Board received information from Ms. Wolf in order to determine if Dr. Futerman's impairment from substance abuse constitutes a substantial danger to public health and safety. Ms. Wolf reviewed the case and responded to questions.
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 Len Futerman, DDS. Additionally, Dr. Watkins moved that Ms. Reen, Ms. Palmatier, Ms. Vu and Board counsel, 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: Dr. Watkins moved that the Board summarily suspend Dr. Futerman's license; schedule him for a formal hearing; and also offer a consent order for indefinite suspension of his license to practice dentistry in the Commonwealth of Virginia, stayed upon Dr. Futerman's compliance with all terms and conditions of his Recovery Monitoring Contract with the Health Practitioners' Monitoring Program. Following a second, a roll call vote was taken. The motion passed unanimously.

CLOSED SESSION:

Case # 152378: 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 consider a Consent Order for the resolution of a disciplinary matter. Additionally, Dr. Watkins moved that Ms. Reen, Ms. Palmatier, Ms. Vu and Board counsel, 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: Dr. Watkins moved that the Board accepts the Consent Order as presented. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 1:16 p.m.

Melanie C. Swain, R.D.H., President	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 5:20 p.m., on July 20, 2015, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Melanie C. Swain, R.D.H., President

MEMBERS PRESENT:
Sharon W. Barnes
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
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.
Evelyn M. Rolon, D.M.D.
Tammy K. Swecker, R.D.H.

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

STAFF PRESENT:
Sandra K. Reen, Executive Director
Lorraine McGehee, Deputy Director, Administrative Proceedings Division
Donna Lee, Discipline Case Manager

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General, Board Counsel
Corie Tillman Wolf, Assistant Attorney General
James E. Schliessmann, Senior Assistant Attorney General

Michael Whyte, D.D.S., Applicant Case No.: 158117;

Alan Bream, D.D.S., Applicant Case No.: 158118;

and

Reza Hangval, D.D.S., Applicant Case No.: 158655

The Board received information from Ms. Wolf regarding settlement of the pending enteral conscious/moderate sedation permit applications submitted by Dr. Whyte, Dr. Bream, and Dr. Hanvgal that were referred to the Board for formal hearings.

Closed Meeting: Dr. Gaskins 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 matters of Dr. Whyte, Dr. Bream, and Dr. Hangval. Additionally, Dr. Gaskins 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.

deliberations. The motion was seconded and passed.

Reconvene: Dr. Gaskins 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: Dr. Gaskins moved that the Board grant an enteral conscious/moderate sedation permit to Dr. Whyte, Dr. Bream, and Dr. Hangval after verifying all the requirements for a permit have been met, and that the applicants be notified by letter of the Board's decision. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:38 p.m.

Melanie C. Swain, R.D.H., Chair	Sandra K. Reen, Executive Director
Date	Date

UNAPPROVED MINUTES

VIRGINIA BOARD OF DENTISTRY
OPEN FORUM ON
POLICY STRATEGIES TO ADDRESS
TELEDENTISTRY

Friday, August 14, 2015

Perimeter Center
9960 Mayland Drive, Suite 201
Richmond, Virginia 23233-1463
Board Room 4

CALL TO ORDER:	The Virginia Board of Dentistry convened an Open Forum at 9:00 a.m. to receive views on the need for policies on the use of teledentistry in Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	John M. Alexander, D.D.S. Charles E. Gaskins, III., D.D.S. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Director Huong Vu, Operations Manager
OTHERS PRESENT:	David E. Brown, D.C., DHP Director
COURT REPORTER:	Earlina King, Court Reporter, Crane-Snead & Associates, Inc.
QUORUM:	Not required.
FORUM COMMENTS:	**Antoinett Kahan, RDH**, Dental Assisting Program Director at Virginia Beach Technical & Career Education Center and President of the Oral Health Improvement Coalition of South Hampton Roads, stated that teledentistry is used on dental access days to give patients their x-rays. She said Emergency Departments (ED) should do this to reduce the number of subsequent ED visits and added that the equipment needed to do this is a NOMAD handheld x-ray unit, digital sensors, laptop, and intraoral camera. She suggested that x-ray technicians should be certified to take dental x-rays, ED physicians should be allowed to approve dental x-rays, and that the telemedicine protocol for the Health Insurance Portability and Accountability Act (HIPAA) should be followed. She asked the Board to amend regulation 18 VAC 60-20-195 to address her recommendations.

Susan Reid Carr, RDH, Virginia Dental Hygienists' Association (VDHA), said that VDHA supports all delivery models of oral health care services which are safe and cost-effective. She said the concepts for teledentistry which VDHA supports are:

- A dentist-patient relationship should be established through an in-person visit to a dentist to establish a dental home, and
- Use of the HIPPA approved communications equipment.

She noted that the initial investment in equipment would improve access and reduce travel costs for patients.

Linda Wilkinson, CEO of Virginia Association of Free and Charitable Clinics, Inc., stated that the clinics serve over 70 thousand people and only 15 thousand receive dental care. She said that teledentistry would allow greater flexibility in expanding access to dental care to all parts of Virginia.

David Sarrett, DDS, Dean of VCU School of Dentistry, said the School uses teledentistry for education and research purposes as well as patient treatment. He asked the Board to allow for these uses in any policy action.

Benita Miller, DDS, Virginia Dental Association (VDA), said that the VDA supports a collaborative pilot project for teledentistry with a Community Dental Health Coordinator (CDHC) as a vital part.

Nicole Pugar read written comment from Sarah Bedard Holland, Executive Director of Virginia Oral Health Coalition (VaOHC). Ms. Holland reported that VaOHC is in support of teledentistry and has convened a teledentistry workgroup which determined that "Store and Forward" teledentistry might be an effective way to increase access. She explained that "Store and Forward" may:

- Create more efficiency in the delivery of health care;
- Reduce transportation burden for families; and
- Result in cost savings to the state for Medicaid patients.

She stated that VaOHC recommends that the Board's policies mirror existing telemedicine protocols on a dentist-patient relationship, communications and equipment requirements.

Ms. Swain opened the floor for questions and discussion.

Dr. Adam Wyatt, DDS, Health Services for the Virginia Department of

Corrections (VADOC), explained that VADOC uses telemedicine for inmates. Based on his experience, he recommends policies for:

- A point of accountability in organizations using teledentistry;
- Camera and Monitor Resolution requirements to prevent misdiagnosis;
- acceptable networks for secure transmission of records;
- completing a comprehensive examination with an Intra-Oral camera;
- time-frames for physical exams and oral cancer screenings;
- procedures permitted using teledentistry guidance; and
- teledentistry guidelines for dental education programs.

Discussion followed about billing codes for teledentistry, the need to train ED doctors and nurses to evaluate dental conditions, the work of national organizations, the availability of dental hygienists and using the Board of Medicine's policies as the model for teledentistry in Virginia.

The proceedings of the open forum were recorded by a certified court reporter. The transcript is attached as part of these minutes.

Ms. Swain reminded everyone that any policy action the Board decides to take will include the standard comment opportunities required for regulatory action and for advancing a legislative proposal.

She thanked everyone for the wealth of information provided and concluded the forum at 10:21 a.m.

Melanie C. Swain, President	Sandra K. Reen, Executive Director
Date	Date

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH PROFESSIONS

FORUM FOR THE BOARD OF DENTISTRY

Complete transcript of the Forum in the above-styled matter, when heard on the 14th day of August, 2015.

CRANE-SNEAD & ASSOCIATES, INC.
4914 Fitzhugh Ave, Suite 203
Henrico, Virginia 23230
Tel. No. (804) 355-4335

PROCEEDING

MS. SWAIN: This is a opem forum to receive your views on policy strategies to address the use of the College of Dentistry of Virginia. Thank you for your participation. If you wish to speak, please sign up on the sheets available outside the open door to this room. Speakers will be called in the order as they appear on the sign-up sheet. Each presentation will be timed and will be limited to ten minutes. Speakers will be notified when they have reached the nine minutes so that they may conclude in the allotted time. The forum will close at noon. If time permits, following the presentation attendees will be asked to participate in a question and answer session to allow for explanation and discussion of the recommendations.

At this time, I will call on persons who have signed up to present. As I call your name, please come forward and speak into the microphone. Start by telling us your name and where you're from and if you're presenting an institutional organization.

Let's start with, it looks like Antwanette Kahan.

MS. KAHAN: Good morning, ladies and gentlemen, colleagues, distinguished members of the board. My name is Antwanette Kahan. I've been a Registered Dental

Hygienist in the great Commonwealth of Virginia for over 30 years. I am the Dental Assisting Program Director for the Virginia Beach Technical Career Education Center and the Standing President of the Oral Health Improvement Coalition of South Hampton Roads. As Program Director, I'm in an extremely fortunate position. The Virginia Beach Public City Schools is more than generous when it comes to providing me with state of the art technology to insure my students leave my two-year, 180 hour curriculum with knowledge and skills required to ensure success in subsequent dental employment or continuing with their education at the community college or university level.

While working the coalition to provide access to the area's steadily underserved, we often use tele-dentistry as a tool to link patient with provider. Our dental access days that we do two times a year had filled a peri preprocessor and that took forever. The City of Virginia Beach gave me a nomad to show my students how to use a wireless x-ray unit. We took that instead, and the taking of the x-rays went faster, but once I got sensors and a dedicated laptop, it went even faster. Taking the digital x-rays and emailing them to the patient, the patient was able to keep the image on their personal device for future use at any dental health facility or another outreach. This capability lit up a spark.

How can we use this technology to serve the public at large? I'm sure you all read the cover story in the Journal of the American Dental Association regarding the Trends in Emergency Department to Fake Visits. The research is overwhelming that something must be done to curtail the costly exsurgents that jam up the emergency departments and confound the medical staff. I think down here it says it's doubled from 2014 the number of people that have gone to the emergency room have doubled in that time. A lot of our patients that we see at our dental access days -- we did a survey, and those students did a survey there; and over half of them said that they have used the emergency room as their dental care provider.

I won't use up most of the time here with redundancy so I'll get right to the point of how Tele-Dentistry can reduce the economic imperative facing emergency room departments with a positive inadvertent component. The equipment required and how it works: You'll need a nomad hand-held unit which is quite expensive but if my public education class can have one, then I can send -- for them. The digital sensors, size one and two, were recommended -- the -- sleeves, a dedicated laptop, an inter-oral camera and then a dental emergency referral service.

So here's your scenario: Dental patients'

1 usually after hours enter the emergency department with oral
2 pain. Interviewer reveals that the patient has been okay
3 for sometime and lacks access to dental care. Perhaps
4 they've tried, unsuccessfully, home remedies. A cursory
5 exam reveals a swollen gum rapid --. The x-ray technician
6 takes a picture of the affected area and emails it to the
7 dentist on call. The doctor, via cell phone, Face Time,
8 Skype, discusses options or referrals with the patient and
9 the emergency room doctor. By the way, should the on-call
10 dentist's finding indicate the need for a medical evaluation
11 due to the oral manifestation that are systemic in nature,
12 not dental, early intervention may save someone's life in
13 the case of leukemia, throat cancer, or osteonecrosis.
14 So the initial obstacles that we can foresee
15 are three: Compliance with 18 VAC 60-20-195 Radiation
16 Certification, the x-ray tech process certification as
17 described in the mentioned regulations right now. There are
18 three ways in which they can do them. They can take the
19 Danby Course. They can take Early View, -- View, at one of
20 the community colleges that offer these courses, or in --
21 radiation, health and safety is built into the X-Ray Tech
22 curriculum as it was with anesthesia dental hygiene.
23 Number two, Compliance with 18 AC 60-20-210
24 Requirements for Directive General Supervision. The
25 emergency room, as it stands, cannot give the okay to take a

1 dental x-ray, so the emergency room doctor calls a dental on
2 call and the doctor can okay it remotely to send an
3 inter-oral picture of the offending tooth, then receives
4 directive for x-ray for the certified x-ray tech to take the
5 x-ray. The second part is the dental board can amend the
6 current regulations to allow, in limited settings such as
7 emergency departments, that emergency room physicians can
8 approve the dental x-ray.
9 Number three is the HIPPA confidentiality.
10 That I minimized to just say see the medical ethics
11 regarding telemedicine because that's what they're already
12 doing.
13 In April, 2015, -- dentistry, Dr. Bruce
14 Donoff, DDS MD, Dean of the Public of School of Dental
15 Medicine writes of his vision to transform dentistry by
16 removing the distinction between oral and systemic health.
17 His persuasive article, The Economic Reform of Poor Health,
18 identifies care as a goal, and states achieving that goal
19 requires a cultural change. The caring medical personnel in
20 the emergency departments would like to be able to offer
21 better treatment to those who seek them out to rid them of
22 their pain and suffering. Yet, they cannot help because so
23 many feel that they are at sea regarding dental treatment.
24 A recent survey found 90 percent of medical doctors think
25 oral health should be addressed, but half of them said that

1 they have little or no training receiving less than two
2 hours of oral health training. Only nine percent of them
3 could answer oral health questions correctly.
4 After collaborating with a radiologist and an
5 emergency room doctor, they both agreed that Tele-Dentistry
6 would not keep patients from using the emergency department
7 as their first stop in their quest for emergency dental
8 care. However, with a proper referral system and follow-up
9 provision in place, it would substantially decrease the
10 number of subsequent visits to the emergency department,
11 providing significant cost-savings to an already
12 heavily-burdened healthcare system.
13 Also the consequence of the medical dental
14 collaboration will eventually improve human health through a
15 more patient-centered model of care. Thank you.
16 MS. SWAIN: Thank you. Sara Holland?
17 MS. DUGAR: She's not here yet. You may want
18 to skip over her?
19 MS. SWAIN: Sure. We can skip over her.
20 MS. DUGAR: That would be great. Thank you.
21 MS. SWAIN: Susan B. Reid.
22 MS. DUGAR: Thanks.
23 MS. REID-CARR: Good morning, ladies and
24 gentlemen. I'm Susan Reid-Carr. I'm the President of --
25 Dental Virginia Hygienist Association, and on behalf of the

1 Virginia Dental Hygienist Association that represents the
2 5,563 licensed dental hygienists in the Commonwealth, we
3 appreciate the opportunity --
4 MS. SWAIN: I'm sorry. Ms. Reid, can you
5 speak up? She can't --
6 MS. REID-CARR: Okay. I'm going to start
7 over.
8 MS. SWAIN: You can pull the mike over.
9 MS. REID-CARR: Okay.
10 MS. SWAIN: Thank you.
11 MS. REID-CARR: You ready?
12 COURT REPORTER: Yes.
13 MS. REID-CARR: On behalf of the Virginia
14 Dental Hygienist Association, that represents the 5,563
15 licensed dental hygienists in the Commonwealth, we
16 appreciate the opportunity to provide comments on
17 Tele-Dentistry in Virginia. The VDHA supports all the
18 delivery modules of oral healthcare services that maintain a
19 safe, cost-effective and high standard of oral healthcare.
20 The discussion that brings us to developing concepts on
21 tele-dentistry is the consistent proven fact that there is
22 an access to oral healthcare issue in the Commonwealth of
23 Virginia.
24 The VDHA believes that tele-dentistry is a
25 critical component in assisting to fulfill that deficit.

1 Using technological methods such as tele-dentistry to
2 provide education, treatment, consultation and necessary
3 referrals can be a vital tool to help solve this problem.
4 In delivering care through tele-dentistry, the VDHA promotes
5 the following concepts that we believe can enhance the safe
6 and effective utilization of dentistry. VDHA supports
7 establishing a dentist-patient relationship through an
8 in-person licensed dental hygienist. To create these
9 opportunities, VDHA supports a collaborative agreement for
10 licensed dental hygienists and dentists. This can create
11 additional opportunities for access to patients and
12 establish a dental home for these patients. HIPAA approved
13 communications equipment seems appropriate as this can
14 maintain the current standard of protective care for
15 patients and providers. VDHA believes that cost may be
16 incurred for equipment, however, the overall investment can
17 provide for far-reaching access to more patients, establish
18 dental homes for more populations, reduce travel cost for
19 patients and potentially reduce costs for payers.
20 As new technology develop, the VDHA
21 encourages the Commonwealth to keep an open mind on ways to
22 adapt safe, cost-effective and quality care. The VDHA is
23 mindful of the fact that while tele-dentistry can benefit
24 various areas of delivery of oral health care, this is a
25 tool that is not the comprehensive solution to the access

1 problem.
2 Thank you.
3 MS. SWAIN: Linda Wilkinson.
4 MS. WILKINSON: Good morning. My name is
5 Linda Wilkinson and I am the CEO of the Virginia Association
6 of Free and Charitable Clinics, and I'm here to remind the
7 Board about the patients that could particularly benefit
8 from these regulations.
9 Our 60-member clinics served 72,000
10 low-income, uninsured adult patients last year. Our clinics
11 are providing medical, behavioral, health, pharmaceutical
12 and/or oral health services. Despite the generosity of time
13 and talent of over 700 volunteer dentists and hygienists,
14 our clinics were only able to serve approximately 15,000 of
15 the 72,000 patient population purely based on the
16 availability of the providers. We're here to support any
17 and all regulations that will expand access to all health
18 services to our patients who are suffering from multiple --
19 exacerbated by their oral health conditions and vice versa.
20 So we ask the Board to please consider again any and all
21 regulations, including and not limited to tele-dentistry
22 regulations that again, will enable our providers to have
23 greater flexibility to provide much needed oral health
24 services to all parts of the Commonwealth and to more than
25 72,000 uninsured low-income patients within the free health

1 system.
2 I thank you for this time, and I thank you
3 for what you do for the Commonwealth.
4 MS. SWAIN: Thank you. David Sarrett.
5 MR. SARRETT: Good morning. Actually, I
6 signed the list. I thought it was attendance but I --
7 I'm the Dean of the School -- certainly we support the
8 use of technology and all forms of the system, patient
9 care, as well as teaching and education and -- I think
10 most people here are addressing, as well as the patient
11 care. I ask that you keep in mind there are
12 educational functions of the search functions --
13 clinical evaluations.
14 They should not fall prey to some - - --
15 consequences of the regulation of the law. I didn't
16 review the document that the Board of Medicine -- I
17 guess it's a guiding document, read carefully, which I
18 thought covered many of the issues that came to my mind
19 quite well. I suggest that's a good starting point so
20 just keep in mind that -- particularly the thorny
21 issues of doctor/patient relationship, establishing the
22 fact that the patient needs to know who the consultant
23 dentist or physician would be in that case, so I found.
24 Thank you.
25 MS. SWAIN: Thank you, Mr. Sarrett. Dr.

1 Bonita Miller.
2 DR. MILLER: I just want to thank the Board
3 as well for considering this concept because there is
4 certainly a great potential use for tele-dentistry and
5 addressing access to care issues. As you know, the
6 Virginia Dental Association has long been interested
7 and active in programs and initiatives and projects,
8 services and other things to try to address the issue.
9 The Virginia Dental Association is very interested in
10 tele-dentistry. It would be great to have ongoing
11 conversations like this to gather the interested
12 stakeholders. It could certainly be a wonderful
13 collaborative effort among our dental oral stakeholders
14 to develop a pilot project.
15 It is certainly something to consider within
16 the Department of Health maybe as a pilot project, and
17 also the Community Dental Health Coordinator could also
18 be an entity that could be a very vital part of the
19 success of the tele-dentistry program. So I thank you
20 for opening the conversation and hopefully gathering an
21 interested group of stakeholders, developing something
22 that would really have a meaningful long-term aspect of
23 addressing access to care. Thank you.
24 MS. SWAIN: Thank you. I hope I don't mess
25 this up, Tonya Adesh.

1 MS. ADESHA: -- sorry.
2 MS. SWAIN: Oh, that's fine, and referring
3 back to Sara Holland, I'm not sure she's here.
4 MS. DUGAR: She's not here. I can read her
5 comments if you'd like?
6 MS. SWAIN: That would be great. Thank you.
7 MS. DUGAR: I'm not Sara Holland. I'm Nicole
8 Dugar, a little obvious, for the Oral Healthcare.
9 COURT REPORTER: I'm sorry, repeat your name?
10 MS. DUGAR: Nicole Dugar, D-U-G-A-R. Let me
11 just touch briefly on what we had submitted oral -- I'm
12 sorry, we had commented. I can just read through some
13 of the highlights here. First of all, thank you for
14 the opportunity to comment on the use of
15 tele-dentistry. The Virginia -- Hospital Coalition is
16 the highest of several hundred organizational and
17 individual partners trying to integrate World
18 Healthcare and all the aspects of health and wellness.
19 One side of this mission is to improve the process to
20 oral health services.
21 Tele-medicine has proven to be an effective
22 mechanism for improving access and to manage.
23 Tele-dentistry appears to have similar promise in
24 improving access to oral healthcare services. The
25 Virginia Oral Health Plan, a state plan offered by over

1 200 state voters from across the Commonwealth, in 2010
2 recommends the goal of prevalence of dental disease as
3 reviewed in Virginia through prevention and early
4 diagnosis and treatment and that stakeholders explore
5 the use of tele-dentistry and server areas of the
6 Commonwealth analyzing -- its appropriate use,
7 reimbursement models and reimbursement models used by
8 other states for tele-dentistry.
9 To support this objective, the Oral Health
10 Coalition needs a support group, and they included a
11 number of different stakeholders including The
12 Department of Health, The Department of Medical
13 Assistance, Private Practice Dentists, Community
14 Healthcare Center Dentists, The Mid Atlantic --
15 Resource Center for the DCS School of Dentistry of
16 Virginia Dental Health, The Dental Association of
17 Headstart and the Coalition. Sara had provided, I
18 think, an attachment of some of the work that the work
19 group had done.
20 Our group members were particularly
21 interested in how well the tele-dentistry could
22 increase access and decrease the transportation burden
23 of families and -- children's program. We particularly
24 would love to have a store-in-forward -- to
25 tele-dentistry as an effective way to address the

1 access issue, a store-in-forward approach because, as
2 you all know, by -- data, says the state of -- x-rays
3 are captured via secured connection and reviewed by a
4 provider at a later time.
5 The working members felt that this was a
6 favorable way to explore the use of this technology as
7 a first step. We thought that it would create more
8 efficiency in the delivery of healthcare. It would
9 produce transportation burden for families, and it
10 would reduce a cost savings to the state for Medicaid
11 patients. It would decrease reliance on the Medicaid
12 transportation benefit.
13 Additionally we thought that a
14 store-in-forward would not be a change in people's
15 practice as it was already occurring in Virginia
16 Medicaid and Dermatology and Radiology and other areas.
17 We had some questions and concerns from the workgroup
18 about duplicative services and this could drive up
19 costs. Examples in California and other common
20 programs demonstrate reduced costs and no duplication.
21 If a consulting provider using tele-dentistry is also
22 the dentist performing the procedure, regulations
23 created by the Board can address and prevent
24 duplicative consults. Given that tele-medicine is
25 already established in Virginia, we recommend as the

1 Coalition that the issues related to the
2 dentist/patient relationship and communication
3 equipment requirements mirror existing tele-medicine
4 protocol.
5 MS. DUGAR: I just also want to make a comment
6 from the Dental -- Foundation and -- you all should
7 have received this as well. Thank you.
8 MS. SWAIN: Thank you. We have time for
9 discussion and a few recommendations of questions. I
10 want to remind everyone that our policy -- I'm sorry.
11 I'm just reading this dialogue here, but I just want to
12 make sure that since we do have time for discussion,
13 I'd like to open the floor for anybody who'd like to
14 speak in regards to -- and any board members who might
15 have questions regarding to -- Mr. Alexander?
16 QUESTIONS BY THE BOARD
17
18 MR. ALEXANDER: The first speaker, I
19 appreciate that. I understand what's going on. Have you
20 discussed this with any of the ER physicians? What is their
21 take on it?
22 MS. KAHAN: Their take, again, was we started
23 thinking about doing this. A friend of mine, her husband is
24 an emergency room dentist, and my other friend's married to
25 a radiologist. They both agreed that it won't stop the

first one. People that don't have insurance or for whatever reason, they don't go to the emergency room that first time, it won't stop the first time, but it would probably cut down on subsequent visits so if there's somewhere in there right now, there isn't a way to get the patient from the emergency room. They leave with pain medicine and antibiotics and that we all know will just be a very short-term fix for them. But if we can provide for them through donated dental care, whatever type of referral service that we have, yes that, but then the dentists can take a look at it, the inter oral picture or the x-ray and they could call the referral, whether it's to an endodontist, and sometimes it might be that the patient just needs a cleaning. The patient needs a filling. It could be a very simple fix. It doesn't necessarily need to be a very big thing so they can make the appropriate referral.

They can refer them to their own office. They can refer to any of the clinics that we have, and they would be provided with that information and given an appointment to go to that particular place. The Oral Health Improvement Coalition -- also has dental vouchers that can be given to the patient to go to any of the clinics to receive the care that they need so that, that way will keep them from returning to the emergency room. So it won't reduce the first one, but hopefully it will reduce subsequent visits.

MR. ALEXANDER: Well I think it's a great idea.

MS. KAHAN: We're trying that as a pilot by the way. One of my students is working on her Masters.

MR. ALEXANDER: You're trying it in the emergency room?

MS. KAHAN: Yeah. That's where she's working on her Masters at Fulton A&M for Community Health. When we started talking about this, she wasn't really quite sure what she was going to do for her project, and this is her project.

MR. ALEXANDER: She's gonna have fun, I'll bet.

MS. KAHAN: We're going to have fun.

MR. ALEXANDER: Have you talked to the emergency room, the people that run it, are they willing to buy this equipment?

MS. KAHAN: That is our next step.

MR. ALEXANDER: The other thing is, you're going to have to have dentists on call that are willing to, having worked in the emergency room for years, a lot of these patients come in after hours in the middle of the night, so you know, having the dental people available is another thing that you're really going to have to work through.

MS: KAHAN: Well, I think what they're hoping to do is get -- with larger practices where they might just have some of the doctors -- some of the doctors might take a week so it won't fall on one particular -- they'll be a bunch of doctors that they could call.

I don't think that it is all that much. It's not like there's ten or 15 a night. It isn't that much, but the few people that do go there really do pose a significant cost increase to emergency rooms, and then, of course, the human cost. While they're in there and they're taking care of somebody who is non-life threatening dental, it's taking the emergency room doctors time away from something that --

MR. ALEXANDER: Thank you.

MS. SWAIN: Are you okay over there?

COURT REPORTER: Just have to speak up?

MR. SARRETT: I think it's great that you're working on this. I will refer ┬ there is a publication. I have a doctor and one of his residents, Adam -- the name will come to me. About two years ago, we had a conversion program for dental issues to the -- Health System. -- to the ER for them being registered in the ER and come to dental to help solve these issues.

That was fairly successful, very successful. As a hospital, they're worse -- of probably undiagnosed is other things like cardiac events so they decided they really

needed a triage so now it's kind of snarled up in the back where you walk in the door.

Even if they say, "I think I've got a toothache," they've got to be somewhat triaged so that kind of complicates things. If I recall their publication, actually they indicated most of the visits were Monday through Thursday during the daytime. I guess, to the nature of that, -- the weekend.

MR. ALEXANDER: Which means there will be more dentists in their office during the daytime that might take a tele-medicine call and not have to be woke up in the middle of the night so that might help out too?

MS. KAHAN: One of the things that they Talked about at Harvard was doing that and to disciplinary because we do know the connection now between dental issues -- now, we need to get those physicians --

MS. SWAIN: Ms. Kahan, I think, Ms. Rucker has a question.

MS. RUCKER: What type of students do you have?

MS. KAHAN: I have juniors and seniors in high school.

MS. RUCKER: Your dental assistant program that they use -- are you going to have one here in Chesterfield?

1 MS. ALEXANDER: Like a technical program.
2 MS. RUCKER: Like a technical program, and so
3 they use it as a stepping stone for hygiene schools?
4 MS. KAHAN: So they're really -- because
5 again, I'm very fortunate that the Virginia schools,
6 whenever something comes up, the head of technical career
7 education, his wife happens to be a dentist, and the person
8 who funds me, her brother, is a dentist up in Boston and so
9 whenever I say to them, I need a plug.
10 As a matter of fact, I have a first-edition nomad,
11 which now, with their lypo hand gliders, this is like the
12 big one, but it's whenever I ask them for anything, they're
13 behind anything I want to do with the students. When I say
14 hey, let's think about this, I make them read these journal
15 articles which is laid out carefully, a lot of them. They
16 do understand. They do empathize with people, some of their
17 families.
18 Twenty-five percent of my school is on free lunch and
19 Medicaid so we do see students in my clinic. Our public
20 health dentist comes one day a week, and my assistants help
21 her help the kids in my school so it's worked out really
22 well so I'm really very, very fortunate.
23 MS. RUCKER: A number of you spoke to the --
24 you made a comment about physicians having more -- and
25 supervising maybe assistants or possibly hygienists. I just

1 know we speak with remote supervision because they are in
2 these settings. They're in nursing homes or free clinics.
3 They're already there and having a broader supervision
4 of a hygienist, possibly instead of just being under direct
5 supervision of a dentist or an assistant. Maybe you could
6 speak to that because you're seeing that in an ER setting,
7 if you'd like to speak on that?
8 MS. KAHAN: Well, I brought that up because a
9 couple of years ago, it's probably Hampton Roads now, but it
10 was the Chesapeake Care Clinic. They only had a dentist
11 there, I think Tuesday and Thursday nights, but during the
12 day, it was mainly a medical facility. Someone had called
13 me and said I have a patient here and there's a dental
14 assistant here, but the physician wants her to take an
15 x-ray. Can they do it? I said I don't know, and I called
16 Sandra Reen, and she was like absolutely, if you can
17 remember. I called and they were like, no. I was sort of
18 -- 18 VAC 60. I mean she knew it like that. It has to come
19 from a dentist.
20 So I already knew that, that would be one of the
21 obstacles that you would suggest to me. An x-ray tech in a
22 hospital -- when we were first initially thinking about
23 this, we were thinking a nurse could do it, and then my
24 friend who is an RN, she was like, no, we're too heavily
25 burdened.

1 So we were going through the people, and we were like
2 they already have x-ray techs, but there is no dental
3 component to x-ray technology, that particular profession.
4 So we either have to add it to their curriculum or they
5 would have to become dental x-ray certified --. There was
6 no other way to do it, and so that was how I knew about it.
7 MS. RUCKER: Then you would have to --
8 MS. KAHAN: They would have to either call
9 the attending dentist, then he could give the remote thing
10 to that person acting as a dental assistant or to x-ray; or
11 you're going to have to change it, at least in the emergency
12 room. In free clinics or whatever, allow the physician to
13 say, okay, go take my x-rays.
14 MS. RUCKER: And that's why I wanted to say
15 that as we have these discussions as board members, that we
16 may need to look at in these settings to have a physician to
17 say all right, we have a hygienist. He could clean this
18 person's teeth or an assistant, he could take this
19 radiograph so that we could have tele-medicine work.
20 MS. KAHAN: Like I said, sometimes it works
21 the other way, sometimes you'll find out that it isn't a
22 dental thing, that it's more of a medical thing and you
23 write down to see a physician. You're having a heart
24 attack.
25 MS: RUCKER: I work in a hospital setting,

1 too.
2 MS. SWAIN: Dr. Wyatt?
3 MR. WYATT: I was just interested in having a
4 conversation. We always used to have a conversation about
5 what are the regulatory barriers providing access to dental
6 care? What I'm hearing is that it's only just another
7 supervision conversation or at least in part, it's
8 supervision.
9 Can a dental hygienist be in an emergency room and be
10 performing any services without a dentist being present? I
11 think that, to some degree, is some of the conversation.
12 You know, I loved hearing the model of just another way of
13 allowing access to care.
14 People currently -- I know it's appalling when you hear
15 the wait list that the free clinics have simply because of
16 manpower, a lack of workforce to be able to --. I think the
17 more specific we can look at this and identify barriers,
18 regulatory barriers, is what I think the point is here and
19 what are potential solutions? What have other states done
20 to allow -- the reality is that when people with oral pain
21 seek help in emergency rooms on a regular basis, how do we
22 make sure they have the most effective care possible when
23 they go there? That's a great task for this board to see if
24 there are any models, things we can do regulatory-wise to
25 pass such regulation that addresses that without

1 compromising the patient's safety.
2 I think we should encourage more discussion on this so
3 we can leave this with some clarity. What are the problems?
4 How are we not able to use tele-dentistry currently in an
5 effective way, and what are the potential solutions to those
6 problems? I'd like to have that as part of a discussions
7 about that or any comments about that, that would be great.
8 MS. SWAIN: Yes, sir.
9 DR. WYATT: Excuse me for being late. I've
10 been traveling around in circles. I'm Dr. Wyatt. I'm
11 representing the doctor and what we do currently for
12 tele-medicine.
13 MS. SWAIN: Yeah. We need for you to speak
14 into the mic.
15 DR. WYATT: In here, okay. What we do
16 currently with tele-medicine and also the county shed
17 some light.
18 MR. ALEXANDER: Just to be clear to my
19 knowledge, you're a dentist or an assistant?
20 DR. WYATT: Yes, I'm a dentist. I've
21 actually been practicing with the department for about
22 eight years. I practiced clinically in various
23 different situations -- I have a Masters in Health
24 Informatics and I've been using tele-dentistry and
25 things of that nature on and off for the past 20 years,

1 either to ripen myself or try to incorporate the
2 methods into wherever I've practiced.
3 What I was wanting to do was give some
4 recommendations based on that experience. I did review
5 the materials that you all gave me. Most of the things
6 that I saw that had been said, I guess that's going to
7 be precedent that you all are going to be looking; I
8 just wanted to add a few things that might be
9 considered that I did not find in that material.
10 Some of those things may have been addressed.
11 I'm not sure, in the board and in different areas, but
12 based on what you all have provided, I just wanted to
13 bring certain things to your attention so that you
14 might want to debate whether they would be an issue or
15 whether they wouldn't be. Did I have enough copies?
16 Did everybody get one of these?
17 MS. SWAIN: Yes, we did.
18 MR. WYATT: Well, currently the Virginia
19 Department of Corrections, if you look on the first
20 page. I've given an example of what we're doing, and
21 we usually communicate with VCU. This is how we get
22 all of our referrals.
23 The materials that you see here on the front
24 of the pictures, these are video conferencing devices
25 that are used. The problem I foresee is that they have

1 taken administrative type of areas in offices, and they
2 have incorporated this pretty well but they're for
3 screening of the papers or the documentation that you
4 provided me. You were interested in seeing how far we
5 could go with tele-dentistry, whether we could do
6 comprehensive examinations and things of that nature.
7 Currently, most of their consultations are
8 for external general review. That's fine for
9 screenings. That's fine for writing prescriptions,
10 things of that nature, but for comprehensive
11 examinations, I think that there are some parameters
12 that should be set through the technology, the use of
13 interval cameras.
14 I didn't see any of that documented as a
15 requirement, specified requirements in the amendments
16 that allow for the tele-dentistry in the other states.
17 I think it's important that Virginia start out that
18 way. The reason I'm saying this is I can see a problem
19 with accountability and whether it's fraud, whether
20 it's misdiagnosis based on the fact that no specifics
21 were set with respect to resolution. Of course, high
22 definition is pretty common, but it's not actually
23 specified in the documentation. You don't want someone
24 snapping a picture and then end up in a case or I end
25 up in a case trying to defend something and the

1 resolution be an issue because it hasn't been -- things
2 like that.
3 We, for instance, the Virginia Department of
4 Corrections, we do everything on a secure network.
5 It's an isolated network. Well, if you allow doctors
6 to pursue this and you haven't defined that that needs
7 to be a parameter, you wouldn't want things being
8 transmitted, not that they would think about that, but
9 being transmitted over unsecured networks because they
10 don't have a list, because they would be doing things
11 like they would normally do, hot-mailing procedures or
12 pictures or images or things like that. So I tried to
13 make a list of certain things that I would think the
14 Board may want to define.
15 It doesn't have to be exhaustive, but at
16 least it gives doctors a framework so everybody's
17 playing on the same rulebook using the same specs, and
18 also you all are provided with the information to where
19 they could resource materials that they need so that
20 everyone is pretty consistent and standardized. Did I
21 make myself clear?
22 MS. SWAIN: Thank you. Does anyone have any
23 questions to Dr. Wyatt's information?
24 MS. REEN: You talked a little bit about what
25 a defined tele-dental liaison would? What is that?

1 DR. WYATT: At the DOC, we actually have a
2 medical tele-medicine liaison. She is the one who is
3 responsible for communicating with the physician and they
4 can either request or fill in the request, communicate with
5 VCU to actually set up the consult. Because we know who
6 that is, if there's any issue with the transmission, if
7 there's any issue with privacy, if there's any issue with
8 whether or not providers were given the health history and
9 that sort of thing, we know who to go to because she set up
10 the appointment.
11 So if the Board ever had to review an issue in
12 tele-dentistry, if you have a liaison and you have one
13 person in the organization responsible for it, you know who
14 to point to, who would have that material, and I just think
15 it would be easier to regulate if you know you have one
16 contact person.
17 MR. ALEXANDER: You said that you are using
18 it? Explain how you document them.
19 DR. WYATT: Right now for us, it's in the
20 dental clinic. We're not using it as far as tele-dentistry
21 with respect to exams and things of that nature. I assume
22 this is what you'd like to expand to. I think it's good,
23 but for instance, if I refer a patient for oral surgery,
24 which I do a lot. I do some surgery, and there are some
25 cases I can't do, I refer to DMVC. Those consultations are

1 set up using the on-site medical liaison who's responsible
2 for that.
3 All the documentation you have here on the first page,
4 she coordinates that document. She sets it up, and then
5 there's a direct coordination with the oral surgery
6 department. Now, I don't have the ability in my clinic to
7 do that, which is what I think would be a good idea, but
8 they're set up like a medical referral. In other words, it
9 just falls in line with the other medical consultations that
10 are in the form at this point.
11 MR. ALEXANDER: So it's not a face-to-face
12 thing?
13 DR. WYATT: Yeah, it's face-to-face, but it's
14 face-to-face with the physician at this point, not with the
15 dentist.
16 I write the consults when I refer to medical and
17 medical sets up the consultation and does the communication,
18 and I assume we want to expand to the point where the
19 dentist can do the same thing, but right now we're set up
20 with tele-medicine, not tele-dental, so I was just trying to
21 see how organizations who are already practicing it, how it
22 could be expanded and regulated?
23 MR. GASKIN: What do you perceive the model
24 MR. WYATT: Well, as with any fields in
25 healthcare, cost is always an issue. So if you want

1 widespread acceptance, I think that there should be some
2 evidence-based practice based on what the resolutions are,
3 what type of networks and what the states are already using.
4 If you have a predominance of equipment that's out there, we
5 should be able to expand with that. The only major
6 barriers, other than what is included in what I've listed
7 here, inter-oral cameras and the areas that the actual
8 examinations are being performed, currently the medical
9 department is able to do there in administrative office
10 settings.
11 It's just an administrative office because they're
12 pretty much teleconferencing and that's because they're not
13 performing exams. What they're doing is consulting and it's
14 fine for screenings or writing prescriptions, but if you
15 want to do actual exams, you would obviously need to either
16 lay a patient back in the clinical chair in the same setting
17 that he or she is comfortable with and be able to do it
18 there. Now, I don't see that as being a huge barrier, but
19 what you don't want is to put the regulations out there and
20 then people reading them the way that they want. If that's
21 not defined, then someone may start doing it in their
22 office. Well, now you see a whole can of worms opening up
23 for things that are not listed, the same thing for the
24 training, the same thing for every aspect of this. I don't
25 think it's complicated. I just think that we --

1 MS. SWAIN: Mr. Gaskin.
2 MR. GASKIN: The liaison that you're speaking
3 of is within your facility or centrally here in Richmond?
4 DR. WYATT: No. It's in my facility, but the
5 way that the correctional facility is, it's similar to a VA.
6 MR. GASKIN: Now, does every correctional
7 facility in the state that has a dental facility have this
8 capability or just you at Suffolk?
9 DR. WYATT: Well, I'm at Deerfield, but I'm
10 not exactly sure. She is a tele-medicine liaison. She is
11 located right there at that facility. Now, I'm not sure if
12 she is a tele-medicine liaison for different facilities
13 because it's common practice with the "now" culture. If a
14 patient needs something and we can't provide it at the
15 facility, we have direct communication with another facility
16 that will. Dental is pretty much in-house. I'm not very
17 familiar with how they're handling their patients. I just
18 know what they're capable of doing. They could very well be
19 shipping in medical patients that either tele-medicine comes
20 from another facility that's close and having that
21 consultation at their facility. I'm not sure.
22 I do know that video conferencing is available at all
23 the facilities because we have medical quarterly meetings
24 with all the providers. But as far as doing consults with
25 VCU and --, I'm not sure what facility has the capability

1 but it's not an issue with us because we move our people to
2 where we will be moving, but expanding to that is probably
3 pretty simple, especially if they're --
4 MR. GASKIN: I'm just trying to sort through
5 in my mind listening to you, how much -- or are you speaking
6 for the Department of Corrections and how they intend to
7 manage all of their dental clinics with these technicians
8 and then trying to overlay that in private practice or any
9 other nursing home or other situation? As far as each one
10 maybe having a liaison or something?
11 MS. SWEEKER: Dr. Wyatt, I used to work for
12 DSA too but this was a million years ago. We had
13 tele-dentistry in 1994 and that dentist actually talked to
14 DCU and they didn't do it. They did it face-to-face. They
15 talked to the oral surgeons T your facility did, but we did
16 that then so I'm familiar with tele-dentistry. The dentist
17 actually talked to the oral surgeon and talked about the
18 wisdom teeth, and they had the radiographs and everything.
19 That was at --
20 It's closed now, or it's getting ready to close, but
21 they did that then. Anyway, now I know why dentists
22 actually talked to the oral surgeon. So I guess each
23 facility -- and we had a coordinator so I'm very familiar
24 with what you're talking about.
25 DR. WYATT: Right, right.

1 MS. SWEEKER: Candy was her name, and she
2 transported everything that went along with tele-medicine,
3 tele-dentistry so that the inmates were transported, because
4 it's different when you're transporting an inmate than when
5 you're transporting someone who can get themselves there on
6 their own accord.
7 MR. GASKIN: So through the Chair, my
8 question still stands, are you speaking for yourself or are
9 you speaking for DSUV? Who are you speaking for today as I
10 read your comments and listen? Could you define that for
11 us?
12 DR. WYATT: I'm speaking for me as a
13 clinician within DOC and I'm also speaking on behalf of DOC
14 because if this is something that's going to be made
15 available, we need to be able to make sure that it works.
16 Now, for clarification, I'm not sure whether it's a contract
17 to state issue. Most of this is administrative, so in order
18 to get approval, there's an approval process that we have
19 now. They don't approval every tele-medicine or every
20 tele-dental consultation. I'm not in that loop, okay.
21 I do refer to oral surgery. We do refer the
22 radiographs, but I haven't found the need to have to consult
23 face-to-face with the surgeon. Usually, they contact me on
24 the phone because it's separate from my dental clinic so I
25 don't have the ability to go in right now and to use that

1 office space for tele-dentistry so I have been locked out.
2 MS. SWEEKER: You used to do it though?
3 DR. WYATT: Right. If that's something that
4 was going on then, I don't see why it can't return to
5 that.
6 MS. SWEEKER: Right.
7 DR. WYATT: Now, it's been eight years. Now,
8 I could request a time and I'm sure that I would be
9 given access but it's common practice in medical to be
10 able to walk into the office and do that. That's not
11 me. I have to go through. Did that answer your
12 question, sir?
13 MS. SWAIN: Thank you. Do you have any
14 questions?
15 MS. DUGAR: I do have a -- I guess in
16 reading all this information, I am realizing that there's a
17 crossover with medicine and dentistry and I didn't know if
18 anybody might have any input on coding or how that's done
19 with filing. I think -T indicated that there's issues with
20 no duplication and cost. Can you speak to that?
21 MS. SWEEKER: I can't speak specifically to
22 that, but what I can speak to is I know that -- had done
23 tele-dentistry in other states. They are working on
24 establishing codes to T - dentistry. I can't prove it, of
25 course, but --

1 MS. DUGAR: I was just curious because
2 obviously that's going to be something that's going to be
3 something we'll have to look at.
4 MS. SWEEKER: In terms of duplication, what
5 the workgroup preferred was making sure that the same
6 dentist who's doing the consultation isn't providing the
7 service so that you're not getting a patient who has a
8 consult done by one dentist, goes back and has another
9 procedure or has the procedure done by another dentist, so
10 you're getting a double charge.
11 MS. DUGAR: Right. Because the standard is,
12 like in private practice, you can only fee out an exam once
13 or twice a year.
14 MS. SWEEKER: Right.
15 MS. DUGAR: Yes.
16 MS. SWAIN: This is an opportunity for
17 everybody to discuss. Does the audience have any
18 questions to ask of each other to get the forum carried
19 over, the information presented to us. Any other
20 comments? Really this is an informational scenario for
21 us, and it would be great for us to have all of the
22 input laid out because we're going out blindly and it
23 would be nice to have as much information to help us
24 review the policies. Ma'am?
25 MS. KAHAN: I don't have a question so much as

1 a comment. Inside dentistry, the Dean of Dental
2 Medicine, this year I think is starting, and again,
3 there's so much research out there. Just to put in
4 emergency room dentistry, whatever it is, there's just
5 so much research. In their clinic, they are now
6 bringing in physicians, dentists, medical students,
7 dental students and nursing.
8 To do this and be disciplinary, starting now,
9 the way that our current system is, that might be a
10 little difficult to change, but starting with medical
11 schools, dental schools, combining and adding more
12 dental curriculum to the medical school and
13 administering -- we don't have a lot of medicine built
14 into our curriculum. I used to tell everybody how over
15 qualified I am to be -- I mean, I'm glad that I'm over
16 qualified but just in dental hygiene, what we have to
17 know about the human body, but then it doesn't transfer
18 over.
19 We take blood pressures, but I've never ever
20 gone -- and my husband's a dentist. I've never ever
21 gotten from the medical practice, although I do know
22 some of them do it, where my neighbors are OBGYN and
23 orthopedists, and I always say to them, do you make
24 sure that your patient has their teeth cleaned before
25 you do the joint replacement.

1 It's always after, so I think maybe where we
2 need to start is intergrating with, and I'm reaching
3 out to our medical, our nursing program, the Virginia
4 Health and Medical Educators Association to try to get
5 more dentists into the nursing programs. At EVMS we
6 had talked about that, coming in and just giving some
7 sort of semester on dentistry because they get so
8 little of it, and so I think once we start
9 incorporating that, there won't be that barrier where,
10 okay, who do we charge for the fee because we're still
11 doing that.
12 We still think the mouth is here, and we have
13 separate fees, and then we have the body here that has
14 its separate fees and he does address that so I know
15 that there -- so we don't have to reinvent the wheel
16 that other -- about putting them both together. It
17 might be a place for discussion.
18 MS. SWAIN: Sir, in the back?
19 MR. BLACK: I'm from Roanoke, and -- Virginia
20 Tech Medical School -- young and he's five years old
21 now. The dental clinic at the Korean Hospital decided
22 they needed to have studies there, and so if you want
23 to look to a model to teach medical students more about
24 dentistry, they have a 25-hour curriculum in the
25 medical school on dentistry. That is Dr.

1 I don't know if you know Dr. -- who is head
2 of that program. So if you want to look to a model for
3 teaching physicians more about this, you don't have to
4 go to Harvard, you can go right here.
5 MS. KAHAN: Sorry to --. It's just from the
6 article.
7 MS. SWAIN: Any other comments? This is
8 really a good time. Dr. Sarrett?
9 DR. SARRETT: I'll just give you a piece of
10 information that may help in the future, and when I
11 tell you this, you're going to think how could this be
12 fixed? There's another organization called the
13 American Association of Medical Colleges, the AAMC,
14 who's kind of the educational oversight for medical
15 education. They're in Washington, DC. There's also an
16 organization called the American Dental Education
17 Association which is the comparable dental education
18 association for US members and Canada.
19 AAMC purchased a large building in Washington
20 DC and moved into it. The American Association is now
21 in the same building as the American Association of
22 Medical Colleges. They have moved from their location
23 and have space right next to the AAMC so I predict that
24 will be the single most important thing that's going to
25 change this entire situation, because you've got

1 everything now.
2 You've got the Dental Education Association
3 people running into and talking to the people at the
4 AAMC, and finally that message will start to trickle
5 through them. Something needs to happen in medical
6 education in order to bring an understanding. I had a
7 personal experience recently with this whole thing
8 which kind of got me interested in what they're doing
9 down there.
10 We frequent a restaurant on Wednesday
11 evenings, -- because it's half price burger night on
12 Wednesday nights, and I've gotten very familiar with a
13 server there, and about a month and a half ago, I could
14 tell she wasn't feeling well.
15 She had this mass swelling under her right
16 here (pointing). I said, "Any of your teeth bothering
17 you?" She said, "Well, I don't know. I haven't been
18 to a dentist in ten years." So I said, "You have to be
19 very careful because if that's an infection under
20 there, that could be very dangerous and you could die
21 from that."
22 So she called her husband. She said, "I
23 think I'm going to go to the hospital when I get off
24 work." I took a napkin and I wrote a note on the
25 napkin and said, "A dentist has talked to you and

1 thinks you might have a dental infection causing that
2 swelling under the midline of your jaw." I said give
3 this to the -- I said to the MCV emergency department
4 because they will have dentists there.
5 I didn't say -- but I knew they would have
6 somebody with dental, give them this note. So we left.
7 I didn't catch back up with her until the following
8 Wednesday night until the next -- hamburger night, and
9 I said, "What happened?" She said, "Well, I went to
10 the hospital, and I spent the night in the hospital and
11 they called in an ENT. They weren't sure what it was.
12 They took me into the operating room and they drained
13 it.
14 They weren't really sure what it was, thought
15 it might be a cyst. I said, "What did they say about
16 your teeth?" She said, "Well, they didn't think it was
17 a T they didn't really know." I said, "Where did you
18 go?" She said she went to another hospital in the
19 city, not MCV. I won't say the name of it. I said,
20 "So a dentist never looked at you?" She said, "No".
21 I'm feeling much better.
22 I'm going to go back and they want to do some
23 scans and figure out what's wrong." So I said, "Okay".
24 So a week and a half later, she texted me. My face is
25 all swollen up on one side, and I'm really hurting and

1 my mouth is hurting terribly. So I got her in the next
2 morning to the AB Williams Clinic, and it turned out
3 she had two bad teeth. They took those teeth out.
4 I saw her last night, Thursday night. It's
5 not -- burger night. I saw her last night. She's
6 feeling fine so the assumption is she had a dental
7 infection this whole time that had crossed the
8 mid-line. I think the medical community needs to
9 really start learning about this stuff because she's
10 got this huge hospital bill. She doesn't have health
11 insurance over at this hospital, and they totally
12 misdiagnosed her because they didn't have the expertise
13 to do it. You have to have provided care. Huge
14 implications, I think, for professional liability. So
15 I think these things are going to change relative to
16 the understanding and a better appreciation for what's
17 between the lips and the tonsils, once people start
18 seeing these issues.
19 MS. SWAIN: Ms. Wilkinson, I believe you had
20 your hand up?
21 MS. WILKINSON: Thank you. I wanted to
22 elaborate on some of that about what Dr. Brown
23 mentioned earlier about wait lists at clinics.
24 Unfortunately, three of our -- in larger practices.
25 That is in Charlottesville, here in Richmond, and the

1 Fredericksburg Clinic known as the Moss Free Clinic.
2 Each of those free clinics has well over a million
3 dollar operating budget.
4 Crossover here has a $3 million budget with
5 two sites here serving over 70,000 unduplicated
6 patients. The Charlottesville Clinic has a $1.5
7 million operating budget, and the Crossover Free Clinic
8 in Fredericksburg has a $1.8 million operating budget.
9 I mentioned their operating budget to give you an idea
10 of the scope of these particular clinics and their
11 practices. They are serving thousands of unduplicated,
12 uninsured adult patients. Each of those three clinics
13 has a dental practice. The Moss Free Clinic, if you've
14 never visited the Moss Free Clinic in Fredericksburg, I
15 encourage you to do so. They have a state of art
16 dental practice. They have six dental operatories that
17 on any given day of the week sits empty because they do
18 not have dentists and dental hygienists who can
19 practice during the day.
20 They cannot afford to hire a dentist at
21 whatever dentists make in the Fredericksburg market.
22 They can afford to hire some dental hygienist who could
23 benefit from remote supervision and/or tele-dentistry.
24 So I mentioned these three specific communities because
25 these are three communities that are known as resource

1 wealthy areas of our state, and imagine the problem
2 that's in Wise, Virginia. You've seen the news.
3 You've probably seen 60 Minutes and you're
4 familiar with the RAM Place that takes place every
5 year. They serve thousands of patients and to the
6 generosity of the VDA and VCU and other providers,
7 they're pulling thousands of teeth from patients every
8 summer that could have otherwise been saved if they had
9 the necessary oral healthcare. There's going to be
10 another RAM Clinic down in Kilmart in November and the
11 same thing is going to happen. They will pull
12 thousands of teeth because we don't have the necessary
13 providers who have the flexibility to serve these
14 patients despite the fact that we know, because the
15 providers tell us, they very much want to volunteer at
16 the free clinics, but they just can't be there during
17 the day when the patients can be there. So I mentioned
18 all of that to follow up with Dr. Brown's comment about
19 the wait list and unfortunately, the Charlottesville
20 free clinic has a wait list that is two years long, and
21 it's 500 hundred patients.
22 I just wanted to share that little extra
23 tidbit and again, I remind you, I know it is a focus
24 for you because it is a focus for us that patients need
25 to be at the center of your conversation. I heard what

1 the other speakers said, and I thank you for having
2 this conversation and for including the patients.
3 MS. SWAIN: Dr. Gaskin.
4 DR. GASKIN: While you're standing, can you
5 tell her whatever medicine -- tele-dentistry because I
6 know Crossover does pay, but here in Richmond. I'm
7 very familiar with that clinic. How do you see
8 tele-dentistry helping with what you're presenting to
9 us as a problem?
10 MS. WILKINSON: Primarily because of the
11 availability of a provider, if I don't have a dentist,
12 I can't afford to hire that dentist, or if I don't have
13 a volunteer dentist who's willing to be onsite during
14 the days that my practice is open, tele-dentistry would
15 expand my practice at all of my free clinics that have
16 onsite dentistry. So it allows greater flexibility.
17 We can serve more patients with more flexible hours.
18 DR. GASKIN: Where do you see having their
19 dentistry done? Do you mean come back after they're
20 screened? I'm not sure logistically what you're
21 telling me.
22 MS. WILKINSON: Oh, I'm sorry. I didn't
23 understand the question. The hygienist could be
24 providing the services onsite.
25 DR. GASKIN: Isn't that the same problem,

1 availability of healthcare, volunteers?
2 MS. WILKINSON: We have 150 volunteer
3 hygienists. Clinics can afford to hire hygienists.
4 They can't afford to hire the dentists. We have in
5 just the past 24 hours, we have had free clinics turn
6 down money from -- because they can't use the money to
7 pay for the dentists. It's not enough money to pay for
8 a dentist. It's great that I hire another hygienist,
9 but if I don't have the dentists to supervise him or
10 her, the hygienists, there's no point. They have
11 actually declined money from the association because
12 it's not enough. It's not enough to hire a dentist,
13 and it doesn't do any good to hire a hygienist when
14 they can't do much without that dentist there.
15 MS. SWAIN: Ms. Wilkinson, do you actually
16 have a list of hygienists who can actually be hired who
17 are willing to volunteer their time?
18 MS. WILKINSON: We do have 150 of them.
19 MS. MILLER: No, no, no, no. I just want to
20 make sure that you actually have hygienists who are
21 willing to work and who are willing to
22 MS. WILKINSON: We have 150, and they are
23 available on those times that you are asking for, not
24 just -- some of those hygienists are, but there are
25 other hygienists that we would like to hire, but we

1 can't hire them without having a dentist. I believe
2 another speaker mentioned the Chesapeake Dental Clinic.
3 Unfortunately, that dentist that we mentioned heard her
4 hours were just cut in half from full time.
5 I'm probably sure it worked out. Her hours
6 were cut in half so it means that half of the patients
7 who were served prior to her hours being cut, because
8 the clinic just couldn't afford her. They just can't
9 afford that six-digit salary that she's being paid, but
10 she's worth every penny of it, but they can't afford
11 it. So now, the patient population will be cut in
12 half. Half the number of pediatric -- at that
13 particular clinic, they serve pediatrics. Half the
14 number of children and half the adults will be served
15 at the Hampton Roads Dental Clinic.
16 MS. SWAIN: Yes, sir, Dr. Wyatt?
17 DR. WYATT: To further the point, I'd like to
18 understand the dilemma of the free clinic --
19 COURT REPORTER: I'm sorry. I cannot hear.
20 DR. WYATT: I understand the dilemma of the
21 free clinics, but it seems that we can also be opening
22 up another can of worms. Patients would still have to
23 have dentistry performed in addition to preventive
24 services, but I think tele-dentistry could help in that
25 regard. Because I am sure that there are contracts

1 that could be written with various businesses
2 throughout the state that would represent
3 tele-dentistry providers.
4 There would be tele-dentistry providers where
5 some of this work could be funneled through their
6 practice if they were willing. Do you follow me? So
7 that you would be sharing resources, and that's what
8 all of this is about; sharing resources, not creating
9 problems off an issue. If you have enough patients who
10 are not being seen, and obviously they're not being
11 treated, then it's great we're being proactive with the
12 preventive, because eventually that will decrease the
13 amount of emergencies and dentistry that needs to be
14 performed, but you also have to make sure that the
15 backend of that is covered because what you create is a
16 scenario where you have a lot of people who need work
17 and then you have a dental shortage. You have to have
18 the foresight in place to fulfill that, and there are a
19 lot of private practitioners I am sure that would be
20 willing to take on that burden if their staff is
21 trained.
22 If that becomes common culture within our
23 profession, then it's just a matter of working together
24 and setting those type of logistics up. Right now, I
25 think we've got gaps. Everybody has these issues, and

1 they figure, well, we can see more patients; but now
2 you've got more procedures. Okay, now, that's not to
3 say ignore the fact that we have these patients out
4 here, they need to be treated. I think we need to make
5 sure that we can address all of these needs.
6 I want to talk about organizations and to
7 include the private practitioners because it would be
8 another source of income for them. They're willing and
9 able, and they're in their own environment so if they
10 know that they're being trained, they might be a pool
11 of private practitioners. That's another source of
12 revenue and treatment. It's a win-win situation for
13 everyone.
14 MS. SWAIN: Yes, sir, Mr. Black?
15 MR. BLACK: David Black again. I'm speaking
16 as a model representative of the UVA party. I started
17 my career in 1971 in Clintwood, Virginia in the
18 Department of Public Health Dental Clinic, a very nice
19 dental clinic that had just opened. We actually had
20 dentist in the Division of Dental Health. I don't know
21 the politics of this, but dentists т - there weren't
22 many dentists who worked for Department of Public
23 Health and they could ask these people to do the
24 dentistry of tele-dentistry.
25 We actually had some dentists who worked for

1 us. I think that's the ultimate rule, as the
2 Department of Dental Health has been obliterated over
3 the last years because of budget concerns because
4 medical Medicaid took up all the money. Like I said,
5 it's too obvious, but maybe we ought to talk to our
6 legislators about getting some dentists to work for the
7 Department of Dental Health.
8 That would be a very obvious place where we
9 could get these people to do the tele-dentistry. I'm
10 for tele-dentistry. I think it's very good, but who
11 are you going to hire to do it? There's a dental
12 clinic in Roanoke that the Department of Health owns,
13 and I think they're trying to sell it at this point.
14 I'm sure there's a bunch of them around the state.
15 Like I said, we need to talk to our legislators about
16 that. The offer was there so I thought I'd make my т -
17 MS. KAHAN: In regards to that, again I think
18 it's the separation of the medical. Medicaid takes up
19 most -- again, we keep separating medicine and
20 dentistry. It's always been, you have medical
21 insurance. You have dental insurance. I think we're
22 getting to that part of the discussion where you can't
23 separate the two anymore.
24 The other thing is that in Virginia Beach I
25 can't speak for anyone else, but assuming we have

1 Heartland Dentists who are coming to Virginia. We have
2 a chain of dentistry and a lot of private dentists take
3 on Medicaid now in their practice which is fabulous and
4 great. Because they extend their hours until 9 o'clock
5 at night, our public health in Virginia Beach, when I
6 tried to get that person to come up into our school, we
7 technically don't have funds for public health dental.
8 That had gone away a long time ago, but they
9 found another way so they don't have to keep worrying
10 about budget cuts. They found a way to find money to
11 keep a dental person in public health, although
12 technically not through that particular type of
13 funding. We do have it. They were sort of not doing
14 anything, and their hours were from 8:30 until 4
15 o'clock, exactly the same time when kids were at
16 school. So I would say to them that you either have to
17 go to the school, and I had a full dental health lab,
18 and it took me eight years to get a four-page
19 memorandum of understanding passed by all of the legal
20 stuff. It took eight years.
21 I retired as a director and a dentist in our
22 public health, until I finally got one to come on down,
23 one day a week, and again, you would think it was like,
24 I don't even know what they thought I was asking.
25 She's finally going to do dentistry here. When I said

1 to them, why didn't you just change your hours? Why
2 are you still 8:30 until 4 o'clock? Why don't you
3 change it, and so Heartland – I got a thing in the
4 mail announcing this new dentist. Guess when she is
5 open? She is open until 9 o'clock at night, seven days
6 a week so they're open on Saturday and Sunday, but of
7 course, that's what I said to public health.
8 Why are you still open? Close on Monday and
9 Tuesday for your weekend and open on Wednesday,
10 Thursday, Friday and come in at 12 and open until 9 and
11 you would make it more easier for patients so the
12 parents would have it more accessible to them. Anyway,
13 public health didn't do it, but Heartland did it and
14 Heartland is getting remunerated through Medicaid for
15 the kids that they see. So sometimes it just takes
16 minor changes.
17 MR. SWAIN: We seemed to be hearing the
18 common lack of providers and economic issues. Does
19 anybody have anything to say about the top three
20 questions: What should the standards for establishing
21 a dentist/patient should be? Should there be
22 requirements for communications equipment at remote
23 sites which I think some of that's been covered, and
24 what are the risks and costs associated with dentistry?
25 Final comments on that?

1 MS. DUGAR: We, specifically, Dental Quest,
2 has specifically addressed each of the questions that
3 were posed, and we just felt like we should hear what
4 is done in tele-medicine in terms of the
5 patient/physician relationship. So if there's an
6 appropriate model and the business that I'm in, when
7 this is discussed in a broader sense in terms of
8 medicine, Virginia has always led, for example, other
9 states in terms of our -- of medical so we felt like it
10 was important to keep -- location and identity of the
11 requesting patient, disclose the validating
12 practitioner's identity credentials to the patient,
13 which I think you touched on, obtain consent from the
14 patient to provide consent to use tele-medicine, that a
15 practitioner has to be licensed in the state. I think
16 the tele-medicine regulations do a nice job of what
17 establishes what constitutes a dentist/patient
18 relationship.
19 MS. SWAIN: Any other comments? Any other
20 questions for the board members?
21 MR. GASKIN: Perhaps for the record, it might
22 be that this is the Department of Health Professions
23 for medicine, it's document 85-12. At this point, I
24 think everyone cited me at this point.
25 MS. SWAIN: I want to remind everyone that

1 any policy action that the Board decides to take will
2 include the standard comment, opportunities require
3 regulatory action and for the legislative of this later
4 proposal. If you would like notice of board meetings
5 and comment opportunities, please add your name and
6 email address on the sign-up sheet outside the door.
7 We appreciate your time this morning, and
8 thank you for the wealth of information provided. This
9 is a big issue, and we appreciate all the input, and
10 this concludes our forum at this time.
11 Thank you.
12 (Proceeding concluded.)
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1 CERTIFICATE OF COURT REPORTER
2
3 I, Earlina O. King, hereby certify that I was the
4 duly sworn Court Reporter in the Board of Dentistry Forum
5 For the City of Richmond, Virginia, on August 14, 2015 at
6 the time of the hearing herein.
7 I further certify that the foregoing transcript,
8 to the best of my ability, is a true and accurate record of
9 the testimony and other incidents of the proceedings.
10 Given under my hand this 27th day of August
11 2015.
12
13
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15 _____
16 Earlina King
17 Court Reporter
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24 COMMISSION EXPIRES October 31, 2015
25

UNAPPROVED - DRAFT

BOARD OF DENTISTRY
NEW MEMBER ORIENTATION

Wednesday, September 2, 2015

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

CALL TO ORDER: The meeting was called to order at 3:06 p.m.

PRESIDING: Melanie Swain, R.D.H., President

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

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

ORIENTATION: Ms. Swain welcomed Dr. Parris-Wilkins and said she is available to answer any questions as Dr. Parris-Wilkins gets started. Ms. Swain explained that the Board speaks as a body and individual members cannot speak for the Board and also encouraged Dr. Parris-Wilkins to refer inquiries she receives to Board staff.

Ms. Reen explained a change in the order of business shown on the posted Agenda, indicating that Ms. Palmatier would begin by addressing disciplinary cases.

Ms. Palmatier explained and discussed the disciplinary case process and the roles of Enforcement and APD. She explained the Probable Cause Review form and discussed the information needed to close a case and to move a case forward for an advisory letter, confidential consent agreement, pre-hearing consent order or informal conference. She also reviewed the guide on case reviews, probable cause decisions and disciplinary action. She encouraged Dr. Parris-Wilkins to use it to help work through cases and to call staff with any questions about a case.

Ms. Swain reviewed the Bylaws and the Code of Conduct for Members and explained the reference materials in the member handbook.

Ms. Reen introduced the Board's website and explained the pertinent information such as the Board's regulations, laws, guidance documents, and the 90-day Case Decisions. 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 SRTA and ADEX. She indicated that serving as an examiner is optional.

Ms. Lee reviewed the state's policies on travel and per diems then gave Dr. Parris-Wilkins the conflict of interest training material to complete and return.

ADJOURNMENT The training was adjourned at 5:45 p.m.

Melanie S. Swain, R.D.H., President	Sandra K. Reen, Executive Director
Date	Date

Board of Health Professions

Virginia Department of Health Professions

DRAFT

Full Board Meeting

August 6, 2015
11:00 a.m. - Board Room 2
9960 Mayland Dr, Henrico, VA 23233

In Attendance	Robert J. Catron, Citizen Member
	Helene D. Clayton-Jeter, OD, Board of Optometry
	Kevin Doyle, Ed.D., LPC, LSATP, Board of Counseling
	Frazier W. Frantz, MD, Board of Medicine
	Yvonne Haynes, LCSW, Board of Social Work
	Allen R. Jones, Jr., DPT, PT
	Robert H. Logan, III, Ph.D., Citizen Member
	Trula E. Minton, MS, RN, Board of Nursing
	Martha S. Perry, MS, Citizen Member
	Ellen Shinaberry, RPH, PharmD, Board of Pharmacy
	Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language Pathology
	James Wells, RPH, Citizen Member
Absent	Jacquelyn M. Tyler, RN, Citizen Member
	Virginia Van de Water, Ed.D., Board of Psychology
	James D. Watkins, DDS, Board of Dentistry
	J. Paul Welch, II, Board of Funeral Directors and Embalmers
DHP Staff	David E. Brown, D.C., DHP Director
	Elizabeth A. Carter, Ph.D., BHP Executive Director
	Jaime Hoyle, Esq., DHP Chief Deputy Director
	Laura L. Jackson, BSHSA, BHP Operations Manager
	Ralph Orr, Manager, Prescription Monitoring Program (PMP)
	Elaine Yeatts, DHP Senior Policy Analyst
Emergency Egress	Dr. Carter
Observers	No observers signed-in

Call to Order

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

Quorum Established

Public Comment

Comment No public comment provided

Approval of Minutes

Presenter Mr. Catron

Discussion

The May 28, 2015 11:00 a.m. Full Board meeting minutes were approved and properly seconded by Dr. Logan. All members in favor, none opposed.

Directors Report

Presenter Dr. Brown

Discussion

Dr. Brown stated that DHP and the PMP are very involved in the Governor's Task Force on Prescription Drug and Heroin Abuse which is in the wrap up stages. Final recommendations will be presented to the Governor along with a plan for implementation.

Board member training: September 28, 2015 10:00 a.m. – 3:00 p.m.
This training session is for established board members and will focus on discipline.

New board member orientation: October 16, 2015 starting at 9:30 a.m.
This orientation will cover the duties and responsibilities of being a board member.

Legislative and Regulatory Report

Presenter Ms. Yeatts

Discussion

Ms. Yeatts stated that there has been very little change since the May 28, 2015 meeting. The 2016 legislative package due date is July 7, 2015. The package process is as follows: board sends legislation request to Dr. Brown, who in turn sends it to Secretary Hazel who in turn sends it to the Governor's policy office. She stated that the 2016 session will be a busy one for DHP.

Ms. Yeatts reported that a request has been made for BHP board members to have concurrent terms with their board. This will create less confusion with board member term expirations.

Prescription Monitoring Program (PMP)

Presenter Mr. Orr

Discussion

Mr. Orr provided a PowerPoint presentation on Virginia's Prescription Monitoring Program. The PMP is a system in which controlled prescription drug data are collected in a database to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of controlled substances.

Executive Directors Report

Presenter Dr. Carter

Agency Performance

Dr. Carter stated that the agency's results on the Key Performance Measures remain

Board Budget/Recruitment

Dr. Carter stated that the Board is currently working within budget.

BHP is in the process of recruitment for the vacant Policy & Planning Specialist III position. This position has been vacant since May 2015.

Sanction Reference

Dr. Carter reported that the evaluation of the Sanction Reference Points (SRPs) for the Boards of Counseling, Psychology and Social Work has revealed some shifts in the types of cases coming before the boards since the first Behavioral Science SRPs were developed in 2009. Because the SRP worksheets are historically based, it is likely to lead to an update in worksheet factors. Research is being conducted to identify any new statistically relevant sanctioning factors. The results of the analysis will be shared with the affected Boards for discussion into the need for updating worksheets.

Telehealth Review

Dr. Susan Gooden with the VCU Wilder School of Government and Public Affairs contacted Dr. Carter about DHP participating in a MPA capstone project. The deliverable for DHP's project will be a comprehensive review of the literature and insights into current best practices in the regulation of telehealth practice. State agencies will be presenting an overview of their proposed projects to the students on August 25, 2015. If DHP is selected, three students will begin work in September and provide a full report and presentation in late November.

Practitioner Self-Referral

A practitioner self-referral request has been submitted by Alliance Xpress Care, LLC. It is currently under review by APD.

Retreat

Dr. Carter stated that the Board will be holding a retreat in the Spring of 2016. Items to be discussed include: telehealth; dental access to care and team delivery. The Boards regulations will also be reviewed at that time.

Healthcare Workforce Data Center Update

The Health Care Workforce Data Center currently surveys 26 professions. Additional surveys will be implemented once the department is fully staffed.

HWDC has entered into an eMOU with the Department of Health. This eMOU allows the VDH Office of Minority Health and Health Equity use of currently licensed healthcare professionals' data to further improve the federal health provider shortage designations process which is vital to health planning and health workforce recruitment in the Commonwealth.

VLDS

VLDS (Virginia Longitudinal Data System) is a pioneering collaboration for Virginia's future, giving the Commonwealth an unprecedented and cost-effective mechanism for extracting, shaping and analyzing partner agency data in an environment that ensures the highest levels of privacy. The Department of Health Professions is in the process of partnering with VLDS

Electronic Health Record Metadata

At the last meeting, Dentistry's requested BHP's assistance in determining how the integrity of electronic health records obtained in disciplinary investigations could be ensured since patient records could be altered after the fact. Several BHP members commented that electronic patient records systems include a metadata component that records the data, time, and name of person entering, and amendments to the record. In follow-up with the assistance of Ms. Yeatts and a law student interning with the agency this summer, initial research indicates that metadata pertaining to patient records have been made available to courts through discovery and subpoena. Dr. Carter noted that this does not constitute legal advice and further legal exploration will require assistance from the Attorney General's office.

NGA

The Board of Nursing has approved inclusion of the "Veterans Variables" questions as updates to the DHP Healthcare Workforce Data Center surveys for LPNs and RNs. The new questions will address service branch, rank, and military occupation and discharge date.

Board Reports

Presenter Mr. Catron

Regulatory Research Committee

Ms. Haynes updated the Board about the VCU Capstone program for the Fall of this year. The Students will be working on telehealth.

The Committee will continue to follow the progress of efforts toward improved dental access being made by the Board of Dentistry.

The Committee met to discuss the findings of the May 28, 2015 Funeral Multi-Level Licensure public hearing. The Committee Chair stated that after review of the research findings the Committee is in need of empirical information to make a recommendation. Ms. Haynes requested a motion be made.

Motion

A motion was made to provide Senator Alexander with a letter explaining findings, to date, and advise of the availability of the Board's standard policies and procedures process for evaluating the need to regulate any new profession. The motion was properly seconded by Dr. Frazier. All members were in favor, none opposed.

Board of Nursing

Ms. Trula Minton stated that the Board of Nursing is requesting competency requirements and prescriptive authority for Nurse Practitioners. Ms. Yeatts stated that the Board of Nursing is going to start utilizing pre-license background checks for RN's and LPN's in 2016.

Board of Physical Therapy

Dr. Jones stated that the Board of Physical Therapy is working on continuing education requirements.

Board of Social Work

Ms. Haynes stated that the Board is reviewing multi-level licensure.

Board of Pharmacy

Dr. Shinaberry stated that the Board of Pharmacy is conducting a full review of their regulations. She happily reported that the Board of Pharmacy received the Fred T. Mahaffey award for their contributions to the regulation of the practice of pharmacy and their efforts to ensure that compounding is performed in a safe and compliant manner.

Board of Optometry

Dr. Clayton-Jeter stated that the Board of Optometry is also looking into a telemedicine review. She will report back to the Board of Optometry that the Board of Health Professions is going to be working with VCU Capstone students in the fall regarding telehealth.

New Business

Presenter Mr. Catron

2015-2016 Board Calendar

Mr. Catron reviewed the October 6, 2015 meeting cancellation and reschedule date of November 3, 2015 along with the 2016 proposed calendar dates. These dates were agreed upon and approved by the Board.

White House Occupational Licensing Report

Dr. Carter informed the Board that the White House has released an occupational licensing report. Dr. Carter was able to assist in providing content for the report.

Adjourned

Adjourned 1:24 p.m.

Acting Chair Robert Catron

Signature: _____ Date: ____/____/____

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

Signature: _____ Date: ____/____/____

Southern Regional Testing Agency, Inc.
4698 Honeygrove Road, Suite 2
Virginia Beach, Virginia 23455-5934
Tel. (757) 318-9082 / Fax (757) 318-9085
www.srta.org

June 15, 2015

Stanwood Kanna, D.D.S, President
American Board of Dental Examiners, Inc.

Dear Dr. Kanna:

My term as president began in August of last year, and it has been a distressing term for both S.R.T.A. and myself. You are aware of the problems incurred by our agency when we discovered that ADEX had grossly misrepresented itself to us, forcing us to refund monies to dental hygiene candidates when those candidates discovered that they were not eligible for licensure in certain states on the basis that successful completion of the S.R.T.A. administered ADEX exam was not recognized by the dental boards of the states in which those dental hygiene candidates were seeking licenses.

By unanimous vote of the S.R.T.A. board of directors it was decided that S.R.T.A. would not administer the ADEX dental hygiene examination for the remainder of the 2015 testing cycle, as our research concluded that it was more advantageous for our candidates to successfully complete our independent S.R.T.A. hygiene examination.

On April 21, 2015, Kathleen White and I, representing S.R.T.A., met with the officers of ADEX to communicate our dissatisfaction with ADEX. Even though the evidence we presented clearly demonstrated that ADEX had misrepresented its scope of acceptance among the fifty states (and other regions,) we left the meeting disappointed that our concerns had not been given the attention we had desired, and we concluded that ADEX was not very interested in correcting its mistakes.

Since that meeting all correspondence addressed to me from ADEX has been regarding the errors made by S.R.T.A. during the ADEX examination at the University of Tennessee on April 10, 2015. Even though S.R.T.A. readily and completely admitted to everyone that the examination violated ADEX standards, and even though the examination results were decertified as an ADEX examination, and even though the issues for those candidates directly affected by the decertification have been resolved, and even though every candidate who successfully completed the examination has been licensed in the state of his original choosing, ADEX continues to badger S.R.T.A. for information that is now irrelevant.

Your letter of June 4, 2015, stated "S.R.T.A.'s failure to comply promptly, thoroughly, and cooperatively will inevitably call into question whether S.R.T.A. can continue to operate as an ADEX testing agency." It is obvious that those who govern ADEX are not happy with S.R.T.A., and I can assure you that the leadership of S.R.T.A. is equally unhappy with ADEX.

The S.R.T.A. board of directors has authorized me to contact you on their behalf to request an amicable termination of our association. It is our desire that we can sever our relationship in a manner which will protect each one's reputation and in a manner which will allow each organization to proceed with its own business pursuits as it sees fit.

You and I know that this type of separation has the potential of getting ugly and costly. S.R.T.A. does not at this time wish to pursue a legal recourse which could be embarrassing to ADEX. Please seriously consider this request. Agree to work with us to accomplish a friendly and useful end.

Sincerely yours:

Marc Muncy

Marcus Muncy, D.D.S. – President

Dianne Embry, R.D.H. - Secretary *Robert B. Hall, Jr., D.D.S. - Treasurer* *Kathleen M. White – Executive Director*

ADEX

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Stanwood Kanna, D.D.S., President
William Pappas, D.D.S., Vice-President
Robert Jolly, D.D.S., Secretary
Jeffery D. Hartsog. D.M.D., Treasurer
Bruce Barrette, D.D.S., Past President

August 12, 2015

FOR IMMEDIATE RELEASE:

The American Board of Dental Examiners, Inc. ("ADEX") and the Southern Regional Testing Agency, Inc. ("SRTA") wish to announce as of August 10, 2015, that SRTA will no longer be administering the ADEX licensure examinations. SRTA will administer its own licensing examinations after that date. The ADEX examinations will continue to be administered by the Commission on Dental Competency Assessments and the Council of Interstate Testing Agencies.

Dr. Stanwood Kanna, the President of ADEX, explained that "ADEX and SRTA have realized that the two organizations have different philosophical approaches regarding licensure testing, and it made sense for each of us to pursue those approaches independently." Dr. Marc Muncy, the President of SRTA, stated: "We have had a productive relationship with ADEX for the past three years, and we value that experience."

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Contact information ADEX at ADEXOFFICE@aol.com or 503-789-2696.

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

2015 SRTA Annual Meeting report

SRTA is no longer administering the ADEX exam.

The reason was applicants were under the impression that the ADEX exam was accepted in 46 states. Applicants found out that it's not the case. SRTA had to issue refunds. Several unsuccessful attempts were made to get ADEX to correct their website and printed material. The ADA also, is not pleased with the inaccuracies.

SRTA had a computer malfunction during the UT exam. SRTA's handling of the situation was satisfactory to all involved but not acceptable to ADEX

The mutual decision to part ways was reached.

As of 7/28/2015, 32 states accept the SRTA exam.

It's noteworthy to mention that Virginia accepts ADEX exam while its neighboring states, Maryland, and North Carolina and the District of Columbia do not accept SRTA exam.

-The dental exam committee is changing the scoring criteria to acceptable and critically deficient (Pass/Fail)

- Fixed Prosthodontic section, SRTA will require candidates to make stints. The stints will be used by examiners if there is a failure due to over reduction. If the stints show the reduction is within limits the candidate will pass rather than fail.

- SRTA is allowing a 2nd submission for Perio, should the first not be accepted.

- SRTA is in a strong financial status.

- SRTA continues to keep open communications with the dental schools through individual liaisons.

Southern Regional Testing Agency
Annual Meeting
August 6-8, 2015

Dental Hygiene Examination Committee:

The Dental Hygiene Examination Committee met on Friday, August 7, 2015 at the Hyatt Regency in Baltimore, Maryland. The following committee members were in attendance:

Members:	**State:**
Sherie Barbare, Chair	South Carolina
Tammy Swecker	Virginia
Mary Warner	Tennessee
Jennifer Lamb	Arkansas
Dina Vaughan	West Virginia

Invited guests:
Gordon Bray, Suann Gaydos, Amy Funk, Heidi Christopher, Jana Jolly, Dianne Embry Gary, Katy Warren, Vickie Jones, Jessica Bui, Elaine Murphy, Marlene Fullilove, Debbie Southall, Denise Claiborne, Nadim Jubram, Julie McKee, Lynn Russell, Beth Mobiliam, Michelle Wiles, Mara Beth Womack, Mary Ann Burch, Chad Buckendahl, Joseph Evans, Marc Muncy, Holly Plemons, Kathleen White, Katherine Campen, Katherine Hall, Harold Marioneaux, Loan Nguyen, Tom Isbell

Discussion:

The committee discussed the current year examination criteria, pass rates, and the examiner survey results. The educators left after the discussion of the examination statistics and criteria. The educator's meeting was led by Marlene Fullilove, SRTA Examiner and former adjunct faculty for the University of Tennessee in Memphis. The educators provided positive comments about the structure and implementation of the clinical examination. The DHEC wants to express its gratitude to all the educators for their presence and valuable contribution to meeting discussions.

Sherie Barbare's term as DHEC Chair expires at the close of the 2015 Annual Meeting. She was reelected to another two year term. Marlene Fullilove's term as the dental hygiene representative on the Board of Directors does not expire until August 2016.

Dr. Marc Muncy spoke briefly concerning the decision to terminate the relationship SRTA has with ADEX. ADEX grossly misrepresented itself forcing SRTA to refund monies to candidates when those candidates discovered that

they were not eligible for licensure in certain states on the basis that successful completion of the SRTA examination administered ADEX exam was not recognized by the dental boards of the states in which those candidates were seeking licensure.

Dental Hygiene Examination Committee Report to the Board of Directors:

#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	Make remaining calculus on unassigned surfaces a stand-alone criteria
#4	Case selection must be one full quadrant plus two posterior teeth from one other quadrant
#5	Examiner #1 lists 15 surfaces for verification. Twelve will be assigned, if verified. Eliminate having candidates list surfaces.
#6	Eliminate slide presentation during orientation. Continue live Q & A, registration, review of day's schedule, etc. by DHA and CFM.
#7	Changed terminology of "Initial Case Presentation" to "Patient Eligibility"
#8	Re-elected Sherie Barbare as DHEC Chair for 2015-2017

SRTA DENTAL HYGIENE POINTS SYSTEM 2016				
	Criteria	**Opportunities for points**	**Points per opportunity**	**Total**
Patient Eligibility: Pt is dismissed	Quad has 6 teeth, one of which must be a molar	Will be moved to "Patient eligibility." If the radiographs of the candidate's selection are non-diagnostic OR the quadrant does not have six teeth or a molar, the patient will be dismissed and the candidate will fail. A "non-diagnostic" radiograph is defined as one that a dentist would be unable to make an accurate diagnosis of caries, periodontal health, or other dental diseases and abnormalities. The CFM shall verify the radiographic error before patient is dismissed.		
	Radiographs			
	Meets calculus criteria (8/5/3)	**6**		
	Detection	**6**		
	Perio	**6**		
	Removal	**72**		

Final Case Presentation	Tissue management (auto-fail if 4 or more are verified OR 1 major is verified)	**2**
	Remaining calc on unassigned	**5**
	Plaque; stain; other; anesthesia record	**3**
	TOTAL POINTS	**100**

Respectfully submitted,

Tammy K Swecker BSDH, RDH, M. Ed.

Tammy K Swecker BSDH, RDH, M. Ed.

REPORT OF THE 40TH SRTA ANNUAL MEETING HELD IN BALTIMORE, MARYLAND: AUGUST 5-8, 2015
From: DR. JAMES D. WATKINS
August 20, 2015

First meeting attended was the Dental Examination committee's calibration session on Thursday. This session was held to revamp all of the scoring criteria for all areas of the dental examination. The exam becomes a PASS/FAIL exam in 2016 so the criteria had to be revised to accommodate a PASS/FAIL format. This meeting consisted of the dental exam committee members and the educators from the SRTA dental schools.

The next meeting of the Dental Examination committee was on Friday to finalize the content of the exam for 2016. Educators participated also. The examination dates and locations for 2016 were presented with one correction. That correction is that Meharry Medical College will change the date they had presented of March 25-26 to April 1-2. (see attached documents). The Progress Reports for each aspect of the PIE 2 (patient portion of exam) were revised. WE DID NOT HAVE A QUORUM FOR THIS MEETING SO THE RECOMMENDATIONS OF THE COMMITTEE (see later in this report) WERE NOT VOTED ON. THESE RECOMMENDATIONS WERE SUBMITTED TO THE BOARD OF DIRECTORS AND TO THE ASSEMBLY ON SATURDAY "FOR INFORMATION ONLY."
The Dental Exam Committee set a future date of Friday, August 28th in Charlotte, NC for a One-day meeting to finalize its exam scoring criteria and other matters it may be presented.

One By-law change accepted by the Assembly is that the president may appoint one consultant from a "former" member state to serve on committees.

The SRTA Board of Directors voted that SRTA WILL NO LONGER BE ASSOCIATED WITH ADEX. THE SRTA EXAM IS ACCEPTED FOR LICENSURE IN 32 JURISDICTIONS (see enclosure).

PLEASE NOTE THAT KENTUCKY AND MISSISSIPPI ARE NO LONGER SRTA MEMBER STATES.

ELECTION OF OFFICERS FOR 2016 CONSISTED OF RETAINING DR. MARC MUNCEY OF ARKANSAS AS PRESIDENT FOR ANOTHER YEAR TO OVERSEE THE TRANSITION AND SEPARATION FROM ADEX. DR. BOB HALL OF VIRGINIA IS THE TREASURER AND MS. DIANE EMBRY-GARY, RDH IS THE SECRETARY.

THE 2016 ANNUAL MEETING WILL BE HELD IN HILTON HEAD, SOUTH CAROLINA FROM AUGUST 3-6.

(MANY *THANKS TO THE BOARD OF DENTISTRY AND DHP FOR ALLOWING ME TO ATTEND THIS VERY IMPORTANT AND INFORMATIVE MEETING.)*

Dental Examination Committee Report to the Board of Directors

August 7, 2015

The Dental Exam Committee met today with Dental Educators, and SRTA members. The DEC did not have a quorum so the following recommendations have not been voted on by the DEC.

For the 2016 exam year:

- Periodontal section, the committee recommends that the candidate be allowed to submit a second patient or selection if rejected for any reason. There will be no point deduction and no additional time will be allowed for the second submission.
- Restorative section, if the candidate fails their first restoration during the restorative scoring for flash, open contact or hyperocclusion, the candidate will be allowed to do their second restorative procedure.
- Fixed Prosthodontic section, SRTA will require candidates to make stints. They can be made during set-up time or clinic time. The candidate will turn them in with their typodont in a baggie with their candidate label attached. The stints will be filed at the scoring desk. If the fixed pros fails due to a reduction error, the SAC will verify the failure with the stints. If he agrees with the failure, no change is required. If the SAC disagrees with the failure, they will have the same three examiners score the typodont again using the stints.
- Restorative Approval, allow one enhanced film in addition to the required radiographs.
- Endodontic section, the Acadental teeth will have a red pulp.
- Scoring will be Pass/Fail. The Dental Exam Committee and Calibration Committee will meet in late August to finish and approve the changes to the criteria to Acceptable and Critically Deficient.
- SRTA has purchased 2 Dine dental cameras. One of these cameras will be available at each dental exam site to take photographs to be used for calibration.

The Committee recommends that SRTA wait on offering Provisional Approval of lesions. Follow up on how it works for WREB who is currently beta testing the program.

2015 Report from the Strategic Planning Committee to SRTA Board of Directors

1. Marketing Strategy
    a. Prepare a Dental Presentation that focuses on state acceptance (32) & candidate respect. This will highlight why candidates should choose our exams over others. SRTA member will present these slides to students at their schools. Candidates will also be able to view the presentation online, and educators will also receive a copy of the slides. We would like to also present this presentation to the D3s.
    b. Comment/Suggestions: Candidate will receive a comment paper in their packet. If they would like, they will be able to turn in any comment/suggestions that may have about the exam. This will be turned in anonymously. OR provide an exit survey online that they will be able to leave comments/suggestions.
    c. Instead of "candidate friendly," we would like to rebrand to "candidate focus" or "candidate respectful." Candidate friendly gives the negative connotation that we are easy.
2. Examiner Webpage
    a. Reimbursements have been provided on the SRTA webpage. Members will be able to submit their reimbursements electronically. We hope that this will eliminate any lost reimbursements or late payments.
    b. Newsletter will be provided on the website. This will inform any members of business matters as well as SRTA members. Newsletter will come out on a quarterly basis.
3. Examiner Mentor Program
    a. Program was implemented last year and has been a successful. We had 5 examiners go through the mentoring program.
4. School Reports
    a. Received reports from the school liaisons. Each liaison has kept open communication with the schools. We still have great relationships with each one.

32 States accepting SRTA as of 7/28/2015

Alabama	New Mexico
Arkansas	North Dakota
Colorado	Ohio
Connecticut	Oregon
Illinois	Pennsylvania
Indiana	Rhode Island
Kansas	South Carolina
Kentucky	Tennessee
Maine	Texas
Massachusetts	Utah
Minnesota	Vermont
Mississippi	Virginia
Missouri	Washington
Montana	West Virginia
Nebraska	Wisconsin
New Hampshire	Wyoming

- Some states, i.e. Arizona accept all examinations however, the cost of obtaining licensure may vary between type of exam taken.
- Students are strongly suggested to verify the licensure acceptance with the state board in which they seek licensure prior to registering for any examination.

Southern Regional Testing Agency

2016 Examination Dates

These are finalized dates for Dental and tentative dates for Dental Hygiene

Dental PIE I = Purple Dental PIE II = Green Dental Complete = Blue Dental Hygiene = Yellow

Test Site	Examination Type	Examination Date
West Virginia University Morgantown, WV	Dental PIE I (Saturday)	January 16, 2016
Medical University of South Carolina Charleston, SC	Dental PIE I (Saturday)	February 6, 2016
University of Alabama Birmingham, AL	Dental Complete (Saturday & Sunday)	February 6-7, 2016
University of Tennessee Memphis, TN	Dental PIE I (Saturday)	February 13, 2016
West Virginia University Morgantown, WV	Dental PIE II (Friday & Saturday)	February 12-13, 2016
West Virginia University Morgantown, WV	Hygiene (Saturday)	February 13, 2016
Virginia Commonwealth University Richmond, VA	Dental PIE I (Saturday)	February 20, 2016
University of Kentucky Lexington, KY	Dental PIE I (Saturday)	March 12, 2016
Meharry Medical College Nashville, TN	Dental PIE I (Saturday)	March 26, 2016
Medical University of South Carolina Charleston, SC	Dental PIE II (Friday & Saturday)	March 25-26, 2016
Virginia Commonwealth University Richmond, VA	Dental PIE II (Friday & Saturday)	April 1-2, 2016
Virginia Commonwealth University Richmond, VA	Hygiene (Friday & Saturday)	April 1-2, 2016
University of Tennessee Memphis, TN	Dental PIE II (Friday & Saturday)	April 8-9, 2016
University of Tennessee Memphis, TN	Hygiene (Friday & Saturday)	April 8-9, 2016
Greenville Technical College Greenville, SC	Hygiene (Friday & Saturday)	April 8-9, 2016
University of Louisville Louisville, KY	Dental Complete (Friday & Saturday)	April 15-16, 2016
University of Louisville Louisville, KY	Hygiene (Friday & Saturday)	April 15-16, 2016
BridgeValley Comm. & Tech. College Montgomery, WV	Hygiene (Friday)	April 15, 2016
Western Kentucky University Bowling Green, KY	Hygiene (Friday & Saturday)	April 22-23, 2016
University of Kentucky Lexington, KY	Dental PIE II (Friday & Saturday)	April 22-23, 2016
Bluegrass Comm. & Tech. College Lexington, KY	Hygiene (Friday & Saturday)	April 22-23, 2016

University of Arkansas for Medical Sci. Little Rock, AR	Hygiene (Friday & Saturday)	April 29-30, 2016
Midlands Technical College West Columbia, SC	Hygiene (Friday & Saturday)	April 29-30, 2016
Meharry Medical College Nashville, TN	Dental PIE II (Friday & Saturday)	May 6-7, 2016
Medical University of South Carolina Charleston, SC	Dental Complete (Friday & Saturday)	May 6-7, 2016
Ozarks Technical College Springfield, MO	Hygiene (Friday & Saturday)	May 6-7, 2016
Wytheville Community College Wytheville, VA	Hygiene (Friday & Saturday)	May 6-7, 2016
Old Dominion University Norfolk, VA	Hygiene (Friday & Saturday)	May 13-14, 2016
Virginia Commonwealth University Richmond, VA	Dental Complete (Friday & Saturday)	May 20-21, 2016
Virginia Commonwealth University Richmond, VA	Hygiene (Friday & Saturday)	May 20-21, 2016
Tennessee State University Nashville, TN	Hygiene (Friday & Saturday)	May 20-21, 2016
University of Arkansas, Fort Smith Fort Smith, AR	Hygiene (Friday & Saturday)	May 27-28, 2016
University of Tennessee Memphis, TN	Dental Complete (Friday & Saturday)	June 3-4, 2016
University of Tennessee Memphis, TN	Hygiene (Friday & Saturday)	June 3-4, 2016
Midlands Technical College West Columbia, SC	Hygiene (Friday)	June 10, 2016
Remington College Nashville, TN	Hygiene (Friday & Saturday)	July 22-23, 2016
Concorde Community College Memphis, TN	Hygiene (Friday & Saturday)	September 9-10
Meharry Medical College Nashville, TN	Dental Complete (Friday & Saturday)	October 7-8, 2016
Tennessee State University Nashville, TN	Hygiene (Friday & Saturday)	October 14-15, 2016
University of Tennessee Memphis, TN	Dental Complete (Friday & Saturday)	December 2-3, 2016
Remington College Nashville, TN	Hygiene (Friday & Saturday)	December 16-17, 2016

Note: Sectional Exams are available at any Dental Exam Site. Complete Exams are allowed at any Dental PIE II Exam Site.

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions (As of August 28, 2015)**

Board	Board of Dentistry	
Chapter		**Action / Stage Information**
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Requirement for jurisprudence examination [Action 4364] NOIRA - *At Governor's Office for 100 days*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Requirement for capnography for monitoring anesthesia or sedation [Action 4411] NOIRA - *At DPB for 9 days* *Action was deemed not appropriate for Fast-track* *NOIRA filed to replace Fast-track*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Recognition of Commission on Dental Accreditation of Canada [Action 4387] Fast-Track - *At Secretary's Office for 11 days*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252] Final - *At Governor's Office for 261 days*

Agenda Item: Regulatory Action – Reduction in Renewal Fees

Included in the agenda package:

- Copy of letter from the Department Director on revenue and expenditure projections
- Analysis from Budget Manager on draft fee reduction
- Proposed regulations for one-time renewal fee reduction

Staff Note:

This action is exempt from the requirements of the Administrative Process Act except it is subject to the Register Act (will become effective 30 days after publication)

6. Regulations of the regulatory boards served by (i) the Department of Labor and Industry pursuant to Title 40.1 and (ii) the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1 that are limited to reducing fees charged to regulants and applicants.

Action:

Adoption of draft regulations for one-time fee reduction

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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MEMORANDUM

TO: Members, Board of Dentistry

FROM: David E. Brown, D.C. DB

DATE: May 6, 2015

SUBJECT: Revenue, Expenditures, & Cash Balance Analysis

Virginia law requires that an analysis of revenues and expenditures of each regulatory board be conducted at least biennially. If revenues and expenditures for a given board are more than 10% apart, the Board is required by law to adjust fees so that the fees are sufficient, but not excessive, to cover expenses. The action by the Board can be a fee increase, a fee decrease, or it can maintain the current fees.

The Board of Dentistry ended the 2012 - 2014 biennium (July 1, 2012, through June 30, 2014) with a cash balance of $2,904,386. Current projections indicate that revenue for the 2014 - 2016 biennium (July 1, 2014, through June 30, 2016) will exceed expenditures by approximately $661,229. When combined with the Board's $2,904,386 cash balance as of June 30, 2014, the Board of Dentistry projected cash balance on June 30, 2016, is $3,565,615.

We recommend the Board consider a one-time renewal fee decrease. Please note that these projections are based on internal agency assumptions and are, therefore, subject to change based on actions by some other state agencies, the Governor and\or the General Assembly.

We are grateful for continued support and cooperation as we work together to manage the fiscal affairs of the Board and the Department.

Please do not hesitate to call me if you have questions.

CC: Sandra Reen, Executive Director
Jaime Hoyle, Chief Deputy Director
Jason Brown, Deputy Director of Administration
Charles E. Giles, Budget Manager
Elaine Yeatts, Senior Policy Analyst

Board of Dentistry
Draft One-time Fee Reduction
FY16

Renewal Fee Types	Number of Licensees (a)	FY16 Projected Renewal Revenue	Current Fees		One-Time Fee Reduction (b)	FY16 Revised Projected Renewal Revenue	Difference
Cosmetic Procedure Certification	33	3,300	$100		$75	2,475	
Dental Full Time Faculty, Current Active	14	3,990	285		210	2,940	
Dental Hygienist, Current Active	5,422	406,650	75		55	298,210	
Dental Hygienist, Current Inactive	203	8,120	40		30	6,090	
Dentist, Current Active	6,804	1,939,140	285		210	1,428,840	
Dentist, Current Inactive	323	46,835	145		105	33,915	
Oral/Maxillofacial Surgeon Registration, Current Active	261	45,675	175		130	33,930	
Conscious/Moderate Sedation	197	19,700	100		75	14,775	
Dental Assistant II	10	500	50		35	350	
Deep Sedation/General Anesthesia	53	5,300	100		75	3,975	
Enteral Conscious/Moderate Sedation	161	16,100	100		75	12,075	
Mobile Dental Facility	13	1,950	150		110	1,430	
Dental Restricted Volunteer	14	210	15		10	140	
Temporary Resident	57	1,995	35		25	1,425	
Dental Hygienist Restricted Volunteer	1	15	15		10	10	
Total	13,566	2,499,480				1,840,580	
Difference between current fees and proposed one time fee reduction							658,900

(a) as of August 25, 2015

(b) approximately 25% one time fee reduction

Project 4497 - none

BOARD OF DENTISTRY

Fee reduction

Part II

Renewal and Fees

18VAC60-20-20. Renewal and reinstatement.

A. Renewal fees. Every person holding an active or inactive license or a dental assistant II registration shall, on or before March 31, renew his license or registration. Every person holding a temporary resident's license, a restricted volunteer license to practice dentistry or dental hygiene, or a temporary permit to practice dentistry or dental hygiene shall, on or before June 30, request renewal of his license.

1. The fee for renewal of an active license or permit to practice or teach dentistry shall be $285, and the fee for renewal of an active license or permit to practice or teach dental hygiene shall be $75. The fee for renewal of registration as a dental assistant II shall be $50.

2. The fee for renewal of an inactive license shall be $145 for dentists and $40 for dental hygienists. The fee for renewal of an inactive registration as a dental assistant II shall be $25.

3. The fee for renewal of a restricted volunteer license shall be $15.

4. The application fee for temporary resident's license shall be $60. The annual renewal fee shall be $35 a year. An additional fee for late renewal of licensure shall be $15.

B. Late fees. Any person who does not return the completed form and fee by the deadline required in subsection A of this section shall be required to pay an additional late fee of $100 for dentists with an active license, $25 for dental hygienists with an active license, and $20 for a dental assistant II with active registration. The late fee shall be $50 for dentists with an inactive license, $15 for dental hygienists with an inactive license, and $10 for a dental assistant II with an inactive registration. The board shall renew a license or dental assistant II registration if the renewal form, renewal fee, and late fee are received within one year of the deadline required in subsection A of this section.

C. Reinstatement fees and procedures. The license or registration of any person who does not return the completed renewal form and fees by the deadline required in subsection A of this section shall automatically expire and become invalid and his practice as a dentist, dental hygienist, or dental assistant II shall be illegal.

1. Any person whose license or dental assistant II registration has expired for more than one year and who wishes to reinstate such license or registration shall submit to the board a reinstatement application and the reinstatement fee of $500 for dentists, $200 for dental hygienists, or $125 for dental assistants II.

2. With the exception of practice with a restricted volunteer license as provided in §§ 54.1-2712.1 and 54.1-2726.1 of the Code of Virginia, practicing in Virginia with an expired license or registration may subject the licensee to disciplinary action by the board.

3. The executive director may reinstate such expired license or registration provided that the applicant can demonstrate continuing competence, that no grounds exist pursuant to § 54.1-2706 of the Code of Virginia and 18VAC60-20-170 to deny said reinstatement, and that the applicant has paid the unpaid reinstatement fee and any fines or assessments. Evidence of continuing competence shall include hours of continuing

education as required by subsection H of 18VAC60-20-50 and may also include evidence of active practice in another state or in federal service or current specialty board certification.

D. Reinstatement of a license or dental assistant II registration previously revoked or indefinitely suspended. Any person whose license or registration has been revoked shall submit to the board for its approval a reinstatement application and fee of $1,000 for dentists, $500 for dental hygienists, and $300 for dental assistants II. Any person whose license or registration has been indefinitely suspended shall submit to the board for its approval a reinstatement application and fee of $750 for dentists, $400 for dental hygienists, and $250 for dental assistants II.

E. For the renewal of licenses, registrations, certifications, and permits in 2016, the following fees shall be in effect:

Dentist - active	$210
Dentist – inactive	$105
Dental full-time faculty	$210
Dental hygienist – active	$55
Dental hygienist – inactive	$30
Dental assistant II	$35
Temporary resident	$25
Dental restricted volunteer	$10
Dental hygienist restricted volunteer	$10
Oral/Maxillofacial surgeon registration	$130
Cosmetic procedure certification	$75
Conscious/moderate sedation certification	$75
Deep sedation/general anesthesia	$75
Mobile dental clinic	$110

Agenda Item: Response to Petition for Rulemaking

Included in your agenda package are:

Copy of petition from Terry Dickinson (for the VDA) to adopt the ADA Code of Ethics

Copy of comments on petition

Copy of ADA Code of Ethics

Chart showing crosswalk between Principles in Code and the Code of Virginia and Regulations of the Board of Dentistry

Staff Note:

There was a comment period on the petition from July 13, 2015 to August 12, 2015.

Board action:

The Board may accept the petitioner's request for amendments to regulations and initiate rulemaking by adoption of a Notice of Intended Regulatory Action

OR

The Board may reject the petitioner's request for amendments. If the petition is rejected, the Board must state its reasons for denying the petition.

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,) Dickinson, Terry D.		
Street Address 3460 Mayland Court #110	**Area Code and Telephone Number** 804-288-5750	
City Henrico	**State** Virginia	**Zip Code** 23233
Email Address (optional)	**Fax (optional)**	

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.

18VAC 60-20-170

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

The ADA "Code of Ethics" is the gold standard for dental professional conduct. Currently, nine states have adopted, by reference, the ADA's "Principles of Ethics and Code of Professional Conduct" as the ethical standards for dentists. Currently the Virginia Board of Dentistry endorses the ADA CDT Codes and the ADA Guidelines on Sedation. Since the Guidelines on Sedation, the CDT Codes and ADA's "Code of Ethics" are universally accepted as the gold standards for the profession, the Virginia Dental Association would urge the Virginia Board of Dentistry to adopt, as part of the dental regulations (18 VAC 60-20-170), the ADA's "Principles of Ethics and Code of Professional Conduct".

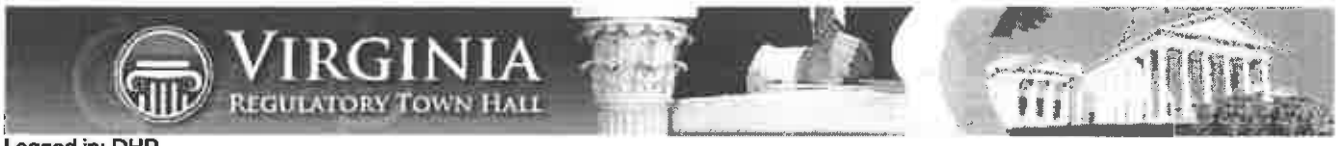
3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference.

Re: 54.1-2400

Signature: **Date: June 10, 2015**

July 2002

Virginia.gov Agencies | Governor



Logged in: DHP

Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter **Regulations Governing Dental Practice [18 VAC 60 - 20]**

All good comments for this forum Show Only Flagged

Next Back to List of Comments Page 1 of 2 50 comments per page go

Commenter: Richard F Roadcap DDS * 7/14/15 1:25 pm

ADA Code of Ethics

If other states can enact this Code, so can the Commonwealth of Virginia. It would give the Board of Dentistry clarity and purpose in decision making, enforcement, and sanctions.

Commenter: Steven Forte DDS * 7/19/15 5:25 pm

ADA Code of Ethics

I strongly support the request to have the ADA Code of Ethics adopted as a guide by which the Board of Dentistry can follow. This is crucial to the integrity of our profession to be able to have this as our guide. It will provide the foundation for all members to understand, to be able to see those who are clearly not abiding by the Code and to allow the BOD to establish sanctions for those infractions that may occur.

Commenter: William J Bennett, D.D.S. * 7/19/15 8:35 pm

Adaption of American Dental Assocition Code.

The American Dental Association's Principles of Ethics and Code of Professional Conduct is considered the Gold Standard for the entire dental profession. The contents are utillzed entirely or in part by most, if not all, dental teaching institutions and dental professional organizations in the United States, if not the world. Adoption by the Virginia Board of Dentistry to utilze the ADA Code would have numerous benefits. Dental professionals are schooled on the ADA's Principles and Code. It is widely regarded and easily accessible. The ADA and other groups promote and uphold it. Education on the Code is ongoing. Over 60% of dentists here in Virginia as Virginia Dental Associaton members pledge each year to uphold this professional standard. Utiilizing the Code as a guide or entirely would reduce Board workload and licencee confusion regarding what is the position of the VA Dental Board. The Board needs to provide regulations and guidelines that are clear and easily understood by all concerned. At present, licensees as well as Board members and staff do not have that available. The ADA standard is well known to all persons that have recieved any formal dental education or certificate to practice in dentistry. Utililzing the ADA's professional standards material, which is done elsewhere and widely accepted,, is urged for serious consideration and adoption.

Respectfully, William J. Bennett, D.D.S.

Commenter: Richard L Taliaferro, DDS, Virginia Dental Association * 7/20/15 4:02 pm

Amend 18VAC 60-20-170 to include the ADA Code of Ethics as a guidance document

I am writing in favor of amending the regulation. Dentistry as a profession has until recently ranked at the top in terms of trust by the public when compared to other professionals. There has been a decline in our standing over the past several years. All dentists should be encouraged and in fact regulated to perform to high ethical standards. The ADA Code of Ethics is an excellent guide to ethical behavior that our profession has practiced throughout the years. Unfortunately we have seen some dentists throughout the Commonwealth act in ways that degrade themselves and our profession. Adherence to the ADA Code of Ethics would help greatly in deterring the problems we face. Other states have adopted the ADA Code of Ethics into their regulations. Virginia should do the same.

Commenter: Thomas J. DeMayo, DDS * 7/21/15 6:03 pm

Adoption of the ADA code on Ethics by the VA Board of Dentisty

The ADA Principles of Ethics and the Code of Professional Conduct is a benchmark code that governs professional conduct in dentistry and therefore should be adopted in its entirety by the VA Board of Dentistry.

Commenter: Scott H Francis, DDS * 7/21/15 9:53 pm

Adoption of ADA Code of Ethics

The incorporation of the ADA Principles of Ethics and Code of Professional Conduct into the Dental Practice Regulations of the Commonwealth of Virginia is an important step in the establishment of a foundation for recognizing ethical conduct and exposing unethical conduct by dental practitioners. The ability of those who try to regulate proper ethics is difficult in the changing world of no-holds-barred marketing and patient overtreatment. It is the patient who suffers by virtue of the misinformation and fraudulent acts of the few unethical providers. Adoption of the ADA Code would provide a framework around which the Board can both build sound ethical guidelines and provide the appropriate steps for management and adjudication of unethical behavior.

Commenter: VDA * 7/23/15 10:00 am

Using the ADA Code of Ethics in Virginia Dental Regulations

I am writing in favor of amending the regulation to adapt the ADA Code of Ethics. For a number of year's there hasn't been anything in the Regulations concerning ethics and I feel this needs to be addressed. The ADA Code is clear and concise. It states what is ethically important and would provide something concrete for Virginia dentists. There is precedence to use the ADA Code given the Board of Dentistry has adapted ADA language for CDT coding and sedation guidelines. Other

states have done the same.

Commenter: Lanny R. Levenson, DDS * 7/23/15 11:29 am

Using the ADA Code of Ethics in Virginia Regulations

I am reposting my comment due to a mistake on a comment which appears as "VDA." It was my intent to disclose I am a member of the VDA and not the VDA. My previous comment is as follows:
Using the ADA Code of Ethics in Virginia Dental Regulations

I am writing in favor of amending the regulation to adapt the ADA Code of Ethics. For a number of year's there hasn't been anything in the Regulations concerning ethics and I feel this needs to be addressed. The ADA Code is clear and concise. It states what is ethically important and would provide something concrete for Virginia dentists. There is precedence to use the ADA Code given the Board of Dentistry has adapted ADA language for CDT coding and sedation guidelines. Other states have done the same.

Commenter: Paul T. Olenyn DDS Ltd. * 7/24/15 12:46 pm

Regulations Governing Dental Practice

I am in favor of the Board of Dentistry adopting the American Dental Associations "Principles of Ethics and Code of Professioal Conduct" as Virginia's ethical standard for dentists.

Commenter: Dr Monroe Harris * 7/27/15 10:54 am

VA Board of Dentistry/ fee splitting

I support the ADA Principles of Ethics and Code of Conduct.

Commenter: Michael E Grosso DDS * 7/28/15 5:34 pm

Ethics

We should adopt the ADA Code of Ethics as part of our bylaws.

Commenter: Virginia Society of Oral & Maxillofacial Surgeons (VSOMS) * 7/31/15 10:27 am

Adoption of ADA Principles of Ethics...

The Virginia Society of Oral & Maxillofacial Surgeons (VSOMS) supports both the *ADA Principles of Ethics and Code of Professional Conduct* and the *AAOMS Code of Professional Conduct* as they both capture all areas of ethical behavior for dentists and oral and maxillofacial surgeons. To

that point, the VSOMS agrees that the *ADA Principles of Ethics and Code of Professional Conduct* should be adopted by the VA Board of Dentistry so that ethical standards for dentists and oral and maxillofacial surgeons are addressed in the regulations.

Commenter: David C. Sarrett, VCU School of Dentistry * 8/4/15 12:54 pm

Adoption the ADA Principles of Ethics and Code of Professional Conduct

As dean of the VCU School of Dentistry, we support amending of regulations for unprofessional conduct to adopt the *ADA Principles of Ethics and Code of Professional Conduct*. We use this code in the admissions, promotion, and graduation evaluation of our dental students. It is listed in all course syllabi as a guiding document.

Commenter: Michael J. Link, D.D.S., President of the Virginia Dental Association * 8/4/15 1:02 pm

Endorsing the ADA's Principles of Ethetics and Code of Professional Conduct

I encourage the approval of the petition for rule-making to the Board of Dentistry to have the Board endorse the ADA Principles of Ethics and the Code of Professional Conduct. Currently, the Board of Dentistry already endorses the ADA's sedation guidelines and the ADA's CPT codes. Having this type of precedence with other endorsements from the ADA will only help the Board deal with unethical behavior and fee splitting by licensed Dentists. If the Board of Dentistry can endorse theses other guidelines from the ADA, then there is no reason they should not be able to endorse these principles of Ethics. Currently, there are 9 other states that currently endorse these principles of ethics in their regulations. All other organizations reference the ADA's ethical guidelines which are considered the gold standard for Dentistry. Passing this petition and having the document in regulation will be ideal.

Commenter: B. Ellen Byrne, Senior Associate Dean, VCU School of Dentistry * 8/4/15 1:31 pm

ADA Principles of Ethics & Code of Professional Conduct

The Commission on Dental Accreditation (CODA) requires that our "Graduates must be competent in the application of the principles of ethical decision making and professional responsibility." We use these Principles in all course work and cite this work for compliance with the afore mentioned standard. These should be adopted by the Board of Dentistry.

Commenter: Jim Burns, Chairman & Professor, VCU Oral Diagnostic Sciences * 8/4/15 2:00 pm

In support of the ADA Principles of Ethics and Code of Professional Conduct

For the last few years we have used the ADA Principles of Ethics with our incoming freshman dental students as we discuss the summer reading book. Additionally the ADA Principles of Ethics and Code of Professional Conduct are listed in all of our course syllabi and used sporadically whenever a "cheating or lying case" comes before the VCU Student Conduct & Academic Integrity group (AKA "Honor System"). I highly endorse the acceptance of the ADA Principles as all dentists throughout the US should have a unified policy.

Commenter: Carol N. Brooks, D.D.S.; Associate Professor, VCU School of Dentistry * 8/4/15 2:34 pm

ADA Code of Ethics and Code of Professional Conduct

I would like to strongly suggest that the ADA Code of Ethics and Code of Professional Conduct be the standard for the profession of dentistry and provide the Board of Dentistry with an appropriate, clear and precise standard for the professional conduct for Virginia dentists. Nothing less would provide a self-governing profession, such as dentistry, with the level of integrity that would protect the future of our profession.

Commenter: David Black, Virginia Dental Association Board * 8/4/15 7:44 pm

Adoption of ADA Code of Ethics

I think it makes sense to adopt the ADA code of ethics because it is the standard for many state's Boards, and there is nothing in it that is contrary to what you are trying to do. I think since so many other ADA guidance documents are used in other areas, that this sets a standard that would make you want to use it also. We don't need to remake all codes, since there are already universal acceptance of this one. Thank you.

Commenter: Richard Archer VCU School of Dentistry * 8/5/15 9:08 am

Adoption of ADA Code of Ethics and Professional Conduct

As the Assistant Dean for Clinical Education at the VCU School of Dentistry I support the adoption of the ADA Code of Ethics and Professional Conduct. This document serves as an outstanding guide for our students as they develop into dental professionals. It makes sense to continue to have this code guide them through their professional careers.

Commenter: Dr. Kasey Farah, DDS Affordable Dentures * 8/5/15 3:26 pm

Opposition to incorperating the ADA Code of Ethics

I oppose this petition for rulemaking because the ADA Code of Conduct is an evolving document.The Code of Ethics contains advisory opinions that materially change the way the code is interpreted.Virginia should not give the force of law to something that can be easily modified by a private entity.

Commenter: Dr Ted Sherwin * 8/5/15 5:11 pm

Adaption of the Principles of Ethics and Code of Professional Conduct of the American Dental Associa

The ADA "Code of Ethics" is the gold standard for dental professional conduct. At last report, the "Principles of Ethics and Code of Professional Conduct" of the American Dental Association is adopted by reference as the ethical standards for dentists, and applies to all dentists in 9 states. Currently the Virginia Board of Dentistry endorses the ADA CDT Codes and the ADA Guidelines on Sedation. Since the Guidelines on Sedation, the CDT Codes, and ADA's "Code of Ethics" are

universally accepted as the gold standards for the Profession, but the Board has not endorsed the "ADA Code of Ethics", I support the VDA Petition to the Board for endorsing the ADA "Principles of Ethics and Code of Professional Conduct".

We dentist in Virginia need and desire endorsement of the ADA "Code of Ethics" to guide us in our ethical behavior during this complex and challanging time.

Commenter: Steven M Hedges, DMD, PC * 8/5/15 5:41 pm

Opposition to adoption of ADA code of ethics

Primarily my opposition stems from the fact that the ADA code is subject to too frequent change and is not drafted by elected legislators. Virginia dental law should be drafted according to our needs by Virginia citizens who have been elected to their office. The ADA is not a legislative body and should not be granted that authority.

Commenter: Bruce R. Hutchison, DDS * 8/5/15 6:02 pm

Board of Dentistry Adoption of ADA's "Principles of Etics and Code of Professional Conduct"

The ADA "Principles of Ethics and Code of Professionl Conduct" should be adopted by the Board of Dentistry for the following resaons:.

1. It is the "gold standard" of ethical conduct in dentistry

2. It has been adopted, by reference, in 14 other states.

3.It is acceopted by the Academy of General Dentistry, the second largest dental organization in the US, as it's Code of Ethics.

4. The ADA recognized specialty organizations use it, with the exception of AAOMS and AAO.

5. the Va Board of Dentistry asks dentists to practice within th estandards of ethics for dentists and dental hygienists, yet provides no guideance or reference to follow.

6. The VA Board of Dentistry endorses the ADA CDT Codes

7. The VA Board of Dentistry endorses the ADA Guideleines on sedation.

8. The VA Board of dentistry endorses the ADA recognized dental specialties.

Not having a Code of Ethics as part of the Board's guidelines and yet saying the Board will enforce sanctions on behavior that is not within the standards of ethics is extremely misguided and confusing. This does not serve the public but rather confuses those dentists the board should be trying to help provide better and more ethical treatment of their patients. the Board could create it's own Code but that would take time and resourses teh board simpley does not have. The ADA's Code is nearly 150 years old and is time tested. It is reviewed and refined by a Council of 17 dedicated dentists, a staff of 3 or more and the ADA legal department. Any changes must be approved by the ADA House of Delegates which represents obver 65% of all dentists in the US. This is the gold standard for ethics in dentistry.

The ADA, the VDA, and the VA Board of Dentistry really are after the same thing, the best possible care of our patients, provided in a competent and ethical manner. We are on the same team, and adopting this Code of Ethics will help dentists in Virginia provde better and more ethical care to the citizens of Virginia.

Commenter: Don Cherry Currently President of the Peninsula Dental Society Virginia * 8/5/15 9:24 pm

EEthical Standards

TypEthical standards of the internet should be scruitinized by the local boards of dentistry to make all dentist , not just ADA members, come into compliance or lose their license to practice dentistry. There is so much misleading and arrogant advertising that our profession has gone to the dogs of ethics with the used car salesmen. What is the purpose of an organization if it is not going to police it's dentist that are entrusted to care for the public in an ethical manner. Don Cherry
Williamsburg, Va

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

Commenter: Robert J Feild DDS , Feild Dentistry * 8/5/15 10:00 pm

ADA code of ethics

I strongly support the adoption of the ADA principles of ethics and code of professional conduct by the BOD. It is the gold standard, and I feel it reduces the chance a dentist can misunderstand their obligations to their patients and the profession. Robert J Feild DDS

Commenter: Sebastiana G Springmann DDS FAGD * 8/6/15 1:26 pm

ADA Code of Ethics

I respectfully urge the Board to adopt the same code of ethics as used by the American Dental Association. The ADA Code of Ethics is comprehensive and serves the profession while protecting the patient public. The Board would be promoting a workable guideline to which the majority of dentists already adhere.

Thank you for your consideration.

Commenter: Dr. Jennifer Alston-Sako, PC * 8/6/15 3:04 pm

I Strongly Oppose The Code of Ethics Proposal

I do not believe that this document is necessary since I have sought to abide by a code of ethical behavior since receiving my dental degree and license in 1995. I do not appreciate over-regulation and this document has that appearance to me. The Virginia Board of Dentistry should have sole jurisdication over dentist conduct and practice related issues.

Commenter: William Betzhold * 8/7/15 7:51 am

For the ADA COD

I would strongly support the adoption of the ADA principles of ethics and code of professional conduct by the VA BoD. I believe it to be the gold standard and adoption would alleviate two different sets of principles.

Commenter: Gerald Awadzi * 8/7/15 9:47 am

Adoption of ADA code of ethics

The Virginia Board of Dentistry should not adopt the ADA Code of Ethics because it would be giving its authority away to a national organization. Further, the ADA Code is an ever evolving document based on advisory opinions of the ADA. It could be a different document tomorrow without any input from Virginians. In addition, the person asking the Board to adopt the ADA Code doesn't provide a basis for its adoption. I think most Virginia dentists currently operate in an ethical manner and don't see how adopting this national code would benefit Virginians. If Virginia needs a Code of Conduct, it should be developed by Virginians.

This petition for rulemaking should also be denied because it is an attempt to circumvent the legislature. The ADA Code of Ethics prohibits fee-splitting. After the board was denied approval by the Governor's office to pursue legislation on this topic, it would be disappointing if the Virginia Board unilaterally imposed a ban via rulemaking. If the board cannot gain the support of the Governor to pursue legislation on fee-splitting, it should not attempt to do so in a backdoor manner as the petitioner proposes.

Please reject the petition.

Commenter: Dental One Associates * 8/7/15 11:02 am

Opposition to incorporating the ADA Code of Ethics

I oppose this adoption of the ADA code because I see the code of conduct as an evolving document and should be evaluated and considered in the future locally within Virginia. Future decisions of the ADA could differ with those here in Virginia.

Commenter: Mayer G. Levy, DDS * 8/7/15 11:22 am

Ethics

I request that the Board of Dentistry enact a CODE OF ETHICS based on the American Dental Association Code of Ethics. The Code of Ethics has been adopted by the American College of Dentists, (probably) all schools of dentistry in the United States of America, included the V.C.U. School of Dentistry, located in Richmond, Virginia.

Commenter: Marvin Becker D.D.S * 8/7/15 11:28 am

Opposition to incorporating the ADA code of Ethics

Adopting the ADA code is not in the best interest of Virginia practitioners. Ceding these standards to the national organization is shortsighted as time evolves we need to control the changes that meet our own local needs and not be governed by outside forces.

Commenter: Gerald M Benson Jr , DDS * 8/7/15 1:21 pm

Opposition comment

I would appreciate consideration of the following comments pertaining to my oppositions on this petition for rulemaking. It is my opinion the board should deny this petition for rulemaking because it takes away its own authority. The ADA's clinical and educational guidelines are very useful, but on topics such as ethics, Virginia's dental community should work together on standards if it is proven that such a code is needed. The person asking the board to adopt the ADA Code doesn't give any reason why the board should do it other than he thinks it is a good idea. The requester identifies no situation that this request is intended to address. Setting this type of precendent undermines our current code and is counter to the self regulation that defines a profession.

Thank you for your consideration.

Commenter: Dr. Qais K Musmar, DDS * 8/7/15 3:01 pm

Opposition to incorporating the ADA Code of Ethics

This petition for rulemaking avoids an important conversation and should be rejected. For the petitioner to file such a petition, they must believe there is an ethics issue in the practice of dentistry in Virginia. If that is the case, the dental community in Virginia would be better served by developing its own set of ethics guidelines and could benefit from the discussion of important issues that comes with the process.

Commenter: Navneet Dhillon, DDS * 8/7/15 3:08 pm

Ethics

I am in opposition to this petition for rulemaking because I do not believe the practice of dentistry in Virginia has an ethics issue.

Commenter: Jeffrey Miller, DDS; Dental Care Alliance * 8/7/15 4:04 pm

Opposing the VDA's Petition

I truly believe that this petition should be denied. The board should not be permitted to circumvent the legislation. Our code of ethic prevents fee splitting. Please reconsider this.

Commenter: Robert Berman, DDS; Dental Care Alliance * 8/7/15 4:08 pm

VDA's Petition

I suggest that this petition be evaluated at the most profound level as to the need for such legislation. If the patitioner believes that we have such an ethical problem in Virginia, we should re-eval and set our our guidelines statewide with full consideration to all parties.

Commenter: Thomas Lin, DMD; Dental Care Alliance * 8/7/15 4:54 pm

Ethics

I strongly oppose this proposal.

Commenter: Saeid Zeiaei DDS * 8/7/15 10:14 pm

Opposing the VDA's Petition

I oppose adopting ADA Code of Ethics and Conduct. ADA is a National Organization. If there are Ethical issues with practice of Dentistry in Virginia, then any Code of Conducts should be discussed and developed by Virginians.

Commenter: Jamiah Dawson, DDS PC * 8/9/15 6:32 pm

Opposition to incorporating the ADA Code of Ethics

I oppose this rule making petition because I'm not confident the ADA can appropriately make decision for me as a dentist practicing in the State of Virginia. The organization is in Chicago, Illinois and has no jurisdiction in my state nor does it have the best interest for the voters.

Also, it should be denied because of the prohibition of fee splitting. I am not willing to have a set fee for services that were not rendered during inclement weather, or other absence to my practice. I am comfortable with variable fees set to variable changes in my practice.

Dr Jamiah Dawson

Commenter: Dr. Mesfin Zelleke PC * 8/9/15 6:57 pm

Opposition to incorporating the ADA code of ethics.

I vehemently oppose this petetion to adapt the ADA code of ethics, because it is my firm belief any issues concerning Virginia must be resolved by the Virginia Dental Board and not by an outside agency. Reject this petetion.

Commenter: Dr. Robert Allen * 8/10/15 7:35 am

Adaption of ADA code of ethics by BOD

I support adaption of the ADA code of ethics by the BOD. Adoption by the Virginia Board of Dentistry to utilze the ADA Code would have numerous benefits. Dental professionals are schooled on the ADA's Principles and Code. It is widely regarded and easily accessible. The ADA and other groups promote and uphold it. Education on the Code is ongoing. Over 60% of dentists here in Virginia as Virginia Dental Associaton members pledge each year to uphold this professional standard. Utiilizing the Code as a guide or entirely would reduce Board workload and licencee confusion regarding what is the position of the VA Dental Board. The Board needs to provide regulations and guidelines that are clear and easily understood by all concerned. At present, licensees as well as Board members and staff do not have that available.

Commenter: Dr. Lynn Livingston * 8/10/15 10:45 am

Opposition to Adopting ADA Code of Ethics

By adopting the ADA Code of Ethics in blanket fashion, the Board is not satisfying its responsibilities, and in light of the recent US Supreme Court opinion in North Carolina Board of Dental Examiners v FTC, raises the specter that the State of Virginia is delegating control over the dental market to a non-sovereign actor and active market participants for anti-competitive purposes. The Board of Dentistry should not adopt the ADA Code of Ethics because it would be giving its authority away to a national organization. If Virginia needs a Code of Conduct, Virginians should develop it. The ADA Code's explanation recognizes ethical obligations often exceed legal duties, stating that the Code is an evolving document and by its very nature cannot be a complete articulation of all ethical [or legal] obligations. The ADA Code is the result of an ongoing dialogue between the dental profession and society, and as such, is subject to continuous review. Although ethics and the law are closely related, they are not the same. Ethical obligations may–and often do–exceed legal duties. Adopting the ADA Code of Ethics and Conduct would be a mistake by the board and the petition for rule making should be defeated

Commenter: Jackie Lanigan, Konikoff Dental Associates, Inc. * 8/10/15 10:55 am

Opposition to incorporating the ADA Code of Ethics

To Whom it May Concern,

I feel that this rule making petition is unnecessary because, as a licensed dentist, I am already subject to the ADA Code of Ethics by virtue of my membership in the that organization. Any rule would be superfluous and potentially costly to the state.

Please consider adopting our own code of ethics that we can vote on.

Commenter: Dr. Eric Lee * 8/10/15 11:54 am

Opposing Code of Ethics Proposal

I strongly oppose in adopting the ADA's Ethics proposal because in my opinion, there is no ethics issue regarding practice of dentistry in VA.

Commenter: Silvija Valleru, Dental Care Alliance * 8/10/15 1:56 pm

Opposition to this rule making petition.

If the Board of Virginia thinks such a code needs to be adopted, then it should develop its own code with input from virginia dentists and citizens.

Commenter: Michele M. Mattioli, Konikoff Dental Assc, Inc * 8/10/15 2:47 pm

Opposition to adopting the ADA Code of Ethics

I am in opposition to this petition for rulemaking because i do not believe the practice of dentistry in Virginia has an ethical issue. If Virginia needs a Code of Conduct, it should be developed by Virginians.

Commenter: Conrad Caleb, Konikoff Dental Assc, Inc * 8/10/15 2:54 pm

Opposition to adopting the A

Commenter: Conrad Caleb, Konikoff Dental Assc, Inc. * 8/10/15 3:04 pm

Opposition to adopting the ADA Code of Ethics

To whom it may concern,

The Board of Dentistry should not adopt the ADA Code of Ethics because it would be giving its authority away to a national organization. These kinds of rules need to be set by Virginia dentists and Virginia citizens. I think most Virginia dentists currently operate in an ethical manner and don't see how adopting this national code. If Virginia needs a Code of Conduct, it should be developed by Virginians. Please reject the petition.

* Nonregistered public user

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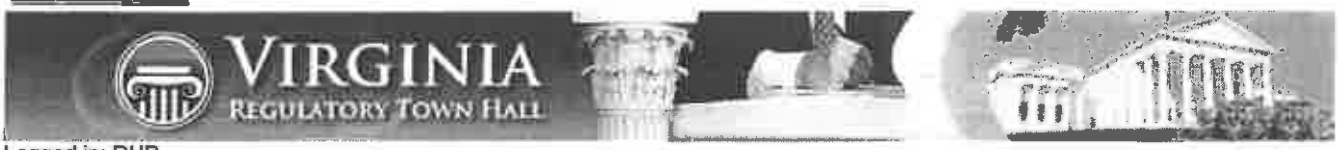

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Board **Board of Dentistry**

Chapter **Regulations Governing Dental Practice [18 VAC 60 - 20]**

All good comments for this forum Show Only Flagged

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Commenter: David B. Konikoff - Konikoff Dental Associates, Inc. * 8/10/15 3:11 pm

Opposition to incorporating the ADA Code of Ethics

The Virginia Board of Dentistry should reject the petition of adopting the ADA Code of Ethics because it would be not only be giving its authority away to a national organization, but it would lead the ADA to believe that they should be allowed to set these kinds of rules nationwide, leaving both the Virginia Board of Dentistry and the dentists who practice under that Board of Dentistry with the inability to set their own rules of ethics and conduct. Most Virginia dentists currently operate in an ethical manner and don't see how adopting a national code is helpful, most importantly to the patients that are served in this state. If Virginia needs a Code of Conduct, it should be developed by Virginians, not the ADA. I kindly ask for your consideration in the rejection of this petiton.

Commenter: DENTAL CARE ALLIANCE * 8/10/15 9:47 pm

Opposing to adopting ADA code of ethics

I am submitting my opposition to this rule making petition. I feel that the regulations such as these need to be set by dentists practicing in and by the citizens of the Commonwealth of Virginia. The VA board of dentistry should not adopt the ADA code of ethics and be influenced by private entities such as ADA. While ADA's clinical and educational guidelines are meaningful, the code of conduct (or ethics) cannot be simply forced by non-governing entity such as ADA. I kindly urge the board to reject such proposal.

Thank you.

Regards,

Dr. Ramisetty DDS

Commenter: Anthony Peluso,DDS * 8/10/15 9:48 pm

Adoption of the ADA code of ethics

I speak in favor of the Virginia BOD adopting the ADA code of ethics. As tripartite members of organized dentistry we already vow to abide by this code. It only seems logical to minimize state to

state confusion by differing opinions of interpretation.Respectively submitted.

Commenter: Dr Mitra Khosravi, Dental Care Alliance * 8/10/15 10:07 pm

VDA

I do not believe the practice of dentistry in virginia has an ethic issue,so I am in opposition to this petitioner for rulemakin.

Commenter: Adenike Ogunbekun, DDS, MS; Dental Care Alliance * 8/10/15 11:35 pm

Opposition to adopting the ADA Code of Ethics

The ADA Code can be a useful framework or reference point in the development of State-level Code of Ethics. I do not support its wholesale adoption given that the peculiarities of each State are different. The contribution of key stakeholders in the State should thus weigh heavily in the development of a Virginia Code.

Commenter: Rebecca Angus, DDS; Angus Dentistry * 8/11/15 6:02 am

Adopt the ADA Code of Ethics for Virginia

I strongly support the adoption of the ADA Code of Ethics for the state of Virginia.

Commenter: Al Stenger, DDS. Drs. Stenger, Cole, Gupta and Associates * 8/11/15 7:06 am

Adoption of ADA Code of Ethics

I support the adoption of the ADA Code of Ethics and Professional Conduct because it is comprehensive, relevant, up to date and widely accepted as the gold standard for the dental profession. Developing a different code of ethics for Virginia would create unnecessary confusion for practitioners, educators, students and patients and thus would not be in the best interest of Virginia citizens.

Commenter: Frank Iuorno * 8/11/15 8:17 am

Simply use the ADA comments

In a day and age when rules and regulations are seem to be more complex than ever, it stands to reason that adoption of the ADA Ethics in VA would not only be simple, but expected. Why reinvent the wheel?

Commenter: Klostermyer DDS PhD / Advanced Dentistry of Richmond * 8/11/15 9:27 am

ADA Principles of Ethics and Code of Professional Conduct

My support is **for the adoption** of the ADA Principles of Ethics and Code of Professional Conduct as these are long time proven rules and regulations the dental community in Virginia should strive for as many more states and organizations in this country do so.

Commenter: Sarah Wilmer, DDS; Sarah C. Wilmer, DDS, PLLC * 8/11/15 9:28 am

Adoption of the ADA Code of Ethics for Virginia

As the "gold standard" for dental professional conduct, I strongly believe the VA Board of Dentistry should endorse the ADA "Code of Ethics." To not support such an important, universally accepted code regarding ethical behavior in our profession seriously concerns me. Accepting this code (as opposed to creating a new one) would alleviate the potential for most misunderstandings between the Board and practitioners, and would allow practitioners to focus on providing the best care possible to our patients.

Commenter: Dr. Robert A. Strauss, VSOMS * 8/11/15 10:41 am

Follow the ADA Guidelines

If the Board feels that a Code of Ethics is necessary, and it unfortunately is, then that Code must be uniform, fair, clearly spelled out and enforceable. The Cide must be easily accessible by all Virginia dentists and written in succinct and easily understood language. As has been pointed out previously, although the Board could create such a Code, it has neither the time nor the resources to do so. The ADA Code is a time-tested document that fits these requirements. In addition, it is something that the vast majority of practitioners in the USA have agreed are fair and reasonable and have agreed to follow. I would respectfully suggest that the aboard adopt the ADA Code of Ethics for all of Virginia.

Commenter: Dental Care Alliance * 8/11/15 11:05 am

Opposing the petitioner

I believe that if the petitioner has such a ethical problem in Virginia we shall set our own guidelines state wide.

Commenter: Dipa J Patel DDS * 8/11/15 11:51 am

Supporting petition to adopt ADA code of ethics

I support the adoption of the ADA Code of Ethics. Whether we are general dentists, oral surgeons, periodontists, endodontists, orthodontists, or pediatrtic dentists, we are all dentists first. This is a comprehensive document which guides the board as to how they shall enforce violations of the law regarding fee splitting.

Most of the "no" opinions you are seeing are coming from those who directly benefit from the practice of fee splitting. When I started my new practice, I was told by a local lab that oral surgeons and periodontists provide abutment parts to the general dentist, or pay for part of their lab bills. With a GP who may be billing for the abutment and receving partial credit for the parts or lab bill, it is quite clear that ethics are violated. We bill patients and include cost of materials within that bill. However because there are no guidelines, there is no way to enforce what one persons idea of ethics is compared with anothers. Without the clear guide from the ADA code, how can the board enforce these laws with local laboratories?

Dentistry is not just about profiting. It is about ethically and honestly providing excellent care. I strongly encourage the board to accept Terry Dickinsons petition.

Commenter: N Ray Lee, DDS * 8/11/15 12:51 pm

Supporting the Adoption of the ADA Code of Ethics for Virginia

The American Dental Association's Principles of Ethics and Code of Professional Conduct is the principal by which this profession stands in an ever changing world of ethical standards. It has been tested and proven to be effective for a nation of dental professionals who have ratified this code in multiple states. It is apparent that the Commonwealth of Virginia needs clear and concise ethical language in regulation form that will guide all dentists in the Commonwealth and benefit the patients which we serve. It is unnecessary for the Virginia Board of Dentistry to develop ethical language that already exists. The time and resources could be better utilized by the Virginia Board of Dentistry to serve the citizens of the Commonwealth in other matters. Therefore, I strongly support Dr. Dickinson's petition, and to respectfully request the Virginia Board of Dentistry amend regulations for unprofessional conduct to adopt, by reference, the Principles of Ethics and Code of Professional Conduct of the American Dental Association.

Commenter: Rohini Shah, DMD * 8/11/15 1:39 pm

Opposition to adoption of ADA Code of Ethics

I, Rohini Shah, am a Virginia dentist opposed to the petition to adopt the ADA's Code of Ethics, as it is an attempt to circumvent the legislature. In addition to this attempt, in order for a petitioner to file such a petition, there must be reason to believe there is an ethics issue in Virginia dentistry. Even if that were the case, although the ADA's clinical and educational guidelines are very useful, the tops of ethics should be developed by Virginians. Please reject the petition.

Commenter: George A. Jacobs, D.D.S. * 8/11/15 1:54 pm

Support endorsing the ADA code of ethics

Commenter: VaCora L. Rainey, DDS * 8/11/15 2:03 pm

Adoption of the ADA Code of Ethics

I support the adoption of the ADA Code of Ethics. The American Dental Association is a trusted organization with a long history of providing sound guidance for our profession. Decisions made in regards to ethics and public policy are not taken lightly. They always strive to do what's best for our patients as well as our collegues. The Commonwealth should follow the lead set forth by the ADA.

Commenter: Riffat S. Saghir, DMD * 8/11/15 2:19 pm

Opposing the VDA's petition

I believe if there is an ethical problem in Virgina we should set our own rules and guidelines by the state board rather than adopting the ADA code. I strongly oppose this petition!

Commenter: Dennis D. Gaskin * 8/11/15 2:24 pm

Opposition to adoption of ADA code of ethics

I am opposed to this rule making petition because it is unnecessary, Trying to fix something thats not broken.Also as a practicing dentist, I am already subject to ADA Code Of Ethics.

Commenter: Marcel G. Lambrechts, Jr. DDs * 8/11/15 2:36 pm

Strongly Support the Petition

NOT having a code of ethics is an issue that could harm the public. The Board of Dentistry is charged with protecting the public. Simply making up "rules" as we go along and trying to cover the bases that the unscrupulous dentists are exposing is like chasing your tail. The ADA has THOUSANDS of dentists and issues that hammered out this code of ethics. If you are against this, most likely you are not fitting in the ethical criteria set out by the ADA or have never read or seen the actual code. As Dr. Iuorno said, why reinvent the wheel? The code has already been hammered out and we just need to adopt it to protect the people of Virginia.

Commenter: Thomas Lin, DMD * 8/11/15 3:08 pm

Ethics

I strongly oppose this proposal.

Commenter: Jeffery Miller, DDS * 8/11/15 3:13 pm

Opposing the VDA's Petition

I truly believe that this petition should be denied. The board should not be permitted to circumvent the legislation. Our code of ethics prevents fee splitting. Please reconsider this.

Commenter: Robert Berman, DDS * 8/11/15 3:17 pm

VDA's Petition

I suggest that this petition be evaluated at the most profound level, as to the need for such legislation. If the patitiioner believes that we have such an ethical problem in Virginia, we should re-eval and set our guidelines statewide with full consideration to all parties.

Commenter: Adenike Ogunbekun, DDS * 8/11/15 3:38 pm

Oppose to Adopt the ADA's Code

The ADA code can be useful framework or reference point in the development of state-level code of ethics. I do not support its wholesale adoption given that the peculiarites of each state are different.The contributor of key stakeholders in the state should thus weigh heavily in the development of a VA code.

Commenter: Dr. Mitra Khosravi * 8/11/15 3:41 pm

VDA

I do not believe the practice of dentistry in Virginia has an ethic issue, so I am in opposition to this petition for rulemakin.

Commenter: Silvija Valleru, DDS * 8/11/15 3:51 pm

Opposition to this rule making petition

If the Board of Virginia thinks such a code needs to be adopted, then it should develop its own code with input from Virginia dentists and citizens.

Commenter: Dr. Chetana Ramisetty * 8/11/15 3:54 pm

Opposing the petitioner

I believe that if the petitioner has such a ethical problem in VA we shall set our own guidelines statewide.

Commenter: Dawn Hassen * 8/11/15 4:28 pm

Strongly Support the ADA code of ethics

While I appreciate the comments of the individuals that oppose this petition. Currently there is no regulation on ethics. Consequently, fee splitting is allowed in the state of Virginia. By endorsing the petition, the Board can regulate these individuals that are engaged in this type of behavior without going through the General Assembly. Therefore, I strongly support the petitioners request to endorse the ADA's code of ethics.

Commenter: Jeffrey N. Kenney, DDS * 8/11/15 5:10 pm

Support the ADA Code of Ethics

The ADA has spent a great deal of time and effort researching and writing an acceptable Code of Ethics. The ADA considered many significant factors while creating this important code. Most of the dentists in Viirginia are members of the ADA. Why reinvent the wheel when an excellent one is already available? I strongly support adopting the ADA Code of Ethics.

Commenter: Chris R. Richardson, DMD, MS * 8/11/15 8:07 pm

I am writing in favor of adoption of the ADA Code of Ethics by the Virginia Board of Dentistry.

It is of utmost importance that the Virginia Board of Dentistry adopts the ADA Code of Ethics. With the current trend of financial based production outcomes on the table in corporate dentistry and that same perspective spilling over to the solo practice arena, I think it sends a strong statement that our patients dental health is the primary concern of our dental care providers in the Commonwealth of Virginia. Dental care decisions based on informed and educated consent are the benchmark for Virginia's background and having this Code of Ethics adopted by our Board helps to solidify that position.

Commenter: Kwesi Gill DDS * 8/11/15 9:57 pm

Code of ethics

Type ovHello to whom this may concern. The reason I am writing is because I would kindly like to state my position on this ethics issue. As a licenced/practicing dentist in the state of Virginia I am opposed to this code of ethics due to the fact that there is no issue to be resolved. I employ the board to not grant the request that practitioners adhere to the ADA code of ethics. er this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Robert W. Bigelow, DDS * 8/11/15 10:19 pm

Support for adoption of the ADA Code of Ethics

The Virginia Board of Dentistry needs to adopt the ADA Code of Ethics. Let us maintain the integrity of our great profession and treat our patients with the highest standard of dental and ethical care.

Commenter: William L. Davenport * 8/11/15 11:25 pm

Code of ethics for Virginia dentists

I write in complete support of adoption of the ADA Code of Ethics as the basis of ethical practice for Virginia's dentists. For those of us who are ADA members, it is already our guidance for practice and has been so for many years. Unfortunately, our profession has fallen prey to a highly competitve environment where it can be easy to lose sight of crossing ethical lines. So often, outside influence by those promoting marketing and advertising lead our members into areas where they may not realize they are acting outside of ethical guidelines. The ADA Code of Ethics serves our patients in providing assurance that decisions are made with their best interests in mind

and not influenced by factors outside of the doctor/patient relationship.

Commenter: Bethany Oliver * 8/12/15 8:36 am

Support for the ADA code of ethics

I believe that the Board of Dentistry should endorse the code of ethics. In this day and time, there are many unethical issues facing the public. By adopting this code, the dentist will stop fee splitting and other questionable behavior. I believe the Board lacks the authority to stop this effort now. By endorsing this code into regulation, the Board will have the ablitity to give guidance to the dentists and hygienist. It also can adopt its own regulation but in the meantime what is the public to do now?

Commenter: Keely Scalizi * 8/12/15 9:02 am

Support for the ADA code of ethetics

I have read most of the comments opposing the inclusion of the ADA code of ethetics. Most of the negative comments are geared towards Virginia creating its own code of conduct. Why not endorse the ADA's code of conduct first? Is there any harm in doing so? I believe there are fee splitting issues that will be resolved when the Board of Dentistry endorses the code of ethics. I see no downside to endorsing the code as most of the opposing views. The code was created as is the gold standard for all ethical behavior among dentists. The public is protected better by endorsing this code. The Public is not protected from fee splitting if not! Trying to have a bill before the General Assembly is admirable, however, the Governor blocked this from happening. The quickest way is to endorse this code.

Commenter: Fernando J. Meza, DMD Northern Virginia Dental Society, VDA, ADA * 8/12/15 11:04 am

Adoption of the ADA Principles of Ethics and Code of Professional Conduct

I am for the adoption of the ADA Principles of Ethics and Code of Professional Conduct. It is broad and comprehensive, and is already implemented by several states. Our new and established members need a guideline to practice dentistry in an ethical manner. It also provides guidance with details on very common ethical scenarios.

Commenter: Richard Barnes, D.D.S. * 8/12/15 2:00 pm

Support inclusion of the ADA code of ethics

I believe the Board should include the ADA code of ethics into the regulation to stop fee splitting amoung dentist. This way unethical behavior will be modified

Commenter: Ross S. Fuller DDS - Williamsburg Dental Group * 8/12/15 2:52 pm

I strongly support the VDA adopting the ADA Code of Ethics.

I believe the VDA should adopt the ADA Code of Ethics. This adoption will help protect the public and support the "gold standard" of ethical behavior as outlined by the ADA.

Commenter: Bruce r Hutchison, DDS * 8/12/15 3:07 pm

Support adoption of ADA Priciples of Ethics

It is interesting to read the many comments on this subject. It has obviously hit a nerve so to speak. The majority of the comments opposed to adoption of this Code seem to focus on the Virginia Board of dentistry writing its own Code. This simply will never happen. So are we better to keep going down the road of having no guideliens for Ethical Behavior in dentitry? I think not! Ethics is the backbone of good and professional dental care, it protects the public from fraud and deceipt. How can any profession oject to havving a standard code of ethics to refer to and to follow? Seems to me that a professional wants to follow ethical behavior. If the fear is the "ever changing nature" of the ADA Code, then adopt the Code as of a specific date. Then the "Code" in Virginia is set and defined until the Board decides to change it. If the fear is adopting somoeone else's Code, then adopt by refernce, any Code of ethics adopted by a nationally recognized dental organization such as the ADA. There are, to the best of my knowledge only a few others, none of which are as complete as the ADA's Code. The ADA Code has stood the test of time- it will be celbrating it's 150th year of existence next year. Are ethics in Virginia drastically (or any) different than they are around this great contry of ours?

The Board of dentistry really needs to do something to gve dentists in Virgonia some definite guideleines to follow. The ADA Code already exists. Why reinvent the wheel? It's already done. I would hope that the Board never finds a reason to find fault of any dentist in Virginia for non-ethical behavior. But how does a dentist know if there are no guidleines? And how does the Board determine a violation of ethical behavior if there are no guidleines?

Let's adopt this Code for the safety and reassurance of the public we serve- the citizens of the Commowealth.

Commenter: Patrice Wunsch DDS MS, Associate Professor, VCU School of Dentistry * 8/12/15 3:30 pm

ADA Code of Ethics

The ADA Code of Ethics is the "Gold Standard" for the practice of dentistry. Therefore, I am in full support of the petition that asks for the Board of Dentistry to adopt the ADA Code of Ethics as part of their dental regulatory process to ensure that all dentists practice in an ethical and professional manner.

Commenter: John J. Doyle DDS Rocky Gap P.C. * 8/12/15 4:43 pm

ADA code of ethics opposition

I am opposed to the Virginia Board of Dentistry adopting the ADA code of ethics. Virginia dentists should not be governed by a national organization. Further, I do not believe that there is an ethics issue in Virginia.

Commenter: Elizabeth C. Reynolds DDS * 8/12/15 6:07 pm

In support of the adoption of the ADA Priciples of Ethics and Code of Professional Conduct

I am writing in support of the Virginia BOD's adoption of the ADA Code as the standard of ethics in the Commonwealth of Virginia. The Code is considered the gold standard of ethics in our profession. It has been adopted by numerous states and other professional dental societies. I am certain that our Board wants to ensure the ethical treatment of our citizens, and this is the obvious choice for regulating this. I urge the adoption of the Code within our Commonwealth; it will provide a framework and a reference point for both the BOD and for the dentists themselves.

Commenter: Cheryl Wells * 8/12/15 9:35 pm

Support for ADA Code of ethics

I believe the Board should support the endorsing of the ADA code of ethics to give guidance to the dentist to protect the public. As Board members it is your sworn duty to protect the public. Without theses guidelines in place the continual unethical behavior such as fee splitting will continue. Please take a stance to stop this NOW not later!

Commenter: Dr. Herb Hughes * 8/12/15 9:35 pm

Support the ADA code of ethics

I'm in support of adopting the ADA's code of ethics. We desperately need guidelines in order to prevent unethical behavior as well as to protect the public. By supporting the ADA's guidlelines on the code of ethics we can send the correct message so that our great profession will continue to be one that is respected by all.

Commenter: Dr. Thomas B Padgett, Richmond Oral and Cosmetic Surgeons * 8/12/15 10:05 pm

Support for ADA Code of Ethics

Over the years I have reviewed the penalties handed down to Dentists in the Commonwealth for unethical practice by the Board of Dentistry. It is obvious to me many Dentists are not quite sure what is and what isn't ethical. The ADA has developed a Code of Ethics which is something the State of Virginia needs to adopt. When I hear negative comments about this I worry about underlying reasons which concerns me. This is not about whether to adopt or not to adopt the ADA Code of Ethics but whether you want the ADA Code of Ethics or do you want the Board of Dentistry version which believe me will be more strict.

Commenter: Mark A. Crabtree, DDS, Piedmont Virginia Dental Health Foundation * 8/12/15 10:35 pm

Strongly Urge Adoption of ADA Code of Ethics as the Basic Ethical Standard in Virgnia

I Urge Adoption of ADA Code of Ethics as the Basic Ethical Standard in Virgnia.

The ADA Website sums up perfectly what the Code is and why we should adopt the Code by reference as the standard of ethical practice in the Commonwealth of Virginia. The Primary principles are patient autonomy, non-maleficence, beneficence, justice and veracity. It is an

evolving document that is on-going dialogue between the dental profession and society, and as such, is subject to continuous review.

The Code is far more comprehnhsive than anything that the Board of Dentistry could develop or manage.

Needless to say, the greatest challenges facing dentistry as profession are of an ethical nature as evidenced by the large case load that the Board of Dentistry must manage. Establishing this excellent standard of ethical practice will help protect the public from unscrupulous practice and reassure the public that licensed dentists must adhere to proper ethical standards. Unfortunately the Public has NO Confidence that an appropriate standard exists in Virginia at this time.

FROM THE ADA WEBSITE:

"The ADA Code has three main components: The Principles of Ethics, the Code of Professional Conduct and the Advisory Opinions.

The Principles of Ethics are the aspirational goals of the profession. They provide guidance and offer justification for the Code of Professional Conduct and the Advisory Opinions. There are five fundamental principles that form the foundation of the ADA Code: patient autonomy, nonmaleficence, beneficence, justice and veracity. Principles can overlap each other as well as compete with each other for priority. More than one principle can justify a given element of the Code of Professional Conduct. Principles may at times need to be balanced against each other, but, otherwise, they are the profession's firm guideposts.

The Code of Professional Conduct is an expression of specific types of conduct that are either required or prohibited. The Code of Professional Conduct is a product of the ADA's legislative system. All elements of the Code of Professional Conduct result from resolutions that are adopted by the ADA's House of Delegates. .....

The Advisory Opinions are interpretations that apply the Code of Professional Conduct to specific fact situations. They are adopted by the ADA's Council on Ethics, Bylaws and Judicial Affairs to provide guidance to the membership on how the Council might interpret the Code of Professional Conduct in a disciplinary proceeding.

The ADA Code is an evolving document and by its very nature cannot be a complete articulation of all ethical obligations. The ADA Code is the result of an on-going dialogue between the dental profession and society, and as such, is subject to continuous review."

Commenter: Dr. Benita Miller * 8/12/15 10:41 pm

In support of adoption of ADA Code of Ethics

I am writing in strong support of Dr. Dickinson's petition requesting the Board of Dentistry amend their regulations for unprofessional conduct to adopt, by reference, the ADA Principles of Ethics and Code of Professional Conduct. The Gold Standard for our profession, the ADA Code of Ethics is long standing and has been well vetted legally and professionally. It is widely recognized and well understood by dental students, by Virginia dentists, and by practitioners moving to our state from various parts of the country. There is no need to use the considerable time and resources necessary to develop a code of ethics and conduct specifically for our state when such a well respected code already exists and can easily be adopted by reference.

Commenter: Michael E. Miller, DDS - Commonwealth Oral and Facial Surgery * 8/12/15 10:57 pm

ADA Code of Ethics as reference

I am fully in support of the petition to have the VA Board of Dentistry adopt the ADA Code of Ethics as reference in adjudication of ethical issues including fee-splitting or other unprofessional conduct. The ethical practice of dentistry should not be a variable option from state to state. The ADA Code encapsulates far more of the ethical issues that could be raised and is considered the overriding gold standard for addressing potentially unethical behavior. Moreover, Board of Dentistry disciplinary decisions based on a national code that has been adopted as reference in numerous other states would be more likely substantiated and less likely questioned.

* Nonregistered public user

Michael H Gorman, DDS
14245-P Centreville Square
Centreville, VA 20121
(703) 830-9110

Department of Health Professions
9960 Mayland Drive
Suite 300
Henrico, VA 23233

Attn: Sandra Reen

Dear Board of Dentistry,

I am writing today to support the Petition for Rulemaking submitted by Dr. terry Dickinson on June 10, 2015 and received June 11, 2015. This is a request for the Board of Dentistry to adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of it's guidelines and dental regulations. The Statutes and regulations concerning dentistry 54.1-2706 Revocation or Suspension, is an ***incomplete list***, lacking the clarity of the ADA Principles of Ethics and Code of Professional Conduct. Bullet point 10 clearly relates to a Code of Ethics but yet there is no reference to one.

Section IV of the ADA Code, describes the interpretation and application of the principles of the ethics and code of professional conduct. It clearly maintains matters that Violate the ADA code should be handle at a State or Local Component Level. This section also allows for additions at a state or component level to the ADA's Code, as well as different interpretations as long as they are not in conflict with the ADA Code.

It would take years for the Board to write it's own Code of ethics. This leaves the dentists in Virginia with little guidance. The Board's responsibility to provide clear guidance to the dentists of the Commonwealth so that they may practice dentistry in a legal and ethical

manner- thereby protecting the public. By not having guidelines it is makes the Board look like a reactionary agency.

The ADA Principles of Ethics and Code of Professional Conduct should be adopted as a guideline for the following reasons:

1. It is the "gold standard" of Ethic conduct in dentistry
2. It has been adopted, by reference, in 14 different states by their respective Boards of Dentistry. These are: Alaska, Arizona, Connecticut, Hawaii, Idaho, Iowa, Massachusetts, Mississippi, New Hampshire, New Mexico, Tennessee, Vermont, West Virginia, and Wyoming.
3. It is accepted by the Academy of General Dentistry, the second largest dental organization in the United States, the Academy of Endodontist, as its Code of Ethics.
4. There is no other code of ethical behavior to be found in dentistry except for the American College of Dentists Ethics Handbook for Dentists.
5. The VA Board of Dentistry asks dentists to practice within the standards of ethics for dentists and dental hygienists, yet provides no such guidance or reference.
6. The VA Board of Dentistry endorses the ADA CDT Codes.
7. The VA Board of Dentistry endorses the ADA Guidelines on Sedation.
8. The VA Board of Dentistry endorses the ADA recognized dental specialties.

So it seems there is really only one logical conclusion, the board needs to adopt a Code of Ethical Behavior.
I urge the Board of Dentistry to adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of its dental regulations.

Michael H Gorman DDS
Centreville, Virginia

Whitney S. Jarrell, DDS
14245-P Centreville Square
Centreville, VA 20121
(703) 830-9110

Department of Health Professions
9960 Mayland Drive
Suite 300
Henrico, VA 23233

Attn: Sandra Reen

August 12, 2015

Dear Board of Dentistry,

I am writing today to support the Petition for Rulemaking submitted by Dr. Terry Dickinson on June 10, 2015 and received June 11, 2015. This is a request that the Board of Dentistry adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of its guidelines and dental regulations. The statutes and regulations concerning dentistry "54.1-2706 Revocation or Suspension, Other Sanctions #10 Conducting his practice in a manner contrary to the standards of ethics of dentistry or dental hygiene" clearly relates to a Code of Ethics, but yet there is no reference to one. I can find no description of "ethical conduct" in the Boards own regulations. I question how a dentist or dental hygienist can possibly practice within the standards expected when the standards are not clearly stated or referenced? And further, how can any prosecution of such behavior be justified without guidelines? As I see it, to protect the public and to promote understanding, the Board has two options. The Board must either write a Code of Ethics or adopt an existing one.

It would most likely take years for the Virginia Board of Dentistry to write it's own Code of ethics. This leaves the dentists in Virginia with little or no guidance for an indeterminate amount of time. The ultimate goal is to protect the public from unethical treatment and this can be ensured immediately with the adoption of the ADA Code of Ethics.

The ADA Principles of Ethics and Code of Professional Conduct is the "gold standard" of ethical conduct in dentistry. It has been adopted, by reference, in 14 different states by their respective Boards of Dentistry. These states include Alaska, Arizona, Connecticut, Hawaii, Idaho, Iowa, Massachusetts, Mississippi, New Hampshire, New Mexico, Tennessee, Vermont, West Virginia, and Wyoming. The Academy of General Dentistry, the second largest dental organization in the United States, has accepted it as its Code of Ethics.

The ADA's Code is written and time tested. The ADA Council on Ethics, Bylaws and Judicial Affairs oversees it. This Council consists of 17 dedicated volunteer dentists plus a staff of 4 or more and the ADA legal team. It has been reviewed and refined over many years of use. Any substantive changes must be approved by 2/3 of the House of Delegates members representing 65% of the dentists in the United States.

Furthermore, in response to the objection that the Board cannot adopt a Code of Ethics that belongs to a certain organization (the ADA), I submit that The Board already does this on several occasions. The VA Board of Dentistry endorses the ADA CDT Codes, the ADA Guidelines on Sedation, and ADA recognized dental specialties. I fail to see how the ADA Code of Ethics is different. The ADA and the Virginia Board of Dentistry really want the same thing- the best dental care for our patients provided in an ethical and caring way. We are on the same side.

With the above statements, I urge the Board of Dentistry to adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of its dental regulations.

Sincerely,

Whitney S. Jarrell, DDS

Member in good standing of:
Virginia Dental Association
American Dental Association
Academy of General Dentistry
Virginia Academy of General Dentistry
Northern Virginia Dental Society

Yeatts, Elaine J. (DHP)

From: Cindy southern <docsouthern@yahoo.com>
Sent: Tuesday, August 11, 2015 5:44 PM
To: Yeatts, Elaine J. (DHP)
Subject: ADA Code of Ethics

Elaine,
I support the Board adopting the ADA Code of Ethics.

Cynthia M Southern,DDS

Sent from my iPhone

BRUCE R. HUTCHISON, DDS
14245-P Centreville Square
Centreville, VA 20121
(703) 830-9110

Department of Health Professions
9960 Mayland Drive
Suite 300
Henrico, VA 23233

July 28, 2015

Attn: Sandra Reen

Dear Board of Dentistry,

I am writing today to support the Petition for Rulemaking submitted by Dr. Terry Dickinson on June 10, 2015 and received June 11, 2015. This is a request that the Board of Dentistry adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of it's guidelines and dental regulations. The Statutes and regulations concerning dentistry "54.1-2706 Revocation or Suspension, Other Sanctions #10 Conducting his practice in a manner contrary to the standards of ethics of dentistry or dental hygiene" clearly relates to a Code of Ethics but yet there is no reference to one. I can find no description of "ethical conduct" in the Boards own regulations. As such, for the protection of the public and to promote understanding and create less confusion, the Board needs to write a Code of Ethics, or adopt an existing one.

It would take years for the Board to write it's own Code of ethics. This leaves the dentists in Virginia with little or no guidance. I believe it is the Boards responsibility to provide guidance to the dentists of the Commonwealth so that they may practice dentistry in a legal and ethical manner- thereby protecting the

public form unethical treatment. If I am wrong and this is not the responsibility of the Board, I would certainly like to know that immediately.

The ADA Principles of Ethics and Code of Professional Conduct should be adopted as a guideline for the following reasons:

1. It is the "gold standard" of Ethical conduct in dentistry
2. It has been adopted, by reference, in 14 different states by their respective Boards of Dentistry. These are: Alaska, Arizona, Connecticut, Hawaii, Idaho, Iowa, Massachusetts, Mississippi, New Hampshire, New Mexico, Tennessee, Vermont, West Virginia, and Wyoming.
3. It is accepted by the Academy of General Dentistry, the second largest dental organization in the United States, as its Code of Ethics.
4. As far as I could discover, there are only three other national dental organizations who have a code of ethical behavior. These are the American College of Dentists Ethics Handbook for Dentists, the American Association of Oral and Maxillofacial Surgeons (AAOMS) and the American Association of Orthodontists (although I could not find their actual Code).
5. The VA Board of Dentistry asks dentists to practice within the standards of ethics for dentists and dental hygienists, yet provides no guidance or reference to follow.
6. The VA Board of Dentistry endorses the ADA CDT Codes.
7. The VA Board of Dentistry endorses the ADA Guidelines on Sedation.
8. The VA Board of Dentistry endorses the ADA recognized dental specialties.

Not having an explicit Code of Ethics as part of the Board of Dentistry's Statutes and Rules, and yet saying that the board will enforce behavior that is not within the standards of ethics is extremely confusing and misguided. How can one possibly practice within the standards expected when the standards are not clearly stated or referenced? How can any prosecution of such behavior be justified with no guidelines?

To say the Board cannot adopt a Code of Ethics that belong to a certain organization (the ADA) is simply not supported by fact. The Board already does this on several occasions. The ADA, the VDA, and the Virginia Board of Dentistry really want the same thing. That is, the best dental care for our patients provided in an ethical and caring way. We are on the same side. There is no conflict of interests.

So it seems there is really only one logical conclusion, the Board needs to adopt a Code of Ethical Behavior. So either the Board creates one, or they adopt an existing one. Would they rather create mediocrity, or copy genius? It would take years for the Board to create their own, and many more years to refine it, and an untold amount of hours by staff and Board members. The ADA's Code is written and time tested. It is overseen by the Council on Ethics, Bylaws and Judicial Affairs, a Council of 17 dedicated volunteer dentists from around the country, a staff of 3 or more, plus the ADA legal team. It has been reviewed and refined over many years of use. Any substantive changes must be approved by the ADA House of Delegates members representing 65% of the dentists in the United States. This is the gold standard for Ethics in Dentistry.

I urge the Board of Dentistry to adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of its dental regulations.

Thank you for your consideration on this matter.

Bruce R. Hutchison, DDS
Virginia Dental Association, Past President
American Dental Association, Council on Ethics, Bylaws and Judicial Affairs, member 2004-2008
American Dental Association, ADPAC Board member 2011-2015, Chair-elect 2015
American College of Dentists, Fellow
Academy of General Dentistry, Master

VSOMS
VIRGINIA SOCIETY
of ORAL *&* MAXILLOFACIAL SURGEONS

DHP AUG 04 2015

RECEIVED
AUG - 4 2015
Board of Dentistry

July 30, 2015

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dear Ms. Reen,

The Virginia Society of Oral & Maxillofacial Surgeons (VSOMS) is of the opinion that fee splitting is unethical. Although VSOMS commends the Board of Dentistry for addressing this issue, we do not agree with the proposed legislation. VSOMS supports the opinions on this issue as stated in the *ADA Principles of Ethics and Code of Professional Conduct* and the *AAOMS Code of Professional Conduct*. To that point, VSOMS believes that if the Board of Dentistry adopted the *ADA Principles of Ethics and Code of Professional Conduct*, as requested by Dr. Terry Dickinson in his recent Petition for Rule Making, it would capture all parts of ethical behavior and not just be limited to addressing fee splitting.

We appreciate the opportunity to address the Board of Dentistry on this issue.

Sincerely,

James M. Solomon, DDS

President

3460 MAYLAND COURT, SUITE 110 • RICHMOND, VIRGINIA 23233 • (804) 523-2185 • FAX (804) 288-1880

Brigid B. Mooney, DDS
14245-P Centreville Square
Centreville, VA 20121
(703) 830-9110

Department of Health Professions
9960 Mayland Drive
Suite 300
Henrico, VA 23233

Attn Sandra Reen:

Dear Board of Dentistry,
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It would take years for the Board to write its own Code of ethics. This leaves the dentists in Virginia with little or no guidance. I believe it is the Boards responsibility to provide guidance to the dentists of the Commonwealth so that they may practice dentistry in a legal and ethical manner- thereby protecting the public from unethical treatment. The ADA Principles of Ethics and Code of Professional Conduct should be adopted as a guideline for the following reasons:

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4. As far as I could discover, there is no other code of ethical behavior to be found in dentistry except for the American College of Dentists Ethics Handbook for Dentists.
5. The VA Board of Dentistry asks dentists to practice within the standards of ethics for dentists and dental hygienists, yet provides no such guidance or reference.
6. The VA Board of Dentistry endorses the ADA CDT Codes.
7. The VA Board of Dentistry endorses the ADA Guidelines on Sedation.

8. The VA Board of Dentistry endorses the ADA recognized dental specialties.

Not having an explicit Code of Ethics as part of the Board of Dentistry's Statutes and Rules, and yet saying that the board will enforce behavior that is not within the standards of ethics is extremely confusing and misguided. How can one possibly practice within the standards expected when the standards are not clearly stated or referenced? How can any prosecution of such behavior be justified with no guidelines given?

To say the Board cannot adopt a Code of Ethics that belong to a certain organization (the ADA) is simply not correct. The Board already does this on several occasions. The ADA and the Virginia Board of Dentistry really want the same thing. That is, the best dental care for our patients provided in an ethical and caring way. We are on the same side.

So it seems there is really only one logical conclusion, the board needs to adopt a Code of Ethical Behavior. So either the Board creates one, or they adopt an existing one. Would they rather create mediocrity or copy genius? It would take years for the Board to create their own, and many more years to refine it, and an untold amount of hours by staff and Board members. The ADA's Code is written and time tested. It is overseen by the Council on Ethics, Bylaws and Judicial Affairs, a Council of 17 dedicated volunteer dentists plus a staff of 4 or more, plus the ADA legal team. It has been reviewed and refined over many years of use. Any substantive changes must be approved by 2/3 of the House of Delegates members representing 65% of the dentists in the United States. This is the gold standard for Ethics in Dentistry.

I urge the Board of Dentistry to adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of its dental regulations.

Brigid B. Mooney, DDS

Member of the American Dental Association, Virginia Dental Association, and Academy of General Dentistry.

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(703) 830-9110

Department of Health Professions
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I urge the Board of Dentistry to adopt the ADA Principles of Ethics and Code of Professional Conduct as a part of its dental regulations.

Brigid B. Mooney, DDS

Member of the American Dental Association, Virginia Dental Association, and Academy of General Dentistry.

Yeatts, Elaine J. (DHP)

From: Vu, Huong (DHP)
Sent: Monday, June 22, 2015 2:28 PM
To: Reen, Sandra (DHP); Yeatts, Elaine J. (DHP)
Subject: FW: Petition for rulemaking

FYI

From: Dag Zapatero [mailto:Dag.Zapatero@verizon.net]
Sent: Monday, June 22, 2015 2:27 PM
To: Vu, Huong (DHP)
Subject: Re: Petition for rulemaking

Dear Virginia Board of Dentistry,

I have read petition by Dr. Dickerson on behalf of the VDA and fully support his efforts to amend 18VAC 60-20-170 to conform with the ADA's "code of ethics" standards. We should do everything possible to maintain the highest professional standards when providing care to the citizens of our Commonwealth.

Best,
Dag Zapatero, DDS

Starfish Dental
Dag Zapatero, DDS, FACD | 3020 Shore Drive | Virginia Beach, VA 23451
office. 757.481.3893 | fax 757.481.0425 | www.Starfishdental.com
Fellow of the American College of Dentists
--

Please consider the environment before printing this e-mail.
The content of this email was intended solely for the recipient, and should not be forwarded or disseminated without the consent of the sender.

On 6/17/15, 11:13 AM, "Vu, Huong (DHP)" <Huong.Vu@DHP.VIRGINIA.GOV> wrote:

Hello,

The attached petition is for your review. The petition will be published on July 13, 2015.

The public comment will begin on July 13, 2015 and ends on August 12, 2015.

The petition and any comments received will be considered by the Board at its meeting scheduled for September 18, 2015.

Huong Q Vu
Operations/Compliance Manager
Virginia Board of Dentistry

American Dental Association

PRINCIPLES OF

Ethics

AND

CODE OF

Professional Conduct

With official advisory opinions revised to April 2012.

ADA American Dental Association®

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I. INTRODUCTION

The dental profession holds a special position of trust within society. As a consequence, society affords the profession certain privileges that are not available to members of the public-at-large. In return, the profession makes a commitment to society that its members will adhere to high ethical standards of conduct. These standards are embodied in the *ADA Principles of Ethics and Code of Professional Conduct (ADA Code)*. The *ADA Code* is, in effect, a written expression of the obligations arising from the implied contract between the dental profession and society.

Members of the ADA voluntarily agree to abide by the *ADA Code* as a condition of membership in the Association. They recognize that continued public trust in the dental profession is based on the commitment of individual dentists to high ethical standards of conduct.

The *ADA Code* has three main components: The **Principles of Ethics**, the **Code of Professional Conduct** and the **Advisory Opinions**.

The **Principles of Ethics** are the aspirational goals of the profession. They provide guidance and offer justification for the *Code of Professional Conduct* and the *Advisory Opinions*. There are five fundamental principles that form the foundation of the *ADA Code:* patient autonomy, nonmaleficence, beneficence, justice and veracity. Principles can overlap each other as well as compete with each other for priority. More than one principle can justify a given element of the *Code of Professional Conduct*. Principles may at times need to be balanced against each other, but, otherwise, they are the profession's firm guideposts.

The **Code of Professional Conduct** is an expression of specific types of conduct that are either required or prohibited. The *Code of Professional Conduct* is a product of the ADA's legislative system. All elements of the *Code of Professional Conduct* result from resolutions that are adopted by the ADA's House of Delegates. The *Code of Professional Conduct* is binding on members of the ADA, and violations may result in disciplinary action.

The **Advisory Opinions** are interpretations that apply the *Code of Professional Conduct* to specific fact situations. They are adopted by the ADA's Council on Ethics, Bylaws and Judicial Affairs to provide guidance to the membership on how the Council might interpret the *Code of Professional Conduct* in a disciplinary proceeding.

The *ADA Code* is an evolving document and by its very nature cannot be a complete articulation of all ethical obligations. The *ADA Code* is the result of an ongoing dialogue between the dental profession and society, and as such, is subject to continuous review.

Although ethics and the law are closely related, they are not the same. Ethical obligations may—and often do—exceed legal duties. In resolving any ethical problem not explicitly covered by the *ADA Code*, dentists should consider the ethical principles, the patient's needs and interests, and any applicable laws.

II. PREAMBLE

The American Dental Association calls upon dentists to follow high ethical standards which have the benefit of the patient as their primary goal. In recognition of this goal, the education and training of a dentist has resulted in society affording to the profession the privilege and obligation of self-government. To fulfill this privilege, these high ethical standards should be adopted and practiced throughout the dental school educational process and subsequent professional career.

The Association believes that dentists should possess not only knowledge, skill and technical competence but also those traits of character that foster adherence to ethical principles. Qualities of honesty, compassion, kindness, integrity, fairness and charity are part of the ethical education of a dentist and practice of dentistry and help to define the true professional. As such, each dentist should share in providing advocacy to and care of the underserved. It is urged that the dentist meet this goal, subject to individual circumstances.

The ethical dentist strives to do that which is right and good. The *ADA Code* is an instrument to help the dentist in this quest.

III. PRINCIPLES, CODE OF PROFESSIONAL CONDUCT AND ADVISORY OPINIONS

Section 1 PRINCIPLE: PATIENT AUTONOMY ("self-governance"). The dentist has a duty to respect the patient's rights to self-determination and confidentiality.

This principle expresses the concept that professionals have a duty to treat the patient according to the patient's desires, within the bounds of accepted treatment, and to protect the patient's confidentiality. Under this principle, the dentist's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient's needs, desires and abilities, and safeguarding the patient's privacy.

CODE OF PROFESSIONAL CONDUCT

1.A. PATIENT INVOLVEMENT.
The dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions.

1.B. PATIENT RECORDS.
Dentists are obliged to safeguard the confidentiality of patient records. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon request of a patient or another dental practitioner, dentists shall provide any information in accordance with applicable law that will be beneficial for the future treatment of that patient.

ADVISORY OPINIONS

1.B.1. FURNISHING COPIES OF RECORDS.
A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish in accordance with applicable law, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental X-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full.

1.B.2. CONFIDENTIALITY OF PATIENT RECORDS.
The dominant theme in Code Section I.B is the protection of the confidentiality of a patient's records. The statement in this section that relevant information in the records should be released to another dental practitioner assumes that the dentist requesting the information is the patient's present dentist. There may be circumstances where the former dentist has an ethical obligation to inform the present dentist of certain facts. Code Section 1.B assumes that the dentist releasing relevant information is acting in accordance with applicable law. Dentists

should be aware that the laws of the various jurisdictions in the United States are not uniform and some confidentiality laws appear to prohibit the transfer of pertinent information, such as HIV seropositivity. Absent certain knowledge that the laws of the dentist's jurisdiction permit the forwarding of this information, a dentist should obtain the patient's written permission before forwarding health records which contain information of a sensitive nature, such as HIV seropositivity, chemical dependency or sexual preference. If it is necessary for a treating dentist to consult with another dentist or physician with respect to the patient, and the circumstances do not permit the patient to remain anonymous, the treating dentist should seek the permission of the patient prior to the release of data from the patient's records to the consulting practitioner. If the patient refuses, the treating dentist should then contemplate obtaining legal advice regarding the termination of the dentist-patient relationship.

Section 2 PRINCIPLE: NONMALEFICENCE ("do no harm"). The dentist has a duty to refrain from harming the patient.

This principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate.

CODE OF PROFESSIONAL CONDUCT

2.A. EDUCATION.
The privilege of dentists to be accorded professional status rests primarily in the knowledge, skill and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.

2.B. CONSULTATION AND REFERRAL.
Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.

2. The specialists shall be obliged when there is no referring dentist and upon a completion of their treatment to inform patients when there is a need for further dental care.

ADVISORY OPINION

2.B.1. SECOND OPINIONS.
A dentist who has a patient referred by a third party[1] for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this *Code of Ethics*. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.

2.C. USE OF AUXILIARY PERSONNEL.
Dentists shall be obliged to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obliged to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction.

2.D. PERSONAL IMPAIRMENT.
It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society.

ADVISORY OPINION

2.D.1. ABILITY TO PRACTICE.
A dentist who contracts any disease or becomes impaired in any way that might endanger patients or dental staff shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger patients or dental staff. A dentist who has been advised to limit the activities of his or her practice should monitor the aforementioned disease or impairment and make additional limitations to the activities of the dentist's practice, as indicated.

2.E. POSTEXPOSURE, BLOODBORNE PATHOGENS.
All dentists, regardless of their bloodborne pathogen status, have an ethical obligation to immediately inform any patient who may have been exposed to blood or other potentially infectious material in the dental office of the need for postexposure evaluation and follow-up and to immediately refer the patient to a qualified health care practitioner who can provide postexposure services. The dentist's ethical obligation in the event of an exposure incident extends to providing information concerning the dentist's own bloodborne pathogen status to the evaluating health care practitioner, if the dentist is the source individual, and to submitting to testing that will assist in the evaluation of the patient. If a staff member or other third person is the source individual, the dentist should encourage that person to cooperate as needed for the patient's evaluation.

2.F. PATIENT ABANDONMENT.
Once a dentist has undertaken a course of treatment, the dentist should not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Care should be taken that the patient's oral health is not jeopardized in the process.

2.G. PERSONAL RELATIONSHIPS WITH PATIENTS.
Dentists should avoid interpersonal relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient.

Section 3 PRINCIPLE: BENEFICENCE ("do good"). The dentist has a duty to promote the patient's welfare.

This principle expresses the concept that professionals have a duty to act for the benefit of others. Under this principle, the dentist's primary obligation is service to the patient and the public-at-large. The most important aspect of this obligation is the competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration being given to the needs, desires and values of the patient. The same ethical considerations apply whether the dentist engages in fee-for-service, managed care or some other practice arrangement. Dentists may choose to enter into contracts governing the provision of care to a group of patients; however, contract obligations do not excuse dentists from their ethical duty to put the patient's welfare first.

CODE OF PROFESSIONAL CONDUCT

3.A. COMMUNITY SERVICE.
Since dentists have an obligation to use their skills, knowledge and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

3.B. GOVERNMENT OF A PROFESSION.
Every profession owes society the responsibility to regulate itself. Such regulation is achieved largely through the influence of the professional societies. All dentists, therefore, have the dual obligation of making themselves a part of a professional society and of observing its rules of ethics.

3.C. RESEARCH AND DEVELOPMENT.
Dentists have the obligation of making the results and benefits of their investigative efforts available to all when they are useful in safeguarding or promoting the health of the public.

3.D. PATENTS AND COPYRIGHTS.
Patents and copyrights may be secured by dentists provided that such patents and copyrights shall not be used to restrict research or practice.

3.E. ABUSE AND NEGLECT.
Dentists shall be obliged to become familiar with the signs of abuse and neglect and to report suspected cases to the proper authorities, consistent with state laws.

ADVISORY OPINION

3.E.1. REPORTING ABUSE AND NEGLECT.
The public and the profession are best served by dentists who are familiar with identifying the signs of abuse and neglect and knowledgeable about the appropriate intervention resources for all populations.

A dentist's ethical obligation to identify and report the signs of abuse and neglect is, at a minimum, to be consistent with a dentist's legal obligation in the jurisdiction where the dentist practices. Dentists, therefore, are ethically obliged to identify and report suspected cases of abuse and neglect to the same extent as they are legally obliged to do so in the jurisdiction where they practice. Dentists have a concurrent ethical obligation to respect an adult patient's right to

self-determination and confidentiality and to promote the welfare of all patients. Care should be exercised to respect the wishes of an adult patient who asks that a suspected case of abuse and/or neglect not be reported, where such a report is not mandated by law. With the patient's permission, other possible solutions may be sought.

Dentists should be aware that jurisdictional laws vary in their definitions of abuse and neglect, in their reporting requirements and the extent to which immunity is granted to good faith reporters. The variances may raise potential legal and other risks that should be considered, while keeping in mind the duty to put the welfare of the patient first. Therefore a dentist's ethical obligation to identify and report suspected cases of abuse and neglect can vary from one jurisdiction to another.

Dentists are ethically obligated to keep current their knowledge of both identifying abuse and neglect and reporting it in the jurisdiction(s) where they practice.

3.F. PROFESSIONAL DEMEANOR IN THE WORKPLACE.
Dentists have the obligation to provide a workplace environment that supports respectful and collaborative relationships for all those involved in oral health care.

ADVISORY OPINION

3.F.1. DISRUPTIVE BEHAVIOR IN THE WORKPLACE.
Dentists are the leaders of the oral healthcare team. As such, their behavior in the workplace is instrumental in establishing and maintaining a practice environment that supports the mutual respect, good communication, and high levels of collaboration among team members required to optimize the quality of patient care provided. Dentists who engage in disruptive behavior in the workplace risk undermining professional relationships among team members, decreasing the quality of patient care provided, and undermining the public's trust and confidence in the profession.

Section 4 PRINCIPLE: JUSTICE ("fairness"). The dentist has a duty to treat people fairly.

This principle expresses the concept that professionals have a duty to be fair in their dealings with patients, colleagues and society. Under this principle, the dentist's primary obligations include dealing with people justly and delivering dental care without prejudice. In its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.

CODE OF PROFESSIONAL CONDUCT

4.A. PATIENT SELECTION.
While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex or national origin.

ADVISORY OPINION

4.A.1. PATIENTS WITH BLOODBORNE PATHOGENS.
A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual is infected with Human

Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus or another bloodborne pathogen, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested should be made on the same basis as they are made with other patients. As is the case with all patients, the individual dentist should determine if he or she has the need of another's skills, knowledge, equipment or experience. The dentist should also determine, after consultation with the patient's physician, if appropriate, if the patient's health status would be significantly compromised by the provision of dental treatment.

4.B. EMERGENCY SERVICE.

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, the dentist, upon completion of treatment, is obliged to return the patient to his or her regular dentist unless the patient expressly reveals a different preference.

4.C. JUSTIFIABLE CRITICISM.

Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services. Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true.

ADVISORY OPINION

4.C.1. MEANING OF "JUSTIFIABLE."

Patients are dependent on the expertise of dentists to know their oral health status. Therefore, when informing a patient of the status of his or her oral health, the dentist should exercise care that the comments made are truthful, informed and justifiable. This should, if possible, involve consultation with the previous treating dentist(s), in accordance with applicable law, to determine under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would unjustly imply mistreatment. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable. Therefore, this section is phrased to address the discretion of dentists and advises against unknowing or unjustifiable disparaging statements against another dentist. However, it should be noted that, where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements.

4.D. EXPERT TESTIMONY.

Dentists may provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

ADVISORY OPINION

4.D.1. CONTINGENT FEES.

It is unethical for a dentist to agree to a fee contingent upon the favorable outcome of the litigation in exchange for testifying as a dental expert.

4.E. REBATES AND SPLIT FEES.
Dentists shall not accept or tender "rebates" or "split fees."

ADVISORY OPINION

4.E.1. SPLIT FEES IN ADVERTISING AND MARKETING SERVICES.
The prohibition against a dentist's accepting or tendering rebates or split fees applies to business dealings between dentists and any third party, not just other dentists. Thus, a dentist who pays for advertising or marketing services by sharing a specified portion of the professional fees collected from prospective or actual patients with the vendor providing the advertising or marketing services is engaged in fee splitting. The prohibition against fee splitting is also applicable to the marketing of dental treatments or procedures via "social coupons" if the business arrangement between the dentist and the concern providing the marketing services for that treatment or those procedures allows the issuing company to collect the fee from the prospective patient, retain a defined percentage or portion of the revenue collected as payment for the coupon marketing service provided to the dentist and remit to the dentist the remainder of the amount collected.

Dentists should also be aware that the laws or regulations in their jurisdictions may contain provisions that impact the division of revenue collected from prospective patients between a dentist and a third party to pay for advertising or marketing services.

Section 5 PRINCIPLE: VERACITY ("truthfulness"). The dentist has a duty to communicate truthfully.

This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people. Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.

CODE OF PROFESSIONAL CONDUCT
5.A. REPRESENTATION OF CARE.
Dentists shall not represent the care being rendered to their patients in a false or misleading manner.

ADVISORY OPINIONS

5.A.1. DENTAL AMALGAM AND OTHER RESTORATIVE MATERIALS.
Based on current scientific data, the ADA has determined that the removal of amalgam restorations from the non-allergic patient for the alleged purpose of removing toxic substances from the body, when such treatment is performed solely at the recommendation of the dentist, is improper and unethical. The same principle of veracity applies to the dentist's recommendation concerning the removal of any dental restorative material.

5.A.2. UNSUBSTANTIATED REPRESENTATIONS.
A dentist who represents that dental treatment or diagnostic techniques

recommended or performed by the dentist has the capacity to diagnose, cure or alleviate diseases, infections or other conditions, when such representations are not based upon accepted scientific knowledge or research, is acting unethically.

5.B. REPRESENTATION OF FEES.
Dentists shall not represent the fees being charged for providing care in a false or misleading manner.

ADVISORY OPINIONS

5.B.1. WAIVER OF COPAYMENT.
A dentist who accepts a third party[1] payment under a copayment plan as payment in full without disclosing to the third party[1] that the patient's payment portion will not be collected, is engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling dentist makes it appear to the third party[1] that the charge to the patient for services rendered is higher than it actually is.

5.B.2. OVERBILLING.
It is unethical for a dentist to increase a fee to a patient solely because the patient is covered under a dental benefits plan.

5.B.3. FEE DIFFERENTIAL.
The fee for a patient without dental benefits shall be considered a dentist's full fee.[2] This is the fee that should be represented to all benefit carriers regardless of any negotiated fee discount. Payments accepted by a dentist under a governmentally funded program, a component or constituent dental society-sponsored access program, or a participating agreement entered into under a program with a third party shall not be considered or construed as evidence of overbilling in determining whether a charge to a patient, or to another third party[1] in behalf of a patient not covered under any of the aforecited programs constitutes overbilling under this section of the *Code*.

5.B.4. TREATMENT DATES.
A dentist who submits a claim form to a third party[1] reporting incorrect treatment dates for the purpose of assisting a patient in obtaining benefits under a dental plan, which benefits would otherwise be disallowed, is engaged in making an unethical, false or misleading representation to such third party.[1]

5.B.5. DENTAL PROCEDURES.
A dentist who incorrectly describes on a third party[1] claim form a dental procedure in order to receive a greater payment or reimbursement or incorrectly makes a non-covered procedure appear to be a covered procedure on such a claim form is engaged in making an unethical, false or misleading representation to such third party.[1]

5.B.6. UNNECESSARY SERVICES.
A dentist who recommends and performs unnecessary dental services or procedures is engaged in unethical conduct. The dentist's ethical obligation in this matter applies regardless of the type of practice arrangement or contractual obligations in which he or she provides patient care.

5.C. DISCLOSURE OF CONFLICT OF INTEREST.
A dentist who presents educational or scientific information in an article, seminar or other program shall disclose to the readers or participants any monetary or other special interest the dentist may have with a company whose products are promoted or endorsed in the presentation. Disclosure shall be made in any promotional material and in the presentation itself.

5.D. DEVICES AND THERAPEUTIC METHODS.
Except for formal investigative studies, dentists shall be obliged to prescribe, dispense, or promote only those devices, drugs and other agents whose complete formulae are available to the dental profession. Dentists shall have the further obligation of not holding out as exclusive any device, agent, method or technique if that representation would be false or misleading in any material respect.

ADVISORY OPINIONS

5.D.1. REPORTING ADVERSE REACTIONS.
A dentist who suspects the occurrence of an adverse reaction to a drug or dental device has an obligation to communicate that information to the broader medical and dental community, including, in the case of a serious adverse event, the Food and Drug Administration (FDA).

5.D.2. MARKETING OR SALE OF PRODUCTS OR PROCEDURES.
Dentists who, in the regular conduct of their practices, engage in or employ auxiliaries in the marketing or sale of products or procedures to their patients must take care not to exploit the trust inherent in the dentist-patient relationship for their own financial gain. Dentists should not induce their patients to purchase products or undergo procedures by misrepresenting the product's value, the necessity of the procedure or the dentist's professional expertise in recommending the product or procedure.

In the case of a health-related product, it is not enough for the dentist to rely on the manufacturer's or distributor's representations about the product's safety and efficacy. The dentist has an independent obligation to inquire into the truth and accuracy of such claims and verify that they are founded on accepted scientific knowledge or research.

Dentists should disclose to their patients all relevant information the patient needs to make an informed purchase decision, including whether the product is available elsewhere and whether there are any financial incentives for the dentist to recommend the product that would not be evident to the patient.

5.E. PROFESSIONAL ANNOUNCEMENT.
In order to properly serve the public, dentists should represent themselves in a manner that contributes to the esteem of the profession. Dentists should not misrepresent their training and competence in any way that would be false or misleading in any material respect.[3]

5.F. ADVERTISING.
Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect.[3]

ADVISORY OPINIONS

5.F.1. PUBLISHED COMMUNICATIONS.

If a dental health article, message or newsletter is published in print or electronic media under a dentist's byline to the public without making truthful disclosure of the source and authorship or is designed to give rise to questionable expectations for the purpose of inducing the public to utilize the services of the sponsoring dentist, the dentist is engaged in making a false or misleading representation to the public in a material respect.[3]

5.F.2. EXAMPLES OF "FALSE OR MISLEADING."

The following examples are set forth to provide insight into the meaning of the term "false or misleading in a material respect."[3] These examples are not meant to be all-inclusive. Rather, by restating the concept in alternative language and giving general examples, it is hoped that the membership will gain a better understanding of the term. With this in mind, statements shall be avoided which would:
a) contain a material misrepresentation of fact, b) omit a fact necessary to make the statement considered as a whole not materially misleading, c) be intended or be likely to create an unjustified expectation about results the dentist can achieve, and d) contain a material, objective representation, whether express or implied, that the advertised services are superior in quality to those of other dentists, if that representation is not subject to reasonable substantiation.

Subjective statements about the quality of dental services can also raise ethical concerns. In particular, statements of opinion may be misleading if they are not honestly held, if they misrepresent the qualifications of the holder, or the basis of the opinion, or if the patient reasonably interprets them as implied statements of fact. Such statements will be evaluated on a case by case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. The fundamental issue is whether the advertisement, taken as a whole, is false or misleading in a material respect.[3]

5.F.3. UNEARNED, NONHEALTH DEGREES.

A dentist may use the title Doctor or Dentist, D.D.S., D.M.D. or any additional earned, advanced academic degrees in health service areas in an announcement to the public. The announcement of an unearned academic degree may be misleading because of the likelihood that it will indicate to the public the attainment of specialty or diplomate status.

For purposes of this advisory opinion, an unearned academic degree is one which is awarded by an educational institution not accredited by a generally recognized accrediting body or is an honorary degree.

The use of a nonhealth degree in an announcement to the public may be a representation which is misleading because the public is likely to assume that any degree announced is related to the qualifications of the dentist as a practitioner.

Some organizations grant dentists fellowship status as a token of membership in the organization or some other form of voluntary association. The use of such fellowships in advertising to the general public may be misleading because of the likelihood that it will indicate to the public attainment of education or skill in the field of dentistry.

Generally, unearned or nonhealth degrees and fellowships that designate association, rather than attainment, should be limited to scientific papers and

curriculum vitae. In all instances, state law should be consulted. In any review by the council of the use of designations in advertising to the public, the council will apply the standard of whether the use of such is false or misleading in a material respect.[3]

5.F.4. REFERRAL SERVICES.

There are two basic types of referral services for dental care: not-for-profit and the commercial. The not-for-profit is commonly organized by dental societies or community services. It is open to all qualified practitioners in the area served. A fee is sometimes charged the practitioner to be listed with the service. A fee for such referral services is for the purpose of covering the expenses of the service and has no relation to the number of patients referred. In contrast, some commercial referral services restrict access to the referral service to a limited number of dentists in a particular geographic area. Prospective patients calling the service may be referred to a single subscribing dentist in the geographic area and the respective dentist billed for each patient referred. Commercial referral services often advertise to the public stressing that there is no charge for use of the service and the patient may not be informed of the referral fee paid by the dentist. There is a connotation to such advertisements that the referral that is being made is in the nature of a public service. A dentist is allowed to pay for any advertising permitted by the *Code*, but is generally not permitted to make payments to another person or entity for the referral of a patient for professional services. While the particular facts and circumstances relating to an individual commercial referral service will vary, the council believes that the aspects outlined above for commercial referral services violate the *Code* in that it constitutes advertising which is false or misleading in a material respect and violates the prohibitions in the *Code* against fee splitting.[3]

5.F.5. INFECTIOUS DISEASE TEST RESULTS.

An advertisement or other communication intended to solicit patients which omits a material fact or facts necessary to put the information conveyed in the advertisement in a proper context can be misleading in a material respect. A dental practice should not seek to attract patients on the basis of partial truths which create a false impression.[3]

For example, an advertisement to the public of HIV negative test results, without conveying additional information that will clarify the scientific significance of this fact contains a misleading omission. A dentist could satisfy his or her obligation under this advisory opinion to convey additional information by clearly stating in the advertisement or other communication: "This negative HIV test cannot guarantee that I am currently free of HIV."

5.G. NAME OF PRACTICE.

Since the name under which a dentist conducts his or her practice may be a factor in the selection process of the patient, the use of a trade name or an assumed name that is false or misleading in any material respect is unethical. Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.[3]

ADVISORY OPINION

5.G.1. DENTIST LEAVING PRACTICE.

Dentists leaving a practice who authorize continued use of their names should receive competent advice on the legal implications of this action. With permission of a departing dentist, his or her name may be used for more than one year, if, after

the one year grace period has expired, prominent notice is provided to the public through such mediums as a sign at the office and a short statement on stationery and business cards that the departing dentist has retired from the practice.

5.H. ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE.
This section and Section 5.I are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program. The dental specialties recognized by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. Dentists who choose to announce specialization should use "specialist in" or "practice limited to" and shall limit their practice exclusively to the announced dental specialties, provided at the time of the announcement such dentists have met in each recognized specialty for which they announce the existing educational requirements and standards set forth by the American Dental Association. Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are qualified to announce themselves as specialists.

GENERAL STANDARDS.
The following are included within the standards of the American Dental Association for determining the education, experience and other appropriate requirements for announcing specialization and limitation of practice:

1. The special area(s) of dental practice and an appropriate certifying board must be approved by the American Dental Association.

2. Dentists who announce as specialists must have successfully completed an educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education and Licensure, or be diplomates of an American Dental Association recognized certifying board. The scope of the individual specialist's practice shall be governed by the educational standards for the specialty in which the specialist is announcing.

3. The practice carried on by dentists who announce as specialists shall be limited exclusively to the special area(s) of dental practice announced by the dentist.

STANDARDS FOR MULTIPLE-SPECIALTY ANNOUNCEMENTS.
The educational criterion for announcement of limitation of practice in additional specialty areas is the successful completion of an advanced educational program accredited by the Commission on Dental Accreditation (or its equivalent if completed prior to 1967)[4] in each area for which the dentist wishes to announce. Dentists who are presently ethically announcing limitation of practice in a specialty area and who wish to announce in an additional specialty area must submit to the appropriate constituent society documentation of successful completion of the requisite education in specialty programs listed by the Council on Dental Education and Licensure or certification as a diplomate in each area for which they wish to announce.

ADVISORY OPINIONS

5.H.1. DUAL DEGREED DENTISTS.
Nothing in Section 5.H shall be interpreted to prohibit a dual degreed dentist who practices medicine or osteopathy under a valid state license from announcing to the public as a dental specialist provided the dentist meets the educational, experience and other standards set forth in the *Code* for specialty announcement and further providing that the announcement is truthful and not materially misleading.

5.H.2. SPECIALIST ANNOUNCEMENT OF CREDENTIALS IN NON-SPECIALTY INTEREST AREAS.
A dentist who is qualified to announce specialization under this section may not announce to the public that he or she is certified or a diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless:

1. The organization granting the credential grants certification or diplomate status based on the following: a) the dentist's successful completion of a formal, full-time advanced education program (graduate or postgraduate level) of at least 12 months' duration; and b) the dentist's training and experience; and c) successful completion of an oral and written examination based on psychometric principles; and

2. The announcement includes the following language: [Name of announced area of dental practice] is not recognized as a specialty area by the American Dental Association.

Nothing in this advisory opinion affects the right of a properly qualified dentist to announce specialization in an ADA-recognized specialty area(s) as provided for under Section 5.H of this *Code* or the responsibility of such dentist to limit his or her practice exclusively to the special area(s) of dental practice announced. Specialists shall not announce their credentials in a manner that implies specialization in a non-specialty interest area.

5.I. GENERAL PRACTITIONER ANNOUNCEMENT OF SERVICES.
General dentists who wish to announce the services available in their practices are permitted to announce the availability of those services so long as they avoid any communications that express or imply specialization. General dentists shall also state that the services are being provided by general dentists. No dentist shall announce available services in any way that would be false or misleading in any material respect.[3]

ADVISORY OPINIONS

5.I.1. GENERAL PRACTITIONER ANNOUNCEMENT OF CREDENTIALS IN INTEREST AREAS IN GENERAL DENTISTRY.
A general dentist may not announce to the public that he or she is certified or a diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless:

1. The organization granting the credential grants certification or diplomate status based on the following: a) the dentist's successful completion of a formal, full-time advanced education program (graduate or postgraduate level) of at least 12 months duration; and b) the dentist's training and experience; and c) successful completion of an oral and written examination based on psychometric principles;

2. The dentist discloses that he or she is a general dentist; and

3. The announcement includes the following language: [Name of announced area of dental practice] is not recognized as a specialty area by the American Dental Association.

5.I.2. CREDENTIALS IN GENERAL DENTISTRY.
General dentists may announce fellowships or other credentials earned in the area of general dentistry so long as they avoid any communications that express or imply specialization and the announcement includes the disclaimer that the dentist is a general dentist. The use of abbreviations to designate credentials shall be avoided when such use would lead the reasonable person to believe that the designation represents an academic degree, when such is not the case.

NOTES:

1. A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services.

2. A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist's professional judgment.

3. Advertising, solicitation of patients or business or other promotional activities by dentists or dental care delivery organizations shall not be considered unethical or improper, except for those promotional activities which are false or misleading in any material respect. Notwithstanding any *ADA Principles of Ethics and Code of Professional Conduct* or other standards of dentist conduct which may be differently worded, this shall be the sole standard for determining the ethical propriety of such promotional activities. Any provision of an ADA constituent or component society's code of ethics or other standard of dentist conduct relating to dentists' or dental care delivery organizations' advertising, solicitation, or other promotional activities which is worded differently from the above standard shall be deemed to be in conflict with the *ADA Principles of Ethics and Code of Professional Conduct.*

4. Completion of three years of advanced training in oral and maxillofacial surgery or two years of advanced training in one of the other recognized dental specialties prior to 1967.

IV. INTERPRETATION AND APPLICATION OF *PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT.*

The foregoing *ADA Principles of Ethics and Code of Professional Conduct* set forth the ethical duties that are binding on members of the American Dental Association. The component and constituent societies may adopt additional requirements or interpretations not in conflict with the *ADA Code.*

Anyone who believes that a member-dentist has acted unethically should bring the matter to the attention of the appropriate constituent (state) or component (local) dental society. Whenever possible, problems involving questions of ethics should be resolved at the state or local level. If a satisfactory resolution cannot be reached, the dental society may decide, after proper investigation, that the matter warrants issuing formal charges and conducting a disciplinary hearing pursuant to the procedures set forth in the ADA *Bylaws*, Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE. The Council on Ethics, Bylaws and Judicial Affairs reminds constituent and component societies that before a dentist can be found to have breached any ethical obligation the dentist is entitled to a fair hearing.

A member who is found guilty of unethical conduct proscribed by the *ADA Code* or code of ethics of the constituent or component society, may be placed under a sentence of censure or suspension or may be expelled from membership in the Association. A member under a sentence of censure, suspension or expulsion has the right to appeal the decision to his or her constituent society and the ADA Council on Ethics, Bylaws and Judicial Affairs, as provided in Chapter XII of the ADA *Bylaws.*

Crosswalk between ADA Code of Ethics - Code of Virginia and Regulations of Board of Dentistry

(Regulations in red are found in Periodic Review action at the final stage in the Governor's office)

ADA Code of Ethics	Virginia Law and Regulation
1A. Patient Involvement	18VAC60-20-170 (4); 18VAC60-21-60 A (3) and A (7); 18VAC60-21-120 (A); 18VAC60-21-260 (F)
1B. Patient Records	32.1-127.1:03; 54.1-2403.3; 54.1-2404; 18VAC60-20-170 (4); 18VAC60-21-90; 18VAC60-21-260 (D)
2A. Education	54.1-2709; 54.1-2706 (12); 18VAC60-20-50; 18VAC60-21-250
2B. Consultation and Referral	54.1-2706 (11); 18VAC60-21-60 A (2)
2C. Use of Auxiliary Personnel	54.1-2706 (6) and (11); 18VAC60-20-170 (8); 18VAC-21-70 A (1); 18VAC60-21-120
2D. Personal Impairment	54.1-2706 (3)
2 E. Postexposure, Bloodborne Pathogens	54.1-2706 (5) and (11)
2F. Patient Abandonment	18VAC-60-21-60 A (5)
2G. Personal Relationships with Patients	18VAC60-21-60 B (5); 18VAC-60-21-70 (B)
3A. Community Service	Not a standard for a finding of unprofessional conduct
3B. Government of a Profession	Not a standard for a finding of unprofessional conduct
3C. Research and Development	Not a standard for a finding of unprofessional conduct
3D. Patents and Copyrights	Not a standard for a finding of unprofessional conduct
3E. Abuse and Neglect	63.2-1509 and 63.2-1606; 18VAC60-20-170 (4); 18VAC60-21-60 A (6)
3F. Professional Demeanor in the Workplace	18VAC60-21-60 A (1)
4A. Patient Selection	Jurisdiction of civil rights protection agencies
4B. Emergency Service	18VAC60-21—280 G (2); 18VAC60-21-291 E (2); 18VAC60-21-301 G (2)
4C. Justifiable Criticism	18VAC60-21-100
4D. Expert Testimony	
4E. Rebates and Split Fees	18VAC60-20-180; 18VAC60-21-60 B; 18VAC60-21-80 B and C;

5A. Representation of Care	54.1-2706 (4); 18VAC60-20-170 (1) and (3); 18VAC60-21-60 A (3)
5B. Representation of Fees	54.1-2706 (4); 18VAC60-20-170 (1) and (2); 18VAC60-21-60 B; 18VAC60-21-80 B & C
5C. Disclosure of Conflict of Interest	54.1-2706 (4); 18VAC60-20-170 (1); 18VAC60-21-60 B (4)
5D. Devices and Therapeutic Methods	54.1-2706 (11); 18VAC60-21-60 A (7); 18VAC60-21-100
5E. Professional Announcement	54.1-2706 (7); 18VAC60-21-80 A and G
5F. Advertising	54.1-2706 (7); 18VAC60-20-180; 18VAC60-21-80
5G. Name of Practice	54.1-2706 (4); 54.1-2716; 54.1-2717; 54.1-2718;
5H. Announcement of Specialization and Limitation of Practice	18VAC60-20-180 F; 18VAC60-21-80 A and G
5I. General Practitioner Announcement of Services	18VAC60-21-80 A and G

Reen, Sandra (DHP)

-----Original Message-----
From: rbadds@cox.net [mailto:rbadds@cox.net]
Sent: Wednesday, September 02, 2015 9:14 AM
To: Board of Dentistry
Subject: Who may own and operate a dental office in VA? (2012 - 2013 - 2014 & again in 2015)

Ms Reen:

I asked that question 3 years ago at the open comment session of the BOD in Sept. 2012 Again I asked the same question 2 years ago at the 2013 Sept meeting; Last year 2014, , I skipped attendance at the Sept meeting, I waiting to give the BOD time to study and resolve the question.

So, it has been 3 years since I first asked the question. To my knowledge , there still is no answer .

I was told by a dentist in the audience that a committee had been formed to study the question . Has such a committee been selected? Has the committee reported their findings? Have I missed something?

The BOD has a regularly scheduled quarterly meeting on Sept 18. Is there any reason that I should not attend that meeting and again during the public comment period raise that same question?

I request that you provide the members of the Governor-appointed Board members with a copy of this email

Dr Bob Allen
1038 POrft Harbour Arch
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757 869 0157

RBADDS@cox.net

Current Statutes on Dental Practice Ownership and Dental Practice Settings

There are several provisions in the Code of Virginia which address practice ownership and practice settings as follows:

- §54.1-2717 addresses the practice of dentistry by professional corporations and professional limited liability companies

- §54.1-2715 lists permissible work sites for certain dentists to qualify for temporary permits. The qualifying locations listed are:
  (a) the Virginia Department of Corrections,
  (b) the Virginia Department of Health,
  (c) the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, or
  (d) 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: (i) as a federal qualified health center designated by the Centers for Medicare and Medicaid Services or (ii) at a reduced or sliding fee scale or without charge.

- §54.1-2716 prohibits a dentist from practicing in a commercial or mercantile establishment.

- §54.1-2718 permits the practice of dentistry by a partnership under a firm name, a licensed dentist practicing as the employee of a licensed dentist, practicing under his own name or under a firm name, or as the employee of a professional corporation, or as a member, manager, employee, or agent of a professional limited liability company or as the employee of a dental clinic operated as specified in subsection A of § 54.1-2715.

- §54.1-2709.4 lists the entities responsible for reporting any type of disciplinary action taken against an oral and maxillofacial surgeon. This list includes health care institutions licensed by the Commonwealth as required reporters.

DHP JUN 29 2015

American Society of Dentist Anesthesiologists

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June 22, 2015

Melanie C. Swain, RDH
Virginia Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Dear Ms. Swain:

On behalf of the Board of Directors of the American Society of Dentist Anesthesiologists, and as a former resident of Virginia, I am writing to voice concerns about the current plan for establishing office inspections for dental anesthesia/sedation permit holders. These concerns are based upon viewing *Guidance Document 60-3* and the draft *Virginia Board of Dentistry Dental Inspection Form*. We appreciate the efforts of the Board to improve the culture of safety in Virginia dental offices, but worry that unforeseen and unintended consequences may thwart the good intentions of the board.

Dentist anesthesiologists have been, and remain, the best trained general anesthesia providers in dentistry. Their unique training and skill set often results in the pairing of their services with pediatric dentists for treating very young children with early childhood caries. As the access to hospital-based general anesthesia for dentistry continues to dwindle, dentist anesthesiologists provide an important option for these patients by providing office-based general anesthesia for pediatric dentists and special care dentists in their own offices. This year, approximately 17,000 Virginia children will require general anesthesia for the treatment of early childhood caries, as well as an equally daunting number of special needs patients with dental needs.

In an attempt to develop one office-inspection plan for all types of permit holders, in all locations, the Board stands to impose unnecessary and costly burdens for traveling ("itinerant") dentist anesthesiologists that do not affect other permit holders. Consider the following:

1. *Number of locations requiring inspection.* As written, the guidance document and draft inspection forms indicate all offices that host dental anesthesia services must pass inspection prior to providing anesthesia services. However, the equipment requirements listed on the inspection form cannot be satisfied unless the dentist anesthesiologist is present at the time of inspection, since a dentist anesthesiologist typically keeps all equipment and supplies in his possession. Most dentist anesthesiologists travel to a different office each day, on a variable schedule. Planning unannounced office inspections on days where the host dentist and staff, dental office, and dentist anesthesiologist are present will be, at a minimum, extremely complex, inefficient, costly, and time consuming.

Given the unique characteristics of mobile, office-based dental anesthesia practice, the process could be improved by requiring one office-inspection per dentist anesthesiologist at a determined location. Since the equipment, protocols and supplies remain the same for mobile dentist anesthesiologists, regardless of location, this practice would achieve the same goal as the current plan. One may claim that inspection of the office for environmental fitness and posting requirements compliance is not addressed by our recommendation. These requirements are required for all types of dental practices, and not limited to permit holders. It is unclear why the Board would single out permit holders for these types of inspections and not include all dental practices.

2. *Evaluation of safety protocols.* The creation and implementation of safety standards and protocols has been part of anesthesia practice for many decades, as reflected in the scientific literature. In 1978, Cooper et al published a classic paper entitled "Preventable Anesthesia Mishaps: a study of human factors (Anesthesiology 49:399-406, 1978). This often quoted paper found that human error was responsible for 82% of preventable anesthesia accidents while equipment failure was responsible for only 14% of events. This conclusion has been upheld in several studies since then, and underscores the fact that clinical judgment is the most important factor in the safe administration of anesthesia, and particularly in the execution of emergency protocols.

The current inspection form asks the inspector to evaluate the education of the dentist and staff by verifying the availability of emergency protocols and the dates for office staff training.

According to the current plan, any permit holder could fulfill this requirement by posting emergency protocols on the wall, producing a copy of some kind of emergency manual and providing a date and time on the office calendar that claims an emergency drill took place.

It is not clear how an unannounced visit by an inspector to obtain this information truly fulfils the guidance document charge to 'assure that appropriate protections are in place for patients undergoing conscious/moderate sedation, deep sedation or general anesthesia for dental treatment.

The Board grants an exemption to oral and maxillofacial surgeons that belong to AAOMS, which infers participating in a peer-review based office inspection program. This practice allows for a better evaluation of safety protocols. The same exemption should be granted for dentist anesthesiologists participating in a peer-review based office-inspection program. Dental anesthesiology and oral and maxillofacial surgery practices differ in crucial ways. According to AAOMS-commissioned study, the average patient undergoing deep sedation/general anesthesia in an oral surgery practice is an adult, scheduled for dentoalveolar surgery that lasts for less than 30 minutes. In contrast, data on dental anesthesia practice reveal the average patient is a preschool-aged child, undergoing complete dental rehabilitation under general anesthesia for more than an hour. Separate peer-review processes are clearly needed for these two classes of general anesthesia providers. Despite these very different forms of anesthesia practice, both dentist anesthesiologists and oral and maxillofacial surgeons have well-established parameters of care and protocols for office emergencies, which provide guidance for the safe practice of anesthesia. Respective peer inspection of these practices would elevate the quality of the inspection and better fulfil the charge of the guidance document.

The American Society of dentist anesthesiologists endorses state dental board evaluation of sedation and general anesthesia practitioner practice and competence in providing sedation and/or general anesthesia at initial licensure and periodically as required. We believe an evaluation performed by a dental board or a recognized national accrediting organization can be at either the fixed office location of a dentist anesthesiologist's practice or in the case of a mobile anesthesia practice, at any one location where the mobile dentist anesthesiologist provides services. It is the quality of the mobile anesthesia practitioner and practice systems that should be evaluated for patient safety, irrespective of the actual physical location of the practice for that particular day.

The ASDA Parameters of Care hold the dentist anesthesiologist to be responsible for confirming that all facilities visited by his anesthesia practice are held to the same standard of excellence, are comparably equipped with anesthetic emergency drugs and equipment, and that the operating dentist and/or auxiliary staff are adequately trained to assist the dentist anesthesiologist.

Thank you in advance for your thoughtful consideration of this important matter.

Sincerely,

Mark A. Saxen, DDS PhD
Immediate Past President
ASDA

Policy Strategies on Teledentistry

Referring back to the minutes and transcript of the Open Forum on Teledentistry, the Board is asked to discuss the recommendations and comments it received and to decide its next steps in this area.

Information provided to facilitate a discussion of current policy and possible actions are:

- Code of Virginia §54.1-2712 Permissible Practices

- Regulations Governing the Practice of Dentistry sections:
    - Part VI. Direction and Delegation of Duties

Code of Virginia § 54.1-2712. Permissible practices.

The following activities shall be permissible:

1. Dental assistants or dental hygienists aiding or assisting licensed dentists, or dental assistants aiding or assisting dental hygienists under the general supervision of a dentist in accordance with regulations promulgated pursuant to § 54.1-2729.01;

2. The performance of mechanical work on inanimate objects only, for licensed dentists, by any person employed in or operating a dental laboratory;

3. Dental students who are enrolled in accredited D.D.S. or D.M.D. degree programs performing dental operations, under the direction of competent instructors (i) within a dental school or college, dental department of a university or college, or other dental facility within a university or college that is accredited by an accrediting agency recognized by the United States Department of Education; (ii) in a dental clinic operated by a nonprofit organization providing indigent care; (iii) in governmental or indigent care clinics in which the student is assigned to practice during his final academic year rotations; (iv) in a private dental office for a limited time during the student's final academic year when under the direct tutorial supervision of a licensed dentist holding appointment on the dental faculty of the school in which the student is enrolled; or (v) practicing dental hygiene in a private dental office under the direct supervision of a licensed dentist holding appointment on the dental faculty of the school in which the student is enrolled;

4. A licensed dentist from another state or country appearing as a clinician for demonstrating technical procedures before a dental society or organization, convention, or dental college, or performing his duties in connection with a specific case on which he may have been called to the Commonwealth;

5. Dental hygiene students enrolled in an accredited dental hygiene program performing dental hygiene practices as a requisite of the program, under the direction of competent instructors, as defined by regulations of the Board of Dentistry, (i) within a dental hygiene program in a dental school or college, or department thereof, or other dental facility within a university or college that is accredited by an accrediting agency recognized by the United States Department of Education; (ii) in a dental clinic operated by a nonprofit organization providing indigent care; (iii) in a governmental or indigent care clinic in which the student is assigned to practice during his final academic year rotations; or (iv) in a private dental office for a limited time during the student's final academic year when under the direct supervision of a licensed dentist or licensed dental hygienist holding appointment on the dental faculty of the school in which the student is enrolled; and

6. A graduate of an accredited dental program or a graduate of an accredited dental hygiene program engaging in clinical practice under the supervision of a licensed faculty member, but only while participating in a continuing education course offered by a dental program or dental

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

(Code 1950, § 54-147; 1970, c. 639; 1972, c. 805; 1975, c. 479; 1985, c. 373; 1988, c. 765; 1989, c. 131; 1994, c. 749; 2004, c. 754; 2005, cc. 505, 587; 2008, cc. 84, 264; 2012, cc. 20, 116.)

Regulations Governing Dental Practice

Part VI. Direction and Delegation of Duties.

18VAC60-20-190. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-20-81, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

4. Authorization of work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;

6. Administering and monitoring general anesthetics and conscious sedation except as provided for in § 54.1-2701 of the Code of Virginia and 18VAC60-20-108 C, 18VAC60-20-110 F, and 18VAC60-20-120 F;

7. Condensing, contouring or adjusting any final, fixed or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-20-61 B;

8. Final positioning and attachment of orthodontic bonds and bands; and

9. Final adjustment and fitting of crowns and bridges in preparation for final cementation.

18VAC60-20-195. Radiation certification.

No person not otherwise licensed by this board shall place or expose dental x-ray film unless he has one of the following (i) satisfactory completion of a radiation safety course and examination given by an institution that maintains a program in dental assisting, dental hygiene or dentistry accredited by the Commission on Dental Accreditation of the American Dental Association, (ii) certification by the American Registry of Radiologic Technologists, or (iii) satisfactory completion of the Radiation Health and Safety Review Course provided by the Dental Assisting National Board or its affiliate and passage of the Radiation Health and Safety examination given

by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

18VAC60-20-200. Utilization of dental hygienists and dental assistants II.

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, with the exception that a dentist may issue written orders for services to be provided by dental hygienists under general supervision in a free clinic, a public health program, or on a voluntary basis.

18VAC60-20-210. Requirements for direction and general supervision.

A. In all instances and on the basis of his diagnosis, a licensed dentist assumes ultimate responsibility for determining the specific treatment the patient will receive and which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with this chapter and the Code of Virginia.

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 18VAC60-20-200. Persons acting within the scope of a license issued to them by the board under §54.1-2725 of the Code of Virginia to teach dental hygiene and those persons licensed pursuant to §54.1-2722 of the Code of Virginia providing oral health education and preliminary dental screenings in any setting are exempt from this section.

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 specific time period, not to exceed 10 months from the date the dentist last examined the patient. Upon expiration of the order, the dentist shall have examined the patient before writing a new order for treatment.

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 no anesthesia can be administered, 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. General supervision shall not preclude the use of direction when, in the professional judgment of the dentist, such direction is necessary to meet the individual needs of the patient.

18VAC60-20-220. Dental hygienists.

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

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices under anesthesia.

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 18VAC60-20-81.

B. The following duties shall only be delegated to dental hygienists and may be delegated by written order in accordance with § 54.1-2722 of the Code of Virginia to be performed under general supervision when the dentist may not be present:

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices.

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.

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 in subsection A of this section and those listed as nondelegable in 18VAC60-20-190.

C. Nothing in this section shall be interpreted so as to prevent a licensed dental hygienist from providing educational services, assessment, screening or data collection for the preparation of preliminary written records for evaluation by a licensed dentist.

D. A dental hygienist employed by the Virginia Department of Health may provide educational and preventative dental care under remote supervision, as defined in subsection D of § 54.1-2722 of the Code of Virginia, of a dentist employed by the Virginia Department of Health and in accordance with the Protocol adopted by the Commissioner of Health for Dental Hygienists to Practice in an Expanded Capacity under Remote Supervision by Public Health Dentists, September 2012, which is hereby incorporated by reference.

18VAC60-20-230. Delegation to dental assistants.

A. Duties appropriate to the training and experience of the dental assistant and the practice of the supervising dentist may be delegated to a dental assistant under the direction or under general supervision required in 18VAC60-20-210, with the exception of those listed as nondelegable in 18VAC60-20-190 and those which may only be delegated to dental hygienists as listed in 18VAC60-20-220.

B. Duties delegated to a dental assistant under general supervision shall be under the direction of the dental hygienist who supervises the implementation of the dentist's orders by examining the patient, observing the services rendered by an assistant and being available for consultation on patient care.

C. The following duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-20-61:

1. Performing pulp capping procedures;

2. Packing and carving of amalgam restorations;

3. Placing and shaping composite resin restorations;

4. Taking final impressions;

5. Use of a non-epinephrine retraction cord; and

6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

18VAC60-20-240. What does not constitute practice.

The following are not considered the practice of dental hygiene and dentistry:

1. Oral health education and preliminary dental screenings in any setting.

2. Recording a patient's pulse, blood pressure, temperature, and medical history.

THE COMMISSION ON **DENTAL COMPETENCY** ASSESSMENTS
1304 CONCOURSE DRIVE, SUITE 100 | LINTHICUM, MD 21090
TEL: 301-563-3300 | FAX: 301-563-3307
cdcaexams.org

Dear Friends,

During the first 6 months since you have elected me as your Chair, it has been an honor and privilege to serve the CDCA while working in concert with my fellow Board of Director members and our committed Central Office staff to meet CDCA's mission of excellence, integrity and fairness at every exam that we deliver. I thank you all again for this opportunity.

The last 6 months have offered many new opportunities for the CDCA.

In January we welcomed the Commonwealth of Jamaica as the first international member of the CDCA. In May, we delivered Jamaica's first ADEX/CDCA examination, at the University of Technology, in Kingston,. During the examination, the Most Honorable Portia Simpson-Miller, the Prime Minister of Jamaica, visited the dental school to welcome the CDCA exam team and thank us for bringing the ADEX examination to Jamaica. I had the pleasure of representing the CDCA and it was one of the proudest moments of my life. I wish you all could have been there to share in the honor that the people of Jamaica gave to us. While we were there, we also scheduled the first exam to be given at the University of the West Indies, also in Kingston, Jamaica. Next year our goal is to schedule both schools at the same time so that one travel team can exam at both sites. We all owe Dr. Maurice Miles our thanks for all of his efforts to make this a reality.

For the last several years a dialogue has been on-going between the New York State Dental Association, the New York State Dental Board and the CDCA. Dr. John Iacono has been instrumental in helping to keep the lines of communication open. This past January at the University Of Buffalo School Of Dental Medicine a major breakthrough was reached. Dr. Michael Glick, Dean at Buffalo School of Dental Medicine, hosted a meeting including Dr. Mark Feldman, New York State Dental Association Executive Director, Dr. Guy Shampaine, myself, and other interested parties. At this meeting a pilot ADEX examination was proposed with the intention that the New York legislature would consider recognizing this new exam as a possible avenue for licensure. The pilot "Buffalo Model" examination would serve as a modification of the traditional licensure exam format which enables the focus of the exam to shift from the candidate to the patient. This new "Buffalo Model" ADEX exam was approved at the November ADEX meeting and CDCA's Buffalo pilot examinations began this past January.

The focus of this year's Steering Committee/Educator's Conference was Dr. Joe Gambacorta's presentation of the new CDCA administered ADEX "Buffalo Model" examination protocol. Dr. Gambacorta and Dean Glick were instrumental in the success of the CDCA/ADEX "Buffalo Model" pilot exams. Dr. Gambacorta's presentation was followed by a panel discussion with Dr. Gambacorta, Dean Glick, Dr. Guy Shampaine and myself. The excitement created by Dr.

Gambacorta was obvious and reflected by the wide variety of questions from the audience. In short, our presenters and panel discussed with the audience how the "Buffalo Model" represents an evolution of the CIF examination format that provides advantages for a more patient-centered approach during examinations. The CDCA plans on making this format available for all dental schools. You will hear more about this new examination process at the CDCA Annual Meeting in Orlando, January 14-15, 2016.

Also at this year's Steering Committee/Educators Conference, the dental hygiene educators were presented with an update on the success of the dental hygiene site consolidation as well as an update on the pilot of the electronic grading of the dental hygiene examination. Through the tremendous efforts of Pat Connolly-Atkins, this project has been a huge success and all hygiene exams will be graded electronically next year. The most significant benefit of this will be the quicker reporting on the results of the examination to the candidates. Additionally, grading electronically has reduced overall grading time for examiners, will help to prevent errors, since examiners cannot log out unless they have completed all grading requirements, and will enable us to gather statistical data for better calibration of examiners.

The Central Office has been integrating Florida examinations into the standard processes for all of our other CDCA dental and dental hygiene examinations. All of us owe Dr. LeeAnn Podruch a huge thank you for all of her efforts over the last five years to ensure that the examinations in Florida went off without a hitch. Florida examiners all now have individual EAS profiles and have been fully incorporated into the CDCA examiner assignment committee processes led by Dr. Dean McCleese. Other ongoing efforts involving candidates, schools and the Florida Department of Health have been assimilated within Central Office support systems. We are blessed to have a Central Office Staff that is as dedicated and committed to the CDCA mission as are all of you. Our exams require the dedication and commitment of each and every one of us. I thank you all for this commitment to excellence.

The State of Ohio through Dr. Mark Armstrong asked the CDCA late last year to consider administering the Expanded Function Dental Assistant (EFDA) examination. Dr. Armstrong provided Dr. Ellis Hall and Dr. Lisa Deem the statute for EFDA's in Ohio and the CDCA submitted our proposal to the Ohio State Dental Board for consideration. The Ohio State Board approved our proposal and the CDCA EFDA examination will be offered in Ohio this June 23rd.

The Florida Board of Dentistry has a required jurisprudence examination that was self-administered up until earlier this year. Florida inquired if the CDCA would be interested in taking over the administration of this examination. Alex Vandiver, our Executive Director, did an analysis and submitted a proposal to Florida that was accepted and the CDCA began implementing this new Florida jurisprudence examination through Prometric starting this past May. The early feedback is that Florida has been extremely pleased with the CDCA and the quicker availability of scores to the candidates.

The CDCA Board continues to reach out to new schools to offer our ADEX/CDCA examinations. We have a new school in Bradenton, Florida, and in Portland, Maine, that will be taking our exam. We have answered requests by schools outside our normal geographical area that have students that are interested in having the ADEX credential for licensure and would

have to travel with patients to be able to take it. We are ready and willing to go wherever we are asked.

Finally, some of you have expressed disappointment in not receiving as many assignments as you may have had in the past, or perhaps not receiving a site that you had enjoyed going to in the past. The Assignment Committee tries to give priority to members on their active State Boards for assignments. Therefore, there may not be as many slots for others. However, I am confident that with the implementation of the "Buffalo Model" examinations that there will be many more opportunities for assignments at multiple exam sites, especially if you have flexibility in your schedule.

While all of this has been going on, we have continued to administer hundreds of exams to our dental hygiene and dental schools throughout the USA. Our staff continues to answer every challenge. With the addition of new schools and the potential that the "Buffalo Model" presents, we will need the continued support of all of you to answer the calls for examiners. These new exams will present many different challenges and exciting opportunities for all of us. I know I can count on all of you. With your support and commitment to excellence there is no challenge that we cannot meet.

Thank you!

Dave Perkins

Disciplinary Board Report for September 18, 2015

Today's report reviews the 2015 calendar year case activity then addresses the Board's disciplinary case actions for the fourth quarter of fiscal year 2015 which includes the dates of January 1, 2015 through June 30, 2015.

Calendar Year 2015

The table below includes all cases that have received Board action since January 1, 2015 through August 31, 2015.

Calendar 2015	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	111	119	4	123
Feb	89	64	0	64
Mar	53	49	16	65
Apr	43	16	4	20
May	30	29	15	44
June	39	37	11	48
July	53	25	8	33
August	22	74	4	78
Totals	**440**	**413**	**62**	**475**

Q4 FY 2015

For the fourth quarter, the Board received a total of 69 patient care cases. The Board closed a total of 66 patient care cases for a 96% clearance rate, which is down from 105% in Q3. The current pending caseload older than 250 days is 24%, and the Board's goal is 20%. In Q4 of 2015, 66% of the patient care cases were closed within 250 days, as compared to 75% in Q3 of 2015. The Board's goal is 90% of patient care cases closed within 250 days. The Board slightly slipped with its statistics but Board staff does appreciate the hard work that you have been putting in.

License Suspensions

Between May 7, 2015 and August 31, 2015 the Board mandatorily suspended the license of one dentist.

VIRGINIA BOARD OF DENTISTRY
Analgesia, Sedation and Anesthesia Practice
Questions and Answers

WHAT ARE THE REQUIREMENTS FOR MANAGING ANXIOLYSIS?

- **Anxiolysis is addressed in the Regulations Governing Dental Practice (Regulations) in the definition of minimal sedation in section 18VAC60-20-10.C and in the provisions for minimal sedation in section 18VAC60-20-107.B.3, C, D, F, G, and H and in section 18VAC60-20-108.**

DOES PRESCRIBING XANAX FOR PRE-APPOINTMENT USE CONSTITUTE SEDATION PRACTICE?

- **Yes, benzodiazepines such as Xanax and Valium which are prescribed or are administered or dispensed for self-administration to reduce anxiety for dental treatment generally fall within the definition of minimal sedation. Adding nitrous oxide or another drug may induce a deeper level of sedation. It is important to keep in mind that the type and dosage of medication, the method of administration and the individual characteristics of the patient must be considered in deciding the level of sedation being administered. See sections 18VAC60-20-107 and 18VAC60-20-108 in the Regulations to review provisions on minimal sedation.**

ARE THERE MODEL FORMS OR TEMPLATES AVAILABLE FOR KEEPING A RECORD OF DRUGS, FOR PERFORMING BIENNIAL INVENTORIES?

- **No, the Board has not adopted model forms.**

HOW SHOULD COMPLETION OF STAFF TRAINING IN EMERGENCY PROCEDURES BE DOCUMENTED?

- **This is guidance for implementing section 18VAC-60-20-107.G.2 of the Regulations. The employing dentist is responsible for keeping a record of the training provided. The record must include the date of the training, the content of the training, and a list of the staff who participated in the training.**

WHO CAN DISMISS THE PATIENT UNDER SEDATION OR GENERAL ANESTHESIA?

- **When <u>minimal sedation</u> has been administered, the dentist is responsible for discharging the patient. See section 18VAC60-20-108.D. *Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.***

- **When <u>conscious/moderate sedation</u> has been administered, the dentist or the anesthesiologist who administered the drugs or another practitioner qualified to administer the drugs is responsible for assessing and discharging the patient. See sections 18VAC60-20-120. J.2. and K.1. *<u>J. Monitoring requirements.2.</u> Monitoring of the patient undergoing conscious/moderate sedation, including direct, visual observation of the patient by a one member of the treatment team, is to begin prior to administration of sedation, or if medication is self-administered by the patient,***

immediately upon the patient's arrival at the dental office and shall take place continuously during the dental treatment and during 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. K. 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.

- **When deep sedation or general anesthesia has been administered, the dentist or the anesthesiologist who administered the drugs or another practitioner qualified to administer the drugs is responsible for assessing and discharging the patient. See sections 60-20-110.G.2 and H.1.** *G. Monitoring requirements.2. Monitoring of the patient undergoing deep sedation/general anesthesia, including direct, visual observation of the patient by one member of the treatment team, is to begin prior to induction and shall take place continuously following induction, during the dental procedure, and during recovery from anesthesia. The person who administered 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. H. 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.*

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?

- **There is no statue 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** ***Monitoring requirements*** **in section 18VAC60-20-120. J. 1.** *The treatment team for conscious/moderate sedation shall at least consist of the operating dentist and a second person to assist, monitor, and observe the patient. Both shall be in the operatory with the patient throughout the dental treatment…*

DOES INFORMED CONSENT HAVE TO BE GIVEN PRIOR TO EACH SEDATION ADMINISTRATION OR IF A LONG-STANDING PATIENT, CAN THERE BE A BLANKET SEDATION INFORMED CONSENT?

- **To meet the requirement in 18 VAC 60-20-107(C), written informed consent must be obtained each time sedation will be administered.**

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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June 19, 2015

Dr. James M. Boyle, III, 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. Boyle:

The Virginia Board of Dentistry (the Board) appreciates this additional opportunity to submit comments on the ADA Sedation and Anesthesia Guidelines as the Council continues its comprehensive review. The Board is in unanimous agreement with the direction taken in the proposed changes in both sets of guidelines. We support and are especially appreciative of the revisions addressing:

- capnography/CO2 monitoring,
- that sedating children age 12 and under requires extra caution and focused training, and
- an integrated competency course for moderate sedation.

The Board does request further clarification of the term "individually-managed" as used in the Moderate Sedation Course Duration provisions on page 27 in line 1381 to require the hands-on participation of each student in:

1. Taking the pre-sedation health history.
2. Performing the appropriate pre-operative examination.
3. Establishing the appropriate monitors.
4. Administering the medications.
5. Continuously assessing the condition of the patient.
6. Appropriately assess the patient's recovery and confirm that the criteria for discharge are met.
7. Evaluating and treating life-threatening conditions.

It is our opinion that the guidelines must expressly require the physical demonstration of competence through supervised clinical practice of the knowledge and skills taught in the didactic portion of the course.

The Board looks forward to the Council's completion of its review and our receipt of the new editions of the guidelines. Please contact me at sandra.reen@dhp.virginia.gov if you have any questions about our submission.

Sincerely,

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

Virginia Board of Dentistry
(804) 367-4538 FAX (804) 527-4428 denbd @dhp.virginia.gov

August 19, 2015

FINAL NOTICE
ACT IMMEDIATELY TO AVOID DISCIPLINARY ACTION

Full Name, Credential
Address

Dear Dr. ( ):

The Board of Dentistry (Board) urges you to act immediately to come into compliance with the Virginia law on dispensing Schedule II (Percocet, Hydrocodone), III (Tylenol with Codeine), or IV (Valium, Xanax) medications. Section 54.1-2521 of the Code of Virginia requires you, a holder of an active dental license in Virginia, to either register with PMP to report the Schedule II, III, or IV medications you dispense **or** to submit a waiver application because you do not dispense any Schedule II, III or IV medications in Virginia. If you fail to apply for a waiver **or** to register to report dispensing by Monday, September 7, 2015, the Board will open a case against you in order to investigate and address your non-compliance.

If you do not dispense any Schedule II, III or IV medications in Virginia, you should go to: http://www.dhp.virginia.gov/pmp/forms.htm to obtain a copy of the "Request for a Waiver for an Exemption from Reporting." Submitting this request to the PMP will bring you into compliance and take you off the list for disciplinary action.

If you do dispense medications in Schedules II, III, or IV in Virginia you should go to: http://www.dhp.virginia.gov/dhp_programs/pmp/pmp_forms.asp to obtain a copy of the "Dispenser Registration Form for PMP Reporting Account." In addition, to facilitate future communications, follow these steps to confirm that the Board has a current email address for contacting you:

1. Go to http://www.dhp.virginia.gov/
2. Under the heading: "Services for Practitioners" on the left side: Select "Update Your Information"
3. Select "Continue to the Login Page"
4. Once logged in, Click on "Mailing Address Change", then "Address of Record". Update or add your ***email address*** as necessary.

To review the answers to frequently asked questions about the requirements related to dispensing, go to http://www.dhp.virginia.gov/dentistry/guidelines/DispensingFAQs.doc. For more information about the PMP, go to http://www.dhp.virginia.gov/pmp/ or contact the PMP at pmp@dhp.virginia.gov, or 804-367-4566.

Sincerely,

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

UNAPPROVED - DRAFT

BOARD OF DENTISTRY
MINUTES of the NOMINATING COMMITTEE MEETING

Friday, August 14, 2015

Perimeter Center
9960 Mayland Drive, Suite 200
Richmond, VA 23233
Board Room 4

CALL TO ORDER:	The meeting was called to order at 12:30 p.m.
PRESIDING:	Melanie C. Swain, R.D.H., Chair
MEMBERS PRESENT:	James D. Watkins, D.D.S. John M. Alexander, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director for the Board
QUORUM:	All members were present.
NOMINATIONS:	Ms. Swain read the description of the role of a nominating committee from the Standard Code of Parliamentary Procedure. Ms. Reen reviewed the nominations received from board members. Following discussion, it was agreed by consensus to nominate Dr. Gaskins for president, Dr. Rizkalla for vice-president and Ms. Swecker for secretary-treasurer.
APPROVAL OF MINUTES:	Ms. Swain asked for a motion to approve the minutes of the July 18, 2014 minutes. Dr. Watkins moved adoption of the minutes. The motion was seconded and passed.
ADJOURNMENT:	With all business concluded, the Committee adjourned at 1:50 p.m.

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

Sandra K. Reen, Executive Director

Date

Date