

VIRGINIA BOARD OF DENTISTRY

AGENDAS

December 10-11, 2015

Department of Health Professions

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

PAGE

December 10, 2015

1:00 p.m. Formal Hearings

December 11, 2015

Board Business

9:00 a.m. Call to Order – Dr. Gaskins, President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- September 17, 2015 Formal Hearing **P.1**
- September 18, 2015 Business Meeting **P.4**
- November 18, 2015 New Board Member Orientation **P.12**

DHP Director’s Report – Dr. Brown

Sanctioning Reference Points Instruction Manual – Dr. Watkins

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- Manual with Recommended Revisions Highlighted – Mr. Kauder **P.17**

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Agency Subordinates Recommendations	
<u>Closed Session</u>	<u>CONFIDENTIAL DOCUMENTS</u>
• Case # 160283	
• Case # 152428	
• Case # 157224	

12:00 p.m. * *Board Member Service Recognition Lunch*
NO BUSINESS WILL BE CONDUCTED

**Or immediately following the conclusion of the Business meeting*

**VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
September 17, 2015**

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 10:04 a.m., on September 17, 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.
Charles E. Gaskins, III, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
Al Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
James D. Watkins, D.D.S.

MEMBERS EXCUSED: Tammy K. Swecker, R.D.H.
Bruce S. Wyman, D.M.D.

MEMBER ABSENT: Sharon W. Barnes, Citizen Member

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 seven members present, a quorum was established.

**Vladimir Soyfer, D.D.S.
Case No.: 153452**

Dr. Soyfer was present with legal counsel, Michael L. Goodman and Eileen M. Talamante, in accordance with the Notice of the Board dated July 23, 2015.

Ms. Swain swore in the witnesses.

Following Ms. Talamante's opening statement, Ms. Swain admitted into evidence Respondent's Exhibits A-D.

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

Testifying on behalf of the Commonwealth were Cheryl Hodgson, RN, DHP Senior Investigator and Patient A.

Testifying on behalf of Dr. Soyfer by phone was Dr. Karen McAndrew, DMD. Dr. Soyfer testified on his own behalf.

Closed Meeting:

Dr. Gaskins 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. Soyfer. 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. 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.

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

Decision:

Dr. Gaskins 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. Gaskins moved to require Dr. Soyfer to complete three continuing education courses as follow:

- 7 hours in remedial periodontics;
- 7 hours in recordkeeping & risk management; and
- 6 hours in coding, accounting, & billing practices.

Following a second, a roll call vote was taken. The motion passed unanimously.

Virginia Board of Dentistry
Formal Hearing
September 17, 2015

ADJOURNMENT: The Board adjourned at 5:05 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
MINUTES
September 18, 2015**

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:05 a.m. on September 18, 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.
Charles E. Gaskins, III, D.D.S.
Tonya A. Parris-Wilkins, 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.
Bruce S. Wyman, D.M.D.

BOARD MEMBERS

ABSENT: Sharon W. Barnes, Citizen Member

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:

James E. Rutkowski, Assistant Attorney General

ESTABLISHMENT OF

A QUORUM:

With nine members of the Board present, a quorum was established.

Ms. Reen read the emergency evacuation procedures.

Ms. Swain welcomed the new Board member, Dr. Parris-Wilkins, and thanked Board staff and Board counsel for their participation.

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

PUBLIC COMMENT: **Dr. Robert Allen, DDS,** asked the Board who may own and operate dental practice in Virginia.

Chris Nolen of McGuire Woods, asked the Board what has changed since the last discussion of practice ownership and noted his clients' interest in participating in any discussion of this matter since it affects public policy on access to care.

Guy Rollings of Kool Smiles stated his agreement with Mr. Nolen's comments.

**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 presented.

**DHP DIRECTOR'S
REPORT:**

Dr. Brown was not present.

**LIAISON/COMMITTEE
REPORTS:**

Board of Health Professions (BHP). Dr. Watkins stated that he did not attend the last meeting and noted that the minutes are provided in the agenda package.

AADB. Ms. Swain stated that she had no report and added that Dr. Gaskins will attend the AADB Annual meeting in November, 2015.

ADEX. Dr. Rolon said she had no report. Dr. Rizkalla noted that SRTA is no longer administering the ADEX dental exam because it was not being accepted by some states and as a result SRTA had to issue refunds. He added the handling of a computer malfunction during a SRTA exam was acceptable to all parties involved except ADEX, which contributed to the decision for ADEX and SRTA to disassociate.

SRTA. Dr. Rizkalla reported that as of July 28, 2015, the SRTA exam is accepted in 32 states. He added that SRTA is concerned that Maryland, North Carolina and District of Columbia do not accept the SRTA exam.

Ms. Swecker reported the Dental Hygiene Committee has modified many areas of the exam and noted Virginia dental education programs receive SRTA scores automatically because the Board is a member of SRTA. Moving forward, this may be a concern as SRTA is no longer administering the ADEX exam.

Dr. Watkins stated the Dental Committee met after the annual meeting to rewrite the exam due to the split with ADEX and a meeting is being planned. He added Mississippi and Kentucky are no longer members of SRTA, but the Kentucky Board is amending their statute so they can accept the SRTA exam.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported:

- The Periodic Review to reorganize Chapter 20 into four chapters has been at the Governor's office for approval to publish as final regulations for more than 261 days;
- The NOIRA for a law exam is pending approval by the Governor to publish for public comment;
- The proposal to accept education programs accredited by the Commission on Dental Accreditation of Canada is moving forward as a fast track action; and
- The proposal to require capnography equipment for monitoring anesthesia or sedation as a fast track action was deemed not appropriate by the Department of Budget and Planning (DPB). This proposal was resubmitted as a NOIRA and is at DPB for review.

One Time Renewal Fee Decrease. Ms. Yeatts explained that the Board is required by law to adjust fees so the revenue and expenditures are not more than 10% apart. She referenced the analysis and recommended reductions provided by the DHP Budget Manager. She requested adoption of the proposed reductions in order to have the reductions in effect for the 2016 renewal notices. Dr. Watkins moved to adopt the recommended regulations for a one-time fee reduction as presented. The motion was seconded and passed.

Response to Petition for Rulemaking from Dr. Dickinson. Ms. Yeatts stated the petition asks the Board to adopt the ADA's Principles of Ethics and Code of Professional Conduct (ADA Code). She said 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 presented a chart showing that many of the ADA Code provisions are addressed in the Code of Virginia, both in current regulations, and in the proposed chapters of regulations which are at the Governor's office for approval to publish as final regulations. She cautioned against adopting the ADA Code by reference because the Board then would be bound to adhere to any changes made by the ADA without the ability to address changes through Virginia's regulatory process.

Mr. Rutkowski advised the Board to reject the petition because some of the standards in the ADA Code are not enforceable and others have already been addressed. Discussion followed about the pros and cons of incorporating the ADA Code in regulations. The idea that the Board could adopt it and selectively enforce the provisions was discussed, but not advanced. Following discussion, Dr. Watkins moved to deny Dr. Dickinson's petition because most of the standards in the ADA Code are addressed in current or proposed regulations and some of the standards in the ADA Code, such as participation in professional societies, are not appropriate grounds for disciplinary action. The motion was seconded and passed.

BOARD

DISCUSSION/ACTION:

Review of Public Comment Topics. Ms. Swain noted that members of the audience had commented on the topic of practice ownership; then she asked for Board discussion. Ms. Reen said there was also written comment from Dr. Allen about practice ownership. She reported that she had provided the current laws and regulations to Dr. Allen and he is possibly was not satisfied with the information. She added that she will address this topic for the Regulatory-Legislative Committee on October 16, 2015, by reviewing her communications with the State Corporation Commission, Department of Medical Assistance Services and the Office of the Attorney General. Dr. Wyman moved to provide an update on the status of practice ownership in the next edition of "BRIEFS". The motion was seconded and passed.

Written Comments from Dr. Saxen and Dr. Wong addressed their concerns about the effect that office inspections for the administration of sedation have on traveling dental anesthesiologists and asked for consideration of allowing an exemption for dental anesthesiologists to have peer review. It was noted that dental anesthesiology is not a recognized specialty and there is no certifying board recognized by the ADA. By consensus, the Board agreed to send letters of acknowledgement to both commenters.

Policy Strategies on Teledentistry. Ms. Reen stated that the minutes and transcript of the Open Forum on Teledentistry are included in the agenda for discussion of the next steps to be taken. During discussion the following policy considerations were noted:

- The hands-on nature of dentistry needs to be reflected;
- Requiring state licensure;
- Cyber security and the use of smart phones; and
- Using teledentistry to address the supervision of dental hygienists in order to address public health needs.

By consensus, it was agreed to refer this matter to the Regulatory-Legislative Committee.

CDCA Letter. Ms. Swecker asked the Board to consider requiring a clinical examination similar to Ohio's for dental assistants II. By consensus, the Board agreed to refer this matter to the Regulatory-Legislative Committee.

**BOARD COUNSEL
REPORT:**

Mr. Rutkowski reminded Board members that they:

- must not "reply to all" when responding to group e-mails because doing so constitutes a meeting;
- do not speak for the Board and should refer inquiries to the executive director; and
- must not engage witnesses or other board members in a debate during hearings.

**REPORT ON CASE
ACTIVITY:**

Ms. Palmatier stated that from January 1, 2015, through September 11, 2015, 451 cases were received and 488 cases were completed. She noted that 69 patient care cases were received and 66 cases were closed achieving a 96% clearance rate for the fourth quarter, which is down from 105% in the third quarter; the pending caseload older than 250 days was 24%; and 66% of cases were closed within 250 days. She added that the license of one dentist had recently been mandatorily suspended. She also reported that Board staff, with Dr. Levitin, has read about 70 C and D cases, which will help with the backlog. She expects the numbers for the first quarter of 2016 to be higher.

**EXECUTIVE
DIRECTOR'S
REPORT/BUSINESS:**

Ms. Reen reported:

- The proposal advanced by the Ad Hoc Committee on Disciplinary Findings to amend the Sanction Reference Points guidance document to add a financial gain factor to the offense scoring tables will be presented at the December meeting. She added that Mr. Kauder of Visual Research has evaluated the effect of adding this offense and will present his findings at the Board's December meeting.
- There were several misstatements about the work of the Board in the VDA President's Message in the latest Virginia Dental Journal. The misstatements were:
 1. *Only 3 – 5% of licensees violate the laws and regulations for dentistry.* She said that in the last five years 8,358 dentists have held an active dental license and 1,472 of those dentists have had at least one case before the Board. This means that 17.6% of

the dentists licensed in this five year snapshot were or are currently being investigated by the Board for possible violations of the laws and regulations which govern dental practice in Virginia.

2. *The Board only communicates to interested third parties about changes.* The Board's Public Participation e-mail list of 167 individuals and organizations includes numerous dentists and dental organizations. BRIEFS which addresses the policy actions of the Board is sent to every licensee with an email address on record.
3. *The Board used to publish a quarterly newsletter.* Looking back to 1988, the records indicate that a year or more passed between bulletins until 2010. Beginning in 2010, BRIEFS has been issued twice a year with the exception that only one was issued in 2014.

She also noted that Dr. Link encouraged VDA members to contact Board members to address their issues. Ms. Reen said that Board members are public officials who can hear comments from the public, but she went on to caution that questions should be referred to her since she is the spokesperson for the Board.

- Ms. Reen asked the Board to consider using agency subordinates to hear cases when two board members are not available to convene a Special Conference Committee. She added that the case decisions made by the agency subordinate must be ratified by the Board at the next Board meeting. Ms. Yeatts stated that §54.1-2400 of the Code of Virginia grants the Board the authority to delegate to a qualified agency subordinate the authority to conduct informal fact-finding proceedings. She also noted that the Board has a regulation which allows the Board to delegate selection of an agency subordinate to its executive director. Dr. Rizkalla moved to authorize the Executive Director to designate an agency subordinate to conduct informal hearings as needed. The motion was seconded and passed.
- **Regulatory-Legislative Committee will meet on 10/16/2015.** Ms. Reen stated that the Committee will meet at 9 a.m. and all Board members are welcome to attend.

- **Guidance Document 60-17 Recovery of Disciplinary Costs.** Ms. Reen stated that the Board revisits this every year to reflect the current costs for investigation and compliance. She asked the Board to adopt the proposed revisions as presented. Dr. Watkins moved to adopt the proposed revisions. The motion was seconded and passed.
- **Proposed Guidance Document.** Ms. Reen stated that the Regulatory-Legislative Committee asked Board staff to create a guidance document to help permit holders better understand sedation/anesthesia regulations. She noted that the questions in the proposed guidance document are frequently asked to the Board, and that the answers provided were crafted by Ms. Reen after research of the current laws and regulations. Dr. Wyman moved to adopt the proposed guidance document as presented. The motion was seconded and passed.

Comments Submitted to CDEL. Ms. Reen stated a copy of the letter is provided as information only, no action needed.

Guidance on Addressing Noncompliance with Dispensing Requirements. Ms. Reen asked the Board how to address licensees' noncompliance with the Prescription Monitoring Programs' (PMP) requirements to report dispensing of controlled substances. She stated every dentist with an active license must either report their dispensing of controlled substances to PMP, or apply for a waiver. She explained Board staff has worked with the PMP and the IT division to send multiple notices about the requirements, and the final notice was sent on August 19, 2015, with a September 7th deadline to come into compliance. She asked for guidance on addressing the lack of responses by an estimated 300 licensees, and for addressing registered dentists who fail to submit required weekly reports. She noted that an advisory letter could not be utilized because these dentists are already out of compliance. She added that Confidential Consent Agreements (CCA) and Prehearing Consent Orders (PHCO) are options the Board could consider. Dr. Watkins moved to offer a CCA, and to include a copy of the forms required to report dispensing or to apply for a waiver. The motion was seconded and passed.

Virginia Board of Dentistry
Board Business Meeting
September 18, 2015

ELECTION OF OFFICERS:

Ms. Swain stated the Nominating Committee nominated

- Dr. Gaskins for President,
- Dr. Rizkalla for Vice-President, and
- Ms. Swecker for Secretary-Treasurer

She then opened the floor for nominations for each office. There were no additional nominations and the Board agreed by consensus to elect the slate of officers as presented by the Nominating Committee.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 12:05 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED - DRAFT
BOARD OF DENTISTRY
NEW MEMBER ORIENTATION

Wednesday, November 18, 2015

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

CALL TO ORDER: The meeting was called to order at 1:35 p.m.

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

MEMBERS PRESENT: Carol R. Russek, J.D., Citizen Member

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

ORIENTATION: Dr. Gaskins welcomed Ms. Russek and expressed his appreciation for her legal experience. Dr. Gaskins explained that a proposal to amend the Board's bylaws will be addressed at the December 11th Board meeting and reviewed the proposal.

Ms. Reen went over the laws, regulations and policies in the Board Member's notebook and explained that the current chapter of regulations is being replaced by four chapters which will be in effect on December 2, 2015. 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.

Ms. Vu reviewed the state's policies on travel and per diems then gave Ms. Russek the conflict of interest training material to complete and return.

Ms. Palmatier explained the disciplinary case process and the Probable Cause Review form and discussed the information needed to close a case and to move a case forward for 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 Ms. Russek to use it to help work through cases and to call staff with any questions about a case.

**Virginia Board of Dentistry
New Member Orientation
November 18, 2015**

2

ADJOURNMENT The training was adjourned at 3:35 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

APPROVED

**VIRGINIA BOARD OF DENTISTRY
AD HOC COMMITTEE MEETING on
DISCIPLINARY FINDINGS**

Wednesday, June 3, 2015

**Perimeter Center
9960 Mayland Drive, Suite 201
Richmond, Virginia 23233-1463
Training Room 1**

CALL TO ORDER: The meeting of the Ad Hoc Committee on Disciplinary Findings was called to order at 2:33 p.m. on June 3, 2015 in Training Room 1, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: James D. Watkins, D.D.S., Chair

MEMBERS PRESENT: Charles E. Gaskins, III., D.D.S.
Tammy K. Swecker, R.D.H.

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

QUORUM: All members were present.

PUBLIC COMMENT: None

DISCIPLINARY FINDINGS: Ms. Reen stated that the Board at its March 13, 2015 meeting established the Committee to discuss adding relevant findings of facts to Board Orders and to consider if Guidance Document 60-2 Sanction Reference Point (SRP) Instruction Manual should be edited to facilitate consistency across the Special Conference Committees (SCCs) in addressing aggravating and mitigating factors which affect consistency in sanctioning.

Following review of the SRP provisions for mitigating and aggravating factors, it was agreed that SCC chairs would facilitate discussion of the presenting evidence to determine if additional findings of fact are needed to support the case decision. Dr. Gaskins noted that SRP pages 9 and 14 would be very helpful in decision making. Staff agreed to have copies of those pages available at all informal conferences.

Ms. Reen then asked the Committee to consider some changes to the SRP based on the staff's review of the Boards of Medicine and Nursing's SRPs. After discussion and by consensus, the Committee decided to forward the following recommendations to the Board for consideration:

SRP pg 8

Add additional bullets as "Pre-Hearing Consent Order (PHCO)" and "Confidential Consent Agreement (CCA)" under Worksheets Not Used in Certain Cases.

SRP pg 9

Add additional bullet as "Obtaining drugs by fraud" under Inability to Safely Practice.

Include "sexual assault and mistreatment" to abuse under Standard of Care.

Add additional bullet as "Omission of required wording/advertising elements" under Business Practice Issues/Advertising.

SRP pg 10

In the bullet section, replace the word Victim with "Patient"

Add another bullet as "Age of prior record"

SRP pg 12

Add "/monitoring" after treatment.

Replace HPIP with "HPMP."

Add additional bullet as "Mental or Physical Evaluation."

Delete bullet point "Read Board laws governing Dentistry" under No Sanction Reprimand Education Terms.

SRP pg 13

Add the word "/monitoring" after each appearance of "Treatment".

SRP pg 16 – Inability to Safely Practice worksheet Instructions

Under Offense Score column, add "Enter "20" if there was financial or other material gain from the offense."

SRP pg 17 – Inability to Safely Practice Worksheet

Under Offense Score, add "Financial or material gain from offense - 20 points."

In the Sanction Grid add "/monitoring" after each appearance of "Treatment".

SRP pg 18 – Standard of Care worksheet Instructions

Under Offense Score column, add "Enter "20" if there was financial or other material gain from the offense."

SRP pg 19 - Standard of Care worksheet

Under Offense Score, add "Financial or material gain from offense - 20 points."

In the Sanction Grid add "/monitoring" after each appearance of "Treatment".

SRP pg 20 – Advertising/Business Practice Issues Worksheet Instructions

Under Offense Score column, add "Enter "20" if there was financial or other material gain from the offense."

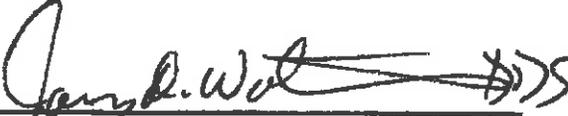
SRP pg 21 - Advertising/Business Practice Issues Worksheet

Under Offense Score, add "Financial or material gain from offense - 20 points."

In the Sanction Grid add "/monitoring" after each appearance of "Treatment".

There was discussion of having these proposed changes considered at the June 12th Board meeting. It was decided that Ms. Reen would contact Mr. Kauder of Visual Research to determine if adding another 20 point offence score for "financial or other material gain from the offense" should be addressed in the delineation of the offense scoring ranges. She commented that addressing this might delay presentation to the Board to the September meeting.

ADJOURNMENT: With all business concluded, the Committee adjourned at 3:35 p.m.


James D. Watkins, Chair


Sandra K. Reen, Executive Director

6-12-15
Date

June 18, 2015
Date

Sanctioning

Reference Points

Instruction Manual

Board of Dentistry

Guidance Document 60-2
Adopted October 2005
Revised September 2012
Revised December 2015

Prepared for
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Robert A. Nebiker
Director

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July 22, 2005

Dear Interested Parties:

In the spring of 2001, the Virginia Department of Health Professions approved a workplan to study sanctioning in disciplinary cases for Virginia's 13 health regulatory boards. The purpose of the study was to "...provide an empirical, systematic analysis of board sanctions for offenses and, based on this analysis, to derive reference points for board members..." The purposes and goals of this study are consistent with state statutes which specify that the Board of Health Professions periodically review the investigatory and disciplinary processes to ensure the protection of the public and the fair and equitable treatment of health professionals.

Each health regulatory board hears different types of cases, and as a result, considers different factors when determining an appropriate sanction. After interviewing current and past Board of Dentistry members and staff, a committee of Board members, staff, and research consultants assembled a research agenda involving one of the most exhaustive statistical studies of sanctioned Dentists in the United States. The analysis included collecting over 130 factors on all Board of Dentistry sanctioned cases in Virginia over a 7 year period. These factors measured case seriousness, respondent characteristics, and prior disciplinary history. After identifying the factors that were consistently associated with sanctioning, it was decided that the results provided a solid foundation for the creation of sanction reference points. Using both the data and collective input from the Board of Dentistry and staff, analysts spent 10 months developing a usable set of sanction worksheets as a way to implement the reference system.

By design, future sanction recommendations will encompass, on average, about 75% of past historical sanctioning decisions; an estimated 25% of future sanctions will fall above or below the sanction point recommendations. This allows considerable flexibility when sanctioning cases that are particularly egregious or less serious in nature. Consequently, one of the most important features of this system is its voluntary nature; that is, the Board is encouraged to depart from the reference point recommendation when aggravating or mitigating circumstances exist.

Equally important to recommending a sanction, the system allows each respondent to be evaluated against a common set of factors—making sanctioning more predictable, providing an educational tool for new Board members, and neutralizing the possible influence of "inappropriate" factors (e.g., race, sex, attorney presence, identity of Board members). As a result, the following reference instruments should greatly benefit Board members, health professionals and the general public.

Sincerely yours,

Cordially,

Robert A. Nebiker
Director

Elizabeth A. Carter, Ph.D.
Executive Director
Virginia Board of Health Professions

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GENERAL INFORMATION

Overview

The Virginia Board of Health Professions has spent the last three years studying sanctioning in disciplinary cases. The study is examining all 13 health regulatory boards, with the greatest focus most recently on the Board of Dentistry. The Board of Dentistry is now in a position to implement the results of the research by using a set of voluntary Sanctioning Reference Points (SRPs). This manual contains some background on the project, the goals and purposes of the system, and the three offense-based sanction worksheets and grids that will be used to help Board members determine how a similarly situated respondent has been treated in the past. This sanctioning system is based on a specific sample of cases, and thus only applies to those persons sanctioned by the Virginia Board of Dentistry. Moreover, the worksheets and grids have not been tested or validated on any other groups of persons. Therefore, they should not be used at this point to sanction respondents coming before other health regulatory boards, other states, or other disciplinary bodies.

The Sanctioning Reference system is comprised of a series of worksheets which score a number of offense and prior record factors identified using statistical analysis. These factors have been isolated and tested in order to determine their influence on sanctioning outcomes. A sanctioning grid found on each of the offense worksheets uses an offense score and a prior record score to recommend a range of sanctions from which the Board may select in a particular case.

In addition to this instruction booklet, separate coversheets and worksheets are available to record the offense score, prior record score, recommended sanction, actual sanction and any reasons for departure (if applicable). The completed coversheets and worksheets will be evaluated as part of an on-going effort to monitor and refine the SRPs. These instructions and the use of the SRP system fall within current Department of Health Professions and Board of Dentistry policies and procedures. Furthermore, all sanctioning recommendations are those currently available to and used by the Board and are specified within existing Virginia statutes.

Background

In April of 2001, the Virginia Board of Health Professions (BHP) approved a work plan to conduct an analysis of health regulatory board sanctioning and to consider the appropriateness of developing historically-based sanctioning reference points for health regulatory boards, including the Board of Dentistry (BOD). The Board of Health Professions and project staff recognize the complexity and difficulty in sanction decision-making and have indicated that for any sanction reference system to be successful, it must be *“developed with complete Board oversight, be value-neutral, be grounded in sound data analysis, and be totally voluntary”*—that is, the system is viewed strictly as a Board decision tool.

Goals

The Board of Health Professions and the Board of Dentistry cite the following purposes and goals for establishing SRPs:

- Making sanctioning decisions more predictable
- Providing an education tool for new Board members
- Adding an empirical element to a process/system that is inherently subjective
- Providing a resource for BOD and those involved in proceedings
- “Neutralizing” sanctioning inconsistencies
- Validating Board member or staff recall of past cases
- Constraining the influence of undesirable factors—e.g., overall Board makeup, race or ethnic origin, etc.
- Helping predict future caseloads and need for compliance monitoring

Methodology

The fundamental question when developing a sanctioning reference system is deciding whether the supporting analysis should be grounded in historical data (a descriptive approach) or whether it should be developed normatively (a prescriptive approach). A prescriptive approach reflects what policymakers feel sanction recommendations should be, as opposed to what they have been. SRPs can also be developed using historical data analysis with normative adjustments to

follow. This approach combines information from past practice with policy adjustments, in order to achieve some desired outcome. The Board of Dentistry chose a descriptive approach with a limited number of normative adjustments.

Qualitative Analysis

Researchers conducted 11 in-depth personal interviews of past and current BOD members, Board staff, and representatives from the Attorney General's office. The interview results were used to build consensus regarding the purpose and utility of SRPs and to further frame the analysis. Additionally, interviews helped ensure the factors that Board members consider when sanctioning were included during the quantitative phase of the study. A literature review of sanctioning practice across the United States was also conducted.

Quantitative Analysis

Researchers collected detailed information on all BOD disciplinary cases ending in a violation between 1996 and 2004; approximately 198 sanctioning "events" covering 222 cases. Over 130 different factors were collected on each case in order to describe the case attributes Board members identified as potentially impacting sanction decisions. Researchers used data available through the DHP case management system combined with primary data collected from hard copy files. The hard copy files contained investigative reports, Board notices, Board orders, and all other documentation that is made available to Board members when deciding a case sanction.

A comprehensive database was created to analyze the offense and respondent factors which were identified as potentially influencing sanctioning decisions. Using statistical analysis to construct a "historical portrait" of past sanctioning decisions, the significant factors along with their relative weights were derived. These factors and weights were formulated into sanctioning worksheets and grids, which are the basis of the SRPs.

Offense factors such as patient harm, patient vulnerability and number of teeth involved were analyzed as well as respondent factors such as substance abuse, impairment at the time of offense, initiation of self-corrective action, and prior disciplinary history of the respondent. Some factors were deemed inappropriate for use in a structured sanctioning

reference system. For example, the presence of the respondent's attorney, the respondent's age or sex, and case processing time, are considered "extra-legal" factors, and were explicitly excluded from the sanction reference points. Although many factors, both "legal" and "extra-legal" can help explain sanction variation, only those "legal" factors the Board felt should consistently play a role in a sanction decision were included in the final product.

By using this method, the hope is to achieve more neutrality in sanctioning, by making sure the Board considers the same set of "legal" factors in every case.

Wide Sanctioning Ranges

The SRPs consider and weigh the circumstances of an offense and the relevant characteristics of the respondent, providing the Board with a sanction range that encompasses roughly 77% of historical practice. This means that 23% of past cases had received sanctions either higher or lower than what the reference points indicate, acknowledging that aggravating and mitigating factors play a role in sanctioning. The wide sanctioning ranges recognize that the Board will sometimes reasonably disagree on a particular sanction outcome, but that a broad selection of sanctions fall within the recommended range.

Any sanction recommendation the Board derives from the SRP worksheets must fall within Virginia law and regulations. If a Sanctioning Reference Point worksheet recommendation is more or less severe than a Virginia statute or DHP regulation, the existing laws or policies supersede any worksheet recommendation.

Two Dimensional Sanctioning Grid Scores Both Offense and Prior Record Factors

The Board indicated early in the study that sanctioning is not only influenced by circumstances associated with the instant offense, but also by the respondent's past history. The empirical analysis supported the notion that both offense and prior record factors impacted sanction outcomes. To this end, the Sanction Reference Points make use of a two-dimensional scoring grid; one dimension assesses factors related to the instant offense, while the other dimension assesses factors related to prior record.

The first dimension assigns points for circumstances related to the violation offense that the Board is currently considering. For example, the respondent may receive points if they were unable to safely practice due to impairment at the time of the offense, or if there were multiple patients involved in the incident(s). The other dimension assigns points for factors that relate to the respondent's prior record. So a respondent before the Board for an unlicensed activity case may also receive points for having had a history of disciplinary violations. This respondent can receive additional points if the prior violation is similar.

Voluntary Nature

The SRP system is a tool to be utilized by the Board of Dentistry. Compliance with the SRPs is voluntary. The Board will use the system as a reference tool and may choose to sanction outside the recommendation. The Board maintains complete discretion in determining the sanction handed down. However, a structured sanctioning system is of little value if the Board is not provided with the appropriate coversheet and worksheet in every case eligible for scoring. A coversheet and worksheet should be completed in cases resolved by Informal Conferences. The coversheet and worksheets will be referenced by Board members during Closed Session.

Worksheets Not Used in Certain Cases

The SRPs will not be applied in any of the following circumstances:

- **Formal Hearings** — Sanction Reference Points will not be used in cases that reach a Formal Hearing level.
- **Mandatory suspensions** – Virginia law requires that under certain circumstances (conviction of a felony, declaration of legal incompetence or incapacitation, license revocation in another jurisdiction) the license of a practitioner must be suspended. The sanction is defined by law and is therefore excluded from the Sanctioning Reference Point system.
- **Compliance/reinstatements** – The SRPs should not be applied to compliance or reinstatement cases
- **Action by another Board** – When a case which has already been adjudicated by a Board from another state appears before the Virginia Board of Dentistry, the Board often attempts to mirror the sanction handed down by the other Board. The Virginia Board of Dentistry usually requires that all conditions set by the other Board are completed or complied with in Virginia. The SRPs do not apply as the case has already been heard and adjudicated by another Board.

The SKPs are organized into three offense groups. This organization is based on a historical analysis showing that offense and prior record factors and their relative importance vary by type of offense. The reference point factors found within a particular offense group are those which proved important in determining historical sanctions for that offense category.

When multiple cases have been combined into one "event" (one notice) for disposition by the Board, only one offense group coversheet and worksheet should be completed and it should encompass the entire event. If a case has more than one offense type, one coversheet and worksheet is selected according to the offense group which appears highest on the following table. For example, a dentist found in violation of both advertising and a treatment-related offense would have their case scored on a Standards of Care worksheet, since Standards of Care is above Advertising/Business Practice Issues on the table. The table also assigns the various case categories brought before the Board to one of the three offense groups. If an offense type is not listed, find the most analogous offense type and use the appropriate scoring worksheet.

Table 1: Offense Groups Covered by the Sanctioning Reference Points

<p style="text-align: center;">Inability to Safely Practice</p>	<p>Inability to safely practice – Impairment or Incapacitation Inability to safely practice - Other Drug Related</p> <ul style="list-style-type: none"> • Prescribing without a relationship • Non-dental purposes • Excessive prescribing/dispensing • Personal Use • Security • Other • Obtaining drugs by fraud
<p style="text-align: center;">Standard of Care</p>	<p>Standard of Care – Diagnosis/Treatment Related</p> <ul style="list-style-type: none"> • Failure to diagnose or treat • Incorrect diagnosis or treatment • Failure to respond to needs • Delay in treatment • Unnecessary treatment • Improper performance of procedure • Failure to refer/obtain consult • Failure to offer patient education • Other <p>Standard of Care - Consent related Standard of Care - Equipment/Product related Standard of Care - Prescription related Sexual assault and mistreatment Abuse/Abandonment/Neglect Records release</p>
<p style="text-align: center;">Business Practice Issues/Advertising</p>	<p>Records/Inspections/Audits Business Practices Issues Fraud Criminal activity Unlicensed activity</p> <ul style="list-style-type: none"> • Aiding/Abetting unlicensed activity • DEA registration revoked/expired/invalid • Practicing on lapsed/expired license • Other <p>Advertising</p> <ul style="list-style-type: none"> • Claim of Superiority • Deceptive/Misleading • Improper use of trade name • Fail to disclose full fee when advertising discount • Other • Omission of required wording/advertising elements

Completing the Coversheet & Worksheet

Ultimately, it is the responsibility of the Board to complete the Sanction Reference Point coversheet and worksheet in all applicable cases.

The information relied upon to complete a coversheet and worksheet is derived from the case packet provided to the Board and respondent. It is also possible that information discovered at the time of the informal conference may impact worksheet scoring. The Sanction Reference Point coversheet and worksheet, once completed, are confidential under the Code of Virginia. However, complete copies of the Sanction Reference Point Manual, including blank coversheets and worksheets, can be found on the Department of Health Professions web site: www.dhp.state.va.us (paper copy also available on request).

Offense Group Worksheets

Instructions for scoring each of the 3 offenses are contained adjacent to each worksheet in subsequent sections of this manual. Instructions are provided for each line item of each worksheet and should be referenced to ensure accurate scoring for a specific factor. When scoring an offense group worksheet, the scoring weights assigned to a factor on the worksheet cannot be adjusted. The scoring weights can only be applied as 'yes or no' with all or none of the points applied. In instances where a scoring factor is difficult to interpret, the Board has final say in how a case is scored.

Coversheet

The coversheet is completed to ensure a uniform record of each case and to facilitate recordation of other pertinent information critical for system monitoring and evaluation.

If the Board feels the sanctioning grid does not recommend an appropriate sanction, the Board is encouraged to depart either higher or lower when handing down a sanction. If the Board

disagrees with the sanction grid recommendation and imposes a sanction greater or less than the recommended sanction, a short explanation can be recorded on the coversheet. The explanation could identify the factors and the reasons for departure. This process will ensure worksheets are revised appropriately to reflect current Board practice. If a particular reason is continually cited, the Board can examine the issue more closely to determine if the worksheets should be modified to better reflect Board practice.

Aggravating and mitigating circumstances that may influence Board decisions can include, but should not be limited to, such things as:

- Severity of the incident
- Monetary gain
- Dishonesty/Obstruction
- Motivation
- Remorse
- ~~Victim~~ Patient vulnerability
- Restitution/Self-corrective action
- Multiple offenses/Isolated incident
- Age of prior record

A space is provided on the coversheet to record the reason(s) for departure. Due to the uniqueness of each case, the reason(s) for departure may be wide-ranging. Sample scenarios are provided below:

Departure Example #1

Sanction Grid Result: Recommend Formal.

Imposed Sanction: Probation with terms – practice restriction.

Reason(s) for Departure: Respondent was particularly remorseful and had already begun corrective action.

Departure Example #2

Sanction Grid Result: No

Sanction/Reprimand/Education.

Imposed Sanction: Treatment – practice monitoring.

Reason(s) for Departure: Respondent may be trending towards future violations, implement oversight now to avoid future problems.

Determining a Specific Sanction

The Sanction Grid has four separate sanctioning outcomes: Recommend formal or accept surrender, Treatment, Monetary Penalty, and No Sanction/Reprimand/Education. The table below lists the most frequently cited sanctions under the four sanctioning outcomes that are part of the sanction grid. After considering the sanction grid recommendation, the Board should fashion a more detailed sanction(s) based on the individual case circumstances.

Table 2: Sanctioning Reference Point Grid Outcomes

<p>Recommend Formal or Accept Surrender</p>	<p>Recommend Formal Accept Surrender Suspension Revocation</p>
<p>Treatment/Monitoring</p>	<p>Stayed Suspension - Immediate Probation Terms</p> <ul style="list-style-type: none"> • Audit/inspection of practice, clinical exam • Quarterly self-reports • Impairment – HPIP- HPMP • Practice Restriction - oversight by a supervisor/monitor • Practice Restriction - specific • Practice Restriction - setting • Practice Restriction - chart/record review • Prescribing - restrictions • Quarterly job performance evaluations • Prescribing - log • Written notification to employer/employees/associates • Mental/physical evaluation
<p>Monetary Penalty</p>	<p>Monetary Penalty</p>
<p>No Sanction/Reprimand/Education</p>	<p>No Sanction Reprimand Education Terms</p> <ul style="list-style-type: none"> • Advertising - cease and desist • Cease and Desist • Continuing Education - general or specific • Continuing Education - record keeping • Continuing Education - prescribing • Read Board laws governing Dentistry • Virginia Dental Law Exam

**Sanctioning Reference Points
Coversheet, Worksheets
and Instructions**

Sanctioning Reference Points Coversheet

- Complete Offense Score section.
- Complete Prior Record Score section.
- Determine the Recommended Sanction using the scoring results and the Sanction Grid.
- Complete this coversheet.

Case Number(s):

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--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

Respondent Name: _____
 (Last) (First) (Title)

License Number: _____

Worksheet Used: _____
 _____ ~~Impairment-Inability to Safely Practice~~
 _____ Standard of Care
 _____ Advertising/Business Practice Issues

Sanction Grid Result: _____
 _____ No Sanction/Reprimand/Education
 _____ No Sanction/Reprimand/Education - Monetary Penalty
 _____ Monetary Penalty -- Treatment/Monitoring
 _____ Treatment/Monitoring
 _____ Treatment - Recommend Formal/Accept Surrender

Imposed Sanction(s): _____
 _____ No Sanction
 _____ Reprimand
 _____ Monetary Penalty: \$_____ enter amount Probation: _____
 _____ duration in months
 _____ Stayed Suspension: _____ duration in months
 _____ Recommend Formal
 _____ Accept Surrender
 _____ Accept Revocation
 _____ Stayed Suspension
 _____ Other sanction: _____
 _____ Terms: _____

Reasons for Departure from Sanction Grid Result (if applicable): _____

Worksheet Preparer's Name: _____ Date Worksheet Completed: _____

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia.

Inability to Safely Practice Worksheet Instructions

Offense Score

Step 1: (score all that apply)

Enter "60" if the respondent was unable to safely practice at the time of the offense due to illness related to substance abuse impairment, or mental/physical incapacitation.

Enter "40" if physical injury occurred. Physical injury includes any injury requiring medical care ranging from first aid treatment to hospitalization. Patient death would also be included here.*

Enter "30" if the offense involves multiple patients.

Enter "20" if the offense involves one or more teeth.

Enter "20" if the patient required subsequent treatment from a licensed third party healthcare practitioner, not necessarily a dentist.

Enter "20" if the offense involves self-prescribing or prescribing beyond the scope.

Enter "20" if there was financial or material gain. Examples of cases involving financial or material gain include, but are not limited to, completing unnecessary treatment to increase fees, failure to comply with provider contracts with insurance companies and billing patient portion of fees, unbundling of services or aiding and abetting the unlicensed practice of dentistry or dental hygiene.

Enter "15" if the patient is especially vulnerable. Patients in this category must be one of the following: under age 18, over age 65, or mentally/physically handicapped.

Enter "10" if multiple respondents were involved.

Enter "10" if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.

Step 2: Combine all for Total Offense Score

Prior Record Score

Step 3: (score all that apply)

Enter "60" if the respondent's license was previously lost due to Revocation, Suspension, or Summary Suspension.

Enter "20" if the respondent has a criminal activity conviction related to the current case.

Enter "20" if the respondent has had a previous finding of a violation.

Enter "20" if the respondent has had a previous violation with a sanction imposed.

Enter "10" if the respondent has had any "similar" violations prior to this case. Similar violations include any cases that are also classified as "Inability to Safely Practice" (see cases that are eligible for scoring listed under "Case Categories" in the table on Page 6).

Step 4: Combine all for Total Prior Record Score

Sanction Grid

Step 5:

Locate the Offense and Prior Record scores within the correct ranges on the top and left sides of the grid. The cell where both scores intersect is the sanction recommendation. Example: If the Offense Score is 60 and the Prior Record Score is 10, the recommended sanction is shown in the center grid cell – "Treatment".

Step 6: Coversheet

Complete the coversheet including the grid sanction, the imposed sanction and the reasons for departure if applicable.

* Original text revised in September 2012. Injury was previously defined as, "Physical injury includes any injury requiring medical care ranging from first aid treatment to hospitalization."

Inability to Safely Practice Worksheet

Board of Dentistry
Revised Dec 2015

Offense Score	Points	Score
Inability to safely practice - Impaired/Incapacitated	60	_____
Patient injury	40	_____
More than one patient involved	30	_____
One or more teeth involved	20	_____
Patient required subsequent treatment	20	_____
Self prescribing or prescribing beyond scope	20	_____
Financial or material gain	20	_____
Patient vulnerable	15	_____
Multiple respondents involved	10	_____
Act of commission	10	_____
Total Offense Score		<input style="width: 50px; height: 30px;" type="text"/>

Respondent Score	Points	Score
License previously lost	60	_____
Concurrent criminal activity conviction	20	_____
Previous finding of a violation	20	_____
Previous violation with a sanction imposed	20	_____
Previous violation similar to current	10	_____
Total Respondent Score		<input style="width: 50px; height: 30px;" type="text"/>

		Offense Score		
		0-30	31-60	61 and over
Prior Record Score	0	No Sanction/Reprimand/ Education Monetary Penalty	Monetary Penalty Treatment/Monitoring	Treatment/Monitoring
	1-30	Treatment/Monitoring	Treatment/Monitoring	Treatment/Monitoring
	31 and over	Treatment/Monitoring	Treatment/ Monitoring Recommend Formal/ Accept Surrender	Treatment/ Monitoring Recommend Formal/ Accept Surrender

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia.

Standard of Care Worksheet Instructions

Offense Score

Step 1: (score all that apply)

Enter “60” if the offense involves multiple patients.

Enter “30” if the patient is especially vulnerable. Patients in this category must be one of the following: under age 18, over age 65, or mentally/physically handicapped.

Enter “25” if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.

Enter “20” if there was financial or material gain. Examples of cases involving financial or material gain include, but are not limited to, completing unnecessary treatment to increase fees, failure to comply with provider contracts with insurance companies and billing patient portion of fees, unbundling of services or aiding and abetting the unlicensed practice of dentistry or dental hygiene.

Enter “10” if the offense involves one or more teeth.

Enter “10” if physical injury occurred. Physical injury includes any injury requiring medical care ranging from first-aid treatment to hospitalization. Patient death would also be included here. *

Enter “10” if the patient required subsequent treatment from a licensed third party healthcare practitioner, not necessarily a dentist.

Enter “10” if multiple respondents were involved.

Enter “10” if the offense involves self-prescribing or prescribing beyond the scope.

Step 2: Combine all for Total Offense Score

Prior Record Score

Step 3: (score all that apply)

Enter “60” if the respondent’s license was previously lost due to Revocation, Suspension, or Summary Suspension.

Enter “20” if the respondent has had a previous finding of a violation.

Enter “20” if the respondent has had a previous violation with a sanction imposed.

Enter “10” if the respondent has had any “similar” violations prior to this case. Similar violations include any cases that are also classified as “Standard of Care” (see cases that are eligible for scoring listed under “Case Categories” in the table on Page 6).

Enter “10” if the respondent has a criminal activity conviction related to the current case.

Step 4: Combine all for Total Prior Record Score

Sanction Grid

Step 5:

Locate the Offense and Prior Record scores within the correct ranges on the top and left sides of the grid. The cell where both scores intersect is the sanction recommendation.

Example: If the Offense Score is 60 and the Prior Record Score is 10, the recommended sanction is shown in the center grid cell – “Monetary Penalty/Treatment”.

Step 6: Coversheet

Complete the coversheet including the grid sanction, the imposed sanction and the reasons for departure if applicable.

* Original text revised in September 2012. Injury was previously defined as, “Physical injury includes any injury requiring medical care ranging from first aid treatment to hospitalization.”

Standard of Care

Board of Dentistry
Revised Dec 2015

Offense Score	Points	Score
More than one patient involved	60	_____
Patient vulnerable	30	_____
Act of commission	25	_____
Financial or material gain	20	_____
One or more teeth involved	10	_____
Patient injury	10	_____
Patient required subsequent treatment	10	_____
Multiple respondents involved	10	_____
Self prescribing or prescribing beyond scope	10	_____
Total Offense Score		<input style="width: 50px; height: 20px;" type="text"/>

Respondent Score		
License previously lost	60	_____
Previous finding of a violation	20	_____
Previous violation with a sanction imposed	20	_____
Previous violation similar to current	10	_____
Criminal activity conviction	10	_____
Total Respondent Score		<input style="width: 50px; height: 20px;" type="text"/>

		Offense Score		
		0-40	41-65	66 and over
Prior Record Score	0	No Sanction/ Reprimand/Education	No Sanction/Reprimand/ Education Monetary Penalty	Monetary Penalty Treatment/Monitoring
	1-20	No Sanction/Reprimand/ Education Monetary Penalty	Monetary Penalty Treatment/Monitoring	Treatment/Monitoring Recommend Formal/ Accept Surrender
	21 and over	Monetary Penalty Treatment/Monitoring	Monetary Penalty Treatment/Monitoring	Treatment/Monitoring Recommend Formal/ Accept Surrender

Advertising Worksheet Instructions

Offense Score

Step 1: (score all that apply)

Enter "60" if the offense involves multiple patients.

Enter "40" if the patient is especially vulnerable. Patients in this category must be one of the following: under age 18, over age 65, or mentally/physically handicapped.

Enter "30" if the offense involves one or more teeth.

Enter "20" if multiple respondents were involved.

Enter "20" if the offense involves self-prescribing or prescribing beyond the scope.

Enter "20" if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.

Enter "20" if there was financial or material gain. Examples of cases involving financial or material gain include, but are not limited to, completing unnecessary treatment to increase fees, failure to comply with provider contracts with insurance companies and billing patient portion of fees, unbundling of services or aiding and abetting the unlicensed practice of dentistry or dental hygiene.

Enter "10" if physical injury occurred. Physical injury includes any injury requiring medical care ranging from first aid treatment to hospitalization. Patient death would also be included here.*

Enter "10" if the patient required subsequent treatment from a licensed third party healthcare practitioner, not necessarily a dentist.

Step 2: Combine all for Total Offense Score

Prior Record Score

Step 3: (score all that apply)

Enter "60" if the respondent's license was previously lost due to Revocation, Suspension, or Summary Suspension.

Enter "40" if the respondent has a criminal activity conviction related to the current case.

Enter "30" if the respondent has had a previous violation with a sanction imposed.

Enter "20" if the respondent has had a previous finding of a violation.

Enter "10" if the respondent has had any "similar" violations prior to this case. Similar violations include any cases that are also classified as "Advertising/Business Practice Issues" (see cases that are eligible for scoring listed under "Case Categories" in the table on Page 6).

Step 4: Combine all for Total Prior Record Score

Sanction Grid

Step 5:

Locate the Offense and Prior Record scores within the correct ranges on the top and left sides of the grid. The cell where both scores intersect is the sanction recommendation.

Example: If the Offense Score is 30 and the Prior Record Score is 10, the recommended sanction is shown in the center grid cell -- "Monetary Penalty".

Step 6: Coversheet Complete the coversheet including the grid sanction, the imposed sanction and the reasons for departure if applicable.

Offense Score	Points	Score
More than one patient involved	60	_____
Patient vulnerable	40	_____
One or more teeth involved	30	_____
Multiple respondents involved	20	_____
Self prescribing or prescribing beyond scope	20	_____
Act of commission	20	_____
Financial or material gain	20	_____
Patient injury	10	_____
Patient required subsequent treatment	10	_____
Total Offense Score		<input style="width: 60px; height: 30px;" type="text"/>

Respondent Score	Points	Score
License previously lost	60	_____
Criminal activity conviction	40	_____
Previous violation with a sanction imposed	30	_____
Previous finding of a violation	20	_____
Previous violation similar to current	10	_____
Total Respondent Score		<input style="width: 60px; height: 30px;" type="text"/>

		Offense Score		
		0-10	11-39	40 and over
Prior Record Score	0	No Sanction/Reprimand/ Education Monetary Penalty	No Sanction/Reprimand/ Education Monetary Penalty	Monetary Penalty Treatment/Monitoring
	1-40	No Sanction/Reprimand/ Education Monetary Penalty	Monetary Penalty	Treatment/Monitoring
	41 and over	Monetary Penalty Treatment/Monitoring	Treatment/Monitoring	Treatment/ Monitoring Recommend Formal/ Accept Surrender

2015 AADB 132nd Annual Meeting Summary

The 2015 American Association of Dental Boards 132nd Annual Meeting was held on November 3rd and 4th, 2015, in Washington, DC, at the Mayflower Renaissance Hotel. The theme of the meeting was "Advocacy". Conference attendees included dental professionals from various dental schools, state boards of dentistry delegations from all 50 states as well as from Puerto Rico, the American Virgin Islands and the District of Columbia, various dental agencies, professional associations, and interested parties. Simultaneously, various states' Board Attorneys held an attorney's roundtable conference, and then reported to the main meeting at the end of the two respective sessions. The Virginia DHP Board of Dentistry was represented at the AADB meeting by Board President, Dr. Charles Gaskins. The meeting encompassed the following presentational topics and speakers:

ADA Update: ADA President, Dr. Maxine Feinberg, described the work of the ADA in the areas of licensure portability and universal acceptance of clinical exams.

Dental Service Organization Principles: David Preble, DDS, JD, ADA Practice Institute Vice-President, described several market forces that are driving DSO's. These involve increased child and adolescent dental care via Medicaid, greatly increased hospital ER visits for dental etiologies, increased federal health center visits for dentistry, decreased in-office and dental school clinical appointments with dental care being deferred or avoided entirely. Spending on dental services remains "flat". The number of dentists per 100,000 pop. is increasing. Dental incomes are down, and student debt is high. From the recent ADA survey of members, dentists in large group practices reported a decreased ability to influence organization or to "corporately advance"; decreased stress related to not having to run a business/practice; decreased satisfaction with the clinical care delivered to patients. A key question relative to DSO's: Who holds the patient records? Corporate, or the dentist?

Baucus-Grassley Report on Corporate Dentistry: Rodney Whitlock, DDS, Health Policy Director to Sen. Chuck Grassley, noted findings to support that provider entities often increase Medicaid claims volume and dental procedures to off-set decreased or low Medicaid reimbursement levels.

Congressional Addresses: Congressmen Paul Gosar, DDS (AZ) and Brian Babin, DDS (TX), separately addressed their personal concerns as dentists that the McCarran-Ferguson Act of 1945, USC 15, should be re-considered as to allowing insurance companies their ongoing exclusion from FTC / Commerce Clause applicability in the business marketplace of insurance.

ADA Legislative Update: Michael Graham, ADA Sr. V.P. for Government Affairs, stated that "mid-level providers" issues are before Congress. Arkansas, Minnesota, and Maine have laws on their books. However, the Minnesota program does not meet CODA standards.

Federal Trade Commission Comments: Marina Lao, JD, Dir. of FTC Ofc. of Policy Planning, presented that in light of the US Supreme Court ruling (N.C. State Bd. of Dental Examiners vs. FTC), that several considerations exist. From an anti-trust laws perspective, competition in “open” markets must be considered against health care regulation. Regarding health care licensing, barriers to a market must be considered against protection of the public. Any skills required for a license must be necessary for a task. Exceeding these skills via licensing requirements may become a restraint of trade. However, when enacting legislation, states are acting in a “sovereign capacity” (vs. regulatory action by state boards and/or agencies).

FTC Addressing New Era of Oversight: William MacLeod, JD, former FTC staff attorney and member of Am. Bar Assn. Committee on FTC, commenting, post- N.C. State Bd. of Dental examiners vs. FTC case, that state action protection is under attack. He affirmed that Boards need to utilize state legislatures for codification of needs, and to utilize courts for actions (i.e.: state law needs to guide and protect Boards from anti-trust claims). Note: as was stated and previously reported from the last AADB meeting in April, 2015, recommendation was made for state health regulatory boards to ongoingly seek their state counsel when confronting “marketplace policy” issues beyond the direct enforcement of valid state laws, and that courts are valid “supervising agencies”. Therefore, lawsuits by boards regarding non-licensed behaviors are worthy of consideration when indicated/needed.

Attorneys Update: Focused on the current difficulty of state attorneys to accurately advise their Boards preemptively. They submitted the issue of “Cheap Dentistry” vs. “Safe Dentistry” as likely needing clarifying regulations.

AADB Assessment Services Program - Remediation: Mark Hinrichs, DDS, Chair., AADB Assessment Services Program, stated that there currently are 4 dental schools available to enroll seriously deficient licensees for in-house remediation training (U. of Maryland, Marquette, LSU, NOVA S. Eastern). The ASP is also available for outside dental expert testimony in adjudication of dental cases.

Buffalo School of Dental Medicine Model Presentation: Joseph Gambacorta, DDS, Asst. Dean for Clinical Affairs, BSDM, presented their school’s initiation of a “Curriculum Integrated Exam” for licensure testing. He stated that ASDA desires portability of licensure, and desires that clinical testing utilize “current” markers of practice. Procedures completed on patients of record in a normal course of treatment, with no live patients at examinations were discussed. The issues of testing agencies taking no responsibility for patients and situations where examiners may not be licensed in the states where testing is given were also presented.

Licensure Issues Update: Daniel Gesek, DDS, AADB rep. to ADA Council on Dental Education and Licensure (CDEL), postulated the benefits of having all license applicants undergo criminal background checks as a requirement of licensure. He stated that New York has recently passed clarification of sites for tele-dentistry usage. Separately, end-tidal CO2 monitoring is now required in 11 states for moderate sedation procedures.

Licensure Portability: David Owsiany, JD, Ohio Dental Assoc., Exec. Dir., stated that while determinations of licensure constitutionally still reside with the states, that federal agencies are increasingly promoting "interstate" work/license practice. There may be a growing questioning of the validity of states licensing professionals.

Snapshot of Dental Education: Eugene Anderson, Ph.D., Managing V.P. and Chief Policy Officer, American Dental Education Association, stated that of 66 dental schools, there are 38 which are attached to "parent institutions" which foster research. Perhaps this is a driver of higher tuitions/fees in these programs for dental enrollees? Current average dental school debt per student is \$224,000 - \$250,000+. The higher debt students may be married and supporting families while in school? Dental schools' faculty is about 50% : 50% men to women for younger faculty; more men than women for older faculty, with many approaching retirement. Currently, about 5 - 12 dental schools have faculty vacancies. 53 of 66 dental schools now have "inter-professional" education of healthcare enrollees.

The upcoming AADB Mid-Year Meeting will be held on April 10 and 11th, 2016, at the ADA Headquarters Building, Chicago, Illinois.

Submitted by Charles E. Gaskins III, DDS

ADEX Meeting
Chicago, Illinois
November 12-15, 2015

Dental Hygiene Examination Committee

Call to Order at 8:30 AM by Nan Dreaves on November 13, 2015

The ADEX Dental Hygiene Examination Committee is comprised of hygienists from thirteen districts, one dentist and a consumer member. The following modifications to the 2017 examination were made:

- **Remove 8 points for radiographs**
- **78% weighted to calculus removal**
- **Redefined calculus- use same terminology as qualifying calculus**
- **Radiographs must be diagnostic**

Based on candidate surveys from the 2014 exam, the exam time was increased from 90 minutes to 120 minutes for the 2016 and 2017 examination cycles.

The piloted electronic system was very successful in 2015. There were 333 candidates with a 92% pass rate.

House of Representatives Dental Hygiene Information
November 15, 2015

Beginning in January, 2016 the Council of Interstate Testing Agencies (CITA) will administer the ADEX dental hygiene exam.

Virginia Commonwealth University (VCU) has been added as a testing site for CITA and will administer the exam for both dental and dental hygiene students.

The significance of CITA administering the ADEX clinical examination at Virginia Commonwealth University is currently the Virginia Board of Dentistry is a member of the Southern Regional Testing Agency (SRTA) and board members are only allowed to examine with SRTA. A majority of VCU candidates will take the ADEX examination administered by CITA since it provides improved portability. With this change, the Board of Dentistry may want to consider becoming a member of CITA or at least allowing Board members to be able to examine for other testing agencies. These changes will allow the Board to participate in examining future practitioners in the State of Virginia.

District 6 did not have dental hygiene representation on the dental hygiene exam committee or in the House of Representatives. Tammy Swecker RDH M.Ed. was nominated by Dr. Al Rizkalla and elected to the position by District 6.

States that accept CDCA/CITA/ADEX will log into a computer system to obtain scores. A brief demonstration of the website was given during the House of Representatives. The system will ensure accuracy and ease in obtaining candidate scores.

**Virginia Board of Dentistry
Regulatory-Legislative Committee Meeting
October 24, 2015**

Assignments:

- 1) Address who may own a dental practice--suggested to draft a guidance document with Board staff after seeking advice and assistance from Board counsel.--The committee recommended to take no action to limit the amount of time a family member can own a dental practice.
- 2) Consider establishing a policy on the role of a dentist treating sleep apnea--The committee agreed that a medical diagnosis is necessary first and no further action at this time.
- 3) Work on a proposal to expand the use of remote supervision to free clinics and settings serving children and the elderly.--The committee moved to present Secretary Hazel's possible proposed Draft Legislation on remote supervision at the December board meeting. Further discussion covered the possibility of expanding the underserved population to include nursing homes and the elderly. It was decided to wait for input from interest groups for consideration at the December meeting. Review the educational requirements for dental assistants II--Ms. Swecker presented her review of improving access to dental care to all Virginians. She recommended establishing a path for dental hygienists to practice the functions delegable to DAII's without requiring them to be certified dental assistants (CDA). Further details are included in the material Ms. Swecker submitted in the agenda packet.
- 4) Consider policy action on the subject of Teledentistry--Discussion about doctor-patient relationship and concerns about security and privacy. Dr. Wyman moved to have Board staff revise the Board of Medicine's Guidance Document and present at the December meeting for review and consideration.
- 5) Consider requiring a clinical examination similar to Ohio's Dental Assistants II--No action was taken regarding establishing a clinical examination. However, the committee agreed with Ms. Reen's recommendation that the Board establish a Regulatory Advisory Panel (RAP) with educators to discuss education requirements and hopefully determine the lack of DAII candidates and interests.
- 6) VDA Legislative Proposal--Dr. Wyman moved to recommend supporting this proposal and the committee unanimously approved the motion.
- 7) Next meeting-- February 12, 2016 as a Regulatory Advisory Panel meeting.

****Please refer to the minutes for a detailed recollection of this meeting.**

Respectfully submitted by,

Melanie C. Swain RDH, BSDH
Regulatory-Legislative Chair

**VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY-LEGISLATIVE COMMITTEE
October 16, 2015**

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order at 9:04 a.m., on October 16, 2015, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 3, Henrico, Virginia.

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

MEMBERS PRESENT: John M. Alexander, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
Bruce S. Wyman, D.M.D.

OTHER BOARD MEMBERS: Charles E. Gaskins, III, 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

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

OTHERS PRESENT: David E. Brown, D.C., Director, Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

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

PUBLIC COMMENT: **Quinn Dufurrena, D.D.S., J.D.**, Executive Director of the Association of Dental Support Organizations (ADSO), stated that ADSO members help owner dentists with back office activities such as accounting, marketing, IT, and equipment. He added that ADSO has a Code of Ethics which prohibits interference with clinical decisions and records access and the creation of quotas. He added that ADSO would like to be involved in any discussion of regulating dental support organizations.

Dennis Gaskins, D.D.S. stated that he owns two dental practices and works under the umbrella of a dental support organization (DSO). He said he does not receive instructions regarding his practice decisions and that working with a DSO allows him to keep his fees low and to treat more people.

David Slezak, D.D.S. of Affordable Care, Inc., noted his concerns about the Texas laws addressing ownership of dental practices. He said he is ready to assist the Board in giving dentists the right to choose how to run their business.

Michelle McGregory, R.D.H., Director of the VCU Dental Hygiene Program and President of the Virginia Dental Hygienists' Association. She said VCU supports expansion of remote supervision. She noted that she provided evidence which supports increasing access to dental care at the Board's May 8th Open Forum. She stated that collaboration between dentists and dental hygienists is a win-win situation to increase access to dental care.

**APPROVAL OF
MINUTES:**

Ms. Swain asked if Committee members had reviewed the October 24, 2014 minutes. Dr. Wyman moved to accept the minutes. The motion was seconded and passed.

**DHP DIRECTOR'S
REPORT:**

Dr. Brown welcomed Dr. Parris-Wilkins to the Board. He then said he has submitted two draft legislative proposals on access to care to Secretary Hazel. He noted that one of the proposals addressed the practice of nurse practitioners and the other addressed the expansion of remote supervision settings for dental hygienists. He explained that Secretary Hazel has not decided if he will advance either of the proposals.

**STATUS REPORT ON
REGULATOR
ACTIONS:**

Ms. Yeatts reported:

- The NOIRA for a law exam is pending Governor's approval to publish and has been in this status for more than 139 days;
- The Fast-Track action to require capnography for monitoring anesthesia or sedation was rejected by the Department of Planning and Budget and was resubmitted as a NOIRA. The NOIRA has been at the Governor's Office for approval to publish for more than 34 days;
- The Fast-Track action to recognize the Commission on Dental Accreditation of Canada is pending Governor's approval to publish and been in this status for more than 24 days;
- The Periodic Review to reorganize Chapter 20 into four chapters will be published as final regulations on November 2, 2015 and go into effect on December 2, 2015. She noted that this has been under review for about four years. She recommended communication with all licensees since the regulations are quite different from the current regulations. She added that the Registrar's Office commented that the regulations were well written and credited Ms. Reen for her effort; and
- The exempt action to decrease one time renewal fees has been approved and will go into effect on December 2, 2015.

Address who may own a dental practice

Ms. Swain called for discussion. Ms. Reen explained the Board asked the Committee to address:

1. How long a non-dentist relative such as a widow can operate a dental practice; and
2. Options for holding practice management companies and other such business entities accountable for policies and practices that contribute to unsafe dental treatment.

Ms. Reen said the Committee asked staff to contact several state agencies to get information on the authority they have to hold practice management companies and other such businesses accountable for policies and practices that contribute to unsafe dental treatment:

- The State Corporation Commission (SCC) indicated that it does not handle complaints against businesses unless they fall under one of their bureaus (insurance company, financial institution, utility company, etc);
- The Department of Medical Assistance Services (DMAS) stated that it monitors Board actions to determine if it will take action against licensees. Several meetings were held with DMAS staff and contact points were established to facilitate information sharing during investigations; and
- The Office of the Attorney General said it takes complaints about fraudulent billing practices through its Consumer Protection Section (CPS) and frequently refers complaints about health care to DHP. This section does do joint investigations with other state agencies and agreed to review cases involving practice management companies where fraud is suspected for conducting joint investigations.

Ms. Reen then expressed her concern that the Board has no legal authority to regulate practice management companies and asked for guidance on addressing this topic further. Discussion followed about: claims by respondents that the management company they have affiliated with has influenced patient care decisions; adding regulations on the boundaries a dentist must adhere to when associating with management companies using the Texas Code as the model; and, the comments from the public that contracts between dentists and management companies are working within reasonable bounds. The Committee agreed by consensus to recommend that the Board continue to monitor this topic for now and asked staff to confer with Board Counsel to develop a guidance document which sets forth the current law on practice ownership and lists the decisions that only a dentist can make.

Dr. Alexander asked if action is needed on how long a widow may own a dental practice. Ms. Reen responded there is no statute which addresses this but the Board does receive inquiries where there is a belief there is a time limit for a spouse to own a dental practice. She added that current law only provides that no dentist shall be supervised by anyone who is not a dentist. The Committee agreed by consensus to recommend that the Board take no action to limit the amount of time a family member can own a dental practice.

Dr. Watkins suggested that the Board issue a guidance document on the legal provisions for ownership and where a dentist might practice and include a list of the decisions only a dentist can make. Following discussion it was agreed by consensus that staff would work with Board Counsel on development of a guidance document.

Consider establishing a policy on the role of a dentist in treating sleep apnea

Ms. Reen stated the Board requested consideration of having a policy on the appropriate role of dentists in treating sleep apnea. She added that the questions is whether a dentist can diagnose the condition then reported that the position of the Board in disciplinary cases has consistently been that sleep apnea must first be diagnosed by a physician who can then coordinate with a dentist to provide treatment. During the Committee's discussion, Ms. Yeatts advised that there is a new law, 54.1-2957.15, which requires the technologists who do sleep study must be under the direction and supervision of a physician. By consensus, the Committee decided to recommend no action be taken at this time.

Work on a proposal to expand the use of remote supervision to free clinics and settings serving children and the elderly and to review the education requirements for dental assistants II

Ms. Swain said many of the speakers at the Board's forum recommended these actions to improve access to dental treatment then asked Ms. Swecker to start discussion by addressing her review of these topics, as noted in the material she submitted in the agenda. Ms. Swecker stated that the requirement to be a certified dental assistant (CDA) is a drawback for increasing the number of dental assistants II (DAII) and recommended establishing a path for dental hygienists to practice the functions delegable to DAII's without requiring them to become a CDA as a way to provide care to elderly patients in facilities such as nursing homes. Discussion followed with no action taken.

Ms. Reen asked Dr. Browder from the Virginia Department of Health (VDH) if he would address the implementation of remote supervision in the health system. He agreed and reported that: the scope of practice of dental hygienists (RDH) was not changed; RDHs are trained and calibrated; they assess patient needs and provide hygiene treatment without a dentist's examination; RDHs have access to a dentist and are required to make contact at least every two weeks; and, schedules are maintained so the supervising dentist knows where practice is occurring and what treatment is being provided. He said treatment needs are referred to community dentists. Dr. Rolon and Dr. Parris-Wilkins commented that the VDH program is working well in their communities. Dr. Brown gave out copies of the proposed draft legislation submitted to Secretary Hazel. Following discussion, a motion by Dr. Alexander to present the proposal to the Board for discussion was seconded and passed. Discussion followed regarding the possibility of expanding the type of underserved groups, but it was agreed to do so at the December board meeting when further input is received from interested groups for consideration.

Discussion moved to the education requirements for dental assistants II (DAII). Ms. Reen said that years ago dentists in rural areas told the Board they needed help in order to see more patients. In response, the Board worked with educators from accredited dental assisting programs and the VCU School of Dentistry to develop the curriculum and regulations for practice as a DA II. She added that there are two programs offering DAII training. Ms. Yeatts noted that DAs II in Virginia have broader duties than the expanded function DAs (EFDA) in other states. Following discussion of reducing the requirements or requiring passage of a clinical examination, Dr. Wyman moved to recommend that the DA II regulations not be changed at this time. The motion was seconded and passed.

Consider policy action on the subject of teledentistry

Ms. Swain opened the floor for discussion. Discussion followed on the need for a policy which requires licensure in Virginia establishes the doctor-patient relationship and addresses the security of patient information. Dr. Wyman moved to have staff revise the Board of Medicine's Guidance Document 85-12 to present to the Board for consideration at its December meeting. The motion was seconded and passed.

Consider requiring a clinical examination similar to Ohio's for dental assistants II

Ms. Swain asked if discussion was needed since the Committee voted earlier not to recommend changes in the DA II regulations. Establishing a clinical examination was discussed with no action taken. Following further discussion, Ms. Reen suggested the Committee recommend that the Board establish a Regulatory Advisory Panel (RAP) of educator to discuss the DAII requirements. By consensus, all agreed.

VDA LEGISLATIVE PROPOSAL:

Ms. Reen stated the VDA proposal to modify the provisions for mobile dental clinics is provided for information. She explained the VDA requested the legislation to require registration and is now requesting an amendment to expand the entities exempt from registration requirements. Dr. Wyman moved to recommend that the Board, at its December meeting, decide to support this proposal. The motion was seconded and passed.

NEXT MEETING:

By consensus, the Committee decided to meet on Friday, February 12, 2016 if this date works for the RAP to address DAII requirements.

ADJOURNMENT:

With all business concluded, Ms. Swain adjourned the meeting at 12:42 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

**BOARD OF DENTISTRY
MINUTES OF EXECUTIVE COMMITTEE**

Friday, October 16, 2015

**Department of Health Professions
9960 Mayland Drive, 2nd Floor
Henrico, Virginia 23233
Board Room 3**

CALL TO ORDER: The meeting was called to order at 1:11 p.m.

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

MEMBERS PRESENT: Al Rizkalla, D.D.S.
Tammy K. Swecker, R.D.H.
Melanie C. Swain, R.D.H.

OTHER BOARD MEMBER: John M. Alexander, D.D.S.

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

QUORUM: With all members of the Committee present, a quorum was established.

PUBLIC COMMENT: None.

APPROVAL OF MINUTES: Dr. Gaskins asked if there are corrections to the January 10, 2014 minutes. No corrections were offered and the minutes were adopted as presented.

REVIEW OF THE BYLAWS: Ms. Reen asked the Committee to review the edited copy of the Bylaws with changes proposed by Dr. Gaskins shown in red.

After review and discussion, the Committee made additional changes:

Article II. Duties of Officers - the words "*President*," "*Vice-President*," and "*Secretary-Treasurer*" will not be italicized in the text of the duties of each position.

Article IV. Meeting –in item number 1, the terms "*act on*" was revised to "*act upon*" and "*summary suspensions*" was changed to "*summary actions*."

Article V. Committees – Examination Committee is now the new number 3 and Special Conference Committees is now the new number 4.

Dr. Rizkalla moved to adopt the Bylaws as amended and to present it to the Board at the December meeting for

consideration. The motion was seconded and passed.

ADJOURNMENT:

With all business concluded, the Committee meeting was adjourned at 1:25 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY

BYLAWS

Article I. Officers Election, Terms of Office, Vacancies

1. Officers

The officers of the Virginia Board of Dentistry (Board) shall be a President, a Vice-President, and a Secretary-Treasurer.

2. Election.

Prior to the Fall meeting, the President shall appoint a Nominating Committee. The eCommittee shall ~~present the names of~~ submit candidates for each office to the Board for election at its Fall meeting. ~~Prior to each election, additional nominations from the floor may be entered.~~

3. Terms of Office.

The terms of office of the President, Vice-President, and Secretary-Treasurer shall be for twelve months, ~~until succeeded,~~ or their successor(s) ~~shall be~~ are elected. The term of each office shall begin at the conclusion of the Fall meeting and end at the conclusion of the subsequent Fall meeting. No officer shall be eligible to serve for more than two consecutive terms in the same office unless serving an unexpired term.

4. Vacancies.

In the event of a vacancy in the office of president, the vice-president shall assume the office of president for the remainder of the term. In the event of a vacancy in the office of vice-president, the ~~secretary/treasurer~~ secretary-treasurer shall assume the office of vice-president for the remainder of the term. In the event of a vacancy in the office of ~~secretary/treasurer~~ secretary-treasurer, the president shall appoint a board member to fill the vacancy for the remainder of the term.

In the event that ~~all of~~ the offices are vacated and succession is not possible, the Board shall be convened to appoint ~~the~~ a Nominating Committee which will develop a slate of candidates for the Board's consideration at its next meeting. Pending the election of ~~new~~ officers, the member of the Board with the longest length of continuous service shall serve as acting president.

Article II. Duties of Officers

1. President.

The ~~President~~ President shall preside at all meetings and conduct all business according to the ~~Virginia~~ Administrative Process Act and ~~the~~ American Institute of Parliamentarians Standard Code of Parliamentary Procedure. The President shall appoint

all committees and designate ~~committee chairs and~~ all representatives, except where specifically provided by law. The President shall sign certificates and documents authorized to be signed by the President, and may serve as an ex-officio member of all committees ~~(at which times possessing all the rights, responsibilities, and duties as any other member of the committee; including the right to vote).~~ ~~He might~~ The President also may serve as a substitute for an absent committee member and, in this role, he shall participate in voting.

2. Vice-President.

The ~~Vice-President~~ Vice-President shall perform all duties of the President in either the absence of, or the inability of the President to serve.

3. Secretary-Treasurer.

The ~~Secretary-Treasurer~~ Secretary-Treasurer shall authorize issuance of the draft unapproved minutes of meetings of the Board, and shall be knowledgeable about the budget of the Board.

Article III. Duties of Members

1. Qualifications.

After appointment by the Governor, each member of the Board shall forthwith take the oath of office to qualify for service as provided by law.

2. Attendance at meetings.

Members of the Board shall attend all regular and special meetings of the full Board, meetings of committees to which they are assigned, and all hearings conducted by the Board at which their attendance is requested by the President or Board Executive Director; unless prevented by illness or other unavoidable cause. In the case of unavoidable absence of any member from any meeting, the President shall reassign the duties of such absent member when necessary to achieve a quorum for the conduct of business.

3. Examinations.

Each member of the Board who is currently licensed as a dentist or as a dental hygienist may participate in conducting clinical examinations; for testing agencies in which the Board holds membership.

4. Code of Conduct.

~~Via incorporation by reference, M~~members of the Board shall abide by the adopted Virginia Board of Dentistry Code of Conduct ~~For Members~~ (Guidance Document 60-9, ~~a~~Adopted: June 12, 2009).

Article IV. Meeting

1. Number.

The Board shall hold at least three regular meetings in each year. The President shall call meetings at any time to conduct the business of the Board, and shall convene conference calls when needed to ~~act on~~ **consider act upon** summary ~~suspensions actions~~ and settlements ~~offers~~. Additional meetings shall be called by the President at the written request of any two members of the Board.

2. Quorum.

A majority of the members of the Board shall constitute a quorum at any meeting.

3. Voting.

All matters shall be determined by a majority vote of the members present.

Article V. Committees

~~As part of their responsibility to the Board, members appointed to a committee shall faithfully perform the duties assigned to the committee. The sStanding committees of the Board shall be the following:~~

Executive Committee
Regulatory-Legislative Committee
~~Credentials Committee~~
Examination Committee
Special Conference Committees

Committee Duties.

1. Executive Committee.

The Executive Committee shall consist of the current officers of the Board and the Past President of the Board, with the President serving as Chair. The Executive Committee shall:

- a) order a biennial review of these Bylaws
- b) review the proposed budget presented by the Executive Director, and submit it ~~and~~ **along with any** recommendations relating to the proposed budget to the Board for approval
- c) periodically review financial reports and may make recommendations to the Board regarding financial matters
- d) select former board members and knowledgeable professionals to be invited to serve as agency subordinates
- e) conduct all other matters delegated to it by the Board.

2. Regulatory-Legislative Committee.

The Regulatory-Legislative Committee shall consist of two or more members, appointed by the President. This Committee shall consider matters bearing upon state and federal regulations and legislation, and make recommendations to the Board regarding policy matters. The Board may direct the Committee to review the law for possible changes.

Proposed changes in State laws, or in the Rules and Regulations of the Board, shall be distributed to all Board members prior to scheduled meetings of the Board.

~~3. Credentials Committee.~~

~~The Credentials Committee shall review and provide guidance to staff on the action to be taken regarding:~~

- ~~a) applications for licensure when the application includes information about criminal activity, practice history, medical conditions or other content issues.~~
- ~~b) applicant or licensee requests for approval of credit for programs when the content or the sponsorship of the course is in question.~~
- ~~c) hold informal fact-finding conferences at the request of the applicant or licensee to determine if the requirements established by the Board have been met.~~

4. **3. Examination Committee.**

The Examination Committee shall develop and oversee the administration of all Board examinations. This shall include, but not be limited to, jurisprudence and licensure examinations.

5. **4. Special Conference Committees.**

Special Conference Committees shall:

- a) review investigation reports to determine if there is probable cause to conclude that a violation of law or regulation has occurred;
- b) hold informal fact-finding conferences, ~~and~~
- c) direct the disposition of disciplinary cases at the probable cause review and informal fact-finding stages. The committee chairs shall provide guidance to Board staff on implementation of their committee's decisions;
- d) review and decide any action to be taken regarding applications for licensure when the application includes information about criminal activity, practice history, medical conditions, or other content issues;
- e) consider applicant or licensee requests for approval of credit for programs when the content or the sponsorship of courses are in question;
- f) hold informal fact-finding conferences at the request of the applicant or licensee to determine if Board requirements have been met.

Each year, on a rotating basis, one of the Special Conference Committees shall be designated to receive all investigation reports alleging violations of the existing Board of Dentistry Rules and Regulations pertaining to advertising.

Article VI. Executive Director

1. Designation.

The Administrative Officer of the Board shall be designated the Executive Director of the Board.

2. Duties.

The Executive Director shall:

- a) Supervise the operation of the Board office and be responsible for **both** the conduct of the staff, and the assignment of cases to agency subordinates.
- b) ~~Carry out~~ **Execute** the policies and services established by the Board.
- c) Provide and disburse all forms as required by law to include, but not be limited to, new and renewal application forms.
- d) Keep accurate record of all applications for licensure, maintain a file of all applications, and notify each applicant regarding the actions of the Board in response to their application. Prepare and deliver licenses to all successful applicants. Keep and maintain a current record of all dental and dental hygiene licenses issued by the Board.
- e) Notify all members of the Board of regular and special meetings of the Board. Notify all Committee members of regular and special meetings of Committees. Keep true and accurate minutes of all meetings and distribute approved draft minutes to the Board members within ten days following such meetings.
- f) Issue all notices and orders, render all reports, keep all records, and notify all individuals as required by these Bylaws or **applicable** law. Affix and attach the seal of the Board to such documents, papers, records, certificates and other instruments as may be directed by law.
- g) Keep accurate records of all disciplinary proceedings. Receive and certify all exhibits presented. Certify a complete record of all documents whenever and wherever required by law.
- h) Present the **Board's** biennial budget, **along** with any revisions, to be reviewed by the Executive Committee prior to submission to the Board for approval.

DEFINITIONS OF TYPES OF COMMITTEE MEMBERS

- 1. **Advisory Member** - Specialized, non-voting member of a committee. Cannot make or second motions, but may participate fully in debate and discussions.
- 2. **Ex-Officio Member** - A member of a committee who serves by virtue of holding a specific office. Has all the rights, responsibilities and duties as any other member of the committee, including the right to vote.

iDentistry | iCare

Innovative Ideas for Patient Care

The 61st Southern Conference of Dental Deans and Examiners Friday, January 29, 2016 – Sunday, January 31, 2016 Marriott - Jackson Mississippi

Agenda

Friday, January 29, 2016

- 4:00 p.m. – 6:00 p.m. Registration and Sign in – *Mezzanine*
- 6:00 p.m. – 8:00 p.m. Reception – *Mezzanine*
Entertainment – Mr. Dan Colbert, pianist

Saturday, January 30, 2016

- 7:00 a.m. – 8:00 a.m. Registration – *Mezzanine*
- 7:00 a.m. – 5:00 p.m. Exhibitor Displays – *Mezzanine*
- 7:00 a.m. – 8:00 a.m. Buffet Breakfast – *Windsor II*
- 8:00 a.m. – 8:30 a.m. **Welcome and Introductions – *Windsor I***
Dr. Robert Scott Gatewood, Associate Dean for Academic Affairs,
University of Mississippi School of Dentistry
Dr. Donald E. Price, President, Mississippi State Board Dental Examiners
- Brief History of University of Mississippi**
Dr. John Hall, Arthur C. Guyton Professor and Chair, Department of
Physiology and Biophysics, University of Mississippi Medical Center
- 8:30 a.m. – 10:00 a.m. **GENERAL SESSION – *Windsor I***
Unconscious Bias
Mr. Howard Ross, Founder & Chief Learning Officer of Cook Ross, Inc.
- 10:00 a.m. – 10:30 a.m. Meet and Greet Break - Visit with exhibitors – *Mezzanine*
- 10:30 a.m. – 12:00 noon **GENERAL SESSION – *Windsor I***
Unconscious Bias (continued)
Mr. Howard Ross
- 12:00 noon – 1:00 p.m. Lunch – *Windsor II*

- 1:00 p.m. – 2:00 p.m. **GENERAL SESSION – Windsor I**
Unconscious Bias (continued)
Mr. Howard Ross
- 2:00 p.m. – 2:30 p.m. Meet and Greet Break–Visit with exhibitors – *Mezzanine*
- 2:30 p.m. – 5:00 p.m. **GENERAL SESSION – Windsor I**
Introductions
Dr. Wilhelmina O’Reilly, Assistant Dean for Student Affairs,
University of Mississippi School of Dentistry
- Dentistry in the Information Age***
Dr. Denise Krause, Associate Professor, Department of Biomedical
Materials Science, University of Mississippi School of Dentistry
- Ms. Diane Howell, Executive Director, Mississippi State Board of
Dental Examiners
- 6:00 p.m. – 9:00 pm Dinner – *Windsor II*
Entertainment – *The Sessions (Jazz Band)*
- Sunday, January 31, 2016**
- 7:00 a.m. – 8:00 a.m. Buffet Breakfast – *Windsor II*
- 8:00 a.m. – 9:30 a.m. **GENERAL SESSION – Windsor I**
Introduction
Dr. Robert Scott Gatewood
- Integrative Medicine and Dentistry: New Opportunities
to Improve Health***
Dr. Gailen D. Marshall, Jr., Chair of Allergy and Immunology, Professor of
Medicine and Pediatrics, University of Mississippi Medical Center
- 9:30 a.m. – 9:45 a.m. Break – *Windsor II*
- 9:45 a.m. – 10:45 a.m. **GENERAL SESSION – Windsor I**
Introductions
Dr. Scott Phillips, Assistant Dean for Clinical Affairs, University of
Mississippi School of Dentistry
- RICE (Rural Interdisciplinary Case Experience) Bowl Competition***
Dr. William Buchanan, Professor, Department of Periodontics and
Preventive Science, University of Mississippi School of Dentistry
- Dr. Bettina Beech, Associate Vice Chancellor for Population Health,
University of Mississippi Medical Center
- 10:45 a.m. – 11:45 a.m. Southern Conference of Dental Deans and Examiners Business Meeting

**Agenda Item: Regulatory Actions - Chart of Regulatory Actions
(As of December 1, 2015)**

Board		Board of Dentistry
Chapter	Action / Stage Information	
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<u>Requirement for jurisprudence examination [Action 4364]</u> NOIRA - Register Date: 11/16/15 Comment ends: 12/16/15
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<u>Requirement for capnography for monitoring anesthesia or sedation [Action 4411]</u> NOIRA - Register Date: 11/30/15 Comment ends: 12/30/15
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<u>Recognition of Commission on Dental Accreditation of Canada [Action 4387]</u> Fast-Track - Register Date: 12/14/15 Effective: 1/28/16
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<u>Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252]</u> Final - Register Date: 11/2/15 Effective: 12/2/15
[18 VAC 60 - 20]	Regulations Governing Dental Practice	<u>Fee reduction [Action 4436]</u> Final - Register Date: 11/2/15 Effective: 12/2/15

16100494D

HOUSE BILL NO. 16
Offered January 13, 2016
Prefiled November 16, 2015

A BILL to amend and reenact § 38.2-3407.17 of the Code of Virginia, relating to health insurance; payment for services by dentists and oral surgeons.

Patrons—Ware and Poindexter

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3407.17 of the Code of Virginia is amended and reenacted as follows:
§ 38.2-3407.17. Payment for services by dentists and oral surgeons.

A. As used in this section:

"Covered services" means the health care services for which benefits under a policy, contract, or evidence of coverage are payable by a dental plan, including services paid by the insureds, subscribers, or enrollees because the annual or periodic payment maximum established by the dental plan has been met.

"Dental plan" includes (i) an insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical, and surgical or major medical coverage on an expense-incurred basis, (ii) an entity providing individual or group accident and sickness subscription contracts, (iii) a dental services plan offering or administering prepaid dental services, (iv) a health maintenance organization providing a health care plan, and (v) a dental plan organization.

B. No contract between a dental plan and a dentist or oral surgeon may establish the fee or rate that the dentist or oral surgeon is required to accept for the provision of health care services, or require that a dentist or oral surgeon accept the reimbursement paid as payment in full, unless the services are covered services under the applicable dental plan.

C. A reimbursement payable or paid by a dental plan for covered services shall be reasonable and not provide nominal reimbursement in order to claim that services are covered services under the applicable dental plan. For purposes of this subsection, "reasonable" means the negotiated fee or rate that is set forth in the participating provider agreement and is acceptable to the provider.

D. This section, except subsection C, shall apply with respect to any contract between a dental plan and a dentist or oral surgeon for the provision of health care to patients that is entered into, amended, extended, or renewed on or after July 1, 2010. The provisions of subsection C shall apply to any contract between a dental plan and a dentist or oral surgeon for the provision of health care to patients that is entered into, amended, extended, or renewed on or after January 1, 2017.

E. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2. That the provisions of this act shall become effective on January 1, 2017.

INTRODUCED

HB16

Department of Health Professions Legislative Proposals for 2016 Session of the General Assembly

1. Clean-up; elimination of outdated or inconsistent language

a. Nursing - CNA renewal annually rather than biennially

- When fees for all professions under the Board of Nursing were increased in 2011, it was decided that an increase from \$50 to \$60 biennially for certified nurse aides would be burdensome. It is easier for CNA's to pay a smaller fee every year, so the regulation was changed from a biennial renewal to an annual renewal. The agency overlooked the provision in Code that specifies a biennial renewal, so the amendment will be consistent with current practice.

b. Medicine - Temporary authorization to practice healing arts in summer camps; CE instruction

- The Board of Medicine has an exemption provision that allows practitioners from other states to practice temporarily (not to exceed 3 months) in a summer camp, while participating in continuing education programs, or in voluntarily rendering care at a free clinic, if they are issued a temporary license or certification "governed by regulations promulgated by the Board." The fee is set in the Code at \$25.
- The Board has always issued an "authorization" letter rather than a "license" upon completion of an application and verification that the practitioner is in good standing with the other licensing board. The Board has never adopted regulations because they were deemed unnecessary.
- The Assistant Attorney General has recently advised that the license (authorization to practice) should not be issued without Board regulations. To avoid the lengthy and unnecessary process of promulgating regulations and to clarify that the Board is authorizing temporary practice rather than issuing a license, the Code needs to be amended.

c. Optometry – repeal of endorsement provisions

- The law currently says the Board of Optometry may recognize other states' examinations if they are *approximately equivalent* to its examination and the state from which the applicant comes grants reciprocity to persons licensed in the Commonwealth.
- There are two issues with the Code: 1) it is impossible to determine equivalency because the Board does not have access to content of the national exam (required in Virginia) and any other examination. All states now required the national exam, but there may still be applicants from states who were licensed earlier; 2) there is no reciprocity agreement with any other state. So, theoretically, Virginia should not endorse an applicant from any other state.
- The Board has acted on general statutory authority to endorse applicants from other states and its regulations, so the restrictive provision in the Optometry law needs to be repealed.

2. Pharmacy – permitting of non-resident medical equipment suppliers

- This bill would also create a new licensing category for non-resident medical equipment suppliers. For several years, the board has allowed a medical equipment supplier (MES)

located in another state to voluntarily obtain a medical equipment supplier permit in order to satisfy reimbursement requirements for Medicaid/Medicare, however, there is no clear authority to license an out of state MES or require licensure for such activity. This bill would formalize the Board's existing process and hold out of state MES facilities to a similar licensure oversight as in-state MES facilities.

3. Prescription Monitoring Program - Proposals are recommendations of the Governor's Task Force on Prescription Drug and Heroin Abuse and the Prescription Monitoring Advisory Committee.

- Allows disclosure to prescribers or dispensers for clinical consultation. It will expand access to the PMP for clinical pharmacists who are participating on healthcare teams with prescribers or for consulting physicians who are assisting a prescriber in making a prescribing decision for a specific patient.
- Changes reporting by dispensers from every 7 days to every 24 hours. There is interest in shortening the time that prescription data gets reported to the PMP, not only in Virginia, but nationally because it makes abuse/diversion more difficult and information more valuable to prescribers and dispensers. Some larger chains already report data to PMPs on a daily basis regardless of individual states' requirements. It was noted that the proposed language states that data shall be transmitted to the Department or its agent within 24 hours or the next business day whichever comes first to accommodate pharmacies that are not open 7 days a week.
- Clarifies that a PMP report requested by a prescriber can be made a part of a medical record.

4. Veterinary Medicine – 2015 bill

- This is the 2015 bill, which was approved by the Governor, but defeated in Senate Education and Health as punishment to Del. Bloxom by Senate Republicans. The need for the legislation continues to exist.

5. Veterinary Medicine – Reporting of animal cruelty; elimination of restriction on employment of veterinary technicians

- The requirement to report animal cruelty currently applies only to veterinarians. Any person regulated by the Board should be also required to report – including veterinary technicians or equine dental technicians – who encounter suspected animal cruelty.
- Veterinary technicians practice under the immediate and direct supervision of a licensed veterinarian but may or may not be employed by the veterinarian. Veterinarians and veterinary technicians may be employed by the veterinary school or by a facility with a third party owner. The amendment retains the current scope of practice of a veterinary technician and the requirement for supervision but eliminates the requirement of employment by the veterinarian. It also clarifies that the supervision must be by a veterinarian licensed to practice in Virginia or a veterinarian practicing at Virginia Tech who does not hold a license by virtue of the exemption in 54.1-3801.

6. Board composition – Nursing; Dentistry; Counseling; BHP; HPMP

- The legislation would add a citizen member to the Board of Dentistry and the Health Practitioners' Monitoring Program (HPMP) Committee. Citizen membership is under-represented in Dentistry and non-existent on the HPMP Committee. It would also add another licensed practitioner to the composition of the HPMP.
- The Board of Nursing would gain one member, who would be a nurse practitioner. That Board is small in proportion to the number of regulants and the workload of the Board.
- The Board of Counseling would be reduced by two members; it is too large in proportion to its number of regulants. The reduction would be in licensed substance abuse practitioners who are over-represented compared to the number of licensees.
- The change in appointment to the Board of Health Professions is to make the terms on that board concurrent with terms on the health regulatory board the appointee represents.

7. Nurse Licensure Compact revisions

- New Compact is same model as current compact. Mutual Recognition: one state based license, issued by state of primary residence, nationally recognized and locally enforced.
- Promotes increased participation by non-compact states and telehealth opportunities, addresses threats to state based licensure and makes necessary improvements.
- No increase in cost. (current fee of \$ 6,000 annually)
- Calls for a higher threshold for issuing a license with multistate privilege; background checks, no felony convictions, no current discipline, no monitoring program participation.
- Does not prohibit states from issuing a single state license if higher threshold not met.
- Renames the oversight body (Commission of Compact Administrators) creating a joint public entity and provides for authority to promulgate uniform regulations related to the NLC, following public participation and enforces Compliance with the NLC.
- Contains a grandfathering provision
- Transition to new Compact is effective by the earlier of 26 enacting states or December 31,2018

8. CME for prescribers licensed by Board of Medicine.

- This is a recommendation of the Governor's Task Force on Prescription Drug and Heroin Abuse. The bill would authorize the Board of Medicine to require doctors who meet certain criteria for prescribing to obtain two hours of continuing education.
- The criteria would be determined by the Board of Medicine and could be based on information from the Prescription Monitoring Programs about thresholds of prescribing opiates and benzodiazepines or could be more generally applied to prescribers at any level.
- Licensees of the Board would be notified prior to January 1st of every odd year about the continuing education requirement, which would give them at least 12 months to obtain the hours prior to renewal in even years.
- This proposal is similar to language in the Code for the Board of Pharmacy, which has authority to specify a topic of continuing education for a given calendar year. Currently, pharmacists must obtain at least one hour of continuing education (CE) in the subject of "opioid use or abuse" during the calendar year of 2015.

9. Requirement to query the PMP for certain prescribing.

- This is a recommendation of the Governor's Task Force on Prescription Drug and Heroin Abuse. The bill would require a report from the Prescription Monitoring Program (PMP) when initiating treatment that includes prescribing of a benzodiazepine or an opiate for the purpose of determining what, if any, other covered substances are currently prescribed to the patient.
- If the prescribing of an opiate or benzodiazepine continues for more than 90 days after the date of the initial prescription, the prescriber or prescriber's designee must make periodic requests from the PMP, no less frequently than once every 90 days until the course of treatment has ended.
- The following exceptions to the requirement for obtaining a patient's PMP report prior to prescribing are if:
 1. The opiate or benzodiazepine is prescribed to a patient currently receiving hospice or palliative care.
 2. The opiate or benzodiazepine is prescribed to a patient as part of treatment for a surgical procedure and such prescription is not refillable.
 3. The program is not operational or available due to temporary technological or electrical failure or natural disaster.

10. Authorizes the PMP to send unsolicited reports on prescribers and dispensers

- This is a recommendation of the Governor's Task Force on Prescription Drug and Heroin Abuse. The purpose of the proposed legislation is to address over-prescribing and doctor-shopping by sending reports of potential unusual prescribing or dispensing to law enforcement or regulatory agencies.
- The bill would grant authority to the Prescription Monitoring Program, through the Director of the Department of Health Professions (DHP), to send unsolicited reports on egregious outlier prescribing and dispensing behavior to the Enforcement Division of DHP and/or to law enforcement, based on criteria developed by the PMP Advisory Panel in consultation with applicable licensing boards
- The criteria for sending an unsolicited report would be developed by the PMP Advisory Panel with input from the applicable licensing boards based on criteria for indicators of misuse, indiscriminate prescribing and dispensing.

11. Remote supervision for dental hygienists in certain clinics

- This is a proposal from the Secretary's office to address issues of access to dental services in certain areas of the state and among a population of citizens who are dependent on free clinics or federally qualified health centers for care.
- The bill would allow a dental hygienist to provide educational and preventive dental care in any clinic which is organized for the delivery of health care services without charge or any clinic for the indigent and uninsured that is organized for the delivery of primary health care services as a federally qualified health center designated by the Centers for Medicare & Medicaid Services under the remote supervision of a dentist licensed in Virginia and affiliated with the clinic.

- A dental hygienist providing such services must practice pursuant to a protocol adopted as regulation by the Board of Dentistry.
- The legislation would expand the model currently in place in which dental hygienists employed by VDH can practice under remote supervision by a public health dentist.

12. Practice by nurse practitioners without practice agreement with physician in certain clinics.

- This is a proposal from the Secretary's office to address issues of access to care in underserved areas of Virginia and among populations that are indigent and uninsured.
- This bill would allow a nurse practitioner with 2,000 hours of post-licensure experience to practice without a practice agreement with a patient care team physician in any clinic which is organized in whole or in part for the delivery of health care services without charge or any clinic for the indigent and uninsured that is organized for the delivery of primary health care services as a federally qualified health center designated by the Centers for Medicare & Medicaid Services or in a medically underserved area of the state as determined by the Virginia Department of Health.

Board of Dentistry
Regulations Governing the Practice of Dentistry
CHAPTER 21 REFERENCE GUIDE

Chapter 21 Sections	Current Chapter 20 Regulatory Sections	Statutory Provisions
PART I General Provisions		
18VAC60-21-10 <u>Definitions</u> Definitions for "AAOMS", "nonsurgical laser", and "topical oral anesthetic" are added	18VAC60-20-10	54.1-2700
18VAC60-21-20 <u>Address of record</u> Information on a public address expanded Posting requirement moved to next section	18VAC60-20-16	
18VAC60-21-30 <u>Posting requirements</u> New section with expanded provisions Duplicate licenses must be obtained from the Board DEA registration to be displayed with license Sedation permit or AAOMS Certificate to be displayed	18VAC60-20-16 18VAC60-20-110.D 18VAC60-20-120.G	54.1-2720 & 54.1-2721
18VAC60-21-40 <u>Fees</u> All fees addressed in this section See H. for 2016 one time renewal fee reductions	18VAC60-20-20, 30, 40, 106, 250, 310 & 320	54.1-2400(5)
PART II Standards of Practice		
18VAC60-21-50 <u>Scope of practice</u> New section on establishing a bona fide dentist-patient relationship		54.1-2700 & 2711
18VAC60-21-60 <u>General responsibilities to patients</u> New section addressing multiple requirements for patient safety and welfare which include: A.5. Written notice of at least 30 days for patient dismissal B.1. Maintaining a list of customary fees	18VAC60-20-170	54.1-2706
18VAC60-21-70 <u>Unprofessional practice</u> Section revised and expanded A.5. addresses failure to cooperate with investigation B. addresses sexual misconduct	18VAC60-20-170	54.1-2706 54.1-111
18VAC60-21-80 <u>Advertising</u> Section revised and expanded D. Retention time increased to 2 years E. Advertised fees limited to CDT terms	18VAC60-20-180	54.1-2706.7
18VAC60-21-90 <u>Patient information and records</u> Section revised and expanded A. Records to be legible and retained for 6 yrs with exceptions listed B.4. Consent for treatment B.6. Images labeled with patient name, date and teeth identified D. Records not to be withheld G. Records not to be abandoned H. Confidentiality preserved when records are destroyed	18VAC60-20-15	20-124.6, 32.1-127.1:03, 54.1-2403.2 & .3, & 54.1-2404, 54.1-2405 & 54.1-2719

18VAC60-21-100 Reportable events during or following treatment or the administration of sedation or anesthesia Section expanded to include events related to treatment Timeframe to report reduced to 15 days	18VAC60-20-107.H	
PART III Direction and Delegation of Duties		
18VAC60-21-110 Utilization of dental hygienists and dental assistants II Section edited only	18VAC60-20-200	54.1-2712.1
18VAC60-21-120 Requirements for direction and general supervision A. Includes patient in determining tx to be provided D. addresses indirect supervision of dental hygienist	18VAC60-20-210	54.1-2722.A & D
18VAC60-21-130 Nondelegable duties; dentists 2. exception added for dental hygienists performing gingival curettage	18VAC60-20-190	
18VAC60-21-140 Delegation to dental hygienists A.1. and B.1. Gingival curettage is added and so is use of nonsurgical lasers	18VAC60-20-220	54.1-2722
18VAC60-21-150 Delegation to dental assistants II Section added to address duties only delegable to DAs II	18VAC60-20-230	54.1-2729.01
18VAC60-21-160 Delegation to dental assistants I and II Section edited to address delegation to any dental assistant	18VAC60-20-230	54.1-2729.01
18VAC60-21-170 Radiation Certification Edited to prohibit delegation to an unqualified person	18VAC60-20-195	
18VAC60-21-180 What does not constitute practice Section edited to identify dental screening settings	18VAC60-20-240	
PART IV Entry, Licensure and Registration Requirements		
18VAC60-21-190 General application provisions Sections on applications combined and edited B. new requirement to attest to reading and remaining current with applicable laws and regulations	18VAC60-20-70 A & 100	
18VAC60-21-200 Education Requires a post-doctoral specialty program to be at least 24 months and to include a clinical component	18VAC60-20-60	54.1-2709
18VAC60-21-210 Qualifications for an unrestricted license Sections on licensure by exam and by credentials combined	18VAC60-20-70, 71	54.1-2709.B & C
18VAC60-21-220 Inactive license Provisions for demonstrating continuing competence expanded to include passage of an exam or refresher course	18VAC60-20-105	54.1-2709.D
18VAC60-21-230 Qualifications for a restricted license Sections on the various restricted licenses were combined Still need to reference respective statutes for education requirements Must rely solely on statute §54.1-2714 to address restricted license for foreign dentists to teach	18VAC60-20-90, 91	54.1-2715.A

PART V Licensure Renewal		
18VAC60-21-240 <u>License Renewal and reinstatement</u> Fees moved to 18VAC60-21-40 C. Requires renewal request for restricted licenses D. Ways to demonstrate continuing competence expanded	18VAC60-20-20	54.1-2711.1, 54.1-2713, 54.1-2715
18VAC60-21-250 <u>Requirements for continuing education</u> A.1. Requires attestation of current knowledge of laws for renewal A.2. requires current training with hands-on airway training for health care providers B.2. business management and marketing courses added as unacceptable C. 1. and 6. Expanded to reference approved providers E. exemption requests due before renewal deadline	18VAC60-20-50	54.1-2709.E
PART VI Controlled Substances, Sedation and Anesthesia		
18VAC60-21-260 <u>General Provisions</u> B.1. DEA registration requirement moved to this section C. section is expanded to address administration of the levels of sedation by ASA Class D. written consent expanded to include the dental procedure I.1. requires staff assisting in administration to hold current training with hands-on airway training for health care providers J. who may assist in administration K. monitoring requirements expanded to address required activities L. dentists using another professional to administer must assure equipment is in working order and staff is qualified	18VAC60-20-107 and 135	54.1-2706.15
18VAC60-21-270 <u>Administration of local anesthesia</u> New section addresses who may administer		54.1-3408.A & J
18VAC60-21-280 <u>Administration of minimal sedation</u> A.1. and 2. expanded to include the indicators of and interventions for complications A.3. New on use and maintenance of equipment C. New on delegation of administration D. expanded to require suction apparatus and pulse oximeter G. dentist responsible for discharging patient following post-operative evaluation	18VAC60-20-108	54.1-3408. A & J
18VAC60-21-290 <u>Requirements for a conscious/moderate sedation permit</u> New section - no change in requirements	18VAC60-20-120	54.1-3408.A & B

18VAC60-21-291 <u>Requirements for administration of conscious/moderate sedation</u> Requirements reorganized but not changed	18VAC60-20-120	
18VAC60-21-300 <u>Requirements for a deep sedation/general anesthesia permit</u> Requirements reorganized but not changed	18VAC60-20-110	54.1-3408. A & B
18VAC60-21-330 <u>Reporting of malpractice paid claims and disciplinary notices and orders</u> No change	18VAC50-20-270.B.	
18VAC60-21-370 <u>Credentials required for certification</u> No change	18VAC60-20-A.7.b(2)	
18VAC60-21-301 <u>Requirements for administration of deep sedation or general anesthesia permit</u> Requirements reorganized but not changed		
PART VII Oral and Maxillofacial Surgeons		
18VAC60-21-310 <u>Registration of oral and maxillofacial surgeons</u> No change	18VAC60-20-250	54.1-2709.2
18VAC60-21-320 <u>Profile of information for oral and maxillofacial surgeons</u> No change	18VAC60-20-260	54.1-2709.2
18VAC60-21-330 <u>Reporting of malpractice paid claims and disciplinary notices and orders</u> No change	18VAC60-20-270	54.1-2709.3 & 4
18VAC60-21-340 <u>Noncompliance or falsification of profile</u> No change	18VAC60-20-280	
18VAC60-21-350 <u>Certification to perform cosmetic procedures; applicability</u> The provisions for procedures are expanded to address the areas of the face and neck where cosmetic treatment might be provided.	18VAC60-20-290	54.1-2709.1.A
18VAC60-21-360 <u>Certification not required</u> No change	18VAC60-20-300	
18VAC60-21-370 <u>Credentials required for certification</u> No change	18VAC60-20-310	54.1-2709.1.A & B
18VAC60-21-380 <u>Renewal of certification</u> No change	18VAC60-20-320	
18VAC60-21-390 <u>Quality assurance reviews for procedures performed by certificate holders</u> No change	18VAC60-20-330	54.1-2709.1.A
18VAC60-21-400 <u>Complaints against certificate holders for cosmetic procedures</u> No change	18VAC60-20-331	54.1-2709.1.C

PART VIII. Mobile Dental Clinics

18VAC60-21-410 <u>Registration of a mobile dental clinic or portable dental operation</u> No change	18VAC60-20-332	
18VAC60-21-420 <u>Requirements for a mobile dental clinic or portable dental operation</u> No change	18VAC60-20-342	
18VAC60-21-430 <u>Exemption from requirement for registration</u> No change	18VAC60-20-352	

Board of Dentistry
Regulations Governing the Practice of Dental Hygiene
CHAPTER 25 REFERENCE GUIDE

Chapter 25 Sections	Current Chapter 20 Regulatory Sections	Statutory Provisions
PART I General Provisions		
18VAC60-25-10 Definitions Definitions for “active practice”, “nonsurgical laser,” and “topical oral anesthetic” are added	18VAC60-20-10	54.1-2700
18VAC60-25-20 Address of record; posting requirements Information on a public address expanded Duplicate licenses must be obtained from the Board	18VAC60-20-16	54.1-2727
18VAC60-25-30 Fees All fees addressed in this section See G. for 2016 one time renewal fee reductions	18VAC60-20-20, 18VAC60-20-30, 18VAC60-20-40, 18VAC60-20-106	54.1-2400 (5)
PART II Practice of Dental Hygiene		
18VAC60-25-40 Scope of practice A. States types of services performed B. Duties restricted to dentists - exception added for dental hygienists performing gingival curettage C. Duties requiring indirect supervision - gingival curettage is added and so is use of nonsurgical lasers D. Duties under indirect supervision or general supervision - gingival curettage is added and so is use of nonsurgical lasers E. Duties only delegable to a Dental Assistant II F. VDH use of remote supervision	18VAC60-20-190 18VAC60-20-220	54.1-2722.D
18VAC60-25-50 Utilization of Dental hygienists and dental assistants No change	18VAC60-20-200	54.1-2724
18VAC60-25-60 Delegation of services to a dental hygienist No change	18VAC60-20-210	54.1-2722
18VAC60-25-70 Delegation of services to a dental assistant New section addressing supervision by a dental hygienist under general supervision		54.1-2729.01
18VAC60-25-80 Radiation Certification Edited to prohibit delegation to an unqualified person	18VAC60-20-195	
18VAC60-25-90 What does not constitute practice Section edited to identify dental screening settings	18VAC60-20-240	

18VAC60-25-100 <u>Administration of controlled substances</u> New section addressing administration of topical substances, nitrous oxide/inhalation analgesia and administration of local anesthesia	18VAC60-20-81, 18VAC60-20-108, 18VAC60-20-110.E, 18VAC60-20-120.H, 18VAC60-20-220	
PART III Standards of Conduct		
18VAC60-25-110 <u>Patient records; confidentiality</u> New section addressing responsibility for hygiene tx information in patient records and for maintaining confidentiality		
18VAC60-25-120 <u>Acts constituting unprofessional conduct</u> New section listing actions that are grounds for disciplinary action		54.1-2706
PART IV Requirements for Licensure		
18VAC60-25-130 <u>General application provisions</u> The term "endorsement" is replaced with "credentials"	18VAC60-20-100	54.1-2722
18VAC60-25-140 <u>Licensure by examination</u> No change	18VAC60-20-60, 18VAC60-20-70	54.1-2722
18VAC60-25-150 <u>Licensure by credentials</u> The term "endorsement" is replaced with "credentials"	18VAC60-20-60, 18VAC60-20-80	54.1-2722
18VAC60-25-160 <u>Temporary permit; faculty license</u> See respective statutes for requirements	18VAC60-20-90	54.1-2725 54.1-2726
18VAC60-25-170 <u>Voluntary practice</u> No change	18VAC60-20-106	54.1-2701.5 54.1-2726.1
PART V Licensure Renewal and Reinstatement		
18VAC60-25-180 <u>Requirements for licensure renewal</u> No change	18VAC60-20-20	54.1-2400(4) 54.1-2729
18VAC60-25-190 <u>Requirements for continuing education</u> A.1. requires current hands-on course in basic cardiopulmonary resuscitation for health care providers C. 1. and 6. expanded to reference approved providers E. exemption requests due at least 30 days before renewal deadline	18VAC60-20-50	54.1-2729
18VAC60-25-200 <u>Inactive license</u> No change	18 VAC60-20-105	54.1-2400(12)
18VAC60-25-210 <u>Reinstatement or reactivation of a license</u> Ways to demonstrate continuing competence expanded	18VAC60-20-20.C 18VAC60-20-105	54.1-2409

Board of Dentistry
Regulations Governing the Practice of Dental Assistants
CHAPTER 30 REFERENCE GUIDE

Chapter 30 Sections	Current Chapter 20 Regulatory Sections	Statutory Provisions
PART I General Provisions		
18VAC60-30-10 <u>Definitions</u> Definition of "radiographs" added	18VAC60-20-10	54.1-2700
18VAC60-30-20 <u>Address of record; posting of registration</u> Information on a public address expanded Duplicate registration must be obtained from the Board	18VAC60-20-16	
18VAC60-30-30 <u>Required fees</u> All fees addressed in this section See G. for 2016 one time renewal fee reductions	18VAC60-20-20, 18VAC60-20-30, 18VAC60-20-40	54.1-2400 (5)
PART II Practice of Dental Assistants II		
18VAC60-30-40 <u>Practice of dental hygienists and dental assistants II</u> No change	18VAC60-20-200	
18VAC60-30-50 <u>Nondelegable duties; dentists</u> Duties restricted to dentists - exception added for dental hygienists performing gingival curettage	18VAC60-20-190	
18VAC60-30-60 <u>Delegation to dental assistants II</u> Addresses duties only delegable to DAs II	18VAC60-20-230	54.1-2729.01
18VAC60-30-70 <u>Delegation to dental assistants I and II</u> Edited only	18VAC60-20-230	
18VAC60-30-80 <u>Radiation Certification</u> Edited to prohibit delegation to an unqualified person	18VAC60-20-195	
18VAC60-30-90 <u>What does not constitute practice</u> Section edited to identify dental screening settings	18VAC60-20-240	
PART III Standards of Conduct		
18VAC60-30-100 <u>Patient records; confidentiality</u> New section addressing responsibility for DA II tx information in patient records and for maintaining confidentiality		
18VAC60-30-110 <u>Acts constituting unprofessional conduct</u> New section listing actions that are grounds for disciplinary action		54.1-2706
PART IV Entry Requirements for Dental Assistants II		
18VAC60-30-115 <u>General application provisions</u> New requirement to attest to reading and remaining current with applicable laws and regulations	18VAC60-20-100	
18VAC60-30-120 <u>Educational requirements for dental assistants II</u> No change	18VAC60-20-61	54.1-2729.01

18VAC60-30-140 <u>Registration by endorsement</u> No change	18VAC60-20-72	54.1-2729.01
PART V Requirements for Renewal and Reinstatement		
18VAC60-30-150 <u>Registration renewal requirements</u> No change	18VAC60-20-20	54.1-2400(4)
18VAC60-30-160 <u>Inactive registration</u> B. Requirements for continuing competence added for reactivation	18 VAC60-20-105	54.1-2400(12)
18VAC60-30-170 <u>Registration reinstatement requirements</u> Ways to demonstrate continuing competence expanded	18VAC60-20-20.C	54.1-2409

Health Investments that Pay Off: Strategies to Improve Oral Health

Executive Summary

Tooth decay is the most common chronic disease among American children. Although most Americans enjoy relatively good oral health, low-income families are disproportionately affected by dental-related disease. In particular, children living below the poverty level are two to three times more likely to suffer from untreated tooth decay than those who are economically better off. Access to oral health care that could prevent tooth decay is significantly worse for low-income and minority children. Dental disease left untreated results in serious health, developmental, and social complications, as well as reliance on treatment in high-cost settings such as hospitals.

Tooth decay and other oral health complications are preventable, and several prevention and early treatment options are safe, effective, and economical. Governors who want to address oral health needs should consider interventions that show strong evidence of improving oral health outcomes.

Those interventions are:

- Dental sealant delivery programs, particularly those administered in schools;
- Community water fluoridation programs; and
- Routine application of fluoride varnish by primary care providers.

In addition, governors should consider strategies that support the oral health workforce to increase access to safe and cost-effective interventions, such as fluoride and dental sealant applications, according to a National Governors Association issue brief.¹

Introduction

With national attention on transforming health care systems increasing, governors and other state leaders are focused on finding interventions that both improve population health and the quality of health care, and reduce health care costs. Three oral health interventions—placement of resin-based dental sealants on permanent molars in children at high risk for dental caries, community water fluoridation, and routine application of fluoride varnish by primary care providers—meet the criteria of improving health outcomes and demonstrating cost saving and, in the case of community water fluoridation, a return on investment (ROI) within three years.²

Oral Health: Overview of the Problem

Most Americans enjoy good oral health, but the burden of dental-related disease is disproportionately heavy among low-income individuals.³ Families living below the poverty level experience higher rates of dental caries (tooth decay) than families living above the poverty

¹ National Governors Association. *The Role of Dental Hygienists in Providing Access to Oral Health Care*, (January 2014), <http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf>.

² Return on investment (ROI) is often presented differently in the literature. For the purposes of uniformity and comparison with other potential interventions, in this paper, ROI is calculated as (intervention benefit – intervention cost) / intervention cost. In some instances, the ROI has been recalculated by economists from the Centers for Disease Controls Prevention using this formula and may differ from the ROI presented in the original source. A positive ROI reflects cost savings after accounting for all intervention costs within a given time frame. A negative ROI indicates that the benefits from the intervention were not enough to offset the cost of the intervention within the timeframe of the study.

³ Center for Disease Control and Prevention, National Center for Health Statistics, “Untreated dental caries, by selected characteristics: United States, selected years 1971-1974 through 2007-2010, Table 71,” 2013, <http://www.cdc.gov/nchs/data/hus/2013/071.pdf> (accessed March, 3, 2015).

level regardless of ethnic or racial background. The problem is particularly severe among young children in those families. Although the rate of untreated tooth decay has dropped by almost half among 6 to 19 year olds living in poverty over the past four decades (from 68 percent to 24.7 percent), the needle has not moved at all for children ages 2 to 5 years old (32 percent to 31.7 percent) during the same period.⁴ One out of every four children ages 6 to 19 living in poverty has untreated tooth decay, compared with one of every 13 children in those age groups who are economically better off.⁵ Just above the poverty level, rates of untreated tooth decay are almost twice as high among African-American and Hispanic children compared with Caucasian children.⁶

The implications of dental-related disease for overall health and well-being are significant. Untreated tooth decay affects all aspects of a person's life. Painful and obvious decay compromises one's ability to eat, sleep, play, and learn, and negatively affects self-esteem and social development.⁷ Access to preventive dental care is problematic for low-income families. In 2012, nearly half (48 percent) of children living in poverty had a dental visit compared with more than 80 percent of those of middle income or higher.⁸ Uninsured

children have significantly less access than those with insurance coverage (either public or private).⁹ Just short of half of children covered by Medicaid actually received dental care in 2010.¹⁰ In addition, millions of Americans live in areas with a shortage of dental professionals, and many more have inadequate access to dentists who accept Medicaid reimbursement.¹¹

Similar to the cost profile of other health conditions, inadequate access to prevention and early intervention in oral health leads to more invasive interventions, such as restorative treatments and extractions, in costly sites of service (such as operating rooms and emergency departments). In 2009, the United States spent more than \$100 billion on dental services, which is less than 5 percent of total spending on health care.¹² That proportion has stayed constant over the last two decades. About 9 percent of total spending on dental services was public spending (that is, state and federal).¹³ For example, in 2009, preventable dental conditions were the primary reason for more than 830,000 emergency room (ER) visits across the United States, with children visiting the ER for preventable dental problems more than 49,000 times during that year.¹⁴ A significant portion of that costly

⁴ Ibid.

⁵ Bruce Dye et al., *Oral Health Disparities as Determined by Selected Healthy People 2020 Oral Health Objectives for the United States, 2009-2010 NCHS Data Brief* (Atlanta, GA: Centers for Disease Control and Prevention, August 2012), 1, <http://www.cdc.gov/nchs/data/databriefs/db104.pdf>; comparison groups include: below 100 percent of the federal poverty level and 400 percent or more of the federal poverty level.

⁶ Bruce Dye et al., *Oral Health Disparities as Determined by Healthy People 2020 Oral Health Objectives for the United States, 2009-2010 NCHS Data Brief* (Atlanta, GA: Centers for Disease Control and Prevention, August 2012), 1, <http://www.cdc.gov/nchs/data/databriefs/db104.pdf>.

⁷ Pew Center on the States, *A Costly Dental Destination: Hospital Care Means States Pay Dearly* (February 2012), 2, <http://www.pewtrusts.org/-/media/Assets/2012/01/16/A-Costly-Dental-Destination.pdf>.

⁸ Erika Steinmetz, Brian Bruen, Leighton Ku, "Children's Use of Dental Care in Medicaid: Federal Fiscal years 2000-2012" Milken Institute School of Public Health, George Washington University, (October 2014) <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/dental-trends-2000-to-2012.pdf>, 1.

⁹ Leighton Ku et al., "Increased Use of Dental Services by Children Covered by Medicaid: 2000-2010," *Medicare Medicaid Research Review* 3, no.3 (July 10, 2013): E1-E12 http://www.cms.gov/mmrr/Downloads/MMRR2013_003_03_b01.pdf, E2.

¹⁰ U.S. Government Accountability Office, *Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needs to Address Ongoing Concerns Report to Congressional Committees*, (Washington DC: November 2010), 1, <http://gao.gov/new.items/d1196.pdf> (accessed December 11 2014).

¹¹ Ibid., E5.

¹² Centers for Medicare and Medicaid, *National health expenditures by type of service and source of funds: CY 1960-2009*, (May 2014), http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp, 25.

¹³ Centers for Medicare and Medicaid, *National health expenditures by type of service and source of funds: CY 1960-2009*, (May 2014), http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

¹⁴ Pew Center on the States, *A Costly Dental Destination: Hospital Care Means States Pay Dearly* (February 2012), 1, <http://www.pewtrusts.org/-/media/Assets/2012/01/16/A-Costly-Dental-Destination.pdf>; and The Pew Charitable Trusts, *Many States are Missing an Opportunity to Prevent Tooth Decay and Reduce Medicaid and Other Health-related Costs* (January 8, 2013), <http://www.pewtrusts.org/en/about/news-room/press-releases/0001/01/01/many-states-are-missing-an-opportunity-to-prevent-tooth-decay-and-reduce-medicare-and-other-health-related-costs>

ER care is paid by taxpayers through Medicaid and other public programs; children account for about one-third of Medicaid's total spending on dental services.¹⁵ A report published by the Pew Charitable Trusts estimated that between 2010 and 2020, annual Medicaid spending for dental care could increase from \$8 billion to more than \$21 billion because of preventable dental disease.¹⁶

To manage the possibility of such a large increase in Medicaid expenditures for preventable dental conditions, states should consider increasing access to oral health interventions shown to be safe and effective in clinics and communities, such as those discussed below. Some of those interventions show rapid ROI (such as community water fluoridation); others show potential cost-savings over a period extending beyond our three-year definition of rapid ROI (such as dental sealant delivery programs and routine application of fluoride varnish by primary care providers).

Improving Oral Health Outcomes with Cost-Saving Interventions

States considering how to address oral health needs should examine the following interventions, which show strong evidence of improving oral health outcomes and are associated with cost savings:

- Dental sealant delivery programs;
- Community water fluoridation programs; and
- Routine application of fluoride varnish.

Dental Sealant Programs

Dental sealant programs, particularly school-based

programs, have been found to be effective in reducing dental caries and improving oral health.¹⁷ School-based programs provide sealants—a resin-based physical barrier placed on the permanent molars' chewing surfaces to prevent caries from beginning or progressing—to students either at schools or in dental clinics. School-based programs are recommended by the Community Preventive Services Task Force, an independent and nonfederal panel of public health and prevention experts that provides evidence-based findings and recommendations about preventive services in the community, programs, and policies through the Guide to Community Preventive Services. The recommendation is based on strong evidence that sealants reduce tooth decay and that school-based programs are effective in increasing the number of school-age children (ages 5 to 16 years) receiving sealants.¹⁸ Those programs typically target schools with high rates of participation in federal programs that provide free or reduced-price meals, a strategy for providing access to children from families with low incomes. Currently, 35 states plus the District of Columbia do not have sealant programs in their highest-need schools.¹⁹

Preliminary evidence suggests that placement of resin-based sealants in children at high risk for developing dental caries (primarily Medicaid beneficiaries) is cost-effective. An analysis by the DentaQuest Foundation, using estimated effectiveness from a Cochrane Review, found that sealing all permanent first molars in high-risk children (defined as: annual caries incidence without sealants is 70 percent) would save Medicaid up to \$53 per child or a net cost savings to Medicaid of up to

¹⁵ The Pew Charitable Trusts, *Many States are Missing an Opportunity to Prevent Tooth Decay and Reduce Medicaid and Other Health-related Costs* (January 8, 2013), <http://www.pewtrusts.org/en/about/news-room/press-releases/0001/01/01/many-states-are-missing-an-opportunity-to-prevent-tooth-decay-and-reduce-medicare-and-other-health-related-costs>

¹⁶ *Ibid.*

¹⁷ Jean Beauchamp et al., "Evidence-based clinical recommendations for the use of pit-and-fissure sealants: A report of the American Dental Association Council on Scientific Affairs," *The Journal of The American Dental Association* 139, no. 3 (March 2008): 257-268.

¹⁸ The Guide to Community Preventive Services, "Preventing Dental Caries: School-Based Dental Sealant Delivery Programs, Task Force Finding and Rationale Statement," Community Preventive Services Task Force, <http://www.thecommunityguide.org/oral/supportingmaterials/RRschoolsealant.htm> (accessed October 18, 2014).

¹⁹ Pew Center on the States Infographic, "Most States Lag on Dental Sealants," The Pew Charitable Trust, <http://www.pewtrusts.org/en/multimedia/data-visualizations/2013/most-states-lag-on-dental-sealants> (accessed December 3, 2014).

\$13,310 per 1000 teeth (approximately 250 children).²⁰

Community Water Fluoridation Programs

According to the Centers for Disease Control and Prevention (CDC), community water fluoridation (fluoridation) is the controlled adjustment of fluoride in a public water supply to optimal concentration in order to prevent caries (tooth decay) among members of the community. Fluoride acts to impede demineralization and to enhance the remineralization of dental enamel, both of which prevent dental caries.²¹ The Community Preventive Services Task Force recommends the use of fluoridation programs, pointing to strong evidence that such programs reduce dental caries across populations.²² Communities using fluoridation programs have a substantially lower prevalence of dental caries compared to communities that do not use the intervention. Evidence shows that fluoridation prevents tooth decay by providing frequent and consistent contact with low levels of fluoride, ultimately reducing tooth decay by 25 percent over a lifetime.²³ Additional evidence shows that schoolchildren living in fluoridated communities, on average, have 2.25 fewer cavities than those not living in fluoridated communities.²⁴ Recently, the U.S. Public Health Service updated its 1962 Drinking Water Standards for fluoridation based on new scientific evidence of available fluoride sources and

trends in dental fluorosis (visually detectable changes in tooth enamel that cause white markings on teeth).²⁵ The new guidance maintains that fluoridation is an effective public health intervention and updates the recommended concentration of fluoride in drinking water from a range of 0.7 to 1.2 milligrams per liter (exact value depends on outdoor air temperatures) to 0.7 milligrams per liter (regardless of outdoor air temperature). Immediately before that update (published in August of 2015), almost half of states did not meet the federal targets for fluoridation of drinking water.²⁶ In addition, there is considerable evidence that fluoridation programs are safe and no convincing evidence that fluoridation results in severe dental fluorosis or other adverse health effects.²⁷ According to the CDC, in 2012, 24 states of 51 including Washington, D.C., did not meet the national health objective for community water fluoridation. That objective was defined as 79.6 percent of the state's population on public water systems receives optimally fluoridated water.²⁸

To the extent states are looking to create or continue fluoridation programs, data suggest strong ROI. The ROI varies with size of the community, increasing as community size increases. The estimated ROI for fluoridation programs over a three-year period was \$3.24 in small communities and \$20.52 in large communities in annual treatment costs per dollar

²⁰ Calculations from DentaQuest Institute re-analysis based on Ahovuo-Saloranta et al., "Sealants for Preventing Dental Decay in the Permanent Teeth Review," *Cochrane Database of Systematic Reviews* 2013, 3. no.: CD001830 (November 1, 2012).

²¹ The Guide to Community Preventive Services, "Preventing Dental Caries: Community Water Fluoridation," Community Preventive Services Task Force, <http://www.thecommunityguide.org/oral/fluoridation.html> (accessed October 18, 2014).

²² The Guide to Community Preventive Services, "Preventing Dental Caries: Community Water Fluoridation," Community Preventive Services Task Force, <http://www.thecommunityguide.org/oral/fluoridation.html> (accessed October 18, 2014).

²³ Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion, "Community Water Fluoridation," Centers for Disease Control and Prevention <http://www.cdc.gov/fluoridation/basics/index.htm> (accessed December 3, 2014).

²⁴ The Guide to Community Preventive Services, "Preventing Dental Caries: Community Water Fluoridation," Community Preventive Services Task Force, <http://www.thecommunityguide.org/oral/supportingmaterials/RRfluoridation.html> (accessed October 18, 2014).

²⁵ U.S. Department of Health and Human Services, *U.S. Public Health Service Recommendation for Fluoride Concentration in Drinking Water for the Prevention of Dental Caries* (July-August 2015), 2, http://www.publichealthreports.org/documents/PHS_2015_Fluoride_Guidelines.pdf.

²⁶ Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "Oral Health in the US: Key Facts," June 2012, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8324.pdf> (accessed December 3, 2014).

²⁷ The Guide to Community Preventive Services, "Preventing Dental Caries: Community Water Fluoridation," Community Preventive Services Task Force <http://www.thecommunityguide.org/oral/supportingmaterials/RRfluoridation.html> (accessed October 18, 2014).

²⁸ Centers for Disease Control and Prevention (US). Community water fluoridation: 2012 water fluoridation statistics <http://cdc.gov/fluoridation/statistics/2012stats.htm> (accessed September 23, 2015).

spent, excluding productivity losses.²⁹ Taking into account the lifetime cost of maintaining restorations and productivity losses, fluoridation programs save an estimated \$38 for every \$1 invested. A study of a fluoridation program in Colorado used an economic model that compares the costs of fluoridation programs with treatment savings achieved through averted tooth decay. The analysis found that Colorado's fluoridation programs yielded an average annual savings of \$60 per person served by the 172 public water systems included in the study (each system served a population of at least 1,000 individuals).³⁰ The authors suggest that additional savings and improved outcomes could be realized if fluoridation programs are implemented in more localities.

Routine Application of Fluoride Varnish

Fluoride varnish is an effective method used to reduce early childhood caries (tooth decay in primary teeth) by re-mineralizing weakened tooth enamel and slowing the progression of decay. Professional application of fluoride varnish prevents 37 percent of decay in primary teeth.³¹ Evidence shows that fluoride varnish is safe to provide to children, is easily applied using a quick procedure, and is effective at reducing dental caries in children.³² The U.S. Preventive Services Task Force recommends that primary medical care providers apply fluoride varnish to teeth when the first tooth comes in through 5 years of age.³³ That method

also can be effectively integrated into well-child visits and delivered by supporting medical staff. Currently, Medicaid programs in 46 states and the District of Columbia pay medical providers for preventive dental care during well-child visits.³⁴ Fewer states have incorporated such reimbursement into their Children's Health Insurance Program (CHIP). A study of Wisconsin's Medicaid program found that reimbursing medical providers for delivering fluoride varnish resulted in a significant uptake in the use of fluoride varnish among children between the ages of 1 and 2.³⁵

Although most states reimburse their Medicaid medical providers for providing the service, uptake varies in primary care practices. The optimal rate of reimbursement to create sufficient incentive for primary care practices to incorporate routine fluoride varnish application into routine care is not known. Rates currently vary from \$15 to \$80 for a bundle of services including screening and referral to a specialist if indicated, fluoride varnish application, and patient education. A reimbursement rate of \$50 has increased uptake in primary care practices in North Carolina for provision of that bundle of services (see box on page 6). Experts suggest that fluoride varnish application might not be a priority during a child's medical visit because of the challenges of incorporating the procedure into an already burdensome workflow.³⁶ In addition, experts

²⁹ Calculations from the Centers for Disease Control and Prevention, based on a re-analysis of Susan Griffin, Karl Jones, Scott Tomar, "An Economic Evaluation of Community Water Fluoridation," *Journal of Public Health Dentistry* 61, no. 2 (Spring 2001): 78-86. Note: This analysis defines productivity losses as lost productivity associated with the parent taking their child to the dentist.

³⁰ Joan O'Connell et al., "Costs and Savings Associated with Community Water Fluoridation Programs in Colorado," *Preventing Chronic Disease, Centers for Disease Control and Prevention 2: Special Issue* (November 2005): 1-13, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1459459/pdf/PCD2SIA06.pdf>, 7.

³¹ Valeria CC Marinho et al., "Fluoride varnishes for preventing dental caries in children and adolescents," *Cochran Database of Systematic Review* 2013 7, no.: CD002279 (May 13, 2013): 1-92.

³² Valeria CC Marinho et al., "Fluoride varnishes for preventing dental caries in children and adolescents," *Cochran Database of Systematic Review* 2013 7, no.: CD002279 (May 13, 2013): 1-92.

³³ U.S. Preventive Services Task Force, "Dental Caries in Children from Birth Through Age 5 Years: Screening." Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, <http://www.uspreventiveservicestaskforce.org/uspstf/uspndch.htm> (accessed December 3, 2014).

³⁴ <http://www.pewtrusts.org/en/research-and-analysis/analysis/2011/08/29/reimbursing-physicians-for-fluoride-varnish>

³⁵ Christopher Okunseri et al., "Increased Children's Access to Fluoride Varnish Treatment by Involving Medical Providers: Effect of a Medicaid Policy Change," *Health Services Research* 44, no.4 (August 2009): 1144-1156.

³⁶ The Pew Charitable Trust, Children's Dental Policy staff, Interview with the National Governors Association, April 2015

North Carolina's Into the Mouths of Babes Program

North Carolina's Into the Mouths of Babes (IMB) program is an example of a promising model for delivery of oral health services to children aimed at preventing and reducing early childhood tooth decay and referring children for additional dental services when needed. The Centers for Medicare & Medicaid Services data from 2013 show that more than 37 percent of children in North Carolina's Medicaid program, aged 0 to 2 years, received oral health services compared with the national average of 7.5 percent.³⁷ The IMB program trains medical providers to deliver a variety of preventive oral health services to children insured by North Carolina's Medicaid program. Medical providers deliver an Oral Preventive Procedure, which includes an oral evaluation and caries risk assessment; counseling with primary caregivers; and the application of fluoride varnish. The services are provided to children from the time their first tooth erupts through age 3½. A child can have that procedure up to six times during that timeframe. The program has shown promising results, including reducing the need for dental treatment for children before 18 months by half, compared with children who were not in the program. As mentioned above, medical providers are reimbursed by North Carolina Medicaid at a rate of \$50 for the bundle of oral health services for each of the six visits.³⁸ The reimbursement rate has been credited by national experts with increased uptake of these procedures in the Medicaid program in North Carolina, but further analyses are required to determine the range of reimbursement rates needed to increase uptake.³⁹

point to inadequate referral pathways from primary care physicians to dentists in some states as a barrier to uptake.⁴⁰ As a result, some primary care physicians might be reluctant to identify an oral health problem without being able to ensure that the necessary referral and wrap-around services are in place for the child.

The routine application of fluoride varnish by primary care providers is a core element of models integrating oral health into primary pediatric services. Preliminary analyses suggest cost savings from the routine application of fluoride varnish by primary care providers to children in Medicaid, starting at 9 months old. Such in-

tervention could yield savings to the Medicaid program within three years.⁴¹ However, the magnitude of savings has not been determined and needs to be studied further.

Strategies to Implement and Finance Evidence-Based Oral Health Interventions

Below are strategies state leaders might consider as they think about how to approach oral health challenges in their state:

- **Expand Dental Sealant Programs.** States should expand or redesign their dental sealant programs

³⁷ FFY 2013 CMS-416 reports, Line 1b, 12f

³⁸ North Carolina Department of Health and Human Services, "Into the Mouths of Babes/Connecting the Docs," <http://www.ncdhhs.gov/dph/oral-health/partners/IMB.htm> (accessed October 15, 2014).

³⁹ Ashley Kranz et al., "North Carolina Physician-Based Preventive Oral Health Services Improve Access And Use Among Young Medicaid Enrollees," *Health Affairs* 33, no. 12 (2014):2144-2152.

⁴⁰ The Pew Charitable Trust, Children's Dental Policy staff, Interview with the National Governors Association, April 2015.

⁴¹ Kristin Hendrix, et al., "Threshold analysis of reimbursing physicians for the application of fluoride varnish in young children," *Journal of Public Health Dentistry* 73, 2013:297-303.

for low-income children to eliminate access barriers. One such barrier is the prior-exam rule. Although dental hygienists are adequately trained to assess molars before applying sealants, state prior-exam rules require a dentist to perform an exam and provide a recommendation for dental sealants before a hygienist places the sealant. Some experts say that such a requirement adds an unnecessary and costly step because hygienists are capable of doing the assessments and because dentists are not usually co-located with hygienists in school-based sealant programs. In addition, growing evidence indicates that incomplete caries removal (the partial removal of a cavity from a tooth) followed by sealant placement is an effective practice.⁴² Dental hygienists in several states already are performing those types of restorative procedures; however, some

state scope-of-practice laws, including the prior exam rule, limit the ability of dental hygienists to practice to the top of their licenses.⁴³ (see box below).

- **Pay Primary Care Providers to Provide Preventive Oral Health Care.** States might adopt an adequate reimbursement rate for primary care providers to provide preventive oral health care, including the application of fluoride varnish. What constitutes an adequate reimbursement rate can only be known by experimentation with different rates. North Carolina's Into the Mouths of Babes program has successfully integrated fluoride varnish into the primary care workflow. In that program, Medicaid reimburses primary care providers \$50 per visit for delivering a package of

Make Better Use of the Current Workforce

To increase access to effective interventions that show cost savings, states might consider expanding scope-of-practice laws and changing Medicaid reimbursement policies to expand opportunities for all dental professionals, including dental hygienists, to practice to the top of their licenses.⁴⁴ Additionally, states should consider emerging models for new types of dental providers, including dental therapists and advanced dental hygienist practitioners. These provider models, new in the United States, have been developed in Alaska and Minnesota and will soon be joined by Maine. Fifteen other states are considering similar provider models to address dental access and improve oral health.⁴⁵ A recent NGA issue brief provides in-depth information about state considerations in expanding the dental health workforce.⁴⁶

⁴² Schwendicke, F, Doerfer, CE and Paris, S, "Incomplete Caries Removal: A Systematic Review and Meta-analysis," *Journal of Dental Research*, 92(4), 2013: 306-314.

⁴³ American Dental Hygienists' Association, "Overview of Restorative Services Provided by Dental Hygienists and Other Non-Dentist Practitioners," December 2014, http://www.adha.org/resources-docs/7517_Restorative_Services_Factsheet.pdf (accessed December 2014); and National Governors Association. *The Role of Dental Hygienists in Providing Access to Oral Health Care*, (January 2014), <http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf>.

⁴⁴ National Governors Association. *The Role of Dental Hygienists in Providing Access to Oral Health Care*, (January 2014), <http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf>.

⁴⁵ The Pew Charitable Trusts, *Expanding the Dental Team: Increasing Access to Care in Public Settings* (June 30, 2014), http://www.pewtrusts.org/~media/assets/2014/06/27/expanding_dental_case_studies_report.pdf.

⁴⁶ National Governors Association. *The Role of Dental Hygienists in Providing Access to Oral Health Care*, (January 2014), <http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf>.

services. States also could require pediatricians and primary care providers in their Medicaid programs to assess caries risk and apply fluoride varnish for every child during well-child visits.

- **Update and Invest in Community Water Fluoridation Systems.** States should consider working with the CDC and other stakeholder groups to invest in communities that are establishing water fluoridation systems or updating the equipment for their current fluoridated water systems. It is estimated that at least 10 percent of community water fluoridation systems have old equipment that needs to be replaced in the near future. Governors also could communicate across their regions and localities about the evidence of safety, improved outcomes (including fewer disparities), and cost savings found in existing programs to inform decision making on local investments in water fluoridation programs.

Strategies to Support Implementation of Data Collection on Oral Health Interventions

Improve Data Analytics Capabilities

States should consider strategies that improve their ability to collect and analyze Medicaid and CHIP data to better inform oral health-related policy decisions on improving program performance, evaluating programs, and identifying gaps in service delivery. The Centers for Medicare & Medicaid Services (CMS) uses state-reported data to monitor progress related to delivery of dental services in the Medicaid benefit for children and adolescents (also known as the Early Periodic Screening, Diagnosis, and Treatment benefit).⁴⁷ The

information reported, derived largely from dental procedure codes recorded on Medicaid claims, is a first step toward monitoring oral health care services for children. States could consider ensuring effective use of that monitoring tool. In addition, the Children's Health Insurance Program Reauthorization Act of 2009 required the U.S. Department of Health and Human Services to identify and publish a core set of children's health care quality metrics that could be used by state Medicaid and CHIP programs. The metrics were updated in the 2015 Child Core metrics set and include two oral health measures: dental sealants for 6 to 9 year old children at elevated caries risk and percentage of beneficiaries who received preventive dental services.⁴⁸ States could collect data on those metrics to measure the quality of care provided to children in Medicaid and CHIP.

Future considerations for data-driven policy making should start with aligning strategies to stratify data across the various sources of data on oral health used for tracking, monitoring, and guiding interventions and reimbursement. For example, agreement on how data will be stratified by age group could allow for meaningful comparison across sources of data on oral health, including national epidemiological data (such as on disease prevalence and access to care) and data used for intervention purposes (such as activities to promote fluoride varnish, sealants, and greater awareness of oral health programs). For example, Maryland's Office of Oral Health (the state's oral health agency) collaborates with the University of Maryland Dental School to periodically collect data on the oral health status of schoolchildren, using kindergartners and third-graders as the sample populations.⁴⁹ Collection of data for children in those grade levels aligns

⁴⁷ An example of the kinds of data and reporting that may be useful to states as they monitor oral health care services for children can be found here: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html>

⁴⁸ Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin." Center for Medicaid & CHIP Services, December 2014, <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf>; and Centers for Medicare & Medicaid Services, "2015 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP" <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html>

⁴⁹ Maryland Office of Oral Health, *Oral Health Status of Maryland School Children* (Maryland: Department of Health and Mental Hygiene, February 2013), <http://ppha.dhmh.maryland.gov/oralhealth/Documents/SurveillanceDigest.pdf>

with the data collected by the National Oral Health Surveillance System, a collaborative effort of CDC's Division of Oral Health and the Association of State and Territorial Dental Directors to monitor the burden of oral disease, the use of the delivery system for oral health care, and the status of community water fluoridation on state and national levels.⁵⁰ Similarly, other states can use such data—reported on everything from who is using services to provider payment mechanisms and performance indicators—to improve interventions and payment strategies.⁵¹

Seek Cooperative Agreement Grants from CDC

States should consider applying for cooperative agreement grants and technical assistance from CDC to support the collection and analysis of data as well as the adoption of oral health intervention. However, national funding is not sufficient to fund all states' needs, and not all states receive such funding from CDC. More information about those funding opportunities is available at the CDC's Division of Oral Health website.⁵²

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October 2015

The National Governors Association Center for Best Practices (NGA Center) wishes to thank the CDC for a cooperative agreement (1U38OT000227) that supported the development of this issue brief. The NGA Center also would like to thank Dr. Maria-Rosa Watson for her assistance in developing this issue brief.

Recommended citation format: S. Wilkniss and S. Tripoli. *Health Investments That Pay Off: Strategies to Improve Oral Health* (Washington, D.C.: National Governors Association Center for Best Practices, October 29, 2015).

⁵⁰ National Oral health Surveillance System, "About NOHSS," Centers for Disease Control and Prevention, <http://www.cdc.gov/nohss/about.htm> (accessed May 2015).

⁵¹ A good resource for states is a toolkit developed by the Centers for Medicaid and CHIP Services, "Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States." (June 2014) <http://www.medicicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/oral-health-quality-improvement-toolkit-for-states.pdf>.

⁵² Additional information about CDC Cooperative Agreement Grants can be found at http://www.cdc.gov/oralhealth/state_programs/cooperative_agreements/index.htm

Vu, Huong (DHP)

From: Reen, Sandra (DHP)
Sent: Thursday, October 01, 2015 3:13 PM
To: Board of Dentistry
Subject: RE: Council Of Interstate Testing Agencies, Inc.

Importance: Low

Hi Ms. Jones:

Your request will be included in the Board's agenda for its December 11, 2015 meeting for discussion. This discussion is needed to consider Virginia's conflict of interest laws for public officials. Shortly after that meeting, I will relay the response made by the Board.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
804-367-4437

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UNDER NO CIRCUMSTANCES SHALL VBOD, ITS MEMBERS, OFFICERS, AGENTS, OR EMPLOYEES BE LIABLE FOR ANY ACTIONS TAKEN OR OMISSIONS MADE IN RELIANCE ON ANY INFORMATION CONTAINED IN THIS EMAIL.

From: Board of Dentistry
Sent: Thursday, September 24, 2015 1:12 PM
To: Reen, Sandra (DHP)
Subject: FW: Council Of Interstate Testing Agencies, Inc.

From: Cindy Jones [<mailto:cjones@citaexam.com>]
Sent: Thursday, September 24, 2015 12:25 PM
To: Board of Dentistry
Subject: Council Of Interstate Testing Agencies, Inc.

The Council Of Interstate Testing Agencies, Inc. ("CITA") would like to extend the invitation to all of the dentists on your board to become an examiner with us. We encourage board members to participate with the examination. We will be coming to your area to administer the ADEX Dental Exam at the Virginia Commonwealth School of Dentistry and we would love to get local dentists and board members involved with CITA. CITA has been around since 2005 and joined ADEX in 2013. The CITA staff and examiners are committed to being professional, proficient, and efficient in exam administration. Please check out our website: www.citaexam.com. If you and your colleagues are interested in joining CITA as an examiner please reach out to me at the below contact information.

Sincerely,

Cindy Jones

Cindy Jones

Office Manager

Council of Interstate Testing Agencies

1003 High House Road, Suite 101

Cary, North Carolina 27513

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Southern Regional Testing Agency, Inc.

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November , 2015

State Board of Dentistry

Dear,

Having responded to a legislature mandated examination review request, I thought that your dental board may also be interested in this data. Please feel free to share this letter with your board members. If you have additional questions, or would welcome one of our examiners as a guest to further clarify items (and/or answer questions), please let me know and I will make arrangements."

I must let you know, that I respect the State Dental Boards for their efforts in keeping abreast of initial licensure examinations. As you are aware, the ADA during its' July 14, 2015 meeting of the "Taskforce on Licensure", again urged all states to accept all regional clinical licensure examinations. This motion was made to further portability for the students, while continuing to work toward a patient-free examination for licensure.

Prior to addressing the eight questions presented, I would like to advise you that I will be sending via email, electronic versions of our 2016 Candidate Manuals for both Dentistry and Dental Hygiene. As I write this letter now, we are close to leaving the "Draft" stage, but you will be receiving "Draft" copies!

Question 1: "How to determine the eligibility of a candidate?"

Candidate eligibility is first based on enrollment at or graduation from a CODA accredited institution. If one has not yet graduated, the dean of the individual's school must provide a letter certifying that the student(s) listed are eligible to take the exam, and are in good standing with an anticipated graduation date within 18 months of the examination date.

For international students that have not graduated from a CODA accredited school or have not successfully completed an AEGD program, the candidate may take the examination based on "State Only" status. The candidate must furnish a letter from a State Board of Dentistry that

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

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clearly states that this candidate, if successful on the examination, may be licensed within their state. A copy of the candidate's diploma along with an English translation is also required. All of the candidate records for state only status, remain marked as "Restricted" to the accepting state. (The candidate cannot seek/obtain initial licensure anywhere but in the sponsoring state).

Question 2: "Describe topics tested and scoring methodology for each topic". [Note scoring methodology and passing score questions from Question 2- rolled into Question 4].

Dental: Manikin based

Manikin setup used: Acidental Modu-Pro

Endodontics- two procedures.

->**Anterior:** Access opening, instrumentation and obturation of tooth #8.

->**Posterior:** Access opening on tooth # 14, must achieve direct access to all three canals.

Prosthodontics: - three procedures.

->**PFM (Porcelain-Fused-to-Metal)** crown preparation. Tooth #5. An anterior abutment for a 3-unit bridge, plus an evaluation of the line of draw for the bridge abutment preparations.

->**Cast Metal/All Zirconia** crown preparation on tooth # 3. This is the posterior abutment for the 3-unit bridge.

->**All-Ceramic** crown preparation on tooth #9. Anterior central incisor.

Dental Patient-Based

Anterior:

->**Class III Composite** prep and restoration

Posterior:

->**Class II (select one of the following three)- Amalgam Prep & restoration; Composite Prep and restoration or slot prep and restoration.** (Note: Wyoming requires a slot prep & restoration for initial licensure and we so note this for candidates).

Periodontal

->**Must select, identify, scale and polish selected teeth keeping within the parameters listed in the candidate manual. Selected teeth must have adequate subgingival calculus, 3 teeth required for pocket depth measurement- these teeth need not be those teeth selected for calculus removal but must be within the treatment selection. This section remains optional based on our task analysis of 2005 and 2011. Candidates may take this section if they so choose without additional cost.**

Question 4: “Determining a passing score for individual components and the complete exam”

Scoring Methodology

The scoring methodology for all components of the exam is as follows: a triple blind system is used (no one knows status of previous evaluators), all examination materials are numbered using the candidate(s) unique number. The candidate's name and school data does not appear on any testing materials. All examiners are vetted current and past State Dental Board members that are experienced practitioners with diverse backgrounds. We also utilize faculty examiners, although they cannot examine in their respective state, the knowledge they gain through their experience is imparted to the students. Examiners are trained and standardized prior to each examination and are evaluated to ensure they are grading to established criteria. The examiners are separated from the candidates and will remain in a separate area of the clinic.

Candidates must observe all signs and follow instructions so as not to breach anonymity. Anonymity is preserved between the scoring examiners and the candidates. Examiners may consult with the SRTA Clinic Floor Coordinator (CFC) or Scoring Area Coordinator (SAC) whenever necessary. Examiners are assigned to grading operatories via a computer generated randomization of those examiners that are available to examine. All times are recorded, from the first “encounter” on the clinic floor (approval of Medical History, BP etc.). Also recorded is every patient check in or out, the examiners in and out times etc. Thus we know from start to finish the stage of each candidate.

The scoring system is criterion referenced and based on an analytical model. The examination is conjunctive in that the contents are divided into 5 separate sections and each section is scored independently. The examination is compensatory within each section for determining the final score within the section. A numeric grade equal to or greater than 75 is a Pass. Less than a numeric grade of 75 is a Fail. This value represents a scale score that is consistent with commonly used interpretive scales for scoring performance. The underlying performance standard that corresponds to minimum competency is based on a combination of standard setting methods, specifically the Dominant Profile Judgment method and the Extended Angoff Method. Both of these methods are discussed in Hambleton and Pitoniak’s chapter about standard setting in *Educational Measurement*, 4th ed. (Brennan, 2006). Similar descriptions of these and other methods that are appropriate for credentialing examinations like SRTA’s clinical skills tests can be found in Buckendahl and Davis-Becker’s chapter about standard setting for credentialing examinations in *Setting Performance Standards* (Cizek, 2012).

All scoring and score calculations are completed using specifically designed computer software. Input is via Kindles. Those examiners that follow the first examiner have no means by which to view the “grading” of any previous examiner(s). Statistics are compiled throughout the day and reviewed with the examiners as necessary to ensure all criteria are being consistently assessed. We are the only clinical examination agency that does immediate/on-site remediation of examiners. This enables the examiner to be aware and to self-correct any defined areas.

A passing determination for a candidate is automatically determined via evaluation by the calibrated grading examiners, based on the defined criteria. Our computer software provides the end result, whether it be numeric or Pass/Fail. On an exam overall approach, the candidate must be successful in all procedures as noted on Page 2 to have "Passed the exam". The candidate retake of single sections may be required to achieve the overall "exam passed" status. (Passing grade numeric is 75).

As a side note, SRTA was the first regional agency in the country to successfully implement computer driven scoring... via PDA's - beginning with the exam cycle of 2008. We of course have continued to enhance our software and we even upgraded to full color Kindles!

Question 3: Process for examiner calibration

Examiner calibration is a multi-step process. An annual (once per exam cycle/year) on-line test is required. This on-line test covers all policies, procedures and protocols. A passing grade of 80% is required for examiners to be eligible to participate in operational scoring.

At each exam site, examiner calibration to the scoring criteria occurs. The calibration takes approximately 4 hours with a 10 question quiz upon completion of each section/segment as outlined on Page 2. All criteria are reviewed during this process. The quizzes consist of photographs of both acceptable and unacceptable preps/restorations. We have 3 different quiz sets which are used throughout the year, such that examiners do not always see the same photos and respond to questions by rote. All examiners must obtain a score of 80% or higher to be considered calibrated and allowed to examine. A failing examiner has one additional attempt to reach 80%. If not successful on the second attempt, the examiner is sent home.

Questions 5 - 8: When was the last review of the examination? What were the Results? Updates to the examination? Comparison to other examinations?

A review of the examination is ongoing with specific milestones that occur at key phases in development and validation. Some of these key milestones include a nationwide job (task) analysis that was most recently conducted in 2011 with a plan to begin conducting the next one in late 2016. This aligns with SRTA's policy to systematically evaluate the content of its examinations relative to the field every 5-6 years. Additional reviews of the examinations occur at least annually with our Examination Committees who review the tasks and scoring criteria associated with each examination to ensure that they continue to align with expectations for minimally competent practice in dentistry or dental hygiene respectively. Ongoing, empirical evaluation of examiners occurs throughout the examination cycle and then annually as part of a technical review of the program. These evaluations focus on the validity and reliability of judgments as applied to candidates' performance. SRTA also maintains an ongoing relationship with a psychometrician (measurement consultant) who provides input on each of these activities.

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The results of these activities support use of the scores for making decisions about candidates' minimum competency in dentistry and dental hygiene, respectively. Content and empirical evidence are evaluated to support this assertion.

Perhaps the best example I can provide as a comparison to other clinical examinations is the nationwide job analysis (task analysis) noted above. This project was conducted in 2011 as a joint effort between SRTA and NERB (now CDCA) under the ADEX partnership. This 2011 nationwide task analysis further points to SRTA as a leader in the development of clinical examinations as the SRTA task analysis of 2006 indicated a lack of the requirement for the periodontal procedure. The periodontal task was deemed as one that was typically referred to periodontists, and not performed by general dentists. Thus, the periodontal procedure became optional in the SRTA examination in 2006 and in the ADEX exam of 2012, when the same conclusion was reached again, via the 2011 task analysis.

SRTA does not include the use of computer assisted examinations in either the Dental or Dental Hygiene exams due to the lack of current data indicating relevancy and assurance that the exam(s) do not duplicate the National Boards in a significant manner.

We continue to have a long-standing relationship with our psychometrician, Chad Buckendahl, PhD. Trust me- we do not make any changes without his blessing! In addition, we would be happy to provide Chad as a supplemental resource for Board Members if they have specific questions about some of the technical features of our examination.

I believe I have answered all of the questions outlined in your letter. Should you find that I missed something or if you need additional clarification, please do not hesitate to contact me.

Again, the Dental and Dental Hygiene candidate manuals are DRAFT versions- close to complete. The Dental forms are newly revised for 2016 and are ready for use.

Again, please feel free to contact me if you have additional questions or if I thoroughly confused you!

Best regards-

Kathleen M. White
Executive Director

Marcus Muncy, D.D.S. – President

Dianne Embry, R.D.H. - Secretary

Robert B. Hall, Jr., D.D.S. - Treasurer

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Kathleen M. White – Executive Director

Virginia Board of Dentistry

Teledentistry

Section One: Preamble.

The Virginia Board of Dentistry ("Board") recognizes that using teledentistry services in the delivery of dental services offers potential benefits in the provision of dental care. The appropriate application of these services can enhance dental care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying dental advice. The Virginia General Assembly has not established statutory parameters regarding the provision and delivery of teledental services. Therefore, practitioners must apply existing laws and regulations to the provision of teledentistry services. The Board issues this guidance document to assist practitioners with the application of current laws to teledentistry service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For clarity, a practitioner using teledentistry services in the provision of dental services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303 and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of teledentistry services as a component of, or in lieu of, in-person provision of dental care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of teledentistry services in the practice of dentistry. The Board is committed to ensuring patient access to the convenience and benefits afforded by teledentistry services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide dental care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of dentists, properly supervise non-dentist clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Definitions.

For the purpose of these guidelines, the Board defines “teledentistry services” consistent with the definition of “telemedicine services” in § 38.2-3418.16 of the Code of Virginia. “Teledentistry services,” as it pertains to the delivery of dental services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient’s diagnosis or treatment. “Teledentistry services” does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

Section Three: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable dental care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship.

Where an existing practitioner-patient relationship is not present,¹ a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.² While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

Specifically, Virginia Code § 54.1-3303(A) provides the requirements to establish a practitioner-patient relationship. *See* Va. Code § 54.1-3303(A).

A practitioner is discouraged from rendering dental advice and/or care using teledentistry services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner’s identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of teledental services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Four: Guidelines for the Appropriate Use of Teledentistry Services.

The Board has adopted the following guidelines for practitioners utilizing teledentistry services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of dentistry occurs where the patient is located at the time teledentistry services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all

¹ This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

² The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

A documented dental evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of teledentistry services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using teledentistry services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a teledentistry encounter;
- Details on security measures taken with the use of teledentistry services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Dental Records:

The dental record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of teledentistry services. Informed consents obtained in connection with an encounter involving teledentistry services should also be filed in the dental record. The patient record established during the use of teledentistry services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using teledentistry services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner

addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Prescribing:

Prescribing medications, in-person or via teledentistry services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via teledentistry services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe medications as part of teledentistry encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Additionally, practitioners issuing prescriptions as part of teledentistry services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of teledentistry services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Disciplinary Board Report for December 11, 2015

Today's report reviews the 2015 calendar year case activity then addresses the Board's disciplinary case actions for the first quarter of fiscal year 2016 which includes the dates of July 1, 2015 through September 30, 2015.

As of November 20, 2015, the Board currently has a total of 223 patient care open discipline cases and 140 non-patient care open discipline cases. One hundred ninety-nine (199) cases are at probable cause. The Board has 14 cases with the Administrative Proceedings Division ("APD"), 128 cases are in Enforcement, 19 cases are scheduled for informal conferences, and 3 for formal hearings. Of the 223 open patient care cases (which is the basis for our Agency's Key Performance Measures), 108 are at probable cause, 10 cases are with APD, 88 are cases with Enforcement, 15 cases are scheduled for informal conferences and 2 are scheduled for formal hearings.

Calendar Year 2015

The table below includes all cases that have received Board action since January 1, 2015 through November 20, 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	32	29	15	44
June	39	37	11	48
July	54	24	9	33
August	32	74	3	77
September	29	35	9	44
October	32	53	12	65
November 20th	12	17	0	17
Totals	526	517	83	600

Q1 FY 2016

For the first quarter of 2016, the Board received a total of 57 patient care cases. The Board closed a total of 104 patient care cases for a 182% clearance rate, which is up from 96% in Q4 of 2015. The current pending caseload older than 250 days is 28%, which is up from 24% in Q4 of 2015. The Board's goal is 20%. In Q1 of 2016, 100% of the patient care cases were closed within 250 days, as compared to 66% in Q4 of 2015. The Board's goal is 90% of patient care cases closed within 250 days.*

License Suspensions

Between September 1, 2015 and November 20, 2015, the Board has not mandatorily or summarily suspended any licenses.

***The Agency's Key Performance Measures.**

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