VIRGINIA BOARD OF DENTISTRY

March 9, 2018 AGENDA

Department of Health Professions
Perimeter Center - 2nd Floor Conference Center, Board Room 4
9960 Mayland Drive, Henrico, Virginia 23233

Board Business		**Page**
9:00 a.m.	**Call to Order – Dr. Alexander, President**	
	Evacuation Announcement – Ms. Reen	
	Public Comment – Dr. Alexander	P.1
	Approval of Minutes - Dr. Alexander	
	• December 14, 2017 Formal Hearings	P.15
	• December 15, 2017 Formal Hearing	P.21
	• December 15, 2017 Business Meeting	P.24
	• January 26, 2018 Public Hearing	P.30
	• February 8, 2018 Telephone Conference Call	P.34
	Director's Report – Dr. Brown	
	Sanctioning Reference Points – Mr. Kauder	
	Liaison/Committee Reports	
	• **Dr. Watkins** *SRTA *BHP *Exam Committee	P.36
	• **Ms. Ridout** *Southern Conference of Dental Deans and Examiners	
	• **Dr. Petticolas** *Regulatory – Legislative Committee	
	• **Dr. Bryant** *ADEX	
	• **Dr. Alexander** *AADB *Advisory Panel on Opioids * Regulatory Advisory Panel/Review of Regulations on Controlled Substances, Sedation and Anesthesia	P.38

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Legislation and Regulation – Ms. Yeatts

Board Discussion/Action

Board Counsel Report – Mr. Rutkowski

Deputy Executive Report/Business – Ms. Palmatier

Executive Director's Report/Business – Ms. Reen

Reen, Sandra (DHP)

From: CHRIS RICHARDSON <periodocusa@msn.com>
Sent: Wednesday, February 7, 2018 3:55 PM
To: Reen, Sandra (DHP)
Subject: For All Board of Dentistry members
Attachments: Texas ruling dissent opinion.docx

Sandra,
Thank you so much for forwarding this email and the attachment to all Virginia Board of Dentistry members. With the recent proposed text change to the Specialty advertising bylaws, I felt it was very important to relay to all board members the fact that the ADA House of Delegates recently passed Resolution 30 which creates the formation of a National Commission on Specialty Recognition and Credentialing. This will be vital in the boards decision as this independent commission will take the House of Delegates out of the equation, where certainly there are conflicts of interest. Please take a few minutes to read the dissent opinion from Judge Graves from the 5th Circuit Court of Appeals in Texas relative to ABDS challenge. It is well worth your time.
Sincerely,
Chris

Chris R. Richardson, DMD, MS
Richardson-Overstreet, Ltd
Periodontal and Dental Implant
Surgical Specialist
4909 Grove Avenue
Richmond, Virginia 23226

JAMES E. GRAVES, JR., Circuit Judge, dissenting:

I disagree with the majority that Rule 108.541 of the Texas Administrative Code is unconstitutional as applied to the plaintiffs (American Board of Dental Specialists.) (hereinafter collectively referred to as "Academy"). The advertising proposed by Academy is inherently misleading. Misleading commercial speech is not entitled to First Amendment protection. Because I would reverse the district court's grant of summary judgment on Academy's First Amendment claim and its enjoinment of the provision as applied to Academy, I respectfully dissent.

Academy wants to advertise as specialists in certain subsets of dentistry that are not recognized as specialties by the American Dental Association ("ADA") and are prohibited from doing so by the rules of the Texas State Dental Board of Dental Examiners (the "Board"). Academy brought a facial and as-applied constitutional challenge against the Board arguing that Rule 108.54, which regulates specialty advertising for dentists, unconstitutionally infringes on commercial speech protected by the First Amendment.

The district court partially granted both parties' cross-motions for summary judgment. Academy was granted summary judgment on its First Amendment claim, invalidating the ordinance as applied to Academy. The Board was granted summary judgment on Academy's equal protection and due process claims. The Board appeals the First Amendment claim. Academy failed to file a cross-appeal, but then attempts to revive a Fourteenth Amendment due process claim in the appellees' brief.

As the majority correctly states, we apply the four-part test from Central Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of New York, 447 U.S. 557 (1980), as follows:

> At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come within that provision, it at least must concern lawful activity and not be misleading. Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine whether the regulation directly advances the governmental interest asserted, and whether it is not more extensive than is necessary to serve that interest.

Id. at 566.

As a threshold determination, for commercial speech to be protected under the First Amendment, "it at least must concern lawful activity and not be misleading." Central Hudson, 447 U.S. at 566. Advertising that is inherently misleading receives no protection, while advertising that is potentially misleading may receive some if it may be presented in a way that is not deceptive. In re R.M.J., 455 U.S. 191, 203 (1982).

This case is analogous to American Board of Pain Management v. Joseph, 353 F.3d 1099 (9th Cir. 2004), which involved a California statute that limits a physician from advertising as board certified in a medical specialty without meeting certain requirements. There, the Ninth Circuit said:

> The State of California has by statute given the term "board certified" a special and particular meaning. The use of that term in advertising by a board or individual physicians who do not meet

the statutory requirements for doing so, is misleading. The advertisement represents to the physicians, hospitals, health care providers and the general public that the statutory standards have been met, when, in fact, they have not.

Because the Plaintiffs' use of "board certified" is inherently misleading, it is not protected speech. But even if the Plaintiffs' use of "board certified" were merely potentially misleading, it would not change the result in this case, as consideration of the remaining three Hudson factors confirms that the State may restrict the use of the term "board certified" in advertising.

Such is the case here. Texas has by statute given the term specialist a particular meaning. See 22 Tex. Admin. Code § 108.54; see also 22 Tex. Admin. Code §§ 119.1-119.9 (setting out special areas of dental practice). Additionally, it is only "in the context of unregulated dental advertising" that the Board contends the term "specialist" is devoid of intrinsic meaning and is inherently misleading. But with regard to the regulated dental advertising and the recognized specialty areas, the term has a special meaning and special requirements.

Further, the areas that Academy seeks to have designated as specialties are actually more like subsets, which are already encompassed within general dentistry and multiple of the existing recognized specialties. See 22 Tex. Admin. Code §§ 119.1-119.9; see also Tex. Occ. Code § 251.003 (setting out the provisions of the practice of dentistry). The majority opinion allows that, instead of a general dentist having to comply with the academic, educational or certification necessary to become, for example, a prosthodontist, a general dentist can simply get "certified" in one small aspect of the branch of prosthodontics, i.e., implants, and advertise at the same level as someone who actually completed an advanced degree in an accredited specialty.2

The majority relies on Peel v. Attorney Registration and Disciplinary Commission of Illinois, 496 U.S. 91 (1990), to conclude that "specialist" is not devoid of intrinsic meaning. In Peel, the issue involved letterhead and a statement that the attorney was a "certified civil trial specialist by the National Board of Trial Advocacy." The Court concluded that this was not inherently misleading, saying that "it seems unlikely that petitioner's statement about his certification as a 'specialist' by an identified national organization necessarily would be confused with formal state recognition." Id. at 104-05. The Court further reiterated that a "State may not, however, completely ban statements that are not actually or inherently misleading, such as certification as a specialist by bona fide organizations such as NBTA" and pointed out that "[t]here is no dispute about the bona fides and the relevance of NBTA certification." Id. at 110. However, that is not the case here where, as the Board correctly asserts, the term "specialist" may be used without reference to any identified certifying organization and there is a dispute about the bona fides and relevance of the certifications.

Thus, despite what the majority says, the problem is not merely that "the organization responsible for conferring specialist credentials on a particular dentist is not identified in the advertisement." Nevertheless, Ibanez v. Florida Dep't of Bus. & Prof'l Regulation, Bd. of Accountancy, 512 U.S. 136, 145, n.9

(1994), is also distinguishable. Ibanez involved an attorney who advertised her credentials as CPA (Certified Public Accountant) and CFP (Certified Financial Planner). Again, there were no questions about the certifications. Further, footnote 9, which addressed only a point raised in a separate opinion, says that a consumer could easily verify Ibanez' credentials – as she was indeed a licensed CPA through the Florida Board of Accountancy and also a CFP. More importantly, Ibanez was not practicing accounting. Further, under 22 Tex. Admin. Code §§ 108.56 additional credentials or certifications are clearly allowed to be advertised in Texas.3

In Joe Conte Toyota, Inc. v. Louisiana Motor Vehicle Commission, 24 F.3d 754 (5th Cir. 1994), this court relied on evidence in the record to support the district court's finding that the use of the term "invoice" in the automobile industry was inherently misleading. That evidence included testimony of various car dealers that "invoice" means different things. Id. at 757. Here, we have testimony that "specialist" in unregulated dental advertising means different things. The majority's statement that "[h]ere, the individual plaintiffs intend to use 'specialist' in the same manner as dentists practicing in ADA-recognized specialties" is erroneous. In fact, the plaintiffs intend to use "specialist" to encompass subsets of existing specialties that do not necessarily require the same academic, educational or certification required of the specialties recognized by both the ADA and Texas.

For these reasons, I would conclude that the term "specialist" in the context of unregulated dental advertising is inherently misleading and, thus, not protected by the First Amendment.

Moreover, even if Academy's proposed speech was only potentially misleading, the Board would still be able to regulate it under the remaining elements of the Central Hudson test quoted previously herein. As the Board asserts, the evidence provided, at the very least, creates a question of fact sufficient to survive summary judgment.

The Supreme Court said in Ibanez:

> Commercial speech that is not false, deceptive, or misleading can be restricted, but only if the State shows that the restriction directly and materially advances a substantial state interest in a manner no more extensive than necessary to serve that interest. Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y., 447 U.S. 557, 566, 100 S.Ct. 2343, 2351, 65 L.Ed.2d 341 (1980); see also id., at 564, 100 S.Ct., at 2350 (regulation will not be sustained if it "provides only ineffective or remote support for the government's purpose"); Edenfield v. Fane, 507 U.S. 761, 767, 113 S.Ct. 1792, 1798, 123 L.Ed.2d 543 (1993) (regulation must advance substantial state interest in a "direct and material way" and be in "reasonable proportion to the interests served"); In re R.M.J., 455 U.S., at 203, 102 S.Ct., at 937 (State can regulate commercial speech if it shows that it has "a substantial interest" and that the interference with speech is "in proportion to the interest served").

Ibanez, 512 U.S. at 142-43.

The majority acknowledges that the Board has a substantial interest. But, the majority then concludes that the Board has not demonstrated that

Rule 108.54 directly advances the asserted interests. I disagree. The Board presented evidence demonstrating how Rule 108.54 would directly and materially advance the asserted interests. That evidence included "empirical data, studies, and anecdotal evidence" or "history, consensus, and simple common sense." See Pub. Citizen Inc. v. La. Attorney Disciplinary Bd., 632 F.3d 212 (5th Cir. 2011).

The majority dismisses the empirical data and studies referenced in Borgner v. Brooks, 284 F.3d 1204, 1211-13 (11th Cir. 2002), because the actual studies are not in the record. The absence of those studies in the record does not undermine the reliability or persuasiveness of the Eleventh Circuit's analysis and conclusions about those same studies including, but not limited to, the following:

These two surveys, taken together, support two contentions: (1) that a substantial portion of the public is misled by AAID and implant dentistry advertisements that do not explain that AAID approval does not mean ADA or Board approval; and (2) that ADA certification is an important factor in choosing a dentist/specialist in a particular practice area for a large portion of the public.

Id. at 1213.

Additionally, the majority dismisses deposition testimony and evidence of complications saying, in part, that the harms would not be remedied by Rule 108.54 because it merely regulates how a dentist may advertise. I disagree. Rule 108.54 regulates what a dentist may hold himself out as being to the public, i.e., a general dentist with or without certain credentials or a specialist. The majority further dismisses witness testimony because it does not necessarily pertain to general dentists who violated the existing rule by holding themselves out as specialists in advertisements. The point of the testimony was to offer support for the fact that an ADA-recognized specialist has a higher success rate and fewer complications than a general dentist who may perform a subset of those recognized specialties. Also, what the Board does clearly establish is that the harms Rule 108.54 seeks to prevent are very real. This was established by way of both anecdotal evidence and simple common sense. With regard to consensus, the Board introduced evidence that numerous other states limit dental-specialty advertising.

Rules 108.55-56 allow any pertinent information about individual plaintiffs' qualifications to be advertised to consumers. See 22 Tex. Admin. Code §§ 108.55-56.4 Rules 108.55-56 also clearly establish that Rule 108.54 is not more extensive than necessary. Dentists are able to advertise any and all dental credentials and certifications so long as they do not hold themselves out as specialists in areas where they have not complied with the statutory requirements.

Thus, even if the speech was only potentially misleading, I would conclude that the Board can still regulate it under the Central Hudson test. For these reasons, I would reverse the district court's grant of summary judgment on Academy's First Amendment claim and its enjoinment of the provision as applied to Academy. Therefore, I respectfully dissent.

Reen, Sandra (DHP)

From: Angel Ray <drangelkray@gmail.com>
Sent: Thursday, February 15, 2018 11:50 AM
To: Reen, Sandra (DHP)
Subject: Advertising regulation amendment

Dear Ms. Reen,

Thank you for taking the time to read this email. I was recently informed by the leadership of the Virginia Society of Periodontists that there is a planned change in the regulations regarding advertising that would no longer prohibit practitioners from advertising as specialists when they have not completed an ADA accredited and recognized specialty residency program. I am requesting that this change with respect to specialty advertising be removed from fast-track and that there be a comment and debate period established prior to making such drastic change that will contribute to significant confusion for patients.

I am requesting that you please distribute this email to all current Board members.

Thank you,

Angel K. Ray, DDS, MS
Diplomate of the American Board of Periodontology
100 Chicurel Lane
Waynesboro, VA 22980
(540) 943-5389

Reen, Sandra (DHP)

From: Roger Hennigh <rhennigh@aol.com>
Sent: Tuesday, February 13, 2018 12:00 PM
To: Reen, Sandra (DHP)
Subject: Amendment to restriction on advertising dental specialties ???

Hello,

I would like to inquire to the Board as to the logic and rational for loosening the restriction on General Dentists pertaining to how they present themselves to the public. It should NOT be policy to make it easier for practioners who haven't completed approved specialty training programs to present themselves as trained and competent to practice any specialty.

I welcome a response.

Sincerely,

Roger

Roger A. Hennigh, D.M.D.
Orthodontist
Diplomate, American Board of Orthodontics

Golden Pediatric Dentistry & Orthodontics
http://www.AnotherGoldenSmile.com

"The House of Smiles"
3320 Noble Pond Way
Suite 109
Woodbridge, VA 22193
703-640-1000 (Opt #1)

"The Center for Grown-Up Dentistry"
14397 Hereford Road
Dale City, VA 22193
703-640-1000 (Opt #3)

"Camp Tooth"
238 Potomac Avenue
Quantico, VA 22134
703-640-1000 (Opt #2)

"Golden Dental Associates"
5200 Lyngate Court
Burke, VA 22015
703-978-1903

Reen, Sandra (DHP)

From: Dr. Rod Rogge <drrogge@rodroggedds.com>
Sent: Monday, February 12, 2018 4:03 PM
To: Reen, Sandra (DHP)
Cc: scvoth@vadentist.com; scvothdds@gmail.com
Subject: 18VAC60-21-80(G) amendment to change specialty designation on advertising

Importance: High

Ms. Reen:
I am a specialty board certified periodontist, not an attorney, but the current amendment to modify 18VAC60-21-80(G) on specialty designation appears to let any dentist declare themselves as a specialist. The purpose of specialty designation in medicine and dentistry is to protect the public, and not allow inadequately trained clinicians to claim to be specialists. The ADA only allows dental practitioners to declare as periodontists if they have successfully graduated from an accredited educational institution program. Practitioners who attend weekend and online courses are not eligible for specialty designation, because it is not possible to complete the requirements and components of a full-time 3 year residency at a credentialed institution any other way. Only fully-trained periodontists, oral and maxillofacial surgeons, endodontists, pediatric dentists, thoracic surgeons, neurosurgeons, etc., etc. can claim the designation of being a specialist in their field. I am confident that you and the board understand this, and I ask that you share my email with the other members of the board.
VR

R. M. Rogge

Rod M. Rogge, DDS
Periodontics and Implants
762 Independence Blvd. #500
Virginia Beach, VA 23455
(757)333-7444

Reen, Sandra (DHP)

From: Claudio Iwamoto <claudio.iwamoto@gmail.com>
Sent: Friday, February 9, 2018 8:42 PM
To: Reen, Sandra (DHP)
Subject: Specialty advertising bylaws change

Dear Ms. Reen,

I hope this email finds you well.
I am sending this email because I am greatly concerned with the proposed bylaws changes regarding specialty advertising. I am requesting that this proposed change be removed from fast track and allow a comment period for concerns to be heard.
I am also requesting that this email be distributed to all Board members.

Best regards,

Claudio Iwamoto, DDS, MS
Virginia Dental License:# 0401410768

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Claudio E. Iwamoto D.D.S., M.S.
Periodontist
Diplomate of the American Board of Periodontology

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Reen, Sandra (DHP)

From: Thanos Dounis <thanosdounis@gmail.com>
Sent: Saturday, February 10, 2018 12:55 PM
To: Reen, Sandra (DHP)
Subject: Specialty advertising bylaws

Dear Ms. Reen,
It has come to my attention that the important discussion about specialty advertising bylaws proposed changes was fast tracked by the Board.

Irrespective of where one stands on his topic, there is no reason for this discussion to be fast tracked. I would like to request that the Board allows a discussion period for this topic and remove this topic from fast track process.

Also, I am curious to know the reason why there is a proposed change on the clinical exam requirement. Can you provide me with some info on this?

Thank you in advance.
Sent from my iPhone

Reen, Sandra (DHP)

From: Gavin A. <gavinaaron@gmail.com>
Sent: Sunday, February 11, 2018 11:37 AM
To: Reen, Sandra (DHP)
Subject: Concern over Specialty Advertising Bylaws

Mrs. Reen,

My name is Gavin Aaron, and I am a board certified periodontist working in Roanoke and Lynchburg.

I recently was informed that non-specialists may soon be able to advertise as specialists. As someone who makes his part of his living fixing the mistakes of general dentists who exceed their skill level, I am urging you to to consider the following:

Specialty advertising bylaws change be removed from fast-track and allow a comment period for our concerns to be heard.

The 3 years of formal training beyond dental school help ensure that our states' residents are treated safely and proficiently.

On a final note, please consider this:

Imagine any medical specialty that requires additional training beyond the four years of dental school (cardiology, plastic surgery, ob/gyn, oncology). Would you want a primary care physician handling your cancer therapy, performing a c-section, inserting a heart stent, after attending a few weekend courses?

Thanks,
Gavin

--
Gavin M. Aaron DDS, MS
Aaron Periodontics & Dental Implants
www.periohub.com

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Lynchburg, VA 24502
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Reen, Sandra (DHP)

From: DR JAMES CULBERSON <sc2vajmc@comcast.net>
Sent: Sunday, February 11, 2018 12:37 PM
To: Reen, Sandra (DHP)
Subject: Proposed changes to dental advertising laws

Dear Ms. Reen,

Please convey to each of the Board members my concern regarding the placement of the proposed changes to the advertising regulations portion of the Virginia law relating to dental practice in fast track status. I cannot conceive of any reason why these changes are so urgently needed that the Board should proceed without a sufficient period of time for comment and debate.

Results of the advertising law changes are potentially so drastic as to dramatically alter the nature of how dentists - GPs, periodontists and other specialists - are perceived by potential patients. I say this as a practitioner who has experienced over thirty years of an evolving dental advertising philosophy. All one with a knowledge of a local dental profession population has to do is peruse available traditional and social media outlets to observe that some advertising is more accurate than others; whereas, a dentist holding a certificate in an ADA-recognized specialty, in addition to being board certified, has certifiable evidence to his claims. (Having such credentials represents required, ongoing obligations not required in other settings.)

The ADA represents a central arena for the debate about what is a dental specialty, as well as who can hold himself or herself out as a specialist. The Board should continue to observe the ADA's central role in this matter. I doubt that the Board has sufficient financial or workforce resources to investigate the entire spectrum of claims to specialized dental services, some more valid than others, I'm sure. Again, let the ADA take the lead in this matter - we don't have to "reinvent the wheel".

Does the Board wish to be merely retroactive, waiting on a patient complaint before acting on a claim to specialty training? Does this serve our patient population well, in keeping with our philosophy and goals as a health profession?

In summary, these changes should be carefully reflected upon and this reflection should be responsible enough to hear the voices of all those that would be affected. Thank you for your time and consideration of this matter.

James M. Culberson, D.M.S., M.S.

Board Certified Specialist in Periodontics

Fredericksburg, VA

Reen, Sandra (DHP)

From: Thomas Glazier <glazierdds@gmail.com>
Sent: Thursday, February 8, 2018 9:03 AM
To: Reen, Sandra (DHP)
Subject: 18VAC60-21-80 Advertising. PLEASE DISTRIBUTE TO ALL VA BOARD OF DENTISTRY MEMBERS

Dear Ms. Reen and The Virginia Board of Dentistry,

I am a specialist in the dental field of Periodontics. I just received notification that the Board is amending its advertising laws to eliminate the specialty recognition lines established by the American Dental Association. **18VAC60-21-80.** This is utterly shocking. Especially since the American Dental Association just established a National commission on dental specialty recognition. This was literally just completed at the recent ADA Meeting via Resolution 30. I would humbly ask that you not fast-track this legislation. It blurs the lines as to who a specialist is, does not recognize the years of hard work a specialist dedicates to becoming an expert in their field and most importantly, confuses the public. The standard of care for dentistry is currently established by the specialist in that arena. This will allow anyone who has been to a weekend course to advertise as a specialist. Clearly this jeopardizes the care the public will receive. I appreciate your assistance in recognition of this problem.

Sincerely,

Thomas. F. Glazier, DDS, MSD
President-Elect, Virginia Society of Periodontists

--
Thomas F. Glazier, D.D.S., M.S.D., DABP
Periodontal and Implant Surgical Specialist
Board Certified, American Board of Periodontology
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Reen, Sandra (DHP)

From: Ronald Rosenberg <rrosenbergdds@gmail.com>
Sent: Saturday, February 10, 2018 7:00 PM
To: Reen, Sandra (DHP)
Cc: Stephanie C. Voth
Subject: Proposed changes to Speciality Advertising Bylaws

Sandra,

I am a Board Certified Periodontist who has been practicing in Virginia since 1973 and am very concerned about potential changes to the Speciality Advertising Bylaws. The dental profession has an obligation to protect the public and the enactment of proposed changes will create confusion on the part of the public. Many people may think, as a result of advertising, that they are receiving optimal speciality care when in fact they may not be seeing a true specialist.

The proposed legistration does not benefit the citizens of Virginia. Changes to the current Bylaws only benefits those dentists who have not spent the time, money and energy necessary to obtain a level of education that entitles them to be recognized as a specialist but would like to hold themselves out as specialists. This proposal should not be passed by The Board of Dentistry and at the very least should be taken off the fast track so that the Board of Dentistry has time to understand the position of those of us who are against changes to the current Bylaws.

Sandra, please forward this email to all members of The Virginia Board of Dentistry

Yours truly,
Ronald M. Rosenberg, DDS,MS

--

Ronald M Rosenberg DDS, MS
Board Certified Periodontist

(703) 893-1640
www.vaperioimplants.com
www.facebook.com/vaperioimplants

8308 Old Courthouse Road, Unit D
Vienna, VA 22182
Directions

--

Ronald M Rosenberg DDS, MS
Board Certified Periodontist

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
December 14, 2017

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:04 a.m., on December 14, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: John M. Alexander, D.D.S

MEMBERS PRESENT:
Nathanial C. Bryant, D.D.S.
Patricia B. Bonwell, R.D.H., PhD
Tammy C. Ridout, R.D.H.
Jamiah Dawson, D.D.S.
James D. Watkins, D.D.S.

MEMBERS ABSENT:
Carol R. Russek, JD
Tonya A. Parris-Wilkins, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Sandra Catchings, D.D.S

STAFF PRESENT:
Kelley W. Palmatier, Deputy Executive Director
Sheila Beard, Executive Assistant

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
Julia Bennett, Assistant Attorney General
Shevaun Roukous, Adjudication Specialist
Jacqueline Barreto, Court Reporter
Margaret Hardy, Esquire, Respondent's Counsel

ESTABLISHMENT OF A QUORUM: With 6 Board members present, a panel was established in accordance with Va. Code §54.1-2400(11).

James M. Coleman, D.D.S. Dr. Coleman was present with legal counsel in accordance with the Notice of the Board dated July 13, 2017.

Case No. 163778 Dr. Alexander swore in the witnesses.

Following Ms. Bennett's opening statement; Dr. Alexander admitted into evidence Commonwealth's exhibits 1-3.

Following Dr. Coleman's opening statement; Dr. Alexander admitted into evidence Respondent's exhibit 1.

Testifying on behalf of the Commonwealth were Patricia Harte-Byers, Retired DHP Senior Investigator and witness "Patient A" via telephone conference call.

Testifying on behalf of Dr. Coleman was Necol Southall. Dr. Coleman testified on his own behalf.

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

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

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

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

Mr. Rutkowski reported that Dr. Clark is assessed a monetary penalty of $5000 and required to complete, within 6 months from the date of entry of the Order, a 7 credit hour course in the subject of recordkeeping and risk management.

Dr. Watkins moved the adoption of the sanctions imposed as read by Mr. Rutkowski. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 12:54 p.m.

John M. Alexander D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
December 14, 2017

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 1:26 p.m., on December 14, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: John M. Alexander, D.D.S

MEMBERS PRESENT: Nathanial C. Bryant, D.D.S.
Patricia B. Bonwell, R.D.H., PhD
August A. Petticolas Jr., D.D.S.
Tammy C. Ridout, R.D.H.
Jamiah Dawson, D.D.S.
James D. Watkins, D.D.S.

MEMBERS ABSENT: Carol R. Russek, JD
Sandra Catchings, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director
Sheila Beard, Executive Assistant

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT: Wayne T. Halbleib, Senior Assistant Attorney General
Lori L. Pound, Adjudication Specialist
Jacqueline Barreto, Court Reporter
Camille E. Shora, Esquire, Respondent's Counsel

ESTABLISHMENT OF A QUORUM: With 7 Board members present, a panel was established in accordance with Va. Code §54.1-2400(11).

Sharokh Soltani, D.M.D. Dr. Soltani was present with legal counsel in accordance with the Notice of the Board dated August 18, 2017.

Case No. 163204 Dr. Alexander swore in the witnesses.

Prior to opening statements, Ms. Shora noted that there are 2 preliminary matters. Exhibit #4 had not been previously disclosed and the a motion being made to exclude the testimony of Dr. Frank R. Portel, the Commonwealths witness on the grounds Dr. Portel does not practice endodontics therefore his testimony would be immaterial and unsubstantial. Mr. Halbleib made a motion to exclude all witnesses until the time came to testify. The motions

were denied by Dr. Alexander and therefore all witnesses remained and testimony would be heard from Dr. Frank R. Portel during the Formal Hearing.

Following Mr. Halbleib's opening statement; Dr. Alexander admitted into evidence Commonwealth's exhibits 1-4.

Following Ms. Shora's opening statement; Dr. Alexander admitted into evidence Respondent's exhibits A-B with an additional 3 exhibits.

Testifying on behalf of the Commonwealth were Mark Cranfill, Senior DHP Investigator, expert witness Dr. Frank R. Portel, and Patient "A".

Testifying on behalf of the respondent was Dr. Jackomis. Dr. Soltani also testified on his own behalf.

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

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

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

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

Mr. Rutkowski reported that Dr. Soltani is assessed a administrative costs of $5000 and required to complete, within 6 months from the date of entry of the Order, a 3 credit hour course in the subject of dental recordkeeping.

Dr. Watkins moved the adoption of the sanctions imposed as read by Mr. Rutkowski. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 8:12 p.m.

John M. Alexander D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
December 15, 2017

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 2:04 p.m., on December 15, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: John M. Alexander, D.D.S.

MEMBERS PRESENT:
Patricia B. Bonwell, R.D.H., PhD
Nathaniel C. Bryant, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
James D. Watkins, D.D.S.
Tammy C. Ridout, R.D.H.
Jamiah Dawson, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.

MEMBERS ABSENT:
Carol R. Russek, JD
Sandra Catchings, D.D.S.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Sheila M. Beard, Executive Assistant

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
Lori L. Pound, Adjudication Specialist
Jackie Barreto, Court Reporter

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

Tracy E. Spraker, R.D.H. Reinstatement Case No.: 182041

Ms. Spraker was present without legal counsel in accordance with the Notice of the Board dated November 15, 2017.

Dr. Alexander swore in the witnesses.

Ms. Spraker made an opening statement, and presented exhibits A-B to the Board.

Ms. Pound presented the opening statement and presentation of Commonwealth's Exhibits 1-3. Exhibits 1-3 were admitted into evidence.

Ms. Spraker testified on her own behalf.

Testifying on behalf of the Commonwealth was Joyce Johnson, DHP Senior Investigator.

Closed Meeting: Dr. Parris-Wilkins moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Ms. Spraker. Additionally, she moved that Board staff, Ms. Reen, Ms. Beard, 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. Parris-Wilkins 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. Parris-Wilkins moved to accept the Findings of Facts and Conclusion of Law as presented by the Commonwealth, amended by the Board, and read by Mr. Rutkowski. The motion was seconded and passed.

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

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

Virginia Board of Dentistry
Formal Hearing
December 15, 2017

ADJOURNMENT: The Board adjourned at 3:30 p.m.

_____ _____

John M. Alexander, D.D.S., President Sandra K. Reen, Executive Director

_____ _____

Date Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY
BOARD MEETING MINUTES
December 15, 2017

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:15 a.m. on December 15, 2017, at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

PRESIDING: John M. Alexander, D.D.S., President

BOARD MEMBERS PRESENT:
Tonya A. Parris-Wilkins, D.D.S.
Nathaniel C. Bryant, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Tammy C. Ridout, R.D.H.
Patricia B. Bonwell, R.D.H., PhD
James D. Watkins, D.D.S.
Jamiah Dawson, D.D.S.
Carol R. Russek, JD

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
Sheila Beard, Executive Assistant for the Board

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
Dr. David E. Brown, Director of DHP
Lisa Hahn, Chief Operating Officer of DHP

ESTABLISHMENT OF A QUORUM: With 9 members of the Board present, a quorum was established.

Dr. Alexander called the meeting to order then Ms. Reen read the emergency evacuation procedures.

PUBLIC COMMENT: Dr. Alexander explained the parameters for public comment and opened the public comment period.

Dr. Edward P. Snyder, submitted comments of concern about the practice of orthodontics by Smile Direct Club which provides appliances to straighten teeth using impressions made and mailed by patients. He stated the methods used by this company omits x-rays and lacks accountability for the irreversible changes that result from improper orthodontic treatment.

Jeffrey Solitizer, DDS said he is a Virginia dentist affiliated with Smiles Direct Club. He said he uses photographs, that radiographs are available and treatment is presented through teledentistry. He went on to explain the patient's status is checked every ninety days, more complex cases are sent for invisalign and patients are referred for treatment of possible periodontic and cavity issues.

Sean Murphy, Esq. spoke on behalf of the American Assoc. of Orthodontists. He reported the Association has filed complaints in over 36 states regarding the use of home impression kits provided by Smile Direct Club. He presented online comments and reviews from Smile Direct patients that complain about ads not identifying the dentist or the steps to follow to address issues that arise.

Sara Thomas, Smile Direct Club counsel, stated Smile Direct Club provides a platform to dentist to provide care to patients. Ms. Thomas stated there are many good reviews posted online surrounding the success of Smile Direct Club.

John Wittrock, requested that the Board endorse and adopt periodic assessment testing of clinical knowledge and skills for dentists.

APPROVAL OF MINUTES:

Dr. Alexander asked if there were any corrections to the 5 sets of minutes presented in the agenda package. Hearing none, a motion by Dr. Watkins to adopt these minutes was seconded and passed.

DHP DIRECTOR'S REPORT:

Dr. Brown, Director of DHP, reported that adding a link to a webpage for Suicide Prevention to board webpages is being considered to provide a resource for licensees. Dr. Brown asked for any thoughts on the appropriateness of adding such a link to the Board of Dentistry website and welcomed comments to be shared through Ms. Reen.

Dr. Brown said Secretary Hazel is not seeking reappointment so there will be a new Secretary of Health and Human Resources. He also noted that he is seeking reappointment to the position of Director of DHP. He noted that the top leadership positions in the agency are appointed by the Governor and his experience led him to establish the classified position of Chief Operating Officer (COO) to assure continuity of operations during changes in leadership. The COO will direct the administrative support services the agency provides to the boards. He introduced Ms. Hahn as the first COO for DHP.

Dr. Brown noted that work is underway on establishing curriculum for educating students pursuing health professions on prescribing practices, pain management and addiction.

Dr. Brown asked the Board to consider his concern that its policy on disciplinary cost recovery is unfair to dental hygienists because they earn about half as much as dentists. He noted that imposing the costs is discretionary and he would like the Board to consider the options of either not using the authority to assess costs since the Board has a large cash balance or changing its policy to charge dental hygienist 50% of the costs that a dentist is charged. He also requested consideration of reserving the steeper costs for the most severe cases.

SANCTIONING REFERENCE POINTS:

Neal Kauder of VisualResearch, Inc. discussed the Sanctioning Reference Points process and the purpose for establishing sanctioning guidelines as a reference tool to achieve consistency in sanctioning decisions including monetary penalties. The purpose is to have similar violations result in similar sanctions. He offered to analyze the Board's data to report on the fines that have been imposed by case type. Dr. Alexander requested that Mr. Kauder provide the report so inconsistencies in sanctioning can be addressed.

HEALTHCARE WORK-FORCE DATA:

Elizabeth Carter, PhD presented the 2017 Dentistry and Dental Hygiene Workforce Data Reports, noting 90% plus response rates for both dentists and dental hygienists. She reported a significant decline in Dentists Full-Time Equivalencies from 2013 to 2016. In contrast she reported that the Dental Hygienist Full-Time Equivalency increased from 2014 to 2016. She added that supervision will be added to future surveys.

Ms. Reen asked Dr. Carter to address the work needed to develop a law examination requirement for applicants. Dr. Carter explained that such an exam would be a condition of licensure and therefore it could be a barrier to employment. She said, in order for it to be defensible, the exam would need to be psychometrically validated to assure all applicants are treated fairly, questions are written properly, and the questions are not biased. Following discussion, Dr. Alexander asked the Exam Committee to address this guidance and report back to the Board.

LIAISON/COMMITTEE REPORTS:

AADB. Dr. Parris-Wilkins thanked the Board for allowing her to attend the annual AADB meeting, indicating that it is a valuable resource. She reviewed the agenda topics addressed in her report and said the meeting was well organized and informational. Dr. Alexander also commented the meeting was an excellent source of

information. He noted that the issues in Virginia are the same ones experienced by other boards.

SRTA. Dr. Watkins stated that SRTA has filed an application to rejoin ADEX.

BHP. Dr. Watkins said the December 7, 2017 meeting went very well. He reported the Board of Physical Therapy is granting continuing education credit for volunteer hours for attendance at board meetings. He suggested the Board consider adopting this policy as well.

Exam Committee. Dr. Watkins stated the committee will meet to discuss the information provided by Dr. Carter about developing exams.

CODA. Dr. Bonwell said she appreciated the opportunity to attend the Northern Virginia Community College site visit which gave her insights into the accreditation process.

Advisory Panel on Opioids. Dr. Alexander reported that the panel is still active pending enactment of the final regulations.

Regulatory-Legislative Committee. Dr. Petticolas stated there was nothing new to report at this time.

ADEX. Dr. Bryant said he had nothing to report at this time.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reviewed the status of the regulatory actions currently in process then requested action on the following proposals:

- Issuing the proposed Notice of Intended Regulatory Action (NOIRA) to change the license renewal schedule from March of each year for all dentists and dental hygienists to birth months. This intended change is anticipated to go into effect in 2019. A motion was made by Ms. Ridout to adopt the NOIRA. The motion was seconded and passed.
- Adoption of a one-time license renewal fee reduction of 50% by exempt action. Dr. Petticolas moved to adopt this action. The motion was seconded and passed.

Ms. Yeatts explained that adding the proposed PGY1 Pathway for Licensure cannot be submitted until the 2019 Session of the General Assembly and proposed deferring action until the next meeting. Ms. Reen recommended consideration of the fact that the Board currently only issues general dental licenses and the implications of eliminating the clinical examination requirement when an applicant

only has advanced training in a CODA accredited program in general dentistry or in an advanced specialty. She asked if specialty licensure should be considered. Ms. Ridout moved to return this proposal to the Regulatory-Legislative Committee. The motion was seconded and passed.

BOARD COUNSEL REPORT:

Mr. Rutkowski reminded members to keep a professional demeanor while in the midst of proceedings. He advised that having side conversations does not show respect for the seriousness of the matter being debated, adding that the Board should never come across as being too casual.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reviewed her report noting that from January 1, 2017 through December 1, 2017, 337 cases were received and 352 were closed. She also noted that in Q1 of 2018 66 patient care cases were received and 51 were closed for a 77% clearance rate.
Ms. Palmatier then proposed changes to update the inspection form, Guidance Document 76-24.3. Ms. Ridout moved to accept the proposed changes. The motion was seconded and passed.

REVIEW OF PUBLIC COMMENTS:

Practices of Smiles Direct Club.
In response to interest in having more information, Ms. Reen agreed to collect information from other states.

Periodic Assessment of Clinical Competency.
It was agreed by consensus to advance Dr. Wittrock's comments to the American Association of Dental Boards for consideration.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Cases. Ms. Reen stated that in light of recent formal hearings ending in findings of only minor violations it may be necessary to reassess a case being appealed following an informal conference to address options for moving the case to closure without a formal hearing. She intends to speak with the other board executives to see if they ever reassess a case based on an IFC decision.

NEW BUSINESS:

Continued Education. Dr. Alexander referred consideration of granting CE for attending Board meetings to the Regulatory-Legislative Committee for review.

Acknowledgements. Dr. Alexander acknowledged past president of the Board, Dr. Al Rizkalla and member, Dr. Bruce Wyman in attendance of the Board meeting. The Board thanked them for their service to the Virginia Board of Dentistry.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 12:28 p.m.

Virginia Board of Dentistry
Board Business Meeting
December 15, 2017

John M. Alexander, D.D.S., President	Sandra K. Reen, Executive Director
Date	Date

VIRGINIA BOARD OF DENTISTRY
PUBLIC HEARING

January 26, 2018

Perimeter Center
9960 Mayland Drive, Suite 201
Henrico, Virginia 23233
Board Room 4

TIME AND PLACE: The Board of Dentistry convened a Public Hearing at 9:00 a.m., on January 26, 2018, to receive comments on proposed amendments to Regulations on the education and training for moderate sedation permits. The changes will conform Board regulations to current ADA guidelines.

PRESIDING: John M. Alexander, D.D.S.

BOARD MEMBERS PRESENT: None

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

COURT REPORTER Denise Holt, Court Reporter, Crane-Snead & Associates, Inc.

QUORUM: Not Required

PUBLIC COMMENT: None

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

Dr. Alexander announced the deadline for submitting written comments is February 23, 2018, and indicated that the Board will consider all comments received before adoption of final Regulations on March 9, 2018.

ADJOURNMENT: The public hearing concluded at 9:04 a.m.

John M. Alexander, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA: ORIGINAL

UNITED STATES DEPARTMENT OF HEALTH PROFESSIONS

VIRGINIA BOARD OF DENTISTRY

* * * * * * * *

The public hearing came on for hearing on Friday, January 26, 2018, at the U.S. Department of Health Professions Office, Perimeter Center, 9960 Mayland Drive, Hearing Room 4, Henrico, 23233, Virginia, before Denise M. Holt, VCR No. 0315066.

BEFORE: John M. Alexander, Chairperson

PANEL: Sandra K. Reen, Executive Director

Elaine J. Yeatts, DHP Senior Policy Analyst

THE COURT: Good morning. I am Dr. John Alexander, President of the Board of Dentistry. This is a public hearing to receive comments on proposed amendments to regulations on the education and training for moderate sedation permits. The changes will conform board regulations to current ADA guidelines. There are copies of the proposed regulations on the sign-up table.

At this time, I will call on persons who have signed up to comment on proposed regulations. As I call your name, please come forward and tell us your name and where you are from. Please be certain that we have the name and mailing address of all persons who have provided comment on the sign-up sheet.

I want to remind everyone that written comments on the proposed regulations should be directed to Sandra Reen, Executive Director of the Board or electronic comment can be posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov or sent by email. The comment period will close on February 23, 2018. The Board will consider all comment before adoption of final regulations on March 9, 2018.

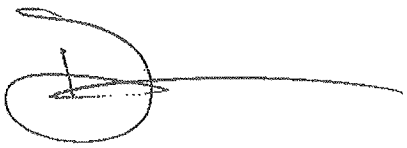
This concludes our hearing.

HEARING CONCLUDED

CERTIFICATE OF COURT REPORTER

I, DENISE HOLT, hereby certify that the hearing was taken down by me in stenotype and therefore reduced to typewriting; that I am neither counsel for, related to, nor employed by any of the parties, and further, that I am not a relative or employee or employed by the parties hereto, nor financially or otherwise interested in the outcome of the hearing.

Given under my hand this 26th day of January, 2018.



Denise Holt
0315066

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION – TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:22 p.m., on February 8, 2018, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 4, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: John M. Alexander, D.D.S., President

MEMBERS PRESENT:
Patricia B. Bonwell, R.D.H., PhD
Nathaniel C. Bryant, D.D.S.
Jamiah Dawson, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.

MEMBERS ABSENT:
Sandra J. Catchings, D.D.S.
Tammy C. Ridout, R.D.H.
Carol R. Russek, J.D.
James D. Watkins, D.D.S.

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

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

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General, Board Counsel
Lori L. Pound, J.D., Adjudication Specialist

Christopher Dail, DDS Case Nos.: 180451 and 180944 The Board received information from Ms. Pound regarding offering a Consent Order to Dr. Dail as a settlement proposal for the resolution of his case in lieu of proceeding with the Formal Hearing.

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

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

DECISION: Dr. Bonwell moved that the Board offer the proposed Consent Order to Dr. Dail for revocation of his license to practice dentistry in the Commonwealth of Virginia in lieu of proceeding with the Formal Hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

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

John M. Alexander, D.D.S., Chair	Sandra K. Reen, Executive Director
Date	Date

VIRGINIA BOARD OF DENTISTRY
EXAMINATION COMMITTEE MINUTES
FEBRUARY 2, 2018

TIME AND PLACE: The Examination Committee convened on February 2, 2018, at 10:00 a.m., at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.

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

MEMBERS PRESENT: Nathaniel C. Bryant, D.D.S.
Patricia B. Bonwell, R.D.H., PhD.
Jamiah Dawson, D.D.S.
Carol R. Russek, J.D.

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

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

Ms. Palmatier read the emergency evacuation procedures.

PUBLIC COMMENT: No public comments.

APPROVAL OF MINUTES: Dr. Watkins asked if there were any corrections or changes to the April 28, 2017 minutes. Dr. Bryant moved to approve the minutes as presented. The motion was seconded and passed.

IMPLEMENTING A LAW EXAM FOR LICENSURE APPLICANTS: Ms. Palmatier stated that the Board of Dentistry (Board) at its December 15, 2017 meeting requested that the Exam Committee determine whether it would recommend that the Board continue to pursue a law examination for new licensees; and if so, how to proceed with implementing that exam. Ms. Palmatier reminded the Committee that it was explained that the law exam would need to be psychometrically validated to assure all applicants are treated fairly, questions are written properly, and the questions are not biased.

The Committee agreed that it is current licensees that they want to ensure are keeping apprised of the changes in the regulations more so than new licensees because most discipline cases involve licensees who have been licensed by the Board for some time.

The Committee unanimously recommended that the Board put five statements of "Did You Know" on the renewal form for both dentists and dental hygienists that would list current changes in regulations or informative regulations for each profession, which would communicate to licensees that it is important to be aware of the laws and regulations of the Board.

The Committee unanimously recommended that the Board not move forward with requiring a law exam for new licensees.

PROPOSE A POSITION STATEMENT ON CLINICAL EXAMINATIONS FOR LICENSURE OF DENTISTS:

Ms. Palmatier reported to the Committee that WREB is the only clinical examination accepted by the Board that does not have a required prosthodontics exam. Ms. Palmatier requested that the Committee consider recommending that the Board adopt a guidance document that states "All examinations taken after March 9, 2018 must include, at a minimum, sections on Endodontics, Prosthodontics, and Restorative dentistry" for dental licensure applicants by examination or credentials.

The Committee unanimously recommended that the Board adopt a guidance document, and also that a regulatory change be made to 18VAC60-21-210(B)(2) to reflect the requirements stated in the guidance document.

No new meeting date set.

ADJOURNMENT:

With all business concluded, the meeting adjourned at 11:24 a.m.

James D. Watkins, D.D.S, Chair

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY

MINUTES OF THE REGULATORY ADVISORY PANEL ON THE CONTROLLED SUBSTANCES, SEDATION, AND ANESTHESIA REGULATIONS FEBRUARY 2, 2018

TIME AND PLACE:	The meeting of the Regulatory Advisory Panel (RAP) of the Board of Dentistry (Board) was called to order on February 2, 2018 at 1:56 p.m., at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.
PRESIDING:	John M. Alexander, D.D.S., Chair
PANEL MEMBERS PRESENT:	Malinda Husson, D.D.S. Carol Russek, J.D. David Sarrett, D.D.S.
PANEL MEMBERS ABSENT:	Jacques Riviere, D.D.S.
OTHERS PRESENT:	Augustus A. Petticolas, Jr., D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Donna Lee, Discipline Case Manager
ESTABLISHMENT OF A QUORUM:	With four members of the RAP present, a quorum was established. Ms. Reen read the emergency evacuation procedure.
APPROVAL OF MINUTES:	The December 1, 2017 minutes were accepted as presented by consensus.
PUBLIC COMMENT:	Catherine Harrison, CRNA, stated that she was present to clarify any questions concerning sedation provided by CRNAs in dental practices.
PANEL DISCUSSION:	Dr. Alexander expressed his appreciation for the information and recommendations the RAP received at the December 1, 2017 Open Forum. He explained that the draft of Part VI of the Regulations Governing the Practice of Dentistry provided for discussion includes the recommendations received throughout the text as well as the notes that he and Dr. Sarrett had added. Ms. Reen noted that a number of changes in the draft address

provisions for moderate sedation to conform to the 2016 ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. She said these changes do not need discussion because they are being addressed in a regulatory action currently in process.

Dr. Alexander facilitated a page-by-page review and discussion of the draft. Recommendations the RAP agreed to advance included:

- Requiring a review of medication use and a focused physical examination in patient evaluation requirements.
- Noting that the guidelines that address sedation of pediatric patients issued by the American Academy of Pediatric Dentistry and the American Academy of Pediatrics should be considered.
- Adding the provision on special needs patients in the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists.
- Clarifying the supervision of certified registered nurse anesthetists.
- Clarifying the provisions on minimal sedation.
- Permitting consideration of extenuating patient circumstances in the monitoring and discharge requirements.
- Adding oxygen saturation to the monitoring requirements.
- Requiring a 3 person treatment team for moderate sedation.

NEXT STEPS: Ms. Reen said the proposed changes will be made to a new draft of Part VI of the Regulations and sent to the RAP for review. She recommended that each panelist submit comments on the draft for Dr. Alexander's review so he might decide if it is necessary to convene the RAP for further discussion. She added that once the RAP proposal is complete the recommendations will go to the Regulatory-Legislative Committee for review.

ADJOURNMENT: With all business concluded, Dr. Alexander adjourned the meeting at 5:15 p.m.

_____ _____

John M. Alexander, D.D.S, Chair Sandra K. Reen, Executive Director

_____ _____

Date Date

Report of the 2018 General Assembly
Board of Dentistry

HB 533 Veterans; acceptance of substantially equivalent military training, etc.

Chief patron: Freitas

Summary as passed House:

Professions and occupations; qualifications for licensure; acceptance of substantially equivalent military training, education, and experience. Directs the Department of Veterans Services to take steps to promote awareness among veterans of the acceptance of such substantially equivalent military training, education, or experience by the Department of Professional and Occupational Regulation, the Department of Health Professions, or any other board named in Title 54.1 (Professions and Occupations).

HB 793 Nurse practitioners; practice agreements.

Chief patron: Robinson

Summary as passed House:

Nurse practitioners; practice agreements. Eliminates the requirement for a practice agreement with a patient care team physician for nurse practitioners who have been licensed as a nurse practitioner by the Boards of Medicine and Nursing, graduated from a nurse practitioner educational program accredited by the Commission on Collegiate Nursing Education, completed at least five years of full-time clinical experience as a licensed, certified nurse practitioner, and submitted an attestation from his patient care team physician stating that the patient care team physician routinely practices in the same specialty practice category as the nurse practitioner and that the nurse practitioner meets the requirements for practice without a practice agreement. The bill establishes title protection for advanced practice registered nurses, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. The bill contains technical amendments.

HB 883 Regulatory reduction pilot program; Department of Planning and Budget to implement, report.

Chief patron: Webert

Summary as passed House:

Department of Planning and Budget; regulatory reduction pilot program; report. Directs the Department of Planning and Budget (the Department), under the supervision of the Secretary

of Finance (the Secretary), to administer a three-year regulatory reduction pilot program aimed at reducing by 25 percent the regulations and regulatory requirements, as defined in the bill, of the Department of Professional and Occupational Regulation and the Department of Criminal Justice Services by July 1, 2021. The bill requires the Secretary to report annually to the Speaker of the House and the Chairman of the Senate Rules Committee no later than October 1, 2019, and October 1, 2020, on the progress of the regulatory reduction pilot program. The bill also requires the Secretary to report by August 15, 2021, to the Speaker of the House and the Chairman of the Senate Rules Committee (i) the progress towards identifying the 25 percent reduction goal, (ii) recommendations for expanding the program to other agencies, and (iii) any additional information the Secretary determines may be helpful to support the General Assembly's regulatory reduction and reform efforts. The bill provides that if, by October 1, 2021, the program has achieved less than a 25 percent total reduction in regulations and regulatory requirements across both pilot agencies, the Secretary shall report on the feasibility and effectiveness of implementing a 2-for-1 regulatory budget providing that for every one new regulatory requirement, two existing regulatory requirements of equivalent or greater burden must be streamlined, repealed, or replaced for a period not to exceed three years. Lastly, the bill directs all executive branch agencies subject to the Administrative Process Act (§ 2.2-4000 et seq.) to develop a baseline regulatory catalog and report such catalog data to the Department, which shall then track and report on the extent to which agencies comply with existing requirements to periodically review all regulations every four years.

HB 1173 Controlled substances; limits on prescriptions containing opioids.

Chief patron: Pillion

Summary as introduced:

Limits on prescription of controlled substances containing opioids. Eliminates the surgical or invasive procedure treatment exception to the requirement that a prescriber request certain information from the Prescription Monitoring Program (PMP) when initiating a new course of treatment that includes prescribing opioids for a human patient to last more than seven days. Under current law, a prescriber is not required to request certain information from the PMP for opioid prescriptions of up to 14 days to a patient as part of treatment for a surgical or invasive procedure. The bill has an expiration date of July 1, 2022. This bill is identical to SB 632.

HB 1440 Schedule I and Schedule II drugs; adds various drugs to lists.

Chief patron: Garrett

Summary as introduced:

Schedule I and Schedule II drugs. Adds MT-45 (1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) to Schedule I of the Drug Control Act and Dronabinol [(-)-delta-9-*trans* tetrahydrocannabinol] in an oral solution in a drug product approved for marketing by the U.S. Food and Drug Administration to Schedule II of the Drug Control Act and removes naldemedine from Schedule II of the Drug Control Act.

SB 258 Subpoenas; issuance by Director of Department of Health Professions or his designee.

Chief patron: Petersen

Summary as passed Senate:

Department of Health Professions; subpoenas. Provides that a subpoena issued by the Director of the Department of Health Professions or his designee may be delivered by (i) any person authorized to serve process under § 8.01-293, (ii) investigative personnel appointed by the Director, (iii) registered or certified mail or by equivalent commercial parcel delivery service, or (iv) email or facsimile if requested to do so by the recipient. The bill provides that upon failure of any person to comply with a subpoena, the Director may request that the Attorney General or the attorney for the Commonwealth for the jurisdiction in which the recipient of the subpoena resides, is found, or transacts business seek enforcement of the subpoena.

SB 544 Prescription drugs; donation of used medicines.

Chief patron: Obenshain

Summary as passed Senate:

Prescription drug donation program. Requires that the existing prescription drug donation program regulated by the Board of Pharmacy accept eligible prescription drugs from individuals, including those residing in nursing homes, assisted living facilities, or intermediate care facilities established for individuals with intellectual disability (ICF/IID), licensed hospitals, any facility operated by the Department of Behavioral Health and Developmental Services, from an agent pursuant to a power of attorney, a decedent's personal representative, a legal guardian of an incapacitated person, and a guardian ad litem donated on behalf of the represented individual. The bill also provides liability protection for those who donate, accept, and dispense such unused drugs.

SB 726 CBD oil and THC-A oil; certification for use, dispensing.

Chief patron: Dunnavant

Summary as passed Senate:

CBD oil and THC-A oil; certification for use; dispensing. Provides that a practitioner may issue a written certification for the use of cannabidiol oil or THC-A oil for the treatment or to alleviate the symptoms of any diagnosed condition or disease determined by the practitioner to benefit from such use. Under current law, a practitioner may only issue such certification for the treatment or to alleviate the symptoms of intractable epilepsy. This bill is a recommendation of the Joint Commission on Health Care. This bill incorporates SB 597, SB 788, and SB 795.

SB 918 Professional and occupational regulation; authority to suspend or revoke licenses, certificates.

Chief patron: Ebbin

Summary as passed Senate:

Professional and occupational regulation; authority to suspend or revoke licenses, certificates, registrations, or permits; default or delinquency of education loan or scholarship. Provides that the Department of Professional and Occupational Regulation, the Department of Health Professions, the Board of Accountancy, and the Board of Education shall not be authorized to suspend or revoke the license, certificate, registration, permit, or authority it has issued any person who is in default or delinquent in the payment of a federal-guaranteed or state-guaranteed educational loan or work-conditional scholarship solely on the basis of such default or delinquency.

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**

(As of February 23, 2018)

Chapter		Action / Stage Information
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Change in renewal schedule [Action 4975] NOIRA - *At Secretary's Office for 56 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Conforming rules to ADA guidelines on moderate sedation [Action 4748] Proposed - *Register Date: 12/25/17* *Comment until 2/23/18*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Prescribing opioids for pain management [Action 4778] Proposed - *At Secretary's Office for 84 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Amendment to restriction on advertising dental specialties [Action 4920] Fast-Track - *At Secretary's Office for 64 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Reduction of renewal fees [Action 4974] Final - *Register Date: 1/22/18* *Effective 2/21/18*
[18 VAC 60 - 25]	Regulations Governing the Practice of Dental Hygienists	Continuing education for practice by remote supervision [Action 4917] Emergency/NOIRA - *Register Date: 11/27/17* *Comment on NOIRA until: 12/27/17*
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	Education and training for dental assistants II [Action 4916] NOIRA - *At Secretary's Office for 140 days*

Agenda Item: Board action on revised ADA Guidelines

Included in your agenda package are:

A copy of proposed amendments to regulations for consistency with the Guidelines

Staff notes:

- A NOIRA was published with one comment in response about the general ADA guidelines on anesthesia. That comment is being considered by the Regulatory Advisory Panel on sedation/anesthesia regulations.
- There were no comments on the proposed regulations; comment period ended 2/23/18
- Education requirements for a permit to administer moderate sedation are already required to follow ADA Guidelines, so changes regulations are for consistency with the current guidelines.

Board action:

To adopt the proposed amended regulations as a final action.

Agenda Item: Board action on revised ADA Guidelines

Included in your agenda package are:

A copy of proposed amendments to regulations for consistency with the Guidelines

A copy of the comment from the Va. Association of Nurse Anesthetists

Staff notes:

- A NOIRA was published with one comment in response about the general ADA guidelines on anesthesia. That comment is being considered by the Regulatory Advisory Panel on sedation/anesthesia regulations.

- There was one comment on the proposed regulations; comment period ended 2/23/18

- Education requirements for a permit to administer moderate sedation are already required to follow ADA Guidelines, so changes regulations are for consistency with the current guidelines.

Board action:

To adopt the proposed amended regulations as a final action.

VANA 1934
Virginia Association of
Nurse Anesthetists
CRNA

February 20, 2018

Ms. Sandra Reen
Virginia Board of Dentistry
Dept. of Health Professions
Perimeter Center
9960 Mayland Drive
Richmond, VA 23233-1463

Re: Public Comment regarding the Proposed Regulations to Conform Rules to the ADA Guidelines on Moderate Sedation

Dear Ms. Reen,

On behalf of the Virginia Association of Nurse Anesthetists ("VANA") I am pleased to provide comments regarding the proposed Regulations Governing the Practice of Dentistry on Controlled Substances, Sedation and Anesthesia ("the proposed regulations") that seek to conform the rules to the ADA Guidelines on Moderate Sedation.

VANA represents the more than 1900 certified registered nurse anesthetists ("CRNA") who practice in every setting in which anesthesia is delivered in Virginia, including hospital surgical suites, outpatient surgery centers and dental offices.

VANA applauds the Board of Dentistry for its efforts to ensure compliance with national guidance and encourages the Board to use this opportunity to review the proposed regulations for conformity and compliance with Virginia law as well.

Delegation of Administration (18VAC60-21-291)

The proposed regulations exceed statutory authority by permitting a dentist who does not hold a permit to administer moderate sedation by delegating the administration to an anesthesiologist.

Virginia Code §54.1-2709.5 states:

"A. Except as provided in subsection C, the Board shall require any dentist who provides or administers sedation or anesthesia in a dental office to obtain either a conscious/moderate sedation permit or a deep sedation/general anesthesia permit issued by the Board. The Board shall establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of sedation and anesthesia to patients in a dental office.

Subsection C of §54.1-2709.5 allows only two exceptions to the requirement that a dentist obtain a permit to administer sedation or anesthesia in a dental office:

"C. This section shall not apply to:

1. An oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the Board with reports which result from the periodic office examinations required by AAOMS; or

2. Any dentist who administers or prescribes medication or administers nitrous oxide/oxygen or a combination of a medication and nitrous oxide/oxygen for the purpose of inducing anxiolysis or minimal sedation consistent with the Board's regulations."

The statute is clear that any dentist who provides or administers ("employs or uses") sedation or anesthesia in a dental office must obtain either a conscious/moderate sedation permit or a deep sedation/general anesthesia permit. The only instances where a permit is not required is specific to oral and maxillofacial surgeons or the administration of anxiolysis for minimal sedation.

We ask the Board to amend the proposed regulations to comply with Virginia Code §54.1-2709.5.

Indirect Supervision of Certified Registered Nurse Anesthetists (18VAC60-21-291)

Virginia Code §54.1-2900 defines CRNAs as advanced practice registered nurses who are jointly licensed by the Board of Medicine and Nursing and practice under the supervision of a doctor of medicine, osteopathy, podiatry or dentistry.

Neither the Virginia Code, nor the regulations promulgated by the Joint Boards of Nursing and Medicine governing nurse practitioners require medical direction of CRNAs and the term "direction" (as it relates to physicians and nurse practitioners) was removed from the Medical Practice Act the regulations governing nurse practitioners in 2012.

To ensure statutory compliance and to avoid confusion among dentists and CRNAs, we ask the Board to remove the term "medical direction."

VANA 1934
Virginia Association of Nurse Anesthetists
CRNA

We appreciate the opportunity to comment and look forward to working with the Board on this important matter.

Sincerely,

/s/ Jerrol Wallace

Jerrol Wallace, DNP, MSN, CRNA
President
Virginia Association of Nurse Anesthetists

cc: Michele Satterlund, McGuireWoods Consulting
Kassie Schroth, McGuireWoods Consulting
Jay Douglas, Executive Director, Board of Nursing

Project 4975 - Proposed

BOARD OF DENTISTRY

Conforming rules to ADA guidelines on moderate sedation

Part I

General Provisions

18VAC60-21-10. Definitions.

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

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

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

"ADA" means the American Dental Association.

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

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

"Code" means the Code of Virginia.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Analgesia" means the diminution or elimination of pain.

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

"Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

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

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

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

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensation of pain with minimal alteration of consciousness.

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

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal

sedation includes "anxiolysis" (the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness) and includes "inhalation analgesia" when used in combination with any anxiolytic agent administered prior to or during a procedure.

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

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

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

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

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

18VAC60-21-30. Posting requirements.

A. A dentist who is practicing under a firm name or who is practicing as an employee of another dentist is required by § 54.1-2720 of the Code to conspicuously display his name at the entrance

of the office. The employing dentist, firm, or company must enable compliance by designating a space at the entrance of the office for the name to be displayed.

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

C. A dentist who administers, prescribes, or dispenses Schedules II through V controlled substances shall maintain a copy of his current registration with the federal Drug Enforcement Administration in a readily retrievable manner at each practice location.

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

18VAC60-21-40. Required fees.

A. Application/registration fees.

1. Dental license by examination	$400
2. Dental license by credentials	$500
3. Dental restricted teaching license	$285
4. Dental faculty license	$400
5. Dental temporary resident's license	$60
6. Restricted volunteer license	$25
7. Volunteer exemption registration	$10
8. Oral maxillofacial surgeon registration	$175
9. Cosmetic procedures certification	$225
10. Mobile clinic/portable operation	$250
11. ~~Conscious/moderate~~ Moderate sedation permit	$100
12. Deep sedation/general anesthesia permit	$100

B. Renewal fees.

1. Dental license - active	$285
2. Dental license - inactive	$145
3. Dental temporary resident's license	$35
4. Restricted volunteer license	$15
5. Oral maxillofacial surgeon registration	$175
6. Cosmetic procedures certification	$100
7. ~~Conscious/moderate~~ Moderate sedation permit	$100
8. Deep sedation/general anesthesia permit	$100

C. Late fees.

1. Dental license - active	$100
2. Dental license - inactive	$50
3. Dental temporary resident's license	$15
4. Oral maxillofacial surgeon registration	$55
5. Cosmetic procedures certification	$35
6. ~~Conscious/moderate~~ Moderate sedation permit	$35
7. Deep sedation/general anesthesia permit	$35

D. Reinstatement fees.

1. Dental license - expired	$500
2. Dental license - suspended	$750
3. Dental license - revoked	$1000
4. Oral maxillofacial surgeon registration	$350
5. Cosmetic procedures certification	$225

E. Document fees.

1. Duplicate wall certificate	$60
2. Duplicate license	$20
3. License certification	$35

F. Other fees.

1. Returned check fee	$35
2. Practice inspection fee	$350

G. No fee will be refunded or applied for any purpose other than the purpose for which the fee is submitted.

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

1. Dentist - active	$210
2. Dentist - inactive	$105
3. Dental full-time faculty	$210
4. Temporary resident	$25
5. Dental restricted volunteer	$10
6. Oral/maxillofacial surgeon registration	$130
7. Cosmetic procedure certification	$75
8. ~~Conscious/moderate~~ Moderate sedation certification	$75
9. Deep sedation/general anesthesia	$75
10. Mobile clinic/portable operation	$110

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

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

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

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

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

B. Every patient record shall include the following:

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

2. A health history taken at the initial appointment that is updated (i) when analgesia, sedation, or anesthesia is to be administered; (ii) when medically indicated; and (iii) at least annually;

3. Diagnosis and options discussed, including the risks and benefits of treatment or nontreatment and the estimated cost of treatment options;

4. Consent for treatment obtained and treatment rendered;

5. List of drugs prescribed, administered, or dispensed and the route of administration, quantity, dose, and strength;

6. Radiographs, digital images, and photographs clearly labeled with patient name, date taken, and teeth identified;

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

8. Duplicate laboratory work orders that meet the requirements of § 54.1-2719 of the Code including the address and signature of the dentist;

9. Itemized patient financial records as required by § 54.1-2404 of the Code;

10. A notation or documentation of an order required for treatment of a patient by a dental hygienist practicing under general supervision as required in 18VAC60-21-140 B; and

11. The information required for the administration of ~~conscious/moderate~~ moderate sedation, deep sedation, and general anesthesia required in 18VAC60-21-260 D.

C. A licensee shall comply with the patient record confidentiality, release, and disclosure provisions of § 32.1-127.1:03 of the Code and shall only release patient information as authorized by law.

D. Records shall not be withheld because the patient has an outstanding financial obligation.

E. A reasonable cost-based fee may be charged for copying patient records to include the cost of supplies and labor for copying documents, duplication of radiographs and images, and postage if mailing is requested as authorized by § 32.1-127.1:03 of the Code. The charges specified in § 8.01-413 of the Code are permitted when records are subpoenaed as evidence for purposes of civil litigation.

F. When closing, selling, or relocating a practice, the licensee shall meet the requirements of § 54.1-2405 of the Code for giving notice and providing records.

G. Records shall not be abandoned or otherwise left in the care of someone who is not licensed by the board except that, upon the death of a licensee, a trustee or executor of the estate may safeguard the records until they are transferred to a licensed dentist, are sent to the patients of record, or are destroyed.

H. Patient confidentiality must be preserved when records are destroyed.

18VAC60-21-130. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue except a dental hygienist performing gingival curettage as provided in 18VAC60-21-140;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-25-100, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

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

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

6. Administering and monitoring ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthetics except as provided for in § 54.1-2701 of the Code and Part VI (18VAC60-21-260 et seq.) of this chapter;

7. Condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-30-120;

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

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

Part V

Licensure Renewal

18VAC60-21-240. License renewal and reinstatement.

A. The license or permit of any person who does not return the completed renewal form and fees by the deadline shall automatically expire and become invalid, and his practice of dentistry shall be illegal. With the exception of practice with a current, restricted volunteer license as provided in § 54.1-2712.1 of the Code practicing in Virginia with an expired license or permit may subject the licensee to disciplinary action by the board.

B. Every person holding an active or inactive license and those holding a permit to administer ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthesia shall annually, on or before March 31, renew his license or permit. Every person holding a faculty license, temporary resident's license, a restricted volunteer license, or a temporary permit shall, on or before June 30, request renewal of his license.

C. Any person who does not return the completed form and fee by the deadline required in subsection B of this section shall be required to pay an additional late fee.

D. The board shall renew a license or permit if the renewal form, renewal fee, and late fee are received within one year of the deadline required in subsection B of this section provided that no grounds exist to deny said renewal pursuant to § 54.1-2706 of the Code and Part II (18VAC60-21-50 et seq.) of this chapter.

E. Reinstatement procedures.

1. Any person whose license or permit has expired for more than one year or whose license or permit has been revoked or suspended and who wishes to reinstate such license or permit shall submit a reinstatement application and the reinstatement fee. The application must include evidence of continuing competence.

2. To evaluate continuing competence, the board shall consider (i) hours of continuing education that meet the requirements of subsection H of 18VAC60-21-250; (ii) evidence of active practice in another state or in federal service; (iii) current specialty board certification; (iv) recent passage of a clinical competency examination accepted by the board; or (v) a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association.

3. The executive director may reinstate such expired license or permit provided that the applicant can demonstrate continuing competence, the applicant has paid the

reinstatement fee and any fines or assessments, and no grounds exist to deny said reinstatement pursuant to § 54.1-2706 of the Code and Part II (18VAC60-21-50 et seq.) of this chapter.

18VAC60-21-250. Requirements for continuing education.

A. A dentist shall complete a minimum of 15 hours of continuing education, which meets the requirements for content, sponsorship, and documentation set out in this section, for each annual renewal of licensure except for the first renewal following initial licensure and for any renewal of a restricted volunteer license.

1. All renewal applicants shall attest that they have read and understand and will remain current with the laws and regulations governing the practice of dentistry and dental hygiene in Virginia.

2. A dentist shall maintain current training certification in basic cardiopulmonary resuscitation with hands-on airway training for health care providers or basic life support unless he is required by 18VAC60-21-290 or 18VAC60-21-300 to hold current certification in advanced life support with hands-on simulated airway and megacode training for health care providers.

3. A dentist who administers or monitors patients under general anesthesia, deep sedation, or ~~conscious/moderate~~ moderate sedation shall complete four hours every two years of approved continuing education directly related to administration and monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.

4. Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.

5. Up to two hours of the 15 hours required for annual renewal may be satisfied through delivery of dental services, without compensation, to low-income individuals receiving

health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.

B. To be accepted for license renewal, continuing education programs shall be directly relevant to the treatment and care of patients and shall be:

1. Clinical courses in dentistry and dental hygiene; or

2. Nonclinical subjects that relate to the skills necessary to provide dental or dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, and stress management). Courses not acceptable for the purpose of this subsection include~~, but are not limited to,~~ estate planning, financial planning, investments, business management, marketing, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any course, to include audio and video presentations, that meets the requirements in subsection B of this section and is given by one of the following sponsors:

1. The American Dental Association and the National Dental Association, their constituent and component/branch associations, and approved continuing education providers;

2. The American Dental Hygienists' Association and the National Dental Hygienists Association, and their constituent and component/branch associations;

3. The American Dental Assisting Association and its constituent and component/branch associations;

4. The American Dental Association specialty organizations and their constituent and component/branch associations;

5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;

6. The Academy of General Dentistry, its constituent and component/branch associations, and approved continuing education providers;

7. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Healthcare Organizations;

8. The American Heart Association, the American Red Cross, the American Safety and Health Institute, and the American Cancer Society;

9. A medical school accredited by the American Medical Association's Liaison Committee for Medical Education;

10. A dental, dental hygiene, or dental assisting program or advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association;

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic Education and Research Foundation;

14. The Dental Assisting National Board and its affiliate, the Dental Auxiliary Learning and Education Foundation; or

15. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, Council of

Interstate Testing Agencies, or Western Regional Examining Board) when serving as an examiner.

D. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted prior to renewal of the license.

E. The board may grant an extension for up to one year for completion of continuing education upon written request with an explanation to the board prior to the renewal date.

F. A licensee is required to verify compliance with the continuing education requirements in his annual license renewal. Following the renewal period, the board may conduct an audit of licensees to verify compliance. Licensees selected for audit must provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

G. All licensees are required to maintain original documents verifying the date and subject of the program or activity, the sponsor, and the amount of time earned. Documentation shall be maintained for a period of four years following renewal.

H. A licensee who has allowed his license to lapse, or who has had his license suspended or revoked, shall submit evidence of completion of continuing education equal to the requirements for the number of years in which his license has not been active, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months preceding an application for reinstatement.

I. Continuing education hours required by board order shall not be used to satisfy the continuing education requirement for license renewal or reinstatement.

J. Failure to comply with continuing education requirements may subject the licensee to disciplinary action by the board.

Part VI

Controlled Substances, Sedation, and Anesthesia

18VAC60-21-260. General provisions.

A. Application of Part VI. This part applies to prescribing, dispensing, and administering controlled substances in dental offices, mobile dental facilities, and portable dental operations and shall not apply to administration by a dentist practicing in (i) a licensed hospital as defined in § 32.1-123 of the Code, (ii) a state-operated hospital, or (iii) a facility directly maintained or operated by the federal government.

B. Registration required. Any dentist who prescribes, administers, or dispenses Schedules II through V controlled drugs must hold a current registration with the federal Drug Enforcement Administration.

C. Patient evaluation required.

1. The decision to administer controlled drugs for dental treatment must be based on a documented evaluation of the health history and current medical condition of the patient in accordance with the Class I through V risk category classifications of the American Society of Anesthesiologists (ASA) in effect at the time of treatment. The findings of the evaluation, the ASA risk assessment class assigned, and any special considerations must be recorded in the patient's record.

2. Any level of sedation and general anesthesia may be provided for a patient who is ASA Class I and Class II.

3. A patient in ASA Class III shall only be provided minimal sedation, ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthesia by:

a. A dentist after he has documented a consultation with the patient's primary care physician or other medical specialist regarding potential risks and special monitoring requirements that may be necessary;

b. An oral and maxillofacial surgeon who has performed a physical evaluation and documented the findings and the ASA risk assessment category of the patient and any special monitoring requirements that may be necessary; or

c. A person licensed under Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1 of the Code who has a specialty in anesthesia.

4. Minimal sedation may only be provided for a patient who is in ASA Class IV by:

a. A dentist after he has documented a consultation with the patient's primary care physician or other medical specialist regarding potential risks and special monitoring requirements that may be necessary; or

b. An oral and maxillofacial surgeon who has performed a physical evaluation and documented the findings and the ASA risk assessment category of the patient and any special monitoring requirements that may be necessary.

5. ~~Conscious/moderate~~ Moderate sedation, deep sedation, or general anesthesia shall not be provided in a dental office for patients in ASA Class IV and Class V.

D. Additional requirements for patient information and records. In addition to the record requirements in 18VAC60-21-90, when ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthesia is administered, the patient record shall also include:

1. Notation of the patient's American Society of Anesthesiologists classification;

2. Review of medical history and current conditions, including the patient's weight and height or, if appropriate, the body mass index;

3. Written informed consent for administration of sedation and anesthesia and for the dental procedure to be performed;

4. Preoperative vital signs;

5. A record of the name, dose, and strength of drugs and route of administration including the administration of local anesthetics with notations of the time sedation and anesthesia were administered;

6. Monitoring records of all required vital signs and physiological measures recorded every five minutes; and

7. A list of staff participating in the administration, treatment, and monitoring including name, position, and assigned duties.

E. Pediatric patients. No sedating medication shall be prescribed for or administered to a patient 12 years of age or younger prior to his arrival at the dentist office or treatment facility.

F. Informed written consent. Prior to administration of any level of sedation or general anesthesia, the dentist shall discuss the nature and objectives of the planned level of sedation or general anesthesia along with the risks, benefits, and alternatives and shall obtain informed, written consent from the patient or other responsible party for the administration and for the treatment to be provided. The written consent must be maintained in the patient record.

G. Level of sedation. The determinant for the application of the rules for any level of sedation or for general anesthesia shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type, strength, and dosage of medication, the method of administration, and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render the unintended reduction of or loss of consciousness unlikely, factoring in titration and the patient's age, weight, and ability to metabolize drugs.

H. Emergency management.

1. If a patient enters a deeper level of sedation than the dentist is qualified and prepared to provide, the dentist shall stop the dental procedure until the patient returns to and is stable at the intended level of sedation.

2. A dentist in whose office sedation or anesthesia is administered shall have written basic emergency procedures established and staff trained to carry out such procedures.

I. Ancillary personnel. Dentists who employ unlicensed, ancillary personnel to assist in the administration and monitoring of any form of minimal sedation, ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthesia shall maintain documentation that such personnel have:

1. Training and hold current certification in basic resuscitation techniques with hands-on airway training for health care providers, such as Basic Cardiac Life Support for Health Professionals or a clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18VAC60-21-250 C; or

2. Current certification as a certified anesthesia assistant (CAA) by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology (ADSA).

J. Assisting in administration. A dentist, consistent with the planned level of administration (i.e., local anesthesia, minimal sedation, ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthesia) and appropriate to his education, training, and experience, may utilize the services of a dentist, anesthesiologist, certified registered nurse anesthetist, dental hygienist, dental assistant, or nurse to perform functions appropriate to such practitioner's education, training, and experience and consistent with that practitioner's respective scope of practice.

K. Patient monitoring.

1. A dentist may delegate monitoring of a patient to a dental hygienist, dental assistant, or nurse who is under his direction or to another dentist, anesthesiologist, or certified registered nurse anesthetist. The person assigned to monitor the patient shall be continuously in the presence of the patient in the office, operatory, and recovery area (i) before administration is initiated or immediately upon arrival if the patient self-administered a sedative agent, (ii) throughout the administration of drugs, (iii) throughout the treatment of the patient, and (iv) throughout recovery until the patient is discharged by the dentist.

2. The person monitoring the patient shall:

a. Have the patient's entire body in sight;

b. Be in close proximity so as to speak with the patient;

c. Converse with the patient to assess the patient's ability to respond in order to determine the patient's level of sedation;

d. Closely observe the patient for coloring, breathing, level of physical activity, facial expressions, eye movement, and bodily gestures in order to immediately recognize and bring any changes in the patient's condition to the attention of the treating dentist; and

e. Read, report, and record the patient's vital signs and physiological measures.

L. A dentist who allows the administration of general anesthesia, deep sedation, or ~~conscious/moderate~~ moderate sedation in his dental office is responsible for assuring that:

1. The equipment for administration and monitoring, as required in subsection B of 18VAC60-21-291 or subsection C of 18VAC60-21-301, is readily available and in good working order prior to performing dental treatment with anesthesia or sedation. The

equipment shall either be maintained by the dentist in his office or provided by the anesthesia or sedation provider; and

2. The person administering the anesthesia or sedation is appropriately licensed and the staff monitoring the patient is qualified.

18VAC60-21-290. Requirements for a ~~conscious/moderate~~ moderate sedation permit.

A. ~~After March 31, 2013, no~~ No dentist may employ or use ~~conscious/moderate~~ moderate sedation in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the board with reports that result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.

B. Automatic qualification. Dentists who hold a current permit to administer deep sedation and general anesthesia may administer ~~conscious/moderate~~ moderate sedation.

C. To determine eligibility for a ~~conscious/moderate~~ moderate sedation permit, a dentist shall submit the following:

1. A completed application form ~~indicating one of the following permits for which the applicant is qualified:~~

~~a. Conscious/moderate sedation by any method;~~

~~b. Conscious/moderate sedation by enteral administration only; or~~

~~c. Temporary conscious/moderate sedation permit (may be renewed one time)~~;

2. The application fee as specified in 18VAC60-21-40;

3. A copy of a transcript, certification, or other documentation of training content that meets the educational and training qualifications as specified in subsection D of this section~~, as applicable~~; and

4. A copy of current certification in advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) as required in subsection E of this section.

D. Education requirements for a permit to administer ~~conscious/moderate~~ moderate sedation. ~~1. Administration by any method.~~ A dentist may be issued a ~~conscious/moderate~~ moderate sedation permit to administer by any method by meeting one of the following criteria:

~~a.~~ 1. Completion of training for this treatment modality according to the ADA's Guidelines for Teaching ~~the Comprehensive~~ Pain Control ~~of Anxiety~~ and ~~Pain in Dentistry~~ Sedation to Dentists and Dental Students in effect at the time the training occurred, while enrolled in an accredited dental program or while enrolled in a post-doctoral university or teaching hospital program; or

~~b.~~ 2. Completion of a continuing education course that meets the requirements of 18VAC60-21-250 and consists of (i) 60 hours of didactic instruction plus the management of at least 20 patients per participant, (ii) demonstration of competency and clinical experience in ~~conscious/moderate~~ moderate sedation, and (iii) management of a compromised airway. The course content shall be consistent with the ADA's Guidelines for Teaching ~~the Comprehensive~~ Pain Control ~~of Anxiety~~ and ~~Pain in Dentistry~~ Sedation to Dentists and Dental Students in effect at the time the training occurred.

~~2. Enteral administration only. A dentist may be issued a conscious/moderate sedation permit to administer only by an enteral method if he has completed a continuing education program that meets the requirements of 18VAC60-21-250 and consists of not less than 18 hours of didactic instruction plus 20 clinically oriented experiences in enteral or a~~

~~combination of enteral and nitrous oxide/oxygen conscious/moderate sedation techniques. The course content shall be consistent with the ADA's Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry in effect at the time the training occurred. The certificate of completion and a detailed description of the course content must be maintained.~~

~~3. A dentist who self-certified his qualifications in anesthesia and moderate sedation prior to January 1989 may be issued a temporary conscious/moderate sedation permit to continue to administer only conscious/moderate sedation until May 7, 2015. After May 7, 2015, a dentist shall meet the requirements for and obtain a conscious/moderate sedation permit to administer by any method or by enteral administration only.~~

E. Additional training required. Dentists who administer ~~conscious/moderate~~ moderate sedation shall:

1. Hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers, such as ACLS or PALS as evidenced by a certificate of completion posted with the dental license; and

2. Have current training in the use and maintenance of the equipment required in 18VAC60-21-291.

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

A. Delegation of administration.

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

shall use a qualified dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer such sedation.

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

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

~~b.~~ A dentist with the training required by 18VAC60-21-290 D ~~1~~ to administer by any method and who holds a moderate sedation permit;

~~c.~~ b. An anesthesiologist;

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

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

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

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

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

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

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

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

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

B. Equipment requirements. A dentist who administers ~~conscious/moderate~~ moderate sedation shall have available the following equipment in sizes for adults or children as appropriate for the patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

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

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

5. Pulse oximetry;

6. Blood pressure monitoring equipment;

7. Pharmacologic antagonist agents;

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

9. Mechanical (hand) respiratory bag;

10. Appropriate emergency drugs for patient resuscitation;

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

12. Defibrillator;

13. Suction apparatus;

14. Temperature measuring device;

15. Throat pack;

16. Precordial or pretracheal stethoscope; and

17. An end-tidal carbon dioxide monitor (capnograph).

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

D. Monitoring requirements.

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

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

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

E. Discharge requirements.

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

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

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

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

Part II

Practice of Dental Hygiene

18VAC60-25-40. Scope of practice.

A. Pursuant to § 54.1-2722 of the Code, a licensed dental hygienist may perform services that are educational, diagnostic, therapeutic, or preventive under the direction and indirect or general supervision of a licensed dentist.

B. The following duties of a dentist shall not be delegated:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue, except as may be permitted by subdivisions C 1 and D 1 of this section;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist who meets the requirements of 18VAC60-25-100 C may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

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

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

6. Administration of deep sedation or general anesthesia and ~~conscious/moderate~~ moderate sedation;

7. Condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-30-120;

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

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

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

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

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

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

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

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

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

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

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

5. Duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist, with the exception of those listed as nondelegable in subsection B of this section and those restricted to indirect supervision in subsection C of this section.

E. The following duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II:

1. Performing pulp capping procedures;

2. Packing and carving of amalgam restorations;

3. Placing and shaping composite resin restorations with a slow speed handpiece;

4. Taking final impressions;

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

6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

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

18VAC60-25-190. Requirements for continuing education.

A. In order to renew an active license, a dental hygienist shall complete a minimum of 15 hours of approved continuing education. Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.

1. A dental hygienist shall be required to maintain evidence of successful completion of a current hands-on course in basic cardiopulmonary resuscitation for health care providers.

2. A dental hygienist who monitors patients under general anesthesia, deep sedation, or ~~conscious/moderate~~ moderate sedation shall complete four hours every two years of approved continuing education directly related to monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.

3. Up to two hours of the 15 hours required for annual renewal may be satisfied through delivery of dental hygiene services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.

B. An approved continuing education program shall be relevant to the treatment and care of patients and shall be:

1. Clinical courses in dental or dental hygiene practice; or

2. Nonclinical subjects that relate to the skills necessary to provide dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, risk management, and recordkeeping). Courses not acceptable for the purpose of this subsection include~~, but are not limited to,~~ estate planning, financial planning, investments, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any course, to include audio and video presentations, that meets the requirements in subdivision B 1 of this section and is given by one of the following sponsors:

1. The American Dental Association and the National Dental Association and their constituent and component/branch associations;

2. The American Dental Hygienists' Association and the National Dental Hygienists Association and their constituent and component/branch associations;

3. The American Dental Assisting Association and its constituent and component/branch associations;

4. The American Dental Association specialty organizations and their constituent and component/branch associations;

5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;

6. The Academy of General Dentistry and its constituent and component/branch associations;

7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;

8. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Healthcare Organizations;

9. The American Heart Association, the American Red Cross, the American Safety and Health Institute, and the American Cancer Society;

10. A medical school accredited by the American Medical Association's Liaison Committee for Medical Education or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association;

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic Education and Research Foundation;

14. The Dental Assisting National Board and its affiliate, the Dental Auxiliary Learning and Education Foundation;

15. The American Academy of Dental Hygiene, its constituent and component/branch associations; or

16. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, Council of Interstate Testing Agencies, or Western Regional Examining Board) when serving as an examiner.

D. Verification of compliance.

1. All licensees are required to verify compliance with continuing education requirements at the time of annual license renewal.

2. Following the renewal period, the board may conduct an audit of licensees to verify compliance.

3. Licensees selected for audit shall provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

4. Licensees are required to maintain original documents verifying the date and the subject of the program or activity, the sponsor, and the amount of time earned. Documentation shall be maintained for a period of four years following renewal.

5. Failure to comply with continuing education requirements may subject the licensee to disciplinary action by the board.

E. Exemptions.

1. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following the licensee's initial licensure.

2. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted at least 30 days prior to the deadline for renewal.

F. The board may grant an extension for up to one year for completion of continuing education upon written request with an explanation to the board prior to the renewal date.

G. Continuing education hours required by board order shall not be used to satisfy the continuing education requirement for license renewal or reinstatement.

18VAC60-30-50. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue except a dental hygienist performing gingival curettage as provided in 18VAC60-21-140;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist who meets the requirements of 18VAC60-25-100 may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

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

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

6. Administering and monitoring ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthetics except as provided for in § 54.1-2701 of the Code and subsections J and K of 18VAC60-21-260;

7. Condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-30-120;

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

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

Agenda Item: Board Action on Regulations for Remote Supervision

Included in your agenda package are:

A copy of emergency regulations currently in effect on the continuing education course required for a dental hygienist to practice under remote supervision

Copy of comment on the Notice of Intended Regulatory Action to replace the emergency regulation

Board action:

Adoption of proposed regulations to replace the emergency regulation on CE for practice by dental hygienists under remote supervision.

Motion to read:

"I move that the Board adopt the amendments to 18VAC60-25-190 to replace the emergency regulation currently in effect."

Project 5208 - Proposed

BOARD OF DENTISTRY

Continuing education for practice by remote supervision

18VAC60-25-190. Requirements for continuing education.

A. In order to renew an active license, a dental hygienist shall complete a minimum of 15 hours of approved continuing education. Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.

1. A dental hygienist shall be required to maintain evidence of successful completion of a current hands-on course in basic cardiopulmonary resuscitation for health care providers.

2. A dental hygienist who monitors patients under general anesthesia, deep sedation, or conscious/moderate sedation shall complete four hours every two years of approved continuing education directly related to monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.

3. Up to two hours of the 15 hours required for annual renewal may be satisfied through delivery of dental hygiene services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.

B. An approved continuing education program shall be relevant to the treatment and care of patients and shall be:

1. Clinical courses in dental or dental hygiene practice; or

2. Nonclinical subjects that relate to the skills necessary to provide dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, risk management, and recordkeeping). Courses not acceptable for the purpose of this subsection include, but are not limited to, estate planning, financial planning, investments, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any course, to include audio and video presentations, that meets the requirements in subdivision B 1 of this section and is given by one of the following sponsors:

1. The American Dental Association and the National Dental Association and their constituent and component/branch associations;

2. The American Dental Hygienists' Association and the National Dental Hygienists Association and their constituent and component/branch associations;

3. The American Dental Assisting Association and its constituent and component/branch associations;

4. The American Dental Association specialty organizations and their constituent and component/branch associations;

5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;

6. The Academy of General Dentistry and its constituent and component/branch associations;

7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;

8. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Healthcare Organizations;

9. The American Heart Association, the American Red Cross, the American Safety and Health Institute, and the American Cancer Society;

10. A medical school accredited by the American Medical Association's Liaison Committee for Medical Education or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association;

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic Education and Research Foundation;

14. The Dental Assisting National Board and its affiliate, the Dental Auxiliary Learning and Education Foundation;

15. The American Academy of Dental Hygiene, its constituent and component/branch associations; or

16. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, Council of Interstate Testing Agencies, or Western Regional Examining Board) when serving as an examiner.

D. Verification of compliance.

1. All licensees are required to verify compliance with continuing education requirements at the time of annual license renewal.

2. Following the renewal period, the board may conduct an audit of licensees to verify compliance.

3. Licensees selected for audit shall provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

4. Licensees are required to maintain original documents verifying the date and the subject of the program or activity, the sponsor, and the amount of time earned. Documentation shall be maintained for a period of four years following renewal.

5. Failure to comply with continuing education requirements may subject the licensee to disciplinary action by the board.

E. Exemptions.

1. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following the licensee's initial licensure.

2. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted at least 30 days prior to the deadline for renewal.

F. The board may grant an extension for up to one year for completion of continuing education upon written request with an explanation to the board prior to the renewal date.

G. Continuing education hours required by board order shall not be used to satisfy the continuing education requirement for license renewal or reinstatement.

H. In order to practice under remote supervision in accordance with subsection F of § 54.1-2722 of the Code of Virginia, a dental hygienist shall complete a continuing education course of

no less than two hours in duration that is offered by an accredited dental education program or a sponsor listed in subsection C of this section and that includes the following course content:

1. Intent and definitions of remote supervision;

2. Review of dental hygiene scope of practice and delegation of services;

3. Administration of controlled substances;

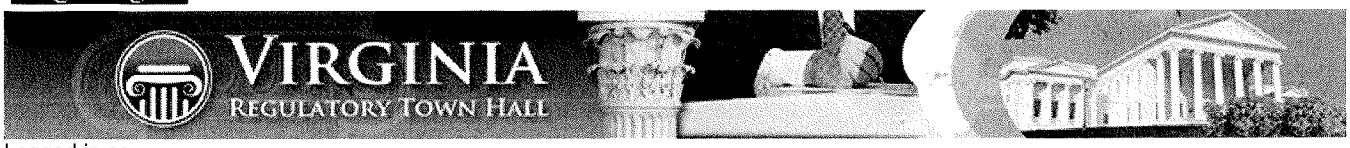
4. Patient records, documentation, and risk management;

5. Remote supervision laws for dental hygienists and dentists;

6. Written practice protocols; and

7. Settings allowed for remote supervision.

Virginia.gov Agencies | Governor



Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter **Regulations Governing the Practice of Dental Hygienists [18 VAC 60 - 25]**

Action	**Continuing education for practice by remote supervision**
Stage	**Emergency/NOIRA**
Comment Period	Ends 12/27/2017

Back to List of Comments

Commenter: Lauren Schmitt, Virginia Dental Hygienists' Association 12/13/17 10:20 am

Public Comment on continuing education for practice by remote supervision

The Virginia Dental Hygienists' Association (VDHA) would like to express our support for the Notice of Intended Regulatory Action (NOIRA) for regulations regarding remote supervision continuing education.

We believe the proposed language outlines thorough and appropriate course content to ensure dental hygienists are prepared to practice in remotely supervised settings. The VDHA has been a long-standing proponent of improving access to dental care by expanding the settings in which dental hygienists may practice under remote supervision. Allowing dental hygienists to practice as an employee and/or volunteer with a supervising dental for remote supervision will help to ease challenges for the underserved to access high quality oral health care. We were pleased to work with the Virginia Dental Association to pass legislation in 2016 and this past General Assembly session to do just this.

The NOIRA for the continuing education course requirements is an important next step in implementing this new law. Thank you for the opportunity to submit comments and for allowing us to engage in this regulatory process.

Guidance Document: 60- Adopted:

Virginia Board of Dentistry

Policy on Clinical Examinations Acceptable to the Board

Excerpts of Applicable Law, Regulation and Guidance

- An application for a license to practice dentistry shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant, among other requirements, has successfully completed a clinical examination acceptable to the Board and has met other qualifications as determined in regulations promulgated by the Board, §54.1-2709.B(iv) and (v).
- The Board may grant a license to practice dentistry to an applicant licensed to practice in another jurisdiction if the applicant, among other requirements, meets the requirements of §54.1-2709.B, §54.1-2709.C(1).
- All applicants for dental licensure by examination shall have, among other requirements, passed a dental clinical competency examination that is accepted by the Board, 18 VAC 60-21-210.A(1)(b).
- All applicants for dental licensure by credentials shall have, among other requirements, successfully completed a clinical competency examination acceptable to the Board, 18 VAC 60-21-210.B(2).
- An **original** score card or report from the testing agency documenting passage of a clinical examination involving live patients is required. Candidate's score cards are not acceptable. ***All score cards or reports must be requested by the applicant.*** (Canadian exams are not accepted.) Certificates are not accepted.
- The determination

Applications for dental licensure by Examination

- **If applying by examination**, the examination results accepted are: SRTA from any year; CRDTS, WREB (request a detailed report) or NERB/CDCA if taken after January 1, 2005; CITA if taken after September 1, 2007; and ADEX if taken after January 1, 2012. ***All examinations taken after December 7, 2012[1] must include, at a minimum, sections on Endodontics; Prosthodontics; and operative dentistry consisting of a Posterior Class II and Anterior Class III restorations.***

Applications for dental licensure by Credentials

- **If applying by credentials**, the examinations results accepted are CRDTS, WREB, NERB/CDCA, CITA and ADEX and the results of state administered examinations are accepted when the scorecard or report shows that testing included live patients. ***All examinations taken after December 7, 2012 must include, at a minimum, sections on Endodontics, Prosthodontics, and operative dentistry consisting of a Posterior Class II and Anterior Class III restorations.***

[1] At the December 7, 2012 Board Business Meeting, the Board voted that only the periodontal portion of the ADEX clinical examination not be required. As such, the periodontal portion is not required of any clinical examination accepted by the Virginia Board of Dentistry.

Practice of a Dental Hygienist under Remote Supervision

References from § 54.1-2722 of the Code of Virginia

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

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

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

   A dentist who holds an active, ~~**unrestricted**~~ license issued by the Virginia Board of Dentistry and who has a dental office physically located in the Commonwealth~~**, which includes**~~ **including** dental offices maintained by a federally qualified health center, charitable safety net facility, free clinic, long-term care facility, elementary or secondary school, Head Start program, or women, infants, and children (WIC) program.

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

   The hygienist must have (i) completed a continuing education course designed to develop the competencies needed to provide care under remote supervision offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of clinical experience.

4. **What is required for a continuing education course in remote supervision?**

   The Board ~~**has proposed regulations that will**~~ require**s** a remote supervision course to be no less than two hours in duration and to be offered by an accredited dental education program or an approved sponsor listed in the regulation. The ~~**proposed regulation will**~~ required ~~**the**~~ course content ~~**to include**~~ **is**: a) Intent and definitions of remote supervision; b) Review of dental hygiene scope of practice and delegation of services; c) Administration of controlled substances; d) Patient records/documentation/risk management; e) Remote supervision laws for dental hygienists and dentists; f) Written practice protocols; and g) Settings allowed for remote supervision.

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

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

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

A hygienist can only practice dental hygiene under remote supervision at a community health center, charitable safety net facility, free clinic, long-term care facility, elementary or secondary school, Head Start program, or women, infants, and children (WIC) program, **including a mobile facility or portable dental operation that is operated by one of these settings.**

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

A hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer ~~**topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine**~~ **Schedule VI topical drugs including topical oral flourides, topical oral anesthetics and topical and directly applied antimicrobial agents** pursuant to subsections **J** and V of §**54.1-3408 of the Code of Virginia**, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation.

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

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

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

Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal confirmation from the patient that he does not have a dentist of record whom he is seeing regularly.

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

a) After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision may provide further dental hygiene services following a written practice protocol developed and provided by the supervising dentist. Such

written practice protocol shall consider, at a minimum, the medical complexity of the patient and the presenting signs and symptoms of oral disease.

b) A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a diagnosis and treatment plan for the patient and either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient.

c) The supervising dentist shall review a patient's records at least once every 10 months.

11. Can a dental hygienist see a patient beyond 90 days if the patient has not seen a dentist?

Only if the supervising dentist authorizes such treatment to address an emergent circumstance requiring dental hygiene treatment. The practice protocol developed by the supervising dentist is the initial authorization for a hygienist to provide hygiene treatment under remote supervision for 90 days of treatment. After that 90 day period (absent emergent circumstances), the supervising dentist (or another dentist) must examine the patient, develop a diagnosis and establish the treatment plan for the patient which might address both future dental treatment and dental hygiene treatment and the time spans for such treatment. The dentist decides how often he will see a patient in accord with his professional judgment of the patient's dental needs and the resulting treatment plan. In addition, by statute the dentist must review the patient's records at a minimum of every 10 months. Treatment planning and record review are two distinct requirements.

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

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

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

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

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

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

person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services to assist with the administration of insulin or to administer glucagon to a person diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia, provided such employee or person providing services has been trained in the administration of insulin and glucagon.

I. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, by (i) licensed pharmacists, (ii) registered nurses, or (iii) licensed practical nurses under the supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist, nurse, or designated emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health under the direction of an operational medical director when the prescriber is not physically present. The emergency medical services provider shall provide documentation of the vaccines to be recorded in the Virginia Immunization Information System.

J. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry.

In addition, a dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia.

K. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered professional nurses certified as sexual assault nurse examiners-A (SANE-A) under his supervision and when he is not physically present to possess and administer preventive medications for victims of sexual assault as recommended by the Centers for Disease Control and Prevention.

L. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a prescriber's instructions pertaining to dosage, frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) an individual receiving services in a program licensed by the Department of Behavioral Health and Developmental Services; (ii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iii) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (iv) a program participant of an adult day-care center licensed by the Department of Social Services; (v) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services; (vi) a resident of a private children's residential facility, as defined in § 63.2-100 and licensed by the Department of Social Services, Department of Education, or Department of Behavioral Health and Developmental Services; or (vii) a student in a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education.

In addition, this section shall not prevent a person who has successfully completed a training program for the administration of drugs via percutaneous gastrostomy tube approved by the Board of Nursing and been evaluated by a registered nurse as having demonstrated competency in administration of drugs via percutaneous gastrostomy tube from administering drugs to a person receiving services from a program licensed by the Department of Behavioral Health and Developmental Services to such person via percutaneous gastrostomy tube. The continued competency of a person to administer drugs via percutaneous gastrostomy tube shall be evaluated semiannually by a registered nurse.

M. Medication aides registered by the Board of Nursing pursuant to Article 7 (§ 54.1-3041 et seq.) of Chapter 30 may administer drugs that would otherwise be self-administered to residents of any assisted living facility licensed by the Department of Social Services. A registered medication aide shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the assisted living facility's Medication Management Plan; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.

N. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with

written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

O. In addition, this section shall not prevent the administration of drugs by a person to (i) a child in a child day program as defined in § 63.2-100 and regulated by the State Board of Social Services or a local government pursuant to § 15.2-914, or (ii) a student of a private school that is accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education, provided such person (a) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, licensed practical nurse, nurse practitioner, physician assistant, doctor of medicine or osteopathic medicine, or pharmacist; (b) has obtained written authorization from a parent or guardian; (c) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; and (d) administers only those drugs that were dispensed from a pharmacy and maintained in the original, labeled container that would normally be self-administered by the child or student, or administered by a parent or guardian to the child or student.

P. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § 32.1-42.1 when (i) the Governor has declared a disaster or a state of emergency or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the State Health Commissioner.

Q. Nothing in this title shall prohibit the administration of normally self-administered drugs by unlicensed individuals to a person in his private residence.

R. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

S. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Board of Health Professions or persons authorized for provisional practice pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.), in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, nurse practitioner, or physician assistant and under the immediate and direct supervision of a licensed registered nurse. Nothing in this chapter shall be construed to prohibit a patient care dialysis technician trainee from performing dialysis care as part of and within the scope of the clinical skills instruction segment of a supervised dialysis technician training program, provided such trainee is identified as a "trainee" while working in a renal dialysis facility.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.).

T. Persons who are otherwise authorized to administer controlled substances in hospitals shall be authorized to administer influenza or pneumococcal vaccines pursuant to § 32.1-126.4.

U. Pursuant to a specific order for a patient and under his direct and immediate supervision, a prescriber may authorize the administration of controlled substances by personnel who have been properly trained to assist a doctor of medicine or osteopathic medicine, provided the method does not include intravenous, intrathecal, or epidural administration and the prescriber remains responsible for such administration.

V. A physician assistant, nurse or a dental hygienist may possess and administer topical fluoride varnish to the teeth of children aged six months to three years pursuant to an oral or written order or a standing protocol issued by a doctor of medicine, osteopathic medicine, or dentistry that conforms to standards adopted by the Department of Health.

W. A prescriber, acting in accordance with guidelines developed pursuant to § 32.1-46.02, may authorize the administration of influenza vaccine to minors by a licensed pharmacist, registered nurse, licensed practical nurse under the direction and immediate supervision of a registered nurse, or emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health when the prescriber is not physically present.

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ADANews

Current Issue

ADA appoints members to dental specialty commission

New group created to reduce potential bias, conflict of interest in recognition process

January 22, 2018

By Kimber Solana

The ADA announced Jan. 11 the members of a new commission established to oversee the decision-making process for recognizing dental specialties, an effort to reduce potential or perceived bias and conflict of interest in the process.

The ADA National Commission on Recognition of Dental Specialties and Certifying Boards is comprised of nine general dentists, appointed by the ADA Board of Trustees, and a dentist from each of the nine recognized specialties, appointed by the sponsoring organization.

The nine ADA appointees are: Drs. Joseph A. Battaglia; James D. Benz; Ralph A. Cooley; Alan E. Friedel; Kevin A. Henner; Denise L. Hering; Roger Kiesling; Charles H. Norman, III; and Mark Zust.

The specialty appointees are: Drs. Wayne A. Aldredge, American Academy of Periodontology; Don Altman, American Association of Public Health Dentistry; James M. Boyle III, American Association of Oral and Maxillofacial Surgery; Robert Delarosa, American Academy of Pediatric Dentistry; Anita Gohel, American Academy of Oral and Maxillofacial Radiology; William T. Johnson, American Association of Endodontists; Andrew J. Kwasny, American Association of Orthodontists; Frank J. Tuminelli, American College of Prosthodontists; and John M. Wright, American Association of Oral and Maxillofacial Pathology.

The establishment of the new commission will enhance the specialty recognition program that sets requirements designed to help dentists excel throughout their careers, and the public ascertain the importance of educationally qualified and board certified dental specialists, according to the ADA Board of Trustees report that accompanied Resolution 30H-2017, which the ADA 2017 House of Delegates approved in Atlanta.

The Board decided to explore a new commission after it charged the Task Force on Specialty and Specialty

Certifying Board Recognition to evaluate the process and criteria by which specialties and specialty certifying boards are recognized.

Previously, the ADA House of Delegates determined the recognition of dental specialties, organizations and certifying boards. According to the Board report, that process carried financial and reputational risks.

The new commission will be guided with a list of principles that include:

- The process must be grounded in objective standards that protect the public, nurture the art and science of dentistry and improve the quality of care.
- The process must serve to reduce potential bias or conflicts of interest, or the perception of bias or conflicts of interest, in the decision-making process.
- The process must include multiple steps, including provisions for appeal.

The commission is expected to hold its first meeting in late spring.

CODA
Commission on Dental Accreditation

CODA Alert

CODA Directs Elimination of "Specialty" Terminology

Dear CODA Community of Interest:

At its February 2, 2018 meeting, the Commission on Dental Accreditation (CODA) took action to remove the word *specialty* from all CODA documentation, as well as its website, and instead refer to all advanced dental education disciplines as *advanced education programs*. The Commission concluded that a revision to CODA's terminology was necessary based upon the following reasons:

- The terminology CODA uses is a carryover of the vocabulary used since 1975, when CODA assumed the policies of the Council on Dental Education and designated postdoctoral dental education programs as specialty programs, or general dentistry programs, based solely on the American Dental Association (ADA) Specialty Recognition Process. This does not reflect the changing environment of dental specialty recognition. In particular, over the past fifteen years, numerous state courts have determined that restricting specialty advertising to the "ADA Recognized Specialties" is restriction of free speech and restriction of trade. The Commission believes that the change in terminology decreases its legal risk in this area.
- The terminology change comports with the scope of the Commission, as recognized by the United States Department of Education (USDE), which does not include specific language to distinguish between "advanced" and "advanced specialty" disciplines within dentistry. The Commission's scope of recognition with the USDE is: *The accreditation of predoctoral dental education programs (leading to the D.D.S. or D.M.D. degree), advanced dental education programs, and allied dental education programs that are fully operational or have attained "Initial Accreditation" status, including programs offered via distance education.*
- The Commission is aware that there are misconceptions among many in the communities of interest of the role, if any, that the Commission plays in regards to specialty recognition. The change in terminology clarifies that the Commission accredits education programs, but does not designate which disciplines in dentistry are "specialties." The Commission's sole mission is to serve the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

At its Winter 2018 meeting, the Commission directed CODA staff to identify all necessary CODA materials to be revised, including CODA's *Rules*, policies and procedures, Accreditation Standards and supporting documents, and CODA's website. The Commission also directed staff to submit an Action Plan, to include a high-level schedule of all revisions and a strategy for communicating the implementation of these revisions to CODA's Communities of Interest. The Commission will consider this Action Plan at its Summer 2018 meeting, to be held August 2–3, 2018. The Commission will

continue to keep its communities of interest informed of progress made related to these revisions.

For questions about this Plan, please contact Dr. Sherin Tooks, director, Commission on Dental Accreditation, at tookss@ada.org

Quick Links

- Commission on Dental Accreditation
- Accreditation Standards
- CODA Staff
- Site Visit Information

This email was distributed to the Commission on Dental Accreditation's communities of interest.

JCNDE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

December 20, 2017

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

Dear Ms. Reen:

This is the second official notice regarding implementation of the Integrated National Board Dental Examination (INBDE). The Joint Commission on National Dental Examinations ("Joint Commission") is pleased to provide details concerning how and when implementation will occur, including the relevance to each state board of dentistry.

The Joint Commission has been working with subject matter experts since 2010 on the development of this innovative new examination program. INBDE content is focused on clinical relevance, and as such integrates knowledge and skills involving the biomedical, behavioral and clinical dental sciences. The purpose of the INBDE mirrors that of the National Board Dental Examination (NBDE) Parts I and II: to assist dental boards in determining the qualifications of individuals who seek licensure to practice dentistry. **The Joint Commission anticipates the INBDE will be available for administration on August 1, 2020, with full replacement of the National Board Dental Examination (NBDE) scheduled to occur by August 1, 2022.**

Details concerning the INBDE implementation plan are enclosed. Dates appearing in the plan represent a best-case scenario and are subject to change. The Joint Commission's website contains additional background information concerning the INBDE, as well as information concerning communications and presentations on this topic to dental boards and communities of interest since 2010.

To best prepare for the upcoming changes to the National Board Dental Examination program, the Joint Commission recommends your dental board undertake the following activities to learn about the INBDE and prepare to use it in licensure decision making:

- Prepare to accept candidates who have successfully completed the National Boards. This could occur under either of the following sequences: 1) INBDE or 2) NBDE Parts I and II.
- Prepare to receive INBDE results on the first day of its availability. Consider whether any modifications to practice acts, rules, policies, or procedures will be required.
- Review INBDE validity evidence and the results of field testing as these studies occur.
- Communicate information concerning the acceptability of the INBDE to future licensure candidates.

In addition to provision of the enclosed implementation plan, the Joint Commission regularly provides up-to-date information regarding the INBDE, its development, and the validity evidence that is available to date. We invite you to:

- Review and monitor INBDE information on the Joint Commission's website (www.ada.org/JCNDE/INBDE).
- Attend the annual National Dental Examiners' Advisory Forum (NDEAF).

Thank you for your consideration and attention to this important matter. If you have any questions, please contact the Joint Commission (nbexams@ada.org) and we will be happy to assist.

Sincerely,

Dr. Lisa Heinrich-Null
Chair, Joint Commission on National Dental Examinations

Enclosure

211 East Chicago Avenue Chicago, Illinois 60611-2637
Main 800.232.1694 Fax 312.587.4105 ADA.org/JCNDE

INBDE Implementation Plan and Recommended Actions

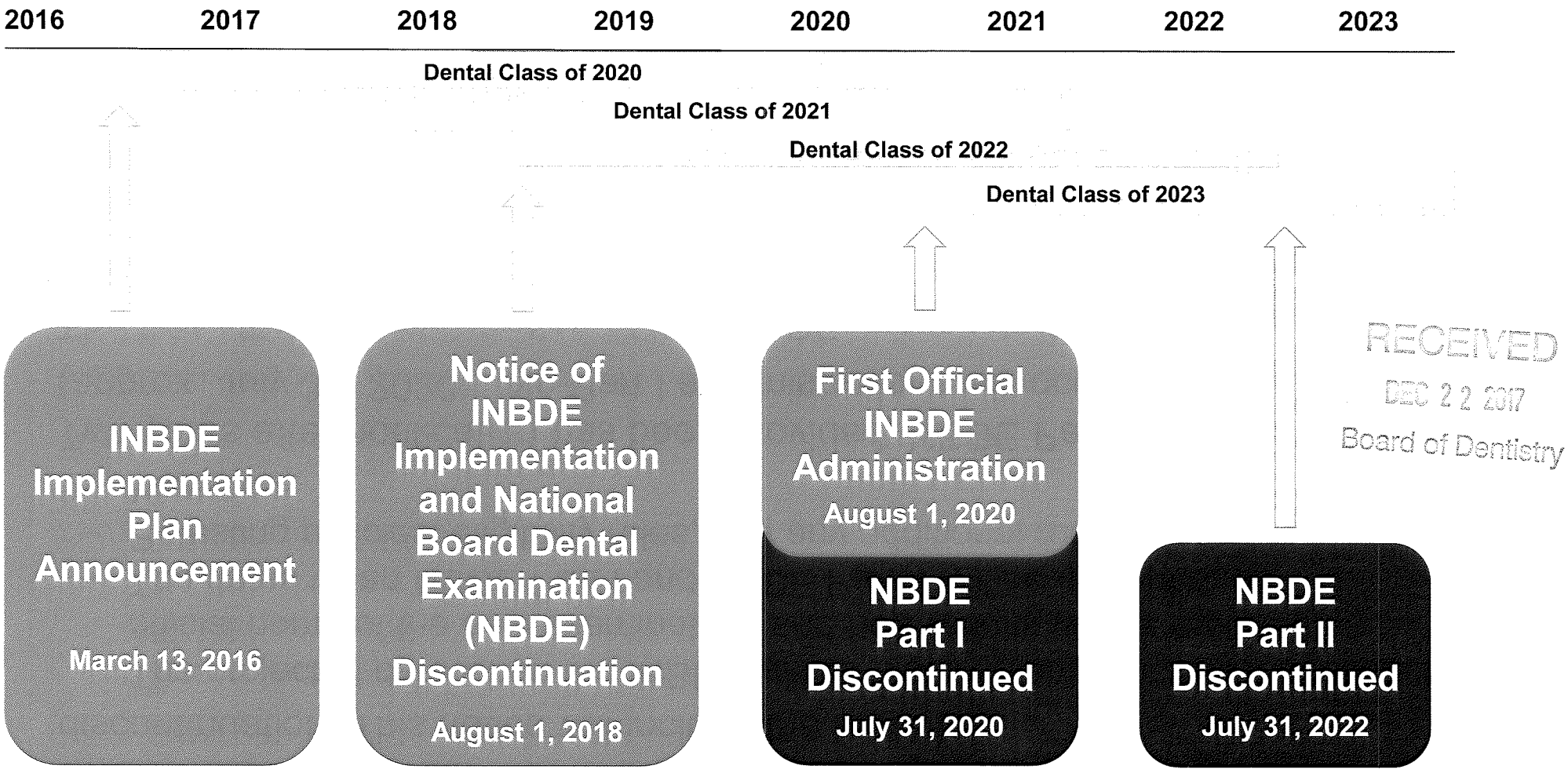
JCNDE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

March 2016

INBDE Implementation Plan

- The Integrated National Board Dental Examination (INBDE) is an examination that is currently in development by the Joint Commission on National Dental Examinations (JCNDE).
- The INBDE is intended to replace National Board Dental Examination (NBDE) Parts I and II. The INBDE is intended for use by state dental boards to help inform decision-making concerning the licensure of entry-level dentists.
- To address concerns from stakeholders and communities of interest regarding the timing of INBDE implementation, the JCNDE indicated it would provide four years' notice before the INBDE is implemented and the NBDE discontinued.
- The current presentation is designed to help address concerns regarding timing and provide this advance notification.
- This presentation provides stakeholders and communities of interest with information concerning how INBDE implementation will occur, the information that will be made available to help facilitate the transition, and recommended actions for stakeholders and communities of interest.
- The slide that follows shows key events associated with INBDE implementation, and the sequence of activity associated with the transition.

Integrated National Board Dental Examination (INBDE) Implementation Plan: "Best Case Scenario"



PRT: March 2016

Note: This implementation plan communicates the best case scenario. Dates presented should be interpreted as "no sooner than." Actual dates will be contingent upon field testing results. INBDE Practice Test Questions are anticipated for release in 2019.

INBDE Implementation Plan

- On August 1, 2018, the Joint Commission intends to provide stakeholders and communities of interest with notice of INBDE implementation and NBDE discontinuation. This notice will include the following:
  - The projected date when the INBDE will be first available for administration, the official name of the new examination, and how results will be reported.*
  - The dates when NBDE Part I and NBDE Part II will be discontinued.
  - Retesting policies, eligibility rules, and any additional rules needed to facilitate the transition.
- Two years after notification has been provided, NBDE Part I will be discontinued (approx. July 31, 2020). No Part I administrations will occur after this date.
- The first official administration of the INBDE is expected to take place on August 1, 2020.
- Two years after NBDE Part I is discontinued, NBDE Part II will be discontinued (approx. July 31, 2022). No Part II administrations will occur after this date.
- Notification of INBDE implementation and NBDE discontinuation is contingent upon successful completion of the INBDE Field Testing Program (not depicted in the preceding diagram).

* Similar to Part I and Part II, INBDE results will be reported as "Pass/Fail."

INBDE Implementation Plan

- In considering the dates provided, please note the following:
  - The plan as presented communicates the "best case scenario."
  - The dates provided may be delayed if difficulties are encountered. However, the dates will not be "moved up" (e.g., NBDE Part I will be discontinued no sooner than August 1, 2020).
  - The Joint Commission reserves the right to make changes to the plan at any time and as needed, in keeping with the Joint Commission's mission and purpose.
  - Any significant changes to this plan will be published as soon as information becomes available.
  - The final slide in the current presentation will provide a log of changes made.

Additional Information from the JCNDE

- Information concerning the INBDE is available via the Joint Commission's website (www.ada.org/JCNDE/INBDE)
- The following information is currently available and is updated as changes occur:
  - INBDE background
  - INBDE FAQ's
  - Domain of Dentistry and general validity evidence
  - Preliminary test specifications
  - Preliminary sample questions
- The following information will be posted as soon as it becomes available:
  - INBDE practice test questions (anticipated one year in advance of initial INBDE administration)
  - Technical report(s) providing detailed information concerning validity

INBDE Information from other Sources (not the JCNDE)

- INBDE eligibility rules for students of U.S. dental schools accredited by the Commission on Dental Accreditation (CODA).
  - These rules are determined by each dental school.

- Additional school requirements concerning the INBDE (e.g., linking successful completion of the INBDE to graduation requirements).
  - These rules are determined by each dental school.

- Written examination requirements for each state.
  - These requirements are determined by each state dental board.

INBDE Implementation Plan Considerations

- The requirements of key stakeholders and communities of interest were carefully considered in developing the implementation plan.
  - State Dental Boards
  - Dental Schools
  - US Dental Licensure Candidates
- The following slides indicate specific considerations involving the aforementioned groups, as well as recommended actions.
- The considerations indicated should NOT be regarded as comprehensive of all of the INBDE-related interests of the aforementioned groups.

State Dental Boards

Implementation Plan Requirement	How Requirement is Addressed

• Provide sufficient time for state dental boards to assess and understand INBDE validity evidence.
• Provide sufficient time for state dental boards to incorporate the INBDE into licensure decision-making and communicate its acceptability to future licensure candidates.
• Provide sufficient time for state dental boards to prepare to receive INBDE results on day one of availability.
• Consider whether any modifications to practice acts, rules, policies, or procedures will be required.
• Provide sufficient time for state dental boards to accept both exam sequences:
1) INBDE and
2) NBDE Parts I and II.
	• Post and update validity information on JCNDE website as it becomes available.
	• Communicate validity information on annual basis at National Dental Examiners' Advisory Forum (NDEAF).
	• Release details of implementation plan in 2016, and provide the following notifications:
	  • INBDE first administration possible as soon as 2020.
	  • NBDE Part I final administration possible in 2020.
	  • NBDE Part II final administration possible in 2022.
	• Provide notice in 2016 of JCNDE plans for indicating the official name of the INBDE and how results will be reported. Current discussions indicate the JCNDE is likely to associate the name "NBDE" with the INBDE, to ease the transition with regard to state rules and practice acts.

Recommended Actions for State Dental Boards

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website (www.ada.org/JCNDE/INBDE), and attend the National Dental Examiners' Advisory Forum (NDEAF) annually.
  - Review INBDE validity evidence and the results of field testing as these studies occur.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare to use the INBDE in licensure decision-making.
  - Prepare to receive INBDE results on day one of availability.
  - Prepare to accept candidates who have successfully completed the National Boards. This could occur under either of the following sequences: 1) INBDE or 2) NBDE Parts I and II.
  - Communicate information concerning the acceptability of the INBDE to future licensure candidates.

Dental Schools

Implementation Plan Requirement	How Requirement is Addressed

• Provide sufficient time for U.S. dental schools to adjust curricula and prepare students for the INBDE (also consistent with current CODA requirements).
• Provide sufficient time for U.S. dental schools to adjust academic policy for incoming students regarding eligibility to sit for National Board Examinations.
• Provide sufficient time for U.S. dental schools to adjust academic policy for incoming students regarding school utilization of NBDE Part I and II results (e.g., as prerequisites for students to continue their studies or as a graduation requirement).
	• Release details of implementation plan in 2016, and provide the following notifications:
	  • INBDE first administration possible as soon as 2020.
	  • NBDE Part I final administration possible in 2020.
	  • NBDE Part II final administration possible in 2022.
	• Post INBDE preliminary sample questions publicly in 2016.
	• Provide INBDE practice test questions one year before INBDE initial administration.
	• Provide updates on the INBDE annually at the ADEA conference and subsequently post the presentations online.

Note: For US candidates, dental schools now approve the eligibility of Part I and Part II examinees and will determine when their students will transition to the new exam, within the feasible available options. For international candidates, eligibility for Parts I and II involves providing proof of dental school graduation (through ECE). This practice is expected to continue for the INBDE.

Recommended Actions for Dental Schools

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website (www.ada.org/JCNDE/INBDE), and attend ADEA sessions on the INBDE.
  - Review INBDE validity evidence and field testing results as these studies occur.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare your school and students for the INBDE.
  - Review and revise curricula to prepare students for the INBDE and the updated CODA standards.
  - Review academic policy for incoming students and revise as needed concerning:
    - student eligibility to sit for National Board Dental Examinations.
    - school utilization of NBDE Part I and II results.

U.S. Dental Licensure Candidates

Implementation Plan Requirement	How Requirement is Addressed

• Provide U.S. dental licensure candidates with a reasonable opportunity to demonstrate competence with respect to the knowledge and skills required for licensure and measured by a written examination.
• Provide reasonable time and sufficient notice so candidates can plan ahead and take action to avoid being "caught between examination programs" (e.g., preparing for Parts I and II but then finding themselves forced to shift to the INBDE).
• Provide sufficient time for candidates to understand retesting policies concerning the INBDE and Parts I and II during the transition period, so candidates can plan and make decisions accordingly.
• Provide test specifications and practice materials so candidates can prepare for the INBDE and know what types of questions to expect.
	• Begin INBDE administrations before NBDE Part II is discontinued.
	• Release details of implementation plan in 2016, and provide the following notifications:
	  • INBDE first administration possible as soon as 2020.
	  • NBDE Part I final administration possible in 2020.
	  • NBDE Part II final administration possible in 2022.
	• Provide practice test questions one year before initial INBDE administration, and post INBDE preliminary sample questions publicly in 2016.
	• Provide notice in 2018 concerning INBDE retest policy, and coordinate INBDE retest policy with NBDE retest policy.

Recommended Actions for U.S. Dental Licensure Candidates

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website (www.ada.org/JCNDE/INBDE).
  - Review INBDE test specifications and practice questions.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare for the National Board Examinations.
  - Determine which examination track to pursue (NBDE Parts I and II or the INBDE) in consultation with the most recent INBDE implementation plan and:
    - your dental school, its requirements, and your progress in meeting those requirements.
    - the dental boards of states where you intend to apply for licensure.
    - Joint Commission policies (e.g., retesting policies under both examination tracks).
  - Study the areas indicated in the test specifications of your intended examination track.

Implementation Plan Version History

Version	Date	Changes
1.0	3/13/2016	First publication.
1.1	3/17/2016	Slide 4 – Further clarified that no administrations for Part I or II would be conducted after the dates listed.

Disciplinary Board Report for March 9, 2018

Today's report reviews the 2018 calendar year case activity then addresses the Board's disciplinary case actions for the second quarter of fiscal year 2018 which includes the dates of October 1, 2017 through December 31, 2017.

Calendar Year 2018

The table below includes all cases that have received Board action since January 1, 2018 through February 20, 2018.

Calendar 2018	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
January	35	24	6	30
February 20th	17	15	5	20
Totals	**52**	**39**	**11**	**50**

Q2 FY 2018

For the second quarter of 2018, the Board received a total of 64 patient care cases. The Board closed a total of 78 patient care cases for a 122% clearance rate, which is up from 77% in Q1 of 2018. The current pending caseload older than 250 days is 29%, which is up from 26% in Q1 of 2018. The Board's goal is 20%. In Q2 of 2018, 90 % of the patient care cases were closed within 250 days, whereas 67% of the patient care cases were closed within 250 days in Q1 of 2018. The Board's goal is 90% of patient care cases closed within 250 days.[1]

IN COMPARISON

Q2 FY 2017

For second quarter of 2017, the Board received a total of 37 patient care cases. The Board closed a total of 58 patient care cases for a 171% clearance rate, which is up from 107% in Q1 of 2017. The current pending caseload older than 250 days is 28%, which is up from 27% in Q1 of 2017. The Board's goal is 20%. In Q2 of 2017, 84 % of the patient care cases were closed within 250 days, whereas 75% of the patient care cases were closed within 250 days in Q1 of 2017. The Board's goal is 90% of patient care cases closed within 250 days.[2]

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[1] The Agency's Key Performance Measures.

- DHP's goal is to maintain a 100% clearance rate of allegations of misconduct through the end of FY 2018.
- 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 2018.
- The goal is to resolve 90% of patient care cases within 250 business days through the end of FY 2018.

[2] 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 2017.
- 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 2017.
- The goal is to resolve 90% of patient care cases within 250 business days through the end of FY 2017.

License Suspensions

There were two mandatory suspension of dental licenses by the Board between December 2, 2017 and February 20, 2018.

Guidance Document

1. Attached to this report is a draft copy of the revisions to Guidance Document 76-24.3, which is the Virginia Board of Dentistry Dental Inspection Form. This form was revised on Page 1 to reflect the change in the DEA registration posting requirements.

Further, on Page 3, the language regarding the second and third columns was adjusted to reflect the position of conscious/moderate sedation and deep sedation and general anesthesia equipment chart.

Board staff is asking that the Board discuss these changes and approve the draft Guidance Document 76-24.3 as revised.

Sedation/Anesthesia Form

Board staff is still working on creating a sample Sedation/Anesthesia form that contains one place to record all of the information required by the Board's sedation and anesthesia regulations. Board staff will have a draft complete for the Board's review and approval at the June 2018 meeting.

Board Member concerns

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

Virginia Board of Dentistry Dental Inspection Form Date Hours Case#
Commonwealth of Virginia
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-367-4538

TYPE OF INSPECTION

_____COMPLAINT INVESTIGATION _____COMPLIANCE _____OMS COSMETIC PROCEDURES AUDIT

_____PERIODIC PERMIT HOLDER Permit type: _____ Conscious/Moderate ____Deep Sedation/General Anesthesia
Permit#: _____ Exp. Date: _____ Facility #: _____

NAME OF SUBJECT DENTIST LICENSE #

PRACTICE NAME SPECIALTY PRACTICE

STREET ADDRESS CITY STATE ZIP CURRENT ADDRESS OF RECORD

PHONE: FAX: HOURS OF OPERATION:

STAFF: (Identify dentists, hygienists, assistants, and general office staff)	POSITION	LICENSE	EXP. DATE	Assists in Sedation or GA

C NC NA	18VAC60-21-110 Utilization of Dental Hygienists and Dental Assistants II No more than 4 dental hygienists or dental assistants II in any combination practicing under direction at the same time.
C NC NA	18VAC60-21-120 If Dental Hygienists practice under general supervision determine if: Y N Written orders are in the patient record. Y N The services on the original order are to be rendered within a specific time period not to exceed 10 months. Y N The dental hygienist has consented in writing to providing services under general supervision. See personnel record. Y N The patient is informed before the appointment that he will be treated under general supervision. See patient record. Y N Written basic emergency procedures are established and the hygienist is capable of implementing those procedures. See the procedures. Ask the hygienist about preparation and training. If any of the requirements above are not met obtain a copy of one patient record to support an allegation of non-compliance.

POSTING OF CURRENT LICENSES, CERTIFICATES, AND REGISTRATIONS

C NC NA	54.1-2720	Name of every dentist practicing in this office is displayed at the entrance of the office.
C NC NA	54.1-2721 18VAC60-21-30	Dental Licenses are posted in plain view of patients.
C NC NA	54.1-2727 18VAC60-25-20.B	Dental Hygiene Licenses are posted in plain view of patients.
C NC NA	18VAC60-30-20.B	Dental Assistant II Registrations are posted in plain view of patients.
C NC NA	18VAC60-30-80	Radiation Certificate is posted for each person who exposes dental x-ray and is not otherwise licensed.
C NC NA	12VAC5-481-370.A(1) (B) & (C)	Department of Health's certification of x-ray machine is current and posted near the x-ray machine.
C NC NA	18VAC60-21-30	Conscious/Moderate Sedation Permit or AAOMS certificate is posted in plain view of patients AND DEA registration is readily retrievable.
C NC NA	18VAC60-21-30	Deep Sedation/General Anesthesia Permit or AAOMS certificate is posted in plain view of patients AND DEA registration is readily retrievable.

EDUCATION				
C	NC		Check which option applies: _18VAC60-21-250.A(2) Dentists must hold current certification in basic life support or basic cardiopulmonary resuscitation with hands-on airway training for healthcare providers. Current training in advanced resuscitation techniques with hands on simulated airway training for health care providers meets this requirement. <u>OR</u> _18VAC60-21-290.E(1) and 18VAC60-21-300.C(3) Dentists who administer conscious/moderate sedation, deep sedation or general anesthesia must hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers; the training for deep sedation and general anesthesia permit holders must include basic electrocardiographic interpretation
C	NC	NA	18VAC60-25-190.A(1)	Dental hygienists must hold current certification of completion of a hands-on course in basic cardiopulmonary resuscitation for health care providers
C	NC	NA	18VAC60-30-150.D	Dental assistants II must hold current certification of completion of a hands-on course in basic cardiopulmonary resuscitation
C	NC	NA	18VAC60-21-250.A(3)	Dentists who administer conscious/moderate sedation, deep sedation or general anesthesia have completed at least four hours of continuing education directly related to such administration and monitoring within the past 2 years
C	NC	NA	18VAC60-25-190.A(2)	Dental hygienists who monitor patients under conscious/moderate sedation, deep sedation or general anesthesia have completed at least four hours of continuing education directly related to such monitoring within the past 2 years
C	NC	NA	18VAC60-21-260.H(2)	Written basic emergency procedures are readily accessible when any level of sedation or general anesthesia is administered
C	NC	NA	18VAC60-21-260.H(2)	Record of staff training to carry out emergency procedures when any level of sedation or general anesthesia is administered NOTE THE MOST RECENT DATE OF TRAINING:_____
C	NC	NA	18VAC60-21-260.I(1)	Unlicensed ancillary personnel, i.e. dental assistants, who assist in the administration and monitoring of conscious/moderate sedation or deep sedation and general anesthesia, must hold current certification in basic resuscitation techniques with hands-on airway training for health care providers or a clinically oriented course.

RECORDKEEPING 18VAC60-21-90 and 18VAC60-21-260.D

Obtain Patient Records for content and compliance review by the Board as follows:

- For inspections addressing Complaint Investigations related to treatment or billing practices obtain the treatment records of all patients identified in the complaint.
- For inspections addressing Complaint Investigations related to unsafe/unsanitary conditions or practices obtain the source's patient record and <u>two (2)</u> additional patient records of patients who were recently treated. Review the patient schedule and randomly select the patients. Interview the source and these two (2) patients about their experience/observations.
- For sedation and anesthesia Permit Holders obtain two (2) patient records of patients who were recently treated under sedation or anesthesia. Review the patient schedule and randomly select the patients.
- Inspect each record collected to determine if:
  - ___ All handwritten and electronic documents and evidence are legible and complete
  - ___ Both sides of 2 sided documents are included
  - ___ X-rays, digital images and photographs are labeled with patient's name, date taken and content of the image including teeth numbers
  - ___ Itemized patient financial record and insurance billing records/correspondence are included
  - ___ Laboratory work orders are included
  - ___ Computerized prescriptions are included
  - ___ Periodontal charting is included
  - ___ CDs will open and content is accessible and legible

ENVIRONMENTAL CONDITIONS §54.1-2706(5) and/or §54.1-2706(11), 18VAC60-21-60.A(1)
Reference the CDC Guidelines for Infection Control in Dental Health-Care Settings

All sections of the facility appear neat and clean without any safety hazards Yes No

Observed equipment with broken or missing parts; oil/grease on any equipment; or dirty suction hoses, etc. Yes No
If yes, describe and photograph:

Describe sterilization process to include equipment used (should include heat and/or spore indicators.)

Who processes spore indicators? Obtain names and positions held.
Verify that results are maintained. Yes No

What is office protocol when sterilization equipment indicates equipment is not working properly?

Is the protocol available to staff in a print or electronic document? Yes No

How are sterilized instruments maintained?

How are clinical surfaces disinfected and sanitized?
Frequency?
Solutions used?

Are sharps containers available? Yes No
Verify that there is a current contract, bill or receipt to document service for disposing of sharps/biohazard waste. Yes No

Appropriate personal protective equipment including gloves, face protection, eye protection and lead aprons are in stock. Yes No

Safe and accessible building exits in case of fire or other emergency were observed. Yes No

DRUG SECURITY, INVENTORY AND RECORDS §54.1-2706(5), §54.1-2706(11) and/or §54.1-2706(15), 18VAC60-21-70.A(4)

The dentist only maintains Sch VI controlled drugs. Yes No

If yes, answer the first question below then skip to the ANESTHESIA, SEDATION AND ANALGESIA section.

If the dentist maintains any Sch II –V controlled drugs complete this section.

C NC		Expired drugs are stored separate from the working stock of drugs until properly disposed
C NC	CFR 1301.75 (b)	Sch II-V controlled substances are stored in a securely locked, substantially constructed cabinet
C NC	CFR 1304.04 (f)	Inventories and records of Sch II controlled substances are maintained separately from all other records and are readily retrievable
C NC	CFR 1304.04 (f)	Inventories and records of Sch III-V controlled substances are maintained either separately from all other records or in such a form that the information is readily retrievable
C NC		Records of Sch II-V controlled substances are maintained in chronological order
C NC	54.1- 3404. F	Required records are maintained completely and accurately for two years from the date of the transaction
C NC	54.1-3404. C	Records of receipt include the actual date of receipt, name and address of the person from whom received, and the name, strength and quantity of drug received
C NC	54,1-3404. D	Records of drugs sold, administered, dispensed or disposed of include the date of the transaction, name of patient, drug name, quantity of drug, and signature of person making the transaction
C NC	54.1-3404. A& B	Biennial inventory of Sch II-V drugs available was taken on a date within two years of the previous biennial inventory
C NC	54.1-3404. A & B	Biennial inventory is dated and indicates whether it was taken at the opening or close of business. Specify.
C NC NA	54.1-3404. E	Theft or unusual loss of drugs in Sch II-V is reported to the board of Pharmacy and an inventory taken if the registrant is unable to determine the exact kind and quantity of drug loss

ANESTHESIA, SEDATION AND ANALGESIA

Dentist only administers local anesthesia? Yes No If yes, stop here. The remaining sections do not apply.

Dentist only administers minimal sedation? Yes No If yes, complete the question on emergency procedures and only the first columns in the next two sections.

Dentist has a conscious/moderate sedation permit? Yes No If yes, complete the question on emergency procedures and only the second columns in the next two sections.

Dentist has a deep sedation and general anesthesia permit? Yes No If yes, complete the question on emergency procedures and only the third columns in the next two sections.

Note here any descriptions provided on the administration practices followed and/or on the level of effect and condition of patients to help the Board assess the level of administration being administered:

EQUIPMENT REQUIREMENTS FOR ANESTHESIA, SEDATION AND ANALGESIA		
18VAC60-21-280.D A dentist who administers MINIMAL SEDATION (anxiolysis or inhalation analgesia) shall maintain the following operational equipment and be trained in its use	18VAC60-21-291.B A dentist who administers CONSCIOUS/MODERATE SEDATION shall maintain the following operational equipment in sizes for adults or children as appropriate for the patient being treated	18VAC60-21-301.C A dentist who administers DEEP SEDATION/GENERAL ANESTHESIA shall maintain the following operational equipment in sizes for adults or children as appropriate for the patient being treated
C NC Blood Pressure Monitoring	C NC Full face masks	C NC Full face masks
C NC Positive Pressure Oxygen	C NC Oral and Nasopharyngeal airway management adjuncts	C NC Oral and Nasopharyngeal airway management adjuncts
C NC Mechanical (hand) respiratory bag	C NC ET tubes with appropriate connectors or airway adjuncts such as a laryngeal mask airway	C NC ET tubes with appropriate connectors or airway adjuncts such as a laryngeal mask
C NC Suction Apparatus	C NC Laryngoscope with reserve batteries and bulbs and appropriately sized blades	C NC Laryngoscope with reserve batteries and bulbs and appropriately sized blades
C NC Pulse Oximeter	C NC Pulse Oximetry and BP Monitoring	C NC Source of delivery of oxygen under controlled positive pressure
	C NC Pharmacological antagonist agents unexpired	C NC Mechanical (hand) respiratory bag
	C NC Source of delivery of oxygen under controlled positive pressure	C NC Pulse Oximetry and BP Monitoring
	C NC Mechanical (hand) respiratory bag	C NC Emergency drugs for resuscitation
	C NC Emergency drugs for resuscitation	C NC EKG monitoring equipment
	C NC EKG monitor when using parenteral or titration	C NC Temp monitoring equipment
	C NC Defibrillator	C NC Pharmacological antagonist agents unexpired
	C NC Suction apparatus	C NC External defibrillator (manual or automatic)
	C NC Temp measuring device	C NC An End-Tidal CO2 monitor
	C NC Throat Pack	C NC Suction apparatus
	C NC Precordial or pretracheal stethoscope	C NC Throat Pack
	C NC An End-Tidal CO2 monitor	C NC Precordial or pretracheal stethoscope

STAFFING REQUIREMENTS FOR ANESTHESIA, SEDATION, & ANALGESIA		
18VAC60-21-280.E A dentist who administers MINIMAL SEDATION by only using nitrous oxide/oxygen assures that: C NC The person who administers the nitrous oxide/oxygen or another dental staff member is always present with the patient until discharged. A dentist who administers MINIMAL SEDATION by anxiolysis with or without nitrous oxide/oxygen uses a: C NC Treatment team which includes the dentist & a second person to assist, monitor & observe the patient until discharged.	18VAC60-21-291.C A dentist who administers CONSCIOUS/MODERATE SEDATION uses a: C NC Treatment team which includes the operating dentist & a second person to assist, monitor & observe the patient.	18VAC60-21-301.D A dentist who administers DEEP SEDATION/GENERAL ANESTHESIA uses a: C NC Treatment team which includes the operating dentist, a second person to monitor & observe the patient, & a third person to assist the operating dentist

ORAL AND MAXILLOFACIAL SURGEONS

Y N 18VAC60-21-310 Has Current Board Registration
Y N 18VAC60-21-320 Has updated practitioner profile. Attach Profile.
Y N 18VAC60-21-350 Performs cosmetic procedures and is certified by the Board according to §54.1-2709.

Please check all certifications for cosmetic procedures this licensee holds:

A. [ ] Rhinoplasty and other treatment of the nose

B. [ ] Blepharoplasty and other treatment of the eyelid

C. [ ] Rhytidectomy and other treatment of facial skin wrinkles and sagging

D. [ ] Submental liposuction and other procedure to remove fat

E. [ ] Browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead

F. [ ] Otoplasty and other procedures to change the appearance of the ear

G. [ ] Laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities

H. [ ] Platysmal muscle plication and other procedures to correct the angle between the chin and neck

I. [ ] Application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions

Compliant (C) Non Compliant (NC) Not Applicable (NA)

Additional Inspection Observations and Notes

Signature of Inspector Date

Signature of Licensee Date

63rd Southern Conference of Dental Deans and Examiners

Kelley W. Palmatier

During the weekend of January 27-28, 2018, the Southern Conference of Dental Deans and Examiners held their 63rd annual conference in Memphis, Tennessee.

This conference provided a platform for discussion of the future of the Integrated National Board Dental Examination, which should phase out the National Board Dental Examination by 7/31/20.

There was also a discussion about the American Dental Association's Dental Licensure Objective Structured Clinical Examination (DLOSCE). This exam should have a pilot in late 2019 and will be deployed in 2020 as another tool for state dental boards to assess candidates for licensure. The DLOSCE supports the American Dental Association's policy of elimination of live patients in examinations.

Further, this conference also covered implementation of inter-professional learning opportunities in the dental curriculum, specifically in the area of dental sleep medicine. Information was provided about the relationship of a dentist and physician when diagnosing and treating obstructive sleep apnea.

Finally, a discussion was held about integrating laser training into the dental school curriculum, examinations and dental practice. Discussion revolved around the various uses of lasers in the dental setting from gingivectomies, cyst removal, crown preparation and caries removal.

DISCUSSION OF GUIDANCE DOCUMENT 60-17
POLICY ON RECOVERY OF DISCIPLINARY COSTS

During the December 15, 2017 Board meeting, Dr. Brown stated his concern that the recovery of administrative costs in disciplinary cases was not fair to dental hygienists who earn about 50% less than dentists and also not fair to any licensee who only receives a reprimand. He asked the Board to consider suspending cost recovery altogether, assessing dental hygienists 50% of the assessed costs and/or reserve cost recovery for licensees found to be guilty of serious violations.

The Guidance Document is attached for discussion.

Statute:

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

Collection of Administrative Costs:

FY 2017	$119,147
FY 2016	$142,924
FY 2015	$143,807
FY 2014	$108,244
FY 2013	$ 23,591

Collections in Calendar Year 2017

- Costs were assessed for 40 licensees, 2 were dental hygienists and 38 were dentists.
- Assessed costs ranged from $700 to $5,000.
- One of the 2 dental hygienists was assessed $2,568 and the other was assessed $1,050.
- Five of the 39 dentists were assessed the maximum amount of $5,000.
    - Dentist 1 was the subject of 3 complaints which were heard by the Board concurrently at an IFC and addressed in one order. Sanctions imposed were 2 CE courses totaling 11 hours.
    - Dentist 2 was the subject of 3 complaints that were heard by the Board concurrently at a FH and addressed in one order. Sanctions imposed were 2 CE courses totaling 7 hours.
    - Dentist 3 was the subject of 5 complaints that were heard by the Board concurrently at an IFC and addressed in one order. Sanctions imposed were a reprimand and 3 CE courses totaling 18 hours.
    - Dentist 4 was the subject of 1 complaint which was heard by the Board at a FH. The sanction imposed was a 3 hour CE course.
    - Dentist 5 was the subject of 1 complaint which was heard by the Board at an IFC. The sanctions imposed were a reprimand, $10,000 monetary penalty, 4 CE courses totaling 21 hours, and an unannounced audit following completion of one of the CE courses.

Virginia Board of Dentistry

Policy on Recovery of Disciplinary Costs

Applicable Law and Regulations

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

- 18VAC60-15-10 of the *Regulations Governing the Disciplinary Process*. The Board may assess:
  - the hourly costs to investigate the case,
  - the costs for hiring an expert witness, and
  - the costs of monitoring a licensee's compliance with the specific terms and conditions imposed up to $5,000, consistent with the Board's published guidance document on costs. The costs being imposed on a licensee shall be included in the order agreed to by the parties or issued by the Board.

Policy

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

Assessment of Costs

Based on the expenditures incurred in the state's fiscal year which ended on June 30, 2017, the following costs will be used to calculate the amount of funds to be specified in a board order for recovery from a licensee being disciplined by the Board:

- $112 per hour for an investigation multiplied by the number of hours the DHP Enforcement Division reports having expended to investigate and report case findings to the Board.
- $137 per hour for an inspection conducted during the course of an investigation, multiplied by the number of hours the DHP Enforcement Division reports having expended to inspect the dental practice and report case findings to the Board.
- If applicable, the amount billed by an expert upon acceptance by the Board of his expert report.
- The applicable administrative costs for monitoring compliance with an order as follows:

- $ 128.25 Base cost to open, review and close a compliance case
- 72.00 For each continuing education course ordered
- 18.75 For each monetary penalty and cost assessment payment
- 18.75 For each practice inspection ordered
- 37.50 For each records audit ordered
- 112.50 For passing a clinical examination
- 102.00 For each practice restriction ordered
- 83.25 For each report required.

Inspection Fee

In addition to the assessment of administrative costs addressed above, a licensee shall be charged $350 for each Board-ordered inspection of his practice as permitted by 18VAC60-21-40 of the *Regulations Governing the Practice of Dentistry.*

Reen, Sandra (DHP)

From: Hooper, Marjorie G. <hooperm@ada.org>
Sent: Friday, February 23, 2018 10:15 AM
Cc: Tooks, Sherin
Subject: CODA Winter 2018 Accreditation Actions - Notice

National, Regional, and Specialized Accreditors and State Boards of Dentistry:

In accordance with established policy of the Commission on Dental Accreditation and regulations of the United States Department of Education, please consider this notification that as a result of action taken by the Commission at its February 1-2, 2018 meeting, the following education programs have been notified of the Commission's "intent to withdraw accreditation" at its next regularly scheduled meeting on August 2-3, 2018 if these programs do not achieve compliance with accreditation standards or policy by that date:

Advanced Education in General Dentistry (12-month)
Howard University – Washington, DC

Dental Assisting
Chaffey College – Rancho Cucamonga, CA
Pickens Technical College – Aurora, CO
Lincoln College of New England – Southington, CT
Miller-Motte College – Raleigh, NC
Martin Community College – Williamstown, NC
Miller-Motte College – Wilmington, NC
Bradford School – Pittsburgh, PA

General Practice Residency (12-month)
Berkshire Medical Center – Pittsfield, MA

Oral and Maxillofacial Surgery
Harlem Hospital Center – New York, NY

Oral Medicine
University of California at San Francisco - San Francisco, CA

Orthodontics and Dentofacial Orthopedics
Howard University – Washington, DC

Pediatric Dentistry
Howard University – Washington, DC
Harlem Hospital Center – New York, NY

In addition, the Commission recognized that the following programs have voluntarily discontinued their participation in the Commission's accreditation program:

Dental Assisting
Miami-Jacobs Career College – Springboro, OH

Dental Hygiene
UAF Community and Technical College – Fairbanks, AK
John A. Logan College – Carterville, IL

Oral and Maxillofacial Surgery
St. Luke's-Roosevelt Hospital Center – New York, NY

The following new programs have been granted accreditation:

Advanced Education in General Dentistry (24-month)
St. Vincent Charity Medical Center – Cleveland, OH

Dental Hygiene
Jackson College – Jackson, MI

General Practice Residency (12-month)
Veterans Affairs Boston Healthcare System – Boston, MA

Orofacial Pain
University of Michigan Health Systems – Ann Harbor, MI

Pediatric Dentistry
Nemours/A.I. DuPont Hospital for Children – Wilmington, DE
Jamaica Hospital – Jamaica, NY

The Commission adopted a resolution to withdraw accreditation from the following program:

Dental Laboratory Technology
J. Sargeant Reynolds Community College – Richmond, VA

Information regarding the J. Sargeant Reynolds Community College dental laboratory technology program, including the disclosure statement, can be found on the Accreditation Notices website linked below.

The accreditation statuses of programs reviewed by the Commission on Dental Accreditation at its Winter 2018 meeting can be found at http://www.ada.org/en/coda/accreditation/accreditation-news/accreditation-notices

The accreditation statuses of all programs accredited by the Commission on Dental Accreditation can be found at http://www.ada.org/en/coda/find-a-program/search-dental-programs

You can also access the CODA-accredited program annual survey results at: http://www.ada.org/en/coda/find-a-program/program-surveys/

If you have further questions regarding this information, please contact the Commission on Dental Accreditation. Thank you.

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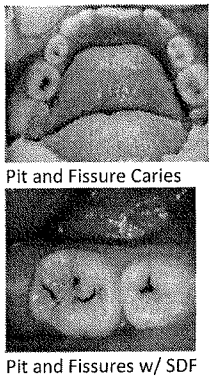
Commission on Dental Accreditation 211 E. Chicago Ave. Chicago, IL 60611 **www.ada.org/coda**

astdd
Where oral health lives

Silver Diamine Fluoride (SDF) Fact Sheet
March 2017 *Amended July 2017*

What is SDF?
Silver diamine fluoride (SDF) has been used extensively outside the United States for many years for caries control.[1] SDF is a colorless liquid containing silver particles and 38% (44,800 ppm) fluoride ion that at pH 10 is 25% silver, 8% ammonia, 5% fluoride, and 62% water. This is referred to as 38% SDF.

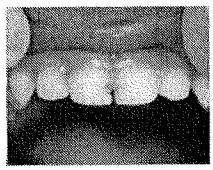
What is the strength of evidence for SDF?
In clinical trials, SDF applied directly to the cavitated lesion outperformed fluoride varnish for the non-surgical arrest of caries in children and older adults. In addition, SDF demonstrated impressive caries prevention to adjoining teeth not receiving direct application of SDF.[1,2] At least eight published reports of randomized clinical trials consistently demonstrated very high rates of caries arrest.[3,4,5,6,7,8,9,10] Although a 2016 systematic review and meta-analysis of clinical trials in children concluded 38% SDF applied at least once per year effectively arrested more than 65% of active caries,[11] there is no consensus for the number and frequency of applications for optimal caries control.[12] A critical summary of the systematic review, published in early 2017, called for more well-designed and well-conducted clinical trials comparing the effectiveness of SDF with no treatment or other caries management approaches in populations with varying caries risk, lesion severities, and other fluoride exposures.[12]

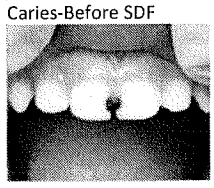

Pit and Fissure Caries

Pit and Fissures w/ SDF
Photos Courtesy Steve Duffin

Does SDF have FDA Approval?
In August 2014, SDF was cleared by the Food and Drug Administration (FDA) as a desensitizing agent, similar to fluoride varnish 20 years ago.[13] As of early 2017, there is only one SDF product on the U.S. market. The FDA granted the manufacturer "breakthrough therapy status," facilitating clinical trials of SDF for caries arrest. It is used off-label for caries arrest.

What are indications for SDF use?
SDF arrests active carious lesions painlessly and without local anesthetic, as long as the teeth are asymptomatic, avoiding or delaying traditional surgical removal of caries. This intervention can be applied to teeth as soon as caries is detected. SDF is indicated in treating caries in people who are unable to access dental treatment or tolerate conventional dental care, including very young "pre-cooperative" children, persons with intellectual/developmental disabilities, or older adults.


Caries-Before SDF


After SDF
Photos: Pediatric Dentistry V 38: No 3, May/June 2016

What are contraindications for SDF therapy?
No adverse events using silver compounds have been reported in more than 80 years of use in dentistry.[1,14] Silver allergy is the only known contraindication.[2] Teeth with evidence of pulpitis or pulpal necrosis are not appropriate for SDF treatment and require surgical treatment. Similarly, teeth with deep lesions where the carious dentin has been excavated are not candidates for SDF, due to the ammonia content and high pH, which may create a pulpal reaction.

Are there other considerations for SDF therapy?
The silver particles in SDF darken active dental caries and if touched, temporarily stain unprotected soft tissues, which may be a concern with patient/parent acceptance. It does not stain sound enamel. See the UCSF protocol (below) for additional information. Some individuals report a transient metallic taste after application of SDF. SDF will also permanently stain floors, clothing, and furniture.

Are there recommended protocols?
All providers applying SDF need appropriate training. In January 2016, for example, the University of California San Francisco (UCSF) School of Dentistry published a thorough clinical protocol for the use of SDF[14] (watch the application of SDF on YouTube). The American Academy of Pediatric Dentistry is currently conducting a review and, depending on the evidence, may include clinical guidelines (personal communication, Norman Tinanoff, University of Maryland, 3/1/2017).

Can SDF be used in addition to fluoride varnish, other professionally applied fluorides, or dental sealants?
SDF is a new addition to professionally applied topical fluoride products available in the U.S. While there is little evidence in the literature to support additional efficacy, some practitioners apply fluoride varnish or fluoride in addition to SDF treatment, but not to the teeth already treated with SDF. For any patient with active caries, UCSF's protocol includes replacement of fluoride varnish with the application of silver diamine fluoride to active lesions only.[14] Dental sealants are more effective than SDF for caries prevention in non-cavitated teeth.[15,16] Compared to SDF, the use of dental sealants is firmly supported for long term caries prevention by the quantity and quality of evidence available.[17]

In which states does Medicaid reimburse for SDF therapy?
State Medicaid policy and coverage guidelines may vary by professional training, risk, age, dentition, and frequency of application. As of December 2016, at least 14 states reported using existing or implementing new policy coverage for SDF application (reported by Vermont Department of Health, informal survey of ASTDD members, December 2016). State Oral Health Programs and interested health professionals should review their individual state Medicaid program dental policy on fluoride applications to determine if and how the policy addresses coverage of SDF application.

Who can apply SDF?
According to the rules and as governed by their state medical and/or dental practice acts, dentists, dental hygienists, physicians, nurses, and their assistants may be permitted to apply fluorides and SDF. Dental hygienists in most states whose Medicaid programs cover SDF application may be permitted to apply SDF under the same authorization or restrictions as other topical fluorides.[18]

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