VIRGINIA BOARD OF DENTISTRY

AGENDAS

June 11-12, 2015

Department of Health Professions

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

PAGE

June 11, 2015

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

June 12, 2015

Board Business

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

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- March 13, 2015 Business Meeting **P1**
- May 8, 2015 Open Forum **P8**
- May 28, 2015 Conference Call
- June 3, 2015 Ad Hoc Committee on Disciplinary Findings

DHP Director's Report – Dr. Brown

Liaison/Committee Reports

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- AADB Mid-Year Meeting
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- CTel Executive Telehealth Summit 2015 – Ms. Barnes **P45**
- Open Forum on Policy Strategies to Increase Access to Dental Treatment – Ms. Swain
- Ad Hoc Committee on Disciplinary Findings – Dr. Watkins

Legislation and Regulation – Ms. Yeatts

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Board Discussion/Action

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Board Counsel Report – Mr. Rutkowski

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Executive Director's Report/Business – Ms. Reen

- 2016 Proposed Calendar **P124**
- Revenues, Expenditures & Cash Balance Analysis **P125**
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Closed Session **CONFIDENTIAL DOCUMENTS**
Case # 152378

VIRGINIA BOARD OF DENTISTRY
MINUTES
March 13, 2015

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:01 a.m. on March 13, 2015, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

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

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

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

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

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

Ms. Reen read the emergency evacuation procedures.

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

PUBLIC COMMENT: **John Bitting** of DOCS Education stated that DOCS has provided sedation education for 15 years and has trained over 20,000 dentists. He expressed concern for sedation permit applicants, indicating a clerical error by DOCS was immediately corrected and should not prevent issuance of permits. Mr. Bitting was advised he could not address an investigation. He said DOCS sedation courses meet and exceed Virginia's requirements and the American Dental Association's (ADA) guidelines. He asked Board

members to attend A DOCS course at no charge or to send an investigator.

Dr. Alan Bream said he has practiced since 1973 and took a DOCS sedation course in 2006. He added that he safely treated patients with the DOCS protocol. He noted that he took a DOCS course again in May 2014 to qualify for a sedation permit and as of today he has not been issued one. Mr. Bream was advised he could not address an investigation. He reported his frustration with how long it is taking to get a permit.

Dr. Michael Link, VDA President, addressed the topic of mid-level providers, expressing concerns about comparisons made nationally to other professions and the training needed to perform irreversible procedures. He advised that any dental hygiene workforce changes would be costly and would require a significant expansion in the number of hygienists. He said the ADA and the VDA believe the Community Dental Health Coordinator (CDHC) model which is a cost-effective approach to improving access to care. CDHCs focus on education, prevention, and patient navigation in the communities where patients reside to connect people to the dental safety net, as well as to dentists for needed treatment. He added that the CDHC model is currently active in eight states and said the VDA is moving forward with the program and offered to give a presentation on the CDHC at a future Board meeting.

APPROVAL OF MINUTES:

Ms. Swain asked if there are any corrections to the minutes as listed on the agenda. Dr. Watkins moved to adopt the minutes in total as presented in the agenda package. The motion was seconded and passed.

DHP DIRECTOR'S REPORT:

Dr. Brown –

- Thanked the Board for notifying dentists that they are required to either report dispensing of controlled substances to the Prescription Monitoring Program (PMP) or request a waiver for reporting.
- Noted that legislation passed to require all prescribers to register with PMP.
- Reported that criminal background checks will be required for RNs and LPNs beginning in 2016. He said Nursing is the first board in DHP to include this requirement for licensure, noting that the Nurse Licensure Compact requires this information.

- An external audit of the Health Practitioners Monitoring Program by the Citizen Advocacy Center is underway to evaluate the structure and functioning of the program.

He also thanked board members for meeting with him to share their perspectives on the work of the Board and the Department.

DHP BUDGET MANAGEMENT:

Mr. Giles, Budget Manager, gave an overview of the internal and external processes followed to develop and manage the budget. He explained that the DHP Director oversees the process and determines how resources are used. He said, in the internal process, cost center managers determine if their current budget resources are adequate then submit an analysis of their department's needs using the base budget and the previous fiscal year spending for a select group of accounts. The external phrase of the budget process is initiated by the DHP Director when proposed changes require approval of the Office of Secretary of Health and Human Resources and review by the Department of Planning and Budget for inclusion in the Governor's budget. Mr. Giles noted that DHP is a non-general fund agency and its revenue is generated by issuing licenses with 83% of the revenue budgeted based on the number of renewals forecasted for a given fiscal year. The remaining 17% of revenue is based on historical data. He added that the Board will soon receive a letter from Dr. Brown about the analysis of the Board's current revenues and expenditures and the possible need to adjust fees.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Watkins noted that the public hearing on BHP's Dental Hygienist Scope of Practice Review was held on January 22, 2015 and the comments submitted by the Board are provided in the agenda materials. He added that due to inclement weather, BHP's February 17, 2015 meetings were cancelled and rescheduled for April 9, 2015. He also noted that the letter conveying the Board's resolution requesting coordination among the health regulatory boards for investigation of electronic health records would be discussed on April 9th.

AADB. Ms. Swain noted that she, Dr. Gaskins, and Ms. Palmatier will attend the Mid-Year meeting in April, 2015 in Chicago.

ADEX. Dr. Rolon stated that the Highlights of the ADEX meeting in November 2014 are provided which includes information on the changes to the Dental and Dental Hygiene examinations. Dr. Rizkalla reported that ADEX has hired Dr. Guy Shampaine as its Chief Executive Officer and Patrick Braatz as its Chief Operating

Officer. He added that NERB changed its name to the Commission on Dental Competency Assessments (CDCA).

SRTA. Ms. Swecker reported that SRTA will not administer the ADEX Dental Hygiene Exam in 2015 as planned because of confusion over which states will accept it. She said that the SRTA Dental Hygiene Exam will be administered and is accepted in 32 states. Dr. Watkins noted that there is no change to SRTA administering the ADEX Dental Exam in 2015.

SCDDE. Dr. Gaskins stated that he, Dr. Alexander and Ms. Reen attended the meeting in January 2015 which included dental professionals from dental schools, boards of dentistry, dental agencies and associations. He then highlighted the discussion of:

- The development and application of the "standard of care."
- Turning risk management into risk avoidance.
- The validity for simulated clinical testing compared to the validity for the use of human subjects in testing.
- The validity for "portfolios" and potential uses for portfolios in education, testing, licensure, and re-certification.
- The relationship of standards of care to risk management, risk avoidance, education, testing, licensure, law enforcement, malpractice claims, and the ethical practice of dentistry.

Examination Committee. Ms. Swecker presented the Committee's recommendations for requiring passage of the law exam for licensure and once every three years for all licensees. She noted that the exam would be open book and three hours of continuing education credit would be granted for passage. Ms. Swecker moved that the Board issue a Notice of Intended Regulatory Action to require passage of a law exam. The motion was seconded and passed.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported that the Periodic Review to reorganize Chapter 20 into four new chapters has been at the Governor's office for more than 78 days. She added that she does not expect action until after April due to the 2015 General Assembly session.

Report of the 2015 General Assembly. Ms. Yeatts reported that DHP followed 88 bills, none of which directly affected Dentistry. She stated that HB1963 extends the ability of DHP to share information about a suspected violation of state or federal law or regulation with other agencies within the Health and Human Resources Secretariat

or federal law-enforcement agencies such as DEA or FBI. Ms. Yeatts was asked if she knew why the Board's proposal on fee splitting was not forwarded to the General Assembly. Ms. Yeatts said she did not know.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics. No discussion occurred.

Infection Control. Dr. Rizkalla requested discussion of amending the Regulations Governing Dental Practice to address infection control. After review of the provisions and information currently in place to address infection control issues, Dr. Rizkalla moved to amend GD 60-15 by adding another bullet point after the sixth bullet as follow: "*Follow the applicable CDC infection control guidelines and recommendations.*" The motion was seconded and passed.

CODA's Proposed Standards. There was general discussion about the standards applying to all programs in the country; the dental hygiene program being very condensed; and accredited programs being allowed to teach delegable duties which differ from state to state. It was also noted that CODA does not accredit DA II and CDCH programs.

Practice Ownership. In response to a question, Ms. Reen reported that she and Ms. Twombly of Enforcement met with the dental oversight staff at DMAS in February. The result was receiving a contact person who could provide employer and practice location information to assist with DHP investigations. She added that a beneficial relationship has been established.

BOARD COUNSEL REPORT:

Mr. Rutkowski reported:

- Dr. Broadaway's appeal of his Board Order to Circuit Court was dismissed because he failed to file on time.
- The formal hearing for an applicant scheduled for today was continued because the applicant's lawyer was disbarred and the applicant needs to obtain new counsel.
- Board members must not reply to all when responding to Board staff e-mails because doing so could constitute a meeting.
- Social gatherings of more than two Board members are discouraged because they would have the appearance of a meeting of a public body.
- The Supreme Court ruled that the North Carolina Board of Dentistry was not entitled to sovereign immunity from FTC oversight of anti-trust activities because:

- NC's Dental Practice Act does not specify that teeth whitening is "the practice of dentistry."
- Most Board members, six dentists and one dental hygienist, are active market participants and are not actively supervised by the State.
- The Board did unreasonably restrain trade in violation of antitrust law.

Mr. Rutkowski added that a task force within the Attorney General's Office is reviewing the decision and which may lead to future policy development regarding boards which regulate professional practice.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported the number of cases received and closed in calendar year 2014 and from January 1, 2015 through February 24, 2015. She then reported on the key performance goals for the second quarter of fiscal year 2015, noting that 71 patient care cases were received and 91 cases were closed achieving a 128% clearance rate; the pending caseload older that 250 days was 23%; and 84% of cases were closed within 250 days. She added that no licenses were suspended between December 1, 2014 and February 25, 2015. She thanked Board members for reviewing cases yesterday which should result in improved performance statistics. She addressed the Board's trend in not adding relevant findings of fact to Board Orders to support the sanctions imposed and provided samples of Orders from Board of Medicine and Board of Nursing for review and discussion. Mr. Rutkowski advised that it is a good practice to note any mitigating or aggravating facts that led to the decision made. Dr. Watkins asked if editing the Sanction Reference Point worksheets would help achieve consistency. Ms. Reen said yes and Ms. Swain assigned this matter to an ad-hoc committee of the three chairs of the Special Conference Committees.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Comments on ADA Sedation & Anesthesia Guidelines. Ms. Reen stated that a copy of the Board's comments is provided for information only and no action is needed. She added that no response has been received.

Travel Reimbursement. Ms. Reen noted that DHP is updating the current travel policy to allow for exempt agencies to directly reimburse DHP travelers for travel expenses. She said Board staff is working with the Finance division to determine if the policy allows board members who examine to be reimbursed directly by SRTA.

She explained that SRTA reimburses a fixed rate for subsistence to cover food and lodging and a fixed rate of remuneration for days worked for examinations and meetings. Ms. Reen added that the

SRTA reimbursement policies are under review by the State Comptroller and she hoped to have more information at the next meeting.

Planning Open Forums. Ms. Reen noted that the Board has registered six Dental Assistants II (DAII).

She stated that the Board will hold two open forums, the first on May 8, 2015. She noted that the date of the second forum on teledentistry hasn't been set but preliminary plans are to hold it in August. She said the May 8th forum will address the training and qualification requirements for DAII registration; creating a pathway for dental hygienists to do reversible procedures; and expanding options for dental hygienists to practice under remote supervision. She asked if the Board had any additional information or questions it would like included in the invitation. It was agreed by consensus to include community health centers, free clinics, and the VA Health Care Coalition on the distribution list. It was also agreed by consensus to add questions about what are the needs, options, costs and outcomes to be considered.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 11:27 a.m.

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

_____ _____

Date Date

UNAPPROVED MINUTES

VIRGINIA BOARD OF DENTISTRY
OPEN FORUM ON
POLICY STRATEGIES TO INCREASE ACCESS TO DENTAL TREATMENT

Friday, May 8, 2015

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

CALL TO ORDER:	The Virginia Board of Dentistry convened an Open Forum at 9:04 a.m. to receive views on policy strategies that will improve access to dental treatment in Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	John M. Alexander, D.D.S. Sharon W. Barnes, Citizen Member Charles E. Gaskins, III., D.D.S. James D. Watkins, D.D.S. Bruce S. Wyman, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Director Huong Vu, Operations Manager
OTHERS PRESENT:	David E. Brown, D.C., DHP Director Elaine Yeatts, DHP Senior Policy Analyst
COURT REPORTER:	Mary F. Treta, Court Reporter, Crane-Snead & Associates, Inc.
QUORUM:	Not required.
FORUM COMMENTS:	**Lynn Browder, DDS**, Dental Quality Assurance Manager for the Virginia Department of Health (VDH), stated that VDH is in support of ensuring access to care to low income populations. He noted that VDH has only two dentists on staff and is focusing on dental hygiene treatment. He added that VDH has no stake in the DA II topic but is in favor of expanding the use of remote supervision for the practice of dental hygienists. He said that VDH's remote supervision program addresses children and employs 10 dental hygienists who are based in schools. The dental hygienists assess dental conditions and apply topical fluoride varnish and sealants. He noted that the program has some success in partnering with community dentists to establish

dental homes for children.

Michelle McGregor, RDH, Director of the VCU Dental Hygiene Program (VCU), stated that 3.8 million Virginians have no dental insurance according to the Virginia Health Care Foundation's 2015 Dental Statistics and Research Report and added that according to the American Dental Association, 2.1 million Americans visited emergency rooms for dental pain in 2010 and nearly 80 percent of these visits were for preventable conditions. She said that VCU supports expansion of the use of remote supervision of dental hygienists in safety net facilities, nursing homes, community health clinics and other non-traditional settings. She cautioned the Board against using the language "expanded scope of practice" in these discussions since the intent is to address supervision requirements not increasing the duties allowed in the current scope of practice. She provided the following reports for review:

- The June 2014 Journal of Evidence-Based Dental Practice Special Issue-annual Report on Dental Hygiene examined direct access care models across the nation.
- The October 2014 VDH Technical Report on "Remote Supervision Hygienists."

Dr. Alan Dow, a general internist, described his experience with a patient with diabetes who had not received needed dental treatment and is now dependent on Medicare at taxpayers' expense. He said there is increasing evidence of the correlation of poor oral health and chronic disease and inflammation. Noting that it is difficult to locate free clinics to provide oral care, he supported expanding the options for dental hygienists to practice under the remote supervision of dentists.

Mark A. Crabtree, DDS, Chairman of the Virginia Dental Association's Community Dental Health Coordinator (CDHC) Task Force, presented information on the CDHC program being implemented by the VDA. He explained that a CDHC:

- works in a community to address the social barriers to obtaining care by assisting with applying for benefits, arranging transportation and obtaining language translation services;
- serves as a conduit between people in underserved communities and dentists;
- lives in the same community; and

- is trained to perform duties that are not regulated by the Board.

He said a CDHC is a cost effective strategy for addressing access to care that does not require regulatory action. He stated that in the future the VDA might pursue legislation to establish an Advanced CDHC who would be trained to perform duties such as placement of sealants, temporary fillings and teeth cleaning.

Michael J. Link, DDS, VDA President, stated that in 2001 the Board of Dentistry received a petition for establishing a "scaling technician" an option that has been overlooked by the Board. He said the VDA still supports establishing scaling technicians as a way to increase access. He then noted that the CDHC model is more cost effective than the strategies being considered by the Board.

Sheri A. Moore read a letter from Dr. Van Der Sommen, a family physician and Chairman of the Charlottesville-Albemarle Oral Healthcare Committee. He reports that for over 45 years he has seen many seniors battling disorders and diseases that had either a direct or indirect connection to poor oral hygiene. He also stated that the regular presence of dental providers, such as dental hygienists, in Long Term Care Facilities would make a significant difference in decreasing costs for the care of seniors. He asked the Board to support more autonomy for dental hygienists who are very skilled providers of preventive and maintenance care.

Richard D. Shinn spoke on behalf of the Virginia Community Healthcare Association. He urged sustainable change and asked that the VDH model for remote supervision of dental hygienists be expanded to dentally underserved areas, and safety net providers, including but not limited to federally qualified health centers and free clinics. He offered to assist in exploring how best to resolve access to dental services.

Cathy Berard, RDH, Virginia Dental Hygienists' Association (VDHA), thanked the Board for the opportunity to provide comment regarding strategies to increase access to dental treatment. She said that VDHA supports the policy change that would expand the options for dental hygienists to practice under the remote supervision of dentists and reviewed data that there are dental hygienists available to provide some of the needed services. She submitted copies of the following reports:

- The April 2015 The PEW Charitable trusts report card for VA;

- The 2014 Report to the General Assembly provided by VDH on the "Remote Supervision" Protocol; and
- The Joint Commission on Health Care October 8, 2014 report.

Kara Sprouse, RDH, asked the Board to consider allowing dental hygienists to qualify for DA II registration without obtaining Certified Dental Assistant (CDA) certification. She also recommended that the measure for clinical experience be changed from hours to the number of procedures required.

Linda Wilkinson, CEO of Virginia Association of Free and Charitable Clinics, Inc., stated that the clinics serve over 70 thousand people and only 15 thousand receive dental care. She asked the Board to consider the underserved when establishing regs and to allow greater flexibility for retired dentists to volunteer. She then invited Board members to volunteer.

Tina Bailey, President of Virginia Dental Assistants Association, asked the Board to make it easier for underserved populations to get access to oral healthcare.

Sharon C. Stull, RDH, said she lectures at Old Dominion University (ODU) where the classroom is in the community where approximately 66 thousand individuals have received oral health education, screening, and clinical services free of charge. She said that she supports expanding the options for dental hygienists to practice under the remote supervision of dentists. She also provided the "*Community Service Projects provided in 2013-2014 by ODU DH students in DNTH 413 and DHTH 419 Community Oral Health Planning and Practice*" report for review.

Joyce Flores, RDH, ODU faculty, thanked the Board for the opportunity to comment and stated that ODU supports policy change to expand options for dental hygienists to practice under the remote supervisions of dentists in VA. She then explained that graduation from a Dental Hygiene Education Program accredited by CODA prepares hygienists to provide safe care.

Sarah Holland, Virginia Oral Health Coalition, thanked the Board for the time to comment and stated that she supports expanding the options for dental hygienists to practice under the remote supervision of dentists.

Ms. Swain opened the floor for questions and discussion.

Drs. Crabtree and Link responded to questions about what states have CDHCs, where they are employed, the education requirements for basic CDHCs and their role in working with dentists and dental hygienists.

Discussion followed about the economics of remote supervision, the opportunity for dentists to send dental hygienists to community settings, the training provided in restorative procedures in dental hygiene programs, engaging social services agencies in identifying patients, requiring CDA certification for dental assistants I and the limited number of dentists participating in the clinical training of dental assistants I.

Dr. Jennifer Lee, Deputy Secretary of Health and Human Resources, stated that as an emergency room and free clinic physician, she sees many patients with poor oral health. She thanked the Board for addressing the issues and noted that it is an important issue to the Governor and Secretary.

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

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

She thanked everyone for the wealth of information provided and concluded the forum at 11:39 a.m.

_____ _____

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

_____ _____

Date Date

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

BOARD OF DENTISTRY

9960 MAYLAND DRIVE

HENRICO, VIRGINIA

OPEN FORUM ON POLICY STRATEGIES TO INCREASE ACCESS TO DENTAL TREATMENT

May 8, 2015

9:00 a.m.

Board Members Present:
Melanie C. Swain, RDH, President
John M. Alexander, DDS
Sharon W. Barnes
Charles E. Gaskins, III, DDS
James D. Watkins, DDS
Bruce S. Wyman, DDS

Staff Members Present:
Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager

DHP Members Present:
David E. Brown, DC, DHP Director
Elaine J. Yeatts, DHP Senior Policy Analyst

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MS. SWAIN: Good morning. Before we start, I would like to have Ms. Reen review the emergency evacuation procedure.

MS. REEN: In case of a fire or other emergency in the building, alarms will sound. You should exit this room immediately, going to either of the doors to my right, your left, then turn right, go through the emergency exit door, proceed through the parking lot to the back, where there is a fence, and await instructions from security personnel. If anyone needs assistance evacuating the room, please let myself or Ms. Vu know, and we will make sure that emergency personnel are aware of your needs.

Thank you.

MS. SWAIN: Good morning. I am Melanie Swain, president of the Board of Dentistry. This is an open forum to receive your views on policy strategies to improve access to dental treatment in Virginia. If are you participating, if you wish to speak, please sign up on the sheets available outside the open door to this room. Speakers will be called in the order they appear on the sign-up sheet. Each presentation will be timed and limited to ten minutes. The speaker will be notified when they have reached nine minutes so that they may conclude in the allotted time. The forum will conclude at noon. If time permits following the presentations, attendees will be asked to participate in a

question-and-answer session to explore and discuss the recommendations made.

At this time I will call on persons who have signed up. As I call your name, please come forward and speak into the microphone. Start by telling us your name, where you are from and if you are representing an institutional organization, and to help our court reporter, it would be great if you could please spell out your name.

Thank you.

The first name is Dr. Lynn Browder.

DR. BROWDER: B-R-O-W-D-E-R.

Good morning. Yes, I am a dentist. I have been so for a lot of years here in Virginia. I am here today representing the Virginia Department of Health today. I have been a dentist with the Health Department for many, many years, as I said, and in the capacity known as the dental quality assurance manager for a lot of years. So, as such, I have been involved in a lot of public health roles, and specifically with the remote supervision project that has been underway in the Health Department for a number of years.

What I would like to do today is to start first by just addressing a couple of points the VDH wanted to make in response to the memo that was sent out for the forum. As you have raised the question of pressing needs, we wanted to go on the record recognizing the main thing, of course, is

general improvement of oral health for our residents, and also the reduction in disparities in healthcare for so many people in the state. We realize that one of the things that needs to be done is assuring access to care for our at-risk and low-income population. So I understand, obviously, this forum is addressing those issues indirectly, but we want to be sure that is never lost sight of, as are the ease and utilization of services that are created to provide for people, because we know there are impairments for some folks that are challenged to access to healthcare, and we take this opportunity to share that with you.

Regarding the policy strategies, an increase in the flexibility of delivery models is something we always think is worthwhile to look at, meaning the opportunities to adjust, perhaps, the settings where care is provided, as well as the folks that are able to provide it. We want to, of course, make a priority of quality of care, but at the same time we understand that there may be some room for exploring opportunities in both conventional dental settings and non-dental settings to improve access to care, not forgetting that that is the main point of this discussion today.

We have identified some parameters that we would prioritize for any model that is considered, of course, those being to use the least-costly method to provide safe, quality care to people in the Commonwealth, and to always

provide opportunities for people, again, in shortage areas that are challenged or perhaps under-resourceful. Now, regarding the specific strategies that were identified for discussion today, the Health Department does not have a big position or stake in the DAII discussions. It is not that we are ignoring that, but I will touch a little more on our transition for employment with hygiene, but at this point we are getting to be very small as far as dental practices. The transition over the past few years is more of a hygiene program. So a dental assistant two is not particularly valuable to VDH, but we recognize, again, and support any mode of providing care that might reduce the cost by increased access.

The main point that we would raise in considering whatever adjustments to the DAII that you are considering is that although something like this may increase capacity in any given practice, which can theoretically improve access and possibly reduce cost to delivery of services, we don't really feel that that type of provider expansion is necessarily going to put care providers in new areas. It may be improve capacity in existing facilities, but it is not going to provide in those areas of the state where we are short of providers, where there are people that are having trouble accessing care for a variety of reasons.

So the main reason that I am here today is to

speak to the remote supervision issue. As you know, this has been going on since 2009. I was involved with it since the inception of it, as many people in this room, as we put together the guidance for it and developed the protocols and regulations. We started it off as a pilot in VDH. We have now moved into expanding this to ten hygienists that are school-based and four hygienists that are Health-Department-based, providing services under remote supervision. So we have literally provided tens of thousands of assessment models where the hygienists are provided supervision, policies and procedures, training, guiding orientation, go into the field and assess, primarily children, although we are not limited to that and we are exploring other segments, and from that point providing better services, as appropriate, and most importantly, working with our partners in the community to try to get specifically children into a dental home.

The first thing we do when we go to any community is contact every dentist there, and at that point, when we go into any school organization, we have a list of willing providers. I am not speaking to the financial commitments that they make, but they are aware of what we are doing and they are willing to take our patients. The reason this has been successful, and the reason that we feel it is a safe way to provide a lot of care to people who otherwise

would not have access, is that we have had the support of dentists in the community and the other community providers serving as our referral. So we feel that we have not only had the opportunity to provide services to children that may not have any, but we also stimulated some care-seeking behavior that may not have happened. If you look at any public health science, you will see that programs such as this have been documented to do just that, to stimulate or facilitate care in the community beyond the initial intake assessment and dental services that are received through hygiene programs such as ours, and that, perhaps, is the greatest thing that we could do, is to get people to access care that they otherwise have just not been able to.

Our hygienists very often function as case managers in trying to get that. Folks, again, I keep saying children, but trying to help parents get these children into care, and particularly when it is a severe issue, they stay with them for quite a long period of time, and then we go back and look for the kids again the next year to make sure that those sealants are still there and maintain the quality standards, but also to see if care has been done, and if not, we start that process again with contacting parents.

So what we have found to be very successful is using a hygienist with lots of training, adequate oversight, to bring care into areas that otherwise would not have

adequate access, or people in areas that would keep them from having full access, making it relatively simple for them to get in, get the kids started, get out in front at a very young age. We have started at the pre-K level with assessments, have the consents and proper paperwork, and as long as we can provide the training and orientation and detailed regulations, we have found this has worked wonderfully. As you can seen in our latest reports, like I said, we have delivered a lot of services, and a lot of services in places that may not otherwise have received them.

I will conclude in my last minute by just saying that we feel like it has been successful and we have accomplished what we hoped to accomplish. We would like to see it continue, of course. The Health Department, having gone through a transition plan and putting some of its funds towards hygiene, is going to try to expand to the extent that it can, but we do feel that it is reasonable to consider the expansion of remote supervision as a way of providing access to more people in the state, as well as those people who are particularly facing barriers because of either where they live or income stress. So I will leave it with you to continue this discussion, but I will remain, and if we do get into a discussion later today, I will be happy to take any questions. Do you want questions at this point?

MS. SWAIN: No. Thank you.

Michelle McGregor.
MS. MCGREGOR: M-C-G-R-E-G-O-R.
Good morning. It is like being on trial, and we can smile. Good morning. My name is Michelle McGregor. I'm a registered dental hygienist, with over thirty years of experience in private practice, group practice and public health and education. Currently, I serve as the Virginia Dental Association president, the program director for the Virginia Commonwealth University Dental Hygiene Program, and I also serve on two national organizations with the American Dental Education Association. So I would like to say I am here representing all of those organizations, but my comments are being brought from VCU's Dental Hygiene Program.
I would like to thank the Board for the opportunity to offer comments on the three concepts outlined during the October 2014 regulatory legislative meeting investigating improving access to dental hygiene care to all Virginians. I would like to provide comment on concept three only, expanded options for dental hygienists to practice under the remote supervision model. I will be brief, and excuse me for reading, but I want to stay on track.
There are many practice models being examined across the nation, but we must focus on the best fit for Virginia. Documentation of need exists and improved access is warranted. I have stated this in previous forums and task

force, but it needs repeating. I strongly caution the Board of Health Professions and the Board of Dentistry in using the language expanded scope of practice in these discussions. It continues to be misleading and confusing, since the intent is to address supervision requirements, not to address increasing duties allowed in the current scope of practice of dental hygiene.
The Virginia Health Care Foundation reported in its 2015 Dental Statistics and Research Report that 3.8 million Virginians have no dental insurance. These individuals often seek care in free or charitable clinics or resort to hospital emergency rooms. According to the American Dental Association, 2.1 million Americans visited emergency rooms for dental pain in 2010, and nearly eighty percent of those were preventable. Dental hygienists, the profession, is rooted in prevention and education. As most of you know, as has been stated earlier, in 2009 the General Assembly enacted legislation that reduces dentist oversight requirements for dental hygienists employed by the Virginia Department of Health in selected underserved areas. This model has already demonstrated success as a safe and effective way to improve access to preventative dental services for those at highest risk. So we have already solved our problem a little bit.
The VDH has documented these outcomes, and I

have provided the 2014 Technical Report on remote supervision as evidence-based support. The June 2014 Journal of Evidence-Based Dental Practice Special Issue Annual Report on dental hygiene examined the direct access model across the nation. I present this document, also, to the Board for reference. Currently, thirty-six states have some type of direct access, and that includes Virginia, due to our Department of Health hygienists. The report acknowledges the adopted models are specific to each state and hygienists must still adhere to federal and state regulations. Some states require additional education or hours of practice, have restrictions on settings for direct access or require formal agreements with a dentist or another supervising entity. The current VDH employed hygienist requires two years of experience and allows hygienists to work collaboratively with a public health dentist who is not physically on site nor has examined these patients. So, again, I say we must think about Virginia.
Schools prepare hygienists to serve in these roles, and the educational process has continued to transform over the years to include course work on public health, research, insurance and tele-dentistry to meet the evolving needs of our communities. This evidence-based practice report concludes that minority populations, such as the elderly, special needs, children and rural populations, have

benefited from care provided directly by dental hygienists. This has also served as an entry point for many into the healthcare system. I receive many calls at the school for people asking students to come to provide care at facilities that have an empty dental chair but no dentist. The 2014 Dental Hygiene Workforce study indicated that there are licensed hygienists in Virginia who are looking for work. The need is there, the workforce is there, and it is time for Virginia to take action.
The VCU Dental Hygiene Program supports the expansion of the remote supervision program to include the utilization of licensed dental hygienists in safety net facilities, nursing homes, community health clinics and non-traditional settings. Again, I emphasize this expands practice settings to reach those in need and does not expand the scope of practice or services provided. Using models of collaborative agreement, such as the Department of Health, between dentists and dental hygienists would allow hygienists to work to their full capacity and us all to better address access-to-care issues.
I thank you for your time.
MS. SWAIN: Dr. Alan Dow.
DR. DOW: Good morning. So my name in Alan Dow. I am a physician. I am in an usual spot here, I guess, and I wanted to talk about sort of the medical prospective.

I am on the faculty at VCU, but I don't represent VCU. However, I think I can speak about sort of the physician perspective on this issue.

So let me tell you a little bit about myself. So I am a general internist. I primarily do hospital work at VCU, and then I also do free clinic work in a primary care setting in Richmond. I wanted to talk to you about a patient that I took care of this February. I am going to call the patient Jesse, not his real name, but Jesse is very typical of the patients that I have taken care of over the past fifteen years at VCU. Jesse was from southern Virginia, a rural area, and he arrived and transferred to our hospital with a diabetic foot ulcer. So Jesse had diabetes that was out of control over years and years, had a large foot ulcer which unfortunately had spread into the bone, the infection, and it required an amputation as part of his care when I was taking care of him.

I talk about Jesse, because when you look at what led him to the condition he was in when I began to take care of him, it was a decade or more of poor access to care, poorly controlled diabetes, and when you ask Jesse about what was going on with him, it wasn't just his foot that was bothering him. It was his poor oral health. He actually had an oral abscess. He was seen by oral surgeons as part of care. We had him on antibiotics for his foot, which also

helped with his abscess. When we sent him home, he was going to get some follow-up care for his oral issues at our clinic at VCU. I think he made the appointments, but I talk about Jesse because we know there is increasing evidence about the link of poor oral health, uncontrolled disease and the manifestations that I see when I take care of patients in the hospital, and our dental colleagues have done a great job of sort of clarifying some of those issues, but when you get chronic inflammation from chronic oral infections, periodontal disease and whatnot, you end up with out-of-control diabetes, which I see in the free clinic setting often, leading to these health outcomes, and Jesse's story is sad for him, and I think we are all sympathetic, but there are broad social implications of Jesse's story as well, because when we think about what happens with Jesse's life after he is in the hospital, what it involves is a lot of cost to our society.

So Jesse was a relatively young man. He was forty-five, and once he gets a foot amputation, he is going to be on disability, he is going to go from being uninsured to being on Medicaid, and all of that is going to cost our state and our society tens of thousands of dollars a year. So, in a sense, our inability to control his chronic diseases to begin with, both oral and medical, has led to a cost of thirty or forty thousand dollars a year for our society for

Jesse's ongoing cost. So if you multiply that times a life expectancy of twenty or thirty years, you are talking about hundreds of thousands of dollars that a patient like Jesse is costing us, the taxpayers.

I also see people like Jesse in the free clinic setting, who come in to get control of their chronic diseases, and I will tell you, as a primary care physician for a lot of these patients, it is very difficult to get their medical problems, particular their diabetes, under control. There is a lot of evidence now linking poor oral health and chronic inflammation to elevated Hemoglobin A1Cs, and this is sort of the midpoint on the path to becoming Jesse.

So how do we sort of think about those patients and try to find them access to care. In the free clinic setting, very, very difficult to find oral health providers for patients. In the City of Richmond we are fortunate we can refer to the VCU dentistry clinic, that helps people on a sliding scale, but a lot of these folks are in rural environments and don't have the ability to come to Richmond and be seen at the VCU clinic.

So hearing what the previous two speakers have said about the pilot study that the Virginia Department of Health has done, and what Ms. McGregor said about 3.8 million people that are uninsured, which is just a shocking number to

me for oral health, I think the question is what can we do to make this better, and it is very clear to me that the Virginia Department of Health's pilot at least provides us a way forward. I don't know much about the first questions. From what I understand, there are eight dental assistants in Virginia right now, so that doesn't seem like an easy number to expand and really increase capacity, but it is very clear that the third strategy, about increasing the practice ability of the dental hygienist, is a viable strategy that is backed up by evidence in terms of moving forward.

I do know from working at VCU that we have a ready workforce for this. We graduate approximately thirty dental hygienists over the year. I know there are other places that are graduating dental hygienists around the state. So we do have a workforce that can provide some of this capacity for some of this preventative care that we need for dental health, and I do see this as a strategy that would work going forward.

It is interesting to me, as a physician, to think about this issue parallel with what I see in the medical profession. So if I think what dental hygienists do in terms of assessments, some procedures that are not particularly invasive, it reminds me of the link between a physician and home health nurse. They both are trained, they are trained to do what their specific role is going to be,

yet our home health nurses function much more autonomously than our dental hygienists do, and it is striking to me that I can have a patient that I discharge from the hospital and I rely on that home health nurse to work relatively autonomously, in terms of making assessments, doing wound care, drawing blood, all that sort of invasive kind of stuff that a home health nurse does, and do that without a lot of concern, yet there seems to be a lot of concern about dental hygienists working, and what I actually see is it is a more narrow scope of intervention than with what a dental hygienist does.

So I want to conclude just by saying that Jesse was a patient that was just one of many patients like that that I have taken care over fifteen years. I think the implications of what we are talking about today goes far beyond oral health. It goes into really the health of the old person and the health of the whole community. If you think about 3.8 million people that do not have access to oral care because they do not have insurance, anything that we can do to sort of start stemming this type of chronic illness early and preventing all those downstream costs and morbidity for our population is really crucial for thinking about building a healthier Virginia.

Thank you.

MS. SWAIN: Dr. Mark Crabtree.

DR. CRABTREE: Good morning. Just a second to get set up here. As the former mayor of Martinsville, I feel like I am off to the races, since I have got ten minutes, so I want to make sure I get it all in.

I am Mark Crabtree, a private-practicing dentist in Martinsville, Virginia; past president of the Virginia Dental Association; past chairman of the Counsel on Access, Prevention and Interprofessional Relations for the American Dental Association. Presently, I am the chairman of the task force that is set up to get the Community Dental Health Coordinator program started in Virginia, a program that was introduced several years ago by the American Dental Association, studied very thoroughly, and also is spreading across the country. So those of you who are ADA members may have been following a little bit of that discussion in the ADA.

So I want to set the discussion about access to care, and when you look at access to care it is a multi-factorial issue. There are many, many factors that keep people from accessing care. Workforce is one piece of it, but there are many, many other things that limit someone's ability to access to care. The ADA is proposing, and the VDA, the Community Dental Health Coordinator is a piece of that. We can address all those factors with one solution. There have to be multiple solutions that we can

come up with, but we think that the one that we are going to provide is going to be much more cost-effective and actually get people to the care that they need.

So the Community Dental Health Coordinator's focus is on reducing the oral health disparities that target the social determinants of oral disease and improving access to dental care. It is focused on primary prevention. I am also president of the Piedmont Virginia Dental Health Foundation in Martinsville, Virginia, who has a very active program that addresses dental disease in the City of Martinsville, with the highest unemployment rate in the State of Virginia, and we have a thirty-one percent reduction in ED visits to our little hospital because we have attacked dental disease and declared war on gum disease, and we do it by not only doing the primary prevention but also doing the care that people need.

So what is the CDHC. The CDHC is a conduit between underserved communities that are in desperate need of care and the dentists who are trained and licensed to provide that care. What Jesse needs, the gentleman that was described earlier, is a CDHC, who could take him by the hand and help him to navigate the maze of the options that are available to him to get his total health taken care of at a community health center and get him the dental care that he needs. There are resources that are available, chairs that

are empty within the State of Virginia that are not being filled because people are not accessing the care because of the social determinants that are there, and that is why we have the CDHC.

It is based on a community health worker model. It is a model that works. It recruits people from the same communities where they work, and it leverages the existing resources that are available to fund it. In 2005 in the Journal of Public Health Dentistry – I can give you a more specific citation for that, but I had to whittle everything back, so I am going to zip right along. The Dental Health Care Coordinator intervention significantly increased dental utilization. They compared with similar children who received routine Medicaid member service. Public health programs and communities endeavoring to reduce the oral health disparities may want to consider incorporating a dental health coordinator. We would want Virginia to be a part of that growing effort across the country.

How they do it, they basically assess the needs. Are they in pain, do they need to see a dentist, do they need financing, is that a barrier, is language a barrier, is transportation a barrier. They are going to help in these areas. It is a navigator, someone who can help people get to the care that they need. It is help in registering for Medicaid. They may even be available for

other programs that they don't know about. Help with transportation. They will provide support for other potential personal access barriers. They will try to address those, such as fear and anxiety. There are a lot of things on those whole socioeconomic scales that can affect their ability to access care. They basically coordinate dental care and manage all aspects.

So in a private dental office, a lot of this is done by your front desk person, triaging, but a lot of people who are in need of care can't get to that point through the community health centers. They are out there in the community suffering, and this is a way where we can actually take people from the community and help them to get the care that they need. They will be trained to work under a dentist's supervision in health and community settings, such as community health centers, schools, churches, senior citizen centers, Head Start programs and other public health settings with residents that have ethnic and cultural backgrounds similar to the CDHC. They collect the information to assist in the triage.

They address their social, environmental and health literacy issues facing that community's population. They will assist the community members in developing goals to promote their personal oral health. I lot of people just don't understand that they need to have preventative dental

care to get rid of that plaque and tartar on their teeth, to save their teeth and prevent abscesses and things that go on there, especially if they are a diabetic like Jesse was. Manage the care and navigate the patients through the maze of health and dental care systems. That is a huge thing. There is care available for a lot of folks, and they don't access it because they don't have the skill sets necessary to do that. Just as a dental assistant, they can do anything that a dental assistant would do, providing regulated activity such screening and fluoride treatments under supervision, which is pretty much standard in any dental office.

The curriculum, these are what they will learn in the basic model. This is where there is a lot of confusion. It has evolved over time. There is a basis model and an advanced model. We are only talking about the basic model. The basic model is a community dental health worker, or a community health worker with some dental skills, so they understand how dentistry works and how the dental programs work that are available. I am off to the races, as I said.

Dental health outreach and advocacy, there is a lot of education that goes on in the schools. They can assist with oral health communication, interviewing skills, legal and ethical issues that are in dental health. They have some dental skill modules, which is basically understanding what dentistry is. The textbook is kind of

like that dental assisting textbook that covers screening and classification; prevention of dental carries; prevention of oral cancer; financing and payment options for dental care. Very simple, basic things that nonregulated people do within community health centers and health educators do. They have an internship model based on what a community health center would be able to utilize them for.

That is the basic model, and the advanced model includes all dental details, the regulated pieces that you all will be concerned with, and which we will, too, if we want to take it to another level. We are not talking about that level at this time. We are only concerned with getting the navigation piece and the basic model up and going.

An advanced CDHC would be possibly trained, even if it was in a community health center with a hygienist, placement of sealants, placement of temporary fillings, simple teeth cleanings, class one stuff, removing gross debris, stains, calculus using scalers and all that stuff. Advanced, that will require probably legislative change and lots of changes in the rules and regs. So I want to make sure we separate those two in people's minds, so they understand that the advanced certificate is the one where there will be a lot of discussion.

Now, the task force at the VDA forum determined that this would be a very feasible model in Virginia, and

this has just occurred since September. We think it should be a two-level certificate program. Obviously, you can't introduce the second one. The basic certificate, there are no regulated duties, but this bottom piece is what we would really like for you all to kind of take a look at. The CDHC should be a part of a career path in oral healthcare, and if you look at the far right, you have the DDSMS. That is our specialist. They are the top of the pyramid. They are the guys and gals that have gone out there and are oral surgeons. They are endodontists. They are periodontists. They are public health Ph.D.s. All those folks are on that end. Then you have the dentists, and then you have the bachelor's degree hygienists, you have associates degree hygienists, and then we have the regulated area of advanced CDHC, the dental assistant two and the basic CDA, which are basically the assistance level.

What does this mean economically. You don't want someone at the top end of the deal doing something that someone at the bottom can do. A basic CDHC will be expected to make the same as a community health worker in Virginia, which is about 35,000; the advanced, 40 to 38. Hygienists in Virginia are at 81,000 a year. Dentist are reporting 156. I am sure some of the specialists make a lot more than that. This is the economic issue that is there.

There is not a shortage of dental hygienists in

Virginia. You take someone out of this equation, but you have to fill it back and increase the problem there, and, basically, why would someone at the upper end want to be doing tasks that could be done by someone at a lower level. It is very simple economics. A hygienist can do everything a basic CDHC would do, but why would they not do that when they are able to earn, and up in Northern Virginia it is even more than that, that amount.

I hate that we have to try to get all of this squeezed in, and I hope there is an opportunity to take it further, but this basically is not dental healthcare, and this one is the last slide. I am going to give you this, if that is okay. I understand, without objection of the Board members, that you could be flexible.

MS. SWAIN: We will have time in the end.

Dr. Michael Link.

DR. LINK: Thank you. I am Dr. Michael Link. I am president of the Virginia Board of Dentistry, and I want to give you a little bit of history -- sorry, I am trying to concentrate on too many things. I am a past chairman of the Virginia Board of Dentistry. I am the current president of the VDA. I want to give you a little history on what happened with the DAIIs.

Back when I was president back in 2001, there was a petition for a ruling to make a change to the

regulation to allow scaling technicians, and the reason that this petitioner asked this was because he could not find a hygienist where he lived and because of the cost. So what ended up happening is, over the next few years, we ended up with the expanded duty dental assistant, or DAII. Currently, I believe as of two weeks ago, Sandy told us that there are seven registered in the whole state. Now, I feel like if you only have seven that maybe currently there is too much of a stringent requirement. However, the main reason for the petition was to have a scaling technician, which was totally overlooked by the Board. The Board approved over the next few years a tandem duty functions to help dentists with such as packing cord, you know the duties, but the intent of the petition was for a scaling technician.

The VDA's policy is, in support of scaling technicians, to help address the access to care issue. As I mentioned, the ADA has done extensive research with more open-chair time in dental offices throughout the state and the nation, and we believe the workforce model is more than adequate. The Commonwealth needs the most economical and feasible way to help access to care. Now, we have researched the issue throughly, and through the Virginia Labor Market website and federal data, the breakdown of hygienists' salaries are consistently higher, and as you look at here, you can see this comes right off the Virginia government

website. It tells you the salaries of the hygienists, and we believe that the CDHC model is much more economically effective and feasible than any model that has been suggested.

Lastly, if the Board is considering any changes in the supervision model, then the VDA's policy does not currently permit this. We would encourage and hope to be encouraging any dialogue for charges. This way it will give our organization the time it needs to either adjust its policies or to have input on these policies.

Thank you very much. That is all I have.

MS. SWAIN: Sheri Moore.

MS. MOORE: Moore, M-O-O-R-E.

Thank you, Madam President. Can you hear me?

MS. SWAIN: We can.

MS. MOORE: My name is Sheri Moore, and I hold the position of council chair for policy bylaws for the American Dental Hygienists' Association, and I am also the Board of Dentistry liaison for VDHA, but I am not speaking in either of those capacities. I was asked to come forward to bring testimony and presentation for Dr. Lyn Van Der Sommen, L-Y-N, V-A-N, D-E-R, S-O-M-M-E-N.

Lyn says: Please accept my apologies for not being physically present today. As power of attorney for my mom, it was necessary for me to accompany her to her

healthcare appointments, but I wanted to share my concerns with you regarding the state of oral healthcare of our Virginia seniors.

I have spent over forty-five years in healthcare. As a family physician who practiced in office, emergency and nursing home settings, I witnessed firsthand many a senior battling disorders and disease that had either a direct or indirect connection to poor oral hygiene. There were those who could not manage a proper diet because of oral infections, a painful mouth or inability to chew properly. Sepsis, poorly controlled diabetes, malnutrition and pneumonia all became possible outcomes. I could only refer my patients to emergency rooms, hoping they would receive more care than I could possibly provide. However, more often than not, treatment included pain medications, antibiotics and a trip back home, and the cycle would begin again.

As a very active volunteer with the American Cancer Society for many years, I saw the devastating malignant results of poor oral care. As a community college program manager for healthcare education and training of direct care staff for seniors, I observed how little training aids are provided with regards to oral care. I fought an uphill battle to stress the importance of such care to those running longterm care facilities. From poor supervision and training, time constraints, lack of equipment and materials,

I saw little oral care being provided on any regular basis. Today, as chairman of a Charlottesville-Albemarle oral healthcare committee, I know little has changed. Only those who can privately pay or have dental insurance obtain the needed services, while the condition of the rest of the residents deteriorates.

With certifications in gerontology and geriatric education, I founded the Geriatric Collaborative of Central Virginia, whose mission is to bring evidenced-based best practices of geriatric education and training to healthcare professionals. One of our goals is to bring attention to the poor oral healthcare of our seniors in longterm care facilities and how changing the present culture of care to one that acknowledges the importance of oral healthcare is a battle worth fighting.

Most recently, as a member of the Virginia Dental Association's Task Force, I have been participating in a pilot study to demonstrate how the regular presence of dental providers in longterm care facilities will make a significant difference in decreasing costs for the care of our seniors. These providers, dental hygienists, can offer training to staff, provide preventative and routine maintenance services to residents and timely referrals to dentists for needed procedures. Studies and implementation of such providers and services in other states throughout the

nation have proven to decrease morbidity, mortality and healthcare dollars. The reduction in emergency room visits and hospital admissions alone have been shown to pay for providing seniors with access and dental insurance.

To provide this level of care, it is not necessary to have a dentist physically present in such facilities. Dental hygienists are very skilled providers of preventative and maintenance care. They are able to access if more care is needed and make the necessary, appropriate and cost-effective referrals. We have an epidemic of poor oral healthcare in America, and the cost to America at so many levels is only going to soar. We need to elevate the importance of oral healthcare. We need to change the dialogue of healthcare to always include oral and dental services, to be proactive to provide affordable and accessible dental care services to all seniors.

Please consider taking such measures as advocating for dental insurance for our Virginia seniors and supporting more autonomy for our Virginia dental hygienists. We have in place a well-trained workforce that is being underutilized and who could make a positive difference in the overall healthcare of our seniors.

Thank you very much.

Lyn Van Der Sommen.

MS. SWAIN: Rick Shinn.

MR. SHINN: Good morning. My name is Rick Shinn, S-H-I-N-N. I am the director of public affairs for the Virginia Community Healthcare Association. I do represent the community health centers in Virginia, and I will be speaking for them this morning.

You have my comments. Someone skipped a lot of this. I do want to give you a little bit of a background about who we are and what we do. We are federally-qualified health centers that work in medically underserved areas, serving over 300,000 Virginias at 144 sites, all the way from Chincoteague clear down to--

MS. SWAIN: Mr. Shinn, I think they need to hear you in the back. Can you speak a little louder, please.

MR. SHINN: All our of our sites are located in medically underserved areas or serving medically underserved populations. Most of those also happen to be dentally underserved areas as well. So we have a considerable shortage of dental professionals and services. In addition, a large percentage of the persons that we serve are uninsured or have Medicaid coverage. Access to dental healthcare services is extremely important to these people, yet gaining access is severely impeded due to the lack of adequate financial coverage and lack of providers willing to locate their practices in underserved areas. Obviously, we do not fault the providers, as they must have sufficient populations

and incomes to operate sustainable practices.

We would appreciate your consideration of the following comments I have given to you this morning. Our main concern is the impact on the patients served by the health centers in regards to any proposed options that may be considered. Our concern is that a mechanism that is effective and sustainable over time be developed to provide dental services to those persons who are living in underserved areas. Since many of the persons in these areas are uninsured or on Medicaid -- that is another issue -- their ability to pay for services is limited or practically nonexistent. The remote supervision dental hygienist model developed for the Virginia Department of Health appears to be meeting the mission intended. This could serve as a model for extending this concept to other safety net providers, while maintaining the integrity of dental services being delivered to persons living in underserved areas of the Commonwealth.

Following on the recent Dental Hygienist Scope of Practice Review, we would ask that consideration be given to expanding the options for dental hygienists to practice under remote supervision of dentists in dentally underserved areas and with safety net providers, including but not limited to federally qualified health centers and free clinics, and that roles in the options that were previously

sent out under a different memo, of the remote supervision and restricting the expanse of the practice to serve the areas of populations I just mentioned.

We look forward to working with you. We know there are a lot of issues to discuss here. There are a lot of parties involved in this, and anything that we can do in working with you on these issues, we would appreciate that.

Thank you.

MS. SWAIN: Cathy Berard.

MS. BERARD: B-E-R-A-R-D.

My name is Cathy Berard. Good morning, first of all. My name is Cathy Berard. I am a dental hygienist, a past president of the Virginia Dental Hygienists' Association, and I currently serve as cochair of our Public Health, Education and Professional Affairs Council. I have over forty years of experience as a dental hygienist, in both general practice and multi-specialty group practice. I am an adjunct faculty at Northern Virginia Community College.

On behalf of the Virginia Dental Hygienists' Association, that represents the 5,563 licensed dental hygienists in the Commonwealth, I would like to thank the Board of Dentistry for the opportunity to provide comment regarding strategies to increase access to dental treatment. Through data, research, stakeholder discussions and a successful statewide Virginia Department of Health program,

the VDHA supports the policy change that would expand the options for dental hygienists to practice under the remote supervision of dentists.

Access to oral healthcare is a national issue, and Virginia is no exception. As stated before, 3.8 million Virginians do not have dental insurance. As you know, most Medicare plans do not include a dental benefit, and Virginia Medicaid provides only full dental coverage for children, covers emergency care for some adults, and most recently started providing dental benefits for pregnant women. Due to the lack of affordable access to dental care, many low-income individuals rely on hospital emergency departments and safety net providers, such as free and charitable clinics and community health centers.

During the summer and fall 2013, oral healthcare stakeholders met to discuss how Virginia can improve oral healthcare and examine how to divert patients from emergency departments. In addition, the group looked at ways providers can practice in additional settings to access patient populations that are not being reached. Oral healthcare leaders among the stakeholder group focused on the importance of providing timely preventive dental service rather than waiting until treatment needs arise, which escalates costs. Improving access to preventive dental services can significantly reduce costs for those low-income

individuals.

The overwhelming belief is that providing preventive oral healthcare access is the focus and dental hygienists within the remote supervision model is the solution. As previously pointed out, in 2009 the General Assembly enacted legislation that reduces dental oversight requirements for dental hygienists employed by the Virginia Department of Health in select dentally underserved areas. VDH dental hygienists worked under remote supervision and had periodic communication with a public health dentist. Under that 2009 legislation, dental hygienists were authorized to perform services such as initial examination of teeth and surrounding tissues, charting existing conditions, prophylaxis of natural and restored teeth, application of topical fluorides, providing dental sealants, scaling and educational services. That initial VDH pilot program focused on providing sealants, fluoride varnish, initial examination and education, and as stated by Dr. Browder, was a glowing success throughout the Commonwealth and was expanded in 2012.

From the 2014 Virginia Department of Health Report on remote supervision, just a few statistics: 4,000 children returned a permission form and were screened by a dental hygienist in a school-based setting; 1,746 received sealants; 3,754 received a fluoride varnish application; 1,220 children were identified as having other oral health

needs and referred to community providers.

This effort has improved access to preventive dental service for those at highest risk of dental disease, as well as reducing barriers and costs for dental care for low-income individuals. The report indicates the remote supervision model has been a successful alternative method of delivery for safety net dental program services that have increased access for underserved populations. Increasing the availability of preventive services such as sealants and fluoride has been proven to significantly reduce the dental disease burden, which is a priority need for those populations at highest risk.

The VDHA support for the remote supervision model comes through evidence-based data that demonstrates the dental hygiene workforce needs to be utilized. Recent public comment and dialogue has improperly defined dental hygienists in the workforce and their salary. I want to take a moment to review the facts of the dental hygiene workforce based on a 2014 survey completed by the Virginia Department of Health Professions Workforce Data Center. The dental hygienist workforce survey had responses from 4,678 of the 5,563 licensed hygienists, which represents an 84-percent response rate. Out of those licensed hygienists, approximately only 47 percent hold a full-time position, and nearly 30 percent have just one part-time position. The survey revealed that

there are 3 percent who are looking for work. These are hygienists who are already educated and licensed by this Board. The average median income for a licensed dental hygienist is between $50,000 and $60,000 per year. Provided to you with out comments is the complete 2014 Virginia Dental Hygienist Workforce Survey.

Additional outside entities have scored the Commonwealth of Virginia on our oral healthcare access. The Pew Charitable Trust provided a report card rating for Virginia. Pew gave Virginia a rate of C minus for dental sealants. In 2012 the grade was a C. The stated reason for the grade drop is due to the fact that the only hygienists permitted to place sealants in schools under remote supervision are those employed by the State Health Department, and I believe Dr. Browder said that number was about ten people. The National Governors Associations, which is a bipartisan collective voice on national policy and innovative solutions to improve state government, recently published their paper on the role of dental hygienists in providing access to oral healthcare. The NGA specifically points out the suggestion of placing dental hygienists in underserved areas.

Some experts question the equity of limiting the work of dental hygienists based on practice settings and argue that expanding their practice areas will help

hygienists fulfill oral healthcare needs for underserved populations. More than half the states allow direct-access hygienists to work with underserved populations in some public settings but explicitly bar them from practicing in private settings. The rationale that state dental boards most commonly use for restricting hygienists from practicing in an unserviced setting focuses on concerns about quality and safety, even though no clear evidence exists to support such restrictions.

When it comes to risks associated with the remote supervision model, I, again, ask you to look no further than the Virginia Department of Health program. There have been no patient safety concerns for the dental hygienists providing care to Virginia's most vulnerable over the last six years. Any concerns about safety and efficacy should apply, regardless of the income level of the recipient of care.

Through the data, research and comments we have made today, the Virginia Dental Hygienists' Association, representing over 5,000 licensed dental hygienists, stands by the need for a policy change. We align ourselves with other oral healthcare stakeholders and believe that expanding the options for hygienists to practice under the remote supervision of dentists is the next step for Virginia to reach those who need oral healthcare services.

Thank you.

MS. SWAIN: Kara Sprouse.

MS. SPROUSE: Good morning. My name is Kara Sprouse. It is spelled K-A-R-A, S-P-R-O-U-S-E. I am a dental hygienist, and actually I just became the eighth person to be licensed to be a dental assistant two. I recently completed the DAII program at Fortis College. I am here today to speak in response to the open forum on policy strategies to increase access to dental treatment and the three strategies under consideration by the Board.

The first thing I would like to comment on is adjusting education endorsement requirements for DAII registration to increase the number of registrants. I am aware that currently there are eight licensed in the State of Virginia. I believe that there are a few different reasons as to why there aren't more. First, many people are probably unaware that there are only two programs in the State of Virginia, one being Fortis College and the other being Germanna. I believe that not everyone who is a dental assistant holds a current CDA. In order to be accepted into this program, a dental assistant must hold a current CDA.

Being a dental hygienist, I have already taken a national board. I felt that taking the CDA to get into the DAII program was a bit redundant. A dental hygienist should be able to enter a DAII program and take the clinical

components to obtain DAII without obtaining CDA status. For dental assistants, the education requirements within the DAII program probably are necessary. Some components of the program are a review for dental hygienists. However, I found them to be a good review. The Virginia Board of Dentistry DAII requirement for didactic and laboratory training hours are necessary.

The clinical hours in a dental office under the direct and immediate supervision of a dentist, however, are difficult to track. For example, it is necessary to complete 120 hours of placement in shaping composite restorations. I feel having hours isn't very measurable. There is no guarantee that within those 120 hours that a student has experienced every class of restoration, such as class one, two, three, et cetera. Also, two clinicians won't perform at the same rate. For example, within one hour clinician A may complete six composites versus clinician B may only complete four. I think the change in the regulations from hours to number of clinical procedures completed should be something to consider. I suggest to the Virginia Board of Dentistry to reach out to the DAII program to decide the amount of procedures that students should complete.

The last point I want to touch on is creating a pathway for dental hygienists to perform these duties delegated to DAIIs. I think this will allow hygienists and

assistants to work together better and closer. Dental offices require teamwork. With the skill I have acquired as a dental hygienist and a DAII, I am able to review the patient's medical history, anesthetize the patient, a DDS will cup the wrap and I return to restore the tooth. I enjoy performing these duties and helping return my patients back to health. I also would like to add that both dental hygienists and DAIIs are regulated under two different boards. However, I feel like this DAII program can bridge the gap between the two professions, because they would be under the same regulatory guidelines.

That is all I have to say, and thank you for the opportunity for me to speak today and I hope you will consider my suggestions.

MS. SWAIN: Linda Wilkinson.

MS. WILKINSON: Good morning. My name is Linda Wilkinson. I hope you can hear me. I am a victim of Virginia's pollen, so hopefully you can hear me.

Good morning, again. My name is Linda Wilkinson, and it is a privilege and pleasure to be the CEO of the Virginia Association of Free and Charitable Clinics. We have sixty member clinics throughout the Commonwealth who serve adult uninsured patients, literally at or below 200 percent of the federal poverty level. To give you an idea of what that looks like, for a family of four, we are talking

about a family of four living at 100 percent of the federal poverty level, we are talking about an annual household income of a little over $24,000.

Free and Charitable Clinics provide uncompensated care, including preventive and chronic care for illnesses such as diabetes, COPD and hypertension. Our services include medical, pharmaceutical, behavioral and/or dental healthcare services. Last year our clinics served over 70,000 unduplicated patients, but only 15,000 of whom received dental care, despite the generous donation of time and talent of 462 volunteer dentists and 142 volunteer hygienists.

I am here today to encourage the Board of Dentistry to consider three simple things:

1.) When developing regulations, please consider Virginia's uninsured population who have very limited access to much needed dental services, despite their significant oral health issues which are complicated by chronic illnesses. I believe you have heard now from two, maybe even three, other speakers that there are 3.8 million residents in Virginia without dental coverage.

2.) Many of our volunteer dentists are retiring, and younger dentists are not replacing them at the same rate. Thus we encourage the Board to consider regulations that allow the greatest flexibility for all

dental providers, including dental hygienists, by expanding remote supervision models such as those that exist with the public health departments; and

3.) I would be remiss and not performing my functions as the CEO of this association if I did not invite every member to this distinguished panel to volunteer at one of our Free and Charitable Clinics.

Thank you, and I am very grateful for this opportunity to address you today, and thank you very much for what you do for the Commonwealth of Virginia.

MS. SWAIN: Tina Bailey.

MS. BAILEY: Hi. Good morning. I am Tina Bailey. I am the current president of the Virginia Dental Assistants' Association and a long-time dental care advocate. Through the dental assisting national board, I currently, and have held since 1982, my certification in dental assisting, and since 1986 my certificate in dental practice administration. I have worked in private practice at the VCU School of Dentistry, in both free clinic settings and in community outreach programs. Specifically, those programs, along with the Mission of Mercy projects through the VDA, I was fortunate to be involved with a program where we provided access and education to children.

Throughout my career I have had the honor of serving along with many other, numerous other, dental

professionals who share a passion for dentistry, and I just ask you -- today I am not here for me or for the other dental professionals -- I am here to ask you to make it more accessible for those folks in the community who need that dental care, and just as you do that, I don't want to say make it easier for us to get to them, but make it easier for them to get to us and have us there in the community.

Thank you.

MS. SWAIN: Sharon Stull.

MS. STULL: Good morning. I am Sharon Stull, and I am coming to you by two organizations. One is Old Dominion University's School of Dental Hygiene, and two, Chesapeake Care, Inc., a charitable clinic in the Hampton Roads area. So I have made the ride up from Hampton Roads today with not too many issues, and I am probably, as all of you, very acutely aware of access needs in oral healthcare service, but I am probably one of the luckiest people in this room, I feel personally, because I teach students, our future oral health providers, that actually our classroom is out in community, and just this last year we have treated, and I have shared that document with you, in 2013/2014 my students at the School of Dental Hygiene have served the underserved, the vulnerable, the at-risk patients in our community with nearly 71,000 donated dental hygiene services. That is impactful, and that is about 6,600 individual. So that is an

enormous amount of data on that sheet.

That sheet also includes the ability that the students provide our community with oral health literacy, increasing that, which is a huge need. They are amazed by how low the oral health literacy is. I want to look at my teeth, and we always tell them look at your gums, they tell the story. I feel that we already have a perspective model in place in the Hampton Roads area. So I hope you would consider that expansion for the remote supervision under a remote dentist for dental hygienists, because we already have that model in place in the Hampton Roads area.

Our students go to seven of the safety net providers to provide clinical services, and then they go into the schools and provide oral health education. So they are making an impact on our community, and they are not licensed yet but they are wanting to be licensed, and it is really a frustration for me as a licensed dental hygienist over thirty years that I see and hear, after the students are in their classroom and learning the skills and the education needed to become a licensed dental hygienist in the State of Virginia, that they come back from their community-service learning experience and say: How do we solve this issue. They are confounded as well, as all of we are.

So I attempt to share, as Professor Flores shares, be political and advocate for your profession and

volunteer. That is such an asset to our community. We all need volunteers. Speaking of volunteering, I have been a member of Chesapeake Care, at the time free clinic, since 1991. I was a volunteer licensed dental hygienist. Since then, seven years now, I have been an executive board member and instrumental in helping the expansion of our dental clinic at Chesapeake Care, which is now called Hampton Roads Dental Center, and I was instrumental in getting the preceptorship program from VCU, bringing the dental students down there so our waitlist could go down at this clinic, and I also have my students go there and serve that public, and they are all at risk. Fifteen years, they have never been to the dentist.

I am imploring you to consider, not only for me when I advocate in the classroom and in community for my thirty-nine students that are graduating this May, next week, is that they, as future oral health providers, are able to not see their only employment opportunities as the private practice model but they see that Virginia has chosen to work in public health. Like Representative Commen said, a strong America has to be a well America.

Thank you for your time.

MS. SWAIN: Joyce Flores.

MS. FLORES: On behalf of the Old Dominion University faculty, staff, undergraduate and graduate

students, RDH candidates and licensees practicing in the Commonwealth, I would like to thank the Board of Dentistry for the opportunity to provide comment regarding strategies to increase access to dental treatment. I am a professor of research methods at Old Dominion, Ph.D. candidate, licensed RDH in three states for over twenty years, and I serve as liaison for the Virginia Dental Hygienists' Association to the Board for people with disabilities. I would like to, again, thank the Board for letting me comment.

We support policy change to expand options for dental hygienists to practice under the remote supervision of dentists in Virginia, after reviewing current evidence-based research on the topics of safe oral healthcare delivery, risk of harm posed by remote supervision collaborative care, less restrictive regulation of dental hygienists and effective outcomes of the statewide Virginia Department of Health Program.

Dental hygienists are providers of safe oral healthcare, regardless of level of supervision. Dental hygienists are educated on the delivery of safe patient care and risk management, guided by our high educational standards required by the American Dental Association's Commission on Dental Accreditation, or CODA. To complete licensure requirements to practice as a registered dental hygienist in Virginia, candidates must graduate from a dental hygiene

education program accredited by CODA and maintain these standards for the continuance of licensure, according to the Virginia Practice Act. The Commission on Dental Accreditation serves the oral healthcare needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental-related educational programs. In order for us to graduate our students, programs must demonstrate effectiveness in these six standards, which include institutional effectiveness; educational programs; administration, faculty and staff; educational support services; health and safety provisions; patient care services.

Specifically, the intention of standard five, health and safety, that provision is that all individuals who provide patient care or have contact with patients should follow all standards of risk management, thus ensuring a safe and healthy environment. All dental hygiene patients should receive appropriate care that assures their right as a patient is protected. Patients should be advised of their treatment needs and scope of care available at the facility and appropriately referred for procedures that cannot be provided. All individuals who provide care or have contact with patients should follow all standards of risk management, thus ensuring a safe and healthy environment.

Old Dominion University and all other institutions providing dental hygiene programs throughout Virginia must comply with those CODA standards in order for us to graduate students. In turn, only graduates of CODA accredited programs can obtain a license to practice dental hygiene in Virginia, in addition to everything else they go through, including passage of an eight-hour written national board examination and a hands-on clinical board examination. Dental hygiene is one of the only remaining health professions that requires the use of a human patient acquired by the student to demonstrate safe and effective dental treatment skills.

As demonstrated in the outcomes of the statewide Virginia Department of Health program, patient safety, risk or harm were not threatened nor resulted in the revocation, suspension or reprimand against the license of any registered dental hygienist practicing under the remote supervision program. All evidence of my references are provided. The program increased the number of patients seen by registered dental hygienists in Virginia and demonstrated the effect of least restrictive regulations.

Remote supervision for dental hygienists does not introduce harm to the citizens of Virginia. By not adopting policy changes, however, the current restrictive supervision of registered dental hygienists could be further

contributing to debilitating fatal disease rates, as stated in numerous published epidemiology studies, and as was referred in earlier testimony today. Retention of the dentition in advanced age, for example, extends the reach of oral and dental diseases into a life state in which professional oral care is critical, especially for those institutionalized in longterm care facilities and nursing homes. Aspiration of bacteria, colonizing on the teeth, calculus deposits and other oral tissues have been found to play a key role in pneumonia. Nursing home acquired pneumonia is the leading case of death in the nursing home population, and is the second most common infection in longterm care facilities, yet there is abundant documentation of inadequate provision of oral care among Virginia institutions.

Our current students want to have opportunities to practice in these kinds of settings, particularly, our bachelor's degree completion and graduate students who have demonstrated desire to seek extensive education in administrative leadership, professional development and research. However, they cannot clinically implement their advanced education due to restrictive practices in Virginia. Please don't let us lose these great providers of care to states with least restrictive supervision. Our citizens of Virginia need and deserve the safe care our students are

educated and skilled to provide.

Thank you for your time.

MS. SWAIN: Sarah Holland.

MS. HOLLAND: Good morning. I am Sarah Holland. I am with the Virginia Oral Health Coalition. The Coalition is a statewide nonprofit organization that works with partners from all parts of the state to integrate oral health into all aspects of healthcare, recognizing the connections between oral health and diabetes, potential connections with pre-term birth. Thank you for your time.

I am here today really just to reiterate the Coalition's position, which is based on our guiding principles. We have a twenty-three member legislative committee, as well as an eighteen member board of directors, which is how we funnel through our legislative positions, and we long stated our support for dental hygienists being able to work under remote supervision in safety net settings as a mechanism for improving access to particularly preventative services throughout the state of Virginia. We recognize that this is not the only path, or this particular path will not solve the problem. Other access options are needed in terms of increasing access to comprehensive dental benefits and other things like that for individuals in the state. We believe it is a good start.

MS. SWAIN: Thank you.

Before we continue with the discussion, I would like to give the Board members a ten-minute break. We will resume at 10:30.

NOTE: The forum stands in recess; whereupon it reconvenes as follows:

MS. SWAIN: We have time to discuss recommendations or questions. Please raise your hand to be recognized before speaking, and I invite you to speak through the microphone so everybody in the room can hear your. Please note that any policy action that the Board eventually decides to take will include the standard for comment, opportunities required for regulatory action and for advancing a legislative proposal. If you would like to notice a Board meeting and comment opportunities, please add your name and email address on the sign-up sheet outside the door. Thank you for the wealth of information provided.

Any questions ready now from anybody?

Dr. Gaskins.

DR. GASKINS: This question is for Dr. Crabtree and all. In speaking of the CDHC option, I would like to hear a little more. Is this group on the ground in the country at this point? What is the status, more specifically in Virginia, with this? Also, I noted that you made the

comment that this would be an unregulated basic procedure of basic entry level at this point. If it is unregulated, what would be your wish list or what is your concern and desire that this Board do, action or inaction, either way at this point? If you can comment on that a little further for us.

DR. CRABTREE: Well, the first question, where the status is across the country, New Mexico, I think Oklahoma and I believe Pennsylvania were the pilot states where they already have it. New Mexico is probably the strongest. Right now the ADA is giving presentations all over the country. Florida, I think, has been involved, and there is a list actually in the last ADA news, a list of several of the states that are actually moving ahead and going forward.

The regulatory levels, the wish list, I guess, is first of all we just think that we need to get people in to the care that they need to get, and the navigation piece, the social worker piece, the community health worker piece of the CDHC is going to be a very good start, and if we can get that going in the State of Virginia, have a community college to provide the educational component with the curriculum that has been developed, and then we have been working with the Eastern Shore right now to actually have a CDHC come in to show how it works within the system, to get these people navigated to the care they need to get.

At some time in the future, we would like to have a rollout of a discussion that will invite all interested parties to come in and talk about how that worked in Virginia, how does that fit into our system of rules and regs, but the big thing is that as a screening and health education thing, it is a like a dental front desk person crossed with a dental assistant type, with added skills as they go along. I think they are cross walking it on the educational piece, where they can become a dental assistant, just a basic dental assistant, and the curriculum, of course, includes the didactic portion of the radiation, which they can take the exam to get a radiation certificate.

So they would actually eventually within the curriculum be able to apply for that. So they could come out of their program when it is done with their CDHC certificate, which would also probably be a dental assisting one. We don't have any of those skill sets that are included with DAII, and then you have the ability to do the radiation. So it could actually be integrated very closely with an understanding of how a patient needs to get involved to see the dentist. To use the example of the gentleman that has the debilitating condition, he is in desperate need of someone to help him navigate the system, and that is really what the CDHC does. It really helps them to get to the care that they need.

Was there a third part to that question?

DR. GASKINS: Regulatory-wise, I am not hearing that there is any direct request–

DR. CRABTREE: None yet. I have already taken down the piece, but in the little arrow, what we are talking about is the basic certificate. The second level would take the same sort of regulatory action that you would have with the DAIIs. Now, I know you all are working closely to try to figure out a way to make that work. It, obviously, is broken and needs to be fixed, and I think the only speaker that actually spoke to it really, what needs to be done, is to address the regulatory requirements of getting those people placed and to show people how it can help relieve access to care, but there are certain skill sets that people have to have to be able to do that.

That is just regulated activity, the scaling of teeth, that stuff is regulated, hygiene and activities and things, dental office routines. Those would be down the road. There will be a lot of dialogue going on. It will be a totally different discussion, because you will probably have to have changes in the code. There will probably have to be code changes to authorize it, and then also you have to have, of course, regulatory things that follow that. So that is a whole bigger ball of wax, because it actually involves patient care, but that is where you will get some bigger bang

for your buck.

The next two levels in that, the social hygiene and the RDH program, the B.A. or B.S. program, they are basically equal, economically speaking. There is no distinction in the marketplace for those two degrees. Dental offices generally don't pay more for one or the other. It is basically the same, and it is reflective of the marketplace.

DR. LINK: If I could add one more thing, when we did our presentation over at the Eastern Shore, one of the things they realized is that the no-show rate will go down dramatically, because these people will be in those communities helping them understand what their problems are, and I think Dr. Crabtree hit it really well about social determinants. They don't understand. They are going to explain the issues to them in a language they understand. Then they are going to transport these people, find navigation to the offices, and before we even finished our presentation, they were on board one hundred percent to do a pilot program.

MS. SWAIN: Dr. Wyman.

DR. WYMAN: I would like to ask Dr. Crabtree, in Northern Virginia we obviously have an abundance of population. We also have a huge need. I cofounded and was president for ten years of the Northern Virginia Dental Clinic. We now have two facilities with nine dental chairs,

with well over two million dollars in dentistry. We don't have an access to care problem in Northern Virginia, but you do in your area. How would the coordinator model work in an area where there are very few dentists, where patients have to go many miles to get to the dentist, if we had any type of role model to refer these patients and identify some of their basic needs?

DR. CRABTREE: It has been reported to us that there are within the federally qualified retail centers across the state, like the Eastern Shore, they have very high no-show rates, very high rates where they are not being utilized. In other words, we have the resources there being paid for with no patients. So the goal is to have the folks in a very widespread region that come from that area to help people identify the resources. They can help them get where they are. They have transportation issues that they can coordinate.

In our area is the seniors. I think every locality has their own way of trying to help people get to their doctors' appointments and the social services departments and the others. So that person is a social worker type navigator and helps them navigate that to get to the places where they can actually receive care. There are a lot of social determinants that keep a lot of folks in the cities. Whether it is a language barrier, huge, that keeps

people from accessing care. This a way to help bridge that, and there is even interest within the private practices of having folks that are culturally competent helping people to get to the care that they need before they end up in the emergency room, because by the time you get to the emergency room, it is way past where it needs to be.

So you want to get them at the front end, so that you can get them in to see the hygienist, you can get them in to see the dentist if they are in pain or if they are abscessing, or the hospital if they need to go that far, but the goal is to constantly reduce the disease burden in the population before they get to the ED, and they will have an overall improvement in their health outlook. So it is starting at the individual level and having someone there as a resource that can help them, and we have discovered, especially with mothers of small children, once you kind of get the mom understanding what needs to be done, the first child may be the one who has had suffering and pain, but the second child she has figured out that the baby doesn't need to suffer the way the first one did, and then all of a sudden you turn around a family.

Someone there has to help them in their own understanding, in their own language, how to prevent the problems that they have, to get them once they are already in that situation to the care that they need, and also, some of

them haven't even applied for Medicaid and they need to do that. That is a very basic thing. The resource are there. Money is not an issue in some cases, but they are not accessing care because they don't think they have the money, but then their child is eligible for Medicaid and they just don't know that.

DR. LINK: One other thing I want to add, the reason we brought this before you today, because this was the only forum that the VDA could talk to the Board about access of care, so we felt like it was extremely important to tell y'all what the VDA is doing to help with access to care. This pilot program has been going on not even year, and the strives that we have encountered right now are huge, and I believe this is really the true answer to access to care and the most economical way to do it.

DR. WYMAN: The question is to everybody here. I certainly thank you all from coming. One of the keys to success in our clinic in Northern Virginia was the social service agencies in the area were trying to help us. They each have contracts with their respective social service agency. Those social service agencies are the only people that can refer patients to our clinic. They cannot come off the street. I cannot, as a president of the organization, cannot refer a patient. They have to go through the screen, and they all have to pay a nominal fee. I believe it is $35

per visit, plus any lab costs that we have. Some of those costs are subsidized by the agencies, but the system that was developed in conjunction with helping us sort of works as a coordinator at the same time, because the social service agencies perform most, if not all, of the coordinator functions, and the key was showing the local governments that they were getting a huge bang for their bucks, I think it was ten to one. As many of you have eloquently represented this morning, the cost of emergency care and the cost of continuing medical care, as a periodontist preaching to the choir in terms of diabetes and chronic inflammatory diseases.

So my question is, are there any of you here who have social service agencies that might be able to be coordinating a situation where we may be able to get both the ADA model and existing local service agencies and local governments, contributing very little if almost nothing, to existing clinics and unutilized chairs that are already there, as opposed to developing new regulations? The only thing we contacted the Board of Dentistry for twenty years ago is when you have, I think we have probably fifty or sixty volunteers per month, plus we have paid staff members, but how do you put sixty names on the front door of the clinic to comply with state law. Is there anybody here that has any suggestions in terms of social service agencies that are affiliated?

MS. SWAIN: Dr. Brown has a question.
DR. BROWN: I don't mean to interrupt your question, but I have a couple follow-up questions. Who would the dental health coordinator work for?
DR. CRABTREE: There is a list on the presentation of federally qualified community health centers. They could be in health departments. My dream would be to have one in every health department.
DR. BROWN: So those type of entities would be paying the salaries?
DR. CRABTREE: Yes, and there are different ways to go about doing that. For instance, in a community health center that has vacancies, they are very interested in filling those chairs. They get reimbursed. Just like in a dental office you don't really have a fee to charge for your receptionist and the people on down the line. The doctor generates the fee, and then the total cost of the program. So if you increase the profitability by decreasing the vacant chairs, then that pays for itself, if that makes sense. So that is why it is important to have the lowest cost individual that they can have. It is very difficult when you have a very expensive auxillary person versus someone who is less expensive.
DR. BROWN: My second question is, since you worked on this as a pilot, it requires developing curriculum.

So if everything goes well for you with the program you started, when could we see people trained to be coordinators?
DR. CRABTREE: Once the community college system has the curriculum, and they have to evaluate it, I don't really know how the educators do that, but I understand it is a cross walking of trying to determine how it overlays with the dental system program and things like that, they could kick it off very quickly, within a year, because it is just like a community health worker, a social worker type program. It is a certificate. There is a lower threshold. It is actually done through their workforce. The community colleges have degree programs, education programs, and they have workforce programs. So, like, if you want to have someone who is certified in Word, you can have a Word certificate that does that. If you want a dental assistant, you have a dental assistant program. It is already established in Virginia that you get your dental assisting certificate, and there are credentials that help the employers determine who has a basic level of didactic knowledge to be able to do what they need to do. The curriculum is developed by the American Dental Association and is licensed. So it is thoroughly there.
DR. BROWN: Thank you.
MS. SWAIN: Does anyone else in the audience have a specific question regarding this model?

Come up and speak at the microphone, and state your name, please.
MS. BRAD: Hi. I am Vicki Brad (phonetic), and I am a registered dental hygienist and a CDA, certified dental assistant, myself. My question is, I actually am a director of a dental assisting program, ECPI University in Virginia Beach. So I am trying to figure what is the difference between what you are proposing in your curriculum as to what a dental assistant already has. It just seems very similar.
DR. CRABTREE: It is cross walking. If we had a lot of time to go through this, but I cut this way back so that we could have some information, but the health promotion modules are probably a little more, so that reaction of they have that working with the departments of social services, the community mental health agencies and the nursing homes and all that type of health system stuff, is not really included.
MS. BRAD: Well, I am just speaking for my school, and I don't want to speak for someone else, but I know at my school we actually have a course called community health. So we actually have a certain amount of hours we have to volunteer at different facilities. So I do believe that is incorporated in most. I can't speak for any other school, but I do believe it is incorporated in some dental

assisting schools.
DR. CRABTREE: And that is why I was talking about the cross walking, how they match up. So there is going to be a social worker piece that you are not really getting, but then you will also have the dental assisting piece. It very likely they will have both, which will be a very marketable skill for someone graduating to have.
MS. BRAD: So the question is, you would become a dental assistant first and then be given an extra certification?
DR. CRABTREE: They cross walk a great deal. It would be great for a partnership. You would get people with a little more skill set and get more job opportunities, targeting the level of care, targeting the people in need.
MS. BRAD: In my personal opinion, I just believe that education is very important to give to the underserved, that it definitely needs to be someone educated.
DR. CRABTREE: When you talk about health education, dealing with that patient, in my office, I will tell you, my assistants are the ones that are doing a lot of that, in terms of health education, to help us get patients to understand what their needs are.
MS. BRAD: I agree. Thank you.
MS. SWAIN: I believe there was another hand raised.

State your name.
MS. BERARD: Cathy Berard, hygienist. I am curious how the CDHC, would it compliment how the hygienist would already work, because we have hygienists who can provide services and also educate in navigating the system and guiding patients to get the care with the doctors. So I am just curious how that would work. How would the procedures compliment each other?
DR. CRABTREE: It is an excellent question, because I think it is a part of the teamwork. If they are in the community and they are working with a family and they are trying to get them over to get the care that they need, well, if they are not having abscessed pain, where are they going to go first. You don't want to take someone who is highly skilled and carved out in the rules and regulations to the only person in the world that can scale teeth, other than this, because there is a huge economic value there. It shows up in the later statistics. There is an economic value to that. You don't want to take that person and have them doing and spending their time at a lower level of services.
So how they work as a team is what it is all about, and attacking disease, I like to call it declaring war on dental disease. That is the only way we are going to do it. So do those two things, and you are going to reduce your ED business. If you don't do that, you sit around and piddle

around the edges, you are going to have the same thing you have got for years. If we change that model and get a team that is going to focus in on the people that need care, get them to the care that they need, then you are going to make a difference, but until we get to that point, we are just kind of spinning our wheels left and right, and then money is always an issue, and I agree one hundred percent. Money is the issue.
They have cut Medicaid rates once again, the State of Virginia. How do you keep anything sustainable in this state when you continue to do what you don't need, decimating the public health department. When I came to Martinsville, we had three public health dentists. No program now. You expect to have a difference in your oral health outcomes, what can you expect. More dental disease in the community, that is what you are going to get, because you are not attacking the problem. We are all out here worrying about all this other stuff, and we need to declare war on dental disease and find the most cost effective way to do it, and we are providing an opportunity to do that in a way that is less of a burden on the population.
DR. LINK: If I may add one thing, I think the task force under Dr. Crabtree, he was also the chairman through the ADA that got to see the project through the ADA, I think it is this type of thinking outside the box that is

really going to help our dental access issues, and that is why the VDA firmly believes that this is the model that we should all be looking at.
MS. SWAIN: Are there other additional questions?
Ms. Barnes.
MS. BARNES: I am Sharon Barnes, a citizen member of the Virginia Board of Dentistry, and my question goes right to the heart of what you are saying about dollars. What kind of source can be utilized to help this issue? Even in Northern Virginia, we have some very diverse populations, diverse economic situations and some great needs, and I just wonder what kind of funding sources, because since we do not have Medicaid expansion and those things, and particularly nursing home facilities, longterm things. I have had people actually come to me and express the need that they can't get care for that patient who is no longer mobile. Are there different kinds of sources you are looking at in utilizing?
DR. CRABTREE: That is the billion dollar question, and in the State of Virginia Medicaid dollars are available from the federal government and they are given back to the state to provide the dental care required by law. Now, what happens in Virginia, unfortunately, is that you talk about Medicaid expansion, they are cutting the reimbursement rates that they have today. So if you expand

it, then you are going to actually spread the resources even thinner, to the point where you are not going to have anybody taken care of, because it is to the point now that they haven't been doing anything in seven years or more. It is getting to the point now where it becomes charitable care, and in the business model it is the government.
In a business model a doctor will do it, as long as he is able to at least break even. When he has to start subsidizing because the reimbursement rates are so low, it ends, because if you don't, you end up bankrupt. Doing something for free in business, you can only do so much, so you are going to decrease even more that settlement. If you expand it to an even greater number, you have given a greater number of people there, but you are not even taking care of the ones at the bottom, and even hurting them more because you are spreading it so thin.
Let's step up to the plate and fund it. States would have to do that. The federal government would have to do that, and I wish we could figure it out. To do the expansion, you have got to tie it to increasing funding. So if you are going to double the number of people that can do it, which is you raise those rates, it will actually more than double the people because of the curve, and then you are going to have to increase the funds just to keep it where it is. So I think the possibilities, if you are going to

improve the oral health, you need to target the people who need it the most, and we need to look at how we are spending our money. This is a totally different discussion, and I will get off that, but you have to look at how we are spending our Medicaid dollars also.

MS. SWAIN: Any other questions?

Speak to the mike and state your name.

MS. FLORES: Joyce Flores. I have a couple of statements, just to remind everyone to make sure we are on the same page, and then a question for you. In regard to the level of reimbursement rates and the acceptable decision to take in lower reimbursement rates, it would only be able to be made by the dentist, because currently the restricted practice of dental hygienists in Virginia doesn't allow dental hygienists, even when we want to, it doesn't allow us to make the decision to see the Medicaid recipients, and that is very problematic, because so many dental hygienists in the State of Virginia want to see that population and we are not able to. We are not able to even see them in the same practice where Monday through Thursday perhaps we see traditional private practice payment, and if the practice is open on Friday, we are not even able to see Medicaid patients. They are in need, and we can't because of restricted practice. We can't even have a decision to say we want to see them.

And in regard to economic value, that cost traditionally in the private practice model for services, dental hygienists in the State of Virginia have never had the chance to say what we would want to charge for service. We have never had that chance, and we would love that chance. Maybe we don't want the same charges that would be the fees for services in the private practice model. If we are able to go into the community and do what we do best, maybe we don't want those same salaries, but we have never been asked. We have never had the opportunity to go outside of the private practice model.

When my students get ready to graduate, after having gone through with Ms. Stull and into the community, they are able to see the needs, but it is disheartening when I have to tell them: Your only employment options are in a private practice model, because you are restricted to practice in certain settings. It is restrictive, and they are not able to see the people most in need. So I am not sure why we would want to use a reduced educational model when we already have an existing provider who is able, willing, ready, licensed and capable of providing services. We just don't have the chance.

So my question to you for the CDHC program is, how inter-orally would disease be treated by the CDHC to treat the disease that we have problems with in the State of

Virginia?

DR. CRABTREE: That would be under licensed activity, and that would be something that if you really like for the CDHC to take it to the next level, that would be a discussion for level advanced. If you did that, then you would actually do some more treatment sort of things, how they did things. So we have agreed that a lot of people would like to treat them to serve. The dentists would like to see treatment to serve. It is not economically feasible. It is very expensive procedures to do, just the set up of the operatories, the turnover of the operatories, and it becomes a certain level based on the cost, no matter who is doing the care, and of course, to have all of the freedoms that were mentioned there would be an independent practice, and that is certainly a totally different discussion.

In an independent practice model, which gives you total freedom and flexibility, and in the case of Colorado which had granted that, has proven the studies show that economically the cost structure is not enough with Medicaid reimbursements to even sustain them, so they end up being placed in communities that are not in the highest areas of need, and there is a study for that, and I don't think that is what you all want to talk about.

MS. MCGREGOR: I have a question and comment, I guess more of a statement.

MS. SWAIN: Name.

MS. MCGREGOR: I am sorry. Michelle McGregor, Virginia Commonwealth University. I feel like we went a little off tangent. I think the CDHC is a great idea. If there is room for that and there is a need and they are going to serve as a social worker and bring more patients into care for the dental hygienist and the dentists, who are really the only two providers that are providing actual care and treatment, I think that is great. My understanding is the purpose of this forum, though, was to discuss the three concepts that were listed for the dental assistants and the remote supervision expansion. There are other models that could have been discussed today besides the CDHC. There are a lot of models that other states are using that are addressing access to care issues, but I don't think that was the purpose of this, but I do think the CDHC, there may be a place for that, and I think that is great.

One other comment going back to economic feasibility, because that seems to be what we are all talking about, I am having trouble understanding why using the remote supervision dental hygienist is not economically feasible. So if I am working for Dr. Link, let's say, but I go to a nursing home one day a week where there are patients that need care, there is not a dentist there, I am still working under the supervision of Dr. Link, I am providing care for

these patients, I will segway those patients to his office if they need more treatment, and he is still getting the income from me seeing those patients. I get calls every day from patients in a nursing home that have insurance. They are not all Medicaid patients. They are just not getting the care because there is nobody there. I know remote supervision doesn't solve the entire issue, but the fact that we have this model in place and you already have the statistics and the evidence showing what it has done, to move that forward is such a great thing, to have people in collaborative agreements, and I know it won't maybe hit all the rural areas, but there is a lot of need right here in our backyards that isn't being addressed, and if we were working collaboratively with a dentist, I think that would be addressed, and that is economically feasible. Thank you.

MS. SWAIN: Are there any other questions regarding this?

MS. MOORE: I have a question. I just wanted to ask if you could tell me the difference between independent practice and remote supervision, because remote supervision is what we were discussing. We weren't discussing anything about independent practice.

DR. CRABTREE: I am sorry. I thought you were talking about the choice to practice and choose reimbursement. I misunderstood that.

MS. SWAIN: I understand there is room for debate on this subject, but we just want to get to the point.

DR. CRABTREE: Exactly. What I heard was different.

MS. SWAIN: Are there any other comments?

Moving on, are there any other questions outside of the CDHC from anybody in the room?

Dr. Gaskins.

DR. GASKINS: I haven't heard anyone directly address the expanded duties part for RDH. I am hearing a lot about remote supervision, given existing duties at this point without regulations. Dr. Crabtree is talking about varying levels of mid-care providers and low-end providers, if you will, and the high-end providers. Taking the other segment of this, if restorative procedures are eventually an outcome for RDHs, since we have got different institutional folks here arguing institutional things, I believe Old Dominion is the only school that has a master's level of training, how does the community feel about changing the curriculum in order to affect producing these expanded duties? We have to go from where we are now to there, and then the marketplace may take care of some of that. Would anybody just like to expand that for me and for the Board?

MS. BERARD: Cathy Berard. Cathy may be the older hygienist in the room. I was actually trained at the

University of Michigan. We had education on placing out. That is all they had then. We learned it then, and I know that it was even taught most recently at VCU. We did have education in placing restorative materials. I would defer to the educators, but I know that hygienists already exist who know how to do that, because that was included in our original education.

DR. GASKINS: Besides the anecdotal side, every time you do a restorative procedure, periodontal, whatever, how does that fit in your thinking?

MS. BERARD: I will just speak for my practice, my group practice, that even with a large group practice I still have open-chair time. I had a cancellation and had two hours open yesterday. So I got to see the dentist swipe, and I had an hour with no patient in my chair. So that even happens in private practice, not just in federally qualified healthcare or free clinics. That is still going to happen.

DR. GASKINS: What about changing the curriculum?

MS. BERARD: That part I will defer to the educators.

MS. MCGREGOR: I will be brief. Michelle, VCU. Our curriculum already contains all that. We have students graduating with all skill sets, pretty much a DAII for the most part, maybe not the amount of hours that is required for

the DAII program, but our students, legally they cannot do those things in this state, but it is a skill set that they have. So that would not be something that is difficult to change, if that is the wishes of the Commonwealth to expand the duties of our RDHs and expanding their skill set, or what is legally permissible in the State of Virginia. I think more immediately we were looking at expanding our settings, because I can provide those services right now. So to be able to go to work in remote supervision, those services are being met. What you are talking about is a completely different avenue of providing more care, and Kara Sprouse, who spoke earlier, she is a dental hygienist and her employer did want her to have the skill sets to do the DAII, because they wanted her to do both things in the office, even though she is still employed as a hygienist, but the curriculum does have these items. That is already there.

DR. BROWN: Is that because your curriculum prepares dental hygienists to be able to practice in other states which have a broader scope?

MS. MCGREGOR: Absolutely, and we wouldn't be doing our duty if we didn't prepare our students for the evolving trends that are happening across the nation. So that is our duty as educators.

MS. SWAIN: Dr. Watkins.

DR. WATKINS: I will ask you, and maybe I will

ask Kara, the dental hygienist that has the DAII, how does that work in a practice model? Because why would a dentist want to have a dental hygienist do both of those things. I heard somebody say something about having an hour of freedom. Well, dentists get cancellations, too. You have an hour free, and there are other things you can be doing, but having these restorative duties, the six things which are indicated, which I wanted to ask, are you qualified for all six?

MS. SPROUSE: No. I am qualified in two of them, composite restorations and the final crown.

DR. WATKINS: So in the whole scheme of a practice model, where would that come into play, and why would I want a dental hygienist to help? I just want to see in the scheme of a practice model how that would work.

MS. SPROUSE: Well, I work for a solo dentist. We have three chairs. We have a hygiene operatory and two for the dentist to work. Sometimes when my schedule frees up, say for a cancellation or a no show, and my dentist has two patients in the chairs and each are doing composites or crowns, he can sit down and prep the two for composites. Then when he is done, he will get up and walk to the next patient and I can sit down and go ahead and place that composite, finish and polish it.

DR. WATKINS: But it is because you had a no show.

MS. SPROUSE: And also on days that my schedule is free, I also assist my dentist. So I do a little bit of everything in my office.

MS. MCGREGOR: I would think that you would want somebody. A dental hygienist is going to primarily do dental hygiene procedures. I think we can't all do everything, just like you don't want me drilling teeth and hygienists supposedly don't want assistants scaling. I mean, everybody has their little territory of what they do, but I think we kind of work to our full scope. So I think every practitioner should do what they do, to the full extent of what they can do legally in that state. I can tell you when I lived in New York and I did have a broader scope of practice of what I could do, and I worked in a very large practice with three dentists, several hygienists, several assistants, and legally I could do some procedures that I cannot do in the State of Virginia. Primarily, ninety percent of my job was working as a dental hygienist, but we worked as a team, so everybody was able to pitch in. So the fact that I did have some of these other skill sets, I could pitch in. It usually wasn't because of cancellations. It was just because we were all working together to help do the best thing for our patients and the productivity of the office.

MS. SWAIN: Yes, ma'am.

MS. BRAD: Vicki Brad, ECPI University. I have so much to say, but I get so nervous. I believe that the short term for the DAII, hygiene would be the quickest way to get more DAIIs in the State of Virginia, obviously. Also, the second thing I believe is that if we created a DAII in Virginia, which is wonderful, but we are having a hard time in getting them, so I believe that if we increase the education of a DAI to be a CDA, very, very quickly would the DAII be filled in the State of Virginia.

There are so many dental assisting schools, every corner, four weeks, four months, six weeks, that sort of thing. When we started our school six years ago in Virginia Beach, we asked the advisory board, dentists in the area, what do you want different about your dental assistant, and they said more educated, more knowledgable. So that is what we are trying to do, but I truly, in the State of Virginia, if the DAI was required to be a CDA, because that is the issue of getting the requirements for the DAII, we only have, I believe it was three dental schools in the area, and now there is one more, so there are four in the State of Virginia that are CODA accredited, that you can get your CDA right after graduation. Otherwise, you have to work for two years or 3,500 hours to get your CDA.

So the majority, I don't know the statistics, but the majority of all the dental assistants working in the

State of Virginia are not CDA, because they are not required to be. The dental assisting schools in Virginia do not require their students to get the CDA either, because it is not a requirement in the State of Virginia. CDA is CODA accredited, which would make the programs, the standards higher, and the curriculum should be included in the CDA program for the DAII. Thank you.

DR. WATKINS: But the CDA is required for the DAII, so the idea behind the process was that first you got the CDA and then you become a dental assistant two. So it would seem that schools that are accredited would be pushing them to do the CDA so that they can approach the DAII. So I don't understand. It seems like what you are saying is actually the way it is supposed to work. The idea behind this process, even when it was first initiated, was first there would be a CDA. Then maybe more schools would come on and produce more CDAs, and then they would have more DAIIs, or so the structure seemed to be. Now, we only have eight. Something is wrong in the process from CDA to DAII. Not that we wouldn't want to have more CDAs, believe me. The whole process was meant to have more CDAs.

MS. BRAD: Exactly. I will tell you, the CDA is a very difficult exam to take if you have not gone to school and been educated. It is very, very difficult. As a matter of fact, I am actually helping five dental assistants

in the area, we just started a week ago, and helping them to review for the CDA, because they have never gone to an education facility. They have been working in the field for ten or fifteen years, and they do want to apply for the CDA -- I'm sorry, for the DAII. So the first process would be to get a CDA, but they are not educated. Radiology, health and safety, infection control, dental materials, it is a lot, and they don't have the education. They don't have the hands-on experience. But to become a CDA is not as easy as you think that it is, but there are a lot of dental assistants in the area, in Virginia, that do want that but are hesitant to get that CDA. So what you said is exactly right.

So, if the schools were required, if the State of Virginia required a dentist assistant one to be a CDA, there would be no issues, but they are not required. A dental assistant doesn't have to have -- we all know this -- a dental assistant doesn't have to have education or any regulations. The only thing they have to have is the radiation/health and safety certification, which they can get in a day and a half. So if the requirements for a DAI were increased, then I think that issue would very quickly be taken care of for the DAII.

MS. SWAIN: Thank you.

I believe there was a question.

MS. JOHNSON-GRAY: Hello. My name is Yolanda

Johnson-Gray. I am the program director of the dental assisting program at Fortis College, and I have five DAIIs out there working as DAII certifications, and I just wanted to say that as far as the CDA component that she is speaking of, no, there is no requirement of the State of Virginia. However, as a certified dental assisting program under CODA, for my program my students are required to sit for all components of the CDA, so that when they graduate they are CDA certified, and I feel, as the program director and a certified dental assistant myself, it is my job to educate my students about that certification and let them know that even though it is not required they should do it.

So we do have them sit, and if you look at the stats for how many CDAs are in the State of Virginia, maybe two years ago and the stats now, it is probably twenty to thirty percent different, and every CDA out there that is certified now comes out of my program. So I think the education and knowledge, and I agree with my other program director, that there are no requirements, but we, as a certified dental assistant association or group, have to actually push that for ourselves.

Can I address the model? I see the model differently. I see the model as we have a DAII to assist the dentist. We have a hygienist to do her or his part in the dental office. The DAII assistant is there to also help the

dentist, also as a producer in the office as well. If there is a schedule befitting and the dentist would be able to see more patients, then the DAII can step into that role of being able to help be a producer in the office. I am not taking anything away from the hygienist component, but I feel that the DAII was made for the dental assistant. The dental assistant should be allowed to practice that. Yes, right now we don't have enough dental assistants able to sit in a DAII class, but we need to work toward that. We need to make dental assistants aware that they can sit for the CDA, educate them and have them become DAIIs. That is a work in progress. That is not something that is going to happen overnight. It is something that I am passionate about and something that I am working toward. So that is all I have.

MS. SWAIN: I do have a question. You indicated your graduates are CDA certified?

MS. JOHNSON-GRAY: Yes, they are.

MS. SWAIN: How many of those graduates indicate to you their interest in pursuing a DAII certification?

MS. JOHNSON-GRAY: Pretty much all of them.

MS. SWAIN: But it doesn't reflect the numbers we are getting.

MS. JOHNSON-GRAY: Well, the problem is the clinical portion component of the DAII, because pretty much

they have to work 300 hours if you total every component that they need to get. So it also falls back on the dentist's side of it. They also have to find a dentist to support them in that to be able to do eighty hours of composites and be able to be right there and direct and attest that they have done those hours. Not every dentist is willing to do that.

MS. SWAIN: Is that a barrier?

MS. JOHNSON-GRAY: That is a big barrier, yes. It is not that we don't have dental assistants who want to do it. The barrier becomes, I can teach them all day long the didactic component, even the laboratory component; however, when you have to do your clinical hours, you have to find a dentist to support you in that. That is the biggest barrier. It is not even that we don't have enough CDAs. We can get the CDAs certified. We need the dentists and the support of being able to provide the clinical aspect of it.

MS. SWAIN: Thank you.

DR. WATKINS: How many per class?

MS. JOHNSON-GRAY: We have had five graduate.

DR. WATKINS: So your class is usually about?

MS. JOHNSON-GRAY: It is usually between five and six, yes.

MS. SWAIN: And that is the cycle every six months?

MS. JOHNSON-GRAY: No, because the DAII program

is twenty-two months long, so it is only maybe twice a year.

MS. SWAIN: Thank you.

Any other questions or comments?

Let's go back to Dr. Wyman's question.

DR. WYMAN: In reference to social service agencies throughout the state, given the Northern Virginia model as one where we utilize social service agencies, they act as coordinators as well as screeners, because the key percentage of what we do is as volunteers, and the last thing you want is a volunteer thinking that they are giving their time for a patient who is trying to take advantage of the system and not pay, or pay very little, are there any social service agencies that you work with in your areas of the state that could be utilized to facilitate more under-privileged patients into existing clinics or private practices that are willing to treat them pro bono?

MS. SPROUSE: Dr. Berard might could help me with this, but in Suffolk they have what is called an oral health navigator. Have you heard of that? She is a navigator, that they have a grant, and she actually reaches out to the community and does exactly what you just asked, but she is funded through a grant, and from what I hear she is doing really great things and getting people into all of the clinics that they have in the Suffolk area, Emporia, Franklin, and she is called an oral health navigator.

DR. WYMAN: A huge percentage of our budget, well over fifty percent, is from foundations and other private sources, including members of the dental society, and also to address Ms. Flores' comment about access to hygienists contributing, we have actively tried to get additional hygienists to volunteer in the clinic for years. There is a core group of hygienists who are volunteering very often, but proportionate to the number of dentists in the area, the hygiene participation is extraordinarily lower than the dentists' participation, and there are some things, socioeconomic factors, involved in that, but there are absences, and I am sure many of the other facilities in the state that have volunteer clinics also would like to have hygienist volunteers in their facilities.

MS. SWAIN: Ma'am, do you want to come up to the microphone, and state your name, please.

DR. BERNHARD: Dr. Elizabeth Bernhard, from the Western Tidewater Health District. I am a public health dentist, and I have been in the system for forty years. So I went all the way back to Joe Dougherty (phonetic), who used to have hygienists go out first, and they assessed all the kids in the school, and then the dentists would come in their dental van to do the procedures that they needed. So I think we are kind of going back in time. I do support the hygiene program that the Health Department currently has. I think it

is a great way for the children to get preventative services. There are other services that need to be provided for the adults, as has already been spoken about, but there is still that group between twenty-two and fifty-five that need to be treated, and I think the community health centers are certainly the avenue for that.

Getting back to what Becky said, we are in a unique situation down in the Tidewater area, that we have what I would consider to be first the first navigator in the state. This woman works with the access partnership program, and this has been a coalition of programs that have been working for years to get something started. We finally have that. They are funded by different healthcare foundations. The navigator is a person who has an MPH, and she is not a dental person or a medical person at all, but she came into the position and immediately her task was to start to get to know the dentists in the area to find out who was there, to get to know who was in charge of the community health centers, and it was kind of like she was just kind of dropped out of nowhere and then had her task to do.

She has done a wonderful job of getting to know people, and through her connections she has been able to help people get out of emergency rooms and into the dental practice, because frequently people go to the emergency room and then they don't have any place else to go. They just go,

okay, now, what do we do now. So they have put people into a couple of the emergency rooms that will connect the person that comes in with a toothache or an infection, connect them to the navigator. She, in turn, does the eligibility determination, and then she can send them to a place where they can get some assistance within a week or so, because frequently it is like here is your antibiotics, here is your pain medicine, go ahead and go to the dentist, but they don't know where to go. So that is why this thing has worked out really well.

Through access partnership they have also developed a voucher program, which enables the person to go a dentist and the dentist is allowed to get paid. So I think that works out really well, but I think that the coordination of where to find services, which dentists are going to do what, is really important in the access issue, but this is treating, I think, the nineteen to fifty-five population that is in great need. The seniors, I think that the remote supervision would be a great idea for getting them taken care of, and with the children, the public health programs, we would go around all those years and see the kids and do the prevention, and at one time we had eighty-five different public health dentists. Now, we have dwindled down to three, and three of us are going to be gone at the end of the year.

But consistency, being there every year, I have

been in Western Tidewater for about twenty years now, and we go to the schools and the children are in great shape. We have been putting sealants on and doing prevention, but once they get out of the grade school levels, then they are kind of off on their own. So I think that a coordinator for the area would be a great thing, whether it is going to be a hygienist or dental assistant, but I think it would be something that would be very important to have.

Thank you.

MS. SWAIN: Any other questions?

Ma'am, yes. Speak through the microphone.

MS. LEE: My name is Jennifer Lee. I am the deputy secretary of health and human resources, and as you begin to close out this forum, I just want to make a couple of quick comments.

So, first of all, on behalf of Secretary Hazel and the Governor's office, I just wanted to thank the whole Board for having this special forum today to look at strategies to enhance access to dental treatment. I am an emergency physician and a free clinic volunteer myself, and I have seen, myself, in my own practice what happens when people don't get access to dental care. I have seen simple dental infections turn into critically complex facial abscesses where patients needed to be admitted and have surgery, get IV antibiotics, and those patients aren't

insured. So, of course, it is not great for the patient, and it is not good for the whole system, because we are all paying for that in the end.

I have also been a volunteer at the RAM clinic last year. I saw thousands of people line up, sleep in their cars overnight to get access to dental treatment. I volunteered in a medical tent down in Wise County, and a lot of patients who I saw down there came and said I need to get my blood pleasure under control so I can be seen by the dentist today. So, to me, it was very striking how urgent and how intense the need is for dental care, for dental treatment, especially in the southwest and rural parts of the state.

So, again, first of all, I just wanted to say thank you for addressing this head-on and for looking for creative strategies to enhance access to treatment. It is something that is very important to us as an administration. We saw it in our Health Virginia Plan, in the fact that we added access to dental care for pregnant moms, for pregnant women, in Famous Moms in the Medicaid program, and we are looking for other ways to do that as well.

So I just ask that you consider the scope of the problem, the urgent need. It is really a crisis situation at this point, and I think whatever you decide to do as you deliberate, or whatever you recommend, that you

really think about the patients that need, and I think the one thing we can't do is nothing. So, again, we just appreciate you taking action, considering various strategies carefully and deliberately, and looking at the data as well to see what the best way forward is.

Thank you.

MS. SWAIN: Thank you.

Any other comments or questions?

Well, as you know, this is obviously an important issue, and it is a matter that we all are passionate about, providing access to care. So I thank you for your time and all the wealth of information that you provided today, and this concludes our forum.

Thank you.

CERTIFICATE OF COURT REPORTER

I, Mary F. Treta, certify that I was the court reporter at the Virginia Department of Health Professions for the Open Forum before the Board of Dentistry on May 8, 2015, at the time of the hearing herein.

I further certify that the foregoing transcript is a true and accurate record of the statements and other incidents taken during the hearing herein, to the best of my ability.

Given under my hand this 19th day of May, 2015.

_____

Mary F. Treta

AMERICAN ASSOICATION OF DENTAL BOARDS
2015 MID-YEAR MEETING
Chicago, IL
April 26-27, 2015

Board Recognition of Dental Specialties and Courts vs. Boards by Craig Bussey, ADA General Counsel:

- NC Dental Board—US Supreme Court ruling on violation of anti-trust laws; according to the US Supreme Court "market participants" make up the NC Dental Board; stating that DDS and NC board members had interest because of competition
- US Supreme Court did not differentiate between appointed vs. elected board members
- Public view--"board members serve to protect their financial gain"
- Active supervision for state (ie. Attorney General approval) when dealing with anti-trust laws
- Specialty recognition and advertising—American Board of Dental Specialties
- Texas lawsuit against Texas Dental Board—advertised as specialist IF not recognized by ADA as a specialty
- Florida and California—court says ADA is NOT the sole authority; what's the public harm? Boards cannot only rely on ADA; they cannot restrict "commercial speech" because of First Amendment rights
- Indiana—obligated dental practice to list ALL DDS in the group; Freedom of Speech and defamation; competitive aspect of advertising
- Boards need to be careful with advertising restrictions and follow anti-trust laws
- Corporate dentistry—states refer to regulation; anti-competitive aspect; portability of licensure
- ADA Trends:
    1. Increase of females in profession
    2. More Millennials and less Boomers
    3. Employee doctor status—Aspen Dental; Great Expressions are types of business models—DSO (Dental Service Org.) models corporations should not interfere with DDS
    4. DSO needs to be regulated i.e. Hospital/MD scenario; states need to specify rules to "protect the public with regulations
    5. DDS are not as busy; more retiring DDS
    6. ADA is concerned with "all" DDS members—focus on member/patient welfare

How Has Medicine Address Impairment by David Johnson, M.A., Senior Vice-President:

- Increase with state medical boards addressing impairment in recent years
- Narcotics and alcohol are commonly abused
- Not uncommon for state boards to fund a portion of PMP program
- Average age is mid 30's and mod 50's treated by physicians (www.fsmb.org)

A guy walks into a bar...State Dental Boards and Impaired Practitioners by Dr. Wade Winker, past Chair, FL Board of Dentistry:

- Alcohol abuse with DDS is 19-22%
- Substances abused--alcohol, opiates, stimulants, nitrous oxide-more with DDS
- Easily accessible substances
- ADA Health and Wellness programs –National Advisory Committee to avoid losing practicing DDS; improved access to treating DDS with issues
- States with diversion programs—MD, TN, NC, OK, MI
- Depression is becoming an illness and a possible link with substance abuse
- Relapse concerns—consider "life long" monitoring if respondent holds a license
- Goal is to protect the public and keep DDS practicing safely
- Educate new members with Diversion Program process
- State dental programs are 85% effective
- Mandatory hair and urine samples; mandatory professional and peer counseling
- Respondent must present to BOD before being allowed to practice
- Educate BOD members of options to treat impaired practitioners; 47 states including DC have assisting programs

ADA Ethics Program by Dr. Thomas Raimann, ADA Council on Ethics, Bylaws and Judicial Affairs:

- Principles of Ethics and Code of Professional Conduct
- Dental impairment—unethical for DD to practice while abusing controlled substance; encourage colleagues to self report
- Patients and practitioners rights to maintain privacy
- Programs are available

ADA Updates by Dr. Maxine Feinberg, ADA President:

- Collaboration to get thoughts from various organizations and various groups
- Inclusion of others; starting with ASDA (student DDS)
- More DDS students graduating concerned with student debt
- Debt to income ratio—private schools 120% and public schools 90%
- DDS practicing in corporate dentistry are not happy
- New DDS are concerned with licensure portability

ADA Dentist Health and Well-Being Outreach by Dr. James Willey, ADA Senior Director, Practice Institute:

- Substance use disorder—abuse/addition disease
- 10-15% of all healthcare professionals will misuse drugs or alcohol
- Dental professionals are at risk because of
  1. Stress burnout
  2. Solo-no social support
  3. Access to meds
  4. Knowledge of pharmacology
  5. Family history—high risk
- Problems:
  1. Denial, cut-back, memory problems, mood swings, paranoia
  2. Withdrawal into isolation, blaming others with habits
  3. "Super DDS" attitude—grandiose mentality; lack of interest or motivation
  4. Errors with record keeping
  5. Frequent job changes
- Treatment options:
  1. State's DDS Well-Being programs
  2. ADA Health and Well-Being programs
  3. State licensing board programs
  4. Referrals
- DDS Well-Being programs have an 85-90% success rate in maintaining recovery rate
- There's ADA grant to cover 4 webinars—"Provider's Clinical Support System Opioid
- Americans take 80% of opioids and 99% hydrocodone abuse

Best Practice of Prescribing and Dispensing by Demetra Ashley, DEA Diversion Program Manager, Chicago Division:

- MD abuse prescription drugs more than DDS
- DDS—record keeping violation; self abuse/self prescribing; a memorandum of agreement
- Scheduled investigation if prescriptions are stored in practice NOT for writing prescriptions
- Prescription storage must be "locked"; trace accountability—record keeping log; NO pre-signed scripts
- Sequence of violation:
  1. Order to show cause—no records to prove what happened
  2. Immediate suspension order—"major" issues—abuse causing harm
  3. Civil fines--$10,000 fine
  4. Immediate suspension
- Opioids/ Benzodiazepines (Xanax, valium) are most commonly used; mostly Caucasian men

- Increased number of babies with pain killers addiction
- Australia and US are biggest consumers of hydrocodone; US produces 100% of hydrocodone and consumes 99% of it

Future of Controlled Substances by Carmen Catizone, M.S. RPh, Dph, Executive Director, National Association of Boards of Pharmacy:

- Indiscriminate prescribing
- Criminal activity
- Vicodin—50% of 12 year old or older abuse prescription drugs from friends and family
- Be careful with over prescribing leaving left over pain drugs readily available
- Future depends on practitioner responsibility; PMP and drug scheduling—making it harder to access schedule II drugs
- PMP—future "mandated" use of PMP
- Medical marijuana use—state source of income

AADB UPDATE by Mr. James Tarrant, Executive Director:

- Benefits—networking, best practice, knowledge on how to protect the public, education research, clearing house (NPMP—national data bank)
- ERA—Expert Review Assignment program $750/ program; fee charged to respondent
- D-Prep—assists if problem "can or cannot" be fixed; $1,000 or $3,000 fee charge to respondent
- Remediation—hours based from D-Prep to create the program; University fee of $15,000 with 3-5 days at the dental school (University of Maryland and LSU are schools with programs) or contact AADB for further information

Year in Review-Panel of Current trends and Difficult Cases-How States Handle External Disciplinary Resources:

- North Carolina
    1. Does not mandate change in NC board composition since the US Supreme Court ruling; No impact to the actions of the Board in disciplinary matters
    2. Cease and Desist letters must now use language dictated by the FTC to ensure that recipients know they have additional rights
    3. Cease and Desist letter is something the Board did long before being sued by the FTC
    4. No need to change Dental Practice Act
    5. NC will no longer use Cease and Desist letters and they will seek AG advice first, other law enforcement and courts
    6. Public was harmed; public complained along with DDSs and RDHs. It was never a cost issue. FTC didn't allow evidence to show "public harm" in case since the focus was Anti-Competitive Act
- Ohio—board regulated in public's safety
- Oklahoma—elected board; licensees cannot oversee themselves

- Colorado—umbrella agency, can issue Cease and Desist

National Dental Examiners" Advisory Forum (NDEAF)-Joint Commission Policy Update and Update on Progress with Respect to the Integrated Examination by Dr. David Waldschmidt, JCNDE, Director, Testing Services:

- NDEAF assists state boards in determining qualifications of DDS and RDH; continue to maintain current exam standards and improve image quality
- JCNDE revokes if candidate takes exam for practice purposes; validity of exam results/ competency
- Test Administration—irregularities question validity of test results accurately reflecting ability/skill; investigation is done when irregularity is identified; candidate given 30m days to submit appeal

The presentation can be found on the following JCNDE web page:
http://www.ada.org/en/jcnde/news-resources/presentations

Here is the direct link to the presentation.
http://www.ada.org/~/media/JCNDE/pdfs/2015%20NDEAF%20and%20AADB%20Meeting.ashx

Respectfully submitted by,

Melanie C. Swain BSDH RDH
President, Virginia Board of Dentistry

2015 AADB Mid-Year Meeting Summary

The 2015 American Association of Dental Boards Mid-Year Meeting was held on April 26th and 27th, 2015, in Chicago, Illinois, at the American Dental Association Building. The official program was entitled: "Impairment - Issues for Regulation". Conference attendees included dental professionals from various dental schools, state boards of dentistry, dental agencies, and professional associations. The Virginia DHP Board of Dentistry was represented by Board members, Ms. Melanie Swain, RDH, President, and Dr. Charles Gaskins, V.P., and by Board Deputy Exec. Dir., Ms. Kelley Palmatier.

Board Recognition of Dental Specialties and Courts vs. Boards: Mr. Craig Busey, JD, ADA Gen. Counsel, reviewed the recent U.S. Supreme Court ruling regarding the N.C. State Board of Dental Examiners vs. Federal Trade Commission case. He noted that "Commercial Speech" is covered by law, and that advertising is permissible unless "deceptive or misleading".

The program content of the conference was configured to present, discuss, and assess many aspects of practitioner impairment issues relative to dentistry. The following points were raised either by the individual presenters, or by an attendee with knowledge of the subject area.

How Has Medicine Addressed Impairment?: Impairment - consisting of mental, narcotics/medicines, alcohol sources was usually treated as a disciplinary matter and was not transparently adjudicated prior to the 1970's. Currently via physicians' health programs (PHPs), disruptive behaviors, stress and wellness are also now addressed.

State Dental Boards and Impaired Practitioners: Alcohol, opioids, stimulants, sedatives all abused by practitioners via "Substance Use Disorders". Genetics is likely a very significant factor in behavior and outcomes; however, treatment programs generally are about 85-90% effective. The investment and cost of a treatment program are greatly out-weighed by the cost to society of the loss of a practitioner due to impairment.

ADA Ethics Program: Ethically, there exists a need to weigh/balance competing "interests" of a patient's right to know of a practitioner's impairment and status, verses the practitioner's right to medical privacy.

ADA Dentist Health and Well-Being Outreach: 10-15% of healthcare professionals will misuse drugs or alcohol during their careers. The USA comprises about 4% of the world's population, but consumes about 80% of the world's opioids and 99.3% of the hydrocodone.

Best Practices for Prescribing and Dispensing: Lock and control physical access to stored controlled substances. Accurate and ongoing log control of all controlled substances. DEA reference: Code of Federal Regulations: Title 21 CFR Sec. 1306.04, Sec. 1306.05

Future of Controlled Substances: Indiscriminate prescribing and criminal activity will both shape the (legislated, enforcement) future for any controlled substances. Limiting both the

number of prescriptions and the quantities of any controlled substances by providers is needed. Individual drugs may be rescheduled in the future to affect their usage, access.

AADB Update / Current Trends, Difficult Cases Panel Discussion: 3-5 day mandated practitioner clinical assessments at participating U.S. dental schools are available as a resource via AADB thru the "D-PREP" program. Current approximate program costs to the reprimanded practitioner include: Application Administration - $1,000; Practitioner Assessment Fee - $3,000; Dental School Remediation Fees - $15,000

Recommendation was made for state health regulatory boards to ongoingly seek counsel when confronting "marketplace policy" issues beyond the direct enforcement of valid state laws, and that courts are valid "supervising agencies". Therefore, lawsuits by boards regarding non-licensed behaviors are worthy of consideration when indicated/needed.

Submitted by Charles E. Gaskins III, DDS

Discussion topics as a result of North Carolina State Board of Dental Examiners v. Federal Trade Commission – the Supreme Court did not order the North Carolina Board of Dentistry to change its composition of dentist and registered dental hygienist board members to non-active market participants or to change the method of selection for its board members from elected to appointed (elected v. appointed to a board was not the determining factor as to whether there is "active supervision" by the state and can therefore invoke state-action antitrust immunity). It was speculated that this decision would not have an effect on disciplinary matters before a board but can envision how a plaintiff's attorney might assert on behalf of a licensee that a board's disciplinary action is affecting the licensee's ability to compete. A board's defense in this type of matter could be this is a public health matter and the disciplinary action is not affecting competition generally but rather a single competitor and the FTC shouldn't be involved. The NC v. FTC decision creates a lot of tension with the Supreme Court case of Withrow v. Larkin 421 U.S. 35 (1975), which will eventually need to be resolved. The tension is created because Larkin says there is a "presumption of honesty and integrity in those serving as adjudicators" but North Carolina v. FTC enshrines the position that board members are presumed to be self-dealing and anti-competitive.

Dental boards in other states are dealing with similar issues to the Virginia Board of Dentistry. Boards are grappling with how to ensure that the public is protected from dentists who administer conscious/moderate sedation, deep sedation and general anesthesia. Although the structure of many dental boards is different than Virginia, there are states that have emergency scenarios conducted by "inspectors"[1] during an office inspection and observe sedation cases being performed by permit holders. Other state dental boards are also attempting to reign in the corporate practice of dentistry but are concerned with whether the FTC will see such an attempt as anti-competitive and use it as another way to expand Federalism. Similar to concerns voiced by the Virginia Board of Dentistry, other boards are concerned how to authenticate electronic patient records. Finally, another large issue for many of the state dental boards is the standard of care issues that are arising from general dentists taking a weekend course in dental implants and then performing complex full mouth rehabilitation with such little knowledge and skill.

Opioid use is a big problem in the United States. The United States produces 100% of the world's supply of hydrocodone and uses 99% of it. There is 1 drug related death every 12.45 minutes. Tools to manage the epidemic are practitioner responsibility (no indiscriminate prescribing where patients have leftover pills that can fall into the wrong hands), use of the Prescription Monitoring Program, and the rescheduling of drugs to Schedule II's to make them harder to prescribe and obtain.

[1] "Inspectors" were typically sedation permit holders who volunteered or were paid by the Board to visit other applicants/permit holders for an inspection. One state employed a CRNA to run the emergency scenarios and conduct inspections to avoid the presumption the permit holder are "self-dealing" and "anti-competitive."

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CTel Executive Tele health Roundtable
Spring Summit 2015
Washington, DC
April 9 and 10

The CTel conference focused on the "case for direct to consumer telemedicine (DTC)." Discussions dealt with "telemedicine as a rapidly evolving form of health care delivery that improves access to care and saves costs."

Keys to successful telemedicine are:

*Education
*Consultation
*Tele-practice
*Tele-research

Coordination of care is essential. Standards of care are necessary and the expansion of telemedicine is dependent on reimbursement. Representatives from insurance providers Anthem and United Healthcare stated they are increasing reimbursements for more telemedicine consultations but expressed the need for consistent standards of care particularly since the United States relies heavily on fee for service payments.

International Direct to Consumer (DTC) telemedicine "transcends boundaries and brings medical care to the most underserved populations. In the European Union countries, 85% of medical treatments are reimbursed by the government. One example is care can be provided to 72 small villages in France, remote access can be used in hospitals and nursing homes as well.

The University of Arkansas for Medical Sciences and Arkansas Children's Hospital holds discussions by teleconferencing each week between pediatricians practicing in the real world and professors in academia. This has improved the way pediatrics is practiced there.

Pharmacists can play a direct role in monitoring whether a prescription is appropriate for a diagnosis and whether other medications taken by the patient might cause interactions. Caregivers/home health aides can be helpful in monitoring patients and coordinating patient's care with medical providers.

Usually a face-to-face doctor to patient relationship is required to be established before utilizing telemedicine to diagnose or prescribe by phone or tele-monitor. Coordination of care is essential. Privacy issues are also a concern. Appropriate HIPPA regulations, secure networks, and consistent standards of care can insure better security.

Telemedicine's "poster child" is the field of psychiatry. They have achieved effective treatment by interactions between doctor and patient by phone, smart phone or monitor. Radiology and cardiology have also been used for years successfully, i.e. monitoring a pacemaker.

Jay Douglas, MSM, RN, CSAC, FRE, Executive Director, Virginia Board of Nursing stated the focus must be on patient protection. At the same time, availability of quality, accessible health care must be increased.

One session dealt with telemedicine apps in the age of the smartphone. Exciting new inventions are coming to the market with apps for in-home diagnostic tests, stethoscope, camera lights to look into ear, thermometer using certain apps for IPad, etc.

Legal ramifications were also discussed by Stuart Gerson, Esq., Epstein Becker & Green, P.C. regarding the recent Supreme Court Decision *North Carolina Board of Dental Examiners v. Federal Trade Commission.* "The Supreme Court held that the North Carolina Dental Board was subject to anti-trust laws related to its efforts to close down teeth-whitening businesses not owned and operated by dentists." He stated this could have a far reaching impact for all state boards, including medical boards. The key is that "*Boards must be subjective to active supervision by the state"* to avoid being subjected to the anti-trust law. In other words, the board could be liable no matter if they are appointed or elected *if there is not a state entity to overrule the board's actions.*

I spoke with Greg Billings, Executive Director, The Robert J. Waters Center for Tele health and e-Health Law, asking if he saw a role for individual dentistry without a presenter in the burgeoning telemedicine field. He said he could not and that he had spoken to Sandra Reen, Executive Director of the Virginia Board of Dentistry regarding this. South Dakota has received a request to practice tele-dentistry in several areas, likely with a dental assistant or clinic aide.

Idaho has used telemedicine effectively in the rural areas saving money and providing better care. The "next wave" is thought to be "Doc in the box" in shopping malls. Some of these could be problematic with "venture capitalists" coming in to pay medical providers to front a kiosk business because of great need for affordable care.

The conference underlined that "a physician-patient relationship can only be established through an examination by tablet, phone app, or web camera. This must (1) provide information equivalent to an in-person exam (2) conform to the standard of care expected of in-person care; and (3) incorporate any tests sufficient to provide an accurate diagnosis. This relationship cannot be established through an (audio-only) phone call or email.

With all of the apps being developed and the increased availability of smart phones and other technology, telemedicine may have a great impact on dentistry, especially in underserved areas. A dental assistant could be the presenter via smart phone or video getting better care to those in need at less cost.

Telemedicine is being utilized increasingly and has great potential for the future of medicine and patient care. This is promising and exciting news for medical care providers and patients.

Sharon W. Barnes
Citizen Member, Virginia Board of Dentistry

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MAY - 1 2015
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Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of May 29, 2015)

Chapter		Action / Stage Information
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252]
		Final - *At Governor's office for 170 days*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Requirement for jurisprudence examination [Action 4364]
		NOIRA - *At Governor's Office for 9 days*

Agenda Item: Response to Petition for Rulemaking

Included in your agenda package are:

Copy of petition from Mandeep Sood (Recognition of dental school programs accredited by CDAC)

Copy of comments on regulations as of May 26, 2015

A copy of applicable sections of the regulations

Staff Note:

There was a comment period on the petition from May 18, 2015 to June 9, 2015.

Board action:

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

OR

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

COMMONWEALTH OF VIRGINIA
Board of Dentistry

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

Petition for Rule-making

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

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

Petitioner's full name (Last, First, Middle Initial, Suffix,) **Mandeep Sood**		
Street Address **2169 Heathcliff Court**	**Area Code and Telephone Number** 1-905-469-1613	
City **Oakville**	**State** **Ontario**	**Zip Code** **L6M 0A5**
Email Address (optional) **mandeep_sood@hotmail.com**	**Fax (optional)**	

Respond to the following questions:

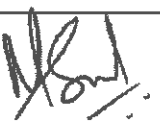
1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

Virginia Board of Dentistry's precedence of not recognizing dental school programs accredited by Commission on Dental Accreditation of Canada (CDAC) in spite of an existing reciprocal agreement between CDAC and Commission on Dental Accreditation of the American Dental Association (CODA) to bilaterally recognize programs that are accredited by either of these commissions.

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

Every year there are many dentists who get their licence to practice dentistry in the province of Ontario that I reside in, although they had their education from a dental school in the US. The foundation of this reciprocation has been built over many years through mutual respect and trust for each other's accreditation criteria and methodology. This has played a vital role between the two countries in collaborating for mutual benefit for the students, dental schools, and the states/provinces in both the countries.

I realize that State Boards have an independent mandate to decide on the criterions they can select to license dentists to practice in their jurisdictions. However, at the same time with Virginia Board not respecting alliances set forth between CODA and CDAC to mutually recognize each other's accredited dental school programs undermines the basis of these collaborations between accrediting commissions of these two great neighboring countries.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference.
Signature:  **Date:** April 17 /15

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Logged in: DHP

Agency **Department of Health Professions**

Board **Board of Dentistry**

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

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Terri slitor * 5/21/15 12:33 pm

registered dental hygienist.

If a hygienist has passed our national boards in th US they should be able to obtain a license and practice.

Commenter: Bruce Svechota-Kingsbury, DDS * 5/21/15 8:39 pm

Dental Hygiene Eligibility

To whom it may concern,

I am writing regarding the issue of licensure for Canadian-trained dental professionals in the Commonwealth of Virginia. In my view it seems that a Canadian-trained dental professional that undergoes the rigors of the same National Boards that American-trained dental professionals go through should be afforded the same opportunity for employment. Given that there is an existing reciprocal agreement between CODA and CDAC, it seems to me the spirit behind this agreement is for just this purpose.

Thank you,

Bruce Svechota-Kingsbury, DDS

* Nonregistered public user

Yeatts, Elaine J. (DHP)

From: Vu, Huong (DHP)
Sent: Monday, April 20, 2015 2:07 PM
To: Reen, Sandra (DHP); Yeatts, Elaine J. (DHP)
Subject: FW: Petition for rulemaking
Attachments: IMG_4093.PNG; Sood petition.pdf

FYI

From: Dag Zapatero [mailto:Dag.Zapatero@verizon.net]
Sent: Monday, April 20, 2015 2:05 PM
To: Vu, Huong (DHP)
Subject: Re: Petition for rulemaking

Dear Ms Vu,

I have read the petition request from Mandeep Sood, and do not feel that our state board should comply with the request to recognize dental school programs accredited by the Commission on Dental Accreditation of Canada even if the ADA is sympathetic to reciprocity. In my opinion we first need a formal request from the CDAC and then study the request before we open this further to discussion. How many states already approve reciprocity?

There are many position that the American Dental Association take that state board have not followed. ADA may takes a position they feel is in the best interest of it's members, or they my act as the voice of dentistry but they are not in a position to determine what's in the best interest of the residents of our Commonwealth. Something I learned first handed as I pushed for a laboratory safety act in Virginia.

I am confused by the petitioner's suggestion that an agreement between the Canadian Dental Accreditation and it's American counterpart has any bearing to compel our Commonwealth to act accordingly. If the petitioner has a problem with the reciprocity practices in the Province of Ontario he should take it up with them. I am not sure how the petitioner feels qualified to determine that the Virginia Board of Dentistry is "not respecting alliances set forth between ADA's CODA and CDAC", nor does the petitioner respect our process by wanting to incite a boarder conflict.

I just saw the attached dental service as on social living for an invisalign evaluation kit, targeting our residents from smilecareclub, los angles. The ad stated it was not valid for residents of North Carolina or Florida, and I asked myself if it's not good for their residents why is this good for Virginia residents? These people are charging for services that will be used to diagnose and render an opinion of a dental condition and provide a treatment plan. How is this not viewed as practicing dentistry within our boarder without a license? If we recognize Canadian programs does this mean they to can market to our residents as this example?

I do not see how approving this petition would benefits the residents of our Commonwealth, and strongly feel it should be denied. There are other mechanism the petitioner could follow to apply for a graduate position and take the appropriate testing as others have done. Thank you in advance for considering my comments in your deliberation.

Best,
Dag Zapatero, DDS
Fellow of the American College of Dentist

Starfish Dental
Dag Zapatero, DDS, MAGD | 3020 Shore Drive | Virginia Beach, VA 23451
office. 757.481.3893 | fax 757.481.0425 | www.Starfishdental.com

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

Petitioner's full name (Last, First, Middle initial, Suffix,) Mandeep Sood		
Street Address 2169 Heathcliff Court	Area Code and Telephone Number 1-905-469-1613	
City Oakville	State Ontario	Zip Code L6M 0A5
Email Address (optional) mandeep_sood@hotmail.com	Fax (optional)	

Respond to the following questions:

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

Virginia Board of Dentistry's precedence of not recognizing dental school programs accredited by Commission on Dental Accreditation of Canada (CDAC) in spite of an existing reciprocal agreement between CDAC and Commission on Dental Accreditation of the American Dental Association (CODA) to bilaterally recognize programs that are accredited by either of these commissions.

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

Every year there are many dentists who get their licence to practice dentistry in the province of Ontario that I reside in, although they had their education from a dental school in the US. The foundation of this reciprocation has been built over many years through mutual respect and trust for each other's accreditation criteria and methodology. This has played a vital role between the two countries in collaborating for mutual benefit for the students, dental schools, and the states/provinces in both the countries.

I realize that State Boards have an independent mandate to decide on the criterions they can select to license dentists to practice in their jurisdictions. However, at the same time with Virginia Board not respecting alliances set forth between CODA and CDAC to mutually recognize each other's accredited dental school programs undermines the basis of these collaborations between accrediting commissions of these two great neighboring countries.

This should be done on a case by case basis. Is there a compelling family basis? Is this just for precedence? Has Sood taken the National and State Board Exams? We cannot accept the world's desire to be in the USA but we can accomodate some, fairly, based on certain guidelines estab. by the Board.
Peter Scuffo, MS (05482)

July 2002

Applicable sections of regulation

18VAC60-20-60. Educational requirements for dentists and dental hygienists.

A. Dental licensure. An applicant for dental licensure shall be a graduate and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty.

18VAC60-20-71. Licensure by credentials for dentists.

In accordance with § 54.1-2709 of the Code of Virginia, an applicant for licensure by credentials shall:

1. Be of good moral character and not have committed any act which would constitute a violation of § 54.1-2706 of the Code of Virginia;

2. Be a graduate of a dental program, school or college, or dental department of a university or college currently accredited by the Commission on Dental Accreditation of the American Dental Association.

3. Have passed Part I and Part II of the examination given by the Joint Commission on National Dental Examinations;

4. Have successfully completed a clinical examination that involved live patients;

5. Hold a current, unrestricted license to practice dentistry in another jurisdiction in the United States and is certified to be in good standing by each jurisdiction in which he currently holds or has held a license; and

6. Have been in continuous clinical practice for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in the dental corps of the United States Armed Forces, volunteer practice in a public health clinic, or practice in an intern or residency program may be accepted by the board to satisfy this requirement. One year of clinical practice shall consist of a minimum of 600 hours of practice in a calendar year as attested by the applicant.

Applicable Regulations from Other Professions

Medicine

18VAC85-20-121. Educational requirements: Graduates of approved institutions.

A. Such an applicant shall be a graduate of an institution that meets the criteria appropriate to the profession in which he seeks to be licensed, which are as follows:

1. For licensure in medicine. The institution shall be approved or accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, or **by the Committee for the Accreditation of Canadian Medical Schools** or its appropriate subsidiary agencies or any other organization approved by the board.

Nursing

18VAC90-20-200. Licensure by endorsement.

A. A graduate of an approved nursing education program who has been licensed by examination in another U.S. jurisdiction and whose license is in good standing, or is eligible for reinstatement, if lapsed, shall be eligible for licensure by endorsement in Virginia, provided the applicant satisfies the same requirements for registered nurse or practical nurse licensure as those seeking initial licensure in Virginia. Applicants who have graduated from approved nursing education programs that did not require a sufficient number of clinical hours, as specified in 18VAC90-20-120, may qualify for licensure if they can provide evidence of at least 960 hours of clinical practice with an active, unencumbered license in another U.S. jurisdiction.

1. **A graduate of a nursing school in Canada where English was the primary language shall be eligible for licensure by endorsement provided the applicant has passed the Canadian Registered Nurses Examination (CRNE) and holds an unrestricted license in Canada.**

Physical Therapy

18VAC112-20-40. Education requirements: graduates of approved programs.

A. An applicant for licensure who is a graduate of an approved program shall submit documented evidence of his graduation from such a program with the required application and fee.

B. If an applicant is a graduate of an approved program located outside of the United States **or Canada,** he shall provide proof of proficiency in the English language by passing TOEFL and TSE or the TOEFL iBT, the Internet-based tests of listening, reading, speaking and writing by a score determined by the board or an equivalent examination approved by the board. TOEFL iBT or TOEFL and TSE may be waived upon evidence that the applicant's physical therapy program was taught in English or that the native tongue of the applicant's nationality is English.

COMMISSION ON DENTAL ACCREDITATION

F. RECIPROCAL AGREEMENT WITH THE COMMISSION ON DENTAL ACCREDITATION OF CANADA

The reciprocal accreditation arrangement between the Commission on Dental Accreditation and the Commission on Dental Accreditation of Canada (CDAC) has been maintained and expanded since its adoption in 1956. Under the reciprocal agreement, each Commission recognizes the accreditation of educational programs in specified categories accredited by the other agency. Under this arrangement, the Commissions agree that the educational programs accredited by the other agency are equivalent to their own and no further education is required for eligibility for licensure. Commissioners and staff of the accrediting agencies will regularly attend the meetings of the other agency and its standing committees. In addition, Commissioners and/or staff will participate annually in at least one site visit conducted by the other agency. The Commissions believe that this cross-participation is important in maintaining an understanding of the accreditation processes in each country and in ensuring that the accreditation processes in each country continue to be equivalent.

The following educational programs are included in the scope of the reciprocal agreement.

- Predoctoral dental education
- Dental hygiene
- Level II dental assisting
- All nine (9) ADA recognized advanced specialty education programs

The following statement is used in each issue of the List of Accredited Advanced Education Programs and in each issue of the List of Accredited Dental Education Programs:

> Canadian Programs
> By reciprocal agreement, programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation of the American Dental Association. However, individuals attending dental programs in one country and planning to practice in another country should carefully investigate the requirements of the licensing jurisdiction where they wish to practice.
>
> By reciprocal agreement, Level II Dental Assisting and Dental Hygiene programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation of the American Dental Association.

Reaffirmed: 8/12, 8/10, 7/07, 1/03, 7/01; Updated: 7/91; CODA: 1/97:03, 1/94:4-5

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, April 07, 2015 4:23 PM
To: 'Debra Quitter'
Subject: RE: Proposed subject for Board discussion

Importance: Low

Hi Ms. Quitter:
Your March 28, 2015 letter to the Board of Dentistry will be included in the agenda package for the next business meeting which will be held on June 12, 2015 at 9960 Mayland Drive, Henrico, VA. The agenda package will be posted on our web page approximately two weeks in advance of the meeting.

In the meantime, I want to ask if you would like to have your treatment experience investigated and addressed by the Board? This link, http://www.dhp.virginia.gov/Enforcement/complaints.htm, will take you to information on the disciplinary process and filing a complaint. The complaint process allows the Board to review patient experiences such as yours to determine if laws and regulations governing the practice of dentistry were violated. When violations are found, any notices and orders issued by the Board are posted online for public review.

Please let me know if you have any questions.

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

Any and all statements provided herein shall not be construed as an official policy, position, opinion, or statement of the Virginia Board of Dentistry (VBOD). VBOD staff cannot and do not provide legal advice. VBOD staff provides assistance to the public by providing reference to VBOD statutes and regulations; however, any such assistance provided by VBOD staff shall not be construed as legal advice for any particular situation, nor shall any such assistance be construed to communicate all applicable laws and regulations governing any particular situation or occupation. Please consult an attorney regarding any legal questions related to state and federal laws and regulations, including the interpretation and application of the laws and regulations of VBOD.

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-----Original Message-----
From: Debra Quitter [mailto:daquitter1@verizon.net]
Sent: Thursday, April 02, 2015 9:41 AM
To: Reen, Sandra (DHP)
Subject: Proposed subject for Board discussion
Importance: High

Dear Ms. Reen,

Good day. I ask that you read the attached personal experience and please ask your board to consider the changes I have noted.
Thank you for your time.

Additionally I have forwarded copies of this information to both of my State Senators and my district Congressman. I believe this is important and worthy of their attention.

Respectfully yours,

Debra Quitter

Debra A. Quitter
4616 Brantingham Drive
Virginia Beach, VA 23464
(757) 467-7771 daquitter1@verizon.net

March 28, 2015

Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

ATTN: Ms. Sandra Reen, Executive Director

Dear Ms. Reen:

Four years ago, after falling on my face at a granddaughter's gymnastic demonstration, while taking photographs, I noticed that aside from bruises over my body my tooth was loose.

While the following describes my experiences after the above mentioned accidental fall I ask that you remember I am not a trained medical professional and my descriptions may lack the preferred medical wording. This describes my experience after that accidental fall:

1. **Met with DDS for consultation and quote. The DDS is knowledgable and possesses implant credentials. Right canine loose and must be removed. The tooth is a baby tooth with no adult tooth above. The loose tooth would have to come out and replacement using an implant. Arranged for procedure. Procedure cancelled. See Number 2 below.**
2. Received call from DDS's assistant asking me to come in to speak with dentist. Met with DDS and he stated a dental bone graft is required to fill the space above the baby right canine. He could not do procedure outlined in No. 1. Was quoted price and scheduled procedure. Also removed Right Canine at this time. Scheduled surgery. *Paid $1,800.00 out of pocket Remove Right Canine: $250.00 out of pocket*
3. **Bone graft complete. Return to DDS's office due to severe pain in area of dental bone graft. Bone graft is infected and DDS removes graft materials. Right Peg Lateral is also removed at that time due to spread of infection. *Paid for removal of Peg Lateral $250.00***
4. After reasonable healing time return to DDS; he quotes price to perform second bone graft to the area of the right Canine and Peg Lateral. *Paid: $2,300.00 out of pocket*
5. **Dental bone graft complete. Toward the end of the procedure unknown to the DDS I awoke. I clearly heard him say to his assistant "the result is not good and all he could do was pray. He is happy I cannot see this." Within three days of procedure gums split open in front and pain. Return to DDS for check of problem; DDS removes entire dental bone graft due to infection and loss of gum tissue. The infection had migrated to the right Central Incisor. The suturing after removal was done with no anesthetic**

because the Novocain was simply running out of the incision. The infection migrated to the right Central Incisor and the Central Incisor had to be removed. I am now missing the Right Canine, Right Peg Lateral and the Right Central Incisor. Additionally my smile and nose have an unusual appearance. The maxillary labial frenum was not reattached to the proper location. ***Cost to remove the Right Central Incisor: $250.00 out pocket***

6. After reasonable healing time return to DDS. He said he absolutely can perform bone graft if a gum tissue graft is performed. He refers me to an oral surgeon for gum graft and to fix the placement of the maxillary labial frenum.
7. **Meet with oral surgeon for consultation. He successfully performs the gum tissue graft and repositions the maxillary labial frenum.** ***Paid: $2,500.***
8. After reasonable healing time I return to the DDS and he said I will not have pay for my next bone graft. DDS makes appointment for bone graft.
9. **DDS does a surgery he describes to me as a brand new procedure. He cuts bone and moves the cut bone downward filling the open area with bone graft material. This is an extremely painful procedure. At this point I have faith in the DDS and his skills and am certain this procedure he has designed himself will work.**
10. After reasonable healing time return to DDS. DDS removes sutures and scans area. DDS said that the bone has grown and look great. I will have to wait for all to heal — about 6 months.
11. **When viewing the surgical area I do not see a visible improvement. It doesn't look like there is more bone. My nose is still pulling to one side. Additionally I now have no channel between the gums and lip area as the DDS closed this. These thoughts end when I seek a consultation with another Oral Surgeon. We have a friend who works in the office. A scan is performed. The scan clearly shows there is no bone growth whatsoever. This Oral Surgeon said that I am not longer a candidate for bone graft surgery or implants. She cannot help me. I thank them and leave office.** ***PAID: $250.00***
12. Follow-up appointment with original DDS; checks mouth and he is ready to do the implant surgery. Told to schedule an appointment for the surgery. The office manager tells me that they have decided to bill me for the last dental bone procedure since it was a success. The cost of the surgery they performed $5,400.00 but at the DDS's request they will hold the bill until he places the implants. Additionally I should expect to pay the cost of the implant procedure.
13. **I say nothing about knowing there is no bone growth and leave the office.**
14. I seek the assistance of a HIGH SKILLED ORAL SURGEON based upon a nurses recommendation. She has seen him operate at the hospital and said I should see him.
15. **Meet with the new and final Oral Surgeon. He X-rays all and scans. He determines at this point I have an actual brake in the upper front jaw (he used a technical term) AND that there was perforation into the nasal cavity. He also needs to reposition the maxillary labial frenum and return open the gum channel to keep my face from becoming further deformed. He advises me that those problems must be repaired and add bone to the area to correct the severe deformity before proceeding with implants. He said he believes I can have implants if done correctly. To successfully make the repairs and add bone will take 3 or possible 4 procedures.**

16. I write a letter to the DDS requesting a refund of monies we paid to him so that I can help to offset the cost of the hospital procedure. His response is to tell me how hurt he is and he did not want his to think I was running ruining his reputation. He wanted to know if I had sent the letter to anyone else. He tells me he does not believe that surgery is necessary to correct these problems and he can supply a fine bridgework instead. He does not send me refund. I feel bad and do not want to ruin his reputation and livelihood. I tell him I will see him and of course I know this is not his fault. I make an appointment with him to return to have and consultation of work to be done and the cost. I never go. Now I am a coward who does not stand my ground wit the DDS. I am appalled that his main concern is that I am not sullying his reputation.
17. **Schedule surgery with final Oral Surgeon. This is first of several operations. Arrive at hospital and I am admitted after procedure. Final Oral Surgeon removes my hip bone and mixes it with other types of filler to fill the break, plates and screws, and repairs the perforation. This is an extremely painful procedure. The oral surgeon's stitches are completely different from the DDS's stitches which were not as carefully completed. The oral surgeon provides excellent care and is confident all will be okay. I use a walker and am so grateful that this could be repaired. Without this procedure I will not be able to get even a partial let alone implants. A small infection did occur but with proper antibiotics and following the Oral Surgeons instructions the bone was not damaged.** ***Cost of this procedure: $7,000 to surgeon out of pocket.*** **My insurance paid for the hospital stay, etc. (Amazingly there is almost no scar where the hip bone was harvested.)**
18. Surgery to remove plates etc from bone, and perform other repairs. He has repaired and grown bone where no else could. *Cost of this procedure: $2,300.00*
19. **We cannot afford to pay Final Oral Surgeon to place implants. I go for a consultation with a different DDS who tells me he is a surgeon and he does these operations all the time. Also he has had specialized training to place implants. He quotes a price and I go home sick to my stomach that I have to use a lesser trained professional because of cost.**
20. After learning of the financial difficulty the Final Oral Surgeon says that he will discount my rate as he does not want anything else to go wrong. Wait until properly healed. Oral Surgeon is able to place a few implants. Stitches are perfectly done. The attachers are not placed at this time. Slow and steady wins this race. *Cost of this procedure: $5,800.00*

I will soon have the attachers placed for the implants to connect to the prosthetic that will attach. This is not a perfect implant ending as the prosthetic will go far up and the gum will not be natural. The best news is I will be able to chew and be able to eat in public. Also, the embarrassment of not having 4 teeth in the front of my is now gone. I am not longer deformed. There is the cost of having the attachers placed onto the implants which is unknown to me at this time. The prosthetic from the dentist is about $7,500 perhaps more.

I, of course, can prove all information provided herein. After giving considerable thought and checking into what procedures dentists, DSSs and implant specialists can legally perform the blame for this happening rests directly on the Board. None of these things would have happened if stringent requirements, including surgical residencies, were required before

implant placement. Attending a two week school, watching videos, a seminar, is not sufficient. In reality the general public is not aware that the person they are trusting to perform surgery has had no long term schooling or residency to perform implant surgery or bone grafts.

Surgery, wherever performed on the human body must be done by a Board Certified Surgeon. A person who has had several years of operative experience. I ask the Board to consider that Oral Surgeons alone be certified to place implants and perform surgery in the mouth. I beg you to do this.

Implants are a large profit making business and there may be a protest by dentists, DDSs and implant specialists and they will not be willing to receive long term training. If the dentists, DDS's, and implant specialists are not willing to receive long term surgical training this will not present a problem for patients. There are already surgically trained Oral Surgeons to do the job. That is, after all, their speciality.

If you wish to discuss my experience I am willing to supply you with proof of this event, and the more technical aspects, and answer any questions you may have that I can answer.

Thank you and I can only hope my experience will encourage the Board to move forward based upon what is best for patients.

Respectfully submitted,

Debra A. Quitter
(757)467- 7771
daquitter1@verizon.net

cc:
Scott Griffith, 2nd Congressional District of Virginia
Tim Kaine, United States Senate
Mark Warner, United Staes Senate
Swain, Melanie C., RDH, President
Gaskins, Charles E., III, DD, Vice-President
Wyman, Bruce S., DMD Secretary-Treasurer
Alexander, John M. DDS
Dhakar, Surya P., DDS
Rolon, Evelyn M., DMD
Rizkalla, A., DDS
Swecker, Tammy K., RDH
Watkins, James D., DDS
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Sandra Reen
Executive Director
sandra.reen@dhp.virginia.gov

Requiring Capnography for Sedation and General Anesthesia

Dr. Alexander requests discussion of amending the Regulations Governing Dental Practice to add capnography to the requirements for administering sedation.

The current regulations on equipment and monitoring requirements are:

18VAC60-20-110. Requirements for the administration of deep sedation/general anesthesia.

F. Required equipment and techniques. A dentist who administers deep sedation/general anesthesia shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation and immediate establishment of an airway and cardiopulmonary resuscitation. He 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 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 for children or adults, or both;
5. Source of delivery of oxygen under controlled positive pressure;
6. Mechanical (hand) respiratory bag;
7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;
8. Appropriate emergency drugs for patient resuscitation;
9. EKG monitoring equipment and temperature measuring devices;
10. Pharmacologic antagonist agents;
11. External defibrillator (manual or automatic);
12. For intubated patients, an End-Tidal CO^2 monitor;
13. Suction apparatus;
14. Throat pack; and
15. Precordial or pretracheal stethoscope.

G. Monitoring requirements.
1. The treatment team for deep sedation/general anesthesia shall at least consist of the operating dentist, a second person to monitor and observe the patient and a third person to assist the operating dentist, all of whom shall be in the operatory with the patient during the dental treatment. The second person may be the health professional delegated to administer sedation or anesthesia.
2. Monitoring of the patient undergoing deep sedation/general anesthesia, including direct, visual observation of the patient by one member of the treatment team, is to begin prior to induction and shall take place continuously following induction, during the dental procedure, and during recovery from anesthesia. The person who administered the anesthesia or another licensed

practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.
3. Monitoring deep sedation/general anesthesia shall include the following:
a. EKG readings and baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility to include: temperature, blood pressure, pulse, oxygen saturation, and respiration. The EKG readings and patient's vital signs shall be monitored, recorded every five minutes, and reported to the treating dentist throughout the administration of controlled drugs and recovery. When depolarizing medications are administered, temperature shall be monitored constantly.
b. A secured intravenous line must be established during induction and maintained through recovery.

18VAC60-20-120. Requirements for administration of conscious/moderate sedation.
I. Required equipment and techniques. A dentist who administers conscious/moderate sedation 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, and 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 masks;
2. Oral and nasopharyngeal airway management adjuncts;
3. Endotracheal tubes for children or adults, or both, with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway and a laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;
4. Pulse oximetry;
5. Blood pressure monitoring equipment;
6. Pharmacologic antagonist agents;
7. Source of delivery of oxygen under controlled positive pressure;
8. Mechanical (hand) respiratory bag;
9. Appropriate emergency drugs for patient resuscitation;
10. Defibrillator;
11. Suction apparatus;
12. Temperature measuring device;
13. Throat pack;
14. Precordial or pretracheal stethoscope; and
15. Electrocardiographic monitor, if a patient is receiving parenteral administration of sedation or if the dentist is using titration.

J. Monitoring requirements.
1. The treatment team for conscious/moderate sedation shall at least consist of the operating dentist and a second person to assist, monitor, and observe the patient. Both shall be in the operatory with the patient throughout the dental treatment. The second person may be the health professional delegated to administer sedation.

2. Monitoring of the patient undergoing conscious/moderate sedation, including direct, visual observation of the patient by a one member of the treatment team, is to begin prior to administration of sedation, or if medication is self-administered by the patient, immediately upon the patient's arrival at the dental office and shall take place continuously during the dental treatment and during recovery from sedation. The person who administers the sedation or another licensed practitioner qualified to administer the same level of sedation must remain on the premises of the dental facility until the patient is evaluated and is discharged.
3. Monitoring conscious/moderate sedation shall include the following:
a. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility and prior to discharge; and
b. Blood pressure, oxygen saturation, and pulse shall be monitored continually during the administration and recorded every five minutes.

Proposed Legislation on Fee Splitting

Dr. Gaskins requests discussion of advancing the legislative proposal the Board adopted at its June 2014 meeting which was submitted for consideration by the Governor for inclusion in the legislative proposals to be advanced to the 2015 General Assembly.

Board of Dentistry
Proposed Legislation
2015 Session of the General Assembly

A bill to enact § 54.1-2718.1 of the Code of Virginia prohibiting an agreement for compensation or any form of rebate or fee-splitting to refer patients for dental services.

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2718.1 of the Code of Virginia is enacted as follows:

§ 54.1-2718.1. Prohibition of an agreement for compensation, rebates or fee-splitting for referrals for dental services.

No dentist shall directly or indirectly accept or tender an agreement for compensation or any form of rebate or split a fee with any third party, including another dentist, for bringing, sending or recommending a patient for dental services. Advertising or marketing dental services by sharing a specified portion of the professional fees collected from prospective or actual patients with the entity providing the advertising or marketing shall constitute fee splitting.

Comments Requested: ADA Sedation and Anesthesia Guidelines

Background:

At the December Board meeting, the ADA Request for Comments on its Sedation & Anesthesia Guidelines was reviewed and the Board authorized the President to review and approve comments drafted by Dr. Rizkalla, Dr. Alexander and Board staff. The comments the Board submitted in January to the ADA Council on Dental Education and Licensure on the ADA Sedation and Anesthesia Guidelines are attached for review.

The ADA has opened another comment period on the guidelines which closes on June 29, 2015. The drafts circulated for comment include changes in language in areas that the Board had commented on, the provisions for children age twelve and under and the requirements for moderate sedation competency courses. Use the references on Bates stamped page number **P74** to review the language being circulated for comment.

The Board might decide to submit additional comments or to take no action.

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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January 2, 2015

Dr. James M. Boyle, III, Chair
Council on Dental Education and Licensure
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Via email, care of: JasekJ@ada.org

Dear Dr. Boyle:

The Virginia Board of Dentistry (the Board) appreciates the opportunity to comment on the ADA Sedation and Anesthesia Guidelines as the Council conducts a comprehensive review of the current guidelines. We would like to preface our specific comments by letting you know that the competency course requirements in the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Guidelines) are incorporated in the Board's Regulations Governing Dental Practice as our education standard for issuance of conscious/moderate sedation permits and deep sedation and general anesthesia permits. The Guidelines are an invaluable resource and a much appreciated reference document.

As a frequent user, the Board has from time to time needed technical assistance from ADA staffers in understanding the intent of the language used in the Guidelines in order to evaluate a continuing education program's compliance with the specifications for a competency course. To date, we have received expert and extremely helpful assistance in identifying the provisions in the Guidelines that have a bearing on our inquiry but are left to draw our own conclusions. We encourage the Council to take an additional step to support implementation of the Guidelines. We request adoption of a process to interpret the Guidelines in response to specific fact situations when questions arise about the intent of a provision. This action on the part of the Council would facilitate consistency in the application of the Guidelines across the various users and could be modeled on the Advisory Opinion process used for the ADA Principles of Ethics and Code of Professional Conduct.

Our specific comments are:

Lines 358 to 368 — Expand the equipment requirements for moderate sedation to include capnography to read as follows:

- A capnograph must be utilized and an inspired agent analysis monitor should be considered.

The Board advocates the use of capnography in all instances where moderate sedation, deep sedation or general anesthesia is administered regardless of the agents utilized and the methods of administration employed.

Line 484 — Strike the phrase "If volatile anesthetic agents are utilized," so that the language at this bullet would read as follows:

- A capnograph must be utilized and an inspired agent analysis monitor should be considered.

The Board advocates the use of capnography in all instances where moderate sedation, deep sedation or general anesthesia is administered regardless of the agents utilized and the methods of administration employed.

Lines 1229 – 1230 — Add more information on the expected parameters for the three live clinical experiences and the role of the participants in managing these experiences.
The Board understands that some continuing education providers involve the participants in the decision making process and administration while others have the faculty explain the steps being taken while the participants observe. Are both approaches acceptable?
The language used in lines 1243 and 1244 is much clearer in stating the expectation for participants.

Lines 1236 – 1237 — Expand the highlighted provision to read as follows:

…this course in moderate enteral sedation is not designed for the management of children (aged 12 and under) or for medically compromised adults.

Lines 1251 – 1252 — Strike the current bolded sentence "Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults." And replace it with:

This course in moderate parenteral sedation is not designed for the management of children (aged 12 and under) or for medically compromised adults.

The current bolded sentence should be replaced because it implies that adding more clinical experiences, presumably involving children and compromised adults, is all that is needed to make this course acceptable for these special populations. This implication fails to respect the vulnerability of these populations and is inconsistent with the ADA's stated position in lines 65 – 68 regarding children. The proposed language is based on the language used in lines 1236 – 1237 as addressed above.

The Board looks forward to receiving information on the Council's discussion of the ADA Sedation and Anesthesia Guidelines and to an opportunity to review any proposed changes. Please contact me at sandra.reen@dhp.virginia.gov if you have any questions about our submission.

Sincerely,

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

Reen, Sandra (DHP)

From: American Dental Association <ADAemail@updates.ada.org>
Sent: Wednesday, May 06, 2015 1:54 PM
To: Reen, Sandra (DHP)
Subject: Comments Requested: ADA Sedation and Anesthesia Guidelines

ADA American Dental Association®

ADA Update

Comments Requested: ADA Sedation and Anesthesia Guidelines

The ADA Council on Dental Education and Licensure is conducting a comprehensive review of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Use Guidelines) and the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Teaching Guidelines) and seeks comment from the communities of interest. The Council proposes changes as highlighted below in addition to several editorial updates.

Use Guidelines
Revisions to anxiolysis and sedation statements regarding children age 12 and under (page 2, lines 72-79).
End-tidal CO2 monitoring during moderate and deep sedation and general anesthesia unless precluded or invalidated by the nature of the patient, procedure or equipment (page 9, lines 438 & 462) (page 11, line 572).

Teaching Guidelines
Revisions to anxiolysis and sedation statements regarding children age 12 and under (page 16, lines 809-815)
Alterations in course duration and other educational requirements for moderate sedation competency courses (pages 26-27, lines 1364-1385).

The Council will consider feedback received by June 29, 2015 and determine whether to recommend revisions to the 2015 ADA House of Delegates.

Please note that two documents are available for comment. We ask that you carefully review and provide feedback on any part of the Guidelines documents, which may be downloaded from the ADA website here.

Comments should reference the page number(s), line number(s), be specific and offer rationale. Address comments to:

Dr. James M. Boyle, III, Chair
Council on Dental Education and Licensure
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611

Via email, care of JasekJ@ada.org

If you have any questions or need assistance accessing the document online, please contact CDEL staff member, Ms. Jane Jasek, for assistance.

cc: Karen M. Hart, director, Council on Dental Education and Licensure and senior director of Education Operations

Quick Links

- ADA Center for Professional Success
- ADA.org
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- ADA Annual Meeting
- MouthHealthy.org
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This email is being distributed to dental anesthesiology communities of interest on behalf of Dr. James M. Boyle, III, Chair, Council on Dental Education and Licensure (CDEL) and Dr. Daniel Gesek, Chair, CDEL Committee on Anesthesiology

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America's leading advocate for oral health

Council on Dental Education and Licensure

Call for Comments

ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists
and
ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

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The ADA Council on Dental Education and Licensure is conducting a comprehensive review of the appended *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists* (Use Guidelines) and the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (Teaching Guidelines) and seeks comment from the communities of interest. The Council proposes changes as highlighted below, in addition to several editorial updates:

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Dr. James M. Boyle, III, Chair
Council on Dental Education and Licensure
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611

Comments may be sent via ground delivery or e-mailed to JasekJ@ada.org.

ADA American Dental Association®

Council on Dental Education and Licensure

Proposed Revisions:

Guidelines for the Use of Sedation and General Anesthesia by Dentists

Underscore denotes proposed additions
~~Strikethrough~~ denotes proposed deletions

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to *Section III. Educational Requirements.*

II. Definitions

Methods of Anxiety and Pain Control

~~**analgesia** – the diminution or elimination of pain.~~ [moved to Terms section]

anxiolysis – the diminution or elimination of anxiety

~~**conscious sedation**[1] – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.~~

~~In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.~~

~~**combination inhalation–enteral conscious sedation** (combined conscious sedation) – conscious sedation using inhalation and enteral agents.~~ [moved to Terms section]

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~ [moved to Terms section]

~~**local anesthesia** – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.~~ [Moved to Terms section]
~~*Note:* Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local~~

~~[1] *Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.*~~

~~anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.~~ [Moved to Terms section]

~~**combination inhalation - enteral conscious sedation** (combined conscious sedation) - conscious sedation using inhalation and enteral agents.~~

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[2]

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

For children age 12 and under, ~~T~~the use of preoperative sedatives ~~for children (aged 12 and under)~~ prior to arrival in the dental office~~, except in extraordinary situations,~~ should ~~must~~ be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Prescription medications intended to accomplish procedural sedation for children age 12 and under must not be administered without the benefit of direct supervision by trained medical personnel. (Source: the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*)

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation:
maximum recommended (MRD) - maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

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[2] *Portions excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014 ~~2004~~, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[3]

> *Note:* In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

> *titration*-administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[3]

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

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[3]

For all levels of sedation, the qualified dentist ~~practitioner~~ must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

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[3] *Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal - a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

analgesia – the diminution or elimination of pain [Moved from Definitions section]

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug. [Moved from Definitions section]

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents. [Moved from Definitions section]

qualified dentist - meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

operating dentist – dentist with primary responsibility for providing operative dental care while a qualifying dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or deep sedation or general anesthesia.

competency – displaying special skill or knowledge derived from training and experience

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should - indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[4]

ASA I - A normal healthy patient.
ASA II - A patient with mild systemic disease.
ASA III - A patient with severe systemic disease.
ASA IV - A patient with severe systemic disease that is a constant threat to life.
ASA V - A moribund patient who is not expected to survive without the operation.
ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.
E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

American Society of Anesthesiologists Fasting Guidelines*

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

*American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Anesthesiology 114:495. 2011. Reprinted with permission.

III. Educational Requirements

A. Minimal Sedation

1. To administer minimal sedation the dentist must demonstrate competency by having ~~have~~ successfully completed:

a. training ~~to the level of competency~~ in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*,

or

b. a comprehensive training ~~program~~ in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

c. ~~b.~~ an advanced education program accredited by the ~~ADA~~ Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines;

and

c. a current certification in Basic Life Support for Healthcare Providers.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must demonstrate competency by having ~~have~~ successfully completed:

[4] *ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

b. an advanced education program accredited by the ~~ADA~~ Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines;

and

c. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent, e.g., Pediatric Advanced Life Support) or completion of an appropriate dental sedation/anesthesia emergency management course on the same recertification cycle that is required for ACLS.

2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must have completed:

a. an advanced education program accredited by the ~~ADA~~ Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines;

and

b. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent, e.g., Pediatric Advanced Life Support) or completion of an appropriate dental sedation/anesthesia emergency management course on the same re-certification cycle that is required for ACLS.

2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.

For all levels of sedation and anesthesia, dentists, who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to these educational requirements. However, all dentists providing sedation and general anesthesia in their offices or the offices of other dentists should comply with the Clinical Guidelines in this document.

IV. Clinical Guidelines

A. Minimal sedation

1. Patient Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-Operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.

- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs (i.e., blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry) must be obtained unless invalidated by the nature of the patient, procedure or equipment ~~the patient's behavior prohibits such determination~~.
- A focused physical evaluation must be performed as deemed appropriate, including recording the patient's body weight.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery system, must be maintained. A pre- and post-procedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

Consciousness:

- Level of sedation (e.g., responsiveness to verbal commands) must be continually assessed.

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.
- Oxygen saturation by pulse oximetry must be used unless precluded or invalidated by the nature of the patient, procedure, or equipment ~~may be clinically useful and should be considered~~.

Ventilation:

- The dentist and/or appropriately trained individual must observe chest excursions continually.
- The dentist and/or appropriately trained individual must verify respirations continually.

Circulation:

- Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, time administered and route of administration, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.

- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

B. Moderate Sedation

1. Patient Evaluation

Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of at least a review, within the previous 30 days, of their ~~current~~ medical history and medication use. ~~However, p~~ Patients with significant medical considerations (e.g., ASA III, IV) may also require consultation with their primary care physician or consulting medical specialist, including an immediate preoperative review prior to administration of sedation.

2. Pre-operative Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed, within the previous 30 days, as deemed appropriate.
- ~~Preoperative dietary restrictions must be considered based on the sedative technique prescribed.~~

- Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery system, must be maintained. A pre- and post-procedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- End tidal CO2 must be monitored unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation shall be monitored by evaluation by continual observation of qualitative signs, including chest excursion and auscultation of breath sounds.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Consciousness:

- Level of sedation ~~consciousness~~ (e.g., responsiveness to verbal command) must be continually assessed.

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.
- Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:

- The dentist must observe chest excursions continually.
- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO2 unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation shall be monitored by continual observation of qualitative signs, including chest excursion and auscultation of breath sounds. ~~This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO_2 or by verbal communication with the patient.~~

Circulation:

- The dentist must continually evaluate blood pressure and heart rate {unless invalidated by the nature of the patient, procedure or equipment, ~~the patient is unable to tolerate~~ and this is noted in the time-oriented anesthesia record}.
- Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record).
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

C. Deep Sedation or General Anesthesia

1. Patient Evaluation

Patients considered for deep sedation or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this must consist of at least a review of their current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs (i.e., body weight, blood pressure, pulse rate, respiration rate, body temperature, and blood oxygen saturation) must be obtained unless invalidated by the patient, procedure or equipment ~~the patient's behavior prohibits such determination~~.
- A focused physical evaluation has been ~~must be~~ performed within the previous 30 days as deemed appropriate, including an immediate pre-operative review prior to administration of sedation.
- ~~Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.~~
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.
- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery systems, must be maintained. A pre- and post-procedural check of equipment for each administration must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- End tidal CO2 must be monitored unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation shall be monitored and evaluated by continual observation of qualitative signs, including chest excursion and auscultation of breath sounds. ~~If volatile anesthetic agents are utilized, a capnograph must be utilized and an inspired agent analysis monitor should be considered.~~
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Oxygenation:

- Color of mucosa, skin or blood must be continually evaluated.
- Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: End-tidal CO_2 must be continuously monitored and evaluated.
- Non-intubated patient: ~~Breath sounds via auscultation and/or e~~ End-tidal CO_2 must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation shall be monitored and evaluated by continual observation of qualitative signs, including chest excursions and auscultation of breath sounds.
- Respiration rate must be continually monitored and evaluated.

Circulation:

- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:

- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record)
- Pulse oximetry and end-tidal CO_2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Pediatric Patients and Those with Special Needs

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.

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Note regarding Section V: Additional Sources of Information as well as references supporting the Guidelines will become available on the ADA's website and no longer listed within the policy document.

~~V. Additional Sources of Information~~

~~American Dental Association. Example of a time oriented anesthesia record at www.ada.org.~~

~~American Academy of Pediatric Dentistry (AAPD). *Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update.* Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/policies.~~

~~American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics.* Available at http://www.perio.org/resources-products/posppr3-1.html *The AAP rescinded this policy in 2008.*~~

~~American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php~~

~~American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php~~

~~American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures.* Available at https://ecommerce.asahq.org/p-178-practice-guidelines-for-preoperative-fasting.aspx~~

~~American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.* Available at http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm~~

~~Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/115.aspx.~~

~~National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/docs/94-100/~~

~~Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502~~

ADA American Dental Association®

Council on Dental Education and Licensure

Proposed Revisions:

Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

Underscore denotes proposed additions
~~Strikethrough~~ denotes proposed deletions

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of dentistry. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists.

Anxiety and pain control can be defined as the application of various physical, chemical and psychological modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental education from predoctoral through continuing education. They are designed to teach initial competency in pain control and minimal and moderate sedation techniques.

These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of anxiety and pain control techniques through a combination of instruction and experience. It is assumed that this has enabled these teachers and practitioners to meet the educational criteria described in this document.

It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education.

The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these *Guidelines*.

Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and techniques for administering these drugs enterally, parenterally and by inhalation as supplements to local anesthesia.

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for the Healthcare

Provider. Though Basic Life Support courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.

II. Definitions

Methods of Anxiety and Pain Control

~~**analgesia** – the diminution or elimination of pain.~~ [Moved to Terms section]

anxiolysis – the diminution or elimination of anxiety.

~~**conscious sedation**[1] – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.~~

~~In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.~~

~~**combination inhalation–enteral conscious sedation** (combined conscious sedation) – conscious sedation using inhalation and enteral agents.~~

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~

~~**local anesthesia** – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.~~ [Moved to Terms section]

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[1] ~~*Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.*~~

~~*Note:* Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.~~ [Moved to Terms section]

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[2]

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

For children age 12 and under, ~~T~~the use of preoperative sedatives ~~for children (aged 12 and under)~~ prior to arrival in the dental office~~, except in extraordinary situations,~~ should ~~must~~ be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Prescription medications intended to accomplish procedural sedation for children age 12 and under must not be administered without the benefit of direct supervision by trained medical personnel. (Source: the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial total dose and should not be

[2] *Portions excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014 ~~2004~~, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[3]

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

titration - administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[3]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.[3]

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[3]

For all levels of sedation, the qualified dentist ~~practitioner~~ must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

[3] *Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014 ~~2004~~, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

analgesia – the diminution or elimination of pain [Moved from Definitions section]

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug. [Moved from Definitions section]
Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents. [Moved from Definitions section]

qualified dentist – meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines,* or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should -indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.
continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

Levels of Knowledge

familiarity - a simplified knowledge for the purpose of orientation and recognition of general principles.

in-depth - a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

Levels of Skill

exposed - the level of skill attained by observation of or participation in a particular activity.

competent - displaying special skill or knowledge derived from training and experience.

~~*proficient* - the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time (highest level of skill).~~

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[4]

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

American Society of Anesthesiologists' Fasting Guidelines*

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

*American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Anesthesiology 114:495, 2011. Reprinted with permission.

Education Courses

Education may be offered at different levels (competency, update, survey courses and advanced education programs). A description of these different levels follows:

1. Competency Courses are designed to meet the needs of dentists who wish to become competent ~~knowledgeable and proficient~~ in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. Update Courses are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. Survey Courses are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. Advanced Education Courses are a component of an advanced dental education program, accredited by the ~~ADA~~ Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental

[4] *ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be competent ~~knowledgeable and proficient~~ in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.

III. Teaching Pain Control

These *Guidelines* present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predoctoral curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;
2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;
3. be competent in monitoring vital functions;
4. be competent in prevention, recognition and management of related complications;
5. ~~be familiar with~~ have in-depth knowledge of the appropriateness of and the indications for medical consultation or referral;
6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
   a. Observation
      (1) Central nervous system
      (2) Respiratory system
         a. Oxygenation
         b. Ventilation
      (3) Cardiovascular system
   b. Monitoring equipment
5. Pharmacologic aspects of anxiety and pain control
   a. Routes of drug administration
   b. Sedatives and anxiolytics
   c. Local anesthetics
   d. Analgesics and antagonists
   e. Adverse side effects
   f Drug interactions
   g. Drug abuse
6. Control of preoperative and operative anxiety and pain
   a. Patient evaluation
      (1) Psychological status
      (2) ASA physical status
      (3) Type and extent of operative procedure
   b. Nonpharmacologic methods
      (1) Psychological and behavioral methods

(a) Anxiety management
(b) Relaxation techniques
(c) Systematic desensitization

(2) Interpersonal strategies of patient management
(3) Hypnosis
(4) Electronic dental anesthesia
(5) Acupuncture/Acupressure
(6) Other

c. Local anesthesia

(1) Review of related anatomy, and physiology
(2) Pharmacology
(i) Dosing
(ii) Toxicity
(iii) Selection of agents
(3) Techniques of administration
(i) Topical
(ii) Infiltration (supraperiosteal)
(iii) Nerve block – maxilla-to include:
(aa) Posterior superior alveolar
(bb) Infraorbital
(cc) Nasopalatine
(dd) Greater palatine
(ee) Maxillary (2nd division)
(ff) Other blocks
(iv) Nerve block – mandible-to include:
(aa) Inferior alveolar-lingual
(bb) Mental-incisive
(cc) Buccal
(dd) Gow-Gates
(ee) Closed mouth
(v) Alternative injections-to include:
(aa) Periodontal ligament
(bb) Intraosseous

d. Prevention, recognition and management of complications and emergencies

C. Sequence of Pain Control Didactic and Clinical Instruction: Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients. The sedative care of pediatric patients and those with special needs requires advanced didactic and clinical training.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

D. Faculty: Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

IV. Teaching Administration of Minimal Sedation

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on Dental Accreditation's *Accreditation Standards* for dental education programs.

These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

These *Guidelines* are not intended for the management of enteral and/or combination inhalation-enteral minimal sedation in children, which requires additional course content and clinical learning experience.
[Moved from Section C]

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult and pediatric anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification ~~and~~ risk assessment, and pre-procedure fasting instructions.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.

Inhalation Sedation (Nitrous Oxide/Oxygen)

A. Inhalation Sedation Course Objectives: Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.

B. Inhalation Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.

2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment (i.e., pulse oximetry), with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of *14 hours* plus management of clinical dental cases, ~~including a clinical component~~ during which clinical competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

Enteral and/or Combination Inhalation-Enteral Minimal Sedation

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives: Upon completion of a competency course in enteral and/or combination inhalation-enteral minimal sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support for Healthcare Providers.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal sedation).
9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral minimal sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration: Participants must be able to document current certification in Basic Life Support for Healthcare Providers and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.

~~These *Guidelines* are not intended for the management of enteral and/or combination inhalation-enteral minimal sedation in children, which requires additional course content and clinical learning experience.~~ [Moved to Section IV]

D. Participant Evaluation and Documentation of Instruction: Competency courses in combination inhalation-enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them to achieve competency. The course director must certify the competency of participants upon satisfactory completion of the course. Records of the course instruction must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

V. Teaching Administration of Moderate Sedation

These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation. These include courses in enteral and parenteral moderate sedation ~~and parenteral moderate sedation~~. The teaching guidelines contained in this section on moderate sedation differ slightly from documents in medicine to reflect the differences in delivery methodologies and practice environment in dentistry. ~~For this reason, separate teaching guidelines have been developed for moderate enteral and moderate parenteral sedation.~~

Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining parenteral sedation with nitrous oxide-oxygen. [Moved from Section C]

A. Course Objectives: Upon completion of a course in moderate sedation, the dentist must be able to:

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.
3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.

5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.
9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions.
4. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
6. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
8. Indications and contraindications for use of moderate sedation.
9. Review of dental procedures possible under moderate sedation.
10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs, ventilation/breathing and reflexes related to consciousness.
11. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
12. Prevention, recognition and management of complications and emergencies.
13. Description, maintenance and use of moderate sedation monitors and equipment.
14. Discussion of abuse potential.
15. Intravenous access: anatomy, equipment and technique.
16. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
17. Description and rationale for the technique to be employed.
18. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

~~**C. Moderate Enteral Sedation Course Duration:** A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation. Participants combining enteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.~~

~~Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult patients; **this course in moderate enteral sedation is not designed for the management of children (aged 12 and under).**~~

~~Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted~~.

Moderate ~~Parenteral~~ Sedation Course Duration: A minimum of *60 hours* of didactic instruction, plus administration of sedation for ~~management of~~ *at least 20 individually-managed dental patients* by ~~the intravenous~~ any route per participant including intravenous administration, is required to demonstrate ~~achieve~~ competency in moderate sedation techniques. Of the 20 cases, all must be individually managed by the anesthesia operator dentist. ~~Participants combining parenteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.~~

Clinical experience in managing a compromised airway is critical to the prevention of emergencies. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in management of the airway. Typically, clinical experience will be provided in managing healthy adult patients. **Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults.** Successful completion of this course does result in clinical competency in moderate ~~parenteral~~ sedation. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted.

D. Participant Evaluation and Documentation of Instruction: Competency courses in moderate sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience and airway management. Records of the didactic instruction and clinical experience, including the number of patients managed by each participant in each anxiety and pain control modality must be maintained and available for review.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than ~~five~~two-to-one when moderate ~~enteral~~ sedation is being taught allows for adequate supervision during the clinical phase of instruction. ~~A participant-faculty ratio of not more than three-to-one when moderate parenteral sedation is being taught allows for adequate supervision during the clinical phase of instruction; a~~ A one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.

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Note regarding Section V: Additional Sources of Information as well as references supporting the Guidelines will become available on the ADA's website and no longer listed within the policy document.

~~**VI. Additional Sources of Information**~~

~~American Dental Association. Example of a time oriented anesthesia record at www.ada.org.~~

American Academy of Pediatric Dentistry (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/policies

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics*. Available at http://www.perio.org/resources-products/posppr3-1.html *The AAP rescinded this policy in 2008.*

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities*. Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition*. Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php

American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures*. Available at https://ecommerce.asahq.org/p-178-practice-guidelines-for-preoperative-fasting.aspx

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. Available at http://www.asahq.org/Home/For-Members/Practice-Management/Practice-Parameters#sedation
The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm

Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/115.aspx .

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/docs/94-100/

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502

Policy Strategies to Increase Access to Dental Treatment

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

In addition to the presentations given at the Forum, the Board received written comments from:

- Virginia Elder Rights Coalition
- Virginia Health Care Foundation and
- Virginia Head Start Association

which follow this page.

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

- Code of Virginia §54.1-2722 Licenses; applications; qualifications; practice of dental hygiene

- Regulations Governing the Practice of Dentistry sections:
  - 18VAC60-20-10. Definitions
  - 18VAC60-20-61. Educational requirements for dental assistants II
  - Part VI. Direction and Delegation of Duties

Reen, Sandra (DHP)

From: Board of Dentistry
Sent: Tuesday, May 12, 2015 9:44 AM
To: Reen, Sandra (DHP)
Subject: FW: VERC Comments on Improving Dental Care in LTC Settings
Attachments: SKM_C554e15051209330.pdf

From: Kathy Pryor [mailto:kathy@vplc.org]
Sent: Tuesday, May 12, 2015 9:39 AM
To: Board of Dentistry; mchesser@jchc.virginia.gov
Cc: Wood, Erica; Kathy Pryor
Subject: VERC Comments on Improving Dental Care in LTC Settings

Virginia Elder Rights Coalition

Virginia Elder Rights Coalition

May 12, 2015

Virginia Board of Dentistry
Department of Health Professions
Perimeter Center
9960 Maryland Drive, Suite 300
Henrico, VA 23233

Re: Open Forum Comments – Improving the Availability of Routine and Preventive Dental Procedures in Long-Term Care Settings

The Virginia Elder Rights Coalition (VERC) is a network of organizations, agencies and individuals working together to promote the rights and autonomy of older Virginians. In 2015, one of VERC's three priorities concerned access to oral health care for older persons in the Commonwealth. While VERC Board members could not attend the May 8 Open Forum on Policy Strategies to Increase Access to Dental Treatment, we are writing today to submit our comments.

As you know, access to dental care is one of the greatest challenges facing older adults, especially those with low incomes and without dental insurance. A decline in oral health – such as gum disease, missing teeth (which both increase with age), and dental cavities – can affect nutritional status, behavior, self-esteem and overall quality of health and life for older people, according to the U.S. Centers for Disease Control and Prevention.

Therefore, in its 2015 Legislative Platform, VERC recommended a study of older Virginian's access to dental care, including: (i) enhancing efforts to educate older adults about oral health; (ii) improving the availability of routine and preventive dental procedures in long-term care settings; (iii) expanding free and low-cost community dental clinic opportunities for older adults; (iv) providing dental services for adult Medicaid beneficiaries; and (v) identifying funding sources and service options to address the gaps that older Virginians face in accessing dental care. Although the proposal for the study did not move forward, VERC continues to advocate for these approaches.

While all of the above options are critical, today we are writing specifically about the need for improving the availability of routine and preventive dental care for individuals in nursing homes, assisted living, group homes and other long-term care residential settings. Many residents in these settings cannot consistently perform oral hygiene, and are at greater risk for poor oral health. Often there are few or no dental health professionals trained and willing to serve them. Sometimes facilities

are insufficiently staffed – and/or staff are insufficiently trained – to assist with daily dental care. Many residents cannot easily leave the facility to get dental care, either because of disabilities or health conditions or because of lack of transportation. Even if they could leave, there is often a lack of community dental resources to serve them, as they frequently have no insurance coverage for dental care.

We applaud the Virginia Dental Association's pilot program to provide and promote preventive dental care for seniors in three selected nursing homes – two in Richmond and one in Charlottesville. The pilot will demonstrate the potential for improving the oral health of residents and avoiding unnecessary emergency treatments and hospital admissions related to dental problems.

Along with the VDA pilot, VERC urges additional strategies to focus on the need for dental services in long-term care. As stated in the Virginia Board of Health Professions 2014 *Review of Dental Hygienist Scope of Practice,* there have been no studies of oral health in Virginia long-term care settings. Studies in other states have found deficiencies in oral care for substantial percentages of residents. The review found that "while oral health is primarily the responsibility of facility staff and nurses, this is an area where the educational and prophylactic services of dental hygienists could improve care" (p. 20).

The Joint Commission on Health Care policy options in the October study presentation on *Dental Safety Net Capacity and Opportunities for Improving Oral Health* included an option to assess expansion of the remote supervision of dental hygienists model to safety net facilities. Nursing homes and other long-term care settings should be considered among such safety net facilities. Possible expanded roles for dental hygienists in nursing homes -- along with other approaches to broaden access to oral health care for older Virginians – appears to hold promise for improved health and well-being for residents, and merits study.

Thank you for your consideration of these comments and for any efforts by the Board of Dentistry to improve the availability of dental care for individuals residing in Virginia's long term care residential settings.

Sincerely,

Kathy Ryan

Chair
Virginia Elder Rights Coalition
kathy@vplc.org

Reen, Sandra (DHP)

From: Deborah Oswalt <doswalt@vhcf.org>
Sent: Thursday, May 07, 2015 4:03 PM
To: Reen, Sandra (DHP)
Cc: Brown, David (DHP); graham, Neal; Linda Wilkinson; Sarah Bedard Holland
Subject: Comments for the Dental Access Hearing tomorrow
Attachments: To the Virginia Board of Dentistry 5_15.docx

Hi, Sandy. Hope you are well.

Thank you for holding the hearing on dental access issues tomorrow. I'm sorry I won't be able to attend, but I will be out of state.

I hope it's okay for me to submit written comments instead of being there in person. I've attached them to this email. I hope you can make copies to share with your Board.

Please let me know if this presents a problem in any way.

Thank you for your help and leadership --d

Deborah D. Oswalt
Executive Director
Virginia Health Care Foundation
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Richmond, VA 23219
Main: (804) 828-5804 Fax: (804) 828-4370
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VIRGINIA
HEALTH CARE
FOUNDATION

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To: The Virginia Board of Dentistry

From: Deborah D. Oswalt, Executive Director

Thank you for holding a hearing to inform yourselves and other interested parties about dental access issues in Virginia. Please accept these written comments in place of oral ones. I will not be in the state on the day of your hearing.

The Virginia Health Care Foundation (*VHCF*) was established to increase access to primary health care for uninsured and medically underserved Virginians in 1992. For the past 15 years, VHCF has devoted more than $11 million in grants to increase the size and capacity of Virginia's dental safety net. These grants have helped establish or expand 48 of Virginia's 82 dental safety net clinics. They have also helped start and support the Mission of Mercy (*MOM*) projects conducted by the Virginia Dental Association over the years. VHCF staff and I have volunteered at a number of the MOM projects, as well. Earlier this year, VHCF also started offering student loan repayment funds to attract dentists and other needed health professionals to shortage areas in conjunction with the Virginia Department of Health.

VHCF is the largest funder of the dental safety net in the state. It also makes available a range of technical assistance, resources, and tools to reduce dental safety net costs. This extensive involvement in helping establish, expand, and enhance the capacity of the dental safety net and our regular interaction with Virginia's dental safety net providers has given VHCF a unique view of dental needs throughout the state. It is in that vein, that the following information and observations are offered:

- Only half of Virginia's 134 localities have a dental safety net clinic or organization, and not all dental safety net clinics are open full-time. In fact, approximately one third of the free clinics providing dental care treat fewer than 100 patients per year. Only four of the 30+ free clinics which provide dental care offer it 30 or more hours per week.

- Of the 3.8 million Virginians with no dental insurance, at least 607,000 have incomes below 200% of the federal poverty level.

- During the last six years, access to oral health care has been at the top of many community health needs assessments. VHCF regularly receives requests from throughout the state that cite these needs assessments. Many are from areas that one wouldn't expect such as Northern Virginia, Winchester, the Peninsula, and Tidewater. Virginia's many rural dental health professional shortage areas cite these needs, as well.

- While the capacity of Virginia's dental safety net has grown over the years, it is still quite limited. In 2013, Virginia's dental safety net clinics were only able to treat 44,739 patients.

- The results of a recent survey of Virginia's dental safety net clinics indicate that the vast majority are inundated with patients with acute dental needs and do not have the capacity to treat them. The following comments from those surveys may be of interest:

  - "Need for dental is overwhelming. We get 10-13 calls a day." (*CrossOver, Richmond*)

  - "There's a huge need from people with acute dental pain." (*Only have a pain clinic one night per week. 3 week wait for pain.*) (*Free Clinic of Northern Shenandoah Valley*)

  - "536 people on waiting list." (*Charlottesville Free Clinic*)

  - "Waiting list for adults is 9 months and we're no longer adding to it." (*Faquier Free Clinic*)

  - "200 people on the waiting list. We triage for pain first." (*Goochland Free Clinic and Family Services*)

  - "The need for dental care is just enormous!" (*Arlington Free Clinic*)

- The clinics use a variety of methods to manage the demand. Once again, the following comments from the survey may be of interest:

  - "We stop screening for eligibility when our backlog is greater than 3 months." (*Augusta Regional Dental Clinic*)

  - "Must be a medical patient for 4 months before you can get in the queue for dental." (then a *9-10 month wait for restorative care*) (*CrossOver, Richmond*)

  - "We've developed a dental triage protocol and scoring sheet to help schedule dental appointments." (*CrossOver, Richmond*)

  - Only provide dental to existing free clinic patients. Can't handle calls from non-medical patients. (*several free clinics*)

  - Only treat for pain – no restorative work, eg., filling cavities. (*several free clinics*)

  - Don't keep waiting lists. (*several free clinics*)

- VHCF is a big supporter of the MOM projects. They do wonderful work and make a big difference in the lives of those lucky enough to be treated. The obvious problem with them, however, is that they are limited to 4-6 localities a year; many have to turn patients away due to lack of capacity; and people who have a dental issue that arises anytime other than the one day a year that the MOM project is there, have nowhere to turn for help.

The integral link between oral health care and good overall health is well documented. The impact of so many low income Virginians with no access to dental care may not be as well-known or appreciated. An estimated 164 million hours of work are missed by adults each year due to dental pain.

For uninsured, low-income Virginians, regular visits to a dentist are a luxury that many can't afford. As they carefully weigh priorities when determining how to spend their limited incomes, a trip to the dentist for routine maintenance often loses out to more immediate needs, such as food, rent, or a child's winter coat. Over time, this almost always leads to the blinding pain of a toothache, the loss of needed teeth, and for some the ability to eat nutritious foods.

There are a variety of approaches for meaningfully addressing this important issue. Some are very expensive (*adding dental coverage as a Medicare and Medicaid benefit*). Some are controversial (*establishing and licensing a dental "mid-level" professional*). Others take a long time to make an impact (*increasing the number of dental school grads in Virginia and keeping them in Virginia*).

One modest approach that could be undertaken in a relatively short period of time is to extend the remote supervision currently permitted for public health dental hygienists to hygienists who work in Virginia's dental safety net organizations (*free clinics, community health centers, and other similar organizations*).

Thank you for your consideration and the opportunity to comment.

Reen, Sandra (DHP)

From: Dawn Ault <dault@headstartva.org>
Sent: Thursday, May 07, 2015 9:24 AM
To: Reen, Sandra (DHP)
Cc: 'Nancy M. Null'; 'Rashanda Jenkins'
Subject: Letter of support for remote supervision
Attachments: VAHSA Letter to BOD Dentistry.pdf

Ms. Reen,

I have read the JCHC report, and the options that were being considered for improving access to care. I am unable to attend tomorrow's Board of Dentistry public forum meeting. Since I cannot attend the May 8 meeting, I am providing the attached letter in support of Option 7, the expansion of the remote supervision model of care for dental hygienists. I have also copied this email to the VAHSA President, Nancy Null, and the VAHSA Health Advisory Chairperson, Rashanda Jenkins, who also endorse this letter of support.

Please let me know if you have any questions. Thank you for your work and efforts for our young children.

Dawn Ault, M.Ed.
Executive Director
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(804) 347-6706

Virginia Head Start Association
P. O. Box 4, Ashland, VA 23005
804-347-6706
www.headstartva.org

To: Virginia Board of Dentistry
Re: Open Forum on Policy Strategies to Increase Access to Dental Treatment
Date: May 7, 2015

This letter is in support of expanding the remote supervision of dental hygienists beyond the realm of the Virginia Department of Health as a means of increasing access to timely preventive dental care. Over the years, the VAHSA has benefited from a strong partnership with the VDH Dental Health Program on education and prevention endeavors, including having access to remote supervision dental hygienists in limited areas of the state.

One of the most pressing health needs of Head Start children is tooth decay. Head Start staff and parents report that the number one health issue among children enrolled in Head Start nationwide is access to affordable oral health services. This is largely attributable to the continued shortage of dentists who will accept Medicaid and the shortage of dentists who are comfortable seeing infants and young children, despite the recommendations of the American Academy of Pediatric Dentistry, American Dental Association, and Academy of General Dentistry.

Because poor oral health can affect school performance in young children, Head Start supports the timely preventive care that the remote supervision model offers to our population of young children, ages 0 - 5. Although all Head Start children are required to have a dental exam within 90 days of enrollment, most do not receive their recommended 6 month check-up visit. VDH hygienists provide the much-needed mid-year oral screenings, fluoride varnish applications and referral services in the programs they serve, both Early Head Start and Head Start. Although best practice denotes that children be seen by a dental home by their dental provider.

Twenty-two Head Start programs are currently supported by VDH remote supervision dental hygienists. With a total of over 50 Head Start programs in Virginia, that leaves more than half of our programs unserved, including some of our largest populations, e.g. Fairfax County, Norfolk/Virginia Beach, resulting in a huge access disparity of services for our children.

Reaching young children in school-based settings is a proven strategy for accessing timely preventive services. Our Head Start children have benefited from the direct on-site services of the remote model of dental hygiene care. Hygienists provide a highly competent source of preventive clinical services and therefore the Virginia Head Start Association strongly supports remote supervision as an option for all Virginia-licensed dental hygienists.

Sincerely,

Dawn P. Ault
VAHSA Executive Director
dault@headstartva.org

Code of Virginia

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

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

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

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

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

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

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

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

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

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

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

Regulations Governing the Practice of Dentistry

18VAC60-20-10. Definitions.

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

"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 American Dental Association.

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

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered to perform reversible, intraoral procedures as specified in this chapter.

"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.

"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 x-rays of hard and soft tissues to be used for purposes of diagnosis.

B. 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 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 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. The order may authorize 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 dental hygienist, or (iii) preparing the patient for dismissal following treatment.

18VAC60-20-61. Educational requirements for dental assistants II.

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete the following requirements from an educational program accredited by the Commission on Dental Accreditation of the American Dental Association:

1. At least 50 hours of didactic course work in dental anatomy and operative dentistry that may be completed on-line.

2. Laboratory training that may be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:

a. At least 40 hours of placing, packing, carving, and polishing of amalgam restorations and pulp capping procedures;

b. At least 60 hours of placing and shaping composite resin restorations and pulp capping procedures;

c. At least 20 hours of taking final impressions and use of a non-epinephrine retraction cord; and

d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.

3. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office in the following modules:

a. At least 80 hours of placing, packing, carving, and polishing of amalgam restorations;

b. At least 120 hours of placing and shaping composite resin restorations;

c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and

d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.

4. Successful completion of the following competency examinations given by the accredited educational programs:

a. A written examination at the conclusion of the 50 hours of didactic coursework;

b. A practical examination at the conclusion of each module of laboratory training; and

c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules.

Part VI. Direction and Delegation of Duties.

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

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

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

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

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

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

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

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

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

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

18VAC60-20-195. Radiation certification.

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

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

A dentist may utilize up to a total of four dental hygienists or dental assistants II in any combination practicing under direction at one and the same time, with the exception that a dentist may issue written orders for services to be provided by dental hygienists under general supervision in a free clinic, a public health program, or on a voluntary basis.

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

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

B. Dental hygienists shall engage in their respective duties only while in the employment of a licensed dentist or governmental agency or when volunteering services as provided in 18VAC60-20-200. Persons acting within the scope of a license issued to them by the board under §54.1-2725 of the Code of Virginia to teach dental hygiene and those persons licensed pursuant to §54.1-2722 of the Code of Virginia providing oral health education and preliminary dental screenings in any setting are exempt from this section.

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

1. The treatment to be provided shall be ordered by a dentist licensed in Virginia and shall be entered in writing in the record. The services noted on the original order shall be rendered within a specific time period, not to exceed 10 months from the date the dentist last examined the patient. Upon expiration of the order, the dentist shall have examined the patient before writing a new order for treatment.

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

3. The patient or a responsible adult shall be informed prior to the appointment that a dentist may not be present, that no anesthesia can be administered, and that only those services prescribed by the dentist will be provided.

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

D. General supervision shall not preclude the use of direction when, in the professional judgment of the dentist, such direction is necessary to meet the individual needs of the patient.

18VAC60-20-220. Dental hygienists.

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

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

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

3. Administering nitrous oxide or local anesthesia by dental hygienists qualified in accordance with the requirements of 18VAC60-20-81.

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

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

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

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

4. Subgingival irrigation or subgingival application of topical Schedule VI medicinal agents.

5. Duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist, with the exception of those listed in subsection A of this section and those listed as nondelegable in 18VAC60-20-190.

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

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

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

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

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

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

1. Performing pulp capping procedures;

2. Packing and carving of amalgam restorations;

3. Placing and shaping composite resin restorations;

4. Taking final impressions;

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

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

18VAC60-20-240. What does not constitute practice.

The following are not considered the practice of dental hygiene and dentistry:

1. Oral health education and preliminary dental screenings in any setting.

2. Recording a patient's pulse, blood pressure, temperature, and medical history.

Disciplinary Board Report for June 12, 2015

Today's report reviews the 2015 calendar year case activity then addresses the Board's disciplinary case actions for the third quarter of fiscal year 2015 which includes the dates of January 1, 2015 through March 31, 2015.

Calendar Year 2015

The table below includes all cases that have received Board action since January 1, 2015 through May 6, 2015.

Calendar 2015	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	111	119	4	123
Feb	89	64	0	64
Mar	53	49	16	65
Apr	43	16	4	20
May 6th	1	4	1	5
Totals	**297**	**252**	**25**	**277**

Q3 FY 2015

For the third quarter, the Board received a total of 61 patient care cases. The Board closed a total of 64 patient care cases for a 105% clearance rate, which is down from 128% in Q2. The current pending caseload older than 250 days is 33%, and the Board's goal is 20%. In Q3 of 2015, 75% of the patient care cases were closed within 250 days, as compared to 84% in Q2 of 2015. The Board's goal is 90% of patient care cases closed within 250 days. The Board slightly slipped with its statistics but Board staff does appreciate the hard work that you have been putting in.

License Suspensions

Between February 26, 2015 and May 6, 2015 the Board mandatorily suspended the license of one dentist and one hygienist.

Sedation Permit Inspections

Since the sedation permit inspections started in November 2014, 116 inspections have been completed in of 324 permit holder locations. Most violations have occurred under the Drug Control Act found at 54.1-3404 et seq. of the Code of Virginia for failure to maintain the proper inventories and records of Schedule II-V controlled substances. There have also been numerous violations of the recordkeeping requirements under 18 VAC 60-20-107. Most of these violations have been for failing to properly document the required vital signs. Approximately 73% of the case decisions so far have resulted in an advisory letter.

BOARD OF DENTISTRY
PROPOSED 2016 CALENDAR

JANUARY

S	M	T	W	T	F	S	
					1	2	
3	4	5	6	7	8	9	SCC-C
10	11	12	13	14	15	16	
17	18	19	20	21	22	23	SCC-A
24	25	26	27	28	29	30	SCC-B
31							

FEBRUARY

S	M	T	W	T	F	S	
	1	2	3	4	5	6	
7	8	9	10	11	12	13	Committee Meeting
14	15	16	17	18	19	20	SCC-C
21	22	23	24	25	26	27	
28	29						

MARCH

S	M	T	W	T	F	S	
		1	2	3	4	5	SCC-A
6	7	8	9	10	11	12	Formals/ Board
13	14	15	16	17	18	19	SCC-B
20	21	22	23	24	25	26	
27	28	29	30	31			

APRIL

S	M	T	W	T	F	S	
					1	2	SCC-C
3	4	5	6	7	8	9	
10	11	12	13	14	15	16	SCC-A
17	18	19	20	21	22	23	
24	25	26	27	28	29	30	SCC-B

MAY

S	M	T	W	T	F	S	
1	2	3	4	5	6	7	Committee Meeting
8	9	10	11	12	13	14	SCC-C
15	16	17	18	19	20	21	
22	23	24	25	26	27	28	
29	30	31					

JUNE

S	M	T	W	T	F	S	
			1	2	3	4	SCC-A
5	6	7	8	9	10	11	Formals/ Board
12	13	14	15	16	17	18	SCC-B
19	20	21	22	23	24	25	SCC-C
26	27	28	29	30			

JULY

S	M	T	W	T	F	S	
					1	2	
3	4	5	6	7	8	9	
10	11	12	13	14	15	16	SCC-A
17	18	19	20	21	22	23	
24	25	26	27	28	29	30	SCC-B

AUGUST

S	M	T	W	T	F	S	
	1	2	3	4	5	6	SCC-C
7	8	9	10	11	12	13	
14	15	16	17	18	19	20	
21	22	23	24	25	26	27	SCC-A
28	29	30	31				

SEPTEMBER

S	M	T	W	T	F	S	
				1	2	3	
4	5	6	7	8	9	10	SCC-B
11	12	13	14	15	16	17	Formals/Board
18	19	20	21	22	23	24	SCC-C
25	26	27	28	29	30		

OCTOBER

S	M	T	W	T	F	S	
						1	
2	3	4	5	6	7	8	SCC-A
9	10	11	12	13	14	15	Committee Meeting
16	17	18	19	20	21	22	SCC-B
23	24	25	26	27	28	29	
30	31						

NOVEMBER

S	M	T	W	T	F	S	
		1	2	3	4	5	SCC-C
6	7	8	9	10	11	12	
13	14	15	16	17	18	19	SCC-A
20	21	22	23	24	25	26	
27	28	29	30				

DECEMBER

S	M	T	W	T	F	S	
				1	2	3	SCC-B
4	5	6	7	8	9	10	Formals/Board
11	12	13	14	15	16	17	
18	19	20	21	22	23	24	
25	26	27	28	29	30	31	

FORMAL HEARINGS	BOARD MEETINGS	Committee Meetings	SCC – A	SCC – B and Credentials	SCC – C
March 10	March 11	Feb 12	January 22	January 29	January 8
June 9	June 10	May 6	March 4	March 18	February 19
September 15	September 16	Oct 14	April 15	April 29	April 1
December 8	December 9		June 3	June 17	May 13
			July 15	July 29	June 24
			August 26	September 9	August 5
			October 7	October 21	September 23
			November 18	December 2	November 4

Red dates are National or State Holidays

Adopted:

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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

www.dhp.virginia.gov
TEL (804) 367- 4400
FAX (804) 527- 4475

MEMORANDUM

TO: Members, Board of Dentistry

FROM: David E. Brown, D.C.

DATE: May 6, 2015

SUBJECT: Revenue, Expenditures, & Cash Balance Analysis

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

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

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

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

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

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

Auditing Continuing Education

Background:
As provided in 18VAC60-20-50 of the Regulations Governing Dental Practice which is provided below, the Board might select licensees for audit. The Board's practice in regard to auditing licensees has been to address the compliance of licensees who are being noticed for an informal conference. Respondents are asked to bring their CE documentation for the previous three renewal years to the conference for review by the Board. This request has been included in the notice for an informal conference as shown on the next page.

Currently the Board is piloting standardized forms for the letters, notices, and orders that are prepared by the Administrative Proceedings Division (APD) of DHP. Copies of the new format of the letter and notice for an informal conference are provided for review. APD plans to use the standardized forms for all the licensing boards. When we agreed to pilot the forms, Board staff was notified that the request for submission of continuing education documents could no longer be addressed in its IFC cover letters or notices. The development of the new forms included a review of the various variations in language used by the boards. Through this process, it was decided that the Board's CE request was not germane to the subject complaint or proceeding and could be addressed in another manner.

The Board is asked to consider if and how it would like to address licensees' compliance with the continuing education requirements.

18VAC60-20-50. Requirements for continuing education.

F. A licensee is required to provide information on compliance with continuing education requirements in his annual license renewal. A dental assistant II is required to attest to current certification by the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association. Following the renewal period, the board may conduct an audit of licensees or registrants to verify compliance. Licensees or registrants 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.

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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

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TEL (804) 367- 4400
FAX (804) 527- 4475

Virginia Board of Dentistry
(804) 367-4538 FAX (804) 527-4428 denbd @dhp.virginia.gov

DATE

NAME
ADDRESS

CERTIFIED MAIL

RE: License No.:

Dear Dr. _____:

This letter is official notification that an informal conference will be held before the Special Conference Committee of the Board of Dentistry on _____, 2015, at _____ a.m./p.m., at the Department of Health Professions, 9960 Mayland Drive, 2nd Floor Conference Center, Henrico, Virginia 23233. Please wait in one of the waiting areas until the Committee is ready to proceed with the conference. **Additionally, please bring documentation of all continuing education credits you have completed for the 2014-2016 renewal years (April 1, 2013 through March 31, 2015).**

In accordance with § 2.2-4019, § 2.2-4021 and § 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), this conference is being held to review allegations that you may have violated certain laws and regulations governing the practice of dentistry in the Commonwealth of Virginia. Specifically:

1. You may have violated § 54.1-2706(5) of the Code in that, [redacted]

2. You may have violated § 54.1-2706(9) and § 54.1-2405 of the Code in that [redacted]

To facilitate the proceeding, please bring your entire original patient file, billing/financial records, and any and all x-rays relating to [redacted] for review and discussion of the allegations outlined above.

Virginia Board of Dentistry
(804) 367-4538 FAX (804) 527-4428 denbd @dhp.virginia.gov

May 5, 2015

Address

CERTIFIED MAIL

RE: Case Numbers [redacted]

Dear Dr. [redacted]:

Attached is a Notice of Informal Conference and Statement of Allegations.

For information regarding this type of proceeding, as well as directions to the Department of Health Professions Conference Center, instructions for requesting subpoenas, the Board's Sanctioning Reference Points, the text of the Administrative Process Act and other statutes and regulations cited herein, and other related information, please see www.dhp.virginia.gov/Dentistry. If you do not have Internet access, you may request a hard copy of any of this information by calling Donna Lee at (804) 367-4538.

Please notify the Board office of your intent to attend this hearing.

Sincerely,

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

cc: Committee Members
[redacted]

BEFORE THE VIRGINIA BOARD OF _____

IN RE: NAMETITLE
A.K.A. NAME
STATE License Number: Out of State License Number with multistate privilege
Issue Date: DATE
Expiration Date: DATE
Case Number: _____

**NOTICE OF * IFC/FH *
AND STATEMENT OF ALLEGATIONS**

You are hereby notified that * IFC/FH * has been scheduled before the Board of _____ ("Board") regarding your license/certification to practice/conduct Profession in the Commonwealth of Virginia.

TYPE OF PROCEEDING:	This is * IFC/FH * of the Board of _____.
DATE AND TIME:	***Month Day, Year*** **HOUR:MINUTE AM/PM**
PLACE:	Virginia Department of Health Professions Perimeter Center - 9960 Mayland Drive 2nd Floor - Virginia Conference Center Henrico, Virginia 23233

LEGAL AUTHORITY AND JURISDICTION:

1. * IFC/FH Code*. This proceeding will be convened as a public meeting pursuant to Virginia Code § 2.2-3700.

2. At the conclusion of the proceeding, the *Board/Committee* is authorized to take any of the following actions:

{FOR IFC}

- Exonerate you;
- Reprimand you;
- Require you to pay a monetary penalty;
- Place you on probation and/or under terms and conditions;
- Refer the matter to the Board of _____ for a formal administrative hearing;
- Offer you a consent order for suspension or revocation of your license/certification in lieu of a formal hearing.

VIRGINIA BOARD OF DENTISTRY
Invitation to an Open Forum on
Policy Strategies to Address Teledentistry

Friday, August 14, 2015 - 9:00 am to 12 pm
Board Room 4, 2nd Floor, Perimeter Center
9960 Mayland Drive, Henrico, VA 23233

The Board of Dentistry (Board) requests your assistance in responding to the following questions regarding the need for policies to protect patients in the use of teledentistry as a method of delivering dental treatment in Virginia –

- **What should be the standard for establishing a dentist-patient relationship?**
- **Should there be requirements for communications equipment at remote sites?**
- **What are the risks and costs associated with teledentistry?**

The forum is an opportunity for individuals, institutions and organizations to present their views on the use of teledentistry and the protections that should be in place to promote safe practice within the standard of care.

Speakers will be given up to ten minutes to express their perspective and make recommendations regarding the use of teledentistry in Virginia. Following the presentations, as time permits, attendees will be asked to participate in a question and answer session to allow for exploration and discussion of the recommendations made.

A transcript of the Forum will be made for future reference by the Board. Any policy action the Board decides to take will include the standard comment opportunities required for regulatory action and for advancing a legislative proposal.

Attachments: **Tennessee Senate Bill 1214, pending legislation, addressing teledentistry and Tennessee Code §63-5-115 which would be amended by the bill**
Arizona Senate Bill 1282, passed legislation to be effective July 1, 2015, addressing teledentistry, dental hygienists, and dental assistants
KHN article on When Connecting With A Dentist Doesn't Mean An Office Visit
KHN article on California to Launch Medicaid-Funded Teledentistry
Center for Telehealth and eHealth Law's CTEL Safe Telemedicine Principles
Virginia Board of Medicine's Guidance Document 85-12 Telemedicine

HOUSE BILL 976
By Hill M

SENATE BILL 1214

By Yarbro

AN ACT to amend Tennessee Code Annotated, Title 63, relative to dentistry.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 63-5-115(b), is amended by adding the following as a new subdivision to be appropriately designated:

( ) Teledentistry. As used in this chapter, "teledentistry" means the use of information by technology and telecommunications for dental care, consultation, education, and public awareness in the same manner as authorized for telemedicine and telehealth;

SECTION 2. Tennessee Code Annotated, Section 63-5-115(d)(1), is amended in the first sentence of the subdivision by inserting the language ", federally qualified health centers," between the language "nonprofit clinics" and "and public health programs".

SECTION 3. Tennessee Code Annotated, Section 63-5-115(d)(1), is further amended by inserting the following language immediately after the third sentence of the subdivision:

Under the protocol, the initial and subsequent examinations by the dentist may be accomplished by means of teledentistry technology.

SECTION 4. This act shall take effect July 1, 2015, the public welfare requiring it.

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Tenn. Code Ann. § 63-5-115 (Copy w/ Cite) Pages: **3**

Tenn. Code Ann. § 63-5-115

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*** Current through the 2014 Regular Session and amendments approved at the November 4, 2014 General Election ***

Title 63 Professions Of The Healing Arts
Chapter 5 Dentists

Tenn. Code Ann. § 63-5-115 (2014)

63-5-115. Employment of and practice by hygienists and assistants.

(a) A duly licensed and registered dentist may employ licensed and registered dental hygienists, registered dental assistants and practical dental assistants. Such licensed and registered dental hygienists may practice as authorized in this section or § 63-5-108 only in the office of and under the direct and/or general supervision of a licensed and registered dentist, in authorized public health programs or at other locations otherwise authorized by this chapter. Such registered and/or practical dental assistants may practice as authorized in this section or § 63-5-108 only in the office of and under the direct supervision of a licensed and registered dentist except in authorized public health programs. No provisions in this chapter shall be construed as authorizing any licensed and registered dental hygienists, registered dental assistants or practical dental assistants to practice as such except as provided in this section.

(b) Definitions.

(1) Direct Supervision. As used in this chapter regarding supervision of licensed and registered dental hygienists or registered dental assistants, "direct supervision" means the continuous presence of a supervising dentist within the physical confines of the dental office when licensed and registered dental hygienists or registered dental assistants perform lawfully assigned duties and functions;

(2) General Supervision. As used in this chapter, "general supervision" is defined as those instances when the dentist is not present in the dental office or treatment facility while procedures are being performed by the dental hygienist, but the dentist has personally diagnosed the condition to be treated, has personally authorized the procedures being performed and will evaluate the performance of the dental hygienist.

(c) Licensed and registered dental hygienists and registered dental assistants are specifically permitted to participate unsupervised in educational functions involving organized groups or health care institutions regarding preventive oral health care. Dental hygienists are permitted to participate in health screenings and similar activities; provided, that no remuneration is given by the organized group to any hygienist or the hygienist's employer for participating in these activities.

(d) (1) Settings in which licensed and registered hygienists may engage in the provision of preventive dental care under the general supervision of a dentist through written protocol

include nursing homes, skilled care facilities, nonprofit clinics and public health programs. Dental hygienists licensed and registered pursuant to this chapter are specifically permitted to render such preventive services as authorized in § 63-5-108 or by regulation of the board, as prescribed by the supervising dentist under a written protocol. Dental hygienists rendering such services shall be under the general supervision of a licensed dentist as specified in a written protocol between the supervising dentist and the hygienist which must be submitted in advance to the board. No dentist may enter into a written protocol with more than three (3) dental hygienists at any one time nor may any hygienist be engaged in a written protocol with more than three (3) dentists at any one time. The supervising dentist must process all patient billings. Each written protocol will be valid for a period of two (2) years at which time it must be renewed through resubmission to the board. Should a dentist cease to be the employer/supervisor of a dental hygienist where a written protocol is in force and on file with the board, the dentist must notify the board within ten (10) working days by certified mail, return receipt requested or electronic mail that the written protocol is no longer in force.

(2) Licensed and registered dental hygienists working under written protocol, in addition to those requirements enumerated under the general supervision as authorized by § 63-5-108(c)(5), must have actively practiced as a licensed dental hygienist for at least five (5) years and have practiced two thousand (2,000) hours in the preceding five (5) years or taught dental hygiene courses for two (2) of the proceeding three (3) years in a dental hygiene program accredited by the American Dental Association's Commission on Dental Accreditation and completed six (6) hours of public health continuing education within the past two (2) years; provided, that, after satisfying the requirement of this subsection (d), in subsequent years the hygienist may work on a part-time basis.

(3) Each written protocol, required for off-site practice under general supervision, shall be submitted to the board by certified mail, return receipt requested and shall include at a minimum:

(A) The name, address, telephone number and license number of the employer (supervising) dentist;

(B) The name, address, telephone number and license number of the dental hygienist;

(C) The name, address, telephone number and other pertinent identification from all locations where the dental hygiene services are to be performed; and

(D) A statement signed by the dentist that the dentist and the dental hygienist that meets all minimum standards for general supervision as well as those required for practice under a written protocol as stipulated in this section and § 63-5-108.

(4) The board will receive each written protocol submitted and keep those on file which meet the minimum requirements enumerated in subdivision (d)(3). Those received by the board and determined not to be complete shall be returned to the submitting dentist within thirty (30) days of receipt with a request for the additional information required. The dentist may then resubmit an amended written protocol to the board.

HISTORY: Acts 1957, ch. 32, § 16; 1978, ch. 824, § 12; T.C.A., § 63-544; Acts 1988, ch. 635, § 17; 1990, ch. 1031, § 19; 1998, ch. 847, §§ 4, 5; 1999, ch. 405, § 3; 2012, ch. 945, §§ 2, 3.

ARIZONA STATE SENATE

Fifty-Second Legislature, First Regular Session

AMENDED
FACT SHEET FOR S.B. 1282

teledentistry; dental hygienists; dental assistants

Purpose

Creates Expanded Function Dental Assistants (EFDA), institutes various requirements concerning teledentistry and modifies the dental affiliated practice statute.

Background

The State Board of Dental Examiners (Board) was established in 1935 to regulate the practice of dentistry. It is charged with protecting the health, safety and welfare of the state through examination, licensure and complaint adjudication and enforcement processes. The Board oversees dentists and supervised personnel including dental hygienists (hygienists) and dental assistants. According to the Auditor General's report, there are roughly 8,800 licensed dentists and hygienists in the state.

Statute allows hygienists and dentists to enter into an affiliated practice relationship (APR) to provide dental hygiene services in an affiliated practice setting. An *APR* is a written agreement between the hygienist and the dentist that allows, subject to the terms of the agreement, the hygienist to perform all dental hygiene procedures within his or her authorized scope of practice in an affiliated practice setting (A.R.S. § 32-1289).

Statute outlines the scope of practice for hygienists and dental assistants. In addition to the functions a dental assistant may perform, a hygienist may administer local anesthetics, examine the oral cavity, remove plaque and apply sealant and topical fluoride. Qualified dental assistants may perform x-rays, polish teeth and provide patient care. Any expansion in this scope requires a review through the sunrise process (A.R.S. § § 32-1281 and 32-1291).

On December 17, 2014, the Senate Health and Human Services and the House of Representatives Health Committee of Reference (COR) held a public hearing to review a sunrise application that had been submitted by the Arizona Dental Association to increase the scope of practice for dental assistants by creating the EFDA position. The COR recommended forwarding the sunrise application to the full Legislature for consideration.

There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

Teledentistry

1. Requires the dentist or dental provider to obtain verbal or written informed consent from the patient or patient's health care decision maker prior to delivery of care through teledentistry.

2. Requires documentation of the consent if it is obtained verbally.

3. Entitles the patient to confidentiality protections outlined in statute and prohibits the dissemination of images or individually identifiable information for research or educational purposes without consent, unless authorized by state or federal law.

4. States all reports resulting from a teledentistry consultation are part of a patient's dental record.

5. Exempts the transmission of diagnostic images to another health care provider or dental specialist or the reporting of diagnostic test results by that specialist from consent requirements.

6. Limits the procedures and requirements concerning teledentistry to within this state and stipulates the procedures and requirements do not expand, reduce or otherwise amend statutory licensing requirements for dentists or dental providers.

7. Requires the Arizona Health Care Cost Containment System to implement teledentistry services for enrolled members under 21 years of age.

Expanded Function Dental Assistants (EFDAs)

8. Expands a dental assistant's functions if the following are successfully completed:
   a) a Board-approved expanded function dental assistant training program completed at an institution accredited by the Commission on Dental Accreditation of the American Dental Association; and
   b) an examination in expanded functions that is approved by the Board.

9. States an EFDA's functions include the following:
   a) placement, contouring and finishing of direct restorations;
   b) placement and cementation of prefabricated crowns following preparation of the tooth by a licensed dentist;
   c) placement of interim therapeutic restorations under the general supervision and direction of a licensed dentist following a consultation conducted through teledentistry; and
   d) application of sealants and fluoride varnish under the general supervision and direction of a licensed dentist.

10. Requires the restorative materials used for the placement of direct restorations and prefabricated crowns to be determined by the dentist.

11. Allows a hygienist to engage in expanded restorative functions with study and examination equivalent to an EFDA.

Affiliated Practice

12. Requires hygienists, in order to be eligible to enter into an APR, to meet one of the following:
    a) be actively engaged in dental hygiene practice at least 500 hours in each of the 2 years immediately preceding the APR, instead of at least 2,000 hours in the 5 years immediately preceding the relationship APR; or
    b) hold a bachelor degree in dental hygiene, have held an active license for at least 3 years and be actively engaged in dental hygiene practice for at least 500 hours in each of the 2 years preceding the APR.

13. Requires the hygienist to consult with the dentist if the proposed treatment is outside the scope of the agreement.

14. Prohibits an affiliated practice hygienist from entering into a contract with, or providing dental hygiene services in, any entity or setting other than the following:
    a) health care organization or facility;
    b) long-term care facility;
    c) public health agency or institution;
    d) public or private school authority;
    e) government-sponsored program;
    f) private nonprofit or charitable organization; and
    g) social service organization or program.

15. Prohibits a dentist in an APR from permitting the provision of services of more than three affiliated practice hygienists at any one time.

16. Removes certain existing requirements included in the APR agreement and applies those requirements to all dental hygiene services provided through an APR.

Miscellaneous

17. Specifies a hygienist may inspect the oral cavity and surrounding structures for the purposes of gathering clinical data to facilitate a diagnosis.

18. Allows a hygienist to perform periodontal screenings or assessments rather than examinations.

19. Defines *teledentistry, assessment, screening, affiliated practice relationship, board, dental provider, dentist* and *health care decision maker*.

20. Relocates the definition of *unprofessional conduct* and statute concerning APRs.

21. Makes technical and conforming changes.

22. Becomes effective on the general effective date.

Amendments Adopted by Health and Human Services Committee

1. Removes requirement for health care insurance entities to cover teledentistry services.

2. Modifies the definition of *teledentisry*.

3. Requires AHCCCS to implement teledentistry services for enrolled members under 21 years of age.

4. Makes technical changes.

Amendments Adopted by Committee of the Whole

- Removes an exception to the consent requirements concerning services provided through teledentistry.

Amendments Adopted by the House of Representatives

- Makes technical changes to address a statutory conflict.

Senate Action				House Action			
FI	2/4/15	DP	6-0-1	HEALTH	3/17/15	DP	4-0-0-2
HHS	2/18/15	DPA	7-0-0	3rd Read	4/1/15		59-0-1

Prepared by Senate Research
April 2, 2015
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KHN
KAISER HEALTH NEWS

When Connecting With A Dentist Doesn't Mean An Office Visit

By **Daniela Hernandez** | April 7, 2014

This KHN story was produced in collaboration with the Los Angeles Daily News

Inside a South Los Angeles classroom filled with plastic dinosaurs, building blocks, stuffed animals and Dr. Seuss books, Mireya Rodriguez counts Hendryk Vaquero's teeth and looks for cavities.

At just 4 years old, he already has nine stainless steel crowns and multiple fillings, and his gums show signs of inflammation and infection. Since a check-up more than three months ago, he's lost a couple of teeth, including a capped tooth his mom pulled out after it started bleeding.

"Pero no llore," said the boy, assuring Rodriguez in Spanish he didn't cry.

This was only the second time the dental hygienist examined his teeth, many of which have rotted, in part because he is eating too many sweets and drinking milk before falling asleep. Later, a dentist at the Venice Family Clinic 16 miles away will pull up his records online and consult with Rodriguez on his case – without ever necessarily seeing the patient.

It's all part of a free "teledentistry" program for low-income patients in California who don't have access to regular dental care. Often they're stymied by high costs and a shortage of dentists who treat the poor. Many also face language barriers, lack legal immigration status, are afraid of dentists or have a poor understanding of what causes dental problems.

Hendryk Rodriguez already has nine stainless steel crowns, multiple fillings and signs of infection. This is the second time the four-year-old has been examined by a dental hygienist (Photo by Heidi de Marco/KHN).

"The only thing that they know is that they have to provide for their family and that's the most important thing for them," said Rodriguez, who comes to the Volunteers of America Silva Head Start program on a regular basis. "You have to educate the parents."

Rodriguez is among 15 specially trained hygienists and dental assistants who work online with dentists as part of a $2.5 million experiment designed to deliver preventive dental care and education to underserved populations. Funded for now by grants from non-profits, trade associations and others, the "Virtual Dental Home Demonstration Project" has been launched in 50 locations throughout the state, including Pacoima, Santa Monica, San Jose, Santa Cruz, East Palo Alto, San Francisco, Sacramento and Eureka.

With special permission from the state, the hygienists and dental assistants travel from place to place performing basic procedures not in their scope of practice – for instance, deciding which X-rays to take or installing temporary fillings that help prevent early decay from progressing—then consult remotely with dentists on how to proceed. Sometimes, after doing what they can, they send a patient to a dentist's office.

Operating at community sites ranging from schools to nursing homes, the program is meant to boost access and maximize the expertise and efficiency of the people delivering care.

The Virtual Dental Home Demonstration Project "really changes the idea of what the dental team and the dental practice is — from being confined to the four walls of a dental office to now having a team that can be spread out," said Dr. Paul Glassman, a dentist at the University of the Pacific in San Francisco, who started the program.

Dental hygienist Mireya Rodriguez conducts an initial screening on Ammi Alvarez, 4, at Silva Head Start in Los Angeles as part of a pilot program to increase oral health awareness, offer preventive care and provide children early access to treatment (Photo by Heidi de Marco/KHN).

A bill pending before the state Legislature would expand the Virtual Dental Home approach statewide and require Medi-Cal, the government health insurance program for the poor and disabled, to pay for procedures facilitated by the Internet.

The bill, AB 1174, passed unanimously in the Assembly. It is expected to come up for vote in the state Senate later this year and enjoys wide bipartisan support. Expanding the program statewide would increase costs minimally in the short-term — by upward of $500,000 a year, according to a State Assembly's Appropriations Committee fiscal analysis. If teledentistry takes off, the costs could be higher.

Advocates think the return on that investment could be substantial. For every dollar spent in preventive services like the ones provided through the Virtual Dental Home demonstration project an estimated $50 is saved on more expensive, complicated procedures, said Dr. James Stephens, a Palo Alto dentist and president of the California Dental Association.

"It's a no brainer," he said. "We should spend more money on prevention."

The association, which represents 25,000 dentists, is generally behind the proposed California law because it gives people access to dental care who wouldn't have a way to get it otherwise. The organization is working with legislators to assure it benefits the public as much as possible and is fiscally sustainable, Stephens said.

Dr. Burton Edelstein, a professor at Columbia University and the founding president of the Children's Dental Health Project, a Washington, D.C.-based advocacy organization, said "quality of care can be just as good or even better" in teledentistry if the benefits of better access are factored in.

Some dental organizations around the country have spoken out against letting hygienists, assistants and other mid-level providers do procedures typically reserved for dentists. In Maine, for example, dentists have fought a bill creating a special category of provider called dental therapists – who would perform some of the duties of hygienists and some of dentists, such as filling cavities. Dental therapists already practice in Minnesota and Alaska.

Maine dentists have said creating this role won't solve the fundamental obstacles to treatment.

"It's a crisis of financing, not a crisis of providers," Dr. Jonathan Shenkin, an Augusta dentist and representative of the Maine Dental Association told the Portland Press Herald. "If people can't afford a dentist, they're not going to be able to afford a dental therapist."

In California and elsewhere, the teledentistry effort has been made more feasible in part because equipment and devices are smaller, more portable and less expensive than before. Also, Obamacare has provided a boost with its emphasis on digital technology to improve care and reduce costs.

Out in the field, what matters is a gentle touch with patients — especially those who have never been to a dentist before or have had frightening experiences in the past.

When Rodriguez examines children at Head Start — government-funded pre-schools — she usually brings them up to her work station in pairs. Meanwhile, their friends are singing and playing with each other and the teachers in the background. It's a fundamentally different experience than going to an office.

Using an intraoral camera, dental hygienist Mireya Rodriguez records digital images of 4-year-old Aezon Solis Cueras' teeth (Photo by Heidi de Marco/KHN).

"These kids are getting something that reframes their connection to dentistry," said Terry Press-Dawson, the grant coordinator for several schools in Sacramento, some of which are participating in the Virtual Dental Home project. "They are connecting dentistry with something that is not scary — and that's huge."

After spending weeks coaxing Hendryk Vaquero, the 4-year-old with serious dental problems, into an examination, hygienist Rodriguez was patient and respectful. She asked his permission as she took pictures of his teeth with a camera connected to a laptop and put fluoride on his teeth with a tiny disposable brush. She told him she was proud of him and complimented him on his shoes and Buzz Lightyear T-shirt.

And at the end of the exam, she gave him a baggie with a toothbrush, toothpaste, mouthwash and a two-minute timer so he could take care of his teeth at home with his mom's help.

All the while, 5–year-old Abigail Velasquez was watching. She was up next. She said she'd never been to the dentist.

"We're going to talk to mom so maybe mom can take you to a dentist when you're done seeing us. Because it's very important that you experience that," she told her. "Going to the dentist is quite an adventure."

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KHN
KAISER HEALTH NEWS

California To Launch Medicaid-Funded Teledentistry

By **Daniela Hernandez** | September 29, 2014

California Governor Jerry Brown has signed into law a bill that would require Medi-Cal, the state's insurance program for the poor, to pay for dental services delivered by teams of hygienists and dentists connected through the Internet.

California is among the first states to launch such teledentistry services, which are intended to increase the options for patients in remote and underserved areas. Other states, like Oregon, Colorado, Hawaii and West Virginia, are interested in creating their own teledentistry programs but are farther behind, advocates for the projects said.

The bill, signed by the governor over the weekend, also expands the types of procedures hygienists and certain assistants can perform without onsite supervision by a dentist — deciding what X-rays to take, for instance, or installing temporary fillings that help prevent decay. The hygienists and other workers will consult with a dentist remotely, sharing records online but will refer a person directly to a dentist if more sophisticated procedures are needed.

The legislation will take effect on Jan. 1.

Expanding teledentistry statewide will increase Medi-Cal costs minimally in the short-term — by upward of $500,000 a year, according to a State Assembly's Appropriations Committee fiscal analysis. If teledentistry takes off, the costs could be higher.

Already, the Medi-Cal budget for dental services is slated to grow from $682 million to roughly $940 million by June 2015, thanks to legislation signed in June 2013 that brought back certain dental benefits for adults.

Dr. James Stephens, a Palo Alto dentist and president of the California Dental Association, said that teledentistry could save money down the line, however.

"That's the real key. It's a way of getting people who are outside the system into the system," he said. "Preventive care costs so much less."

The newly signed law is the culmination of years of work and research by hygienists, dentists and patient advocacy organizations across the state. About five years ago, Dr. Paul Glassman, a dentist at the University of the Pacific in San Francisco, started the pilot Virtual Dental Home Demonstration Project to show that teledentistry could provide a means to improve access at low costs.

"We're very very excited. It's a great ending to a long, long adventure here," Glassman said. "The next

challenge is to be able to spread this system."

According to Glassman, as many as 50 percent of consumers eligible for dental services through Medi-Cal don't get care. The idea is to deploy hygienists and dental assistants to schools, nursing homes and other community organizations where underserved populations gather. Glassman and other advocates say that will ease transportation, financial, language and cultural barriers that typically keep people from accessing treatment.

Telemedicine in general has been gaining traction, thanks in part to an increasing number of small Internet-enabled medical devices and consumer health trackers as well as growing interest among venture capitalists. The federal Affordable Care Act has emphasized the use of digital technologies to improve care and cut costs. Recently, a bill was introduced in the U.S. House of Representatives that would allow accountable care organizations to get reimbursed for and use telemedicine more widely.

"Technology has really allowed things that weren't possible before," said Shelly Gehshan, the director of the children's dental policy team at the Pew Charitable Trust. "But it's not like flipping a switch."

Before the promise of teledentistry can be borne out, the state still has to figure out the billing mechanism and payment structure for telemedicine-enabled services. Glassman acknowledged this could be a topic of debate: Providers will want to bill at the same rates as for in-person consultations, while Medi-Cal might opt for lower rates to control costs.

Professional organizations still need to build programs to train hygienists and dental assistants on taking X-rays by themselves, applying temporary fillings, and working as part of a teledentistry team. The bill spells out the type of training that will be necessary.

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CTEL EXECUTIVE TELEHEALTH SPRING SUMMIT 2015:

CTEL SAFE TELEMEDICINE PRINCIPLES

Telemedicine is a mechanism to deliver safe, effective healthcare.

Telemedicine is the means by which healthcare is delivered. Telemedicine can deliver safe, effective healthcare. Or, not unlike the general practice of medicine, corners can be cut.

Legally recognize an examination through telemedicine technology that provides the practitioner with information equal to or superior to an in person examination.

States commonly require that a physician-patient relationship be established prior to diagnosing and treating a patient. Most states require that first examination to be "in-person" or "face-to-face". Once a physician-patient relationship has been established, the physician may communicate with the patient through whatever medium the physician chooses (e.g. telephone, web camera, email, etc.). Approximately 20 states allow telemedicine technology to be used to establish this first examination between physician and patient. Provided the information exchanged between the practitioner and the patient is equal to the information that would be included in an in-person exam, we believe that state laws and regulations should permit the practitioner to utilize telemedicine technology to conduct the first time examination to establish the physician-patient relationship.

A physician-patient relationship can only be established through an examination by tablet, phone app, or web camera if the examination 1) provides information equivalent to an in person exam, 2) conforms to the standard of care expected of in-person care; and 3) if necessary, incorporates peripherals and diagnostic tests sufficient to provide an accurate diagnosis. A physician-patient relationship cannot be established through an examination by telephone (audio-only) or email.

In order to practice safe telemedicine, the standard of care applied by a practitioner must be the same standard required of the practitioner for an in-person visit. There may be certain diagnosis that can be rendered by a practitioner using any of these mediums. However, we maintain the mere communication between a practitioner and patient using one of these mediums does not ensure either that the telemedicine examination is equal to an in-person encounter or that it conforms to the standard of care. This is particularly true if the diagnosis is rendered without the use of appropriate peripherals or diagnostic tests, if necessary to confirm the diagnosis.

We believe that an encounter mirroring an in-person examination and conforming to the standard of care must incorporate diagnostic tests and peripherals, such as an otoscope and stethoscope, if necessary to provide and confirm an accurate diagnosis. For example, if the standard of care for an in-person encounter requires a visual examination of the patient's tympanic membrane prior to diagnosing, the same should be applied to a telemedicine encounter. Likewise, if a diagnostic test is required for an accurate diagnosis of strep throat or a urinary tract infection, then a diagnostic test should be available to the practitioner prior to diagnosing what are described by some in the telemedicine industry as "uncomplicated" issues.

"On call" language may not be used by a physician to prescribe for a patient never seen by the physician unless there is an established agreement between the patient's personal physician and covering physician, compliant with state law governing on call relationships between practitioners.

The only time that a physician should diagnose through the "on call" language (commonly found in all states) without previously establishing a physician-patient relationship is through an established agreement between the two physicians. We recognize legally-compliant "on call" relationships, but do not believe the patient may self-designate the on-call relationship to a physician designated by the patient, and not designated by the patient's physician.

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. The Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.
These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For clarity, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303 and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

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

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

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

Section Two: Definitions.
For the purpose of these guidelines, "telemedicine services" shall be defined as it is in HB 2063,[1] which was approved by the Virginia General Assembly as an amendment to § 38.2-3418.16 of the Code of Virginia. Under that definition,

> "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.
> Va. Code § 38.2-3418.16 (as amended by HB 2063).[2]

Section Three: Establishing the Practitioner-Patient Relationship.
The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[3] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[4] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

Specifically, Virginia Code § 54.1-3303(A) provides the requirements to establish a practitioner-patient relationship. *See* Va. Code § 54.1-3303(A).[5]

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

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[1] HB 2063 amended Virginia Code §§ 38.2-3418.16 and 54.1-3303. HB2063 was passed by the Virginia General Assembly during the 2015 Legislative Session and, if signed by the governor, will become law on July 1, 2015.

[2] The Board reserves the right to revisit these Guidelines and in particular this definition should the General Assembly further alter the statutory definition of "telemedicine services" or authorize the Board to provide a definition of telemedicine or telehealth.

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

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

[5] By passing HB 2063, the General Assembly amended Virginia Code § 54.1-3303(A), which amendment specifically addresses the establishment of a patient-practitioner relationship for the purposes of prescribing Schedule VI controlled substances via telemedicine services. Once signed by the governor, this amendment will become law on July 1, 2015. All licensees are responsible for ensuring and maintaining compliance with applicable laws.

Section Four: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

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

Informed Consent:

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

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

Medical Records:

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

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Prescribing:

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

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A) as amended by HB 2063. Additionally, practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care

and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.