VIRGINIA BOARD OF DENTISTRY

AGENDAS

March 7-8, 2013

Department of Health Professions

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

PAGE

March 7, 2013

9:00 a.m. **Conflict Training – Mr. Casway**

10:30 a.m. **Review of ADA Guidelines for Conscious/Moderate Sedation Continuing Education Training – Ms. Yeatts** P1-P55

Review of Regulatory Requirements for Conscious/Moderate Sedation Training – Ms. Reen P56-P114

12:00 **Lunch**

12:30 p.m. to 4:00 p.m. **Probable Cause Case Reviews**

12:30 p.m. **Executive Committee (Boyd, Levin, Cutright)**

- Discuss Article III, #3 of the Bylaws – Dr. Boyd P115-P119

1:00 p.m. **Examination Committee (Cutright, Watkins, Swecker)**

- Approval of February 1, 2013 Minutes P120-P124
- Discuss the Clinical Exam Advisory Panel's Advice
- Future of Dental Law Exam

4:00 p.m. **Adjourn**

March 8, 2013

Board Business

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

Evacuation Announcement – Ms. Reen

Public Comment P125-P131

Approval of Minutes

- December 6, 2012 Formal Hearing P132-P134
- December 7, 2012 Board Business Meeting P135-P143
- January 16, 2013 Telephone Conference Call P144-P145
- February 14, 2013 Telephone Conference Call P146-P147

DHP Director's Report – Dr. Reynolds-Cane

Liaison/Committee Reports

- BHP – Dr. Levin
- AADB – Dr. Levin
- ADEX – Dr. Cutright & Dr. Watkins **P148-P192**
- SRTA – Dr. Watkins
- Examination Committee – Dr. Cutright
- Executive Committee – Dr. Boyd

Legislation and Regulation – Ms. Yeatts

- Report of 2013 General Assembly **P193-P195**
- Status Report on Regulatory Actions **P196**
- Correction of Code cite and term **P197-P199**
- Response to Petition for Rulemaking from AADH **P200-P212**

Board Discussion/Action

- Review of Public Comment Topics

Disciplinary Activity Report – Ms. Palmatier **P213-P214**

Board Counsel Report – Mr. Casway

Executive Director's Report/Business – Ms. Reen

- Sanctioning for Billing Practice Violations **P215-P216**

Case Recommendations **CONFIDENTIAL DOCUMENTS**

Closed Session

- Applicant Case # 146265

Applications for Enteral Conscious/Moderate Sedation Permits

Closed Session for Legal Advice §2.2-3711(A)

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Thursday, December 13, 2012 2:58 PM
To: 'Joy Sylvester-Johnson'
Subject: RE: foreign dentist certification
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi again:
Your request will be on the March 8, 2013 agenda.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Joy Sylvester-Johnson [mailto:joy@rescuemission.net]
Sent: Thursday, December 13, 2012 12:06 PM
To: Reen, Sandra (DHP)
Cc: Debbie Oswaldt; Mary Ellen Goodlatte
Subject: Re: foreign dentist certification

Thank you for the information. If you will let me know if it is being discussed at the March meeting we will try to have a representative there.

On Thu, Dec 13, 2012 at 9:28 AM, Reen, Sandra (DHP) <Sandra.Reen@dhp.virginia.gov> wrote:

Hi Ms. Sylvester-Johnson:

Thank you for sharing your recommendation for changing the Code of Virginia with the Board of Dentistry. The Board will hold its next business meeting on March 8, 2013. At that time, the Board will decide whether to pursue your idea. You might attend the meeting to make public comment and I will let you know the Board's decision shortly after the meeting.

I hope you understand that only the Virginia General Assembly has the authority to enact new laws and that you might discuss your interest with one of your legislators. If you decide to request introduction of legislation, the Department of Health Profession's senior policy analyst, Elaine Yeatts, is available to provide technical assistance to you and your legislator to develop a legislative proposal. Ms. Yeatts' e-mail address is elaine.yeatts@dhp.virginia.gov.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Joy Sylvester-Johnson [mailto:joy@rescuemission.net]
Sent: Thursday, December 13, 2012 8:19 AM
To: Board of Dentistry; Reen, Sandra (DHP); Palmatier, kelley (DHP); Vu, Huong (DHP); Lackey, Kathy (DHP); Deborah.southall@dhp.virignia.gov; donna.lee@dhp.virignia.gov; trudy.levitin@dhp.virignia.gov; Williams, Kelly (DHP)
Subject: Fwd: foreign dentist certification

Good Morning:

I did not know who exactly to send this request to, so I am sending it to the entire staff in hopes that it will reach the right person.

I am forwarding an idea that I would like to see explored regarding the use of international dentists who are not certified to practice in the state of Virginia. The idea I would like to propose is that these dentists be given some sort of provisional license to practice in free clinic and community health center operations under the mentorship of a certified dentist. This would provide many hours of volunteer dentistry to an undeserved population and it would allow foreign trained dentist the opportunity to work with a certified dentist and perhaps lead to state certification. Currently we have one clinic volunteer who is a dentist trained overseas who would like to volunteer. We have her filing and answering the phone and cleaning instruments, but would much rather have her seeing patients. It seems like a waste to not use her when we always have a waiting room filled with patients and a long waiting list for services. I would just like to see the conversation begun about this topic. Thank you for any feedback you may have.

---------- Forwarded message ----------
From: **Laura Givens** <Givens@vadental.org>
Date: Wed, Dec 12, 2012 at 12:14 PM
Subject: RE: foreign dentist certification
To: "joy@rescuemission.net" <joy@rescuemission.net>
Cc: Barbara Rollins <Rollins@vadental.org>

Good afternoon Joy,

I have attached the laws pertaining to the practice of dentistry. Highlighted on page 17, you will find the law regarding foreign trained dentists. They are given authority to practice dentistry only for the purpose of teaching. This went into law just this year during the 2012 legislative session.

If you would like to send your suggestion to the Board of Dentistry, their contact information (as well as further information) can be found on their website: http://www.dhp.virginia.gov/dentistry/dentistry_board.htm

Best,
Laura

Laura Givens
Director, Legislative & Public Policy
Virginia Dental Association

3460 Mayland Ct., Ste. 110
Richmond, VA 23233
(P) 804-523-2185
(F) 804-288-1880
-----Original Message-----
From: Barbara Rollins
Sent: Tuesday, December 11, 2012 11:11 AM
To: Laura Givens
Subject: FW: foreign dentist certification
Your Name: Joy Sylvester-Johnson
Company Name: The Rescue Mission of Roanoke
Telephone: 540-777-7655
E-mail: joy@rescuemission.net
Your Comments or Questions: Here is the idea I would like to float:

What if Dentists who are not American or Virginia State certified volunteered under a mentoring state certified dentist in a free clinic situation or community health center for so many hours (800 hours?) which would eventually translate to state certification. They would have to pass the same boards as new graduates do. The gain would be that all free clinics and community health centers would gain valuable service hours from dentists (we know dentistry is one of the most unmet health needs in every locality) and the foreign dentists would have a way to attain certification especially in undeserved areas?

Feedback requested.

Thanks all.

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Error! Filename not specified. Error! Filename not specified.

Joy Sylvester-Johnson,CEO

Rescue Mission

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Roanoke, VA 24022

joy@rescuemission.net

(540) 777-7655

www.rescuemission.net

www.2ndhelpings.org

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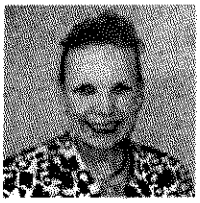

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Reen, Sandra (DHP)

From: William Griffin [williamgriffindds@gmail.com]
Sent: Friday, February 22, 2013 11:51 AM
To: Reen, Sandra (DHP)
Subject: Re: Sedation Regulations

Thank you, Sandra. If they do away with the EKG requirement, this seems like more than a "language" change to me. While I very much want them to do away with the EKG requirement, I have purchased one to stay in compliance with what seems to me to be an unnecessary regulation. If they don't change this requirement, it would be unfortunate. However, if they do change it, then what do we all do with our EKG machines?

Respectfully,
Bill Griffin

On Fri, Feb 22, 2013 at 11:47 AM, Reen, Sandra (DHP) <Sandra.Reen@dhp.virginia.gov> wrote:

Hi Dr. Griffin:

You are correct in understanding that it is possible that the Board would change its proposed language.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: William Griffin [mailto:williamgriffindds@gmail.com]
Sent: Friday, February 22, 2013 11:39 AM
To: Reen, Sandra (DHP)
Subject: Re: Sedation Regulations

Sandra, I was under the possibly mistaken impression that the EKG requirement could be changed. Is this not the case?

On Fri, Feb 22, 2013 at 11:23 AM, Reen, Sandra (DHP) <Sandra.Reen@dhp.virginia.gov> wrote:

Hi Dr. Griffin:
Thank you for sending your perspective on the EKG requirement to the Board. I will include your comment in the agenda materials for the Board's March 8th meeting.

I am concerned that you may have misinterpreted the information provided in BRIEFS. Any dentist who uses titration to administer conscious/moderate sedation is currently required to have an EKG. These dentists will still be required to have an EKG if the proposed final language is adopted. The proposed change in the requirement will only apply to dentists who

administer conscious/moderate sedation in a single dose by an enteral method.

Please let me know if I might provide further information.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

-----Original Message-----
From: William Griffin [mailto:williamgriffindds@gmail.com]
Sent: Thursday, February 21, 2013 9:18 PM
To: Board of Dentistry
Subject: Sedation Regulations

Dear Virginia Board of Dentistry,

I am grateful for the job that you do for the profession of dentistry. However, it seems unwise to pass a sedation regulation that requires an EKG for titration sedation, as an "emergency regulation," which may very well be rescinded in 12-18 months. So we sedation dentists are to buy and learn to use an EKG, and then if the regulation is changed, what do we do with the EKG's? Will you buy them back from us? Don't get me wrong, I very much hope that this regulation is rescinded, as it seems to me to be overkill and contrary to the best interests of the health of Virginia dental patients. However, whatever happens in the future, to pass such a significant regulation as a possibly "temporary" measure isn't right.

Respectfully,
William T. Griffin
VCU '83
Newport News, VA
williamgriffindds@gmail.com

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709 Mobjack Place
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VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
December 6, 2012

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:05 a.m., on December 6, 2012 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

MEMBERS PRESENT:
Martha C. Cutright, D.D.S.
Charles E. Gaskins, III, D.D.S.
Jeffrey Levin, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBER ABSENT:
Surya P. Dhakar, D.D.S.
Myra Howard, Citizen Member

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

COUNSEL PRESENT: Howard M. Casway, Senior Assistant Attorney General

OTHERS PRESENT:
Wayne T. Halbleib, Senior Assistant Attorney General
Indy Toliver, Adjudication Specialist
Mary F. Treta, Court Reporter, Crane-Snead & Associates, Inc.

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

Michelle Rice, R.D.H.
Case No.: 145441

Ms. Rice was not present. Mr. Halbleib addressed the matter that proper notice was sent to the Respondent, and introduced into evidence an Affidavit signed by Ms. Reen that verified that the Notice of Summary Suspension and Formal Hearing and Statement of Particulars were sent by certified mail to Ms. Rice's address of record on file with the Board.

Dr. Boyd ruled that adequate notice was given in this case based upon the representations of the Commonwealth and the hearing proceeded in the Respondent's absence.

Dr. Boyd swore in the witness.

Following Mr. Halbleib's opening statement, Dr. Boyd admitted into evidence Commonwealth's Exhibits 1 through 3.

Testifying on behalf of the Commonwealth was Sherry Foster, DHP Senior Investigator.

Closed Meeting:

Dr. Levin moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Ms. Rice. Additionally, it was moved that Board staff, Sandra Reen, Donna Lee, and Board counsel, Howard Casway, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Levin moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

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

Decision:

Dr. Boyd asked Mr. Casway to report the Findings of Fact, Conclusions of Law and Sanctions adopted by the Board.

Mr. Casway reviewed the findings and conclusions and then reported that the Board decided to indefinitely suspend Ms. Rice's license to practice dental hygiene in the Commonwealth of Virginia; stayed the suspension contingent upon her entry into a Recovery Monitoring Contract with the Health Practitioners' Monitoring Program and remaining compliant with the terms of the Recovery Monitoring Contract.

Dr. Levin moved to adopt the Findings of Fact, Conclusions of Law and Sanctions as read by Mr. Casway. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 10:33 a.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES
DECEMBER 7, 2012

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:04 a.m. on December 7, 2012, in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

BOARD MEMBERS PRESENT:
Martha C. Cutright, D.D.S.
Charles E. Gaskins, III, D.D.S.
Myra Howard, Citizen Member
Jeffrey Levin, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, B.S.D.H-R.D.H
Tammy K. Swecker, R.D.H
James D. Watkins, D.D.S.

BOARD MEMBERS ABSENT: Surya P. Dhakar, D.D.S.

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Dianne L. Reynolds-Cane, M.D., DHP Director
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

OTHERS PRESENT: Howard M. Casway, Senior Assistant Attorney General

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

PUBLIC COMMENT: Dr. Boyd reminded everyone that the comment period for the NOIRA on the Sedation and Anesthesia Regulations is closed. Then he asked for public comment.

Dr. Kirk Norbo, Virginia Dental Association (VDA) President, thanked Dr. Boyd for attending VDA's meetings to facilitate communications. He added that the VDA decided not to pursue a petition on fee splitting. He asked that the Board adopt the American Dental Association (ADA) Code of Ethics in the periodic review of the Regulations.

Dr. William Bennett from Williamsburg commented that he has appealed to the Board repeatedly to address advertising issues for many years but little has been done. He stated the public is definitely being harmed and provided copies of the ADA Principles of Ethics and Code of Professional Conduct. He urged the Board to review the ADA information and to take a more aggressive approach toward advertising complaints.

APPROVAL OF MINUTES:

Dr. Boyd asked if the Board members had reviewed the September 7, 2012 Business minutes. Dr. Levin moved to accept the minutes. The motion was seconded and carried.

Dr. Boyd asked if the Board members had reviewed the September 7, 2012 Formal Hearing minutes. Dr. Gaskin moved to accept the minutes. The motion was seconded and carried.

Dr. Boyd asked if the Board members had reviewed the October 11, 2012 and November 13, 2012 Telephone Conference Call minutes. Ms. Howard moved to accept the minutes. The motion was seconded and carried.

DHP DIRECTOR'S REPORT:

Dr. Boyd noted that Dr. Cane let him know she has nothing to report.

SURVEY RESULTS:

Dr. Carter stated that the reports address the responses made by licensees who renewed their licenses online by March 2012. She then reported the following:

- Response rates - 80% of dentists and 88% of dental hygienists
- Completed undergraduate programs in VA - 48% of dentists and 99% of dental hygienists
- Average age – 49 years old for dentists, of which 72% are males; 42 years old for dental hygienists, of which 98% are females
- Diversity (White, non-Hispanic) – 73% of dentists and 85% of dental hygienists
- No Educational debt – 2/3 of dentists and 3/4 of dental hygienists

Dr. Carter added that most licensees saw less than 100 patients per week. She handed out two embargoed reports on the surveys and asked Board members for their feedback by December 21, 2012, so the reports might be posted to the DHP website.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Levin stated that he participated in the agency's new Board member orientation. He then suggested telecasting or video conferencing a formal hearing to facilitate observation by dental students.

AADB (meeting in San Francisco). Dr. Cutright stated that her report is on P12 and P13 and that the Board is current with the national issues that were discussed at the meeting.

ADEX (meeting in Chicago). Dr. Cutright thanked the Board for sending her and added that her report is on P14 and P15.

Dr. Watkins stated that his report is on P16 and noted that the Board may want to remove the phase "minimum competency" if it is in the current laws and regulations language. He suggested using a similar phrase like "meets the criteria" for licensure.

SRTA. Dr. Watkins reported that the SRTA Board met last Friday, exam assignments were made, and SRTA will send them out within the week. He added that he attended the ADEX exam in Boston as an observer and that ADEX exams are administered there during the weekdays.

SRTA Board of Directors Report. Dr. Boyd stated that the report from Dr. Hall is in the agenda package.

Executive Committee. Dr. Boyd reported that the Committee met yesterday to revise the current Bylaws, which will be on the Board's March agenda.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported the following:

- Sedation and Anesthesia permits for dentists - The emergency regulations for sedation and anesthesia permits went into effect on September 14, 2012. She noted that the comment period on the Notice of Intended Regulatory Action (NOIRA) closed on November 7, 2012, and the proposed regulations to replace the emergency regulations appear later on the Board's agenda for action.
- Periodic Review – The proposed regulations to establish four chapters have been at the Secretary's Office for 179 days.
- Training in pulp capping for dental assistants –This regulation went into effect on November 22, 2012.
- Radiation Certification –This regulation became effective on December 6, 2012.

- Recovery of Disciplinary Costs – This regulation went into effect on November 21, 2012. She added that Dentistry is the first Board in DHP with the authority to recover costs.
- Changes to temporary and faculty licensure – These regulations became effective on November 21, 2012.
- Remote supervision of dental hygienists in public health clinics – This regulation also went into effect on November 21, 2012.

Tabitha McGlaughlin Petition for Rulemaking. Ms. Yeatts stated that it is presented for Board action and that Ms. McGlaughlin petitioned the Board to add Ursus Lifesavers & Aquatics to the list of accepted continuing education (CE) providers in regulation 18VAC60-20-50. Ms. Reen commented that several years ago the Board removed the provision for it to review and approve individual providers due to the lack of staff resources to oversee such providers.

Dr. Watkins moved to deny the petition due to lack of time and resources to properly evaluate each potential provider of CE. The motion was seconded and passed.

Review/Adopt Proposed Sedation/Anesthesia Permit Regs. Ms. Yeatts stated that the Regulatory-Legislative Committee has reviewed and addressed the comments received and asked if there were any questions about the comments. No questions were asked. She explained that the proposal before them shows the changes proposed by the Committee in the current emergency regulations, but the version that will be issued for public comment will be released as changes to the current final regulations. She asked the Board to review section by section and to make changes as needed. All agreed.

18VAC60-20-10.Definitions.

Ms. Yeatts noted that the words and terms are arranged in order as general definitions, supervision definitions, and sedation definitions. Dr. Levin moved to add the definition of "titration" because the absorption of medication is unpredictable; titration can be harmful to patients if not used properly. Following discussion of an appropriate definition, Ms. Yeatts read the proposed definition: "'Titration' means the incremental increase in drug dosage to a level that provides the optimal therapeutic effect of sedation." The motion to adopt this definition was seconded and passed.

Dr. Watkins moved to adopt Section 10 as amended. The motion was seconded and passed.

18VAC60-20-30. Other fees
No changes were proposed. Dr. Gaskins moved to adopt Section 30 as amended. The motion was seconded and passed.

18VAC60-20-107. General provisions.
Ms.Yeatts said the Committee recommended adding a general requirement for blood pressure and pulse to be taken prior to administration of any level of sedation and anesthesia. Ms.Swain stated such a requirement would be overkill. Dr. Levin moved to not include this as a requirement. The motion was seconded. There was a discussion of making this a requirement only for patients with high blood pressure .Then the motion by Dr. Levin was passed with eight votes in favor and one vote against.

Section F – Dr. Levin moved to include the provision for pediatric patients. The motion was seconded and passed.

New section H – Dr. Levin moved to add a reference to the requirement in 18VAC60-20-140 for reporting adverse reactions. The motion was seconded and passed.

New section I – Dr. Levin moved to add a reference to the CE requirements for administration in 18VAC60-20-50(A)(2). The motion was seconded and passed.

Dr. Levin moved to adopt section 107 as amended. The motion was seconded and passed.

18VAC60-20-108.Administration of minimal sedation (anxiolysis or inhalation analgesia)
Dr. Levin moved to adopt section 108 as proposed. The motion was seconded and passed.

18VAC60-20-110. Requirement for the administration of deep sedation/general anesthesia.
Section D - Ms. Yeatts said the word "***should***" should be changed to "***must***" in the last sentence. This change was agreed to by consensus.

Section E.2(c) – Ms. Yeatts said the subsection referenced should be "C" instead of "B." This change was agreed to by consensus.

Section E.3 – Dr. Levin asked that the word "***numb***" be changed to "***anesthetize***." This change was agreed to by consensus.

Section F.1 and F.2 – Dr. Levin asked that the regulations specify that equipment must be appropriately sized for children and adults.

Ms. Yeatts recommended including the provision for appropriately sized equipment in these sections rather than adding it multiple times in the list of equipment. This recommendation was agreed to by consensus, and development of the language was delegated to staff.

Sections G.1and G.2 were reversed and basic edits were agreed to by consensus.

Section G.3 (a) – The term "***pulse oximeter***" was deleted by consensus.

Dr. Boyd asked if a provision should be added to address how many patients a dentist might have under deep sedation/general anesthesia at the same time. Discussion followed about the variety of situations that might need to be addressed. No motion was made.

Dr. Watkins moved to adopt section 110 as proposed and amended. The motion was seconded and passed.

18VAC60-20-120. Requirements for administration of conscious/moderate sedation.

Section G –By consensus, the word "***should***" was replaced with "***must***" in the last sentence.

Section H.3 – By consensus, the last sentence on pediatric patients was retained.

Section H.4 – By consensus, the word "***numb***" was replaced with "***anesthetize***."

Section I.15 – The word "***intravenous***" was replaced with the word "**parenteral**" and "***or if the dentist is using titration***" was added by consensus.

Section J2 – The Board agreed to add "***at least***" after "***shall consist of"*** in the first sentence.

Dr. Watkins moved to adopt section 120 as proposed and amended. The motion was seconded and passed.

18VAC60-20-135. Personnel assisting in sedation or anesthesia.

Dr. Watkins moved to adopt section 135 as proposed. The motion was seconded and passed.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics. Dr. Boyd stated that the comments received will be considered.

Diagnosing and Treating Sleep Apnea. Ms. Reen said that the American Academy of Sleep Medicine and the American Association of Oral and Maxillofacial Surgeons have asked the Board for its position in regard to sleep apnea. She asked for guidance on how to respond. Dr. Gaskins asked about the wisdom of accepting information from unknown organizations. Dr. Levin moved to refer this to the Regulatory-Legislative Committee for study. The motion was seconded and passed. Ms. Reen was advised to let the organizations know the Board is reviewing the topic but has found in disciplinary cases that diagnosis of sleep apnea is outside the scope of practice of dentistry.

Dental Practice Ownership and Fee Splitting. Dr. Gaskins moved to refer this to the Regulatory-Legislative Committee for further study. The motion was seconded and passed.

Dr. Boyd asked if a Regulatory Advisory Panel can be developed to help in addressing these issues. Ms. Reen said, "Yes". Dr. Levin moved to appoint a panel to assist in addressing these issues. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported that in the first quarter of FY2013 the Board received a total of 89 patient care cases and closed a total of 37 for a 54% clearance rate. She added that the current caseload older than 250 days is 13%, and 87% of all cases were closed within 250 business days. She noted that the Board did not meet the agency's performance goals. She reminded Board members that the Board needs to close at least as many patient care cases as were opened. She added that Board members should plan to stay after informal conferences to review cases.

BOARD COUNSEL REPORT:

Mr. Casway said he heard the arguments in the NC and FTC litigation about teeth whitening, and he will update the Board when the outcome of the case is available.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Ms. Reen reported the following:

- Conflict of Interest statements must be completed by Board members and staff by January 15, 2013.

- The AADA meeting focused on the new assessment and expert review services offered by AADB.
- The VDA has decided not to pursue legislation for the registration of dental laboratories.
- Adoption of revised dental lab work order forms was delayed pending the VDA's decision on pursuing legislation. The proposed forms which were developed by the Board/VDA workgroup are presented for adoption. She added that the workgroup requested that they be issued as guidance documents (GDs). Dr. Gaskins suggested to insert due date on both forms. Dr. Watkins moved to adopt the forms as amended. The motion was seconded and passed. Dr. Gaskins moved to post them as forms and as GDs. The motion was seconded and passed.
- GD 60-7 (Policy on Recovery of Disciplinary Costs) was effective on November 21, 2012. The revision of GD 60-7 is presented for action to revise the cost figures to reflect FY12 expenditures. Dr. Levin moved to adopt the GD as revised. The motion was seconded and passed.
- Board action is needed so she might respond to candidate inquiries about whether the optional ADEX Periodontal Clinical Exam is required for licensure in Virginia. She noted that there is no law or regulation which specifies the content of exams and that SRTA does not require a periodontal clinical exam. Dr. Levin moved that the ADEX Periodontal Clinical Exam not be required. The motion was seconded and passed.

CASE RECOMMENDATIONS: **Case# 142784 and Case# 143977**

Closed Meeting: Dr. Levin moved that the Board convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* for the purpose of deliberation to reach decisions in the matters of Case # 142784 and Case # 143977. Additionally, Dr. Levin moved that Board staff, Ms. Reen, Ms. Vu, Ms. Palmatier and Mr. Casway, Board Counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and will aid the Board in its deliberations.

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

Dr. Watkins moved to accept the Consent Order for Case # 142784 as amended. The motion was seconded and passed.

Dr. Levin moved to accept the recommended Order of the Credentials Committee for Case # 143977. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 1:45 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:18 p.m., on January 16, 2013, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

MEMBERS PRESENT:
Charles E. Gaskins, III, D.D.S.
Jeffrey Levin, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBERS ABSENT:
Martha C. Cutright, D.D.S.
Surya P. Dhakar, D.D.S.
Myra Howard

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

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

OTHERS PRESENT:
Howard Casway, Senior Assistant Attorney General
Wayne Halbleib, Senior Assistant Attorney General

Emily Furrow, R.D.H.
Case No.: 144173

The Board received information from Mr. Halbleib in order to determine if Ms. Furrow's impairment from substance abuse constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.

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

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

which the closed meeting was convened. The motion was seconded and passed.

DECISION:

Dr. Levin moved that the Board summarily suspend Ms. Furrow's license to practice dental hygiene in that she is unable to practice dental hygiene safely due to impairment resulting from substance abuse, and schedule her for a formal hearing. The motion was seconded and a roll call vote was taken. The motion passed unanimously.

Ms. Swecker moved that the Board offer Ms. Furrow a consent order for the indefinite suspension of her license to practice dental hygiene; stay the suspension contingent upon her entry into a Recovery Monitoring Contract with the Health Practitioners' Monitoring Program and remaining compliant with the terms of the Recovery Monitoring Contract. The motion was seconded and a roll call vote was taken. The motion passed with a 6 to 1 vote.

ADJOURNMENT:

With all business concluded, the Board adjourned at 5:53 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:20 p.m., on February 14, 2013, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

MEMBERS PRESENT:
Martha C. Cutright, D.D.S.
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
Myra Howard
Evelyn M. Rolon, D.M.D.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBERS ABSENT:
Jeffrey Levin, D.D.S.
Melanie C. Swain, R.D.H.

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

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

OTHERS PRESENT:
Howard Casway, Senior Assistant Attorney General
Corie Wolf, Assistant Attorney General

Demetrios Milonas, DDS
Case No.: 147805

The Board received information from Ms. Wolf in order to determine if Dr. Milonas' impairment from alcohol abuse constitutes a substantial danger to public health and safety. Ms. Wolf reviewed the case and responded to questions.

Closed Meeting:

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

Reconvene:

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

which the closed meeting was convened. The motion was seconded and passed.

DECISION:

Dr. Gaskins moved that the Board summarily suspend Dr. Milonas' license to practice dentistry in that he is unable to practice dentistry safely due to impairment resulting from alcohol abuse, and schedule him for a formal hearing. The motion was seconded and a roll call vote was taken. The motion passed unanimously.

Ronald Downey, DDS
Case No.: 147013

The Board received information from Ms. Reen regarding a Consent Order signed by Dr. Downey for the possible resolution of a disciplinary matter.

Dr. Gaskins moved that the Board adopt the Consent Order pertaining to Dr. Downey as presented. The motion was seconded and passed unanimously.

ADJOURNMENT:

With all business concluded, the Board adjourned at 6:10 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Bruce Barrette, D.D.S., President
Stanwood Kanna, D.D.S., Vice-President
William Pappas, D.D.S., Secretary
Robert Jolly, DDS, Treasurer
Guy Shampaine, D.D.S., Past President

January 3, 2013

TO: ADEX Member States

FROM: Bruce Barrette, D.D.S., ADEX President

SUBJECT: ADEX 8th Annual Meeting

Enclosed is a draft copy of the Proceedings of the ADEX House of Representatives Meeting held on November 11, 2012, in Rosemont, IL as well as the 2011-2012 ADEX Annual Report

The success and achievements of ADEX over the past eight years is due to the commitment of the member state dental boards.

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DRAFT

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

8th ADEX House of Representatives
November 11, 2012

PROCEEDINGS

Call to Order and Introductions: President Bruce Barrette called to order the 8th meeting of the ADEX House of Representatives at 8:10 a.m. on Sunday, November 11, 2012 in the Signature Ballroom, Doubletree Hotel, Rosemont, IL.

Roll Call: President Barrette introduced the members of the House of Representatives: Dentist/Administrator Representatives: Dr. Robert Ray, DC; Dr. David Perkins, CT; Dr. Mark Baird, HI; Mr. Maulid Miskell, CO; Dr. Dennis Manning, IL; Dr. Stephen Pritchard, IN; Dr. Peter DeSciscio, NJ; Dr. Katherine King, KY; Dr. David Averill, VT; Dr. Ngoc Chu, MD; Dr. William Wright, MI; Dr. Patrica Parker, OR; Dr. Jade Miller, NV; Dr. Andy McKibbin, Jr,, NH; Dr. John Reitz, PA; Dr. Jancito Beard, OH; Dr. Scott Houfek, WY; Dr. William Kochenour, FL; Dr. Craig Meadows, WV; Dr. Keith Clemence, WI; Dr. H. Warren Whitis, AR; Dr. Michael Tabor, TN; Dr. Z. Vance Morgan, SC; Dr. M. Christine Benoit, RI; Dr. Mina Paul, MA; Dental Hygiene Representatives: Mary Davidson, RDH, OR, District 2; Ms. Nan Kosydar Dreves, RDH, WI, District 4; Ms. Mary Johnston, RDH, MI, District 5; Ms. Mary Ann Burch, RDH, KY District 6; Cheryl Bruce, RDH, MD, District 7; Sibyl Gant, RDH, DC, District 8; Ms. Nancy St. Pierre, RDH, NH, District 9; Ms. Karen Dunn RDH, MA, District 10; Ms. Irene Stavros, RDH, FL, District 12; Consumer Representatives: Ms. Judith Ficks, WI, District 4, Ms. Clance LaTurner, IN, District 5; Mr. Allan Horwitz, PA, District 7; Ms Lynn Joslyn, NH, District 9; Ms. Diane Denk, ME District 10; Ms. Vicki Campbell, FL, District 12.. There were 49 out of 52 State Board, District Hygiene and Consumer Representatives present.

President Barrette introduced ADEX officers, Dr. Stan Kanna, HI, Vice-President and District Director 2; Dr. William Pappas, NV, Secretary, Dr. Robert Jolly, AR, Treasurer, Dr. Guy Shampaine, MD, Immediate Past President and District 7 Director.

President Barrette also introduced representatives from Associate Member organizations: Dr. Peter Robinson, American Dental Education Association (ADEA); Dr. Maxine Feinberg American Dental Association (ADA) and Mr. David Johnson Federation of State Medical Boards (FSMB).

ADEX Board Of Directors Members in attendance: Dr. M.H. VanderVeen, MI, District 5; Dr. Michelle Bedell, District 6; Dr. Richard Dickinson, VT, District 10; Dr. Jeffery Hartsog, Ms; District 11; Dr. Wade Winker, FL, District 12; Mr. James McKernan, RDH, NV, Hygiene Member; Zeno St. Cyr II, MD, Consumer Member; Dr. Cathy Turbyne, ME, Hygiene Member.

Additional Guests: Dr. Stephen Klein, Gansk & Associates, CA, Ms. Kathleen White, Executive Director-SRTA, VA, E.W. Looney, Brightlink, GA; Dr. Ellis Hall, NERB, MD; Mr. Michael Zeder, MD, NERB, Dr. Robert Sherman, HI, Dr. A Roddy Scarborugh, MS, Dr. Ronald Chenette, NERB, MD, Lynda Sabat, RDH, OH, Dr. Hal Haering, AZ, Ms. Sherie William Barbie, RDH, SRTA, Ms. Jennifer Lamb, RDH SRTA, Ms. Jan Jolly, RDH, SRTA., Dr. LeeAnn Podruch, NERB, VT, Ms. Leah Diane Howell, Executive Director Mississippi Dental Board, Dr. James Watkins, VA.

Also in attendance: Patrick D. Braatz, ADEX volunteer Administrator

Adoption of Agenda: Dr. Dennis Manning, IL moved and Ms. Diane Denk, ME seconded a motion to adopt the agenda with the proviso that the President could reorder items if necessary. The motion passed by general consent.

Adoption of Proceedings of the 7th ADEX House of Representatives, November 7, 2011

Ms. Nan Kosydar Dreves WI, moved and Ms. Irene Stavros, RDH, FL seconded a motion to adopt the Proceeding of the 7th ADEX House of Representatives, November 7, 2011. The motion passed by general consent.

Presentations from Associate Members

ADEA - Dr. Robinson ADEA had no official report.

FSMB - Mr. David Johnson had no official report.

ADA – Dr. Maxine Feinberg brought greetings from the ADA.

President's Report

On behalf of the ADEX Executive Committee and the ADEX Board of Directors, I am pleased to welcome you to the 8th Annual meeting of ADEX and excited to be able to give you a positive report on ADEX this year.

As always, our primary concern is the development of the dental and dental hygiene examinations. The Occupational Analysis, which we did last year, suggested that while dentists, both newly graduated and seasoned dentists do perio scaling, perio scaling is performed less frequently than the supervision of this skill. Perio scaling was not judged as critical as some of the other skills that are included for measurement on the ADEX clinical examinations. As a result, the ADEX Dental Examination Committee voted to make the present perio examination an optional part of the exam, depending on the requirements of a particular state board. In other words, ADEX will be offering the present clinical perio examination for those states that require a patient based perio exam, but for those states that do not require a patient based perio examination, candidates will not be required to successfully complete a patient based perio exam.

At the same time, we have appointed a perio committee to explore the possibility of developing a patient based perio examination that more accurately reflects what dentists do once they begin their professional careers. In addition, the DSCE, which is the computer component of the ADEX Dental Examination, has had more emphasis added to it in the area of periodontics.

Furthermore, during the past year, the DSCE has undergone a periodic and comprehensive review by Alpine Testing Solutions and, as a result, the exam has been refined and shortened.

Other changes, on the dental examination, include further refinements of the protocols on lesion acceptance and assignment.

New improvements in the ADEX dental hygiene examination include the separation of calculus detection and calculus removal into two separate exercises. Measures also have been enacted to create a fair playing field for candidates regarding the number of surfaces available for calculus removal.

We have devoted a considerable amount of time and expense to improve our dental calibration exercises. Dr. Pappas and his Calibration Committee have worked diligently over the course of the last year to increase both the number and quality of the images in our calibration. The committee has also created new scenarios to mimic circumstances that examiners encounter during the course of our examinations. Our goal is, over a period of time, to increase the number of images and scenarios to where we can offer a series of different calibrations. During the February/March perio restorative examination, we will begin to roll out the new calibration exercises.

Our communication committee has completed the video that we commissioned last year and Mary Johnson will be showing it a little later in the program. We continue to inform and educate our state boards through our website, written communications and presentations. The "ADA NEWS", a publication of the American Dental Association, featured us twice this year regarding our examination and its growing acceptance.

During August, Dr. Shampaine, Dr. Pappas, Nan Dreves RDH and I were invited to the SRTA Annual Meeting in Bonita Springs, Florida. At this meeting, old friendships were renewed and new relationships were formed. Plans were formulated to familiarize and assist SRTA with the transition into ADEX. SRTA also announced that they voted to administer the ADEX Dental Hygiene examination in 2014. We welcome that decision and look forward to working with the SRTA dental hygienists.

This past year, the ADEX Dental Examination was administered at two new locations. In March, we were invited to bring the Examination to Arizona at Midwestern University where we examined 38 candidates. Just a note, this year, the number of candidates at Midwestern has increased to 57. In Mississippi, with the assistance of examiners from Mississippi, Alabama and Louisiana, the ADEX examination was given for the first time in May.

Those exams would not have occurred at the new sites without the support of our Quality Assurance Chair Dr. Hal Haering in Arizona and in Mississippi, the Executive Director of the Mississippi Board, Diane Howell and Dr. Jeff Hartsog. Thank you all for your assistance and perseverance.

Three states have joined ADEX as new members: Virginia, Mississippi and New Mexico. We welcome them and look forward to their participation in ADEX. With the addition of these three states that brings us to a total of 30 members with 41 states accepting the exam for initial licensure.

Our outreaches to non-member state boards continue and we have several appearances scheduled. We are hopeful that we will have further good news for you in the future. For these presentations there has been a new PowerPoint developed which Dr. Shampaine will show you later in the program. We remain open to conversations with any state boards and testing agencies as we continue to seek common ground in order to realize our goal of a unified national examination.

I think it's important to remember that the leadership and membership of ADEX are non-paid volunteers who give their time and talents in order to better the dental and dental hygiene professions. So I personally want to thank all of you for your commitment and dedication, whether you serve on the Executive Committee, the Board of Directors, the House of Representatives, or any of the Committees.

We especially want to thank our Volunteer Executive Director, Patrick Braatz who single-handedly coordinates all of ADEX's clerical work during the year and whose attention to endless details makes this meeting possible and successful. Thank you Patrick and thank all of you.

Presentation from:

Mr. David Johnson, MA, Vice-President of Assessment Servicers Federation of State Medical Boards

The Long and Winding Road: "A National Medical Licensing Examination"

The introduction of the United States Medical Licensing Examination (USMLE) in 1992 culminated a multi-year dialogue between the Federation of State Medical Boards (FSMB), the National Board of Medical Examiners (NBME) and other organizations in the house of medicine. The introduction of the USMLE coincided with the FSMB and NBME decision to discontinue their prior examination programs (FLEX, NBME Parts) in favor of the USMLE as a streamlining of the examination pathway toward medical licensure. The USMLE then served now serves as not only the primary examination pathway to medical licensure in the United States but meets secondary needs such as the basic science assessment necessary for international medical graduates' certification by the Educational Commission for Foreign Medical Graduates (ECFMG) and supplementing the assessment of medical education curriculum by US medical schools.

The introduction of the USMLE was prompted in part by multiple factors, including legislative and examinee pressures for a common examination pathway and the long standing historical desire of the FSMB for a uniform examination pathway that would support and facilitate license portability among physicians. The USMLE culminated the long process in the 20th century of state medical boards moving out of the business of exam development and administration and delegating much of this function to recognized national testing agencies. This trend accelerated in the 1960's with the introduction of the Federation Licensing Examination (FLEX) though it left multiple (though notably fewer) examination pathways toward medical licensure.

Looking forward it is possible that the recently announced decision for joint accreditation of allopathic (MD) and osteopathic (DO) residency programs beginning in 2015 may foster renewed interest in trying to consolidate the current two national examinations (USMLE; COMLEX for osteopathic students and graduates) for medical licensure into a true single pathway. Prior conversations on a single pathway (1980s and early 2000s) proved challenging though continued environmental changes such as the accreditation mentioned above may create renewed interest in revisiting this issue.

Presentation from:

Dr. Guy Shampaine, Immediate Past President ADEX

"ADEX Structure and Examination – if you could see what we see"

Dr. Shampaine made a presentation on the history of ADEX, including a detailed description of the organizational structure, and the role of state dental boards in directing the governance of ADEX. A description of the principles governing examination development was also presented.

Dr. Stephen Klein, Gansk & Associates, ADEX Psychometrician:

Dr. Klein reviewed both the Dental and Dental Hygiene post examination Analysis that are found in the 2011-2012 ADEX Annual Report.

Dental Examination:

Dr. Klein reported on his findings with the over 1,500 candidates who took the full ADEX test battery for the first time between August 1, 2011 and May 31, 2012.

The five tests in this battery were administered in the Curriculum Integrated Format by NERB or the Nevada State Board of Dental Examiners. All but one test had a first timer passing rate over 94%. The sole exception was Restorative Care which had a first timer rate of 87%. However, all five tests had a 99% success rate after candidates could repeat a previously failed exam in the testing window. Unlike previous ADEX examinations, candidates could choose which type of posterior restoration they would prep and perform, namely: amalgam, box composite or conventional composite. First timer passing rates on these procedures ranged from 88.1% for an amalgam to 90.8% for a Box composite.

All three examiners agreed on the pass/fail status of 93% of the candidates taking the Endodontics exam. Consensus on pass/fail decisions on the Prosthodontics, Amalgam, Box composite, and Conventional composite were 76%, 67%, 72%, and 67%, respectively. With the exception of Prosthodontics, all these agreement rates were greater than what was likely to occur by chance.

All the Periodontic examiners arrived at the same overall pass/fail decision for about 89% of the candidates. However, because almost every applicant passed the perio exam, this test's inter-examiner agreement rate was only slightly better than chance. The reliability of DSE total scores ($r = .83$) was slightly below what is generally considered acceptable for a high stakes licensing test. However, because of the especially high passing rate, the slightly less than desired score reliability is likely to have little or no effect on decision consistency.

Dental Hygiene Examination:

Dr. Klein reported on his findings from the analyses he conducted with the over 2,100 candidates who took the Clinical Hygiene exam (which is a performance test) and the Computer Simulated Clinical exam (which is a multiple choice test) for the first time between April and August 2012. He found that 87% of the candidates passed both of these exams, 1% failed both, and the remaining 12% were split fairly evenly in which tests they passed and failed. However, this high degree of decision consistency stems mainly from their both exams having very high passing rates. This situation reinforces the need for test takers to pass both tests in order to pass overall.

Calculus detection and removal were by far the major factors determining a candidate's pass/fail status on the Clinical exam. Although 205 candidates (9.7%) received penalty points, only 82 of these candidates (4% of the total takers) failed because of the penalty points they received. All three examiners made the same pass/fail decision for 87% of the candidates.

Mary Johnston, RDH, Chair ADEX Communications Committee

"ADEX Trailer"

The Communications Committee presented the full board and membership with a professionally constructed product reflecting the ADEX message, exam construct and its goals and objectives. The "ADEX Mission" trailer can be viewed on the homepage of the website. Our gratitude goes out to the diligent work of our voice talent that volunteered their time and talent Ms. Clance LaTurner (District V public member) and John Rice.

Dr. Scott Houfek, Chair - ADEX Dental Examination Committee - Dental Examination Overview

Dr. Scott Houfek presented the report of the Examination Committee meeting which was held on Friday and Saturday, November 9-10, 2012. The following recommendations were made by the examination committee:

The following are the recommendations to the ADEX House of Representatives regarding the Dental Examination.

2013 Dental Examination Recommendations:

- 2013 – Recommend if the examiner is unable to floss criteria to be changed. If 2 examiners rate crit def cannot pass floss it is scored as a sub, and if all 3 examiners score a crit def it will be a crit def.

2014 Dental Examination Recommendations:

- Change the SAT & ACC criteria to no more than 1mm for the Buccal and Lingual proximal box clearance. Substandard more than 1mm to 2.5 mm, Crit Def – More than 2.5mm
- Recommendation – Combine the SAT & ACC categories.
- Recommends – Report passing scores as 75 or higher.
- Recommends – Score anterior & posterior procedures separately. If candidate passes the first procedure and fails second – retake second and if fails the first has to retake both restorative procedures.
- Recommend – CFE's evaluate all medical histories.
  Separate restorations to be allowed for occlussal decay and a slot prep if 1 mm or more tooth structure exists between the slot prep and the occlussal prep.
- Recommend – The criteria for the posterior slot prep & the posterior conventional composite for breaking gingival contact be the same. i.e. gig. Contact does not have to broken for SAT.
- Timelines
  4 –Hours – 1 procedure
  7 – Hours – 2 procedures
  9 – Hours – 3 procedures
- Recommend – CFE's ask the patient if Blood Pressure was taken – no longer observe procedure.

2015 Dental Examination Recommendations:

- Recommend – Utilize a radiopaque radiographable tooth in 2015 for anterior endo procedure pending feedback from the schools on implementation. The root portion on the endo procedure will be graded on the radiographs.

Dr. Peter DeSciscio, NJ moved and Dr. Stephen Pritchard, IN seconded a motion to accept the Dental Examination Committee Report. Motion approved by general consent.

Nancy St. Pierre - Chair ADEX Dental Hygiene Exam Committee - Dental Hygiene Examination Overview

Nancy St. Pierre, RDH presented the report of the Dental Hygiene Examination Committee meeting which was held on Friday and Saturday, November 9-10, 2012. The following recommendations were made by the examination committee:

The following are the recommendations to the ADEX House of Representatives regarding the Dental Hygiene Examination for 2013 and 2014

2013 Dental Hygiene Examination Recommendations:

- Recommend detection of calculus on the three assigned teeth on 4 rather than 6 surfaces.
- Recommend that the actual patient treatment time for the examination be 90 minutes rather than 2 hours as many of the procedures will now be accomplished prior to the patient being sent initially to the Evaluation Station.
- Have the CFE select the two teeth for probing and the three teeth for calculus detection and have the candidate accomplish these procedures before the patient is sent to the Evaluation Station for the initial patient evaluation.
- Create clarity in the manual for candidates that calculus on a surface for the detection portion of the examination does not have to meet the same criteria for "qualifying" calculus and can be supragingival and/or sub gingival.

2014 Dental Hygiene Examination Recommendations:

- Recommend reporting to candidates their passing with a score of 75 or higher and failure as a score of less than 75 while also describing the criteria where they were unsuccessful.
- Recommend to utilize a scoring rubric jointly decided upon by ADEX and Southern Regional Testing Agency, Inc. (SRTA). This rubric would include penalty points if examiners verify four (4) or more surfaces of remaining calculus.
- Recommend to allow candidates to choose twelve (12) surfaces with qualifying calculus that are verified by two examiners. If any surfaces are not verified, substitute surfaces are chosen systematically by an examiner in the primary quadrant or additional selection and verified by two examiners.
- A manual revision committee established to include participants from SRTA. This committee is not a standing committee, but temporary for the purposes of this specific project.

Dr. Arthur McKibbin, Jr., NH moved and Ms. Nan Kosydar, RDH, WI seconded a motion to accept the Dental Hygiene Examination Committee Report. Motion approved by general consent.

Dr. Barrette presented an award to Ms. Nancy St. Pierre, RDH thanking her for serving as the Chair of the Dental Hygiene Examination Committee.

President Barrette announced that the Board of Directors has selected Ms. Nan Kosydar Dreves, RDH of Wisconsin to be the new Dental Hygiene Examination Committee Chair.

Ms. Nan Kosydar Dreves, RDH presented thanks to Nancy St. Pierre from the members of the ADEX Dental Hygiene Committee.

Treasurer Report and ADEX Budget

Dr. Robert Jolly, ADEX Treasurer reported that the current ADEX Fund Balance is $102,553.24

Dr H. Warren Whitis, AR moved and Mary Ann Burch, RDH, MD seconded motion to accept the Treasurer's Report. Motion passed by general consent.

Mr. Patrick Braatz on behalf of the ADEX Budget Committee presented the 2012 – 2013 ADEX Budget which has been recommended by the ADEX Budget Committee and has been recommended to the ADEX House of Representatives. The 2012 - 2013 Budget is Revenue of $250,000 which is paid by NERB, SRTA and the State of Nevada and proposed expenses of $250,000.00.

Mary Ann Burch, RDH, MD moved and Dr. Dennis Manning, IL seconded a motion to approve the 2012 – 2013 ADEX Budget. Motion passed by general consent.

Business Session

Proposed Bylaws Amendments: Dr. Robert Ray, Chair of the By-Laws Committee reported that there were no recommended changes to the By-Laws.

Dr Barrette passed the gavel to Dr. Shampaine, Immediate Past President to accept the nominations for the Officers of ADEX.

Dr. H Warren Whitis, AR moved and Mary Ann Burch, RDH, MD seconded a motion to nominate Dr. Robert Jolly, AR as Treasurer of ADEX for 2012-2013 term. There were no other nominations. The motion passed by general consent.

Dr. Shampaine, MD moved and Dr. Peter DeSciscio, NJ seconded a motion to nominate Dr. William Pappas as Secretary of ADEX for 2012-2013 term. There were no other nominations. The motion passed by general consent

Dr. Mina Pau, MA moved and Ms. Lynn Josyln, NH seconded a motion to nominate Dr. Stanwood Kanna, HI as Vice-President of ADEX for 2012-2013 term. There were no other nominations. The motion passed by general consent.

Dr. Scott Houfek, WY moved and Ms. Judith Ficks, WI seconded a motion to nominate Dr. Bruce Barrette, WI as President of ADEX for 2012 - 2013 term. There were no other nominations. The motion passed by general consent.

Nomination of Consumer Board of Director Member

Dr. Stephen Pritchard, IN moved and Dr. Dennis Manning, IL seconded a motion to nominate Ms. Clance LaTurner of Indiana as a Consumer Member to the ADEX Board of Directors for a three year term.

Nomination of Dental Hygiene Board of Directors Member.

Ms. Nan Kosydar Dreves, RDH, WI, moved and Mary Davidson, RDH, OR seconded a motion to nominate Mary Johnston, RDH, of Michigan as a Dental Hygiene Member to the ADEX Board of Directors.

Dr. Dennis Manning, IL moved and Ms. Cheryl Bruce, RDH, MD seconded a motion to nominate Ms.Linda Sabat, RDH of Ohio.

Caucuses: The House broke into district caucuses.

District Elections: The following are the caucus election results and include new appointees as well as re-elected representatives:

District 2
Patricia Parker, DDS, OR, District Director for a three year term
Mary Davidson, RDH, OR, House District RDH Representative
Jill Mason, RDH, OR, RDH Examination Committee Member
Lisa Wark NV, Consumer Representative
Dr. Rick Thiriot, NV, District Educator Dental Exam Committee

District 4:
Dr. Keith Clemence, WI, District Director for a three year term
TBD House District RDH Representative
TBD, RDH Examination Committee Member
Judy Ficks, RDH, Consumer Member
Dr. Leo Huck, District Educator Dental Exam Committee

District 5:
Linda Sabat, RDH, OH, House District RDH Representative
Linda Sabat, RDH, OH RDH Examination Committee member
Ms. Clance LaTurner, IN, Consumer Representative
Dr. Peter Yaman, MI, Educator Dental Exam Committee

District 6:
Mary Ann Burch, RDH, WV, House District RDH Representative
Dina Vaughan, RDH, WV, RDH Examination Committee Member
TBD, Consumer Representative
Dr. Rick Archer, VA, Educator Dental Exam Committee Member

District 7:
Dr. John Reitz, PA, Board of Directors
Cheryl Bruce, R.D.H., MD, House District RDH Representative
Mariellen Brickley-Raab, RDH, PA, RDH Examination Committee Member
Allan Horwitz, Esq., PA, Consumer Representative
Dr. Uri Hangorsky, DDS, PA, Educator Dental Exam Committee

District 8
Sibyl Gant, RDH, DC, House District RDH Representative
Judith Neely, RDH, DC, RDH Examination Committee Member
TBD Consumer Representative:
Dr. John Bailey, DC, Educator Dental Exam Committee

District 9: Nancy St. Pierre, RDH, NH, House District RDH Representative
Shirley Birenz, RDH, NJ RDH Examination Committee Member
Ms. Lynn Joslyn, NH Consumer Representative
Dr. Marc Rosenblum, NJ, Educator Dental Exam Committee

District 10: Karen Dunn, RDH, MA, House District RDH Representative
Karen Dunn, RDH, MA, RDH Examination Committee Member
Diane Denk, ME, Consumer Representative
Dr. Steven DuLong, MA, Educator, Dental Exam Committee

District 11: Dr. Jeffery Hartsog, District Director for a three year term
Janet Brice McMurphy, RDH, MS, House District RDH Representative
Janet Brice McMurphy, RDH, MS, RDH Examination Committee Member
TBD, Consumer Representative
Dr. Larry Breeding, MS Educator Dental Exam Committee

District 12: Irene Stavros, RDH, FL, House District RDH Representative
Irene Stavros, RDH, FL, RDH Examination Committee Member
Vicki Campbell, FL, Consumer Representative
Dr. Boyd Robinson, FL, Educator Dental Exam Committee

Election of Board of Director Dental Hygiene Member

Dr. Dennis Manning. IL withdrew the nomination of Ms. Linda Sabat, RDH, OH

Dr. Barrette noted since there was no additional nominations that the Secretary would cast a unanimous ballot for Ms. Mary Johnston, RDH of Michigan to be the Dental Hygiene Member of the Board of Directors.

Election of Board of Directors Consumer Member

Dr. Barrette noted since there was no additional nominations that the Secretary would cast a unanimous ballot for Ms. Clance Turner of Indiana to be the Consumer Member of the Board of Directors.

Dr. Denny Manning, IL moved and Peter DeScisio, NJ seconded a motion to approve the dental examination as recommended by the Board of Directors. The motion passed by general consent.

Ms. Diane Denk, ME moved and Dr Robert Ray, DC seconded a motion to approve the dental hygiene examination as recommended by the Board of Directors. Motion passed by general consent.

Future Meeting Dates

Ms. Mary Ann Burch, RDH, KY moved and Dr Ngo Chu, MD seconded a motion to empower the ADEX Executive Committee to select the official dates of the 2013 ADEX Meetings. The motion passed by general consent.

Adjournment: Ms. Judith Ficks, WI moved and Dr. Robert Gheardi, NM seconded a motion for adjournment. The motion passed by general consent. The meeting was adjourned at 11:00 a.m.

Proc. 8th H of R 11.11.12(1)

Contents

Message from the President

Welcome to the Eighth Annual ADEX House of Representatives. The American board of Dental Examiners (ADEX) has just finished its seventh full year of initial licensure examinations in dentistry and dental hygiene. This has been an especially busy year with much accomplished. Three new states (Virginia, Mississippi and New Mexico) have become members. At the same time, we continue to strengthen our examinations with a special emphasis this year on improving our calibration exercises.

ADEX still remains the largest licensure test development entity for dentistry in the United States with 30 state dental boards as members and with approximately 41 states accepting the examinations for licensure. This progress is due to the support and commitment of the member state boards and the volunteers chosen by those state dental boards toward developing the most valid, reliable and defensible examinations possible for the dental profession.

Thank you for your dedication and participation in the 2012 ADEX House of Representatives.

Bruce Barrette, DDS
President, ADEX

ADEX Membership

Membership gives a recognizing state dental board direct involvement in the development and evolution of the examinations through committee appointments; and approval of the final form of the examinations in dentistry and dental hygiene through their appointments to the House of Representatives.

Consumer members of state dental boards are full active voting members of ADEX directly involved in the evolution and participation of the examinations.

Member Jurisdictions

Arkansas
Colorado
Connecticut
District of Columbia
Florida
Hawaii
Illinois
Indiana
Iowa
Kentucky
Maine
Maryland
Massachusetts
Michigan
Mississippi
New Mexico
Nevada
New Hampshire
New Jersey
Ohio
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Wyoming
Vermont
Virginia
West Virginia
Wisconsin

ADEX

ADEX Districts

ADEX initial districts were drawn to try to equalize the number of dental students, dentists licensed each year, and to some degree practicing dentist numbers.

District 1:	California
District 2:	Alaska, Arizona, ***Colorado, Hawaii***, Idaho, Montana, ***Nevada, New Mexico***, ***Oregon***, Utah, Washington, ***Wyoming***
District 3:	Kansas, Missouri, Nebraska, Oklahoma, Texas
District 4:	***Iowa***, Minnesota, North Dakota, South Dakota, ***Wisconsin***
District 5:	***Illinois, Indiana, Michigan, Ohio***
District 6:	***Arkansas***, Georgia, ***Kentucky, South Carolina***, ***Tennessee***, ***Virginia, West Virginia***
District 7:	***Maryland, Pennsylvania***
District 8:	***Connecticut***, Delaware, ***District of Columbia***, U.S. Virgin Islands
District 9:	***New Hampshire, New Jersey***, New York, ***Rhode Island***
District 10:	***Maine, Massachusetts, Vermont***
District 11:	Alabama, Louisiana, ***Mississippi***, North Carolina, Puerto Rico
District 12:	***Florida***

States highlighted in ***bold italics*** are Member States

ADEX Governance

Governing Principle

ADEX's governing principle is that the governing authority is vested with the active member state boards of dentistry. Representatives are directly appointed by the active state dental board and the directors elected by state board representatives.

Important committee appointments are directly made through the representatives of the active state dental boards.

House of Representatives

Governance is from the Member State Dental Boards in the House of Representatives.

- The House of Representatives consists of dentist or executive director representatives from the member state dental boards. They hold final approval of major examination changes.
- Each state board will designate one representative.
- Representatives are required to have been active voting board members of the member state at some time.
- A Dental Hygiene representative from each ADEX district is required to be or have been an active board member from a member state.
- A Consumer representative from each ADEX district is required to be or have been an active board member from a member state.
- Each state will determine the qualifications of their representative.
- Members from American Dental Association (ADA), American Student Dental Association (ASDA), American Dental Education Association (ADEA), American Dental Hygienists' Association (ADHA), The National Dental Examining Board of Canada (NDEB), Canadian Dental Association (CDA), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) are chosen by their respective organizations.

2011 ADEX House of Representatives

Dentist or Executive Director Representatives

Colorado – Mr. Maulid Miskell

Connecticut – David Perkins, DDS

District of Columbia – Robert Ray, DMD

Florida – Wade Winker, DDS

Hawaii – Mark Baird, DDS

Illinois – Dennis Manning, DDS

Indiana – Matthew Miller, DDS

Iowa – No Representative

Kentucky – H.M. "Bo" Smith< DDS

Maine – Rockwell Davis, DDS

Maryland – Maurice Miles, DDS

Massachusetts – Mina Paul, DDS

Michigan – William Wright, DDS

Nevada – William Pappas, DDS

New Hampshire – Neil Hiltunen, DMD

New Jersey – Peter DeSciscio, DDS

Ohio – Phil Beckwith, DDS

Oregon – Patricia Parker, DMD

Pennsylvania – John V. Reitz, DDS

Rhode Island – Henry Levin, DDS

South Carolina – Michelle Bedell, DDS

Vermont – Richard Dickinson, DDS

West Virginia – Craig Meadows, DDS

Wisconsin – Dr. Keith Clemence, DDS

Wyoming – Scott Houfek, DDS

2011 ADEX House of Representatives (cont.)

Dental Hygiene Representatives

Mary Davidson, RDH, MPH, OR	District 2
Nan Dreves, RDH, MBA, WI	District 4
Mary Johnston, RDH, MI	District 5
Dina Vaughn, BSDH, MS, WV	District 6
Cheryl Bruce, RDH, MD	District 7
Sibyl Gant, RDH, DC	District 8
Nancy St. Pierre, RDH, NH	District 9
Karen Dunn, RDH, MA	District 10
Irene Stavros, RDH, FL	District 12

Consumer Representatives

Marian Grey, HI	District 2
Ms. Judith Ficks, WI	District 4
Ms. Clance LaTurner, IN	District 5
Mr. Allan D. Francis, KY	District 6
Allan Horwitz, Esq., PA	District 7
No Representative	District 8
Ms. Lynn Joslyn, NH	District 9
Ms. Diane Denk, ME	District 10
Ms. Vicki Campbell, FL	District 12

2011 ADEX House of Representatives (cont.)

Associate Members

American Dental Association – Samuel Low, DDS, ADA Trustee

American Student Dental Association – Mr. Ken Randall, President

American Dental Education Association – Peter Robinson, DDS

American Dental Hygienists' Association – No Representative

National Dental Examining Board of Canada – No Representative

Canadian Dental Association – No Representative

Federation of State Medical Boards – No Representative

National Board of Medical Examiners –No Representative

ADEX Board of Directors

ADEX Officers

Bruce Barrette, DDS	Wisconsin	President
Stanwood Kanna, DDS	Hawaii	Vice-President
William Pappas, DDS	Nevada	Secretary
H.M. "Bo" Smith, DMD	Arkansas	Treasurer
Guy Shampaine, DDS	Maryland	Immediate Past President

ADEX Board of Directors – Up to 17 Members

12 Districts, Examination Committee Chairs, Dental Hygiene Representatives

Directors elected by state board representatives in House of Representatives

Board of Directors

Stan Kanna, DDS	Hawaii	District 2
Bruce Barrette, DDS	Wisconsin	District 4
M.H VanderVeen, DDS	Michigan	District 5
Michelle Bedell, DMD	South Carolina	District 6
Guy Shampaine, DDS	Maryland	District 7
Robert Ray, DMD	DC	District 8
Peter DeSciscio, DMD	New Jersey	District 9
Richard Dickinson, DDS	Maine	District 10
Jeffrey Hartsog, DDS	Mississippi	District 11
Wade Winker, DDS	Florida	District 12
Ms. Judith Ficks	Wisconsin	Consumer Member
Mr. Zeno St. Cyr, II	Maryland	Consumer Member
Cathy Turbyne, EdD, MS, RDH	Maine	Hygiene Member
James "Tuko" McKernan, RDH,	Nevada	Hygiene Member
Nancy St. Pierre, RDH,	New Hampshire	Chair, Dental Hygiene Examination Committee
Scot Houfek, DDS	Wyoming	Chair, Dental Examination Committee

Terms for Current ADEX Board of Directors*

District	Incumbent	Remaining Tenure
District 2	Stan Kanna, DDS	0 Year
District 4	Bruce Barrette, DDS	0 Year
District 5	M. H. VanderVeen, DDS*	1 Years
District 6	Michelle Bedell, DMD*	2 Years
District 7	Guy Shampaine, DDS	0 Year
District 8	Robert Ray, DMD	1 Years
District 9	Peter DeSciscio, DMD	1 Years
District 10	Richard Dickinson, DDS	2 Years
District 11	Jeffrey Hartsog, DDS*	0 Year
District 12	Wade Winker, DDS*	2 Years
Consumer Member	Ms. Judith Ficks	1 Years
Consumer Member	Mr. Zeno St. Cyr, II	0 Year
Hygiene Member	Cathy Turbyne, EdD, MS, RDH	0 Year
Hygiene Member	James "Tuko" McKernan, RDH*	1 Years

* members of the Board of Directors are eligible to serve a second three-year term if elected by their district.

ADEX Committees

Dental Examination Committee

- One (1) dentist from each Member Board.
- One (1) Member Board consumer representative
- 1 Consumer
- The Chair of the Dental Examination Committee
- All appointments are nominated by the representatives of the member state dental boards.

Dental Examination Committee Members

Scott Houfek, DDS, WY – Chair

District 2: (CO, HI, NV, OR, WY)
Peter Carlesimo, DDS, CO
Stan Kanna, DDS, HI
William Pappas, DDS, NV
Jonna Hongo, DMD, OR
TBD, WY
Rick Thiriot, DDS, NV Educator

District 4: (IA, WI)
Gary Roth, DDS, IA
Keith Clemence, DDS, WI
Leo Huck, DDS, WI Educator

District 5: (IL, IN, MI, OH)
Dennis Manning, DDS, IL
Matthew Miller, DDS, IN
Chuck Marinelli, DDS, MI
Eleanore Awadalla, DDS, OH
Peter Yaman, DDS, MI, Educator

Dental Examination Committee Members (cont.)

District 6: (AK, KY, SC, TN, WV)
George Martin, DDS, AR
Robert Zena, DDS, KY
Michelle Bedell, DDS, SC
John M. Douglas, Jr. DDS, TN
James Watkins, DDS, VA
John Dixon, DDS, WV
Rick Archer, DDS, VA Educator Rep

District 7: (MD, PA)
Guy Shampaine, DDS, MD
Susan Calderbank, DMD, PA
Uri Hangorski, PA, Educator

District 8: (CT, DC)
David Perkins, DMD, CT
Rahele Rezai, DMD, DC
John Bailey, DDS, DC, Educator

District 9: (NH, NJ, RI)
Barbara Rich, DMD, NJ
Arthur McKibbin, Jr., DMD, NH
Henry Levin, DMD, RI
Marc Rosenblum, DMD, NJ, Educator

District 10: (ME, MA, VT)
Robert DeFrancesco, DMD, MA
LeeAnn Podruch, DDS, VT
Rockwell Davis, DDS, ME
Stephen DuLong, DMD, MA, Educator

District 11: (AL, LA, MS, NC, PR)
A. Roddy Scarbrough, DMD, MS
Larry C. Breeding, DMD, MS, Educator

District 12: (FL)
William Kuchenour, DDS, FL
Boyd Robinson, DDS, FL, Educator

Dental Examination Committee Members (cont.)

Consumer:
Alan Horwitz, Esq., PA

Testing Specialist:
Steven Klein, Ph.D, CA

Ex-Officio:
Bruce Barrette, DDS, WI ADEX President

NERB Administrative Liaison:
Ronald Chenette, DMD, MD

Nevada Administrative Liaison:
Kathleen Kelly, NV

SRTA Administrative Liaison:
Kathleen White, VA

ADEX Committees (cont.)

Dental Hygiene Examination Committee

- 1 Dental Hygienist from each district
- 1 Dental Hygiene Educator
- 1 Dentist
- 1 Consumer
- All appointments are nominated by the active member state dental boards.

Dental Hygiene Examination Committee Members

Nancy St. Pierre, RDH, NH – Chair

District 2: Jill Mason, RDH, MPH, OR

District 4: Nanette Kosydar Dreves, RDH, MBA, WI

District 5: Lynda Sabat, RDH, OH

District 6: Diana Vaughan, RDH WV

District 7: Marellen Brickley-Raab, RDH, PA

District 8: Judith Neely, RDH, BS, DC

District 9: Shirley Birenz, RDH, BS, NJ

District 10: Karen Dunn, RDH, MA

District 11: Janet Brice McMurphy, RDH, MS

District 12: Irene Stavros, RDH, FL

Dentist: Maxine Feinberg, DDS, NJ

Educator: Donna Homenko, RDH, PhD, OH

Consumer: Zeno St. Cyr II, MPH, MD

NERB Administrative Liaison: Ellis Hall, DDS, MD

NERB Administrative Liaison: Michael Zeder, MD

Testing Specialist: Steven Klein, Ph.D, CA

ADEX President - Ex-Officio, Bruce Barrette, DDS, WI

ADEX Committees (cont.)

Budget Committee

H. M. "Bo" Smith, DMD, AR - Chair
Scott Houfek, DDS, WY
Neil Hiltunen, DDS, NH
Tony Guillen, DDS, NV
Guy Shampaine, DDS, MD
Charles Ross, DDS, FL
Kathleen White, VA
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

Bylaws Committee

Robert Ray, DDS, WI - Chair
Garo Chalian, DDS, CO
James "Tuko" McKernan, NV
Alan Horowitz, Esq., PA
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

Calibration Committee

William Pappas, DDS, NV - Chair
Scott Houfek, DDS, WY
Tony Guillen, DDS, NV
Rick Thiriot, DDS, NV
Neil Hiltunen, DDS, NH
Ogden Munroe, DDS, IL
Ken Van Meter, DDS, VT
Rick Kewlowitz, DDS, FL
Wendell Garrett, DDS, AR
Ronald Chenette, DMD, MD
Richard Marshall, DDS, WV
Peter Yaman, DDS, MD
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

Communications Committee

Mary Johnston, RDH, MI - Chair
Stanwood Kanna, DDS, HI
Kathy Heier, RDH, IL
Mary Davidson, RDH, OR
Clance LaTurner, IN
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

Quality Assurance Committee

Hal Haering, DDS, AZ - Chair
Stanwood Kanna, DDS, HI
Patricia Parker, DMD OR
Robert Sherman, DDS, HI
J. George Kinnard, DDS, NV
Barbara Rich, DMD, NJ
Nan Kosydar Dreves, RDH, MBA, WI
James Haddix, DMD, FL
Guy Shampaine, DDS, MD
Richard Marshall, DDS, VA
Kathleen White, VA
Ronald Chenette, DMD, MD
Scot Houfek, DDS, WY
Nancy St. Pierre, RDH, NH
Bruce Barrette, DDS, WI - ADEX President Ex-Officio

ADEX Dental Examination

Content

- Five stand alone examinations
  - Critical skill sets identified by criticality in the Occupational Analysis
- Computerized Examination in Applied Diagnosis and Treatment Planning
- Endodontic Clinical Examination
  - Manikin-based
- Fixed Prosthodontic Clinical Examination
  - Manikin-based
- Restorative Clinical Examination
  - Patient-based
- Periodontal Clinical Examination
  - Patient-based

Scoring

- Criterion based scoring system
- Three (3) independent raters without collaboration

Rating Levels

- Satisfactory
- Minimally Acceptable
- Marginally Substandard
- Critically Deficient

ADEX Dental Exam Scoring

Criterion-Based Analytical Scoring Rubric:

- More detailed feedback.
- More consistent scoring.
- Allows for the separate evaluation of factors.
- Evaluation of all gradable criteria.
- Scoring methodologies were developed with consultation from the Buros Institute, University of Nebraska and the Rand Institute with input from studies completed by testing specialists from the University of Chicago.
- Three (3) independent raters evaluate all measurable criteria.
- Median score is utilized when there are no matching scores; all zeros must be independently corroborated to be utilized as a critical deficiency.
- Performance criteria-based scoring will be provided to both the candidate and the dental school so that appropriate remediation can be completed prior to a retake when required.
- Clinical sections utilize compensatory grading with critical errors within a skill set.
- No grading across skills.
- Critical errors are those performance deficiencies that would cause treatment to fail. A critical error forces a failure on that skill set examination. Not all criteria have critical errors.

Evaluation Criteria

Objective measurable criteria developed by a panel of experts consisting of examiners, practitioners, and educators.

Amalgam Prep External Outline Criteria (Example)

SATISFACTORY

1. Contact is visibly open proximally and gingivally up to 0.5 mm.
2. The proximal gingival point angles may be rounded or sharp.
3. The isthmus must be 1-2 mm wide, but not more than ¼ the intercuspal width of the tooth.
4. The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The gingival floor is flat, smooth and perpendicular to the long axis of the tooth.
5. The outline form includes all carious and non-coalesced fissures, and is smooth, rounded and flowing.
6. The cavosurface margin terminates in sound natural tooth surface. There is no previous restorative material, including sealants, at the cavosurface margin. There is no degree of decalcification on the gingival margin.

MINIMALLY ACCEPTABLE

1. Contact is visibly open proximally, and proximal clearance at the height of the contour extends beyond 0.5 mm but not more than 1.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 0.5 mm but not greater than 2 mm.
3. The isthmus is more than ¼ and not more than 1/3 the intercuspal width.
4. The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel.

MARGINALLY SUBSTANDARD

1. The gingival floor and/or proximal contact is not visually open; or proximal clearance at the height of contour extends beyond 1.5 mm but not more than 2.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 2 mm but not more than 3 mm.
3. The outline form is inappropriately overextended so that it compromises the remaining marginal ridge and/or cusp(s).
4. The isthmus is less than 1 mm or greater than 1/3 the intercuspal width.
5. The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s).
6. The cavosurface margin does not terminate in sound natural tooth structure; or, there is explorer penetrable decalcification remaining on the cavosurface margin, or the cavosurface margin terminates in previous restorative material. *(See glossary under Previous Restorative Material).*
7. There is explorer-penetrable decalcification remaining on the gingival floor.
8. Non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form.

CRITICAL DEFICIENCY

1. The proximal clearance at the height of contour extends beyond 3 mm on either one or both proximal walls.
2. The gingival clearance is greater than 3 mm.
3. The isthmus is greater than ½ the intercuspal width.
4. The outline form is overextended so that it compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the pulpal-occlusal wall is unsupported by dentin or the width of the marginal ridge is 1 mm or less.

Endodontic Clinical Examination on a Simulated Patient (Manikin)

Part II: Endodontics – 18 Scorable Items

- Anterior Endodontic Procedures — 12 Criteria
  - Access Opening
  - Canal Instrumentation
  - Root Canal Obturation
- Posterior Access Opening — 6 Criteria

Fixed Prosthodontic Examination on a Simulated Patient (Manikin)

Part III: Fixed Prosthodontics – 43 Scorable Items

- Cast Gold Crown — 15 Criteria
- Porcelain-Fused-to-Metal Crown — 14 Criteria
- Ceramic Crown Preparation — 14 Criteria
- Preparations 1 & 2 evaluated as a mandibular posterior 3-unit bridge

Part V: Restorative – 47 Scorable Items

- Class II Amalgam Preparation — 16 Criteria
- Amalgam Finished Restoration — 9 Criteria
- Class III Composite Preparation — 12 Criteria
- Composite Finished Restoration — 10 Criteria

Periodontal Clinical Examination

Treatment Selection (Procedural)

- Patient Selection severity of periodontal disease.

Treatment

1. Subgingival Calculus Detection
2. Subgingival Calculus Removal
3. Plaque/Stain Removal
4. Pocket Depth Measurement
5. Treatment Management

ADEX Dental Post-Exam Analysis

- Technical Report Developed
- Demographic Data/Analysis
  - Conducted by respective administering agencies
  - Synopsis of data provided for Restorative and Periodontal Procedures with several years of history:

Demographic Data on the Candidate Pool
Failure Rate Summaries
Analysis of Candidate Performance by Test Section
Analysis of Failure Rates by Group Assignment
Analysis of Mean Scores by Procedure/Examination Part
Examiners' Score Agreement Summary
Frequency of Rating Assignments
Correlation of Treatment Selection with Restorative Results
Frequency of Penalty Assignments
Annual Schools Report

- Schools are provided with data regarding their performance annually
- Schools are provided individual candidate performance after each examination series.
- School identities are coded so that each school may compare their performance confidentially
- Performance data for each area of examination content is analyzed and presented
- By procedure
- By individual criterion

Examiner Profiles

- Data is collected for each examiner and compiled into profiles providing information to the examiners regarding their evaluations.

Summary of Total Number of Evaluations per Dental Examiner
Summary of Examiner Agreements for each Examination/Procedure
Percentage Rating Level Assigned per Procedure
Summary of Examiner Agreements & Disagreements across all Procedures
Peer Evaluations

- This information is utilized to monitor examiner performance

TECHNICAL ANALYSIS OF ADEX RESULTS: 2011-2012

Prepared by Stephen Klein, Ph.D. and Roger Bolus, Ph.D.

I. Examination Structure and Rules

Passing the ADEX test battery in 2012 was accepted by 47 states as evidence that a candidate seeking licensure to practice dentistry had acquired the knowledge, skills, and abilities that are necessary for providing safe and appropriate care. Candidates also must satisfy specific state educational and other requirements to be licensed.

Examination Components, Administration, and Format. The ADEX test battery consists of five separate tests: Diagnostic Skills Examination (DSE), Endodontics, Fixed Prosthodontics, Periodontics, and Restorative.

The DSE is a computer based enhanced multiple choice test. Many of its items require candidates to make judgments about clinical conditions based on radiographs, photographs, laboratory data, and working models that are displayed on the candidate's computer screen. This one-day test is administered at professional test centers across the country.

The other four measures are performance tests that are administered using standardized dental instruments and performed at work stations at accredited dental schools. These work stations correspond to ones typically used in practice. The Endodontics and Fixed Prosthodontics tests involve candidates working on manikins that are specially constructed and standardized for the ADEX. A candidate typically takes one of the four performance tests in the morning and another in the afternoon. The Restorative and Periodontics tests are given on one day and the other two performance tests on another day.

Case Acceptance. The Periodontics and Restorative care tests involve live patients who are recruited by the candidates. On the restorative test, two examiners independently review each patient to determine the patient's suitability for treatment, that is, that the patient has the necessary oral conditions to be treated, the appropriate diagnosis and treatment plan is in place, and the medical history does not contain any counter indications for treatment. If the first two examiners do not agree about the patient's suitability, a third examiner is called to break the tie. The ADEX Technical Manual (which is available on the web) describes each test's operational procedures, specifications, and scoring and decision rules.[1]

Dental Examiners. The quality of a candidate's work on each of the four performance tests is evaluated by three specially trained dentists. They record their judgments on an electronic tablet that is programmed for this purpose. The examiners work independently (e.g., they do not discuss the quality of a candidate's performance with the other examiners or the patient). To preserve anonymity and independence, examiners do not see or interact with the candidates and they do not watch the candidate perform the work.

[1] Case acceptance on the Periodontics exam is discussed later in this report.

Pass/Fail Rules. Candidates must pass all five tests to receive ADEX certification and they must repeat all the parts and sections of any test they fail. A high score on one performance test or test section cannot offset a low score or failing status on another test. Candidates are allowed to retake the exams they failed during the August through May testing window, but they cannot carry a passing status on a test across windows. They must pass all five tests within a window to pass overall.

If in the judgment of at least two examiners the candidate made a critical error or deficiency on a live patient, the candidate is excused from continuing the test and receives a failing grade on it. If that happens, the condition of the candidate's patient is temporized and where appropriate, patients are counseled to have any problems with their oral condition addressed by a licensed professional.

Analysis Sample and Testing Window. Except as noted otherwise, results are based on the roughly 1,548 candidates who took all five tests with the Curriculum Integrated Format (CIF) for the first time between August 1, 2011 and May 31, 2012.[2] Results are based on examinations administered by NERB and the Nevada State Board of Dental Examiners.

II. Pass/Fail Decisions

This report focuses mainly on pass/fail decisions (rather than scores) because (1) all the tests were designed to make that type of decision and (2) candidates had to pass each exam to pass overall.

Table 1-A shows the percentage of candidates passing each test on their first attempt and by their last attempt (i.e., if they failed initially and took the exam again). For example, 96.8% passed the DSE on their first try and 98.8% passed after taking this test at least one more time. Most but not all of those failing an exam elected to repeat it.

Table 1-A
Number of Candidates Taking Each Test and Percent Passing

Test	% Pass on 1st Attempt	% Pass by last Attempt	% Did Not Repeat after Initial Fail
DSE	96.8	98.8	1.0
Endodontics	96.8	99.9	0.1
Fixed Prosthodontics	94.1	99.9	0.0
Periodontics	96.9	99.6	0.2
Restorative Dentistry	86.8	97.7	0.5
Mean	94.3	99.2	0.4

On the Restorative exam, all candidates had to perform an anterior composite restoration and a posterior restoration. However, for the posterior restoration, they could choose to do an amalgam, a box composite, or a conventional restoration. Candidates were classified as having chosen an option if they had a non-zero score or a critical error or deficiency

[2] N's vary slightly across analyses as a result of merging of diverse data sets.

associated with that option. The 27 candidates (1.8% of the total) who did not perform any type of posterior restoration were assumed to have taken and failed the anterior composite and therefore were not allowed to continue (see Table 1-B).

Table 1-B
Number of Candidates Taking and Percent Passing Each Restorative Option

Restorative Test Options	Number of Candidates	% Pass
Anterior Test Only	27	0.0
Anterior w. Amalgam	922	88.1
Anterior w. Box Composite	251	90.8
Anterior w. Conventional Composite	340	88.8

The small differences in passing rates among the three restorative options may stem from inherent differences in the difficulty of these procedures, differences in grading standards among the options, differences in the skills of the applicants who select one option over another, chance, or some combination of these and other factors.

The restorative exam had the most influence on a candidate's overall pass/fail status because for most applicants, it was the most difficult one to pass. This was true regardless of which option they selected. Slightly over 75% of the candidates passed the entire exam (all five tests) on their first attempt and 96% passed after repeating one or more tests. Thus, 4% did not pass despite having the option of retaking the exam.

Table 2 shows the median (50th percentile) score on each test. Medians (rather than means) are reported because the zero's assigned to critical errors and deficiencies skew the score distributions.

Table 2
Median Scores by Exam for First Timers

Test	Median
DSE	86.0
Endodontics	98.0
Fixed Prosthodontics	95.0
Periodontics	100.0
Restorative	96.0

Examiners may classify a portion of a procedure within a section (such as "proper placement of the access opening") as critically deficient (DEF) or they may indicate a critical error for the section as a whole, such as saying the candidate treated the wrong tooth or tooth surface. If two or more examiners agree the candidate made a particular type of critical error or DEF, then such corroboration results in the candidate failing the exam.

Table 3 shows that with the exception of the Periodontics exam, only a very small percentage of first timers failed a test without having a critical deficiency or committing at least one corroborated critical error (i.e., few failed because of a low point total). And, no one with even an uncorroborated DEF or critical error passed the Endodontics or fixed Prosthodonitics exam.

Table 3
Role of Critical Errors and Deficiencies in Pass/Fail Decisions

Test	Fail with Critical Error		Fail without Critical Error	
	N	%	N	%
Endodontics	46	3.0	3	0.2
Fixed Prosthodontics	90	5.8	1	0.1
Periodontics	13	0.8	35	2.3
Restorative	179	11.6	19	1.2

Table 4 shows that because of the very high passing rates on all the tests, there was little or no correspondence in their pass/fail decisions other than what would occur by chance. For example, the chance agreement rate was usually less than one percentage point lower than the actual agreement rate.[3] This finding supports the policy of requiring that applicants pass all five tests in the ADEX battery in order to pass overall.

Table 4
Actual and Chance Agreement in Pass/Fail Decisions Between Examinations

Test Combination	Actual Agreement Rate	Chance Agreement Rate	Difference in Agreement Rates
DSE & Endodontics	94.0	93.8	0.2
DSE & Prosthodontics	92.1	91.3	0.8
DSE & Periodontics	94.2	93.9	0.3
DSE & Restorative	85.7	84.4	1.3
Endodontics & Prosthodontics	91.9	91.3	0.6
Endodontics & Periodontics	94.1	93.9	0.2
Endodontics & Restorative	85.0	84.4	0.6
Prosthodontics & Periodontics	91.4	91.4	0.0
Prosthodontics & Restorative	82.3	82.5	-0.2
Periodontics & Restorative	85.2	84.5	0.7
Average	89.6	89.1	0.5

[3] The chance agreement rate between two tests is the product of their passing rates plus the product of their failure rates. For example, if the passing rates on the Endodontics and Prosthodontics exams were 95.5 and 94.5%; then their chance agreement rate would be [(.955 x .945) + (.045 x .055)] = 90.5%.

Table 5 shows the reliability (coefficient alpha) of the scores on each test. These values indicate that the very low correlations between tests were not due to score reliability problems. In addition, as a result of the combination of very high pass rates and adequate score reliabilities, an applicant's pass/fail status is unlikely to change simply by chance (i.e., as distinct from being better prepared).[4] This is referred to as "decision consistency" in the psychometric literature. Analyses were based on the candidates who took all four performance tests and the DSE.

Table 5
Number of Items per Test and Internal Consistency Reliability

Test	Number Of Items	Number of Candidates	Reliability
Endodontics	24	1,522	0.505
Periodontics	37	1,536	0.627
Prosthodontics	43	1,527	0.826
Restorative w. amalgam	54	833	0.655
Restorative w. box	54	234	0.653
Restorative w. conventional	56	308	0.690

III. Inter-Examiner Agreement

Endodontic, Prosthodontic, and Restorative exams. As noted in Table 3, failing one of these tests was driven mainly by whether or not the candidate committed a "critical" error or deficiency. Almost no one failed without committing a corroborated critical error or deficiency; and no one passed who did. A candidate also can fail a test by not earning enough points (the so-called "paper grade") but that almost never occurred except on the Periodonticsl test where it was usually the sole determiner of a candidate's pass/fail status.

The foregoing considerations led us to look at inter-examiner agreement in two ways on the Endodontic, Prosthodontic, and Restorative exams. The first method involved constructing four ratios that focused on the extent to which the examiners agreed the candidate did or did not commit any of the test's possible critical errors or DEFs. For example, there were 21 different types of DEF or critical errors that could be called on the Endodontics test. All four ratios had the same denominator, namely: the number of candidates times the number of possible DEF or critical errors that could be called. The numerator for the first ratio was the total number of patients where all three examiners said there were no DEF or a critical error calls times the number of opportunities for such a call. The numerator for the second ratio was the number of patients where only two of the examiners said there were no DEF or critical error calls times the number of opportunities for making such a call, and so on.

[4] Klein, S., Buckendahl, C., Mehrens, W., & Sackett, P. (2009). Evaluating clinical licensing exams for dentists and dental hygienists. American Board of Dental Examiners. Chicago, IL.

Table 6 shows the examiners achieved consensus 98 to 99 percent of the time. This extremely high rate of decision consistency was due in part to the examiners rarely encountering work that they felt deserved being classified as a critical error or DEF (which is not surprising since almost all the candidates completed dental school). The rates also were inflated due to counting all the DEF and critical error calls that theoretically could be called but were hardly ever made.

Table 6
Percent Agreeing Critical Errors Were or Were Not Present

Test	No Critical Error		With Critical Error	
	% 3/3	% 2/3	% 3/3	% 2/3
Endodontics	99.5	0.4	0.1	0.1
Fixed Prosthodontics	98.6	1.2	0.0	0.2
Restorative w. amalgam	97.8	1.7	0.1	0.3
Restorative w. box	98.7	1.1	0.0	0.2
Restorative w. conventional	97.8	1.9	0.0	0.3

Note: The percentages in a row may not sum to 100.0% due to rounding.

The other way we measured examiner agreement involved calculating how often the three examiners made the same overall decision about a candidate's pass/fail status based on that candidate's "paper grade" which is a function of the number of points the candidate receives and where a score of 75% or higher of the possible maximum score is needed for passing (see Tables 7-A and 7-B). For example, the last row of Table 7-B shows that all three examiners agreed that of the candidates they saw who did a posterior conventional box prep restoration, 58.3% should pass and 8.2% should fail, for an overall perfect agreement rate of 66.5%. In contrast, the perfect agreement rate that was expected to occur by chance was only 48.4%.

Table 7-A
Inter-Examiner Agreement Rates on Endodontics and Prosthodontics

Test	Agree Pass		Agree Fail		Total % Agree	Chance % Agree
	% 3/3	% 2/3	% 3/3	% 2/3		
Endodondtics	91.3	5.6	2.0	1.0	93.4	87.6
Prosthodondtics	72.9	19.1	2.6	5.3	75.5	77.2

Table 7-B
Inter-Examiner Agreement Rates on Restorative Test Options

Restorative Test with Posterior:	Agree Pass		Agree Fail		Total % Agree	Chance % Agree
	% 3/3	% 2/3	% 3/3	% 2/3		
Amalgam	58.2	26.3	9.2	6.3	67.4	47.3
Box	65.9	23.3	6.4	4.4	72.3	56.8
Conventional	58.3	27.2	8.2	6.3	66.5	48.4

It is not clear why the actual degree of agreement between two Prosthodontic examiners (75.5%) was slightly (but not statistically significantly) lower than the chance rate (77.2%). This result came as a surprise since manikins rather than live patients are used for this test. Thus, the lower than expected agreement rate cannot be attributable to variation in patient characteristics. This finding suggests a more in-depth investigation is warranted for this test.

Periodontics. Case acceptance decisions on this test were done sequentially. In stage 1, the floor examiner classified a patient as "acceptable" (i.e., satisfied the case qualification criteria) or not. If "acceptable" the candidate could begin the calculus detection and removal portions of the exam. If the floor examiner determined the patient was not acceptable, then a second examiner evaluated the patient and classified that patient as acceptable or not. If the second examiner said the patient was acceptable, the candidate was cleared for the next portion of the exam. If the second examiner said the patient was not acceptable, the candidate could offer another patient or repeat the exam on another occasion.

There were 17 candidates who were flagged for possible penalty point deductions related to Periodontics case acceptance. The floor examiner flagged two candidates for 30-point deductions, but neither deduction was corroborated by another examiner. The first examiner gave two candidates a 20-point penalty, but only one of those cases was corroborated by a second examiner. The first examiner flagged 13 cases for 5-point penalties, but only 9 of them were corroborated by a second examiner. Thus, all told, only 10 of the 17 candidates that were flagged (59%) actually received penalty point deductions.

On the Periodontics exam itself, two examiners arrived at the same overall pass/fail decision (based on the "paper grade") for about 89% of the candidates. However, because this exam's overall pass rate was so high, the 89% figure is only 2 percentage points greater than what would be expected to occur by chance (such as by simply passing 9 out of every 10 of the candidates they evaluated).

IV. Psychometric Properties of the DSE

The DSE has the following three sections: DOR (Diagnosis, Oral Medicine, and Radioloogy), CTP (Comprehensive Treatment Planning), and PPMC (Periodontics, Prosthosdontics, and Medical Considerations). Responses to the DSE are scored by computer. Examiner judgment is not required.

Table 8 provides summary data on each part of the DSE and the total score. The internal consistency (score reliability) estimates for the DSE were probably dampened by the restricted score range as indicated by the high mean and median scores. Ideally, reliability coefficients should be about 0.90 for this type of test.

Table 8
DSE Statistical Characteristics

Subtest	Number of Items	Mean percent correct	Standard Deviation	Internal Consistency
CTP	80	85.3	5.3	.511
DOR	100	85.5	6.4	.735
PPMC	100	85.7	5.4	.624
Total	280	85.5	4.8	.828

The moderate observed correlations among the three sections (see Table 9) support the policy of having a pass/fail rule for the DSE that allows for some but not total compensatory scoring; i.e., it is appropriate to assign penalty points if the score on one or two of its sections is especially low. The last column of Table 9 shows what the correlations among the sections are likely to be if they were all perfectly reliable (this is called a "correction for attenuation").

Table 9
Observed and Corrected Correlations Between DSE Subtests

Subtests	Observed Correlation	Corrected Correlation
CTP with DOR	.589	.961
CTP with PPMC	.524	.928
DOR with PPMC	.494	.729

We continue to recommend that ADEX monitor whether p-values (percent correct) on repeated items are climbing (which could occur if there was a breach in test security) and explore whether pass/fail decisions can be based on equated rather than raw scores.

STATISTICAL ANALYSIS OF THE 2012 DENTAL HYGIENE EXAM

Stephen Klein, Ph.D. and Roger Bolus, Ph.D.
October 24, 2012

This report provides summary results on ADEX's Clinical Hygiene Examination and on its Computer Simulated Clinical Examination (CSCE) for dental hygienists. Results are for the 2,124 candidates who took both tests for the first time between April and August 2012.

A total score of 75 or higher is needed for passing each test. The percent passing the clinical exam, the CSCE, and both tests on the first try were: 93.5, 93.1 and 87.2 percent, respectively.

Clinical Exam Scoring Rules

Table 1 shows the number of points candidates could receive on each part of the clinical exam. A candidate's score on a part is the median of the scores assigned by three independent examiners. The first two scores are for the "Pre-treatment" portion of the exam and the last three are for the "Post-treatment" portion. The total score is the sum of the five part scores minus any penalty points. Appendix A describes the point deductions that could be assigned.

Table 1
Possible Points In Each Section

Section	Number of judgments	Points per judgment	Total Points
Pocket Depth Measurement	12	1.5	18
Calculus Detection	12	3.0	36
Calculus Removal	12	3.0	36
Plaque/Stain Removal	6	1.0	6
Hard/Soft Tissue	2	2.0	4
Total			100

Table 2 shows the mean score and standard deviation on each part. A comparison of these means with the corresponding maximum possible scores indicates that most candidates had perfect or near perfect scores on each part. Nevertheless, the reliability (coefficient alpha) of the total score was 0.80, which is high given that (a) candidates may have had different examiners for the pre- and post-treatment sections and (b) there was a significant restriction in the range of scores assigned.

Table 2
Summary Test Statistics by Performance Test Section

Exam Section	Maximum Score	Mean Score	Standard Deviation	Score Reliability
Pocket Depth Measurement	18	17.54	1.15	.54
Calculus Detection	36	34.77	3.46	.77
Calculus Removal	36	32.94	4.75	.68
Plaque/Stain Removal	6	5.98	0.17	.26
Hard/Soft Tissue	4	3.89	0.31	.01
Total Score	100	93.90	10.50	.80

Penalty points were not included in these calculations. A candidate's final score on an item corresponded to the score that at least two of the three examiners assigned.

Effect of Penalties

Table 3 shows the number and percentage of candidates that lost points for the reasons noted in Appendix A, such as making a pocket depth qualification error. It also shows the number and percent that failed the exam because of these errors; i.e., these candidates would have passed were it not for the penalties they received. The policy of imposing only the largest applicable penalty (rather than the sum of all the separate ones assigned to the candidate) had no effect on the passing rate. No candidate received a deficient (def) score for hard or soft tissue and there were no pocket depth *measurement* penalties. The mean total clinical score before and after penalty points were awarded were 95.1 and 94.0, respectively.

Table 3
Percentage of Candidates Receiving Penalty Points

	All candidates		Candidates failing because of penalty	
Received penalty for:	N	Percent	N	Percent
Case Acceptance	54	2.5	1	0.0
Pocket Depth Qualification	16	0.8	1	0.0
Calculus Detection	59	2.8	8	0.4
Calculus Removal	76	3.6	72	3.4
Any section	205	9.7	82	3.9

Inter-Examiner Agreement

Each candidate's work on the Clinical Examination was evaluated by three independent examiners (i.e., the examiners made their judgments without consultation with each other or knowing the scores assigned by other examiners). Table 4 shows that despite the extreme restriction in range noted in Table 2, there was still an adequate overall correlation between examiners in the scores they assigned.[1]

Table 4
Mean Correlation Between Two Examiners on Each
Clinical Examination Section and Overall

Exam Section	Correlation
Pocket Depth Measurement	0.415
Calculus Detection	0.391
Calculus Removal	0.311
Plaque/Stain Removal	0.082
Hard/Soft Tissue	0.100
Total	0.330

Another way to look at examiner agreement is to see how often different examiners would make the same pass/fail decision about an applicant. This analysis (which did not consider penalty points) found that 86.3% of the applicants received a passing grade from all three examiners and 0.6% percent received a failing grade from all three. The total perfect agreement rate was therefore 86.9% (see Table 5). however, an 86.9% agreement rate is only 3.3 percentage points higher than the rate that would occur by chance alone.[5]

Table 5
Percent Agreement in Overall Pass/Fail Decisions Among
the First, Second, and Third Examiners

3/3 Agree Pass	2/3 Agree Pass	3/3 Agree Fail	2/3 Agree Fail	% All agree	% All Agree by Chance
86.3	10.6	0.6	2.5	86.9	83.6

[5] The chance rate is the product of the average of the three examiners' individual passing rates. Specifically, the first, second, and third examiners had passing rates of 93.8%, 94.4%, and 94.6%, respectively. The product of these three rates was 83.6%. Analyses were not conducted of the degree to which different examiners and Hygiene Coordinators would make the same decisions regarding case acceptance, the assignment of penalty points, or tooth selection for pocket depth measurements.

Comparison of Clinical and CSCE Statistics

Table 6 shows that 87.2% of the candidates passed both tests and 0.6% failed both for an overall agreement rate of 87.8%. However, given the marginal totals, this is very close to the agreement rate that would occur by chance.[6]

Table 6
Correspondence in the Percentage of Pass/Fail Decisions
Between the Clinical and CSCE Exams

	Fail Clinical	Pass Clinical	Total
Fail CSCE	0.6	6.3	6.9
Pass CSCE	5.9	87.2	93.1
Total	6.5	93.5	100.0

There was a very low correlation between CSCE and Clinical Examination scores (r = 0.104). If this correlation is corrected for the less than perfect reliability of the measures, it would still be only 0.133. In short, the degree of agreement in pass/fail decisions and scores between these two tests was not much higher than what would occur by chance alone.

Table 7 shows that the very low correlation between the Clinical and CSCE was **not** the result of their scores being unreliable. They both had adequate reliabilities (coefficient alphas) for making pass/fail decisions, especially given their high passing rates. Taken together, these findings support ADEX's use of a "conjunctive" rule (i.e., a rule that requires candidates to pass both tests in order to pass overall) rather than a "compensatory" rule (that would allow candidates to offset a low score on one test with a high score on the other).

Table 7
Summary Test Statistics for the Clinical and CSCE Exams

Test	Mean	Median	Standard Deviation	Reliability
Clinical	93.9	97.0	10.5	.80
CSCE	85.4	86.0	6.8	.77

Clinical scores are after penalty points were imposed.

[6] Data on repeaters were not analyzed for this report.

Appendix A
Clinical Exam Penalty Point And Disqualification Rules

Case Acceptance

There are five case acceptance criteria, the first four of which are initially evaluated by a single examiner and have 2 to 4 scoring levels. The fifth criterion, Pocket Depth Qualification, is evaluated by three examiners. The five criteria are:

- Required Forms (SAT, ACC, SUB, or DEF)
- Blood Pressure (SAT, ACC, or DEF)
- Radiographs (SAT, ACC, SUB, or DEF)
- Teeth Deposit Requirements (SAT or ACC)
- Pocket Depth Qualification

No penalty points are deducted if the first examiner assigns a SAT to all of the first four of these criteria. However, if the examiner assigns a non-SAT score to one or more of them, then a second examiner is called in to evaluate all four criteria. If the two examiners agree on a non-SAT call, then that call stands. The point deductions for a corroborated ACC, SUB, and DEF call are 5, 15, and 30, respectively.

If the two examiners disagree as to the seriousness of a problem, then the penalty for the *least* serious call is used. For instance, if the first and second examiners made calls of DEF and ACC for Blood Pressure, then the 5-point penalty for the ACC call stands.

Pocket Depth Qualification is evaluated by three independent examiners. Candidates select 3 teeth they believe satisfy the requirements. Three examiners independently make their calls as to whether these teeth are satisfactory. There is a 10-point deduction off the candidate's total score if two or three examiners agree that the teeth the candidate nominated do not satisfy the requirements; and 20 points are deducted if two or three examiners agree that two or three of the nominated teeth do not satisfy the requirements.

Penalty points do not accumulate across the five case acceptance criteria. Only the *largest* deduction for any of the five criteria is applied. For example, there is a total deduction of 20 points even if a candidate would otherwise lose 10 points for Blood Pressure, 5 points for Radiographs, and 20 points for Pocket Depth Qualification.

Other Point Deductions and Disqualifications

Candidates lose 3 points for each corroborated calculation detection or removal error, such as by saying a surface is calculus free when two or three examiners say it is not free of calculus. Candidates fail the exam if they make: (a) 4 or more corroborated calculus detection errors, (b) 4 or more corroborated calculus removal errors, or (c) a corroborated hard or soft tissue critical error. Candidates lose 1.5 points for each corroborated pocket depth measurement error and 1 point for each plaque and stain removal error.

Report of the 2013 General Assembly

Board of Dentistry

HB 1349 Dental hygiene and dental hygienist; definitions and licensure.

Chief patron: Bell, Richard P.

Summary as passed House:

Dental hygiene and dental hygienist; definitions and licensure. Defines "dental hygiene" as duties related to patient assessment and the rendering of educational, preventive, and therapeutic dental services specified in regulations of the Board and not otherwise restricted to the practice of dentistry. The bill defines "dental hygienist" as a person who is licensed by the Board of Dentistry to practice dental hygiene. The bill also clarifies the licensure requirement for a dental hygienist of graduation from a dental hygiene program accredited by the Commission on Dental Accreditation and offered by an accredited institution of higher education.

02/18/13 Senate: Read third time
02/18/13 Senate: Passed Senate (40-Y 0-N)
02/21/13 House: Enrolled
02/21/13 House: Bill text as passed House and Senate (HB1349ER)
02/21/13 House: Impact statement from DPB (HB1349ER)

HB 1422 Interchangeable biosimilar biological products; permits pharmacists to dispense, etc.

Chief patron: O'Bannon

Summary as passed:

Dispensing of interchangeable biosimilar biological products. Permits pharmacists to dispense a biosimilar that has been licensed by the U.S. Food and Drug Administration as interchangeable with a prescribed biological product unless the prescriber indicates such substitution is not authorized or the patient insists on dispensing of the prescribed biological product. The bill requires any pharmacist who dispenses an interchangeable biosimilar to inform the patient prior to dispensing the biosimilar, provide notification of the substitution to the prescriber, record the brand name or the product name and name of the manufacturer of the biosimilar on the record of dispensing and the prescription label, and provide retail cost information for both the prescribed biological product and the interchangeable biosimilar to the patient.

02/19/13 House: Placed on Calendar
02/19/13 House: Senate substitute agreed to by House 13105162D-S1 (91-Y 0-N)

02/19/13 House: VOTE: ADOPTION (91-Y 0-N)
02/21/13 House: Impact statement from DPB (HB1422S1)
02/22/13 House: Bill text as passed House and Senate (HB1422ER)

HB 1704 Prescription Monitoring Program; disclosure of information to local chief law enforcement officer.

Chief patron: Stolle

Summary as passed House:

Prescription Monitoring Program; disclosure of information to local law enforcement. Adds an agent designated by the chief law-enforcement officer of any county or city to the list of individuals to whom the Department of Health Professions must disclose information relevant to a specific investigation of a specific recipient, dispenser, or prescriber upon request, and provides that agents designated by the superintendent of the Department of State Police or the chief law-enforcement officer of a county or city to receive information relevant to a specific investigation of a specific recipient, dispenser, or prescriber shall have completed the Virginia State Police Drug Diversion School. The bill also provides that the Department may disclose information relating to prescriptions for covered substances issued by a specific prescriber to that prescriber.

02/14/13 House: Enrolled
02/14/13 House: Bill text as passed House and Senate (HB1704ER)
02/14/13 House: Impact statement from DPB (HB1704ER)
02/14/13 House: Signed by Speaker
02/14/13 Senate: Signed by President

HB 1791 Practitioners; suspension of license, etc., by health regulatory agency.

Chief patron: Garrett

Summary as introduced:

Suspension of license, registration, or certificate by a health regulatory agency; practice pending appeal. Prohibits a practitioner of the healing arts whose license, certificate, registration, or permit has been suspended or revoked by a health regulatory board from engaging in practice pending appeal of the board's order.

02/14/13 House: Enrolled
02/14/13 House: Bill text as passed House and Senate (HB1791ER)
02/14/13 House: Impact statement from DPB (HB1791ER)
02/14/13 House: Signed by Speaker
02/14/13 Senate: Signed by President

HB 2136 Methasterone and prostanozol; added to list of Schedule III controlled substances.

Chief patron: Hodges

Summary as introduced:
Adding methasterone and prostanozol to Schedule III. Adds methasterone and prostanozol to Schedule III.

02/18/13 Senate: Read third time
02/18/13 Senate: Passed Senate (40-Y 0-N)
02/21/13 House: Enrolled
02/21/13 House: Bill text as passed House and Senate (HB2136ER)
02/22/13 House: Impact statement from DPB (HB2136ER)

HB 2181 Medical equipment suppliers; delivery of sterile water and saline.

Chief patron: Hodges

Summary as introduced:
Medical equipment suppliers; delivery of sterile water and saline. Adds sterile water and saline to the list of prescription drugs and devices that a permitted medical equipment supplier may receive, store, and distribute to a consumer.

02/15/13 Senate: Constitutional reading dispensed (40-Y 0-N)
02/18/13 Senate: Read third time
02/18/13 Senate: Passed Senate (40-Y 0-N)
02/21/13 House: Enrolled
02/21/13 House: Bill text as passed House and Senate (HB2181ER)

HB 2312 Pharmacies; clarifies definition of compounding, etc.

Chief patron: Jones

Summary as introduced:
Compounding pharmacies. Clarifies the definition of "compounding" and adds a requirement for a current inspection report for registration or renewal of a registration for a nonresident pharmacy.

02/18/13 Senate: Passed Senate with amendment (40-Y 0-N)
02/19/13 House: Placed on Calendar
02/19/13 House: Senate amendment agreed to by House (93-Y 0-N)
02/19/13 House: VOTE: ADOPTION (93-Y 0-N)
02/22/13 House: Bill text as passed House and Senate (HB2312ER)

Agenda Item: Regulatory Actions - Chart of Regulatory Actions
(As of February 22, 2013)

Chapter	Action / Stage Information	
Regulations Governing Dental Practice [18 VAC 60 - 20]	Action:	Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30
	Stage:	Proposed - *At Secretary's Office for 277 days*
Regulations Governing Dental Practice [18 VAC 60 - 20]	Action:	Sedation and anesthesia permits for dentists
	Stage:	Proposed - *DPB Review in progress*

Agenda Item: **Regulatory Action – Correction of Code cite and term used in regulations**

Staff Note: Included in your package is a copy of:

Amendments to Section 220 to correct a Code cite and one word in subsection D

Action:

Motion to adopt amendments as presented in the agenda package as an action exempt from the Administrative Process Act process.

Project 3532 – exempt action

BOARD OF DENTISTRY

Correction of Code and term

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 ~~§ 54.1-3408~~ § 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 ~~dentist~~ 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.

Agenda Item: Response to Petition for Rulemaking

Included in your agenda package are:

A copy of the petition received from American Academy of Dental Hygiene with attached information

A copy of Section 50 of the regulations

Staff Note:

There was a comment period on the petition from December 31, 2012 to Janary 25, 2013. There were no comments on the petition.

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 by fast-track action

OR

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

COMMONWEALTH OF VIRGINIA
Board of Dentistry

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

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

Petition for Rule-making

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

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

Petitioner's full name (Last, First, Middle Initial, Suffix,) American Academy of Dental Hygiene		
Street Address 13 Hamilton Avenue	**Area Code and Telephone Number** 925-735-3238	
City Stamford	**State** CT	**Zip Code** 06902
Email Address (optional) kmenageb@aol.com **AADH Web Page:** www.aadh.org	**Fax (optional)** 925-735-3238	

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.

18VAC60-20-50. Requirements for continuing education.

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

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

Amend this section by adding "American Academy of Dental Hygiene" to the list of approved sponsors. The AADH is the only entity in dental hygiene that has developed Standards for Quality Continuing Education and maintains an international provider program. The AADH Standards have been included. The AADH approves such entities as the American Dental Hygienists' Association and their state/local societies.

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

To establish the qualifications for registration, certification, licensure or the issuance of a multistate licensure privilege in accordance with the applicable law which are necessary to ensure competence and integrity to engage the regulated professions.

Signature: Kristy Menageberne
AADH President Elect

Date: 2/7/12
11/26/12

6 PAGES SENT VIA FAX 2/7/12 804-527-4428 11/26/12

* PLEASE CONFIRM REC: Virg 11/26/12

AMERICAN ACADEMY OF DENTAL HYGIENE

Standards of Quality Continuing Education

The following Standards represent the minimum criteria to which AADH continuing dental education Provider/Sponsors adhere:

I. **Administration** - Administration of the program must be consistent with:
   a. Goals of the program.
   b. Objectives of the planned activities.
   c. Continued guidance of an administrative authority and/or individual responsible for its quality, content and ongoing conduct.
   d. Issuing continuing education certificates with current provider logo, provider number and specified verbiage.

II. **Fiscal Responsibility** - Resources shall be sufficient to meet:
   a. Goals of the program.
   b. Objectives of the planned activities.

III. **Goals**
   a. The Provider/Sponsor shall develop and operate in accordance with a written statement of its broad, long-range goals related to the continuing education program.
   b. Goals shall relate to the health care needs of the public and/or interests and needs of the profession as it relates to patient care.

IV. **Needs Assessment**
   a. Provider/Sponsors shall utilize identifiable mechanisms to determine objectively the current professional needs and interests of the intended audience, and the content of the program shall be based upon these needs.

V. **Continuing Education Course Content**
   a. Courses offered shall be a means of an orderly learning experience in the area of dental and medical health, preventive dental services, diagnosis and treatment planning, clinical procedures, basic health sciences, emerging sciences or dental practice administration, or the Dental Practice Act and other laws specifically related to dental practice which is designed to directly enhance the licensee's knowledge, skill or competence in the provision of service to patients or the community.
   b. The following subjects meet AADH course content guidelines:
      i. Courses based on current dental hygiene practice, research and patient care delivery.
      ii. Courses in preventive services, dental hygiene diagnosis/assessment, comprehensive treatment planning, implementation, and re-evaluation.
      iii. Courses dealing primarily with nutrition counseling of the patient.
      iv. Courses in dentistry's role in individual and community health emergencies and disasters.

VI. **Continuing Education Course Content - continued**

v. Courses that pertain to the legal requirement governing the licensee in the areas of auxiliary employment and delegation of responsibilities; the Health Insurance Portability and Accountability Act (HIPAA); actual delivery of care; and workplace, environmental and general safety.

vi. Courses addressing infection control practices.

vii. Courses addressing the evaluation, improvement and/or methods of correction for recall and scheduling systems.

viii. Courses addressing ergonomics, and the improvement of office operations for the patient's benefit and/or to improve the continuity of care provided to the patient.

ix. Courses addressing the implementation and/or mechanism of alternative delivery systems.

x. Courses addressing patient record keeping.

xi. Courses in skills such as communication, behavioral sciences, patient management and motivation when oriented specifically to the needs of the dental practice and will improve the health of the patient.

xii. Courses in other subjects of direct concern to dentistry such as dentolegal matters, including but not limited to risk management, liability, and malpractice, employment law and employment practices.

xiii. Courses in methods of health care delivery and sociopolitical problems directly involving dental hygiene.

b. The following course subjects are considered outside the scope of AADH guidelines:

i. Money management, the licensee's personal finances or personal business matters.

ii. General physical fitness or the licensee's personal health.

iii. Presentations by political or public figures or other persons that do not deal primarily with dental practice.

iv. Basic skills such as memory training and speed reading.

v. Courses designed to make the licensee a better business person.

vi. Courses in which the primary beneficiary is the licensee.

VII. **Objectives**

a. Specific written educational objectives or learning outcomes must be developed for each course and published.

b. Objectives must be measurable as evidenced by the course description.

VIII. **Admissions**

a. In general, continuing education activities shall be made available to all dental professionals, as appropriate.

b. If activities require previous training or preparation, the necessary level of knowledge, skill or experience shall be specified in course announcements.

IX. **Commercial Relationships**
   a. All commercial relationships must be fully disclosed to participants at the beginning of the program.
   b. Provider/Sponsor and instructor commercial relationships must be fully disclosed in all promotional materials and participant handouts.

X. **Educational Methods**
   a. Educational methods must be appropriate to the stated objectives for the activity.
   b. Where participation is involved, enrollment must be related to available resources to assure effective participation by enrollees.

XI. **Facilities** - Facilities selected for each activity must be appropriate to accomplishing:
   a. Educational method(s) being used
   b. Stated educational objectives

XII. **Patient Protection**
   a. Participants must be cautioned about the hazards of using limited knowledge when integrating new techniques into their practices.
   b. Where patient treatment is involved, either by course participants or instructors, patient protection must be assured as follows:
      i. Sponsor must seek assurance prior to the course, that participants have the basic skills, knowledge, and expertise necessary to assimilate instruction and perform the treatment techniques being taught in the course.
      ii. Informed consent form from the patient must be obtained in writing, prior to treatment.
      iii. Appropriate equipment and instruments must be available and in good working order.
      iv. Adequate and appropriate arrangements and/or facilities for emergency and postoperative care must exist.
      v. Liability insurance is recommended for all professional participants.

XIII. **Instructors**
   a. Instructors chosen to teach courses must be qualified by education and/or experience to provide instruction in the relevant subject matter.
      i. The number of instructors employed for a CE activity must be adequate to assure effective educational results.

XIV. **Publicity** - Publicity shall be informative and not misleading. It shall include:
   a. Course title
   b. Description of course content
   c. Educational objectives
   d. Description of teaching methods to be used
   e. Costs/Tuition
   f. Name of the sponsor and a contact person
   g. Course instructor(s) and their qualifications
   h. Refund and cancellation policies
   i. Date & Location

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j. Specifics as to the approvals granted and credits available.
k. The prior level of skill, knowledge, or experience required (or suggested) of participants shall be clearly specified in publicity materials, for effective presentation and assimilation of course content.
l. Current AADH Logo and provider number/verbiage must be used on all promotional material (electronic and hard copy.

XV. **Provider Approval** – Upon review of the AADH Course Approval Committee provider status will be conferred as follows:
   a. One year, renewable with full reporting for the following provider categories:
      i. National/International Association
      ii. State Association
      iii. Accredited Colleges, Universities, State Association Components/Societies and Study Clubs
      iv. Non-AADH Member/Individual
      v. AADH Member/Individual
   b. Two years, renewable with full reporting for Corporate Providers.

XVI. **Evaluation** - The Provider/Sponsor shall develop and utilize activity evaluation mechanisms that:
   a. Are appropriate to the objectives and educational methods.
   b. Measure the extent to which course objectives have been accomplished.
   c. Assess course content, instructor effectiveness, and overall administration.

XVII. **Course Records and Annual Reporting**
   a. Provider/Sponsors shall maintain permanent and accurate records of individual attendance and make such records accessible to attendees, if needed.
   b. Any record granted in connection with the continuing education activity may be a certificate however, must not be, nor resemble, a diploma.
   c. Provider must submit annual report at the end of the conferred year on the provided AADH renewal form and submitted via email to include:
      i. Date of renewal
      ii. Provider name
      iii. Provider address
      iv. Provider phone
      v. Provider contact name
      vi. Provider contact email
      vii. Name of courses provided as well as:
         a. Number of continuing education credits issued
         b. Speaker name and credentials
         c. Date of course
         d. Location, city, state
         e. AADH course code number

XVIII. **Complaints**

Formal written complaints about recognized CE providers will be considered by the AADH Course Approval Committee if the complaint documents substantial noncompliance with the AADH standards and criteria for recognition or established recognition policies. Complaints can be forwarded to the committee by course participants, course faculty, other AADH approved CE providers, constituent dental/hygiene societies, state boards of dentistry/hygiene and other interested parties. Upon receipt of such a formal complaint, the committee will initiate a formal review of the provider's recognition status. Any such reviews will be conducted in accord with the AADH Provider policy on complaints, in a manner that ensures due process.

A recognized provider may also be reevaluated at any time if information is received from the provider or other sources that indicates the provider has undergone changes in program administration or scope, or may no longer be in compliance with the AADH standards and criteria for recognition.

XIX. **Denied or Revocation AADH Provider Recognition**

a. Recognition will be denied or revoked if there is non-compliance with the AADH standards and criteria for recognition. If recognition is denied or revoked, the applicant provider will be provided with the following by certified mail:
    1. Identification of the specific standards and criteria with which the AADH Course Approval Committee found noncompliance.
    2. Requirements and recommendations for alterations and/or improvements in the provider's continuing dental education program.
    3. Rules and mechanisms governing resubmission of an application.
    4. Procedures for reconsideration.

b. Recognition will be revoked IMMEDIATELY by the AADH Governing Council for any of the following reasons:
    1. A voluntary request is received from the recognized provider.
    2. A finding of noncompliance with the AADH standards and criteria for recognition.
    3. The provider submits false and/or misleading information.
    4. The provider fails to submit documentation requested in writing in a timely manner.
    5. CE activities have not been offered for a period of two years or more.
    6. Required fees have not been paid.
    7. The provider does not use the AADH provider logo in accordance with these standards or falsifies the use of the logo in any manner.
    8. The provider does not follow these standards for logo use and provider verbiage on promotional material and continuing education certificates.
    9. The provider fails to submit an annual report of current contact information.

AADH CE PROVIDER COMPLAINTS POLICY

Potential complaints will be evaluated to ascertain that they pertain to AADH standards and criteria and/or recognition policies. A potential complainant will be asked to provide complete information and documentation about the alleged lack of compliance with the standards and criteria or recognition policies.

The AADH Course Approval Committee will consider appropriate complaints against AADH-recognized programs from course participants, faculty, other AADH recognized providers, constituent dental/hygiene societies, state boards of dentistry/dental hygiene and other interested parties. The AADH Course Approval Committee may initiate a complaint or inquiry about an AADH recognized provider. In this regard, an appropriate complaint is defined as one alleging that there exists a practice, condition or situation within the program of an AADH-recognized provider which indicates potential non-compliance with AADH standards and criteria or established recognition policies. The AADH Course Approval Committee will review documentation and determine the disposition of such complaints and make a recommendation to the AADH Governing Council for necessary action.

Attempts at resolution between the complainant and the provider should be documented prior to initiating a formal complaint. Only written, signed complaints will be considered by the AADH Course Approval Committee. The complaint will be considered at the earliest possible opportunity. When setting this date, the due process rights of both the provider and the complainant will be protected to the degree possible.

The following procedures have been established to review appropriate complaints:

1. The complaint will become a formally lodged complaint only when the complainant has submitted a written, signed statement of the program's non-compliance with a specific standard and/or recognition policy; the statement should be accompanied by documentation of the non-compliance whenever possible. The confidentiality of the complainant shall be protected, except as may be required by legal process.
2. The continuing dental education provider will be informed that the AADH has received information indicating that compliance with a specific standard or recognition policy has been questioned.
3. The provider will be required to provide documentation supporting its compliance with the standard or policy in question by a specific date (usually within 30 days). The AADH Course Approval Committee has the right to seek information from alternate sources including, but not limited to, surveys of program participants, on-site visits, observation of the provider's CE activities, or other means considered necessary to determine whether the CE provider is in compliance with the standards and criteria. Refusal or failure to provide all requested information, or to cooperate with the Committee's information-gathering efforts, will be considered cause for revocation of the provider's recognition status.
4. The provider's report and documentation, as well as any additional information obtained from other sources, will be considered by the AADH Course Approval Committee.
5. Following consideration, the AADH Course Approval Committee will take action, as follows:
    a. If the complaint is determined to be unsubstantiated and the provider is found to be in compliance with AADH standards and criteria or established recognition policies, the complainant and the provider will be notified accordingly and no further action will be taken.

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b. If the complaint is substantiated and it is determined that the CE provider is not in compliance with the standards and criteria or established recognition policies, the AADH Course Approval Committee may either request additional information or initiate action to revoke recognition by making a recommendation to the AADH Governing Council. The AADH Governing Council may:
   i. Postpone action until the next AADH Governing Council meeting pending the receipt of additional information through a comprehensive re-evaluation of the provider; a written report by the provider documenting progress in meeting the relevant standards or policies prior to the next regularly-scheduled meeting of the AADH Governing Council Meeting. The complainant and the provider may be represented by legal counsel. The costs to the complainant and the provider of such personal appearances and/or legal representation shall be borne by the complainant and the provider, respectively; or
   ii. Revocation the provider's recognition status upon vote by the AADH Governing Council.

6. The complainant and the provider will receive written notice of the AADH Governing Council Committee's action on the complaint within thirty (30) days following the AADH Governing Council meeting.
7. The records/files related to such complaints shall remain the property of the AADH Governing Council for five years and shall be kept confidential. After 5 years, the records will be destroyed.
8. Providers whose recognition status has been revoked may reapply the following January 1st plus 12 months.

AMERICAN ACADEMY OF DENTAL HYGIENE

CONTINUING EDUCATION

AADH is a respected organization responsible for accrediting continuing education courses for dental professionals. These standards have been accepted by various state licensing agencies for satisfying continuing education requirements. There are 48 states and the District of Columbia that require continuing education for re-registration, 30 states require advanced sponsor approval and the remaining request course approval by an agency.* Since 1985, the American Academy of Dental Hygiene, Inc. has fulfilled this process.

The American Academy of Dental Hygiene, Inc. (AADH) developed Standards for Continuing Education. Courses are evaluated relative to content, depth, accuracy and outcome. This process has been used to approve courses for continuing education credit and is modeled after the Academy of General Dentistry (AGD).

The AADH reviewed the courses for many professional organizations such as the International Federation of Dental Hygiene (IFDH) Symposium and the American Dental Hygienists' Association Annual Meeting and Center for Lifelong Learning. In addition, the annual RDH Under One Roof Meeting works with AADH for review and approval. There are numerous state and regional meetings that also have their courses evaluated and approved.

The process for individuals and agency approval is available.

An agreement with the Provider/Sponsors must be completed and reviewed before approval is granted and they are able to offer courses that the American Academy of Dental Hygiene has certified.

1. Click **HERE** to download a copy of our **Application for Continuing Education Provider/Sponsor.** (Fillable Word document).
2. Click **HERE** to download a copy of our **Standards of Quality Continuing Education.** (PDF format)
3. Click **HERE** to download a copy of our **Sample Letter of Attestation.** (Word format).
4. Click **HERE** to download a copy of our **Provider Brochure.** (PDF format).
5. Click **HERE** to download a copy of our **Approved Providers and States Accepting AADH Accredited Continuing Education Credits.** (PDF format).

All paperwork and fees should be submitted 8 -10 weeks prior to the event to allow enough time for review by the Course Approval Committee.

If you can not open any of the above PDF files, you will need to download and install a free version of Adobe® Reader®. This software will allow to easily and reliably view, print, and search PDF files using a variety of platforms and devices.

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For more information: info@aadh.org
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18VAC60-20-50. Requirements for continuing education.

A. A dentist or a dental hygienist shall be required to have completed a minimum of 15 hours of approved continuing education for each annual renewal of licensure. A dental assistant II shall be required to maintain current certification from the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association.

1. A dentist, a dental hygienist, or a dental assistant II shall be required to maintain evidence of successful completion of training in basic cardiopulmonary resuscitation.

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

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

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

1. Clinical courses in dental practice; or

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

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

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

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

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

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

5. American Medical Association and National Medical Association, their specialty organizations, constituent, and component/branch associations;

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

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

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

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

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

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

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic and Research Foundation;

14. The Dental Assisting National Board; or

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

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

E. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

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.

G. All licensees or registrants are required to maintain original documents verifying the date and subject of the program or activity. Documentation must be maintained for a period of four years following renewal.

H. A licensee who has allowed his license to lapse, or who has had his license suspended or revoked, must submit evidence of completion of continuing education equal to the requirements for the number of years in which his license has not been active, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months preceding an application for reinstatement. A dental assistant II who has allowed his registration to lapse or who has had his registration suspended or revoked must submit evidence of current certification from a credentialing organization recognized by the American Dental Association to reinstate his registration.

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

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

Disciplinary Board Report for March 8, 2013

Today's report reviews 2013 calendar year case activity then addresses the Board's disciplinary case actions for the first quarter of fiscal year 2013 which includes the dates of October 1, 2012, to December 31, 2012.

Calendar Year 2013

The table below includes all cases that have received Board action since January 1, 2013 through February 22, 2013.

Calendar 2013	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan. 2013	46	13	4	17
Feb. 22, 2013	9	3	2	5
Totals	**55**	**16**	**6**	**22**

Q2 FY 2013

For the second quarter, the Board received a total of 77 cases which included patient care cases. A total of 60 patient care cases were closed for a 78% clearance rate. The current pending caseload older than 250 days is 16%[1]. Of the 60 cases closed in the second quarter of 2013, 90%[2] (54 cases) were within 250 days. The Board did not meet the clearance rate goals for the Agency's Key Performance Measures for the second quarter of 2013, however, we have ensured that no more than 25% of all open patient care cases are older than 250 business days and have processed 90% of patient care cases within 250 work days.

For the month of December 2012, the Board received 28 cases and closed 42, mostly as a result of the "blitz" that we had on December 6, 2012.

Q3 FY 2013

The Board currently has a total of 342 open cases. One hundred fifty-five (155) cases are at probable cause. The Board has 34 cases with the Administrative Proceedings Division ("APD"), 126 cases are in enforcement, 21 cases are scheduled for informal conferences, and 4 for formal hearings. Of the 342 total cases, there are 256 patient care cases in the stages of probable cause, APD, enforcement, or pending a hearing.

Of the 155 total cases at probable cause, 108 are patient care cases. Of the 108, there are approximately 64 cases that are waiting review by Board Staff, approximately 14 cases are out with Board Members for review, 11 cases with additional information received pending Board Member review, approximately 3 cases have been returned by Board Members that are waiting for resolution by Board Staff, 15 cases are

[1] Up from 13% at the end of first quarter of FY 2013.
[2] At the end of first quarter FY 2013, this number was only 87%.

pending a hearing or have been offered a resolution document, 1 awaiting expert review. Fifty-two (52) cases are priority D cases which include advertising violations, business practice, records release, continuing competency requirements, or criminal activity.

License Suspensions

Between December 1, 2012 and February 22, 2013, the Board summarily suspended the license of one dental hygienist and one dentist. The Board also accepted consent orders for suspension of the license of two dentists. Furthermore, the Department of Health Professions mandatorily suspended the license of one dentist.

We hope to continue to receive the Board's cooperation with case reviews on dates when administrative hearings are scheduled until we no longer have a backlog of cases and ALL of our Key Performance Measures are met.

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*The Agency's Key Performance Measures.

- We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
- We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
- We will investigate and process 90% of patient care cases within 250 work days.

Virginia Board of Dentistry

Policy on Sanctioning for
Failure to Comply with Insurance and Billing Practices

Excerpts of Applicable Law, Regulation and Guidance

- The Board may sanction any licensee for any unprofessional conduct likely to defraud or to deceive the public or patients, §54.1-2706(4)
- The Board may sanction any licensee for intentional or negligent conduct in the practice of dentistry or dental hygiene which causes or is likely to cause injury to a patient or patients, §54.1-2706(5)
- The Board may sanction any licensee for conducting his practice in a manner contrary to the standards of ethics of dentistry or dental hygiene, §54.1-2706(10)
- Fraudulently obtaining, attempting to obtain or cooperating with others in obtaining payment for services, 18VAC60-20-170(1)
- Certifying completion of a dental procedure that has not actually been completed, 18VAC60-20-170(6)
- If a disciplinary proceeding will not be instituted, a board may send an Advisory Letter to the subject of a complaint or report, §54.1-2400.2(F)
- Confidential Consent Agreements ("CCA's") may be used to address minor or technical violations, Guidance Document 60-1

A. Guidelines for Sending an Advisory Letter

1. The reviewing Board member or staff (the "Reviewer") should only request an Advisory Letter when there is not clear and convincing evidence to support a finding that a violation of law or regulation has occurred.
2. Advisory letters may be used to close cases when the Reviewer is concerned that the presenting information indicates that the licensee may be acting in ignorance of the applicable law and regulations.

B. Guidelines for Offering a Confidential Consent Agreement

1. The Reviewer shall offer a CCA for a first offense where there is only one finding of probable cause for fraudulent insurance and/or billing practices.
2. In cases where there are findings of probable cause for violations in addition to a single first offense of fraudulent insurance/billing practice violation, the Reviewer may offer a CCA consistent with Guidance Document 60-1.
3. The offered CCA shall include a finding that a violation occurred, shall request that the license cease and desist the fraudulent insurance and/or billing practices, and shall require continuing education in recordkeeping.

C. Guidelines for Imposing Disciplinary Sanctions

1. The Reviewer may offer a Pre-Hearing Consent Order ("PHCO") or request an informal fact finding conference when probable cause is found that the licensee has prior insurance and/or billing practice violations.
2. The Reviewer may offer a PHCO or request an informal fact finding conference when probable cause is found that there were multiple patients affected by the licensee's fraudulent insurance and/or billing practice violations.
3. The Reviewer shall offer a PHCO or request an informal fact finding conference when probable cause is found that there were fraudulent insurance and/or billing practice violations.
4. The Reviewer shall consider the following sanctioning guidelines:
   a. A $1,000.00 monetary penalty per violation, and continuing education in recordkeeping and risk management for a second single offense of fraudulent insurance and/or billing practices; or a first offense where there were multiple patients affected by the fraudulent insurance and/or billing practices
   b. A $5,000.00 monetary penalty per violation, a reprimand and continuing education in ethics for a third offense of fraudulent insurance and/or billing practices.
5. In cases where there are findings of probable cause for violations in addition to fraudulent insurance and/or billing violations, the Reviewer may offer a PHCO or request an informal act finding conference.