VIRGINIA BOARD OF DENTISTRY

REVISED AGENDAS

March 12-13, 2015

Department of Health Professions

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

PAGE

March 13, 2015

Board Business

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

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

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DHP Director's Report – Dr. Brown

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- New Business

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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., December 9, 2014, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

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

MEMBERS PRESENT:
Sharon W. Barnes
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
John M. Alexander, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Tammy K. Swecker, R.D.H.

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

STAFF PRESENT:
Sandra K. Reen, Executive Director
Donna Lee, Discipline Case Manager
Tiffany Laney, Adjudication Specialist

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General
Corie Tillman Wolf, Assistant Attorney General

Darlene Nicoletti, D.D.S.
Case No.: 152378

The Board received information from Ms. Wolf regarding a Consent Order signed by Dr. Nicoletti for the resolution of her case in lieu of proceeding with the formal hearing.

DECISION: Dr. Gaskins moved that the Board accept the Consent Order pertaining to Dr. Nicoletti as presented. The motion was seconded and passed. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:26 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
December 11, 2014

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:08 a.m., on December 11, 2014 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Bruce S. Wyman, D.M.D., Secretary-Treasurer

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

MEMBERS EXCUSED:
Charles E. Gaskins, III, D.D.S.
Al Rizkalla, D.D.S.
Melanie C. Swain, R.D.H.

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

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
Wayne H. Halbleib, Sr., Assistant Attorney General
Shevaun Roukous, Adjudication Specialist
Andrea Pegram, Court Reporter, Court Reporting Services LLC.

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

Ismael El Khouly Castilla, D.D.S.
Case No.: 154322

Dr. Castilla was present without legal counsel in accordance with the Notice of the Board dated October 21, 2014.

Dr. Wyman swore in the witnesses.

Following Mr. Halbleib's opening statement, Dr. Wyman admitted into evidence Commonwealth's Exhibits 1 through 2.

Following Dr. Castilla's opening statement, Dr. Wyman admitted into evidence Respondent's Exhibits A through D.

Testifying on behalf of the Commonwealth was Kevin Almeida, DHP Senior Investigator.

Dr. Castilla testified on his own behalf.

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

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

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

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

Dr. Watkins moved to deny Dr. Castilla's application for licensure by credentials to practice in the Commonwealth of Virginia. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 11:05 p.m.

_____ _____

Bruce S. Wyman, D.M.D. Secretary-Treasurer Sandra K. Reen, Executive Director

_____ _____

Date Date

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES
December 12, 2014

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:02 a.m. on December 12, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

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

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

BOARD MEMBERS ABSENT: Sharon W. Barnes, Citizen Member

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

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

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

Ms. Swain welcomed Dr. Brown and guests to the meeting and thanked Board staff and Mr. Rutkowski for their work on behalf of the Board.

PUBLIC COMMENT: None.

APPROVAL OF MINUTES: Ms. Swain asked if there are any corrections to the minutes as listed on the agenda. She suggested changing the term "smart phones" on page 8 of the September 12, 2014 business meeting minutes to "personal electronic devices". All agreed. Dr. Watkins

moved to adopt the minutes in the agenda package as amended. The motion was seconded and passed.

DHP DIRECTOR'S REPORT:

Dr. Brown reported the following:

- The Governor issued Executive Order 29 establishing the Task Force on Prescription Drug and Heroin Abuse to advise him on measures that can be taken to address the misuse and abuse of these drugs. He noted that he and several DHP staff are participating in this initiative.
- It has recently come to his attention that dentists are not reporting when they dispense Schedule II-IV controlled substances as required by §54.1-2521 of the Code of Virginia. He said that dentists will be notified of this reporting requirement so they may come into compliance. Board members commented that dispensing is on the decline in dental practices; improper dispensing is an issue in cases; and, drug supply companies may be a good source of information on who is dispensing.
- He is meeting with members of the health regulatory boards to gain their perspective on the work of the boards and the department. He said Dr. Wyman met with him prior to the meeting and he encouraged other members to schedule a time to talk with him.

PRESCRIPTION MONITORING PROGRAM UPDATE:

Mr. Orr, PMP Director, reported the following:

- The results of the recent National Survey on Drug Use and Health indicates that 53% of Americans do not get rid of left over prescription drugs; and, in 2012, dentists were the number one prescribers of opioid analgesics for patients aged 10 to 19.
- The PMP operates a 24/7 database on the number of Schedule II-IV drugs prescribed or dispensed in Virginia and has more than 1000 dentists registered as users. He added that the database is interoperable within 17 states and that over 1.3 million requests were received in 2013. He said that effective July 1, 2015 it will be mandatory for all prescribers to register and that an email address must be provided. He added that dentists, who do not have DEA registrations, must provide a National Provider Identifier (NPI) and that dentists will be notified to register through the renewal notices to be sent in 2016 but that dentists can register now.

Discussion followed about:

- Educating dentists about using nonsteroidal anti-inflammatory drugs instead of narcotic.
- Hydrocodone being scheduled as a level II drug may add to the problem of leftover medicine because many long distance patients will receive larger prescriptions since prescribers no longer have the ability to phone in refills.
- Prescribers educating patients about the importance of disposing unused drugs. Unused prescription narcotics left in the medicine cabinet and used by other family members is one of the most common reasons for entrance into addiction.
- Emergency provisions for Schedule II drugs.

HWDC 2014 DENTISTRY & DENTAL HYGIENIST SURVEY RESULTS:

Mr. Crow of the Healthcare Workforce Data Center (HWDC) stated that the same data fields are addressed across the health professions to facilitate comparisons and that boards can add additional questions. He said that surveys are completed voluntarily by dentists and dental hygienists who renewed their licenses online. He provided the 2014 reports and highlighted the following:

- 77% of dentists (about 5500), and 84% of dental hygienists (about 4700) completed the surveys;
- 4589 dentists and 3078 dental hygienists reported working in Virginia;
- 40% of dentists and 64% of dental hygienist obtained their professional degree in Virginia; and
- The median age for dentists is 49 and for dental hygienists is 43.

Mr. Crow asked the Board for input or comments by the end of 2014 so the reports can be posted to DHP's website by the first week of January 2015. In response to questions, he said:

- The Board could, for example, add a question to the dental survey to get information on the number of dentists who dispense medications.
- The next survey results will be available in June or July 2015.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Watkins reviewed the powers and duties of BHP to address the budget, policies and activities of the Department of Health Professions. He said that, as a member of BHP, he could present questions and issues that may also affect the other health profession boards for discussion. It was

noted that a public hearing will be held in January 2015 on BHP's Dental Hygienist Scope of Practice Review.

AADB. Ms. Swain noted that she, Dr. Wyman, and Ms. Reen attended the annual meeting in October, 2014 and asked Dr. Wyman to comment on the meeting.
Dr. Wyman said the topics addressed were:

- The benefits of joining Dental Support Organizations and the voluntary Code of Ethics in place for these organizations.
- Corporate owned group dental practices and the Nevada Board of Dentistry's work with its "State Corporation Commission" to hold corporations accountable for practice requirements.
- The dentist's role in addressing sleep apnea.

ADEX. Dr. Rolon stated that the House of Representative meeting was great and that a standardized test for dental hygienists modeled after the SRTA exam will be administered next year.

Dr. Rizkalla stated that he attended the Dental Examination Subcommittee meeting where making the periodontal component mandatory was discussed but no action was taken. He said that ADEX advises everyone to take the periodontal component even if a state does not require it. He added that candidates are now allowed to have a second submission for the periodontal component but imposing a 21-point penalty for a second submission is being considered.

SRTA. There was no new information to report.

Regulatory-Legislative Committee. Dr. Wyman reviewed the topics discussed by the Committee on October 24, 2014 then made the following motions for action as advanced by the Committee:

- Dr. Wyman moved to establish a task force to look at the DA II requirements. The motion was seconded. During discussion of the motion, it was suggested that an open forum format be used instead of a task force and that the motion be expanded to include consideration of allowing dental hygienists to take continuing education classes to qualify to perform the duties delegable to DAsII, and consideration of expansion of remote supervision of dental hygienists to community clinics. Dr. Wyman amended his previous motion to hold an open forum and to include consideration of the practice of dental hygiene. The seconder agreed and the motion passed as amended.

- Dr. Wyman moved to authorize the Board's president to convene an open forum to address teledentistry. The motion was seconded and passed.

Dr. Gaskins moved to accept the Committee's report as presented. The motion was seconded and passed.

LEGISLATION AND REGULATIONS:

Status Report on Proposed Legislation. Dr. Brown reported that the Board's proposed legislation on fee-splitting was not approved by the Governor for submission to the 2015 General Assembly. In response to questions, he said he was not given a reason and that the Board has no recourse for this session. Dr. Brown indicated he just found out about this and would attempt to find the reason for the Governor's action.

Status Report on Regulatory Actions. Ms. Reen reported that the Periodic Review to reorganize Chapter 20 into four new chapters: 15, 21, 25 and 30, was approved by the Secretary of Health and Human Resources and is now at the Governor's office.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics.
VSOMS Letter on Obstructive Sleep Apnea – Gr. Gaskins moved to include this information in the materials for the open forum. The motion was seconded and passed.

AAO Letter on "Do It Yourself" Teeth Straightening – Dr. Gaskins stated that the Board has no authority over companies outside of VA. Ms. Swain said that the Board will take this as information only.

VDA Invitation for Dinner. Ms. Swain reported that the Board received an invitation for a dinner meeting with the VDA board of directors. After expressing her appreciation for the invitation, she stated that, based on advice of counsel, the Board has to decline. She asked Mr. Rutkowski to address his guidance. Mr. Rutkowski stated that when three or more Board members meet to discuss professional practice, all FOIA requirements apply. He added that holding a meeting with a particular association could raise anti-trust concerns and open the Board to collusion litigation.

AADB Letter about Membership. Dr. Wyman commented that he thought it was worthwhile to participate in the meetings for the discussion of issues, noting that the Board can attend without membership; he and Ms. Reen also recommended not to have the board hold membership in the AADB. Discussion followed about the voting structure and policies of AADB which led the Board to not

renew its membership several years ago. Dr. Gaskins moved that, until AADB changes its parliamentary procedures for adequate voting, the Board send members to the meetings but not join. The motion was seconded and passed.

LA Board Letter to ADEX. Dr. Rizkalla reported that ADEX maintains information on the number of failures for its exam and felt no action on its part is needed. Ms. Reen said this was discussed at the recent meeting of dental board administrators and there was general support for having a clearinghouse where all testing agencies reported results. She asked for the Board's guidance given that the Board accepts all exams and is now relying solely on the honesty of applicants to report all failures. She added that there is a regulation requiring dental applicants who fail any section of a clinical exam three times to complete a minimum of 14 hours of additional clinical training on that component in order to take the exam a fourth time. Dr. Rizkalla moved that the Board encourage the development of a centralized databank for clinical exam results. The motion was seconded and passed.

ADA Request for Comments on its Sedation & Anesthesia Guidelines. Dr. Rizkalla and Dr. Alexander said they had reviewed and are impressed with the Guidelines. Ms. Reen noted that it is an opportunity for the Board to address the Board's reliance on the Guidelines for issuing permits and its need for assistance with interpretations from time to time. Ms. Reen suggested that the Board authorize the President to review and approve comments drafted by Dr. Rizkalla, Dr. Alexander and Board staff. Dr. Rizkalla moved to accept Ms. Reen's suggestion. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported on the Board's disciplinary case statistics, noting that Q1 of FY2015, the Board received 70 cases and closed 79 cases for a 113% clearance rate; which is up from 62% in Q4 of FY2014, and 67% of the patient care cases were closed within 250 days, as compared to 63% in Q4 of FY2014. She pointed out that the Board is again moving in the right direction for the first quarter of 2015 and staff appreciates the hard work of the Board members.

PERMIT INSPECTION REPORT:

Ms. Palmatier said the Board has received about 15 inspection reports and staff is requesting guidance on how to address them. She added that the inspectors report that permit holders are cooperative and interested in learning. She said that in most cases only minor violations such as recordkeeping are identified. Ms. Reen asked if the Board would like to grant staff the authority to

send advisory letters when only minor violations are identified. She said this approach was used when audits of OMSs with cosmetic certification were commenced. Dr. Rizkalla moved to authorize staff to issue advisory letter for minor deficiencies. The motion was seconded by Dr. Watkins. Dr. Gaskins commented that missing equipment and drug violations are not minor. Dr. Rizkalla amended his motion to add that Dr. Alexander will serve as a consultant for staff to address questions about the seriousness of a finding. Dr. Watkins agreed to the amendment and the motion passed.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Review of Executive Order Number 2. Ms. Reen stated this order prohibiting the receipt of certain gifts applies to every Board member and asked for careful consideration of this policy.

Review of Guidance Document 60-20 on Radiation Certification. Ms. Reen said that the vacated guidance document on radiation certification and the proposed revision are presented for Board consideration and action. She noted that the vacated document was removed from Board's web page because it is outdated as a result of changes made to 18VAC60-20-195 of the Regulations Governing Dental Practice. She added that the proposed draft addresses the Board's prior decision to continue to recognize persons who qualified to take x-ray under previous regulatory provisions which were stricken in 2011. Dr. Wyman moved to accept the proposed draft as presented. The motion was seconded and passed.

Department of Medical Assistance Services (DMAS). Ms. Reen said she wanted to make the Board aware that as a result of Dr. Brown's leadership, she and Enforcement staff are working with DMAS to identify information that can be shared about health professionals, including dentists, whose participation in the Medicaid program has been terminated.

New Business. Dr. Gaskins noted that at the June 13, 2014 business meeting, the Board passed a resolution to send Dr. Brown a request that DHP expands its investigation capacity to include a forensic IT specialist(s). He moved to amend the previous motion to also send the resolution to the Board of Health Professions. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 11:30 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION – TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:16 p.m., on March 2, 2015, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Hearing Room 1, 9960 Mayland Drive, Henrico, VA 23233.

FIRST PRESENTATION: 5:16 p.m.

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

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

MEMBERS ABSENT: Melanie C. Swain, R.D.H.

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

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

OTHERS PRESENT: James E. Rutkowski, Assistant Attorney General

Stephen E. Burch, D.D.S.
Case No.: 149456

The Board received information from Ms. Palmatier regarding a Consent Order signed by Dr. Burch for the resolution of his case in lieu of proceeding with the informal conference.

Closed Meeting: Dr. Wyman 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 Stephen E. Burch. Additionally, Dr. Wyman moved that Ms. Reen, Ms. Palmatier, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Wyman 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. Wyman moved that the Board accept the Consent Order that was signed by Dr. Burch in lieu of proceeding with the informal conference. Following a second, a roll call vote was taken. The motion passed unanimously.
SECOND PRESENTATION:	5:26 p.m.
PRESIDING:	Charles E. Gaskins, III, D.D.S., Vice-President
MEMBERS PRESENT:	John M. Alexander, D.D.S. Sharon W. Barnes Surya P. Dhakar, D.D.S. A. Rizkalla, D.D.S. Evelyn M. Rolon, D.M.D. Tammy K. Swecker, R.D.H.
MEMBERS ABSENT:	Melanie C. Swain, R.D.H. James D. Watkins, D.D.S. Bruce S. Wyman, D.M.D.
QUORUM:	With seven members present, a quorum was established.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Executive Director Tiffany Laney, Adjudication Specialist Donna Lee, Discipline Case Manager
OTHERS PRESENT:	James E. Rutkowski, Assistant Attorney General
Timothy K. Johnston, D.D.S. Case Nos.: 142931, 157653, and 160021	The Board received information from Ms. Palmatier regarding a Consent Order signed by Dr. Johnston for the resolution of his cases in lieu of proceeding with the formal hearing.
DECISION:	Ms. Swecker moved that the Board accept the Consent Order that was signed by Dr. Johnston in lieu of proceeding with the formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.
ADJOURNMENT:	With all business concluded, the Board adjourned at 5:31 p.m.

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

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 5:31 p.m., on March 2, 2015, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Hearing Room 1, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Bruce S. Wyman, D.M.D., Secretary-Treasurer

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

MEMBERS ABSENT:
John M. Alexander, D.D.S.
Charles E. Gaskins, III, D.D.S.
Melanie C. Swain, R.D.H.

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

STAFF PRESENT:
Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
LaTonya D. Hucks, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT: James E. Rutkowski, Assistant Attorney General

Tasha N. Willoughby, D.D.S. Case No.: 150815 The Board received information from Ms. Palmatier regarding a Consent Order signed by Dr. Willoughby for the resolution of her case in lieu of proceeding with the formal hearing.

DECISION: Ms. Swecker moved that the Board accept the Consent Order that was signed by Dr. Willoughby in lieu of proceeding with the formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:37 p.m.

_____
Bruce S. Wyman, D.M.D., Chair

_____
Sandra K. Reen, Executive Director

_____
Date

_____
Date

Department of Health Professions

Board of Dentistry

Budget Development Process

&

Financial Data Review

March 13, 2015

Department of Health Professions

Budget Development

DHP employs an internal and external budget development process for budget expenditures. The internal budget process is used by department managers to analyze their department needs through a formal process to determine if the current budget resources are adequate. Based on this analysis, departments can maintain the status quo or request supplemental funding. The internal process starts with approval of the budget calendar by the Agency Director. The budget calendar sets milestones for delivery of financial and program information critical for completion of the agency's internal budget.

Department managers are provided a budget package that includes instructions and forms necessary to complete their department's budget. Included in the instructions is a base budget used as the funding foundation for budget development. The base budget is a previous fiscal year spending for a select group of accounts. Base budget funding represents approximately 14% of departments' operating budget. Unless otherwise noted departments' staffing remains the same. The remaining 86% of the base budget is calculated by the Budget Manager.

If a department manager deems their department's base budget funding (including personnel) is not adequate, they can request supplemental funding. Supplemental funding requests require justification and supporting documents in order to be considered.

After the submission of department's base budgets and supplemental requests they are summarized and presented to the Agency Director for critique. Meetings are scheduled with department managers to discuss their submission.

Once the agency's internal budget is finalized the Agency Director must determine if the external phrase of the budget process is necessary. The external phrase involves submitting budget requests (known as "Decision Packages") that

extent the agency's legal authority, increase a current service, increase appropriation, and\or increase maximum employment level (MEL) to the Office of Secretary of Health and Human Resources for review and potential approval. If approved, decision packages are entered into the Department of Planning and Budget's performance budgeting system to be considered for submission into the Governor's budget.

Lastly, DHP is a non-general fund agency. The agency's revenue is generated by issuing licensees and not tax dollars (general fund). Eighty-three percent of the agency's revenue is budgeted based on number of renewals forecasted for a given fiscal year. The remaining revenue (17%) is budgeted based on historical data.

Virginia Department of Planning and Budget
Decision Package Narrative Justification (Form NJ)

Section 1: Summary Information

1. Agency name: Department of Health Professions **2. Agency code:** 223

3. Amendment number: 351 **4. Title:** Regulation of Medication Aides

5. Priority of this amendment: 1

6. Summary of costs and positions

	GF Dollars	NGF Dollars	Personal Services Costs	Nonpersonal Services Costs	GF Positions	NGF Positions
FY 2007	0	0	0	0	0	
FY 2008	0	$153,550	$147,522	$6,028	0	3.0 FTEs
FY 2009	0	$153,550	$147,522	$6,028	0	3.0 FTEs
FY 2010	0	$153,550	$147,522	$6,028	0	3.0 FTEs
FY 2011	0	$153,550	$147,522	$6,028	0	3.0 FTEs
FY 2012	0	$153,550	$147,522	$6,028	0	3.0 FTEs

7. Summary of nongeneral fund sources. (For nongeneral fund amounts only, complete the table below):

Revenue Source Code	Fund/ Fund Detail Code	Fund/Fund Detail Title	FY 2007 amount	FY 2008 Amount
2406	0900	Dedicated Special	0	$153,550

(Insert additional rows as needed)

Explanation of / comments on nongeneral fund sources:
Funds generated by the Board of Nursing renewal fees.

8. Description (Including discussion on need for request and explanation on how this request is inherently governmental):

Pursuant to Chapters 610 and 924, 2005 Acts of Assembly, the Board of Nursing, a health regulatory board within the Department of Health Professions, is mandated to promulgate regulations for the registration of medication aides who administer drugs to residents of assisted living facilities. The regulations are required by statute to be in effect by July 1, 2007. Additional appropriations and FTEs are necessary to enable DHP to complete implementation of the program. All funding would be derived from fees charged to licensees by the Board of Nursing.

Section 2: Expected Outcomes (this section optional for technical adjustments)

9. Consequences of not funding:

Failure to fund this amendment would put the Department of Health Professions in the position of not being able to comply with state law. It should be noted that 100% of the funding for this effort will come from fees charged to licensees regulated by the Board of Nursing.

10. Alternatives considered:

There are no other alternatives.

11. What are the expected results to be achieved if this request is funded?

The number of medication aides currently employed in assisted living facilities is unknown. However, the Virginia Geriatric Education Center does conduct a medication administration training program that has been approved by the Board of Nursing. The Center reports that 33,157 persons have been through this program and it is assumed that a similar number would be registered as medication aides. Therefore, it is anticipated that the medication aide registry would be comparable in size and scope to the nurse aide registry (approximately 40,000 nurse aides) that already exists under the Board of Nursing. Regulation of this profession, as with all other professions within DHP, would provide a much needed measure of safety to consumers of health care, particularly those in assisted living facilities, by ensuring that all medication aides meet minimum training and credentialing requirements established by the Board of Nursing.

12. Does the request impact existing service area objectives, measures and/or targets [X] YES [ ] NO

If yes, complete the following table:

Objective(s)	Target(s)	Measure(s)
#1.1 To promptly process applications for initial licensure and, where necessary, conduct examinations and deny eligibility, for all individuals and entities who seek to provide services.	Maintain a quarterly rolling average of 4,941 through FY 2007-08	#1.1.1 Number of applications processed for health regulatory boards
#2.1 To detect, evaluate, and investigate allegations of misconduct.	1,270 cases by the last quarter of FY 2008	#2.1.1 Number of allegations that are detected, investigated, and reported to health regulatory boards
#2.2 To adjudicate and impose appropriate findings and conclusions and impose sanctions when there is sufficient evidence that practitioners have engaged in conduct which violates law or regulation governing their practice.	1,459 cases by FY 2008	#2.2.2 Number of cases in which a written agreement or order is entered imposing a public finding.
#3.1 To provide information to practitioners, clients and patients to promote access to and compliance by providers.	3,400,000 visits by FY 2008	#3.1.1 Number of visits to DHP's web sites

(Insert additional rows as needed)

Explanation of / comments on objectives, measures, and targets:

As noted above, implementation of the medication aides regulations may add as many as 40,000 licensees to the number of health care providers regulated by the Department of Health Professions. Under Title 54.1 of *Code of Virginia*, DHP is also responsible for investigating and adjudicating complaints against health care providers. Therefore, the addition of medication aides affects not only the licensing staff of the Board of Nursing, also affected will be the case intake and investigative staff of the Enforcement division and the legal staff of the Administrative Proceedings division.

13. **Does the request create new objective(s) and/or new measure(s** ☐ YES ☒ NO

If yes, list the new objective(s) and associated measure(s) in the following table:

Objective(s)	New Objective?	New Measure(s)

(Insert additional rows as needed)

Explanation of / comments on objectives and measures:

Section 3: Detailed Cost Information (this section optional for technical adjustments)

14. **Does the request contain one-time funding?** ☐ YES ☒ NO

Explanation of one-time funding:

15. **Does the request contain recurring funding?** ☒ YES ☐ NO

Explanation of recurring funding:
Implementation of the medication aides regulation will necessitate the creation of a permanent organizational subunit within the Board of Nursing.

16. **Does the request contain funding for the cost of new positions?** ☒ YES ☐ NO

If yes, complete a copy of Form NP (Excel file) and include it with your submission. Enter the totals from the Form NP file in the table below. (Make sure the attached Form NP file is named with your agency code and the amendment number for this request.)

New Positions Request (See Form NP For Details)	GF Dollars	NGF Dollars	GF Positions	NGF Positions
FY 2007	0		0	0
FY 2008	0	$147,522	0	3.0 FTE

Explanation of and methodology used in request for new positions:
It is assumed that the medication aide program will be comparable in size and scope to that already in existence for Certified Nurse Aides (CNA). The positions requested in this amendment are support positions necessary for education, licensing and disciplinary functions patterned after staff required for the CNA program.

17. **Does the request contain funding for personal services costs other than new positions? (example; added wage employees or a job class regrade)** ☐ YES ☒ NO

If yes, complete the following table:

Other Personal Services Items	FY 2007GF	FY 2007NGF	FY 2008 GF	FY 2008NGF

(Insert additional rows as needed)

Explanation of and methodology used in other personal services costs request:

18. **Does the request contain funding for nonpersonal services?** [X] YES [ ] NO

If yes, complete the following table:

	FY 2007GF	FY 2007NGF	FY 2008 GF	FY 2008NGF
Contractual Services				$2,000
Supplies & Materials				$500
Transfer Payments				
Continuous Charges				
Property & Improvements				
Equipment				$3,528
Plant & Equipment				
Obligations				

Explanation of and methodology used in nonpersonal services request:
Three personal computers cost based on VITA's MOU. Other costs are copy services and office supplies.

Section 4: Other Information and Requirements (this section optional for technical adjustments)

19. **Are the proposed services mandated?** [X] YES [ ] NO

Explanation of mandate:
Chapters 610 and 924, 2005 Acts of Assembly, mandate the Board of Nursing to promulgate regulations for the registration of medication aides who administer drugs to residents of assisted living facilities.

20. **Will new legislation be required as a result of this request?** [ ] YES [X] NO

Explanation of required legislation:

21. **Is Appropriation Act language required as part of this request?** [ ] YES [X] NO

Explanation of required Appropriation Act language:

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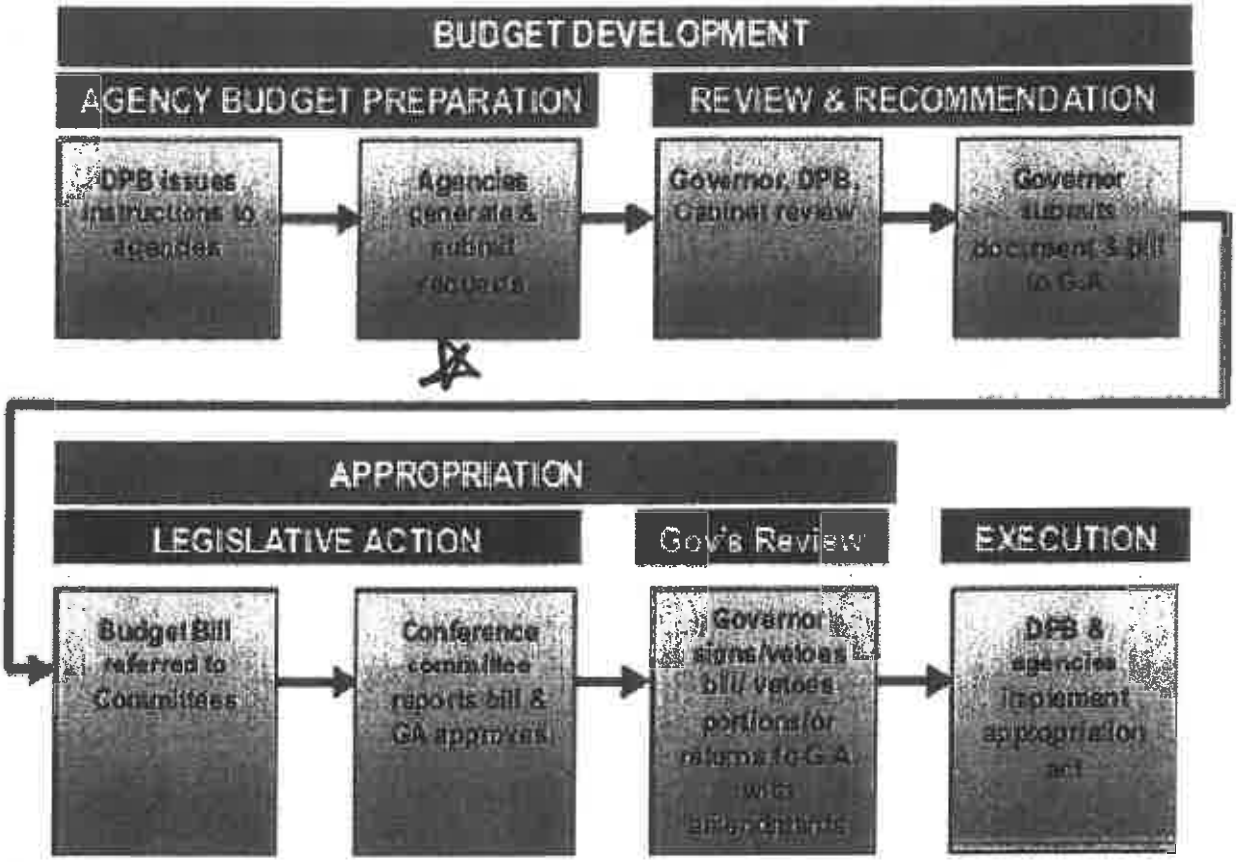
Commonwealth of Virginia

Budget Development



DHP
FY15 Budget Revenue and Expenditures Summary
Major Categories and Percentages

Revenue			
License & Renewal Fee	25,604,229	83.3%	
Application Fee	3,225,334	10.5%	
Board Endorsement In\Out	677,450	2.2%	
Certified Nurse Aide Reimbursement	560,273	1.8%	
Monetary Penalty & Late Fees	412,715	1.3%	
Other	167,925	0.5%	
Interest	95,000	0.3%	
Total	30,742,926	100.0%	
Expenditures			
Salaries & Wages	14,269,878	46.3%	(a)
Employee Benefits	5,424,582	17.6%	(a)
Virginia Information Technologies Agency (VITA) Charges	2,076,841	6.7%	
Impaired Practitioners Monitoring Fees	1,822,886	5.9%	(a)
Building Lease	1,321,910	4.3%	(a)
Computer Technical Services	1,132,623	3.7%	
Contractual Services	1,073,305	3.5%	
Clerical Services (Temps)	782,418	2.5%	
Attorney General Fee	754,521	2.4%	(a)
Credit Card Fees	499,980	1.6%	(a)
Telecommication Serivces	427,130	1.4%	
Transportation Services *(Travel Reimbursement & State Cars)*	383,039	1.2%	
Postal Services	315,547	1.0%	
Supplies And Materials	239,926	0.8%	
Equipment Leases	89,568	0.3%	
Insurance	81,493	0.3%	(a)
Nurse Scholarship	65,000	0.2%	(a)
Cash Transfers	47,200	0.2%	(a)
Office Equipment	29,435	0.1%	
	30,837,282	100.0%	

(a) primarily developed by Budget Manager ($24.3M, or 79%)

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Virginia Department of Health Professions
Departments' Direct Revenue and Expenditures Summary
FY15

Direct Revenue	Annual Budget	
101- Nursing	10,894,620	
102- Medicine	6,873,504	
103- Dentistry	2,654,769	
104- Funeral Directors and Embalmers	520,760	
105- Optometry	335,760	
106- Veterinary Medicine	1,032,755	
107- Pharmacy	2,863,790	
108- Psychology	492,200	
109- Counseling	710,655	
110- Social Work	740,240	
112- Certified Nurse Aides	1,678,912	
114- Long-Term Care Administrators	384,450	
115- Audiology and Speech Language Pathology	318,390	
116- Physical Therapy	1,147,120	
117- Prescription Monitoring	95,000	
Total Revenue	30,742,925	
Direct Expenditures		
101- Nursing	3,913,754	
102- Medicine	2,780,463	
103- Dentistry	882,726	
104- Funeral Directors and Embalmers	174,635	
105- Optometry	99,108	
106- Veterinary Medicine	188,197	
107- Pharmacy	1,216,234	
108- Psychology	116,478	
109- Counseling	251,775	
110- Social Work	187,944	
112- Certified Nurse Aides	422,819	
114- Long-Term Care Administrators	159,004	
115- Audiology and Speech Language Pathology	114,462	
116- Physical Therapy	210,928	
117- Prescription Monitoring	981,938	
201- Behavioral Science Exec	371,414	(b)
202- Opt\Vet-Med\ASLP Exec Dir	138,332	(b)
204- Nursing / Nurse Aide	105,441	(b)
206- Funeral\LTCA\PT	283,768	(b)
301- Data Center	4,553,301	(b)
302- Human Resources	430,132	(b)
303- Finance	1,382,072	(b)
304- Directors Office	838,961	(b)
305- Enforcement	7,151,067	(b)
306- Administrative Proceedings	1,907,088	(b)
307- Impaired Practitioners	101,530	(b)
308- Attorney General	754,521	(b)
309- Broad of Health Professions	463,297	(b)
310- SRTA	4,229	(b)
311- Maintenance & Repairs	13,937	(b)
313- Employee Recognition Program	11,861	(b)
314- Conference Center	7,328	(b)
315- Program Development and Implementation	486,952	(b)
317- Miscellaneous Grants	19,386	
Nurse Scholarship (Cash Transfer)	65,000	
Cash Transfers	47,200	(b)
Total	30,837,282	

(b) departments allocated to boards

DHP
Cost Allocation Methods by Department

Departments	Cost Allocation Methodologies
201 Behavioral Science Executive Director	Based on the Executive Director estimates of time spent on each board.
202 Optometry\Vet-Med\ALSP	Based on the Executive Director estimates of time spent on each board.
204 Nursing / Nurse Aide	Allocation to the boards of Nursing and CNA-State based on the number of disciplinary cases.
206 Funeral\Long-Term Care Administrators\PT	Based on the Executive Director estimates of time spent on each board.
Data Center	Number of personal computers by board plus PCs of Enforcement and APD based on their monthly hours to each board.
Human Resources	Percentage of salaries and wages by board (includes 200 level cost centers).
Finance	Weighted average of salaries and wages (40%) and number of licensees (60%).
Directors Office	Weighted average of salaries and wages (40%) and number of licensees (60%).
Enforcement	Percentage of current month and the proceeding two months hours worked on each board.
Administrative Proceedings	Percentage of current month hours worked on each board.
Impaired Practitioners (HPMP)	Number of participates receiving monitoring services by board.
Attorney General	Prior fiscal year hours by board.
Board of Health Professions	Weighted average of salaries and wages (40%) and number of licensees (60%).
Maintenance and Repairs	Square Feet
Employee Recognition Program	Percentage of salaries and wages by board (includes 200 level cost centers).
Conference Center	Square Feet
Program Development and Implementation	Weighted average of salaries and wages (40%) and number of licensees (60%).
Cash Transfer	Percentage of salaries and wages by board (includes 200 level cost centers).

DHP
Enforcement Budget and Actual Cost Allocation
FY14 Data

Enforcement Budget	6,819,855
Budgeted percentage of Enforcement budget to the Board of Medicine	23.77%
Enforcement allocation budget for BOM	1,621,319
Actual Enforcement expenditures	6,611,507
Actual BOM allocation percentage	26.12%
Actual allocation amount	1,726,926
Difference	105,607

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Virgina Department of Health Professions
Cash Balance
As of December 31, 2014

	103- Dentistry
Board Cash Balance as of June 30, 2014	$ 2,904,386
YTD FY15 Revenue	245,885
Less: YTD FY15 Direct and In-Direct Expenditures	1,191,545
Board Cash Balance as of December 31, 2014	1,958,726

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Virginia Department of Health Professions
Revenue Report
July 1, 2014 through December 31, 2014

Board of Dentistry	Revenue Operating Budget	Jul 14	Aug 14	Sep 14	Oct 14	Nov-14	Dec-14	TOTAL	(Over) Under Revenue Operating Budget	% of Budget Remaining
Revenue										
2400 · Fee Revenue										
2401 · Application Fee	158,640.00	25,585.00	17,165.00	12,995.00	17,025.00	12,400.00	15,025.00	85,170.00	73,470.00	46.3%
2406 · License & Renewal Fee	2,331,369.00	1,510.00	2,015.00	1,580.00	760.00	33,310.00	14,345.00	39,175.00	2,292,194.00	98.3%
2407 · Dup. License Certificate Fee	4,040.00	580.00	640.00	640.00	360.00	220.00	660.00	2,440.00	1,600.00	39.6%
2408 · Board Endorsement - In	33,750.00	1,925.00	1,650.00	275.00	1,100.00	825.00	275.00	5,775.00	27,975.00	82.9%
2409 · Board Endorsement - Out	8,400.00	2,345.00	2,170.00	1,995.00	2,135.00	1,400.00	1,610.00	10,045.00	-1,645.00	-19.6%
2421 · Monetary Penalty & Late Fees	3,500.00	175.00	275.00	315.00	125.00	125.00	125.00	1,015.00	2,485.00	71.0%
2432 · Misc. Fee (Bad Check Fee)	70.00	0.00	0.00	35.00			-	35.00	35.00	50.0%
2680 · Administrative Fees	115,000.00	14,840.25	4,116.00	13,781.00	15,129.25	14,326.00	6,662.75	62,192.50	52,807.50	45.9%
3020 · Misc. Sales-Dishonored Payments		0.00	0.00	285.00				285.00	-285.00	
9060 · Miscellaneous Revenue		0.00	0.00	350.00		350.00	350	700.00	-700.00	
Total Revenue	2,654,769.00	46,960.25	28,031.00	32,251.00	36,634.25	62,956.00	39,052.75	245,885.25	2,408,883.75	90.7%

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Commonwealth of Virginia

Budget to Actual-Department by Account

Report ID: RGL0615
Layout ID: VGLR0615
Scope: VGLR0615
Period Ending: June 30, 2015
Business Unit: 22300 Dept of Health Professions
Department: 10300 BOARD OF DENTISTRY

Account	Description	Operational Budget	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Current Year Expenditures	(Over) Under Operational Budget	% of Budget Remaining
5011110	Employer Retire Contrb-Def Ben	48,273.00	4,776.30	3,524.34	3,933.70	3,933.70	3,933.70	3,933.70	24,035.44	24,237.56	0.50
5011120	Salary Social Security&Medicare	29,951.00	3,119.19	2,077.18	2,328.06	2,328.05	2,328.03	2,328.06	14,508.57	15,442.43	0.52
5011130	Wage Social Security&Medicare	5,294.00	274.48	249.88	229.28	216.21	285.05	172.41	1,407.31	3,886.69	0.73
5011140	Group Life Insurance	5,168.00	510.21	340.14	383.14	383.14	383.14	383.14	2,382.91	2,785.09	0.54
5011150	Employer Health Ins Premium	85,764.00	8,491.50	5,757.00	7,147.00	7,147.00	7,147.00	7,147.00	42,836.50	42,927.50	0.50
5011160	Retiree Health Ins Cr Premium	4,581.00	443.07	300.14	338.08	338.08	338.08	338.08	2,095.53	2,485.47	0.54
5011170	VSDB & Longterm Disability Ins	2,858.00	255.81	168.84	212.48	212.48	212.48	212.46	1,294.37	1,563.63	0.55
5011230	Salaries, Classified	391,503.00	42,875.37	26,583.58	32,196.72	32,196.72	32,196.72	32,196.72	200,245.83	191,257.17	0.49
5011250	Salaries, Overtime	214.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	214.00	1.00
5011380	Deferred Comp Match Payments	3,360.00	290.00	200.00	160.00	160.00	130.00	130.00	1,070.00	2,290.00	0.68
5011410	Wages, General	69,152.00	3,568.02	3,266.40	2,997.24	2,826.16	3,464.84	2,253.63	18,396.29	50,755.71	0.73
5011620	Salaries, Annual Leave Balance							0.00	0.00		
5011660	DefContMatch-VRS HybridRetPlan	0.00	0.00	0.00	36.14	36.14	36.14	36.14	144.56	(144.56)	0.00
5012110	Express Services	622.00	0.00	90.78	75.17	117.96	0.00	90.06	373.97	248.03	0.40
5012120	Outbound Freight Services	75.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	75.00	1.00
5012130	Messenger Services	0.00	0.00	0.00	0.00	0.00	0.00	41.66	41.66	(41.66)	0.00
5012140	Postal Services	14,000.00	871.36	1,571.05	602.83	156.18	1,356.50	397.68	4,955.60	9,044.40	0.65
5012150	Printing Services	425.00	0.00	0.00	0.00	403.30	0.00	0.00	403.30	21.70	0.05
5012160	Telecom Services (VITA)	3,800.00	231.91	0.00	519.15	259.56	242.39	236.12	1,489.13	2,310.87	0.61
5012170	Telecom Services (Non-State)	0.00	67.50	45.00	45.00	45.00	45.00	45.00	292.50	(292.50)	0.00
5012190	Inbound Freight Services	0.00	0.00	3.00	0.00	9.75	0.00	0.00	12.75	(12.75)	0.00
5012210	Organization Memberships	5,600.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5,600.00	1.00
5012240	Employee Training/Workshop/Conf	2,000.00	0.00	0.00	650.00	0.00	0.00	1,170.00	1,820.00	180.00	0.09
5012270	Employee Training Travel	2,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2,000.00	1.00
5012360	X-Ray & Laboratory Services	126.00	0.00	0.00	113.04	0.00	0.00	22.00	135.04	(9.04)	-0.07
5012420	Fiscal Services	40,820.00	221.20	19.57	8.42	0.00	28.19	8.06	285.44	40,534.56	0.99
5012440	Management Services	475.00	36.49	0.00	0.00	278.46	0.00	36.63	351.58	123.42	0.26
5012470	Legal Services	1,040.00	250.00	0.00	0.00	0.00	150.00	0.00	400.00	640.00	0.62
5012510	Custodial Services	0.00	0.00	40.68	33.88	16.94	0.00	66.84	158.34	(158.34)	0.00
5012530	Equipment Repair & Maint Srvc	0.00	0.00	0.00	125.00	0.00	0.00	0.00	125.00	(125.00)	0.00
5012630	Clerical Services	0.00	0.00	1,200.00	0.00	0.00	0.00	0.00	1,200.00	(1,200.00)	0.00
5012640	Food & Dietary Services	2,100.00	0.00	362.96	118.73	764.26	0.00	309.32	1,555.27	544.73	0.26
5012660	Manual Labor Services	3,500.00	147.77	275.64	412.67	0.00	442.49	319.45	1,598.02	1,901.98	0.54
5012670	Production Services	14,130.00	1,420.00	2,477.45	2,992.35	1,366.66	3,178.28	0.00	11,434.74	2,695.26	0.19
5012680	Skilled Services	64,314.00	4,425.12	6,075.12	4,179.28	6,352.19	3,441.76	7,170.12	31,643.59	32,670.41	0.51
5012820	Travel, Personal Vehicle	7,600.00	1,177.11	13.72	677.27	26.32	1,399.00	992.26	4,285.68	3,314.32	0.44
5012830	Travel, Public Carriers	1,500.00	0.00	725.40	354.20	0.00	353.50	1,759.69	3,192.79	(1,692.79)	-1.13
5012850	Travel, Subsistence & Lodging	7,400.00	858.28	0.00	564.24	20.00	488.42	1,584.87	3,315.81	4,084.19	0.55

Commonwealth of Virginia

Budget to Actual-Department by Account

Report ID: RGL0615
Layout ID: VGLR0615
Scope: VGLR0615
Period Ending: June 30, 2015
Business Unit: 22300 Dept of Health Professions
Department: 10300 BOARD OF DENTISTRY

Account	Description	Operational Budget	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Current Year Expenditures	(Over) Under Operational Budget	% of Budget Remaining
5012880	Travel, Meal Reimb-Not Rpt Irs	3,600.00	358.75	0.00	501.33	0.00	452.00	656.00	1,968.08	1,631.92	0.45
5013110	Apparel Supplies	0.00	0.00	0.00	0.00	0.00	0.00	17.00	17.00	(17.00)	0.00
5013120	Office Supplies	2,500.00	0.00	374.02	195.83	794.82	0.00	555.74	1,920.51	579.49	0.23
5013130	Stationary & Forms	400.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	400.00	1.00
5013350	Packaging & Shipping Supplies	40.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	40.00	1.00
5013620	Food & Dietary Supplies	75.00	0.00	0.00	13.72	0.00	0.00	0.00	13.72	61.28	0.82
5013630	Food Service Supplies	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	1.00
5013730	Computer Operating Supplies	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	50.00	1.00
5014130	Premiums	70.00	0.00	0.00	200.00	0.00	0.00	60.00	260.00	(190.00)	-2.71
5015160	Property Insurance	163.00	145.95	0.00	0.00	0.00	0.00	0.00	145.95	17.05	0.10
5015340	Equipment Rentals	3,296.00	0.00	270.29	274.65	274.65	0.00	274.65	1,094.24	2,201.76	0.67
5015350	Building Rentals	35.00	0.00	8.91	0.00	0.00	8.91	0.00	17.82	17.18	0.49
5015390	Bldg Rental-NonState DGS Adm	54,012.00	4,241.57	4,970.59	4,352.79	4,352.79	4,898.03	4,352.79	27,168.56	26,843.44	0.50
5015510	General Liability Insurance	613.00	523.84	0.00	0.00	0.00	0.00	0.00	523.84	89.16	0.15
5015540	Surety Bonds	37.00	30.91	0.00	0.00	0.00	0.00	0.00	30.91	6.09	0.16
5022180	Computer Software Purchases	0.00	0.00	0.00	0.00	238.20	0.00	0.00	238.20	(238.20)	0.00
5022240	Reference Equipment	0.00	0.00	0.00	0.00	0.00	0.00	323.30	323.30	(323.30)	0.00
5022630	Office Incidentals	90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	90.00	1.00
	Expenditures	$82,726.00	$79,431.71	$63,011.48	$66,971.49	$65,254.72	$66,919.65	$69,820.60	$411,209.65	$471,516.35	53.42%

Department of Health Professions
Board of Dentistry
Cost Allocation Expenditures
FY15

9001 · Allocated Expenditures	FY15 Budget	YTD Sept. 2014	Oct. 14	Nov-14	Dec-14	Current Year Expenditures	(Over) Under Operational Budget	% of Budget Remaining
9301 · DP Operations & Equipment	415,491.72	84,195.29	39,570.30	11,199.10	32,826.35	167,791.03	247,700.69	59.6%
9302 · Human Resources	40,277.52	10,532.04	2,646.61	16,731.42	913.12	30,823.19	9,454.33	23.5%
9303 · Finance	86,994.22	24,083.65	11,415.19	11,796.88	3,822.40	51,118.12	35,876.10	41.2%
9304 · Director's Office	52,808.25	12,685.74	5,667.82	4,224.22	3,834.38	26,412.16	26,396.09	50.0%
9305 · Enforcement	595,936.20	201,783.25	48,265.08	42,950.49	51,570.16	344,568.98	251,367.22	42.2%
9306 · Administrative Proceedings	189,105.48	50,065.34	13,279.09	21,213.21	19,248.05	103,805.69	85,299.79	45.1%
9307 · Impaired Practitioners	3,329.40	898.06	214.88	226.90	223.78	1,563.61	1,765.79	53.0%
9308 · Attorney General	75,244.56	27,913.68	-	-	-	27,913.68	47,330.88	62.9%
9309 · Board of Health Professions	29,442.60	6,581.45	1,709.82	2,503.43	2,405.45	13,200.15	16,242.45	55.2%
9310 · SRTA	4,229.00	2,788.67	(991.32)	-	-	1,797.35	2,431.65	57.5%
9311 · Maintenance and Repairs	1,291.68	0.00	-	-	-	0.00	1,291.68	100.0%
9313 · Emp. Recognition Program	1,110.71	6.83	3.96	-	22.25	33.03	1,077.68	97.0%
9314 · Conference Center	679.19	143.18	42.12	27.67	3.11	216.08	463.11	68.2%
9315 · Pgm Devlpmnt & Implmentn	30,651.05	5,858.43	1,691.23	1,637.08	1,905.23	11,091.97	19,559.08	63.8%
987900 · Cash Trsfr Out- Appr Act Pt. 3	4,419.84	0.00	-	-		0.00	4,419.84	100.0%
Total	1,531,011.42	427,535.61	123,514.78	112,510.39	116,774.28	780,335.06	750,676.36	49.0%

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
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Virginia Board of Dentistry

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February 9, 2015

Justin Crow, MPA
Virginia Board of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

RE: The Draft of the Review of Dental Hygienist Scope of Practice

Dear Mr. Crow:

I am writing in response to the invitation issued by the Board of Health Professions' Regulatory Research Committee (BHP) for comment on the draft Review of Dental Hygienist Scope of Practice (Review). I am commenting as the executive director of the Board of Dentistry (Board) because the Board was unable to convene a meeting in order to adopt comments within the comment period. Given that the Review addresses the regulation of dental hygienists, a matter within the statutory authority of the Board, I polled each board member individually, as permitted by §2.2-3710(B) of the Freedom of Information Act, to determine if I should comment. Nine of the ten Board members said I should submit comment to make BHP aware of the action taken by the Board at its December 12, 2014 meeting on the recommendations made for the practice of dental hygienists advanced in the Joint Commission on Health Care's Oral Health Study Report.

On December 12, 2014, the Board decided to hold a public forum to receive comment on:

- adjusting the education and endorsement requirements for dental assistant II registration;
- creating a pathway for dental hygienists to perform the reversible intraoral procedures which are delegable to dental assistants II; and
- expanding the options for dental hygienists to practice under the remote supervision of dentists.

The Board is planning to hold this forum in the spring of this year. The Board's initiative will address the Review's policy options 3, 4 and 5 which you advanced to BHP. In light of the Board's decision and its regulatory authority to address these matters, your policy option 6 as currently stated is unnecessary. It would be more appropriate for BHP to inform the Board of its conclusions in these matters then defer regulatory action, including the requisite public comment opportunities, to the Board.

As noted in several comments made to BHP and to me, there is concern in the dental community about the accuracy of the Review in regard to the current rules governing supervision of dental hygiene practice in Virginia. To assist BHP's members in making informed decisions based on a clear understanding of the current parameters for dental hygiene practice, I would welcome the opportunity to give BHP a presentation on the current definitions and regulations in effect in Virginia.

I hope my remarks and offer of assistance prove useful to BHP and I look forward to hearing the discussion of public comment on February 17, 2015.

Sincerely,

Sandra K Reen

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

cc: Board of Dentistry Members
David E. Brown, D.C.

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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February 13, 2015

TO: Virginia Van de Water, Ed.D., Chair
Virginia Board of Health Professions

FROM: Melanie C. Swain, President
Virginia Board of Dentistry

RE: Investigation of Electronic Health Records

The Board of Dentistry (BOD) requests that the Board of Health Professions (BHP) evaluate the need for coordination among the health regulatory boards in the Department of Health Professions (DHP) regarding patient health records which are created and maintained electronically as addressed in this resolution:

Virginia Board of Dentistry
Electronic Dental Records Resolution:

Background: In the face of a significant electronics/IT 'arena" of dental (and other professional offices) opportunities for modification of treatment records; records which need to be/remain accurate and truthful when used as evidence in investigations and/or hearing phases before the DHP:

Be It Resolved, that the Board of Dentistry seeks help from the BHP to provide forensic IT ("expert witness") personnel and assistance, whenever needed, to determine veracity and any evidence of electronic records tampering; relevant to any cases in investigation and/or disciplinary hearing phases before the Board of Dentistry.

Adopted 12/12/2014

BOD is asking BHP to determine if other boards in DHP share this concern about ensuring the authenticity of electronic records. Our goal is to receive findings and recommendations from

BHP on the need for an agency level resource for technical assistance in authenticating patient records collected in disciplinary cases. The expertise needed by BOD is:

- information on the integrity of software in use to store patient records, such as Dentrix and Eagle Soft which are in use in dentistry;
- evaluation of case records to determine if and when an alteration occurred; and
- to serve as a technical expert in informal conferences and hearings to facilitate informed decisions in disciplinary cases.

This request is made in keeping with BHP's power to evaluate the need for coordination among the health regulatory boards as set forth in §54.1-2510 of the Code. It is prompted by the increasing number of complaints BOD is receiving which involve allegations of fraudulent billing and falsification of treatment notes.

If you would like more information on our request, please contact me through BOD's executive director, Sandra Reen at 804-367-4437 or sandra.reen@dhp.virginia.gov.

cc: James D. Watkins, D.D.S.

Vu, Huong (DHP)

From: adexoffice@aol.com
Sent: Tuesday, December 16, 2014 1:33 PM
To: kclemence@ameritech.net; dperkdmd@yahoo.com; admckibbin@gmail.com; jhartsog@comcast.net; lmwark@gmail.com; dds@tribcsp.com; ndreves@charter.net; lisamehelichfox@gmail.com; jonnahongo@gmail.com; rgherardi2@comcast.net; randyrfd@gmail.com; zvmorgan@aol.com; chzoisdds@raodrunner.com; lbritten@verizon.net; allanesq@aol.com; dr.acesar@hotmail.com; dmanning@lsbd.org; kjndunn@aol.com; ijstavros@bellsouth.net; danmarydavidson@gmail.com; lsabat@aol.com; cherylbrdh@verizon.net; carlastack@carolina.rr.com; gantrdh@yahoo.com; lynnjoslyn@comcast.net; denkhansen@gmail.com; jhembyjr@nc.rr.com; mabdds@gmail.com; proshard49@gmail.com; jkbeard610@aol.com; drkking@windstream.net; charlesholtjrdds@bellsouth.net; ksadlerncdentalboard@gmail.com; wvgerb@hotmail.com; Board of Dentistry; 7rmiles@gmail.com; lisadmdjd@gmail.com; 2dkdoc@gmail.com; drg@glicksman.net; daverill1@mac.com; ddsdc2@aol.com; wchesser313@troycable.net; tpinther@gmail.com; drmstarsiak@yahoo.com; docowl@ipa.net; battagja@prodigy.net
Cc: shkanna@msn.com; papagianas@aol.com; robertjsr@sbcglobal.net; jhartsog@comcast.net; bbarrette@mac.com; bjb4141@new.rr.com; pdontia@aol.com; kclemence@ameritech.net; dennydds@aol.com; hnrjl2@aol.com; reitzdds@gmail.com; dperkdmd@yahoo.com; admckibbin@gmail.com; drdickinson@dbdentalcarevt.com; dr.satrinca@gmail.com; clancelaturner@gmail.com; maburch@dcr.net; mfj6of8@gmail.com; jdixon5734@aol.com; ndreves@charter.net; docgss@gmail.com
Subject: Highlights from ADEX House of Representaives Meeting, SUnday, November 9, 2014
Attachments: Highlights 2014.pdf

Attached please find the ADEX Highlights memo that was recently sent to all Member Boards and to the States that do accept the ADEX Examinations and those that do not.

If you have any questions, please feel free to contact me.

Thanks

PDB
ADEX
503-724-1104

ADEX
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Highlights of the American Board of Dental Examiners, Inc. (ADEX)
10th House of Representatives
November 9, 2014
Rosemont, IL

The following are highlights of the 10th ADEX House of Representatives:

34 out of 35 member states were represented and there were 49 out of 55 State Board, District Hygiene and District Consumer Representatives present.

2014 – 2015 Officers were elected: Dr. Stanwood Kanna, HI, President; Dr. William Pappas, NV, Vice-President; Dr. Robert Jolly, AR, Secretary and Dr. Jeffery D. Hartsog, MS, Treasurer.

District 6 re-elected Dr. Michelle Bedell, SC, to the ADEX Board of Directors.

District 8 elected Dr. David Perkins, CT, to the ADEX Board of Directors.

District 10 re-elected Dr. Richard Dickinson, VT to the ADEX Board of Directors.

District 12 re-elected Dr. Wade Winker, FL to the ADEX Board of Directors

Ms. Mary Ann Burch, RDH, KY was elected as one of the Dental Hygiene Members to the Board of Directors.

ADEX Staffing

The ADEX Board of Directors announced that Dr. Guy Shampaine, MD will become the Chief Executive Officer of ADEX on February 1, 2015 and that there will an announcement on February 1, 2015 regarding the appointment of a Chief Operating Office for ADEX.

The House of Representatives heard presentations from:

Dr. Chad Buckendahl, Psychometrician "Update on Psychometric Issues"

Ms. Sarina Butler of The Butler Group. "ADEX Business Plan"

Dr. Howard Strassler, Calibration Consultant "ADEX Calibration Update"

Changes to the Dental Examination:

- A change to two criteria areas (Pass/Fail) for Exam cycle 2015-2016.
- A pilot exam, true CIF, will be conducted this year.
- Allowing a second periodontal patient if first patient does not qualify.

P.O. Box 8733 • Portland, Oregon 97207-8733
Telephone (503) 724-1104
ADEXOFFICE@aol.com
www.adex.org

Changes to the Dental Hygiene Examination:

- 2015 ADEX Dental Hygiene manual reviewed, revisions made and approved.
  - ODU explorer or UNC probe highly recommended – not required.
  - Selection is one quadrant and 2 posterior teeth from one other quadrant (one must be a molar).
  - Examiner one will add 2 additional surfaces with qualifying calculus to the 12 already chosen by the candidate for a total of 14.
  - Examiner #2 and #3 will get the same list.
  - Only 12 surfaces will be graded by the computer.
  - All teeth and surfaces in the selection will be debrided by the candidate.
  - An 8/5/3 criterion remains the same and minimum of 6 teeth.
  - Calculus detection and probing remain the same.

2015 ADEX House of Representatives: The 11th ADEX House of Representatives Meeting is scheduled for Sunday, November 15, 2015, at the Doubletree Hotel, Rosemont, IL.

Southern Regional Testing Agency, Inc.

PRESS RELEASE

February 12, 2015

SRTA has decided to administer the SRTA Dental Hygiene Examination in 2015.

This exam is based on the prior SRTA Dental Hygiene Exams which were extensively tested and well received by Dental Hygiene Schools, Candidates, and States Licensing Boards.

Also note the clinical component that will be administered is the accepted and approved Dental Hygiene Clinical Examination for ADEX in 2016.

While SRTA has been given permission by ADEX to offer this same exam as the ADEX Dental Hygiene Exam, SRTA has decided to not use the ADEX label because there is a great deal of confusion concerning exactly which States accept the ADEX Dental Hygiene Exam for licensing.

The SRTA Dental Hygiene Exam is currently accepted in 32 jurisdictions. The SRTA Examination will not be using the CSCE written component for the 2015 year.

We strongly suggest that all students verify acceptance of any exam they choose to sit for, to confirm acceptance of the results in the state in which they seek licensure before they register for an exam. If you have already registered for the ADEX examination offered by SRTA and now believe it will not be accepted by the state for which you seek licensure, please contact the SRTA office for further information on your options.

Note that the issues relating to the Dental Hygiene Exam do not apply to the Dental Exam and SRTA will continue to offer the ADEX Dental Exam in 2015.

60th SCDDE Meeting Summary

The 60th Southern Conference of Dental Deans and Examiners was jointly hosted by the University of Louisville School of Dentistry and the University of Kentucky College of Dentistry, from January 23rd thru 25th, 2015, in Louisville, at the Downtown Marriott. The official program was entitled: "Standards of Care, Risk Management, and Licensure". Conference attendees included dental professionals from various dental schools, boards of dentistry, dental agencies, and associations. The Virginia DHP Board of Dentistry was represented at the conference by Board members, Drs. John Alexander and Charles Gaskins, and by Board Exec. Dir., Ms. Sandra Reen.

The program content of the conference was configured to present, discuss, and assess the following current issues relative to dentistry:

- Standards of Care development and application in clinical practice, education, testing, risk management, and legal proceedings, including malpractice claims and enforcement of state dental laws.
- Turning Risk Management into Risk Avoidance.
- The current scientific validity for simulated clinical testing compared to the scientific validity for the use of human subjects in testing.
- The current scientific validity for "portfolios" and potential uses for portfolios in education, testing, licensure, and re-certification.
- The relationship of Standards of Care to risk management, risk avoidance, education, testing, licensure, law enforcement, malpractice claims, and the ethical practice of dentistry.

Regarding each of these issues, the following points were raised either by the individual presenters, or by an attendee with knowledge of the subject area.

Standards of Care - Development and Application: "Standard of Care" entails a significant amount of subjectivity. A possible mandated number of C.E. hours per term dealing directly with ethics and professionalism course materials was discussed. Billing, patient communication, and "overtreatment" issues were cited by one state dental board director as the leading sources of complaints to their board.

Risk Management, Risk Avoidance: Kentucky Board of Dentistry does not act on anonymous complaints. "Social Media Traps" (i.e.: "posts", "pics" likely are subpoena targets for attorneys. Aspiration of a foreign body or material warrants mention as a surgery or extraction "risk" per an informed consent summary with a patient. Two "Mock" cases/trials were staged for the attendees. The two scenarios

that were presented and then discussed depicted: 1) A root canal procedure that was performed on the wrong tooth, under a rubber dam, by a dental student while in an academic clinic period, and 2) A tooth that was aspirated by a sedated patient, immediately subsequent to its extraction from the socket.

Simulated vs. Human Subjects Used In Testing: Assessment of student-level outcomes. What have students learned? Valid assessment of professional competence remains elusive. Dental Licensing Exams are just measurements with measurement errors:

- False Positive - a "Bad" student or applicant PASSES.
- False Negative - a "Good" student or applicant FAILS.

Per testing, the following concepts and terms were discussed:
* Internal Consistency - did Good candidates do well on the same questions or specific tests?
* Test - Retest - the score of a candidate on a test should equal the score of that candidate on a re-test (assuming no study attempts in-between tests).
* Validity - Does the test measure what it is supposed to measure (like a similar, "proven" test)?

Portfolios And Their Usefulness, Use: A non-traditional assessment measure of competency-based education. A purposeful collection of evidence over time from multiple sources to document the learning process by students. "Competency" is difficult to define or measure. Miller's Pyramid of Professional Competence was discussed as having four increasing levels of competency: the base level being 1) "Knows"; next, 2) "Knows How"; then, 3) "Shows How"; then finally, 4) "Does". There was brief discussion regarding the future usefulness of portfolios in managing "Continuing Competency" for practitioners.

Standards of Care - Relationships: Cases are always reviewed with "Hindsight Bias". "Advisable Documentation" - after the fact (documented) records entries to enable completion of a recorded incident.

After the SCDDE's annual business meeting, there was a show of appreciation for the VCU School of Dentistry and its hosting of the 59th meeting in Richmond in 2014. The 61st annual meeting will be hosted by the University of Mississippi School of Dentistry in 2016.

Submitted by Charles E. Gaskins III, DDS

UNAPPROVED DRAFT

BOARD OF DENTISTRY
MINUTES OF EXAMINATION COMMITTEE
FEBRUARY 13, 2015

TIME AND PLACE:	The Examination Committee convened on February 15, 2015, at 9:04 a.m., at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.
PRESIDING:	Tammy K. Swecker, R.D.H.
MEMBERS PRESENT:	James D. Watkins, D.D.S. Melanie C. Swain, R.D.H.
MEMBERS ABSENT:	Bruce S. Wyman, D.M.D.
OTHER MEMBER PRESENT:	Al Rizkalla, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Executive Director Huong Vu, Operations Manager
ESTABLISHMENT OF A QUORUM:	Three members of the Committee were present.
APPROVAL OF MINUTES:	Ms. Swecker asked if the Committee members had reviewed the March 8, 2013 minutes. No changes or corrections were made. Dr. Watkins moved to accept the March 8, 2013 minutes. The motion was seconded and passed.
STATUS OF PORTFOLIO MODEL CLINICAL EXAM DISCUSSION:	Ms. Reen reviewed the Committee's exploration of establishing a portfolio exam as an alternative clinical exam option for graduates of the VCU School of Dentistry. She said it was decided that the California portfolio exam model wasn't feasible for Virginia. She added that a letter was sent to Dr. Sarrett, Dean of the VCU School of Dentistry (School), requesting that he propose one or more portfolio models addressing both content and administration that could be accommodated at the School. She reported that she has not received a reply and that without the requested information the Board is not able to take further action. Following discussion, Dr. Watkins moved to table this matter pending a response from the school and for Ms. Reen to follow up with the school again. The motion was seconded and passed.

VA DENTAL LAW EXAM:

Ms. Reen stated that the Committee is charged with making a recommendation about the future of the Dental Law Exam. She reviewed the history of the exam and the lack of response to the last RFP issued for a testing agency to administer the exam. She advised that there were not enough licensees voluntarily taking the exam for CE credit to make it financially feasible for a testing agency to contract for its administration. She added that applicants frequently complained about the previous testing agency. She said that Board staff currently administers the exam for licensees who are required by a Board Order to take it.

After reviewing other states' provisions for law exams, the Committee agreed by consensus that the Board should reinstitute the requirement for passage of the law exam for licensure which is available online and preferably on the Board's web page. Ms. Reen stated that if the Committee wishes to require the law exam then it should recommend initiation of the needed regulatory process at the March Board meeting. She asked the Committee to put forward concepts for the development and implementation of the exam to facilitate discussion within DHP and testing agencies on establishing an online exam.

Following discussion, the Committee agreed by consensus to make the following recommendations to the Board:

- Issue a Notice of Intended Regulatory Action to require passage of a law exam;
- Require applicants for licensure to pass the exam;
- Require all licensees to pass the exam once every three years;
- Phase in the periodic exam requirement over a three year period starting with the lowest license numbers;
- Set the passing grade at 75;
- Give three hours CE credit for passage of the exam;
- Allow the exam to be "open book" and to be completed within 24 hours; and
- Have licensees certify at renewal that they have passed the exam within the last three years.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 11:27 a.m.

Tammy K. Swecker, R.D.H, Chair

Sandra K. Reen, Executive Director

Date

Date

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of February 27, 2015)

Chapter		Action / Stage Information
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252] Final - *At Governor's office for 78 days*

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 54.1-2400.2 of the Code of Virginia, relating to Department of Health Professions; disclosure of confidential information.

[H 1963]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2400.2 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2400.2. Confidentiality of information obtained during an investigation or disciplinary proceeding; penalty.

A. Any reports, information or records received and maintained by *the Department of Health Professions or* any health regulatory board in connection with possible disciplinary proceedings, including any material received or developed by a board during an investigation or proceeding, shall be strictly confidential. ~~A~~ *The Department of Health Professions or a* board may only disclose such confidential information:

1. In a disciplinary proceeding before a board or in any subsequent trial or appeal of an action or order, or to the respondent in entering into a confidential consent agreement under § 54.1-2400;

2. To regulatory authorities concerned with granting, limiting or denying licenses, certificates or registrations to practice a health profession, including the coordinated licensure information system, as defined in § 54.1-3030;

3. To hospital committees concerned with granting, limiting or denying hospital privileges if a final determination regarding a violation has been made;

4. Pursuant to an order of a court of competent jurisdiction for good cause arising from extraordinary circumstances being shown;

5. To qualified personnel for bona fide research or educational purposes, if personally identifiable information relating to any person is first deleted. Such release shall be made pursuant to a written agreement to ensure compliance with this section; or

6. To the Health Practitioners' Monitoring Program within the Department of Health Professions in connection with health practitioners who apply to or participate in the Program.

B. In no event shall confidential information received, maintained or developed by *the Department of Health Professions or* any board, or disclosed by the *Department of Health Professions or a* board to others, pursuant to this section, be available for discovery or court subpoena or introduced into evidence in any civil action. This section shall not, however, be construed to inhibit an investigation or prosecution under Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2.

C. Any claim of a physician-patient or practitioner-patient privilege shall not prevail in any investigation or proceeding by any health regulatory board acting within the scope of its authority. The disclosure, however, of any information pursuant to this provision shall not be deemed a waiver of such privilege in any other proceeding.

D. This section shall not prohibit the Director of the Department of Health Professions, after consultation with the relevant health regulatory board president or his designee, from disclosing to the Attorney General, or the appropriate attorney for the Commonwealth, investigatory information which indicates a possible violation of any provision of criminal law, including the laws relating to the manufacture, distribution, dispensing, prescribing or administration of drugs, other than drugs classified as Schedule VI drugs and devices, by any individual regulated by any health regulatory board.

E. This section shall not prohibit the Director of the Department of Health Professions from disclosing matters listed in subdivision A 1, A 2, or A 3 of § 54.1-2909; from making the reports of aggregate information and summaries required by § 54.1-2400.3; or from disclosing the information required to be made available to the public pursuant to § 54.1-2910.1.

F. *This section shall not prohibit the Director of the Department of Health Professions, following consultation with the relevant health regulatory board president or his designee, from disclosing information about a suspected violation of state or federal law or regulation to other agencies within the Health and Human Resources Secretariat or to federal law-enforcement agencies having jurisdiction over the suspected violation or requesting an inspection or investigation of a licensee by such state or federal agency when the Director has reason to believe that a possible violation of federal or state law has occurred. Such disclosure shall not exceed the minimum information necessary to permit the state or federal agency having jurisdiction over the suspected violation of state or federal law to conduct an inspection or investigation. Disclosures by the Director pursuant to this subsection shall not be limited*

to requests for inspections or investigations of licensees. Nothing in this subsection shall require the Director to make any disclosure. Nothing in this section shall permit any agency to which the Director makes a disclosure pursuant to this section to re-disclose any information, reports, records, or materials received from the Department.

G. Whenever a complaint or report has been filed about a person licensed, certified, or registered by a health regulatory board, the source and the subject of a complaint or report shall be provided information about the investigative and disciplinary procedures at the Department of Health Professions. Prior to interviewing a licensee who is the subject of a complaint or report, or at the time that the licensee is first notified in writing of the complaint or report, whichever shall occur first, the licensee shall be provided with a copy of the complaint or report and any records or supporting documentation, unless such provision would materially obstruct a criminal or regulatory investigation. If the relevant board concludes that a disciplinary proceeding will not be instituted, the board may send an advisory letter to the person who was the subject of the complaint or report. The relevant board may also inform the source of the complaint or report (i) that an investigation has been conducted, (ii) that the matter was concluded without a disciplinary proceeding, (iii) of the process the board followed in making its determination, and (iv), if appropriate, that an advisory letter from the board has been communicated to the person who was the subject of the complaint or report. In providing such information, the board shall inform the source of the complaint or report that he is subject to the requirements of this section relating to confidentiality and discovery.

~~G.~~ *H.* Orders and notices of the health regulatory boards relating to disciplinary actions shall be disclosed. Information on the date and location of any disciplinary proceeding, allegations against the respondent, and the list of statutes and regulations the respondent is alleged to have violated shall be provided to the source of the complaint or report by the relevant board prior to the proceeding. The source shall be notified of the disposition of a disciplinary case.

~~H.~~ *I.* This section shall not prohibit investigative staff authorized under § 54.1-2506 from interviewing fact witnesses, disclosing to fact witnesses the identity of the subject of the complaint or report, or reviewing with fact witnesses any portion of records or other supporting documentation necessary to refresh the fact witnesses' recollection.

~~I.~~ *J.* Any person found guilty of the unlawful disclosure of confidential information possessed by a health regulatory board shall be guilty of a Class 1 misdemeanor.

Agenda item: Infection Control

Dr. Rizkalla requests discussion of amending the Regulations Governing Dental Practice to address infection control.

Here are the current Code provisions used to address improper infection control practices:

> § 54.1-2706. Revocation or suspension; other sanctions.
> The Board may refuse to admit a candidate to any examination, refuse to issue a license to any applicant, suspend for a stated period or indefinitely, or revoke any license or censure or reprimand any licensee or place him on probation for such time as it may designate for any of the following causes:
> 5. 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;
> 11. Practicing or causing others to practice in a manner as to be a danger to the health and welfare of his patients or to the public;

Provided below is an excerpt from Guidance Document 60-15 Standards for Professional Conduct in the Practice of Dentistry. See the 6th bullet under Practitioner Responsibility.

Practitioner Responsibility

- Once a course of treatment is undertaken, the dentist shall not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Emergency care must be provided during the notice period to make sure that the patient's oral health is not jeopardized or to stabilize the patient's condition.
- Only prescribe, dispense, and utilize those devices, drugs, dental materials and other agents accepted for dental treatment.
- Make reasonable arrangements for the emergency care of patients of record.
- Exercise reasonable discretion in the selection of patients. Dentists may not refuse patients because of the patient's race, creed, color, sex, or national origin.
- Do not refuse to treat a patient because the individual has AIDS, is HIV positive, or has had hepatitis. Use a proper protocol in the office to protect the public and staff.
- Follow the rules and regulations of HIPPA, OSHA, FDA, and the laws governing health practitioners in the Code of Virginia.
- Be knowledgeable in providing emergency care and have an acceptable emergency plan with delegated duties to the staff in written form, maintain accurate records and be current in basic CPR.
- Avoid interpersonal relationships with patients and staff that could impair professional judgment or risk the possibility of exploiting the veracity and confidence placed in the doctor-patient relationship.

Provided below is an excerpt from Chapter 21 of the proposed regulations, 18VAC60-21-60.A.(1).

> 18VAC60-21-60. General responsibilities to patients.
>
> A. A dentist is responsible for conducting his practice in a manner that safeguards the safety, health, and welfare of his patients and the public by:
>
> 1. Maintaining a safe and sanitary practice, including containing or isolating pets away from the treatment areas of the dental practice. An exception shall be made for a service dog trained to accompany its owner or handler for the purpose of carrying items, retrieving objects, pulling a wheelchair, alerting the owner or handler to medical conditions, or other such activities of service or support necessary to mitigate a disability.
>
> 2. Consulting with or referring patients to other practitioners with specialized knowledge, skills, and experience when needed to safeguard and advance the health of the patient.
>
> 3. Treating according to the patient's desires only to the extent that such treatment is within the bounds of accepted treatment and only after the patient has been given a treatment recommendation and an explanation of the acceptable alternatives.
>
> 4. Only delegating patient care and exposure of dental x-rays to qualified, properly trained and supervised personnel as authorized in Part III (18VAC60-21-110 et seq.) of this chapter.
>
> 5. Giving patients at least 30 days written notice of a decision to terminate the dentist-patient relationship.
>
> 6. Knowing the signs of abuse and neglect and reporting suspected cases to the proper authorities consistent with state law.
>
> 7. Accurately representing to a patient and the public the materials or methods and techniques to be used in treatment.

Action Options:

- Amend Guidance Document 60-15.
- Request development of a Guidance Document on infection control.
- Initiate regulatory action to amend current regulations.
- Assign to Regulatory Committee to address in next Regulatory Review.
- Take no action.

CODA
Commission on Dental Accreditation

Hearings on Standards/Comments Due

The purpose of a hearing on a standards document is to provide individuals, institutions and organizations that will be affected by the document with an opportunity to comment. The goal of the hearing is to hear as many varied points of view on the proposed documents as possible in an orderly fashion.

Hearing Information and Comment Due Dates

American Dental Education Association (ADEA) Annual Session Hearing

The Commission will conduct a hearing on standards at the ADEA Annual Session on Saturday, March 7, 2015 in Boston, Massachusetts, from 11:00 a.m. to 12:00 p.m. in the Sheraton Boston Hotel, 2nd Level-Independence West. Please verify the room location upon arrival.

- CODA Hearing Agenda - ADEA Annual Meeting (PDF)

If you are unable to attend a hearing, you may submit written comments to CODA until the comment due date. Please submit comments to: Dr. Sherin Tooks, Director, Commission on Dental Accreditation, 211 East Chicago Avenue, Chicago, IL 60611 or by email to: tookss@ada.org.

I. Hearing Guidelines (Appendix I) (PDF)

Comments due June 1, 2015:

II. Proposed Accreditation Standards for Dental Education programs, specifically Standards 1-8, 4-6, and 4-7 (Appendix 2) (PDF)

III. Proposed Accreditation Standards for Dental Hygiene Education Programs, specifically Standard 2-18 (Appendix 3) (PDF)

IV. Proposed Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics (Appendix 4) (PDF)

Commission on Dental Accreditation

At its Summer 2014 meeting, the Commission on Dental Accreditation directed that proposed revisions of the Accreditation Standards for Dental Education Programs be distributed to the communities of interest for review and comment, with comment due June 1, 2015, for the Summer 2015 meeting.

The proposed revisions are found in the following areas:

New Proposed Standard 1-8 on page 21, with appropriate renumbering to end of Standard 1

New Proposed Standard 4-6 on page 35, with appropriate renumbering to end of Standard 4

Addition to end of Standard 4-7, previously 4-6, on page 35

Written comments can be directed to horanc@ada.org or mailed to:

ATTN: Catherine A. Horan, PhD, manager
Predoctoral Dental Education
Commission on Dental Accreditation
211 E. Chicago Avenue, 19th Floor
Chicago, IL 60611

Proposed Revised Standards Additions are Underlined; ~~Strikethroughs~~ indicate Deletions

Accreditation Standards For Dental Education Programs

Accreditation Standards for Dental Education Programs

Commission on Dental Accreditation
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
www.ada.org

Document Revision History

Date	Item	Action
August 6, 2010	Accreditation Standards for Dental Education Programs	Adopted
February 3, 2012	Revision to Standard 2-23 e	Approved
February 1, 2013	Revision to Standard 3-2	Approved
July 1, 2013	Accreditation Standards for Dental Education Programs	Implemented
July 1, 2013	Revision to Standard 2-23 e	Implemented
July 1, 2013	Revision to Standard 3-2	Implemented

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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs.

Commission on Dental Accreditation
Revised: October 2012

Accreditation Status Definitions

Programs Which Are Fully Operational

APPROVAL (without reporting requirements): An accreditation classification granted to an education program indicating that the program achieves or exceeds the basic requirements for accreditation.

Approval *(with reporting requirements)*: An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Circumstances under which an extension for good cause would be granted include, but are not limited to:

- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program

Programs Which Are Not Fully Operational

The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is "Initial Accreditation."

Initial Accreditation: Initial Accreditation is the accreditation classification granted to any dental, advance dental or allied dental education program which is in the planning and early stages of development or an intermediate stage of program implementation and not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the program for the specific occupational area. The classification "initial accreditation" is granted based upon one or more site evaluation visit(s) and until the program is fully operational.

Introduction

Accreditation

Accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Specialized accrediting agencies exist to assess and verify educational quality in particular professions or occupations to ensure that individuals will be qualified to enter those disciplines. A specialized accrediting agency recognizes the course of instruction which comprises a unique set of skills and knowledge, develops the accreditation standards by which such educational programs are evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards. Accreditation standards are developed in consultation with those affected by the standards who represent the broad communities of interest.

The Commission on Dental Accreditation

The Commission on Dental accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs that provide basic preparation for licensure or certification in dentistry and the related disciplines.

Standards

Dental education programs leading to the D.D.S. or D.M.D. degree must meet the standards delineated in this document to achieve and maintain accreditation.

Standards 1 through 6 constitute *The Accreditation Standards for Dental Education* by which the Commission on Dental Accreditation and its consultants evaluate Dental Education Programs for accreditation purposes. This entire document also serves as a program development guide for institutions that wish to establish new programs or improve existing programs. Many of the goals related to the educational environment and the corresponding standards were influenced by the work of the American Dental Education Association Commission on Change and Innovation and by best practices in accreditation from other health professions.

The standards identify those aspects of program structure and operation that the Commission regards as essential to program quality and achievement of program goals. They specify the minimum acceptable requirements for programs and provide guidance regarding alternative and preferred methods of meeting standards.

Although the standards are comprehensive and applicable to all institutions that offer dental education programs, the Commission recognizes that methods of achieving standards may vary according to the mission, size, type and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission recognizes the importance of academic freedom, and an institution is allowed considerable flexibility in structuring its educational program so that it can meet the *Standards*. No curriculum has enduring value, and a program will not be judged by conformity to a given type. The Commission also recognizes that schools organize their faculties in a variety of ways. Instruction necessary to achieve the prescribed levels of knowledge and skill may be provided by the educational unit(s) deemed most appropriate by each institution.

The Commission has an obligation to the public, the profession and prospective students to assure that accredited Dental Education Programs provide an identifiable and characteristic core of required education, training and experience.

Format of the Standards

Each standard is numbered (e.g., 1-1, 1-2) and in bold print. Where appropriate, standards are accompanied by statements of intent that explain the rationale, meaning and significance of the standard. This format is intended to clarify the meaning and application of standards for both those responsible for educational programs and those who evaluate these programs for the Commission.

Goals

The assessment of quality in educational programs is the foundation for the *Standards*. In addition to the emphasis on quality education, the *Accreditation Standards for Dental Education Programs* are designed to meet the following goals:

1. to protect the public welfare;
2. to promote an educational environment that fosters innovation and continuous improvement;
3. to guide institutions in developing their academic programs;
4. to guide site visit teams in making judgments regarding the quality of the program and;
5. to provide students with reasonable assurance that the program is meeting its stated objectives.

Specific objectives of the current version of the Standards include:

- streamlining the accreditation process by including only standards critical to the evaluation of the quality of the educational program;
- increasing the focus on competency statements in curriculum-related standards; and
- emphasizing an educational environment and goals that foster critical thinking and prepare graduates to be life-long learners.

To sharpen its focus on the quality of dental education, the Commission on Dental Accreditation includes standards related to institutional effectiveness. Standard 1, "Institutional Effectiveness," guides the self-study and preparation for the site visit away from a periodic approach by encouraging establishment of internal planning and assessment that is ongoing and continuous. Dental education programs are expected to demonstrate that planning and assessment are implemented at all levels of the academic and administrative enterprise. The *Standards* focus, where necessary, on institutional resources and processes, but primarily on the results of those processes and the use of those results for institutional improvement.

The following steps comprise a recommended approach to an assessment process designed to measure the quality and effectiveness of programs and units with educational, patient care, research and services missions. The assessment process should include:

1. establishing a clearly defined purpose/mission appropriate to dental education, patient care, research and service;
2. formulating goals consistent with the purpose/mission;
3. designing and implementing outcomes measures to determine the degree of achievement or progress toward stated goals;
4. acquiring feedback from internal and external groups to interpret the results and develop recommendations for improvement (viz., using a broad-based effort for program/unit assessment);
5. using the recommendations to improve the programs and units; and
6. re-evaluating the program or unit purpose and goals in light of the outcomes of this assessment process.

Implementation of this process will also enhance the credibility and accountability of educational programs.

It is anticipated that the *Accreditation Standards for Dental Education Programs* will strengthen the teaching, patient care, research and service missions of schools. These *Standards* are national in scope and represent the minimum requirements expected for a dental education program. However, the Commission encourages institutions to extend the scope of the curriculum to include content and instruction beyond the scope of the minimum requirements, consistent with the institution's own goals and objectives.

The foundation of these *Standards* is a competency-based model of education through which students acquire the level of competence needed to begin the unsupervised practice of general dentistry. Competency is a complex set of capacities including knowledge, experience, critical thinking, problem-solving, professionalism, personal integrity and procedural skills that are necessary to begin the independent and unsupervised practice of general dentistry. These components of competency become an integrated whole during the delivery of patient care. Professional competence is the habitual and judicious use of communication, knowledge, critical appraisal, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities served. Accordingly, learning experiences help students blend the various dimensions of competency into an integrated performance for the benefit of the patient, while the assessment process focuses on measuring the student's overall capacity to

function as an entry-level, beginning general dentist rather than measuring individual skills in isolation.

In these *Standards* the competencies for general dentistry are described broadly. The Commission expects each school to develop specific competency definitions and assessment methods in the context of the broad scope of general dental practice. These competencies must be reflective of an evidence-based definition of general dentistry. To assist dental schools in defining and implementing their competencies, the Commission strongly encourages the development of a formal liaison mechanism between the dental school and the practicing dental community.

The objectives of the Commission are based on the premise that an institution providing a dental educational program will strive continually to enhance the standards and quality of both scholarship and teaching. The Commission expects an educational institution offering such a program to conduct that program at a level consistent with the purposes and methods of higher education and to have academic excellence as its primary goal.

Educational Environment

Among the factors that may influence predoctoral curricula are expectations of the parent institution, standing or emerging scientific evidence, new research foci, interfaces with specialty or other dental-related education programs, approaches to clinical education, and pedagogical philosophies and practices. In addition, the demographics of our society are changing, and the educational environment must reflect those changes. People are living longer with more complex health issues, and the dental profession will routinely be expected to provide care for these individuals. Each dental school must also have policies and practices to achieve an appropriate level of diversity among its students, faculty and staff. While diversity of curricula is a strength of dental education, the core principles below promote an environment conducive to change, innovation, and continuous improvement in educational programs. Application of these principles throughout the dental education program is essential to achieving quality.

Comprehensive, Patient-Centered Care

The *Standards* reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching and oral health care delivery. Administration, faculty, staff and students are expected to develop and implement definitions, practices, operations and evaluation methods so that patient-centered comprehensive care is the norm.

Institutional definitions and operations that support patient-centered care can have the following characteristics or practices:

1. ensure that patients' preferences and their social, economic, emotional, physical and cognitive circumstances are sensitively considered;
2. teamwork and cost-effective use of well-trained allied dental personnel are emphasized;
3. evaluations of practice patterns and the outcomes of care guide actions to improve both the quality and efficiency of care delivery; and
4. general dentists serve as role models for students to help them learn appropriate therapeutic strategies and how to refer patients who need advanced therapies beyond the scope of general dental practice.

Critical Thinking

Critical thinking is foundational to teaching and deep learning in any subject. The components of critical thinking are: the application of logic and accepted intellectual standards to reasoning; the ability to access and evaluate evidence; the application of knowledge in clinical reasoning; and a disposition for inquiry that includes openness, self-assessment, curiosity, skepticism, and dialogue. In professional practice, critical thinking enables the dentist to recognize pertinent information, make appropriate decisions based on a deliberate and open-minded review of the available options, evaluate outcomes of diagnostic and therapeutic decisions, and assess his or her own performance. Accordingly, the dental educational program must develop students who are able to:

- Identify problems and formulate questions clearly and precisely;
- Gather and assess relevant information, weighing it against extant knowledge and ideas, to interpret information accurately and arrive at well-reasoned conclusions;
- Test emerging hypotheses against evidence, criteria, and standards;
- Show intellectual breadth by thinking with an open mind, recognizing and evaluating assumptions, implications, and consequences;
- Communicate effectively with others while reasoning through problems.

Self-Directed Learning

The explosion of scientific knowledge makes it impossible for students to comprehend and retain all the information necessary for a lifetime of practice. Faculty must serve as role models demonstrating that they understand and value scientific discovery and life-long learning in their daily interactions with students, patients and colleagues. Educational programs must depart from teacher-centered and discipline-focused pedagogy to enable and support the students' evolution as independent learners actively engaged in their curricula using strategies that foster integrated approaches to learning. Curricula must be contemporary, appropriately complex and must encourage students to take responsibility for their learning by helping them learn how to learn.

Humanistic Environment

Dental schools are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A humanistic pedagogy inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising and small group interaction. A dental school environment characterized by respectful professional relationships between and among faculty and students establishes a context for the development

of interpersonal skills necessary for learning, for patient care, and for making meaningful contributions to the profession.

Scientific Discovery and the Integration of Knowledge

The interrelationship between the basic, behavioral, and clinical sciences is a conceptual cornerstone to clinical competence. Learning must occur in the context of real health care problems rather than within singular content-specific disciplines. Learning objectives that cut across traditional disciplines and correlate with the expected competencies of graduates enhance curriculum design. Beyond the acquisition of scientific knowledge at a particular point in time, the capacity to think scientifically and to apply the scientific method is critical if students are to analyze and solve oral health problems, understand research, and practice evidence-based dentistry.

Evidence-based Care

Evidence-based dentistry (EBD) is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.[1] EBD uses thorough, unbiased systematic reviews and critical appraisal of the best available scientific evidence in combination with clinical and patient factors to make informed decisions about appropriate health care for specific clinical circumstances. Curricular content and learning experiences must incorporate the principles of evidence-based inquiry, and involve faculty who practice EBD and model critical appraisal for students during the process of patient care. As scholars, faculty contribute to the body of evidence supporting oral health care strategies by conducting research and guiding students in learning and practicing critical appraisal of research evidence.

Assessment

Dental education programs must conduct regular assessments of students' learning throughout their educational experiences. Such assessment not only focuses on whether the student has achieved the competencies necessary to advance professionally (summative assessment), but also assists learners in developing the knowledge, skills, attitudes, and values considered important at their stage of learning (formative assessment). In an environment that emphasizes critical thinking and humanistic values, it is essential for students to develop the capacity to self-assess. Self-assessment is indicative of the extent to which students take responsibility for their own

[1] American Dental Association, http://www.ada.org/prof/resources/positions/statements/evidencebased.asp. Accessed Oct 25, 2006.

learning. To improve curricula, assessment involves a dialogue between and among faculty, students, and administrators that is grounded in the scholarship of teaching and learning. Data from program outcomes, assessment of student learning, and feedback from students and faculty can be used in a process that actively engages both students and faculty.

Application of Technology

Technology enables dental education programs to improve patient care, and to revolutionize all aspects of the curriculum, from didactic courses to clinical instruction. Contemporary dental education programs regularly assess their use of technology and explore new applications of technological advances to enhance student learning and to assist faculty as facilitators of learning and designers of learning environments. Use of technology must include systems and processes to safeguard the quality of patient care and ensure the integrity of student performance. Technology has the potential to reduce expenses for teaching and learning and help to alleviate increasing demands on faculty and student time. Use of technology in dental education programs can support learning in different ways, including self-directed, distance and asynchronous learning.

Faculty Development

Faculty development is a necessary condition for change and innovation in dental education. The environment of higher education is changing dramatically, and with it health professions education. Dental education programs can re-examine the relationship between what faculty do and how students learn to change from the sage authority who imparts information to a facilitator of learning and designer of learning experiences that place students in positions to learn by doing. Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.

Collaboration with other Health Care Professionals

Access to health care and changing demographics are driving a new vision of the health care workforce. Dental curricula can change to develop a new type of dentist, providing opportunities early in their educational experiences to engage allied colleagues and other health care professionals. Enhancing the public's access to oral health care and the connection of oral health to general health form a nexus that links oral health care providers to colleagues in other health professions. Health care professionals educated to deliver patient-centered care as members of an interdisciplinary team present a challenge for educational programs. Patient care by all team members will emphasize evidence-based practice, quality improvement approaches, the

application of technology and emerging information, and outcomes assessment. Dental education programs are to seek and take advantage of opportunities to educate dental school graduates who will assume new roles in safeguarding, promoting, and caring for the health care needs of the public.

Diversity

Diversity in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, religions, and backgrounds; come from cities, rural areas and from various geographic regions; and have a wide variety of interests, talents, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively homogeneous environment. Programs must create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines.

Summary

These principles create an environmental framework intended to foster educational quality and innovation in ways that are unique to the mission, strengths, and resources of each dental school. The Commission believes that implementation of the guidance incorporated in this document will ensure that dental education programs develop graduates who have the capacity for life-long and self-directed learning and are capable of providing evidence-based care to meet the needs their patients and of society.

Definition of Terms Used in Accreditation Standards for Dental Education Programs

Community-based experience: Refers to opportunities for dental students to provide patient care in community-based clinics or private practices. Community-based experiences are not intended to be synonymous with community service activities where dental students might go to schools to teach preventive techniques or where dental students help build homes for needy families.

Comprehensive patient care: The system of patient care in which individual students or providers, examine and evaluate patients; develop and prescribe a treatment plan; perform the majority of care required, including care in several disciplines of dentistry; refer patients to recognized dental specialists as appropriate; and assume responsibility for ensuring through appropriate controls and monitoring that the patient has received total oral care.

Competencies: Written statements describing the levels of knowledge, skills and values expected of graduates.

Competent: The levels of knowledge, skills and values required by the new graduates to begin independent, unsupervised dental practice.

Cultural competence: Having the ability to provide care to patients with diverse backgrounds, values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers' understanding the relationship between diversity of culture, values, beliefs, behavior and language and the needs of patients.

Dimensions of Diversity: The dimensions of diversity include: structural, curriculum and institutional climate.

Structural: Structural diversity, also referred to as compositional diversity, focuses on the numerical distribution of students, faculty and staff from diverse backgrounds in a program or institution.

Curriculum: Curriculum diversity, also referred to as classroom diversity, covers both the diversity-related curricular content that promote shared learning and the integration of skills, insights, and experiences of diverse groups in all academic settings, including distance learning.

Institutional Climate: Institutional climate, also referred to as interactional diversity, focuses on the general environment created in programs and institutions that support diversity as a core value and provide opportunities for informal learning among diverse peers.

Evidence-based dentistry (EBD): An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Examples of evidence to demonstrate compliance include: Desirable condition, practice or documentation indicating the freedom or liberty to follow a suggested alternative.

Must: Indicates an imperative need or a duty; an essential or indispensable item; mandatory.

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

Instruction: Describes any teaching, lesson, rule or precept; details of procedure; directives.

Intent: Intent statements are presented to provide clarification to dental education programs in the application of and in connection with compliance with the *Accreditation Standards for Dental Education Programs*. The statements of intent set forth some of the reasons and purposes for the particular Standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with

developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

Predoctoral: Denotes training leading to the DDS or DMD degree.

Quality assurance: A cycle of PLAN, DO, CHECK, ACT that involves setting goals, determining outcomes, and collecting data in an ongoing and systematic manner to measure attainment of goals and outcomes. The final step in quality assurance involves identification and implementation of corrective measures designed to strengthen the program.

Service learning: A structured experience with specific learning objectives that combines community service with academic preparation. Students engaged in service learning learn about their roles as dental professions through provision of patient care and related services in response to community-based problems.

Should: Indicates an expectation.

Standard: Offers a rule or basis of comparison established in measuring or judging capacity, quantity, quality, content and value; criterion used as a model or pattern.

Accreditation Standards for Dental Education Programs

STANDARD 1-INSTITUTIONAL EFFECTIVENESS

1-1 The dental school **must** develop a clearly stated purpose/mission statement appropriate to dental education, addressing teaching, patient care, research and service.

Intent:
A clearly defined purpose and a mission statement that is concise and communicated to faculty, staff, students, patients and other communities of interest is helpful in clarifying the purpose of the institution.

1-2 Ongoing planning for, assessment of and improvement of educational quality and program effectiveness at the dental school **must** be broad-based, systematic, continuous, and designed to promote achievement of institutional goals related to institutional effectiveness, student achievement, patient care, research, and service.

Intent:
Assessment, planning, implementation and evaluation of the educational quality of a dental education program that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students. The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of general dentistry.

1-3 The dental education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

Intent:
The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.

Examples of evidence to demonstrate compliance may include:

- Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available
- Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities
- Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment

1-4 The dental school **must** have policies and practices to:

a. achieve appropriate levels of diversity among its students, faculty and staff;
b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and
c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

Intent:
The dental school should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The dental school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.

1-5 The financial resources **must** be sufficient to support the dental school's stated purpose/mission, goals and objectives.

Intent:
The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment; procure supplies, reference material and teaching aids as reflected in annual operating budget. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the discipline. The Commission will assess the adequacy of financial support on the basis of current appropriations and the stability of sources of funding for the program.

1-6 The sponsoring institution **must** ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:
- Written agreement(s)
- Contracts between the institution/ program and sponsor(s) (For example: contract(s)/agreement(s) related to facilities, funding, faculty allocations, etc.)

1-7 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

1-8 The sponsoring institution of the educational program **must** accept full responsibility for the quality of education provided in all affiliated sites.

~~**1-8**~~ **1-9** The dental school **must** be a component of a higher education institution that is accredited by a regional accrediting agency.

~~**1-9**~~ **1-10** The dental school **must** show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems.

STANDARD 2-EDUCATIONAL PROGRAM

Instruction

2-1 In advance of each course or other unit of instruction, students **must** be provided written information about the goals and requirements of each course, the nature of the course content, the method(s) of evaluation to be used, and how grades and competency are determined.

2-2 If students do not meet the didactic, behavioral and/or clinical criteria as published and distributed, individual evaluations **must** be performed that lead to an appropriate decision in accordance with institutional due process policies.

Curriculum Management

2-3 The curriculum **must** include at least four academic years of instruction or its equivalent.

2-4 The stated goals of the dental education program **must** be focused on educational outcomes and define the competencies needed for graduation, including the preparation of graduates who possess the knowledge, skills and values to begin the practice of general dentistry.

2-5 The dental education program **must** employ student evaluation methods that measure its defined competencies.

Intent:
Assessment of student performance should measure not only retention of factual knowledge, but also the development of skills, behaviors, and attitudes needed for subsequent education and practice. The education program should assess problem solving, clinical reasoning, professionalism, ethical decision-making and communication skills. The evaluation of competence is an ongoing process that requires a variety of assessments that can measure not only the acquisition of knowledge and skills but also assess the process and procedures which will be necessary for entry level practice.

Examples of evidence to demonstrate compliance may include:

- Narrative descriptions of student performance and professionalism in courses where teacher-student interactions permit this type of assessment
- Objective structured clinical examination (OSCE)
- Clinical skills testing

2-6 Biomedical, behavioral and clinical science instruction **must** be integrated and of sufficient depth, scope, timeliness, quality and emphasis to ensure achievement of the curriculum's defined competencies.

2-7 The dental school **must** have a curriculum management plan that ensures:

a. an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;
b. evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;
c. elimination of unwarranted repetition, outdated material, and unnecessary material;
d. incorporation of emerging information and achievement of appropriate sequencing.

2-8 The dental school **must** ensure the availability of adequate patient experiences that afford all students the opportunity to achieve its stated competencies within a reasonable time.

Critical Thinking

2- 9 Graduates **must** be competent in the use of critical thinking and problem-solving, including their use in the comprehensive care of patients, scientific inquiry and research methodology.

Intent:
Throughout the curriculum, the educational program should use teaching and learning methods that support the development of critical thinking and problem solving skills

Examples of evidence to demonstrate compliance may include:

- Explicit discussion of the meaning, importance, and application of critical thinking
- Use of questions by instructors that require students to analyze problem etiology, compare and evaluate alternative approaches, provide rationale for plans of action, and predict outcomes
- Prospective simulations in which students perform decision-making
- Retrospective critiques of cases in which decisions are reviewed to identify errors, reasons for errors, and exemplary performance
- Writing assignments that require students to analyze problems and discuss alternative theories about etiology and solutions, as well as to defend decisions made
- Asking students to analyze and discuss work products to compare how outcomes correspond to best evidence or other professional standards
- Demonstration of the use of active learning methods, such as case analysis and discussion, critical appraisal of scientific evidence in combination with clinical application and patient factors, and structured sessions in which faculty and students reason aloud about patient care

Self-Assessment

2-10 Graduates **must** demonstrate the ability to self-assess, including the development of professional competencies and the demonstration of professional values and capacities associated with self-directed, lifelong learning.

Intent:
Educational program should prepare students to assume responsibility for their own learning. The education program should teach students how to learn and apply evolving and new knowledge over a complete career as a health care professional. Lifelong learning skills include student assessment of learning needs.

Examples of evidence to demonstrate compliance may include:

- Students routinely assess their own progress toward overall competency and individual competencies as they progress through the curriculum
- Students identify learning needs and create personal learning plans
- Students participate in the education of others, including fellow students, patients, and other health care professionals, that involves critique and feedback

Biomedical Sciences

2-11 Biomedical science instruction in dental education **must** ensure an in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems.

2-12 The biomedical knowledge base **must** emphasize the oro-facial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.

2-13 In-depth information on abnormal biological conditions **must** be provided to support a high level of understanding of the etiology, epidemiology, differential diagnosis, pathogenesis, prevention, treatment and prognosis of oral and oral-related disorders.

2-14 Graduates **must** be competent in the application of biomedical science knowledge in the delivery of patient care.

Intent:
Biological science knowledge should be of sufficient depth and scope for graduates to apply advances in modern biology to clinical practice and to integrate new medical knowledge and therapies relevant to oral health care.

Behavioral Sciences

2-15 Graduates **must** be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving and maintaining oral health.

2-16 Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

Intent:
Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in:

- *basic principles of culturally competent health care;*
- *recognition of health care disparities and the development of solutions;*
- *the importance of meeting the health care needs of dentally underserved populations, and;*
- *the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.*

Practice Management and Health Care Systems

2-17 Graduates **must** be competent in applying legal and regulatory concepts related to the provision and/or support of oral health care services.

2-18 Graduates **must** be competent in applying the basic principles and philosophies of practice management, models of oral health care delivery, and how to function successfully as the leader of the oral health care team.

2-19 Graduates **must** be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.

Intent:
Students should understand the roles of members of the health care team and have educational experiences, particularly clinical experiences, that involve working with other healthcare professional students and practitioners. Students should have educational experiences in which they coordinate patient care within the health care system relevant to dentistry.

Ethics and Professionalism

2-20 Graduates **must** be competent in the application of the principles of ethical decision making and professional responsibility.

Intent:
Graduates should know how to draw on a range of resources, among which are professional codes, regulatory law, and ethical theories. These resources should pertain to the academic environment, patient care, practice management and research. They should guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.

Clinical Sciences

2-21 Graduates **must** be competent to access, critically appraise, apply, and communicate scientific and lay literature as it relates to providing evidence-based patient care.

Intent:
The education program should introduce students to the basic principles of clinical and translational research, including how such research is conducted, evaluated, applied, and explained to patients.

2-22 Graduates **must** be competent in providing oral health care within the scope of general dentistry to patients in all stages of life.

2-23 At a minimum, graduates **must** be competent in providing oral health care within the scope of general dentistry, as defined by the school, including:

a. patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;
b. screening and risk assessment for head and neck cancer;
c. recognizing the complexity of patient treatment and identifying when referral is indicated;
d. health promotion and disease prevention;
e. local anesthesia, and pain and anxiety control;
f. restoration of teeth;
g. communicating and managing dental laboratory procedures in support of patient care;
h. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;
i. periodontal therapy;
j. pulpal therapy;
k. oral mucosal and osseous disorders;
l. hard and soft tissue surgery;
m. dental emergencies;
n. malocclusion and space management; and
o. evaluation of the outcomes of treatment, recall strategies, and prognosis.

Intent:

Graduates should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dentistry, independently, at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school's goals, resources, accepted general practitioner responsibilities and other influencing factors. The comprehensive care experiences provided for patients by students should be adequate to ensure competency in all components of general dentistry practice. Programs should assess overall competency, not simply individual competencies in order to measure the graduate's readiness to enter the practice of general dentistry.

2-24 Graduates **must** be competent in assessing the treatment needs of patients with special needs.

Intent:
An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. The assessment should emphasize the importance of non-dental considerations. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques and assessing the treatment needs compatible with the special need.

2-25 Dental education programs **must** make available opportunities and encourage students to engage in service learning experiences and/or community-based learning experiences.

Intent:
Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.

STANDARD 3- FACULTY AND STAFF

3-1 The number and distribution of faculty and staff **must** be sufficient to meet the dental school's stated purpose/mission, goals and objectives.

3-2 The dental school **must** show evidence of an ongoing faculty development process.

Intent:
Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession

Examples of evidence to demonstrate compliance may include:

- Participation in development activities related to teaching and learning
- Attendance at regional and national meetings that address education
- Mentored experiences for new faculty
- Scholarly productivity
- Maintenance of existing and development of new and/or emerging clinical skills
- Documented understanding of relevant aspects of teaching methodology
- Curriculum design and development
- Curriculum evaluation
- Student/Resident assessment
- Cultural Competency
- Ability to work with students of varying ages and backgrounds
- Use of technology in didactic and clinical components of the curriculum

3-3 Faculty **must** be ensured a form of governance that allows participation in the school's decision-making processes.

3-4 A defined evaluation process **must** exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.

3-5 The dental school **must** have a stated process for promotion and tenure (where tenure exists) that is clearly communicated to the faculty.

STANDARD 4-EDUCATIONAL SUPPORT SERVICES

Admissions

4-1 Specific written criteria, policies and procedures **must** be followed when admitting predoctoral students.

4-2 Admission of students with advanced standing **must** be based on the same standards of achievement required by students regularly enrolled in the program.

4-3 Transfer students with advanced standing **must** receive an individualized assessment and an appropriate curriculum plan that results in the same standards of competence for graduation required by students regularly enrolled in the program.

Examples of evidence to demonstrate compliance may include:

- Policies and procedures on advanced standing
- Results of appropriate qualifying examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge

4-4 Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population.

Intent 4-1 to 4-4:
The dental education curriculum is a scientifically oriented program which is rigorous and intensive. Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program.

Facilities and Resources

4-5 The dental school **must** provide adequate and appropriately maintained facilities and learning resources to support the purpose/mission of the dental school and which are in conformance with applicable regulations.

4-6 Any clinical practice model, established or renewed after January 1, 2016, including but not limited to private practice or community-based practice, not owned by an educational sponsoring institution, **must** have a written agreement, which is held with the sponsoring institution regarding off-campus learning experiences that meet accreditation standards or program requirements, and covers the following items of agreement:

a. A contingency plan developed by the sponsoring institution should an agreement be terminated;
b. Inactive sites maintain resources as approved initially;
c. Designation of the dean, or another person to whom the dean has delegated the responsibility of monitoring the supervision of the instruction and scheduling;
d. Clinical assessment (formative and summative) and calibration of the program faculty, to ensure that all predoctoral dental students receive comparable instruction across sites and specialties;
e. A location, equipment and facilities, and time available for use of the equipment and facilities are compatible with the instructional needs of the program; and
f. Policies and procedures of the facility compatible with the goals and instructional needs of the predoctoral dental education program.

(For the addition of new off-campus sites, refer to the relevant Commission Policy and Guidelines.)

Student Services

~~4-6~~ 4-7 Student services **must** include the following:

a. personal, academic and career counseling of students;
b. assuring student participation on appropriate committees;
c. providing appropriate information about the availability of financial aid and health services;
d. developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;
e. student advocacy; and
f. maintenance of the integrity of student performance and evaluation records.
g. instruction on personal debt management and financial planning.

Intent:
All policies and procedures should protect the students and provide avenues for appeal and due process. Policies should ensure that student records accurately reflect the work accomplished and are maintained in a secure manner. Students

should have available the necessary support to provide career information and guidance as to practice, post-graduate and research opportunities.

Student Financial Aid

~~4-7~~ 4-8 At the time of acceptance, students **must** be advised of the total expected cost of their dental education.

Intent:
Financial information should include estimates of living expenses and educational fees, an analysis of financial need, and the availability of financial aid.

~~4-8~~ 4-9 The institution **must** be in compliance with all federal and state regulations relating to student financial aid and student privacy.

Health Services

~~4-9~~ 4-10 The dental school **must** advise prospective students of mandatory health standards that will ensure that prospective students are qualified to undertake dental studies.

~~4-10~~ 4-11 There **must** be a mechanism for ready access to health care for students while they are enrolled in dental school.

~~4-11~~ 4-12 Students **must** be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.

STANDARD 5- PATIENT CARE SERVICES

5-1 The dental school **must** have a published policy addressing the meaning of and commitment to patient-centered care and distribute the written policy to each student, faculty, staff, and patient.

Intent:
A written statement of patient rights should include:

- *considerate, respectful and confidential treatment;*
- *continuity and completion of treatment;*
- *access to complete and current information about his/her condition;*
- *advance knowledge of the cost of treatment;*
- *informed consent;*
- *explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments;*
- *treatment that meets the standard of care in the profession.*

5-2 Patient care **must** be evidenced-based, integrating the best research evidence and patient values.

Intent:
The dental school should use evidence to evaluate new technology and products and to guide diagnosis and treatment decisions.

5-3 The dental school **must** conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:

a. standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria;
b. an ongoing review and analysis of compliance with the defined standards of care;
c. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;
d. mechanisms to determine the cause(s) of treatment deficiencies; and
e. implementation of corrective measures as appropriate.

Intent:
Dental education programs should create and maintain databases for monitoring and improving patient care and serving as a resource for research and evidence-based practice.

5-4 The use of quantitative criteria for student advancement and graduation **must** not compromise the delivery of comprehensive patient care.

5-5 The dental school **must** ensure that active patients have access to professional services at all times for the management of dental emergencies.

5-6 All students, faculty and support staff involved in the direct provision of patient care **must** be continuously certified in basic life support (B.L.S.), including cardiopulmonary resuscitation, and be able to manage common medical emergencies.

5-7 Written policies and procedures **must** be in place to ensure the safe use of ionizing radiation, which include criteria for patient selection, frequency of exposing radiographs on patients, and retaking radiographs consistent with current, accepted dental practice.

5-8 The dental school **must** establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste.

5-9 The school's policies and procedures **must** ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained.

STANDARD 6- RESEARCH PROGRAM

6-1 Research, the process of scientific inquiry involved in the development and dissemination of new knowledge, **must** be an integral component of the purpose/mission, goals and objectives of the dental school.

6-2 The dental school faculty, as appropriate to meet the school's purpose/mission, goals and objectives, **must** engage in research or other forms of scholarly activity.

6-3 Dental education programs **must** provide opportunities, encourage, and support student participation in research and other scholarly activities mentored by faculty.

Intent:
The dental education program should provide students with opportunities to experience research including, but not limited to, biomedical, translational, educational, epidemiologic and clinical research. Such activities should align with clearly defined research mission and goals of the institution. The dental education program should introduce students to the principles of research and provide elective opportunities beyond basic introduction, including how such research is conducted and evaluated, and where appropriate, conveyed to patients and other practitioners, and applied in clinical settings.

Commission on Dental Accreditation

At its Winter 2015 meeting, the Commission on Dental Accreditation directed that the proposed new Standard 2-18 of the Accreditation Standards for Dental Hygiene Education Programs be distributed to the communities of interest for review and comment, with all comments due June 1, 2015, for consideration at the Summer 2015 Commission meeting.

Written comments can be directed to renfrowp@ada.org or mailed to:

ATTN: Patrice Renfrow, manager
Allied Dental Education
211 E. Chicago Avenue, 19th Floor
Chicago, IL 60611

Accreditation Standard 2-18 for Dental Hygiene Education Programs

Proposed Revised Standards
Additions are Underlined
~~Strikethroughs~~ indicate Deletions

Dental Hygiene Education Programs

Standard 2. Education Program

2-18 Where graduates of a CODA accredited dental hygiene program are authorized to perform additional functions defined by the program's state specific dental board or regulatory agency, program curriculum must include content at the level, depth, and scope required by the state. Further, curriculum content must include didactic and laboratory/preclinical/clinical objectives for the additional dental hygiene skills and functions. Students must demonstrate laboratory/preclinical/clinical competence in performing these skills.

Intent:
Functions allowed by the state dental board or regulatory agency for dental hygienists are taught and evaluated at the depth and scope required by the state. The inclusion of additional functions cannot compromise the length and scope of the educational program or content required in the Accreditation Standards and may require extension of the program length.

Commission on Dental Accreditation

At its Summer 2012 meeting, the Commission on Dental Accreditation directed the proposed revisions of the Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics be distributed to the communities of interest for review and comment, with comment due June 1, 2013, for the Summer 2013 meeting.

At the Summer 2013 meeting, Commission on Dental Accreditation reviewed the proposed revisions to the Accreditation Standards and believed that the proposed Prosthodontics Standards did not provide enough guidance on the students'/residents' training in surgical placement of implants and directed that the proposed revisions to the Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics be referred back to the Review Committee on Prosthodontics Education for further review and development.

In Winter 2014 the Prosthodontic Education Review Committee and Commission considered further changes to the proposed revisions of the Accreditation Standards. At the Winter 2014 meeting, the Commission on Dental Accreditation directed that the proposed revisions of the Advanced Specialty Education Program in Prosthodontics be distributed to the communities of interest for review and comment, with comment due June 2, 2014, for review at the Summer 2014 meeting.

In Summer 2014 the Prosthodontic Education Review Committee and Commission considered further changes to the proposed revisions of the Accreditation Standards. At the Summer 2014 meeting, the Commission on Dental Accreditation reviewed the proposed revisions to the Accreditation Standards and did not adopt the Accreditation Standards.

At the Winter 2015 meeting, the Commission on Dental Accreditation directed immediate implementation of changes to Standard 1 and Standard 5, common language, which are included in this document. Additionally, the Commission on Dental Accreditation directed that the proposed revisions of the Accreditation Standards for Advanced Specialty Education Program in Prosthodontics be distributed to the communities of interest for review and comment, with comment due June 1, 2015, for review at the Summer 2015 meeting.

Proposed revisions prior to Winter 2015 are noted in red; additions are underlined and deletions are ~~stricken~~.

Proposed revisions resulting from the Winter 2015 CODA meeting are noted as yellow highlighted changes; additions are underlined and green, and deletions are ~~stricken~~.

Written comments can be directed to baumannc@ada.org or mailed to:

ATTN: Ms. Catherine Baumann, 19th Floor
Manager, Advanced Specialty Education
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611

Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics

Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
www.ada.org/coda

Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes. *(Adopted April 2003)*

Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics

Document Revision History

Date	***Item***	***Action***
	Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics	*Adopted*
	Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics	*Implemented*

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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental related educational programs.

Commission on Dental Accreditation
Revised: August 10, 2012

Accreditation Status Definitions

Programs That Are Fully Operational:

Approval *(without reporting requirements)*: An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

Approval *(with reporting requirements)*: An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Circumstances under which an extension for good cause would be granted include, but are not limited to:

- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program

Programs That Are Not Fully Operational:

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is "initial accreditation." When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program's accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.

Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification "initial accreditation" is granted based upon one or more site evaluation visit(s).

Preface

Maintaining and improving the quality of advanced education in the nationally recognized specialty areas of dentistry is a primary aim of the Commission on Dental Accreditation. The Commission is recognized by the public, the profession, and the United States Department of Education as the specialized accrediting agency in dentistry.

Accreditation of advanced specialty education programs is a voluntary effort of all parties involved. The process of accreditation assures students/residents, specialty boards and the public that accredited training programs are in compliance with published standards.

Accreditation is extended to institutions offering acceptable programs in the following recognized specialty areas of dental practice: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. Program accreditation will be withdrawn when the training program no longer conforms to the standards as specified in this document, when all first-year positions remain vacant for a period of two years or when a program fails to respond to requests for program information. Exceptions for non-enrollment may be made by the Commission for programs with "approval without reporting requirements" status upon receipt of a formal request from an institution stating reasons why the status of the program should not be withdrawn.

Advanced education in a recognized specialty area of dentistry may be offered on either a certificate-only or certificate and degree-granting basis.

Accreditation actions by the Commission on Dental Accreditation are based upon information gained through written submissions by program directors and evaluations made on site by assigned consultants. The Commission has established review committees in each of the recognized specialties to review site visit and progress reports and make recommendations to the Commission. Review committees are composed of representatives selected by the specialties and their certifying boards. The Commission has the ultimate responsibility for determining a program's accreditation status. The Commission is also responsible for adjudication of appeals of adverse decisions and has established policies and procedures for appeal. A copy of policies and procedures may be obtained form the Director, Commission on Dental Accreditation, 211 East Chicago Avenue, Chicago, Illinois 60611.

This document constitutes the standards by which the Commission on Dental Accreditation and its consultants will evaluate advanced programs in each specialty for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all dental specialties, institution and programs regardless of specialty. Each specialty develops specialty-specific standards for education programs in its specialty. The general and specialty-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the education content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular specialty.

As a learned profession entrusted by the public to provide for its oral health and general well-being, the profession provides care without regard to race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status.

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

The profession adheres to ethical principles of honesty, compassion, kindness, respect, integrity, fairness and charity, as exemplified in the ADA Principles of Ethics and Code of Professional Conduct and the ADEA Statement on Professionalism in Dental Education.

General standards are identified by the use of a single numerical listing (e.g., 1). Specialty-specific standards are identified by the use of multiple numerical listings (e.g. 1-1, 1-1.2, 1-2).

REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an educational program. The Commission views change as part of a healthy educational process and encourages programs to make them as part of their normal operating procedures.

At times, however, more significant changes occur in a program. Changes have a direct and significant impact on the program's potential ability to comply with the accreditation standards. These changes tend to occur in the areas of finances, program administration, enrollment, curriculum and clinical/laboratory facilities, but may also occur in other areas. Reporting changes in the Annual Survey does not preclude the requirement to report changes to the Commission. Failure to report and receive approval in advance of implementing the change, using the Guidelines for Reporting Program Change, may result in review by the Commission, a special site visit, and may jeopardize the program's accreditation status. Advanced specialty education programs must adhere to the Policy on Enrollment Increases in Advanced Specialty Programs. In addition, programs adding off-campus sites must adhere to the Policy on the Accreditation of Off-Campus sites. Guidelines for Reporting Off-Campus Sites are available from the Commission office.

The Commission's Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breech of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

When a change is planned, Commission staff should be consulted to determine reporting requirements. This report must document how the program will continue to meet accreditation standards. The Commission's Guidelines for Reporting Program Changes are available on the ADA website and may clarify what constitutes a change and provide guidance in adequately explaining and documenting such changes.

The following examples illustrate, but are not limited to, changes that must be reported at least thirty (30) days prior to a regularly scheduled, semi-annual Review Committee meeting and must be reviewed by the appropriate Review Committee and approved by the Commission **prior to the implementation** to ensure that the program continues to meet the accreditation standards:

- Establishment of Off-Campus Sites used to meet accreditation standards or program requirements;
- Transfer of sponsorship from one institution to another;
- Moving a program from one geographic site to another;
- Program director qualifications not being in compliance with the standards. In lieu of a CV, a copy of the new or acting program director's completed BioSketch should be provided to Commission staff. Contact Commission Staff for the BioSketch template.
- Substantial increase in program enrollment as determined by preliminary review by the

discipline-specific Review Committee Chair. (Specialty programs see Policy on Enrollment Increases In Advanced Specialty Programs);

- Change in the nature of the program's financial support that could affect the ability of the program to meet the standards;
- Curriculum changes that that could affect the ability of the program to meet the standards;
- Reduction in faculty or support staff time commitment;
- Change in the required length of the program;
- Reduction of program dental facilities that could affect the ability of the program to meet the standards; and/or
- Expansion of a developing dental hygiene or assisting program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

The Commission recognizes that unexpected, changes may occur. If an unexpected change occurs, it must be reported no more than 30 days following the occurrence. Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster. Failure to proactively plan for change will not be considered unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

The following examples illustrate, but are not limited to, additional program changes that must be reported in writing at least thirty (30) days prior to the anticipated implementation of the change and are not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:

- Expansion or relocation of dental facilities within the same institution;
- Change in program director. In lieu of a CV, a copy of the new or acting program director's completed BioSketch should be provided to Commission staff. Contact Commission Staff for the BioSketch template.

The Commission uses the following process when considering reports of changes. Program administrators have the option of consulting with Commission staff at any time during this process.

1. A program administrator submits the report at least thirty (30) days prior to a regularly scheduled Review Committee meeting.
2. Commission staff reviews the report to assess its completeness and to determine whether the change could impact the program's potential ability to comply with the accreditation standards. If this is the case, the report is reviewed by the appropriate Review Committee for the discipline and by the Commission.
3. Receipt of the report and accompanying documentation is acknowledged in one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate

Review Committee and by the Commission at their next regularly scheduled meeting. Additional information may be requested prior to this review if the change is not well-documented; or

b. The program administrator is informed that the reported change will be reviewed during the next site visit.

4. If the report will be considered by a Review Committee and by the Commission, the report is added to the appropriate agendas. The program administrator receives notice of the results of the Commission's review.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of changes received from accredited educational programs.

- *Approve the report of program change:* If the Review Committees or Commission does not identify any concerns regarding the program's continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change(s) have been noted and will be reviewed at the next regularly-scheduled site visit to the program.
- *Approve the report of program change and request additional information:* If the Review Committees or Commission does not identify any concerns regarding the program's compliance with the accreditation standards, but believes follow up reporting is required to ensure continued compliance with accreditation standards, additional information will be requested for review by the Commission. Additional information could occur through a supplemental report or a focused site visit,
- *Postpone action and continue the program's accreditation status, but request additional information:* The transmittal letter will inform the institution that the report of program change has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request.
- *Postpone action and continue the program's accreditation status pending conduct of a special site visit:* If the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit will be conducted.
- *Deny the request:* If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for a program change. The institutions will be advised that they may re-submit the request with additional information if they choose.

Revised: 8/13 2/12, 8/11, 8/10, 7/09, 7/07, 8/02, 7/97; Reaffirmed: 7/07, 7/01, 5/90; CODA: 05/91:11

POLICY ON ENROLLMENT INCREASES IN ADVANCED DENTAL SPECIALTY PROGRAMS

A program considering or planning an enrollment increase, or any other substantive change, should notify the Commission early in the program's planning. Such notification will provide an opportunity for the program to seek consultation from Commission staff regarding the potential effect of the proposed change on the accreditation status and the procedures to be followed.

A request for an increase in enrollment with all supporting documentation must be submitted in writing to the Commission one (1) month prior to a regularly scheduled semiannual Review Committee meeting. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional students/residents.

The Commission will not retroactively approve enrollment increases without a special focused site visit. Special circumstances may be considered on a case-by-case basis, including, but not limited to, temporary enrollment increases due to:

- Student/Resident extending program length due to illness, incomplete projects/clinical assignments, or concurrent enrollment in another program;
- Unexpected loss of an enrollee and need to maintain balance of manpower needs;
- Urgent manpower needs demanded by U.S. armed forces; and
- Natural disasters.

Failure to comply with this policy will jeopardize the program's accreditation status, up to and including withdrawal of accreditation. If a program has enrolled beyond the approved number of students/residents without prior approval by the Commission, a special focused site visit will be required at the program's expense.

If the focused visit determines that the program does not have the resources to support the additional student(s)/resident(s), the program will be placed on "intent to withdraw" status and no additional student(s)/resident(s) beyond the previously approved number may be admitted to the program until the deficiencies have been rectified and approved by the Commission. Student(s)/Resident(s) who have already been formally accepted or enrolled in the program will be allowed to continue.

Revised: 8/10; Reaffirmed: 7/07; CODA: 08/03:22

Definitions of Terms Used in Prosthodontics Accreditation Standards

The terms used in this document (i.e. shall, **must**, should, can and may) were selected carefully and indicate the relative weight that the Commission attaches to each statement. The definitions of these words used in the Standards are as follows:

Must or Shall: Indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

Intent: Intent statements are presented to provide clarification to the advanced specialty education programs in prosthodontics in the application of and in connection with compliance with the Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics. The statements of intent set forth some of the reasons and purposes for the particular Standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

Examples of evidence to demonstrate compliance include: Desirable condition, practice or documentation indicating the freedom or liberty to follow a suggested alternative.

Should: Indicates a method to achieve the standards.

May or Could: Indicates freedom or liberty to follow a suggested alternative.

~~Levels of Knowledge:~~

~~In-depth: A thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding.~~

~~Understanding: Adequate knowledge with the ability to apply.~~

~~Familiarity: A simplified knowledge for the purpose of orientation and recognition of general principles.~~

~~Levels of Skills:~~

~~Proficient: The level of skill beyond competency. It is that level of skill acquired through advanced training or the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time.~~

~~Competent: The level of skill displaying special ability or knowledge derived from training and experience.~~

~~Exposed: The level of skill attained by observation of or participation in a particular activity.~~

Graduates of specialty education programs provide unique services to the public. While there is some commonality with services provided by specialists and general dentists, as well as commonalities among the specialties, the educational standards developed to prepare graduates of specialty programs for independent practice should not be viewed as a continuum from general dentistry. Each specialty defines the educational experience best suited to prepare its graduates to provide that unique specialty service.

Competencies: Statements in the specialty standards describing the knowledge, skills and values expected of graduates of specialty programs.

Competent: Having the knowledge, skills and values required of the graduates to begin independent, unsupervised specialty practice.

In-depth: Characterized by thorough knowledge of concepts and theories for the purpose of critical analysis and synthesis.

Understanding: Knowledge and recognition of the principles and procedures involved in a particular concept or activity.

Other Terms:

Institution (or organizational unit of an institution): a dental, medical or public health school, patient care facility, ~~private practice office~~ or other entity that engages in advanced specialty education.

Sponsoring institution: primary responsibility for advanced specialty education programs.

Affiliated institution: support responsibility for advanced specialty education programs.

Advanced specialty education student/resident: a student/resident enrolled in an accredited advanced specialty education program.

A degree-granting program is a planned sequence of advanced courses leading to a master's or doctoral degree granted by a recognized and accredited educational institution.

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in a specialty recognized by the American Dental Association.

Student/Resident: The individual enrolled in an accredited advanced education program.

International Dental School: A dental school located outside the United States and Canada.

Evidence-based dentistry: Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating

to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Formative Assessment*: guiding future learning, providing reassurance, promoting reflection, and shaping values; providing benchmarks to orient the learner who is approaching a relatively unstructured body of knowledge; and reinforcing students' intrinsic motivation to learn and inspire them to set higher standards for themselves.

Summative Assessment*: making an overall judgment about competence, fitness to practice, or qualification for advancement to higher levels of responsibility; and providing professional self-regulation and accountability.

*Epstein, R.M. (2007) *Assessment in Medical Education.* The New England Journal of Medicine, 387-96.

Prosthodontic Specific Terms:

Removable Prosthodontics – is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures for edentulous or partially edentulous patients by artificial substitutes that are removable from the mouth.

Fixed Prosthodontics – is that branch of prosthodontics concerned with the replacement and/or restoration of teeth by artificial substitutes that are not removable from the mouth.

Implant Prosthodontics – is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures by artificial substitutes partially or completely supported and/or retained by alloplastic implants.

Maxillofacial Prosthetics – is that branch of prosthodontics concerned with the restoration and/or replacement of stomatognathic and associated craniofacial structures by artificial substitutes.

Educationally Qualified: An individual is considered Educationally Qualified after the successful completion of an advanced educational prosthodontics program, which is accredited by the Commission on Dental Accreditation.

Board Eligible: An individual is Board Eligible when his/her application has been submitted to and approved by the Board and his/her eligibility has not expired.

Diplomate: Any dentist who has successfully met the requirements of the Board for certification and remains in good standing.

STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

The program **must** develop clearly stated goals and objectives appropriate to advanced specialty education, addressing education, patient care, research and service. Planning for, evaluation of and improvement of educational quality for the program **must** be broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service.

The program **must** document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement.

Intent: *The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of prosthodontics and that one of the program goals is to comprehensively prepare competent individuals to initially practice prosthodontics. The outcomes process includes steps to: (a) develop clear, measurable goals and objectives consistent with the program's purpose/mission; (b) develop procedures for evaluating the extent to which the goals and objectives are met; (c) collect and maintain data in an ongoing and systematic manner; (d) analyze the data collected and share the results with appropriate audiences; (e) identify and implement corrective actions to strengthen the program; and (f)review the assessment plan, revise as appropriate, and continue the cyclical process.*

The financial resources **must** be sufficient to support the program's stated goals and objectives.

Intent: *The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment, procure supplies, reference material and teaching aids as reflected in annual budget appropriations. Financial allocations should ensure that the program will be in a competitive position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the advanced specialty discipline. The Commission will assess the adequacy of financial support on the basis of current appropriations and the stability of sources of funding for the program.*

The sponsoring institution **must** ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

Advanced specialty education programs **must** be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity. Hospitals that sponsor advanced specialty education programs **must** be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced specialty education programs **must** be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of advanced specialty education programs **must** ensure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

United States military programs not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) **must** demonstrate successful achievement of Service-specific organizational inspection criteria.

The authority and final responsibility for curriculum development and approval, student/resident selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

The institution/program **must** have a formal system of quality assurance for programs that provide patient care.

The position of the program in the administrative structure **must** be consistent with that of other parallel programs within the institution and the program director must have the authority responsibility, and privileges necessary to manage the program.

AFFILIATIONS

The primary sponsor of the educational program **must** accept full responsibility for the quality of education provided in all affiliated institutions.

Documentary evidence of agreements, approved by the sponsoring and relevant affiliated institutions, **must** be available. The following items **must** be covered in such inter-institutional agreements:

a. Designation of a single program director;
b. The teaching staff;
c. The educational objectives of the program;
d. The period of assignment of students/residents; and
e. Each institution's financial commitment.

Intent: *An "institution (or organizational unit of an institution)" is defined as a dental, medical or public health school, patient care facility, or other entity that engages in advanced specialty education. The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).*

POLICY STATEMENT ON ACCREDITATION OF OFF-CAMPUS SITES

The Commission on Dental Accreditation recognizes primary and off-campus sites as locations where students/residents gain required educational experiences designed to meet accreditation or program requirements. Guidance regarding policy and procedures for each type of site follows.

Primary site: The sponsoring institutional site for an accredited program is the primary site. This site holds primary responsibility for clinical or didactic learning experiences that meet the program requirements or accreditation standards for a specific program. The site further holds responsibility for the written agreement with off-campus sites to meet accreditation standards.

Off-campus site: A training site located away from the primary site. For students/residents in a specific program, an off-campus site could be their principal learning site. An off-campus site could be one of the following:

1. A site with which a written agreement is held with the sponsoring institution regarding off-campus learning experiences that meet accreditation standards or program requirements.
2. A site owned/operated by the sponsoring institution that provides additional learning experiences that meet accreditation or program requirements and does not require a separate written agreement.

The Commission recognizes that dental assisting and dental laboratory technology programs utilize numerous extramural private dental offices and laboratories to provide students with clinical/laboratory work experience. The program will provide a list of all currently used extramural sites in the self-study document. The Commission will then randomly select and visit several facilities at the time of a site visit to the program. Prior Commission approval of these extramural dental office and laboratory sites will not be required.

Optional Enrichment/Optional Observation site: The Commission also recognizes optional enrichment and optional observation sites for the purposes of providing optional, *elective* enrichment or observational experiences. These sites are not used for achieving accreditation or program requirements. Therefore, these sites do not require Commission approval.

An institution may use one or more than one site to support student learning and meet CODA standards or program requirements. Initiation of activities at the off-campus site as well as documentation and reporting of site activities is expected to follow the EOPP guidelines and accreditation standards.

The Commission on Dental Accreditation must be informed when a program accredited by the Commission plans to initiate an off-campus site (distance site and/or additional training site not located on the main campus). The Commission must be informed in writing site at least thirty (30) days prior to a regularly scheduled semi-annual Review Committee meeting. There may be extenuating circumstances when a special review is necessary. A program must receive Commission on Dental Accreditation approval of the off-campus site prior to recruiting students/residents and initiating use of the site.

Generally, only programs without reporting requirements will be approved to initiate educational experiences at off-campus sites. The Commission must ensure that the necessary education as defined by the standards is available, and appropriate resources (adequate faculty and staff, availability of patient experiences, and distance learning provisions) are provided to all students/residents enrolled in an accredited program. When the Commission has received notification that an institution plans to offer its accredited program at an off-campus site, the Commission will conduct a special focused site visit to each off-campus location where a significant portion of each student's/resident's educational experience is provided, based on the specifics of the program, the accreditation standards, and Commission policies and procedures, or if other cause exists for such a visit as determined by the Commission.

A significant portion of each student's/resident's educational experience at an off-campus site is defined as any experience that impacts the program's ability to meet a CODA standard. The program must report the rationale for adding an off-campus site and how that site affects the program's goals, objectives, and outcomes. For example, program goals, objectives, and outcome measures may address institutional support, faculty support, curriculum, student didactic and clinical learning, research, and community service. The program must support the addition of an off-campus site with trends from pertinent areas of its outcomes assessment program that indicates the rationale for the additional site.

After the initial visit, each off campus site may be visited during the regularly scheduled CODA evaluation visit to the program.

Expansion of a developing dental hygiene and/or assisting program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

All programs accredited by the Commission pay an annual fee. Additional fees will be based on actual accreditation costs incurred during the visit to on and off-campus location. The Commission office should be contacted for current information on fees.

Revised: 8/13, 2/13, 2/12, 8/10, 7/09, 7/07; Reaffirmed: 2/02, 1/06; Adopted: 07/98

STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program **must** be administered by ~~a~~ one director who is board certified in the respective specialty of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)

Intent: *The director of an advanced specialty education program is to be certified by an ADA-recognized certifying board in the specialty. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified, but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.*

Examples of evidence to demonstrate compliance may include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced specialty program in the respective discipline; letter from the previous employing institution verifying service)

The program director **must** be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program's effectiveness in meeting its goals.

Documentation of all program activities **must** be ensured by the program director and available for review.

2-1 The program director **must** have primary responsibility for the organization and execution of the educational and administrative components to the program.

2-1.1 The program director **must** devote sufficient time to:

a. Participate in the student/resident selection process, unless the program is sponsored by federal services utilizing a centralized student/resident selection process;

b. Develop and implement the curriculum plan to provide a diverse educational experience in biomedical and clinical sciences;

c. Maintain a current copy of the curriculum's goals, objectives, and content outlines;

d. Maintain a record of the number and variety of clinical experiences accomplished by each student/resident;

e. Ensure that the majority of faculty assigned to the program are educationally qualified prosthodontists;

f. Provide written faculty evaluations at least annually to determine the effectiveness of the faculty in the educational program;
g. Conduct periodic staff meetings for the proper administration of the educational program; and
h. Maintain adequate records of clinical supervision.

2-2 The program director **must** encourage students/residents to seek certification by the American Board of Prosthodontics.

2-3 The number and time commitment of the teaching staff **must** be sufficient to
a. Provide didactic and clinical instruction to meet curriculum goals and objectives; and
b. Provide supervision of all treatment provided by students/residents through specific and regularly scheduled clinic assignments.

2-4 The program **must** show evidence of an ongoing faculty development process.

Intent: *Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.*

Examples of evidence to demonstrate compliance may include:
Participation in development activities related to teaching, learning, and assessment
Attendance at regional and national meetings that address contemporary issues in education and patient care
Mentored experiences for new faculty
Scholarly productivity
Presentations at regional and national meetings
Examples of curriculum innovation
Maintenance of existing and development of new and/or emerging clinical skills
Documented understanding of relevant aspects of teaching methodology
Curriculum design and development
Curriculum evaluation
Student/Resident assessment
Cultural Competency
Ability to work with students/residents of varying ages and backgrounds
Use of technology in didactic and clinical components of the curriculum
Evidence of participation in continuing education activities

STANDARD 3 - FACILITIES AND RESOURCES

Institutional facilities and resources **must** be adequate to provide the educational experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies **must** be readily accessible and functional.

Intent: *The facilities and resources (e.g.; support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, students/residents, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.*

The program **must** document its compliance with the institution's policy and applicable regulations of local, state and federal agencies, including but not limited to radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. Policies **must** be provided to all students/residents faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on bloodborne and infectious diseases **must** be made available to applicants for admission and patients.

Intent: *The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the students/residents faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.*

Students/Residents, faculty and appropriate support staff **must** be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk to patients and dental personnel.

Intent: *The program should have written policy that encourages (e.g., delineates the advantages of) immunization of students/residents, faculty and appropriate support staff.*

All students/residents, faculty and support staff involved in the direct provision of patient care **must** be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

Intent: *Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.*

The use of private office facilities as a means of providing clinical experiences in advanced specialty education is only approved when the specialty has included language that defines the use of such facilities in its specialty-specific standards.

Intent: *Required prosthodontic clinical experiences do not occur in private office facilities unless affiliated with the sponsoring institution.* ~~*Practice management and elective experiences may be undertaken in private office facilities.*~~

3-1 Physical facilities **must** permit students/residents to operate under circumstances prevailing in the practice of prosthodontics.

- 3-1.1 The clinical facilities **must** be specifically identified for the advanced education program in prosthodontics.
- 3-1.2 There **must** be sufficient number of completely equipped operatories to accommodate the number of students/residents enrolled.
- 3-1.3 Laboratory facilities **must** be specifically identified for the advanced education program in prosthodontics.
- 3-1.4 The laboratory **must** be equipped to support the fabrication of most prostheses required in the program.
- 3-1.5 There **must** be sufficient laboratory space to accommodate the number of students/residents enrolled in the program, including provisions for storage of personal and laboratory armamentaria.

3-2 Radiographic equipment for extra-and intraoral radiographs **must** be accessible to the student/resident.

3-3 Lecture, seminar, study space and administrative office space **must** be available for the conduct of the educational program.

3-4 Library resources **must** include access to a diversified selection of current dental, biomedical, and other pertinent reference material.

- 3-4.1 Library resources **must** also include access to appropriate current and back issues of major scientific journals as well as equipment for retrieval and duplication of information.

3-5 Facilities **must** include access to computer, photographic, and audiovisual resources for educational, administrative, and research support.

3-6 Adequate allied dental personnel **must** be assigned to the program to ensure clinical and laboratory technical support.

3-7 Secretarial and clerical assistance **must** be sufficient to meet the educational and administrative needs of the program.

3-8 Laboratory technical support **must** be sufficient to ensure efficient operation of the clinical program and meet the educational needs of the program.

STANDARD 4 – CURRICULUM AND PROGRAM DURATION

The advanced specialty education program **must** be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted standards of specialty practice as set forth in specific standards contained in this document.

Intent: *The intent is to ensure that the didactic rigor and extent of clinical experience exceeds pre-doctoral, entry level dental training or continuing education requirements and the material and experience satisfies standards for the specialty.*

Advanced specialty education programs **must** include instruction or learning experiences in evidence-based practice. Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or "searching publication databases and appraisal of the evidence")
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

The level of specialty area instruction in certificate and degree-granting programs **must** be comparable.

Intent: *The intent is to ensure that the students/residents of these programs receive the same educational requirements as set forth in these Standards.*

Documentation of all program activities **must** be ensured by the program director and available for review.

If an institution and/or program enrolls part-time students/residents, the institution/program **must** have guidelines regarding enrollment of part-time students/residents. Part-time students/residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis **must** ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

PROGRAM DURATION

4-1 A postdoctoral program in prosthodontics **must** encompass a minimum of ~~33~~ 34 months.

4-2 A postdoctoral program in prosthodontics that includes integrated maxillofacial training **must** encompass a minimum of 45 months.

4-3 A 12-month postdoctoral program in maxillofacial prosthetics **must** be preceded by successful completion of an accredited prosthodontics program.

CURRICULUM

4-4 Students/Residents **must** have the didactic/clinical background that supports successful completion of the prosthodontic specialty board examination and fosters life-long learning.

Intent: *Program directors should promote prosthodontic board certification. It is expected that students/residents should continue their life-long professional development by employing the didactic and clinical knowledge acquired during the program.*

~~4-4 The curriculum must be designed to enable the student/resident to attain skills representative of a clinician proficient in the theoretical and practical aspects of prosthodontics. Advanced level instruction may be provided through the following: formal courses, seminars, lectures, self instructional modules, clinical assignments and laboratory assignments.~~

4-5~~4.1~~ Written goals and objectives, including course outlines for didactic courses, **must** be developed for all instruction included in this curriculum.

Intent: *The curriculum should be designed to enable the student/resident to attain skills representative of a clinician competent in the theoretical and practical aspects at the specialty level of prosthodontics. Advanced level instruction may be provided through the following: formal courses, seminars, lectures, self-instructional modules, clinical assignments and laboratory.*

~~4-4.2 Content outlines must be developed for all didactic portions of the program.~~

4-6 ~~4-4.3~~ Students/Residents **must** prepare and present diagnostic data, treatment plans and the results of patient treatment.

4-7 ~~4-4.4~~ The amount of time devoted to didactic instruction and research **must** be at least 30% of the total educational experience.

4-8 ~~4-4.5~~ A minimum of 60% of the total program time **must** be devoted to providing patient services, including direct patient care and laboratory procedures.

4-9 ~~4-4.6 The program may include organized teaching experience. If time is devoted to this activity, it should be carefully evaluated in relation to the goals and objectives of the overall program and the interests of the individual student/resident.~~ Time devoted to organized teaching experiences **must** not compromise the didactic and clinical goals and objectives of the overall program.

***Intent**: If time is devoted to teaching experiences for the student/resident, it should be evaluated in relation to the goals and objectives of the overall program and the benefit of the individual student/resident.*

DIDACTIC PROGRAM~~: BIOMEDICAL SCIENCES~~

4-10 Instruction **must** be provided at the in-depth level for the diagnosis of diseases affecting prosthodontic treatment.

***Intent**: Students/Residents should receive instruction regarding diagnosis, etiology, pathogenesis and prevention of diseases that directly affect treatment outcomes. Risk assessment and prognosis should be included. It is expected that such foundational learning would be directly supportive of requisite clinical curriculum competencies.*

4-11 Instruction **must** be provided at the in-depth level in each of the following areas as both separate entities and integrated treatment approaches used to address patient needs and expectations.

a. Fixed prosthodontics;
b. Removable prosthodontics;
c. Implants and implant therapy;
d. Occlusion;
e. Esthetics;
f. Biomaterials;
g. Wound healing;
h. Surgical principles;
~~h~~ i. Infection Control;
~~i~~ j. Craniofacial anatomy and physiology related to prosthodontic therapy including dental implant placement;
~~j~~ k. Diagnostic Imaging, including three dimensional imaging related to prosthodontic therapy including dental implant placement; and
~~k~~ l. Prosthodontic diagnosis and treatment planning.

***Intent**: Students/Residents should receive in-depth didactic instruction that supports prosthodontic treatment outcomes. Didactic learning should directly support clinical decision making and requisite clinical curriculum competencies toward achieving patient esthetics and function. This includes foundational knowledge of surgical principles, ~~and~~ procedures, and complications, as they relate to implant placement, as well as biomaterial*

properties including biocompatibility, biomechanics and biotechnology as they apply to prosthodontic treatment plans.

4-~~12~~5 Instruction **must** be provided at the understanding level in each of the following biomedical areas:

a. Oral pathology;
b. Applied pharmacology;
c. ~~Craniofacial anatomy and physiology;~~
d. ~~Risk assessment for oral disease;~~Oral microbiology
e. ~~Infection control; and~~
f. ~~Wound healing.~~

~~4-6 Instruction **must** be provided at the familiarity level in each of the following:~~

~~a. Craniofacial growth and development;~~
~~b. Immunology; and~~
~~c. Oral microbiology.~~

~~*Intent: Students/Residents will have the didactic background that supports the various aspects of comprehensive prosthodontic therapy they provide or guide during their clinical experiences with dentate, partially edentulous and completely edentulous patients. This fundamental didactic background is necessary whether the student provides therapy or serves as the referral source to other providers. It is expected that such learning would be directly supportive of requisite clinical curriculum proficiencies and competencies.*~~

~~**DIDACTIC PROGRAM: PROSTHODONTICS AND RELATED DISCIPLINES**~~

~~4-7 Instruction **must** be provided at the in-depth level in each of the following:~~

~~a. Fixed prosthodontics;~~
~~b. Implant prosthodontics;~~
~~c. Removable prosthodontics, and~~
~~d. Occlusion.~~

~~*Intent: Students/Residents will have in-depth knowledge in all aspects of prosthodontic therapy to serve their leading role in the management of patients from various classification systems such as the Prosthodontic Diagnostic Index for edentulous, partially edentulous and dentate patients. This includes surgical and post-surgical management of the implant patient.*~~

4-~~13~~8 Instruction **must** be provided at the understanding level in each of the following clinical areas:

a. ~~Biomaterials~~Temporomandibular disorders and orofacial pain;

b. ~~Geriatric dentistry~~Evidence-based health care principles including identifying, appraising and applying available evidence;
c. ~~Maxillofacial prosthetics~~Emerging science and technology;
d. ~~Preprosthetic surgery; including surgical principles and procedures~~Ethics and professionalism;
e. ~~Evidence-based decision-making~~ Preprosthetic surgery; ~~, including surgical principles and procedures;~~
f. ~~Temporomandibular disorders and orofacial pain~~Geriatric considerations in prosthodontic care;
~~g. Medical emergencies~~
g. ~~Diagnostic radiology~~Maxillofacial prosthetics;
h. ~~Research methodology; and~~Medical emergencies;
i. ~~Emerging science and technology.~~Research methodology~~;~~ and
j. Pain control and sedation.

4-14 Instruction **must** be provided at the understanding level in diagnostic and treatment planning aspects of other recognized dental specialties as they relate to referral, patient treatment and prosthodontic outcomes.

***Intent**: Students/Residents should receive instruction in diagnosis and treatment planning and as a member of interdisciplinary teams in order to develop, implement and assess treatment approaches that optimize therapeutic outcomes. Students/Residents should receive instruction in relating proposed treatments to survival, physiologic, psychological and economic outcomes. Instruction should be provided in risk assessment and prognosis prediction based upon considered treatment options and individual patient needs.*

4-15~~9~~ ~~Instruction must be provided at the familiarity level in each of the following.~~ Students/Residents **must** receive didactic specialty instruction including but not limited to:

a. ~~Endodontics~~Craniofacial growth and development;
b. ~~Periodontics~~Biostatistics;
c. ~~Orthodontics~~Intraoral photography;
d. ~~Sleep disorders~~Practice management;
e. ~~Sedation~~Scientific writing;
f. ~~Intraoral photography~~Sleep disorders;
g. ~~Practice management~~Teaching methodology including public speaking; and
h. ~~Ethics~~Behavioral science.
~~i. Biostatistics;~~
~~j. Scientific writing; and~~
~~k. Teaching methodology~~.

CLINICAL PROGRAM

Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes (CDEL Approved 2003). At the specialty level, Prosthodontics embraces its role as part of a therapy team. To support this definition and vision, programs will provide appropriate clinical experiences for students/residents to develop the following competencies:

4-16 Students/Residents **must** be competent at the prosthodontic specialty level in the treatment of clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes by achieving clinical competence in the following areas:

a. Patient assessment, including medical history, dental history, temporomandibular assessment, extraoral and intraoral examination, radiologic assessment and occlusal analysis;
b. Systemic, infectious and neoplastic disease screening, including patient education for prevention;
c. Diagnosis;
d. Risk assessment and prognosis;
e. Treatment planning;
f. Adjunct referral;
~~f~~ g. Patient Care;
~~g~~ h. Outcomes assessment; and
~~h~~ i. Maintenance.

***Intent**: Students/Residents should use advanced methods including existing and emerging technologies for diagnosis, treatment planning, referral, and prosthodontic treatment to optimize occlusion, masticatory function and esthetics.*

~~4-10 The program must provide sufficient clinical experiences for the student/resident to be proficient in the comprehensive treatment of a wide range of complex prosthodontic patients with various categories of need.~~

4-17 Students/Residents **must** be competent in managing and treating a wide scope of complex clinical conditions for edentulous, partially edentulous and dentate patients.

***Intent**: Students/Residents should manage and treat patients with clinical conditions at a level beyond experiences at the predoctoral dental education level. Students/Residents should provide prosthodontic therapy for a wide scope of patients with esthetic and functional needs above the level of general dentistry, including patients with varying degrees of cognitive and physical impairment.*

~~4-11 The program must provide sufficient clinical experiences for the student/resident to be proficient in:~~

~~a. Collecting, organizing, analyzing, and interpreting diagnostic data;~~

~~b. Determining a diagnosis;~~

~~c. Developing a comprehensive treatment plan and prognosis;~~

~~d. Critically evaluating the results of treatment; and~~

~~e. Effectively utilizing the professional services of allied dental personnel, including but not limited to, dental laboratory technicians, dental assistants, and dental hygienists.~~

~~4-12 The program must provide sufficient clinical experiences for the student/resident to be proficient in the comprehensive diagnosis, treatment planning and rehabilitation of edentulous, partially edentulous and dentate patients.~~

~~a. Clinical experiences must include a variety of patients within a range of prosthodontic classifications, such as in the Prosthodontic Diagnostic Index for edentulous, partially edentulous and dentate patients.~~

~~b. Clinical experiences must include rehabilitative and esthetic procedures of varying complexity.~~

~~c. Clinical experiences must include treatment of geriatric patients, including patients with varying degrees of cognitive and physical impairments.~~

~~d. This may include defects, which are due to genetic, functional, parafunctional, microbial or traumatic causes.~~

~~Intent: *Students/Residents will be proficient in the use of adjustable articulators to develop an integrated occlusion for opposing arches; complete and partial coverage restorations, restoration of endodontically treated teeth, fixed prosthodontics, removable partial dentures, complete dentures, implant supported and/or retained prostheses, and continual care and maintenance of restorations. Students/Residents will diagnose and treat patients using advances in science and technology.*~~

4-18 Students/Residents **must** be competent in the application of principles associated with fixed prosthodontics, removable prosthodontics and implants, and as members of a treatment team.

***Intent**: Students/Residents should evaluate and use existing and appropriate newly introduced technologies to replace teeth and their associated structures using biologically active and passive therapies for fixed and removable prosthodontic treatment. These experiences should be beyond those learned at the predoctoral level and use natural teeth and dental implants as part of the treatment.*

4-19 Students/Residents **must** be competent in the application of evidence-based health care principles.

***Intent**: Students/Residents should be able to identify, appraise, apply and communicate best evidence as it relates to health care and clinical and translational research, including how such*

research is conducted, evaluated, applied and communicated to patients and health care providers.

4-20 Students/Residents **must** be competent regarding principles of ethical decision making pertaining to academic, research, patient care and practice environments.

***Intent**: Students/Residents should be able to draw on a range of resources such as professional codes, regulatory law, and ethical theories to guide judgment and action for issues that are complex, novel, ethically arguable, divisive or of public concern.*

4-21 Students/Residents **must** be competent in the application of principles of esthetic dentistry.

***Intent**: Students/Residents should use existing and newly introduced technologies and apply principles of esthetic dentistry to restore existing teeth and replace missing teeth and their associated structures. These experiences should be beyond those learned at the predoctoral level supported by natural teeth and dental implants as part of the treatment.*

4-22 Students/Residents **must** be competent in the pre-treatment assessment, diagnosis, placement, and restoration of dental implants, including referral.

***Intent**: Replacement of missing teeth and the associated oral and maxillofacial tissues using biocompatible substitutes is a core component of Prosthodontics and its definition. Students/Residents should perform surgical placement of dental implants in healed edentulous sites with adequate vertical and horizontal osseous tissue as a part of prosthodontic treatment for patients. These experiences should demonstrate the student's/resident's role in the process of assessment, diagnosis, treatment planning, ~~and~~ implementation of prosthetic rehabilitation, and referral.*

4-23 Students/Residents **must** be competent in leading and coordinating oral health care with other members of the health care team.

***Intent**: Students/Residents should be able to plan, evaluate and provide direction for patient treatment in consultation with other health care providers in a multi-disciplinary team. Students/Residents should be able to direct laboratory technicians supporting treatment at the prosthodontic specialty level.*

4-24 Students/Residents **must** be competent in selection and application of biomaterials recognizing esthetic, biomechanical and biocompatibility implications of prosthodontic therapies.

Intent: *Students/Residents should be able to treatment plan for clinical predictability based on patient and restoration factors.*

4-2513 ~~The program must provide sufficient dental laboratory experience for the~~ sStudent/Residents ~~to~~ **must** be competent in ~~the~~ laboratory ~~aspects of~~ procedures used in the treatment of ~~complete edentulism~~edentulous, partially ~~edentulism~~edentulous and dentate patients.

***Intent**: Students/Residents should be able to use existing technologies to plan, design and fabricate prostheses. They should be capable of directing dental technicians in prosthodontic laboratory procedures. They should be able to evaluate newly introduced technologies and apply these as appropriate.*

4-2614 Students/Residents **must** be competent in the prosthodontic management of patients with temporomandibular disorders and/or orofacial pain.

***Intent**: Students/Residents should recognize signs and symptoms associated with temporomandibular disorders and/or orofacial pain. Students/Residents should either provide appropriate treatment or refer, consistent with contemporary practice and the best interest of the patient.*

4-2715 Students/Residents ~~must be exposed to~~ **must** have experience with patients requiring ~~various~~ maxillofacial prosthetic ~~services~~care.

***Intent**: Students/Residents should have clinical patient experiences screening, diagnosing, assessing risk, treatment planning, referring and following-up patients requiring maxillofacial services.*

~~4-16 Students/Residents **must** participate in all phases of implant treatment including implant placement.~~

~~4-17 Students/Residents **must** be exposed to preprosthetic surgical procedures.~~

~~Intent: *Surgical procedures should include contouring of residual ridges, gingival recontouring, placement of dental implants, and removal of teeth.*~~

~~4-18 Students/Residents **must** be exposed to patient management through sedation.~~

~~Intent: *Students/Residents will observe procedures for patients who are sedated.*~~

~~4-19 Students/Residents **must** be competent in oral/head/neck cancer screening and patient education for prevention.~~

~~Intent: *Students/Residents will be competent in clinical identification of potential pathosis and referral to a specialist. Students/Residents will also educate patients to promote oral/head/neck cancer prevention.*~~

MAXILLOFACIAL PROSTHETICS

Note: Application of these Standards to programs of various scope/length is as follows:

a. Prosthodontic programs that encompass a minimum of forty-five months that include integrated maxillofacial prosthetic training: all sections of these Standards apply;

b. Prosthodontic programs that encompass a minimum of thirty-three months: all sections of these Standards apply except sections ~~4-20~~ 4-28 through ~~4-26~~ 4-36 inclusive; and

c. Twelve-month maxillofacial prosthetic programs: all sections of these Standards apply except sections 4-4 and ~~4-5~~ 4-10 through ~~4-19~~ 4-27, inclusive.

PROGRAM DURATION

4-28~~20~~ An advanced education program in maxillofacial prosthetics **must** be provided with a forty-five month integrated prosthodontic program which includes fixed prosthodontic, removable prosthodontic, implant prosthodontic and maxillofacial prosthetic experiences; or a one-year program devoted specifically to maxillofacial prosthetics which follows completion of a prosthodontic program.

DIDACTIC PROGRAM

4-29~~1~~ Instruction **must** be provided at the in-depth level in each of the following:

~~a. Maxillary defects and soft palate defects, which are the result of disease or trauma (acquired defects);~~

~~b. Mandibular defects, which are the result of disease or trauma (acquired defects);~~

~~c. Maxillary defects, which are naturally acquired (congenital or developmental defects);~~

~~d. Mandibular defects, which are naturally acquired (congenital or developmental defects);~~

~~e. Facial defects, which are the result of disease or trauma or are naturally acquired;~~

~~f. The use of implants to restore intraoral and extraoral defects;~~

~~g. Maxillofacial prosthetic management of the radiation therapy patient; and~~

~~h. Maxillofacial prosthetic management of the chemotherapy patient.~~

a. Etiology, multidisciplinary treatments, treatment sequela, and prosthetic treatment planning of defects of the craniofacial complex that are the result of disease, trauma and developmental/congenital processes;

b. Implant therapy in the patients described in 4-28a;

c. Intra-oral and extra-oral prosthetic considerations for patients receiving surgical, radiation or drug therapies that impact the health of the craniofacial structures.

Intent: *Students/Residents should have the biomedical and clinical didactic background that supports the various aspects of prosthodontic therapy they provide and guide during their*

clinical experiences in treating patients with craniofacial deformities. Students/Residents should receive instruction in the advantages, disadvantages, indications and outcome assessments of multidisciplinary care of these patients and the impact this has on prosthetic interventions. This fundamental didactic background is necessary whether the student/resident provides therapy or serves as the referral source to other providers. This includes surgical and postsurgical management of patients requiring implant therapy. It is expected that such foundational learning would be directly supportive of requisite clinical curriculum competencies.

4-30 Students/Residents **must** have the didactic/clinical background that supports successful completion of the prosthodontic specialty board examination and fosters life-long learning.

***Intent**: Program directors should promote prosthodontic board certification to attain the appropriate hospital appointment for the clinical practice of maxillofacial prosthetics.* It is expected that students/residents continue their life-long professional development by employing the didactic and clinical knowledge acquired during the maxillofacial program.

4-3122 Instruction **must** be provided at the ~~familiarity~~ understanding level in each of the following as they impact health and reconstruction of the craniofacial complex and prosthodontic rehabilitation:

a. Medical oncology;
b. ~~Principles of head and neck surgery~~Ablative and reconstructive surgery of the head and neck;
c. Radiation oncology;
d. Speech and deglutition; ~~and~~
e. ~~Cranial defects~~Developmental and congenital craniofacial anomalies;
f. Advanced digital technology; and
g. Biomaterials used in maxillofacial prosthetics.

CLINICAL PROGRAM

4-3223 Students/Residents **must** be competent to perform pre-prosthetic and maxillofacial prosthetic treatment procedures ~~performed~~ in the hospital ~~operation~~operating room.

***Intent**: Students/Residents should be able to perform pre-prosthetic procedures in preparation for maxillofacial rehabilitation as members of an inter-disciplinary treatment team in the hospital operating room that will directly affect the final reconstructive and rehabilitative outcome of patients with craniofacial complex defects.*

4-33 Students/Residents **must** be competent in the hospital operation room to guide and assist multidisciplinary team members in resection and reconstructive treatment procedures that impact prosthetic rehabilitation for patients with maxillofacial and craniofacial complex defects.

Intent: Students/Residents should be able to guide and assist multidisciplinary team members in the operating room to enhance the resection contours and selection and positioning of flaps/grafts for reconstruction and rehabilitation of prosthetic patients with various craniofacial complex defects.

~~4-24 Students/Residents must gain clinical experience to become proficient in the pre-prosthetic, prosthetic and post-prosthetic management and treatment of patients with defects of the maxilla and mandible. Clinical experience regarding management and treatment should include:~~

~~a. Patients who are partially dentate and for patients who are edentulous;~~
~~b. Patients who have undergone radiation therapy to the head and neck region;~~
~~c. Maxillary defects of the hard palate, soft palate and alveolus;~~
~~d. Mandibular continuity and discontinuity defects; and~~
~~e. Acquired, congenital and developmental defects.~~

4-3425 Students/Residents **must** ~~gain clinical experience to become~~ be competent in the pre-prosthetic, prosthetic and post-prosthetic management and performing treatment of patients with defects of ~~facial structures~~ the craniofacial complex.

Intent: Students/Residents should be able to deliver care for various deformities restoring/improving functional deficits. Such experiences should be beyond those learned at graduate prosthodontic level, and should use natural teeth and dental and craniofacial implants as part of the treatment

4-35 Students/Residents **must** be competent to direct and teach laboratory technicians supporting treatment for the maxillofacial prosthetic patients.

Intent: Students/Residents should be able to instruct laboratory technicians and allied health personnel in the unique laboratory and supportive procedures required for intraoral and extraoral maxillofacial prostheses.

4-36 Students/Residents **must** demonstrate competency in ~~inter~~multidisciplinary diagnosis and treatment planning conferences relevant to clinical maxillofacial prosthetics, as it fulfills the mission of the program, which may include:

a. Cleft palate and craniofacial conferences;
b. Clinical pathology conferences;
c. Head and neck cancer ~~diagnostic~~ treatment planning conferences;
d. Medical oncology treatment planning conferences;
e. Radiation therapy diagnosis and treatment planning conferences;
f. Reconstructive surgery conferences; and
g. Tumor boards.

STANDARD 5 - ADVANCED EDUCATION STUDENTS/RESIDENTS

ELIGIBILITY AND SELECTION

~~Dentists with the following qualifications are eligible to enter advanced specialty education programs accredited by the Commission on Dental Accreditation:~~

~~a. Graduates from institutions in the U.S. accredited by the Commission on Dental Accreditation;~~
~~b. Graduates from institutions in Canada accredited by the Commission on Dental Accreditation of Canada; and~~
~~c. Graduates of international dental schools who possess equivalent educational background and standing as determined by the institution and program.~~

Eligible applicants to advanced specialty education programs accredited by the Commission on Dental Accreditation **must** be graduates from:

a. Predoctoral dental programs in the U.S. accredited by the Commission on Dental Accreditation; or
b. Predoctoral dental programs in Canada accredited by the Commission on Dental Accreditation of Canada; or
c. International dental schools that provide equivalent educational background and standing as determined by the program.

Specific written criteria, policies and procedures **must** be followed when admitting students/residents.

Intent: *Written non-discriminatory policies are to be followed in selecting students/residents. These policies should make clear the methods and criteria used in recruiting and selecting students/residents and how applicants are informed of their status throughout the selection process.*

Admission of students/residents with advanced standing **must** be based on the same standards of achievement required by students/residents regularly enrolled in the program. Students/Residents with advanced standing **must** receive an appropriate curriculum that results in the same standards of competence required by students/residents regularly enrolled in the program.

Examples of evidence to demonstrate compliance may include:

- policies and procedures on advanced standing
- results of appropriate qualifying examinations
- course equivalency or other measures to demonstrate equal scope and level of knowledge

Intent: *Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant's past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing students/residents will not result in an increase of the program's approved number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for students/residents in the conventional program and be held to the same academic standards. Advanced standing students/residents, to be certified for completion, are expected to demonstrate the same standards of competence as those in the conventional program.*

EVALUATION

A system of ongoing evaluation and advancement **must** ensure that, through the director and faculty, each program:

a. Periodically, but at least semiannually, ~~evaluates the knowledge, skills, ethical conduct and professional growth of its students/residents, using appropriate written criteria and procedures~~ assesses the progress toward (formative assessment) and achievement of (summative assessment) the competencies for the specialty using formal evaluation methods;
b. Provides to students/residents an assessment of their performance, at least semiannually;
c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and
d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.

Intent: *(a) The evaluation of competence is an ongoing process that requires a variety of assessments that can measure the acquisition of knowledge, skills and values necessary for specialty-level practice. It is expected that programs develop and periodically review evaluation methods that include both formative and summative assessments. (b) Student/Resident evaluations should be recorded and available in written form (c) Deficiencies should be identified in order to institute corrective measures (d) Student/Resident evaluation is documented in writing and is shared with the student/resident*

DUE PROCESS

There **must** be specific written due process policies and procedures for adjudication of academic and disciplinary complaints, which parallel those established by the sponsoring institution.

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the advanced specialty education students/residents **must** be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all advanced specialty education students/residents **must** be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.

Intent: *Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a student/resident (for academic or disciplinary reasons). In addition to information on the program, students/residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the students/residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.*

STANDARD 6 - RESEARCH

Advanced specialty education students/residents **must** engage in scholarly activity.

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS *v.* FEDERAL TRADE COMMISSION

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 13–534. Argued October 14, 2014—Decided February 25, 2015

North Carolina's Dental Practice Act (Act) provides that the North Carolina State Board of Dental Examiners (Board) is "the agency of the State for the regulation of the practice of dentistry." The Board's principal duty is to create, administer, and enforce a licensing system for dentists; and six of its eight members must be licensed, practicing dentists.

The Act does not specify that teeth whitening is "the practice of dentistry." Nonetheless, after dentists complained to the Board that nondentists were charging lower prices for such services than dentists did, the Board issued at least 47 official cease-and-desist letters to nondentist teeth whitening service providers and product manufacturers, often warning that the unlicensed practice of dentistry is a crime. This and other related Board actions led nondentists to cease offering teeth whitening services in North Carolina.

The Federal Trade Commission (FTC) filed an administrative complaint, alleging that the Board's concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition under the Federal Trade Commission Act. An Administrative Law Judge (ALJ) denied the Board's motion to dismiss on the ground of state-action immunity. The FTC sustained that ruling, reasoning that even if the Board had acted pursuant to a clearly articulated state policy to displace competition, the Board must be actively supervised by the State to claim immunity, which it was not. After a hearing on the merits, the ALJ determined that the Board had unreasonably restrained trade in violation of antitrust law. The FTC again sustained the ALJ, and the Fourth Circuit affirmed the FTC in

all respects.

Held: Because a controlling number of the Board's decisionmakers are active market participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here that requirement is not met. Pp. 5–18.

(a) Federal antitrust law is a central safeguard for the Nation's free market structures. However, requiring States to conform to the mandates of the Sherman Act at the expense of other values a State may deem fundamental would impose an impermissible burden on the States' power to regulate. Therefore, beginning with *Parker* v. *Brown*, 317 U. S. 341, this Court interpreted the antitrust laws to confer immunity on the anticompetitive conduct of States acting in their sovereign capacity. Pp. 5–6.

(b) The Board's actions are not cloaked with *Parker* immunity. A nonsovereign actor controlled by active market participants—such as the Board—enjoys *Parker* immunity only if "'the challenged restraint . . . [is] clearly articulated and affirmatively expressed as state policy,' and . . . 'the policy . . . [is] actively supervised by the State.'" *FTC* v. *Phoebe Putney Health System, Inc.*, 568 U. S. ___, ___ (quoting *California Retail Liquor Dealers Assn.* v. *Midcal Aluminum, Inc.*, 445 U. S. 97, 105). Here, the Board did not receive active supervision of its anticompetitive conduct. Pp. 6–17.

(1) An entity may not invoke *Parker* immunity unless its actions are an exercise of the State's sovereign power. See *Columbia* v. *Omni Outdoor Advertising, Inc.*, 499 U. S. 365, 374. Thus, where a State delegates control over a market to a nonsovereign actor the Sherman Act confers immunity only if the State accepts political accountability for the anticompetitive conduct it permits and controls. Limits on state-action immunity are most essential when a State seeks to delegate its regulatory power to active market participants, for dual allegiances are not always apparent to an actor and prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. Accordingly, *Parker* immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State's own. *Midcal*'s two-part test provides a proper analytical framework to resolve the ultimate question whether an anticompetitive policy is indeed the policy of a State. The first requirement—clear articulation—rarely will achieve that goal by itself, for entities purporting to act under state authority might diverge from the State's considered definition of the public good and engage in private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this

Syllabus

harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity. Pp. 6–10.

(2) There are instances in which an actor can be excused from *Midcal*'s active supervision requirement. Municipalities, which are electorally accountable, have general regulatory powers, and have no private price-fixing agenda, are subject exclusively to the clear articulation requirement. See *Hallie* v. *Eau Claire*, 471 U. S. 34, 35. That *Hallie* excused municipalities from *Midcal*'s supervision rule for these reasons, however, all but confirms the rule's applicability to actors controlled by active market participants. Further, in light of *Omni*'s holding that an otherwise immune entity will not lose immunity based on ad hoc and *ex post* questioning of its motives for making particular decisions, 499 U. S., at 374, it is all the more necessary to ensure the conditions for granting immunity are met in the first place, see *FTC* v. *Ticor Title Ins. Co.*, 504 U. S. 621, 633, and *Phoebe Putney*, *supra*, at ___. The clear lesson of precedent is that *Midcal*'s active supervision test is an essential prerequisite of *Parker* immunity for any nonsovereign entity—public or private—controlled by active market participants. Pp. 10–12.

(3) The Board's argument that entities designated by the States as agencies are exempt from *Midcal*'s second requirement cannot be reconciled with the Court's repeated conclusion that the need for supervision turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade. State agencies controlled by active market participants pose the very risk of self-dealing *Midcal*'s supervision requirement was created to address. See *Goldfarb* v. *Virginia State Bar*, 421 U. S. 773, 791. This conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants' confusing their own interests with the State's policy goals. While *Hallie* stated "it is likely that active state supervision would also not be required" for agencies, 471 U. S., at 46, n. 10, the entity there was more like prototypical state agencies, not specialized boards dominated by active market participants. The latter are similar to private trade associations vested by States with regulatory authority, which must satisfy *Midcal*'s active supervision standard. 445 U. S., at 105–106. The similarities between agencies controlled by active market participants and such associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules. See *Hallie*, *supra*, at 39. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. Thus,

the Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*'s active supervision requirement in order to invoke state-action antitrust immunity. Pp. 12–14.

(4) The State argues that allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation. But this holding is not inconsistent with the idea that those who pursue a calling must embrace ethical standards that derive from a duty separate from the dictates of the State. Further, this case does not offer occasion to address the question whether agency officials, including board members, may, under some circumstances, enjoy immunity from damages liability. Of course, States may provide for the defense and indemnification of agency members in the event of litigation, and they can also ensure *Parker* immunity is available by adopting clear policies to displace competition and providing active supervision. Arguments against the wisdom of applying the antitrust laws to professional regulation absent compliance with the prerequisites for invoking *Parker* immunity must be rejected, see *Patrick* v. *Burget*, 486 U. S. 94, 105–106, particularly in light of the risks licensing boards dominated by market participants may pose to the free market. Pp. 14–16.

(5) The Board does not contend in this Court that its anticompetitive conduct was actively supervised by the State or that it should receive *Parker* immunity on that basis. The Act delegates control over the practice of dentistry to the Board, but says nothing about teeth whitening. In acting to expel the dentists' competitors from the market, the Board relied on cease-and-desist letters threatening criminal liability, instead of other powers at its disposal that would have invoked oversight by a politically accountable official. Whether or not the Board exceeded its powers under North Carolina law, there is no evidence of any decision by the State to initiate or concur with the Board's actions against the nondentists. P. 17.

(c) Here, where there are no specific supervisory systems to be reviewed, it suffices to note that the inquiry regarding active supervision is flexible and context-dependent. The question is whether the State's review mechanisms provide "realistic assurance" that a nonsovereign actor's anticompetitive conduct "promotes state policy, rather than merely the party's individual interests." *Patrick*, 486 U. S., 100–101. The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, see *id.*, at 102–103; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, see *ibid.*; and the "mere potential for state

Syllabus

supervision is not an adequate substitute for a decision by the State," *Ticor*, *supra*, at 638. Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case. Pp. 17–18.

717 F. 3d 359, affirmed.

KENNEDY, J., delivered the opinion of the Court, in which ROBERTS, C. J., and GINSBURG, BREYER, SOTOMAYOR, and KAGAN, JJ., joined. ALITO, J., filed a dissenting opinion, in which SCALIA and THOMAS, JJ., joined.

SUPREME COURT OF THE UNITED STATES

No. 13–534

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS, PETITIONER *v.* FEDERAL TRADE COMMISSION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

[February 25, 2015]

JUSTICE KENNEDY delivered the opinion of the Court.

This case arises from an antitrust challenge to the actions of a state regulatory board. A majority of the board's members are engaged in the active practice of the profession it regulates. The question is whether the board's actions are protected from Sherman Act regulation under the doctrine of state-action antitrust immunity, as defined and applied in this Court's decisions beginning with *Parker* v. *Brown*, 317 U. S. 341 (1943).

I

A

In its Dental Practice Act (Act), North Carolina has declared the practice of dentistry to be a matter of public concern requiring regulation. N. C. Gen. Stat. Ann. §90–22(a) (2013). Under the Act, the North Carolina State Board of Dental Examiners (Board) is "the agency of the State for the regulation of the practice of dentistry." §90–22(b).

The Board's principal duty is to create, administer, and enforce a licensing system for dentists. See §§90–29 to

90–41. To perform that function it has broad authority over licensees. See §90–41. The Board's authority with respect to unlicensed persons, however, is more restricted: like "any resident citizen," the Board may file suit to "perpetually enjoin any person from . . . unlawfully practicing dentistry." §90–40.1.

The Act provides that six of the Board's eight members must be licensed dentists engaged in the active practice of dentistry. §90–22. They are elected by other licensed dentists in North Carolina, who cast their ballots in elections conducted by the Board. *Ibid.* The seventh member must be a licensed and practicing dental hygienist, and he or she is elected by other licensed hygienists. *Ibid.* The final member is referred to by the Act as a "consumer" and is appointed by the Governor. *Ibid.* All members serve 3-year terms, and no person may serve more than two consecutive terms. *Ibid.* The Act does not create any mechanism for the removal of an elected member of the Board by a public official. See *ibid.*

Board members swear an oath of office, §138A–22(a), and the Board must comply with the State's Administrative Procedure Act, §150B–1 *et seq.*, Public Records Act, §132–1 *et seq.*, and open-meetings law, §143–318.9 *et seq.* The Board may promulgate rules and regulations governing the practice of dentistry within the State, provided those mandates are not inconsistent with the Act and are approved by the North Carolina Rules Review Commission, whose members are appointed by the state legislature. See §§90–48, 143B–30.1, 150B–21.9(a).

B

In the 1990's, dentists in North Carolina started whitening teeth. Many of those who did so, including 8 of the Board's 10 members during the period at issue in this case, earned substantial fees for that service. By 2003, nondentists arrived on the scene. They charged lower

prices for their services than the dentists did. Dentists soon began to complain to the Board about their new competitors. Few complaints warned of possible harm to consumers. Most expressed a principal concern with the low prices charged by nondentists.

Responding to these filings, the Board opened an investigation into nondentist teeth whitening. A dentist member was placed in charge of the inquiry. Neither the Board's hygienist member nor its consumer member participated in this undertaking. The Board's chief operations officer remarked that the Board was "going forth to do battle" with nondentists. App. to Pet. for Cert. 103a. The Board's concern did not result in a formal rule or regulation reviewable by the independent Rules Review Commission, even though the Act does not, by its terms, specify that teeth whitening is "the practice of dentistry."

Starting in 2006, the Board issued at least 47 cease-and-desist letters on its official letterhead to nondentist teeth whitening service providers and product manufacturers. Many of those letters directed the recipient to cease "all activity constituting the practice of dentistry"; warned that the unlicensed practice of dentistry is a crime; and strongly implied (or expressly stated) that teeth whitening constitutes "the practice of dentistry." App. 13, 15. In early 2007, the Board persuaded the North Carolina Board of Cosmetic Art Examiners to warn cosmetologists against providing teeth whitening services. Later that year, the Board sent letters to mall operators, stating that kiosk teeth whiteners were violating the Dental Practice Act and advising that the malls consider expelling violators from their premises.

These actions had the intended result. Nondentists ceased offering teeth whitening services in North Carolina.

C

In 2010, the Federal Trade Commission (FTC) filed an

administrative complaint charging the Board with violating §5 of the Federal Trade Commission Act, 38 Stat. 719, as amended, 15 U. S. C. §45. The FTC alleged that the Board's concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition. The Board moved to dismiss, alleging state-action immunity. An Administrative Law Judge (ALJ) denied the motion. On appeal, the FTC sustained the ALJ's ruling. It reasoned that, even assuming the Board had acted pursuant to a clearly articulated state policy to displace competition, the Board is a "public/private hybrid" that must be actively supervised by the State to claim immunity. App. to Pet. for Cert. 49a. The FTC further concluded the Board could not make that showing.

Following other proceedings not relevant here, the ALJ conducted a hearing on the merits and determined the Board had unreasonably restrained trade in violation of antitrust law. On appeal, the FTC again sustained the ALJ. The FTC rejected the Board's public safety justification, noting, *inter alia*, "a wealth of evidence . . . suggesting that non-dentist provided teeth whitening is a safe cosmetic procedure." *Id.*, at 123a.

The FTC ordered the Board to stop sending the cease-and-desist letters or other communications that stated nondentists may not offer teeth whitening services and products. It further ordered the Board to issue notices to all earlier recipients of the Board's cease-and-desist orders advising them of the Board's proper sphere of authority and saying, among other options, that the notice recipients had a right to seek declaratory rulings in state court.

On petition for review, the Court of Appeals for the Fourth Circuit affirmed the FTC in all respects. 717 F. 3d 359, 370 (2013). This Court granted certiorari. 571 U. S. ___ (2014).

II

Federal antitrust law is a central safeguard for the Nation's free market structures. In this regard it is "as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms." *United States* v. *Topco Associates, Inc.*, 405 U. S. 596, 610 (1972). The antitrust laws declare a considered and decisive prohibition by the Federal Government of cartels, price fixing, and other combinations or practices that undermine the free market.

The Sherman Act, 26 Stat. 209, as amended, 15 U. S. C. §1 *et seq.*, serves to promote robust competition, which in turn empowers the States and provides their citizens with opportunities to pursue their own and the public's welfare. See *FTC* v. *Ticor Title Ins. Co.*, 504 U. S. 621, 632 (1992). The States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition. While "the States regulate their economies in many ways not inconsistent with the antitrust laws," *id.*, at 635–636, in some spheres they impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives. If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States' power to regulate. See *Exxon Corp.* v. *Governor of Maryland*, 437 U. S. 117, 133 (1978); see also Easterbrook, Antitrust and the Economics of Federalism, 26 J. Law & Econ. 23, 24 (1983).

For these reasons, the Court in *Parker* v. *Brown* interpreted the antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity. See 317 U. S., at 350–351. That ruling

recognized Congress' purpose to respect the federal balance and to "embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution." *Community Communications Co.* v. *Boulder*, 455 U. S. 40, 53 (1982). Since 1943, the Court has reaffirmed the importance of *Parker*'s central holding. See, *e.g.*, *Ticor*, *supra*, at 632–637; *Hoover* v. *Ronwin*, 466 U. S. 558, 568 (1984); *Lafayette* v. *Louisiana Power & Light Co.*, 435 U. S. 389, 394–400 (1978).

III

In this case the Board argues its members were invested by North Carolina with the power of the State and that, as a result, the Board's actions are cloaked with *Parker* immunity. This argument fails, however. A nonsovereign actor controlled by active market participants—such as the Board—enjoys *Parker* immunity only if it satisfies two requirements: "first that 'the challenged restraint . . . be one clearly articulated and affirmatively expressed as state policy,' and second that 'the policy . . . be actively supervised by the State.'" *FTC* v. *Phoebe Putney Health System, Inc.*, 568 U. S. ___, ___ (2013) (slip op., at 7) (quoting *California Retail Liquor Dealers Assn.* v. *Midcal Aluminum, Inc.*, 445 U. S. 97, 105 (1980)). The parties have assumed that the clear articulation requirement is satisfied, and we do the same. While North Carolina prohibits the unauthorized practice of dentistry, however, its Act is silent on whether that broad prohibition covers teeth whitening. Here, the Board did not receive active supervision by the State when it interpreted the Act as addressing teeth whitening and when it enforced that policy by issuing cease-and-desist letters to nondentist teeth whiteners.

A

Although state-action immunity exists to avoid conflicts

between state sovereignty and the Nation's commitment to a policy of robust competition, *Parker* immunity is not unbounded. "[G]iven the fundamental national values of free enterprise and economic competition that are embodied in the federal antitrust laws, 'state action immunity is disfavored, much as are repeals by implication.'" *Phoebe Putney*, *supra*, at ___ (slip op., at 7) (quoting *Ticor*, *supra*, at 636).

An entity may not invoke *Parker* immunity unless the actions in question are an exercise of the State's sovereign power. See *Columbia* v. *Omni Outdoor Advertising, Inc.*, 499 U. S. 365, 374 (1991). State legislation and "decision[s] of a state supreme court, acting legislatively rather than judicially," will satisfy this standard, and "*ipso facto* are exempt from the operation of the antitrust laws" because they are an undoubted exercise of state sovereign authority. *Hoover*, *supra*, at 567–568.

But while the Sherman Act confers immunity on the States' own anticompetitive policies out of respect for federalism, it does not always confer immunity where, as here, a State delegates control over a market to a nonsovereign actor. See *Parker*, *supra*, at 351 ("[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful"). For purposes of *Parker*, a nonsovereign actor is one whose conduct does not automatically qualify as that of the sovereign State itself. See *Hoover*, *supra*, at 567–568. State agencies are not simply by their governmental character sovereign actors for purposes of state-action immunity. See *Goldfarb* v. *Virginia State Bar*, 421 U. S. 773, 791 (1975) ("The fact that the State Bar is a state agency for some limited purposes does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members"). Immunity for state agencies, therefore, requires more than a mere facade of state involvement, for it is necessary in light of

Parker's rationale to ensure the States accept political accountability for anticompetitive conduct they permit and control. See *Ticor*, 504 U. S., at 636.

Limits on state-action immunity are most essential when the State seeks to delegate its regulatory power to active market participants, for established ethical standards may blend with private anticompetitive motives in a way difficult even for market participants to discern. Dual allegiances are not always apparent to an actor. In consequence, active market participants cannot be allowed to regulate their own markets free from antitrust accountability. See *Midcal*, *supra*, at 106 ("The national policy in favor of competition cannot be thwarted by casting [a] gauzy cloak of state involvement over what is essentially a private price-fixing arrangement"). Indeed, prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. See, *e.g.*, *Allied Tube & Conduit Corp.* v. *Indian Head, Inc.*, 486 U. S. 492, 501 (1988); *Hoover*, *supra*, at 584 (Stevens, J., dissenting) ("The risk that private regulation of market entry, prices, or output may be designed to confer monopoly profits on members of an industry at the expense of the consuming public has been the central concern of . . . our antitrust jurisprudence"); see also Elhauge, The Scope of Antitrust Process, 104 Harv. L. Rev. 667, 672 (1991). So it follows that, under *Parker* and the Supremacy Clause, the States' greater power to attain an end does not include the lesser power to negate the congressional judgment embodied in the Sherman Act through unsupervised delegations to active market participants. See Garland, Antitrust and State Action: Economic Efficiency and the Political Process, 96 Yale L. J. 486, 500 (1986).

Parker immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State's own.

See *Goldfarb*, *supra*, at 790; see also 1A P. Areeda & H. Hovencamp, Antitrust Law ¶226, p. 180 (4th ed. 2013) (Areeda & Hovencamp). The question is not whether the challenged conduct is efficient, well-functioning, or wise. See *Ticor*, *supra*, at 634–635. Rather, it is "whether anticompetitive conduct engaged in by [nonsovereign actors] should be deemed state action and thus shielded from the antitrust laws." *Patrick* v. *Burget*, 486 U. S. 94, 100 (1988).

To answer this question, the Court applies the two-part test set forth in *California Retail Liquor Dealers Assn.* v. *Midcal Aluminum, Inc.*, 445 U. S. 97, a case arising from California's delegation of price-fixing authority to wine merchants. Under *Midcal*, "[a] state law or regulatory scheme cannot be the basis for antitrust immunity unless, first, the State has articulated a clear policy to allow the anticompetitive conduct, and second, the State provides active supervision of [the] anticompetitive conduct." *Ticor*, *supra*, at 631 (citing *Midcal*, *supra*, at 105).

Midcal's clear articulation requirement is satisfied "where the displacement of competition [is] the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature. In that scenario, the State must have foreseen and implicitly endorsed the anticompetitive effects as consistent with its policy goals." *Phoebe Putney*, 568 U. S., at ___ (slip op., at 11). The active supervision requirement demands, *inter alia*, "that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy." *Patrick*, *supra*, U. S., at 101.

The two requirements set forth in *Midcal* provide a proper analytical framework to resolve the ultimate question whether an anticompetitive policy is indeed the policy of a State. The first requirement—clear articulation—rarely will achieve that goal by itself, for a policy may

satisfy this test yet still be defined at so high a level of generality as to leave open critical questions about how and to what extent the market should be regulated. See *Ticor*, *supra*, at 636–637. Entities purporting to act under state authority might diverge from the State's considered definition of the public good. The resulting asymmetry between a state policy and its implementation can invite private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity.

Midcal's supervision rule "stems from the recognition that '[w]here a private party is engaging in anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State.'" *Patrick*, *supra*, at 100. Concern about the private incentives of active market participants animates *Midcal*'s supervision mandate, which demands "realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests." *Patrick*, *supra*, at 101.

B

In determining whether anticompetitive policies and conduct are indeed the action of a State in its sovereign capacity, there are instances in which an actor can be excused from *Midcal*'s active supervision requirement. In *Hallie* v. *Eau Claire*, 471 U. S. 34, 45 (1985), the Court held municipalities are subject exclusively to *Midcal*'s "'clear articulation'" requirement. That rule, the Court observed, is consistent with the objective of ensuring that the policy at issue be one enacted by the State itself. *Hallie* explained that "[w]here the actor is a municipality, there is little or no danger that it is involved in a private price-fixing arrangement. The only real danger is that it will seek to further purely parochial public interests at the

expense of more overriding state goals." 471 U. S., at 47. *Hallie* further observed that municipalities are electorally accountable and lack the kind of private incentives characteristic of active participants in the market. See *id.*, at 45, n. 9. Critically, the municipality in *Hallie* exercised a wide range of governmental powers across different economic spheres, substantially reducing the risk that it would pursue private interests while regulating any single field. See *ibid.* That *Hallie* excused municipalities from *Midcal*'s supervision rule for these reasons all but confirms the rule's applicability to actors controlled by active market participants, who ordinarily have none of the features justifying the narrow exception *Hallie* identified. See 471 U. S., at 45.

Following *Goldfarb*, *Midcal*, and *Hallie*, which clarified the conditions under which *Parker* immunity attaches to the conduct of a nonsovereign actor, the Court in *Columbia* v. *Omni Outdoor Advertising, Inc.*, 499 U. S. 365, addressed whether an otherwise immune entity could lose immunity for conspiring with private parties. In *Omni*, an aspiring billboard merchant argued that the city of Columbia, South Carolina, had violated the Sherman Act—and forfeited its *Parker* immunity—by anticompetitively conspiring with an established local company in passing an ordinance restricting new billboard construction. 499 U. S., at 367–368. The Court disagreed, holding there is no "conspiracy exception" to *Parker*. *Omni*, *supra*, at 374.

Omni, like the cases before it, recognized the importance of drawing a line "relevant to the purposes of the Sherman Act and of *Parker*: prohibiting the restriction of competition for private gain but permitting the restriction of competition in the public interest." 499 U. S., at 378. In the context of a municipal actor which, as in *Hallie*, exercised substantial governmental powers, *Omni* rejected a conspiracy exception for "corruption" as vague and unworkable, since "virtually all regulation benefits some

segments of the society and harms others" and may in that sense be seen as "'corrupt.'" 499 U. S., at 377. *Omni* also rejected subjective tests for corruption that would force a "deconstruction of the governmental process and probing of the official 'intent' that we have consistently sought to avoid." *Ibid.* Thus, whereas the cases preceding it addressed the preconditions of *Parker* immunity and engaged in an objective, *ex ante* inquiry into nonsovereign actors' structure and incentives, *Omni* made clear that recipients of immunity will not lose it on the basis of ad hoc and *ex post* questioning of their motives for making particular decisions.

Omni's holding makes it all the more necessary to ensure the conditions for granting immunity are met in the first place. The Court's two state-action immunity cases decided after *Omni* reinforce this point. In *Ticor* the Court affirmed that *Midcal*'s limits on delegation must ensure that "[a]ctual state involvement, not deference to private price-fixing arrangements under the general auspices of state law, is the precondition for immunity from federal law." 504 U. S., at 633. And in *Phoebe Putney* the Court observed that *Midcal*'s active supervision requirement, in particular, is an essential condition of state-action immunity when a nonsovereign actor has "an incentive to pursue [its] own self-interest under the guise of implementing state policies." 568 U. S., at ___ (slip op., at 8) (quoting *Hallie*, *supra*, at 46–47). The lesson is clear: *Midcal*'s active supervision test is an essential prerequisite of *Parker* immunity for any nonsovereign entity—public or private—controlled by active market participants.

C

The Board argues entities designated by the States as agencies are exempt from *Midcal*'s second requirement. That premise, however, cannot be reconciled with the Court's repeated conclusion that the need for supervision

turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade.

State agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing *Midcal*'s supervision requirement was created to address. See Areeda & Hovencamp ¶227, at 226. This conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants' confusing their own interests with the State's policy goals. See *Patrick*, 486 U. S., at 100–101.

The Court applied this reasoning to a state agency in *Goldfarb*. There the Court denied immunity to a state agency (the Virginia State Bar) controlled by market participants (lawyers) because the agency had "joined in what is essentially a private anticompetitive activity" for "the benefit of its members." 421 U. S., at 791, 792. This emphasis on the Bar's private interests explains why *Goldfarb*, though it predates *Midcal*, considered the lack of supervision by the Virginia Supreme Court to be a principal reason for denying immunity. See 421 U. S., at 791; see also *Hoover*, 466 U. S., at 569 (emphasizing lack of active supervision in *Goldfarb*); *Bates* v. *State Bar of Ariz.*, 433 U. S. 350, 361–362 (1977) (granting the Arizona Bar state-action immunity partly because its "rules are subject to pointed re-examination by the policymaker").

While *Hallie* stated "it is likely that active state supervision would also not be required" for agencies, 471 U. S., at 46, n. 10, the entity there, as was later the case in *Omni*, was an electorally accountable municipality with general regulatory powers and no private price-fixing agenda. In that and other respects the municipality was more like prototypical state agencies, not specialized boards dominated by active market participants. In important regards, agencies controlled by market partici-

pants are more similar to private trade associations vested by States with regulatory authority than to the agencies *Hallie* considered. And as the Court observed three years after *Hallie*, "[t]here is no doubt that the members of such associations often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm." *Allied Tube*, 486 U. S., at 500. For that reason, those associations must satisfy *Midcal*'s active supervision standard. See *Midcal*, 445 U. S., at 105–106.

The similarities between agencies controlled by active market participants and private trade associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules. See *Hallie*, *supra*, at 39 (rejecting "purely formalistic" analysis). *Parker* immunity does not derive from nomenclature alone. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. See Areeda & Hovencamp ¶227, at 226. The Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*'s active supervision requirement in order to invoke state-action antitrust immunity.

D

The State argues that allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation. If this were so—and, for reasons to be noted, it need not be so—there would be some cause for concern. The States have a sovereign interest in structuring their governments, see *Gregory* v. *Ashcroft*, 501 U. S. 452, 460 (1991), and may conclude there are substantial benefits to staffing their

agencies with experts in complex and technical subjects, see *Southern Motor Carriers Rate Conference, Inc.* v. *United States*, 471 U. S. 48, 64 (1985). There is, moreover, a long tradition of citizens esteemed by their professional colleagues devoting time, energy, and talent to enhancing the dignity of their calling.

Adherence to the idea that those who pursue a calling must embrace ethical standards that derive from a duty separate from the dictates of the State reaches back at least to the Hippocratic Oath. See generally S. Miles, The Hippocratic Oath and the Ethics of Medicine (2004). In the United States, there is a strong tradition of professional self-regulation, particularly with respect to the development of ethical rules. See generally R. Rotunda & J. Dzienkowski, Legal Ethics: The Lawyer's Deskbook on Professional Responsibility (2014); R. Baker, Before Bioethics: A History of American Medical Ethics From the Colonial Period to the Bioethics Revolution (2013). Dentists are no exception. The American Dental Association, for example, in an exercise of "the privilege and obligation of self-government," has "call[ed] upon dentists to follow high ethical standards," including "honesty, compassion, kindness, integrity, fairness and charity." American Dental Association, Principles of Ethics and Code of Professional Conduct 3–4 (2012). State laws and institutions are sustained by this tradition when they draw upon the expertise and commitment of professionals.

Today's holding is not inconsistent with that idea. The Board argues, however, that the potential for money damages will discourage members of regulated occupations from participating in state government. Cf. *Filarsky* v. *Delia*, 566 U. S. ___, ___ (2012) (slip op., at 12) (warning in the context of civil rights suits that the "the most talented candidates will decline public engagements if they do not receive the same immunity enjoyed by their public employee counterparts"). But this case, which does not

present a claim for money damages, does not offer occasion to address the question whether agency officials, including board members, may, under some circumstances, enjoy immunity from damages liability. See *Goldfarb*, 421 U. S., at 792, n. 22; see also Brief for Respondent 56. And, of course, the States may provide for the defense and indemnification of agency members in the event of litigation.

States, furthermore, can ensure *Parker* immunity is available to agencies by adopting clear policies to displace competition; and, if agencies controlled by active market participants interpret or enforce those policies, the States may provide active supervision. Precedent confirms this principle. The Court has rejected the argument that it would be unwise to apply the antitrust laws to professional regulation absent compliance with the prerequisites for invoking *Parker* immunity:

> "[Respondents] contend that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings. This argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such is properly directed to the legislative branch. To the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny only if the State effectively has made this conduct its own." *Patrick*, 486 U. S. at 105–106 (footnote omitted).

The reasoning of *Patrick* v. *Burget* applies to this case with full force, particularly in light of the risks licensing boards dominated by market participants may pose to the free market. See generally Edlin & Haw, Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny? 162 U. Pa. L. Rev. 1093 (2014).

E

The Board does not contend in this Court that its anticompetitive conduct was actively supervised by the State or that it should receive *Parker* immunity on that basis.

By statute, North Carolina delegates control over the practice of dentistry to the Board. The Act, however, says nothing about teeth whitening, a practice that did not exist when it was passed. After receiving complaints from other dentists about the nondentists' cheaper services, the Board's dentist members—some of whom offered whitening services—acted to expel the dentists' competitors from the market. In so doing the Board relied upon cease-and-desist letters threatening criminal liability, rather than any of the powers at its disposal that would invoke oversight by a politically accountable official. With no active supervision by the State, North Carolina officials may well have been unaware that the Board had decided teeth whitening constitutes "the practice of dentistry" and sought to prohibit those who competed against dentists from participating in the teeth whitening market. Whether or not the Board exceeded its powers under North Carolina law, cf. *Omni*, 499 U. S., at 371–372, there is no evidence here of any decision by the State to initiate or concur with the Board's actions against the nondentists.

IV

The Board does not claim that the State exercised active, or indeed any, supervision over its conduct regarding nondentist teeth whiteners; and, as a result, no specific supervisory systems can be reviewed here. It suffices to note that the inquiry regarding active supervision is flexible and context-dependent. Active supervision need not entail day-to-day involvement in an agency's operations or micromanagement of its every decision. Rather, the question is whether the State's review mechanisms provide "realistic assurance" that a nonsovereign actor's anticom-

petitive conduct "promotes state policy, rather than merely the party's individual interests." *Patrick*, *supra*, at 100–101; see also *Ticor*, 504 U. S., at 639–640.

The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it, see *Patrick*, 486 U. S., at 102–103; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, see *ibid.*; and the "mere potential for state supervision is not an adequate substitute for a decision by the State," *Ticor*, *supra*, at 638. Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case.

* * *

The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.

The judgment of the Court of Appeals for the Fourth Circuit is affirmed.

It is so ordered.

SUPREME COURT OF THE UNITED STATES

No. 13–534

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS, PETITIONER *v.* FEDERAL TRADE COMMISSION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

[February 25, 2015]

JUSTICE ALITO, with whom JUSTICE SCALIA and JUSTICE THOMAS join, dissenting.

The Court's decision in this case is based on a serious misunderstanding of the doctrine of state-action antitrust immunity that this Court recognized more than 60 years ago in *Parker* v. *Brown*, 317 U. S. 341 (1943). In *Parker*, the Court held that the Sherman Act does not prevent the States from continuing their age-old practice of enacting measures, such as licensing requirements, that are designed to protect the public health and welfare. *Id.*, at 352. The case now before us involves precisely this type of state regulation—North Carolina's laws governing the practice of dentistry, which are administered by the North Carolina Board of Dental Examiners (Board).

Today, however, the Court takes the unprecedented step of holding that *Parker* does not apply to the North Carolina Board because the Board is not structured in a way that merits a good-government seal of approval; that is, it is made up of practicing dentists who have a financial incentive to use the licensing laws to further the financial interests of the State's dentists. There is nothing new about the structure of the North Carolina Board. When the States first created medical and dental boards, well before the Sherman Act was enacted, they began to staff

them in this way.[1] Nor is there anything new about the suspicion that the North Carolina Board—in attempting to prevent persons other than dentists from performing teeth-whitening procedures—was serving the interests of dentists and not the public. Professional and occupational licensing requirements have often been used in such a way.[2] But that is not what *Parker* immunity is about. Indeed, the very state program involved in that case was unquestionably designed to benefit the regulated entities, California raisin growers.

The question before us is not whether such programs serve the public interest. The question, instead, is whether this case is controlled by *Parker*, and the answer to that question is clear. Under *Parker*, the Sherman Act (and the Federal Trade Commission Act, see *FTC* v. *Ticor Title Ins. Co.*, 504 U. S. 621, 635 (1992)) do not apply to state agencies; the North Carolina Board of Dental Examiners is a state agency; and that is the end of the matter. By straying from this simple path, the Court has not only distorted *Parker*; it has headed into a morass. Determining whether a state agency is structured in a way that militates against regulatory capture is no easy task, and there is reason to fear that today's decision will spawn confusion. The Court has veered off course, and therefore I cannot go along.

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[1] S. White, History of Oral and Dental Science in America 197–214 (1876) (detailing earliest American regulations of the practice of dentistry).

[2] See, *e.g.*, R. Shrylock, Medical Licensing in America 29 (1967) (Shrylock) (detailing the deterioration of licensing regimes in the mid-19th century, in part out of concerns about restraints on trade); Gellhorn, The Abuse of Occupational Licensing, 44 U. Chi. L. Rev. 6 (1976); Shepard, Licensing Restrictions and the Cost of Dental Care, 21 J. Law & Econ. 187 (1978).

I

In order to understand the nature of *Parker* state-action immunity, it is helpful to recall the constitutional landscape in 1890 when the Sherman Act was enacted. At that time, this Court and Congress had an understanding of the scope of federal and state power that is very different from our understanding today. The States were understood to possess the exclusive authority to regulate "their purely internal affairs." *Leisy* v. *Hardin*, 135 U. S. 100, 122 (1890). In exercising their police power in this area, the States had long enacted measures, such as price controls and licensing requirements, that had the effect of restraining trade.[3]

The Sherman Act was enacted pursuant to Congress' power to regulate interstate commerce, and in passing the Act, Congress wanted to exercise that power "to the utmost extent." *United States* v. *South-Eastern Underwriters Assn.*, 322 U. S. 533, 558 (1944). But in 1890, the understanding of the commerce power was far more limited than it is today. See, *e.g.*, *Kidd* v. *Pearson*, 128 U. S. 1, 17–18 (1888). As a result, the Act did not pose a threat to traditional state regulatory activity.

By 1943, when *Parker* was decided, however, the situation had changed dramatically. This Court had held that the commerce power permitted Congress to regulate even local activity if it "exerts a substantial economic effect on interstate commerce." *Wickard* v. *Filburn*, 317 U. S. 111, 125 (1942). This meant that Congress could regulate many of the matters that had once been thought to fall exclusively within the jurisdiction of the States. The new interpretation of the commerce power brought about an expansion of the reach of the Sherman Act. See *Hospital*

[3] See Handler, The Current Attack on the *Parker* v. *Brown* State Action Doctrine, 76 Colum. L. Rev. 1, 4–6 (1976) (collecting cases).

Building Co. v. *Trustees of Rex Hospital*, 425 U. S. 738, 743, n. 2 (1976) ("[D]ecisions by this Court have permitted the reach of the Sherman Act to expand along with expanding notions of congressional power"). And the expanded reach of the Sherman Act raised an important question. The Sherman Act does not expressly exempt States from its scope. Does that mean that the Act applies to the States and that it potentially outlaws many traditional state regulatory measures? The Court confronted that question in *Parker*.

In *Parker*, a raisin producer challenged the California Agricultural Prorate Act, an agricultural price support program. The California Act authorized the creation of an Agricultural Prorate Advisory Commission (Commission) to establish marketing plans for certain agricultural commodities within the State. 317 U. S., at 346–347. Raisins were among the regulated commodities, and so the Commission established a marketing program that governed many aspects of raisin sales, including the quality and quantity of raisins sold, the timing of sales, and the price at which raisins were sold. *Id.*, at 347–348. The *Parker* Court assumed that this program would have violated "the Sherman Act if it were organized and made effective solely by virtue of a contract, combination or conspiracy of private persons," and the Court also assumed that Congress could have prohibited a State from creating a program like California's if it had chosen to do so. *Id.*, at 350. Nevertheless, the Court concluded that the California program did not violate the Sherman Act because the Act did not circumscribe state regulatory power. *Id.*, at 351.

The Court's holding in *Parker* was not based on either the language of the Sherman Act or anything in the legislative history affirmatively showing that the Act was not meant to apply to the States. Instead, the Court reasoned that "[i]n a dual system of government in which, under the Constitution, the states are sovereign, save only as Con-

gress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress." 317 U. S., at 351. For the Congress that enacted the Sherman Act in 1890, it would have been a truly radical and almost certainly futile step to attempt to prevent the States from exercising their traditional regulatory authority, and the *Parker* Court refused to assume that the Act was meant to have such an effect.

When the basis for the *Parker* state-action doctrine is understood, the Court's error in this case is plain. In 1890, the regulation of the practice of medicine and dentistry was regarded as falling squarely within the States' sovereign police power. By that time, many States had established medical and dental boards, often staffed by doctors or dentists,[4] and had given those boards the authority to confer and revoke licenses.[5] This was quintessential police power legislation, and although state laws were often challenged during that era under the doctrine of substantive due process, the licensing of medical professionals easily survived such assaults. Just one year before the enactment of the Sherman Act, in *Dent* v. *West Virginia*, 129 U. S. 114, 128 (1889), this Court rejected such a challenge to a state law requiring all physicians to obtain a certificate from the state board of health attesting to their qualifications. And in *Hawker* v. *New York*, 170 U. S. 189, 192 (1898), the Court reiterated that a law

[4] Shrylock 54–55; D. Johnson and H. Chaudry, Medical Licensing and Discipline in America 23–24 (2012).

[5] In *Hawker* v. *New York*, 170 U. S. 189 (1898), the Court cited state laws authorizing such boards to refuse or revoke medical licenses. *Id.*, at 191–193, n. 1. See also *Douglas* v. *Noble*, 261 U. S. 165, 166 (1923) ("In 1893 the legislature of Washington provided that only licensed persons should practice dentistry" and "vested the authority to license in a board of examiners, consisting of five practicing dentists").

specifying the qualifications to practice medicine was clearly a proper exercise of the police power. Thus, the North Carolina statutes establishing and specifying the powers of the State Board of Dental Examiners represent precisely the kind of state regulation that the *Parker* exemption was meant to immunize.

II

As noted above, the only question in this case is whether the North Carolina Board of Dental Examiners is really a state agency, and the answer to that question is clearly yes.

- The North Carolina Legislature determined that the practice of dentistry "affect[s] the public health, safety and welfare" of North Carolina's citizens and that therefore the profession should be "subject to regulation and control in the public interest" in order to ensure "that only qualified persons be permitted to practice dentistry in the State." N. C. Gen. Stat. Ann. §90–22(a) (2013).
- To further that end, the legislature created the North Carolina State Board of Dental Examiners "as the agency of the State for the regulation of the practice of dentistry in th[e] State." §90–22(b).
- The legislature specified the membership of the Board. §90–22(c). It defined the "practice of dentistry," §90–29(b), and it set out standards for licensing practitioners, §90–30. The legislature also set out standards under which the Board can initiate disciplinary proceedings against licensees who engage in certain improper acts. §90–41(a).
- The legislature empowered the Board to "maintain an action in the name of the State of North Carolina to perpetually enjoin any person from . . . unlawfully practicing dentistry." §90–40.1(a). It authorized the Board to conduct investigations and to hire legal

counsel, and the legislature made any "notice or statement of charges against any licensee" a public record under state law. §§ 90–41(d)–(g).

- The legislature empowered the Board "to enact rules and regulations governing the practice of dentistry within the State," consistent with relevant statutes. §90–48. It has required that any such rules be included in the Board's annual report, which the Board must file with the North Carolina secretary of state, the state attorney general, and the legislature's Joint Regulatory Reform Committee. §93B–2. And if the Board fails to file the required report, state law demands that it be automatically suspended until it does so. *Ibid.*

As this regulatory regime demonstrates, North Carolina's Board of Dental Examiners is unmistakably a state agency created by the state legislature to serve a prescribed regulatory purpose and to do so using the State's power in cooperation with other arms of state government.

The Board is not a private or "nonsovereign" entity that the State of North Carolina has attempted to immunize from federal antitrust scrutiny. *Parker* made it clear that a State may not "'give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful.'" *Ante*, at 7 (quoting *Parker*, 317 U. S., at 351). When the *Parker* Court disapproved of any such attempt, it cited *Northern Securities Co.* v. *United States*, 193 U. S. 197 (1904), to show what it had in mind. In that case, the Court held that a State's act of chartering a corporation did not shield the corporation's monopolizing activities from federal antitrust law. *Id.*, at 344–345. Nothing similar is involved here. North Carolina did not authorize a private entity to enter into an anticompetitive arrangement; rather, North Carolina *created a state agency* and gave that agency the power to regulate a particular subject affecting public health and

safety.

Nothing in *Parker* supports the type of inquiry that the Court now prescribes. The Court crafts a test under which state agencies that are "controlled by active market participants," *ante*, at 12, must demonstrate active state supervision in order to be immune from federal antitrust law. The Court thus treats these state agencies like private entities. But in *Parker*, the Court did not examine the structure of the California program to determine if it had been captured by private interests. If the Court had done so, the case would certainly have come out differently, because California conditioned its regulatory measures on the participation and approval of market actors in the relevant industry.

Establishing a prorate marketing plan under California's law first required the petition of at least 10 producers of the particular commodity. *Parker*, 317 U. S., at 346. If the Commission then agreed that a marketing plan was warranted, the Commission would "select a program committee *from among nominees chosen by the qualified producers*." *Ibid.* (emphasis added). That committee would then formulate the proration marketing program, which the Commission could modify or approve. But even after Commission approval, the program became law (and then, automatically) only if it gained the approval of 65 percent of the relevant producers, representing at least 51 percent of the acreage of the regulated crop. *Id.*, at 347. This scheme gave decisive power to market participants. But despite these aspects of the California program, *Parker* held that California was acting as a "sovereign" when it "adopt[ed] and enforc[ed] the prorate program." *Id.*, at 352. This reasoning is irreconcilable with the Court's today.

III

The Court goes astray because it forgets the origin of the

Parker doctrine and is misdirected by subsequent cases that extended that doctrine (in certain circumstances) to private entities. The Court requires the North Carolina Board to satisfy the two-part test set out in *California Retail Liquor Dealers Assn.* v. *Midcal Aluminum, Inc.*, 445 U. S. 97 (1980), but the party claiming *Parker* immunity in that case was not a state agency but a private trade association. Such an entity is entitled to *Parker* immunity, *Midcal* held, only if the anticompetitive conduct at issue was both "'clearly articulated'" and "'actively supervised by the State itself.'" 445 U. S., at 105. Those requirements are needed where a State authorizes private parties to engage in anticompetitive conduct. They serve to identify those situations in which conduct *by private parties* can be regarded as the conduct of a State. But when the conduct in question is the conduct of a state agency, no such inquiry is required.

This case falls into the latter category, and therefore *Midcal* is inapposite. The North Carolina Board is not a private trade association. It is a state agency, created and empowered by the State to regulate an industry affecting public health. It would not exist if the State had not created it. And for purposes of *Parker*, its membership is irrelevant; what matters is that it is part of the government of the sovereign State of North Carolina.

Our decision in *Hallie* v. *Eau Claire*, 471 U. S. 34 (1985), which involved Sherman Act claims against a municipality, not a State agency, is similarly inapplicable. In *Hallie*, the plaintiff argued that the two-pronged *Midcal* test should be applied, but the Court disagreed. The Court acknowledged that municipalities "are not themselves sovereign." 471 U. S., at 38. But recognizing that a municipality is "an arm of the State," *id.*, at 45, the Court held that a municipality should be required to satisfy only the first prong of the *Midcal* test (requiring a clearly articulated state policy), 471 U. S., at 46. That municipalities

are not sovereign was critical to our analysis in *Hallie*, and thus that decision has no application in a case, like this one, involving a state agency.

Here, however, the Court not only disregards the North Carolina Board's status as a full-fledged state agency; it treats the Board less favorably than a municipality. This is puzzling. States are sovereign, *Northern Ins. Co. of N. Y.* v. *Chatham County*, 547 U. S. 189, 193 (2006), and California's sovereignty provided the foundation for the decision in *Parker*, *supra*, at 352. Municipalities are not sovereign. *Jinks* v. *Richland County*, 538 U. S. 456, 466 (2003). And for this reason, federal law often treats municipalities differently from States. Compare *Will* v. *Michigan Dept. of State Police*, 491 U. S. 58, 71 (1989) ("[N]either a State nor its officials acting it their official capacities are 'persons' under [42 U. S. C.] §1983"), with *Monell* v. *City Dept. of Social Servs., New York*, 436 U. S. 658, 694 (1978) (municipalities liable under §1983 where "execution of a government's policy or custom . . . inflicts the injury").

The Court recognizes that municipalities, although not sovereign, nevertheless benefit from a more lenient standard for state-action immunity than private entities. Yet under the Court's approach, the North Carolina Board of Dental Examiners, a full-fledged state agency, is treated like a private actor and must demonstrate that the State actively supervises its actions.

The Court's analysis seems to be predicated on an assessment of the varying degrees to which a municipality and a state agency like the North Carolina Board are likely to be captured by private interests. But until today, *Parker* immunity was never conditioned on the proper use of state regulatory authority. On the contrary, in *Columbia* v. *Omni Outdoor Advertising, Inc.*, 499 U. S. 365 (1991), we refused to recognize an exception to *Parker* for cases in which it was shown that the defendants had

engaged in a conspiracy or corruption or had acted in a way that was not in the public interest. *Id.*, at 374. The Sherman Act, we said, is not an anticorruption or good-government statute. 499 U. S., at 398. We were unwilling in *Omni* to rewrite *Parker* in order to reach the allegedly abusive behavior of city officials. 499 U. S., at 374–379. But that is essentially what the Court has done here.

III

Not only is the Court's decision inconsistent with the underlying theory of *Parker*; it will create practical problems and is likely to have far-reaching effects on the States' regulation of professions. As previously noted, state medical and dental boards have been staffed by practitioners since they were first created, and there are obvious advantages to this approach. It is reasonable for States to decide that the individuals best able to regulate technical professions are practitioners with expertise in those very professions. Staffing the State Board of Dental Examiners with certified public accountants would certainly lessen the risk of actions that place the well-being of dentists over those of the public, but this would also compromise the State's interest in sensibly regulating a technical profession in which lay people have little expertise.

As a result of today's decision, States may find it necessary to change the composition of medical, dental, and other boards, but it is not clear what sort of changes are needed to satisfy the test that the Court now adopts. The Court faults the structure of the North Carolina Board because "active market participants" constitute "a controlling number of [the] decisionmakers," *ante*, at 14, but this test raises many questions.

What is a "controlling number"? Is it a majority? And if so, why does the Court eschew that term? Or does the Court mean to leave open the possibility that something less than a majority might suffice in particular circum-

stances? Suppose that active market participants constitute a voting bloc that is generally able to get its way? How about an obstructionist minority or an agency chair empowered to set the agenda or veto regulations?

Who is an "active market participant"? If Board members withdraw from practice during a short term of service but typically return to practice when their terms end, does that mean that they are not active market participants during their period of service?

What is the scope of the market in which a member may not participate while serving on the board? Must the market be relevant to the particular regulation being challenged or merely to the jurisdiction of the entire agency? Would the result in the present case be different if a majority of the Board members, though practicing dentists, did not provide teeth whitening services? What if they were orthodontists, periodontists, and the like? And how much participation makes a person "active" in the market?

The answers to these questions are not obvious, but the States must predict the answers in order to make informed choices about how to constitute their agencies.

I suppose that all this will be worked out by the lower courts and the Federal Trade Commission (FTC), but the Court's approach raises a more fundamental question, and that is why the Court's inquiry should stop with an examination of the structure of a state licensing board. When the Court asks whether market participants control the North Carolina Board, the Court in essence is asking whether this regulatory body has been captured by the entities that it is supposed to regulate. Regulatory capture can occur in many ways.[6] So why ask only whether

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[6] See, *e.g.*, R. Noll, Reforming Regulation 40–43, 46 (1971); J. Wilson, The Politics of Regulation 357–394 (1980). Indeed, it has even been

the members of a board are active market participants? The answer may be that determining when regulatory capture has occurred is no simple task. That answer provides a reason for relieving courts from the obligation to make such determinations at all. It does not explain why it is appropriate for the Court to adopt the rather crude test for capture that constitutes the holding of today's decision.

IV

The Court has created a new standard for distinguishing between private and state actors for purposes of federal antitrust immunity. This new standard is not true to the *Parker* doctrine; it diminishes our traditional respect for federalism and state sovereignty; and it will be difficult to apply. I therefore respectfully dissent.

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charged that the FTC, which brought this case, has been captured by entities over which it has jurisdiction. See E. Cox, "The Nader Report" on the Federal Trade Commission vii–xiv (1969); Posner, Federal Trade Commission, Chi. L. Rev. 47, 82–84 (1969).

Disciplinary Board Report for March 13, 2015

Today's report reviews the 2014 and 2015 calendar years case activity then addresses the Board's disciplinary case actions for the second quarter of fiscal year 2015 which includes the dates of September 30, 2014 through December 31, 2014.

Calendar Year 2014

The table below includes all cases that have received Board action since January 1, 2014 through December 31, 2014.

Calendar 2014	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	36	21	7	28
Feb	37	14	5	19
March	72	29	8	37
April	50	5	4	9
May	31	12	9	21
June	48	24	20	44
July	29	6	6	12
August	46	24	8	32
September	33	55	25	80
October	70	25	11	36
November	18	30	8	38
December	28	43	7	50
Totals	**498**	**288**	**118**	**406**

Calendar Year 2015

The table below includes all cases that have received Board action since January 1, 2015 through February 24, 2015. The large number of cases received so far in January and February 2015 reflect the late license renewal cases that have been handled by Board staff per Guidance Document 60-6.

Calendar 2015	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	111	119	4	123
Feb 24th	80	55	0	55
Totals	**191**	**174**	**4**	**178**

Q2 FY 2015

For the second quarter, the Board received a total of 71 patient care cases. The Board closed a total of 91 patient care cases for a 128% clearance rate, which is up from 113% in Q1. The current pending caseload older than 250 days is 23%, and the Board's goal is 20%. In Q2 of 2015, 84% of the patient care cases were closed within 250 days, as compared to 67% in Q1 of 2015. The Board's goal is 90% of patient care cases closed within 250 days. The Board is again moving in the right direction with its statistics and Board staff does appreciate the hard work that you have been putting in.

License Suspensions

Between December 1, 2014 and February 25, 2015 the Board has not suspended any licenses.

Findings of Fact in Informal Conference and Formal Hearing Orders

Board staff would like assistance and insight from the Board regarding the Board's trend to not add relevant findings of fact to Board Orders to substantiate the Board's decisions.

Each case stands on its own set of facts and circumstances. In crafting orders that reflect the decision of the Board, the findings of fact may be identical to the allegations cited in the notice for the proceeding, or they may be altered to include a contrary fact basis or additional mitigating information which supports the Board's decision, even if the decision is to remove an allegation that was listed in the notice for the proceeding. Generally, the findings of fact should be limited to those which substantiate a Board's case decision. The order, particularly at the informal conference level, is the record and the only record that can be relied on when we need to "look back" at what was clear and convincing evidence to support their decision.

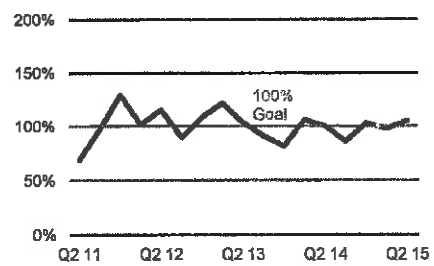
Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

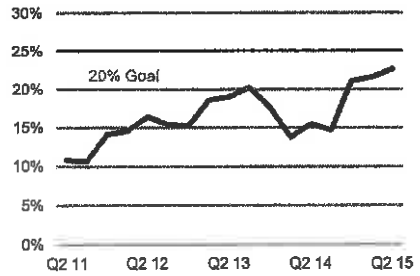
Clearance Rate

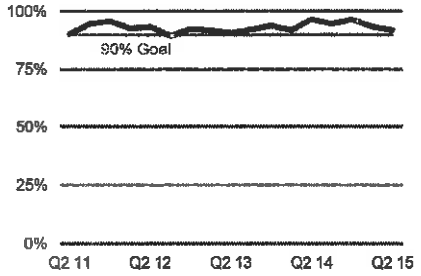
Age of Pending Caseload
(percent of cases pending over one year)

Percent Closed in 250 Business Days

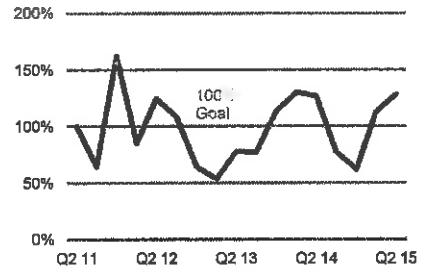
Medicine - In Q2 2015, the clearance rate was 105%, the Pending Caseload older than 250 business days was 23% and the percent closed within 250 business days was 92%.
Q2 2015 Caseloads:
Received=238, Closed=251
Pending over 250 days=139
Closed within 250 days=226

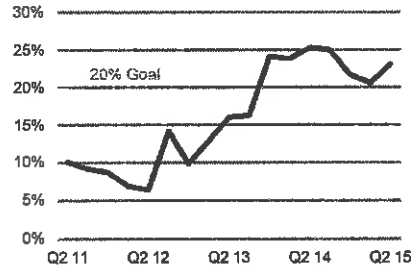


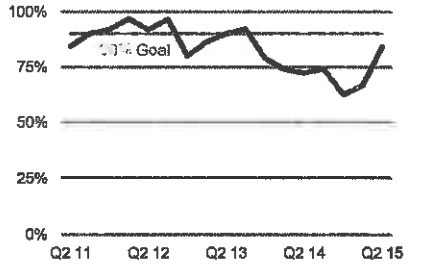




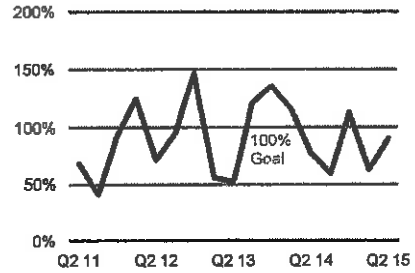
Dentistry - In Q2 2015, the clearance rate was 128%, the Pending Caseload older than 250 business days was 23% and the percent closed within 250 business days was 84%.
Q2 2015 Caseloads:
Received=71, Closed=91
Pending over 250 days=63
Closed within 250 days=74

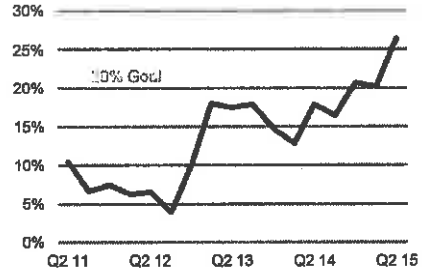


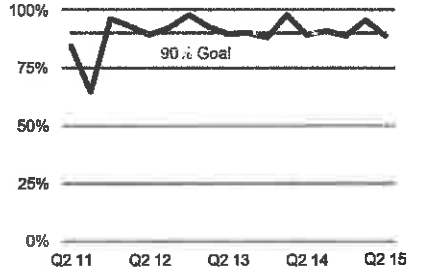




Pharmacy - In Q2 2015, the clearance rate was 90%, the Pending Caseload older than 250 business days was 26% and the percent closed within 250 business days was 89%.
Q2 2015 Caseloads:
Received=30, Closed=27
Pending over 250 days=28
Closed within 250 days=24







Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Submitted: 1/8/2015

Prepared by: VisualResearch, Inc.

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TOTALS	498	288	118	406

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Jun				
Jul				
Aug				
Sept				
Oct				
Nov				
Dec				
TOTALS				

Mandatory Suspension = 0 Summary Suspension = 0

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January 2, 2015

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

Dear Dr. Boyle:

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

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

Our specific comments are:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

Virginia Board of Dentistry
Invitation to an Open Forum on
Policy Strategies to Increase Access to Dental Treatment

Friday, May 8, 2015
9:00 am to 12 pm
Board Room 4, 2nd Floor, Perimeter Center
9960 Mayland Drive
Henrico, VA 23233

The forum is an opportunity for individuals, institutions and organizations concerned with the practice of dentistry to present their views on policy strategies that might improve access to dental treatment. Three such strategies identified for consideration by the Board of Dentistry (Board) are:

- adjusting the education and endorsement requirements for dental assistant II registration to increase the number of registrants;
- creating a pathway for dental hygienists to perform the reversible intraoral procedures which are delegable to dental assistants II to more fully utilize these licensees; and
- expanding the options for dental hygienists to practice under the remote supervision of dentists .

Each attendee will be given up to 10 minutes to present their views and recommendations on these strategies and to identify additional strategies for consideration by the Board. Following the presentations, with time permitting, attendees will be asked to participate in a question and answer session to allow attendees to explore and discuss the recommendations advanced.

A transcript of the Forum will be made for future reference by the Board as it decides whether to undertake policy action. Any policy action undertaken will include the standard comment opportunities required for regulatory action and for advancing a legislative proposal.

Attachments:
Dental Assistant II Regulations
Guidance Document 60-8 Educational Requirements for Dental Assistants II
Department of Health Protocol for Remote Supervision
Joint Commission on Health Care Study Recommendations for Dental Hygiene Practice

Virginia Board of Dentistry

Educational Requirements for Dental Assistants II

- §54.1-2729.01 of the Code of Virginia permits the Board to prescribe the education and training requirements that must be completed for a person to qualify for registration as a dental assistant II.

- Every applicant for registration must complete 50 hours of didactic coursework in dental anatomy and operative dentistry required by 18VAC60-20-61(B)(1) and the written examinations required by 18VAC60-20-61(B)(4)(a) and (c).

- 18VAC60-20-61(B) (2), (3) and (4) of the Regulations Governing Dental Practice specifies four modules of laboratory training, clinical experience and examination that may be completed in order to qualify for registration as a dental assistant II. The Board interprets these provisions to permit someone to complete one or more of the modules to qualify for registration. An applicant does not have to complete all four modules. However, the educational institution offering the dental assistant II program has the discretion to decide how to structure its program.

- The registration issued by the Board to a dental assistant II shall specify which of the six delegable duties listed in 18VAC60-20-230(C) may be delegated to the registrant as follows:

    - Completion of the laboratory training, clinical experience module on placing, packing, carving, and polishing amalgam restorations qualifies a registrant to perform pulp capping procedures and to pack and carve amalgam restorations.

    - Completion of the laboratory training and clinical experience module on placing and shaping composite resin restorations qualifies a registrant to perform pulp capping procedures and to place and shape composite resin restorations.

    - Completion of the laboratory training and clinical experience module on taking final impressions and using non-epinephrine retraction cord qualifies a registrant to take final impressions and to use non-epinephrine retraction cord.

    - Completion of the laboratory training and clinical experience module on final cementation of crowns and bridges after adjustment and fitting by a dentist qualifies a registrant to perform final cementation of crowns and bridges.

VIRGINIA BOARD OF DENTISTRY

Excerpts from the **Regulations Governing Dental practice on the**

Registration and Practice of Dental Assistants II

18VAC60-20-61. Educational requirements for dental assistants II.

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete the following requirements from an educational program accredited by the Commission on Dental Accreditation of the American Dental Association:

1. At least 50 hours of didactic course work in dental anatomy and operative dentistry that may be completed on-line.

2. Laboratory training that may be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:

a. At least 40 hours of placing, packing, carving, and polishing of amalgam restorations;

b. At least 60 hours of placing and shaping composite resin restorations;

c. At least 20 hours of taking final impressions and use of a non-epinephrine retraction cord; and

d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.

3. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office in the following modules:

a. At least 80 hours of placing, packing, carving, and polishing of amalgam restorations;

b. At least 120 hours of placing and shaping composite resin restorations;

c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and

d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.

4. Successful completion of the following competency examinations given by the accredited educational programs:

a. A written examination at the conclusion of the 50 hours of didactic coursework;

b. A practical examination at the conclusion of each module of laboratory training; and

c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules.

C. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.

18VAC60-20-70. Licensure examinations; registration certification.

C. Dental assistant II certification. All applicants for registration as a dental assistant II shall provide evidence of a current credential as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board, which was granted following passage of an examination on general chairside assisting, radiation health and safety, and infection control.

18VAC60-20-72. Registration by endorsement as a dental assistant II.

A. An applicant for registration by endorsement as a dental assistant II shall provide evidence of the following:

1. Hold current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association;
2. Be currently authorized to perform expanded duties as a dental assistant in another state, territory, District of Columbia, or possession of the United States;
3. Hold a credential, registration, or certificate with qualifications substantially equivalent in hours of instruction and course content to those set forth in 18VAC60-20-61 or if the qualifications were not substantially equivalent the dental assistant can document experience in the restorative and prosthetic expanded duties set forth in 18VAC60-20-230 for at least 24 of the past 48 months preceding application for registration in Virginia.

B. An applicant shall also:

1. Be certified to be in good standing from each state in which he is currently registered, certified, or credentialed or in which he has ever held a registration, certificate, or credential;
2. Be of good moral character;
3. Not have committed any act that would constitute a violation of § 54.1-2706 of the Code of Virginia; and
4. Attest to having read and understand and to remain current with the laws and the regulations governing dental practice in Virginia.

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

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

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

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

1. Performing pulp capping procedures;
2. Packing and carving of amalgam restorations;
3. Placing and shaping composite resin restorations;
4. Taking final impressions;
5. Use of a non-epinephrine retraction cord; and
6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

Title of document: Protocol adopted by Virginia Department of Health (VDH) for Dental Hygienists to Practice in an Expanded Capacity under Remote Supervision by Public Health Dentists

Reference to 18VAC60-20-220: Regulations Governing Dental Practice – Dental Hygienists

Filed by: Virginia Board of Dentistry

Date filed: September 7, 2012

Document available from:

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

Definitions:

- *"Expanded capacity"* means that a VDH dental hygienist provides education, assessment, prevention and clinical services as authorized in this protocol under the remote supervision of a VDH dentist.
- *"Remote supervision"* means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but who has not done an initial examination of the patients who are to be seen and treated by the dental hygienist, and who is not necessarily onsite with the dental hygienist when dental hygiene services are delivered.

Management:

- Program guidance and quality assurance shall be provided by the Dental Program in the Division of Child and Family Health at VDH for the public health dentists providing supervision under this protocol. Guidance for all VDH dental hygienists providing services through remote supervision is outlined below:
    - VDH compliance includes a review of the remote supervision protocol with the dental hygienist. The hygienist will sign an agreement consenting to remote supervision according to the protocol. The hygienist will update the remote agreement annually attaching a copy of their current dental hygiene license, and maintain a copy of the agreement on-site while providing services under this protocol.
    - VDH training by the public health dentist will include didactic and on-site components utilizing evidence based protocols, procedures and standards from the American Dental Association, the American Dental Hygienists' Association, the Centers for Disease Control and Prevention, Association of State and Territorial Dental Directors, as well as VDH OSHA, Hazard Communication and Blood Borne Pathogen Control Plan.
    - VDH monitoring during remote supervision activities by the public health dentist shall include tracking the locations of planned service delivery and review of

daily reports of the services provided. Phone or personal communication between the public health dentist and the dental hygienist working under remote supervision will occur at a minimum of every 14 days.

- VDH on-site review to include a sampling of the patients seen by the dental hygienist under remote supervision will be completed annually by the supervising public health dentist. During the on-site review, areas of program and clinical oversight will include appropriate patient documentation for preventive services (consent completed, assessment of conditions, forms completed accurately), clinical quality of preventive services (technique and sealant retention), patient management and referral, compliance with evidence-based program guidance, adherence to general emergency guidelines, and OSHA and Infection Control compliance.

- No limit shall be placed on the number of full or part time VDH dental hygienists that may practice under the *remote supervision* of a public health dentist(s)
- The dental hygienist may use and supervise assistants under this protocol but shall not permit assistants to provide direct clinical services to patients.
- The patient or responsible adult should be advised that services provided under the remote supervision protocol do not replace a complete dental examination and that he/she should take his/her child to a dentist for regular dental appointments.

Remote Supervision Practice Requirements:

- The dental hygienist shall have graduated from an accredited dental hygiene school, be licensed in Virginia, and employed by VDH in a full or part time position and have a minimum of two years of dental hygiene practice experience.
- The dental hygienist shall annually consent in writing to providing services under remote supervision.
- The patient or a responsible adult shall be informed prior to the appointment that no dentist will be present, that no anesthesia can be administered, and that only limited described services will be provided.
- Written basic emergency procedures shall be established and in place, and the hygienist shall be capable of implementing those procedures.

Expanded Capacity Scope of Services:

Public health dental hygienists may perform the following duties under *remote supervision:*

- Performing an initial examination or assessment of teeth and surrounding tissues, including charting existing conditions including carious lesions, periodontal pockets or other abnormal conditions for further evaluation by a dentist, as required.
- Prophylaxis of natural and restored teeth.
- Scaling of natural and restored teeth using hand instruments, and ultrasonic devices.
- Assessing patients to determine the appropriateness of sealant placement according to VDH Dental Program guidelines and applying sealants as indicated. Providing dental sealant, assessment, maintenance and repair.
- Application of topical fluorides.
- Providing educational services, assessment, screening or data collection for the preparation of preliminary written records for evaluation by a licensed dentist.

Required Referrals:

- Public health dental hygienists will refer patients without a dental provider to a public or private dentist with the goal to establish a dental home.
- When the dental hygienist determines at a subsequent appointment that there are conditions present which require evaluation for treatment, and the patient has not seen a dentist as referred, the dental hygienist will make every practical or reasonable effort to schedule the patient with a VDH dentist or local private dentist volunteer for an examination, treatment plan and follow up care.

Dental Safety Net Capacity and Opportunities for Improving Oral Health

Joint Commission on Health Care
October 8, 2014 Meeting

Michele Chesser, Ph.D.
Senior Health Policy Analyst

Study Mandate

- In 2012, Senate Joint Resolution 50 (Senator Barker) directed the Joint Commission on Health Care (JCHC) to conduct a two year study of the fiscal impact of untreated dental disease in the Commonwealth of Virginia
- The study resulted in a policy option to include in the 2014 JCHC Work Plan a targeted study of the dental capacity of Virginia's oral health care safety net providers, and the option was approved by JCHC members during the Decision Matrix meeting last November

Current Feasibility of Creating a Statewide ED Diversion Plan

- Preliminary data indicate that ED diversion plans can be effective in helping individuals find the oral health care they need in a more appropriate setting
- However, these programs are only possible in localities in which there is a dental school or full-time community dental clinic to receive the diverted ED dental patients
  - Significant portions of the State lack a dental safety net facility
  - In the localities with a dental safety net provider, many have waiting lists and/or lack the resources to care for all who are in need of services

Expansion of the Remote Supervision of Dental Hygienists Model

Expansion of Remote Supervision of Dental Hygienists Model

- In 2009, the General Assembly enacted legislation to reduce the dentist oversight requirement for hygienists employed by VDH in selected dentally underserved areas
  - VDH dental hygienists are allowed to work under the remote, rather than general or direct, supervision of a dentist
  - Remote supervision means "a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but who has not done an initial examination of the patients who are to be seen and treated by the dental hygienist, and who is not necessarily onsite with the dental hygienist when dental hygiene services are delivered." Under remote supervision, VDH hygienists may perform:
    - Initial examination of teeth and surrounding tissues, charting existing conditions
    - Prophylaxis of natural and restored teeth
    - Scaling using hand instruments and ultrasonic devices
    - Providing dental sealant, assessment, maintenance and repair
    - Application of topical fluorides
    - Educational services, assessment, screening or data collection for the preparation of preliminary records for evaluation by a licensed dentist

Expansion of Remote Supervision of Dental Hygienists Model

- Remote supervision dental hygienists provide services in elementary schools utilizing portable equipment
- In 2012, additional legislation was passed allowing a dental hygienist employed by VDH to practice throughout the Commonwealth under the protocol established for the pilot program
- The program has "improved access to preventive dental services for those at highest risk of dental disease, as well as reduced barriers and costs for dental care for low-income individuals"*

*Report on Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a "Remote Supervision" Practice Protocol, 2013

Expansion of Remote Supervision of Dental Hygienists Model

- The Board of Health Professions is currently considering the expansion of the remote supervision of dental hygienist model, but no action has been taken at this point
  - The Board met on September 27, but did not have a quorum and; therefore, was unable to call a vote on the issue
- Options to expand the model include allowing dental hygienists not currently employed by VDH to practice via remote supervision in other settings such as safety net facilities, hospitals, nursing homes or all dental sites, including the private sector, in order to provide access to a greater portion of Virginia's at-risk, underserved population
- Our work group considered the range of expansion options and the majority of members support an incremental approach with initial expansion to safety net facilities

Expansion of Remote Supervision of Dental Hygienists Model

- Further, it was suggested that a work group of primary stakeholders, including Virginia Dental Association, Virginia Dental Hygienists' Association, Virginia Department of Health, Virginia Association of Free and Charitable Clinics, Virginia Community Healthcare Association, Virginia Oral Health Coalition, Virginia Board of Dentistry, Old Dominion University's School of Dental Hygiene, and Virginia Commonwealth University's School of Dentistry, be created to develop a pilot program for the expansion of the remote supervision model, giving stakeholders the chance to be involved in determining the bounds/scope of the model and the specific protocol