

VIRGINIA BOARD OF DENTISTRY

AGENDA

March 10, 2017

Department of Health Professions

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

Board Business

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

Evacuation Announcement – Ms. Reen

Public Comment – Dr. Rizkalla

Approval of Minutes - Dr. Rizkalla

- December 9, 2016 Business Meeting

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Liaison/Committee Reports

- **Dr. Bryant**

*ADEX

- **Dr. Watkins**

*SRTA

*62nd Southern Conference of Dental Deans and Examiners

*BHP

*Exam Committee

December 16, 2016 minutes

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- **Dr. Alexander**

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*Advisory Panel on Opioids

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*Regulatory-Legislative Committee – RAP Meeting

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**VIRGINIA BOARD OF DENTISTRY
BUSINESS MEETING MINUTES
December 9, 2016**

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:05 a.m. on December 9, 2016, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

PRESIDING: A. Rizkalla, D.D.S., President

**BOARD MEMBERS
PRESENT:** John M. Alexander, D.D.S
Tonya A. Parris-Wilkins, D.D.S.
Patricia Bonwell, R.D.H., PhD.
Nathaniel Bryant, D.D.S.
Augustus Petticolas, D.D.S.
Carol Russek, J.D.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

**BOARD MEMBERS
ABSENT:** Tammy Ridout, R.D.H

STAFF PRESENT: Sandra K. Reen, Executive Director for the Board
Kelley Palmatier, Deputy Executive Director for the Board
Christine M. Houchens, Licensing Manager for the Board
Elaine Yeatts, DHP Senior Policy Analyst

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT: David E. Brown, D.C. Director, DHP

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

Ms. Reen read the emergency evacuation procedures.

Dr. Rizkalla explained the parameters for public comment and opened the public comment period.

PUBLIC COMMENT: Lauren Schmidt, lobbyist for the VDHA, asked the Board to support the proposed legislation that will amend the provisions for practice under remote supervision. She noted the law needs to be

amended to expand the practice settings, adding that the VDHA and the VDA are working together on amending this legislation.

**APPROVAL OF
Minutes:**

Dr. Rizkalla asked if there were any corrections to the September 15, 2016 Formal Hearing minutes, September 16, 2016 Public Hearing Minutes; September 16, 2016 Business Meeting minutes; and the September 26, 2016 and November 28, 2016 Telephone Conference Call Minutes. It was agreed that the last sentence in the last paragraph of the September 15, 2016 minutes should be removed because it was a repetition of the previous sentence. In the September 16, 2016 minutes, it was agreed to add in the last paragraph of the DHP Director's Report that Dr. Rizkalla had asked Dr. Alexander to spearhead a committee to work on guidelines for opioids and that Dr. Alexander accepted. Dr. Watkins moved to approve the minutes with the changes discussed. The motion was seconded and passed.

**DHP DIRECTOR'S
REPORT:**

Dr. Brown welcomed the new Board Members and noted the work of the Board members is essential and is to protect the public. He reported on the success of the Board Member Training that took place in October and encouraged all Board members to attend next year. He noted there was an in-depth presentation on the Freedom of Information Act (FOIA) and emphasized that a public meeting is taking place when more than 2 board members are discussing board related topics and indicates such meetings are not allowed unless public notice has been given and minutes are taken.

Dr. Brown said the Commissioner of Health has declared a state of public health emergency to address the opioid crisis. He stated that while prescriptions for these drugs are harder to obtain, the Commonwealth does not offer enough help for those that are already addicted and who turn to street drugs, such as heroine. He asked the Board to look into the need for emergency regulations to address prescribing by dentists.

**2016 WORKFORCE
REPORTS:**

Elizabeth A. Carter, Ph.D. and Director of DHP Healthcare Workforce Data Center reviewed the work of the Center and presented the two 2016 Workforce reports for Dentistry and Dental Hygiene. She explained that the Center is working with other states to address a common set of questions and is working to get the data down from the regional level to the county level. She highlighted the following survey results:

1. The number of licensed dentists has grown 1.5% from 2014 to 2016 to approximately 7300 licensed dentists but 24% of those do not currently practice in Virginia. She also noted that 18% of licensed Dental Hygienists do not work in Virginia.

2. She reported that there is great cultural diversity among the Board's licensees which is rare in healthcare.

Dr. Carter concluded by noting that Dentistry has a very high response rate to the surveys which allows for solid, accurate data.

**VIRGINIA'S
PRESCRIPTION
MONITORING
PROGRAM (PMP):**

Ralph A. Orr, Director of the PMP explained the new data system application platform, PMP Aware, for addressing reporting requirements. He said that, instead of accessing the system by license or DEA numbers, licensed dentists will now use their email address and will also be able to designate additional users to access the PMP data on their behalf. Ms. Yeatts added these additional users are required to sign confidentiality agreements as they will have regular access to confidential information. In response to a question, Mr. Orr stated dentists will be able to see information about the additional user's access to the platform. He added that the new system includes a simplified reset password feature.

Mr. Orr also reported that almost all licensed dentists have obtained reporting waivers and said that those who do currently report dispensing information will be required to report daily effective January 1, 2017. He added if unusual dispensing or prescribing practices are discovered, DHP now has the authority to report this information to the Enforcement Division for investigation of possible violations.

Mr. Orr also briefly reviewed a handout regarding how to calculate total daily dose of opioids for safer dosing and said an advisory panel is addressing ways to identify unusual prescription writing practices.

**LIAISON/COMMITTEE
REPORTS:**

AADB. Dr. Rizkalla reported the following topics were addressed at the 2016 Annual Meeting:

1. interstate medical board compacts for license reciprocity;
2. hygienists practicing in health access settings;
3. programs available to address a licensee's ethics and boundary violations;
4. the ADA Licensing Task Force's work to establish an objective structured clinical examination (OSCE) for initial licensure to eliminate the use of patients in clinical exams; and
5. the Board's executive director was elected as Vice-President of the American Association of Dental Administrators (AADA).

ADEX. Dr. Rizkalla noted that his term on the House of Representatives has expired and Dr. Bryant is now serving and that

Ms. Russek is currently serving as a consumer representative for Region Six.

CITA. Dr. Rizkalla briefly reviewed the approved agreement between the Board and CITA regarding travel, which allows Board representatives to administer CITA examinations.

SRTA. Dr. Watkins reported there have been no meetings since the September business meeting.

Dr. Rizkalla asked Dr. Brown if Board members can serve on CITA's board of directors. Discussion followed about being members of the other testing agencies accepted for licensure. Dr. Brown noted that he would need additional information before responding.

BHP. Dr. Watkins reported he was reappointed to the Board and there have been no recent meetings.

Exam Committee. Dr. Watkins said the committee is meeting on December 16th.

Regulatory-Legislative Committee. Dr. Wyman reviewed the minutes of the committee's last minutes, noting that Germanna Community College reported getting DAII courses accredited for college credit which allows students to receive student loans for taking these courses. He added that the VDA & VDHA reported on proposed changes to the remote supervision legislation which the Board will address later in the agenda and that the RAP on Dental Assistants is meeting in January to address DAII eligibility requirements.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported that the Board has two fast track regulatory actions that are approved and will go into effect on February 10, 2017: one addressing CE credit for volunteer hours and the other addressing the administration of only nitrous oxide.

Board Action on Capnography: Ms. Yeatts reported no public comments were received at the public hearing held on 09/16/2016 and only one comment was posted on Town Hall. She said the commenter supported the proposed amendment but did include a question about monitoring. Ms. Yeatts indicated that the need to monitor end-tidal carbon dioxide had been overlooked and could be addressed. Following discussion, Dr. Wyman moved to add end-tidal carbon dioxide to the monitoring requirements for conscious/moderate sedation and deep sedation and general

anesthesia. The motion was seconded and passed. Dr. Watkins moved to adopt the final proposed regulations as amended. The motion was seconded and adopted.

Respond to Petition for Rulemaking. Ms. Yeatts reviewed Dr. Barry's petition for rulemaking which requests amendment of the list of accepted sponsors in 18VAC60-21-250.C to add a number 16 as "any other provider approved by the Board." Ms. Yeatts said the Board could initiate rulemaking or deny for specified reasons. Discussion followed on the extensive list of approved sponsors, several of which credential providers and others that could be approached for affiliation. Concerns discussed included the lack of objective criteria; authority to regulate CE providers; and the lack of resources to undertake this activity. A motion by Dr. Watkins to deny the petition was seconded and passed.

Adoption of Proposed Amendment on Moderate Sedation: Ms. Yeatts explained that recent changes made in the renamed and issued ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (the Guidelines) need to be addressed in the Board's regulations on conscious/moderate sedation to avoid confusion over the requirements for a permit. The Guidelines, in Section V. Teaching Administration of Moderate Sedation, no longer include different provisions for the administration of moderate sedation by an enteral method. Instead, the same course requirements now apply to all the methods used to administer moderate sedation. Ms. Yeatts reviewed the proposed amendments which remove references to enteral administration and make it clear that the course requirements for moderate sedation in the ADA Guidelines now apply to all applicants for a moderate sedation permit. She added that this could be advanced as a fast track action since it is needed to conform to incorporated guidelines. Dr. Petticolas moved to adopt the amended regulations as a fast track action. The motion was seconded and passed.

**BOARD DISCUSSION/
ACTION:**

Establishing a Guidance Document on Opioid Prescriptions. Dr. Wyman moved to create a Regulatory Advisory Panel (RAP) chaired by Dr. Alexander to draft a guidance document on opioid prescribing. Discussion followed with Ms. Yeatts noting the RAP should be allowed to consider guidance and/or regulations. Dr. Brown said Secretary Hazel wants Dentistry to follow Medicine's example and hold its licensees accountable. He added that the RAP is not expected to create the regulatory language but is to create the points to be addressed in regulations. Dr. Wyman then moved to convene a RAP to develop guidance and regulations. This motion was seconded and adopted.

VDA and VDHA Amendments to Remote Supervision Statute.

Dr. Wyman said the Regulatory-Legislative Committee voted to recommend that the Board support the proposed legislation then a motion to accept the recommendation. The Committee's motion passed. Dr. Bonwell questioned why the word office was replaced by the word practice? Ms. Yeatts said it was changed to ensure that a dentist could not open an office to have his name on the door for the sake of remote practice without actually having a clinical practice.

Clarification of Regulatory Provisions. Ms. Reen stated she is requesting an interpretation of several regulatory provisions or lack thereof which have been questioned by licensees as follows.

1. To comply with 18VAC60-21-30.B, 18VAC60-25-20.B and 18VAC60-30-20.B may a licensee post the wallet size license issued by the Board? Discussion followed about the posting requirement was changed to prevent duplication of licenses and the ability to duplicate or create any size license. Ms. Reen said the regulations also require the license to be displayed in a conspicuous location where patients can see it and asked if the wallet size license could meet this requirement. There was general agreement that posting to meet this requirement was possible so Dr. Watkins made a motion to clarify that the wallet license can be used to meet the posting requirements. The motion was seconded and passed.
2. Why don't the posting regulations (18VAC60-21-30B, 18VAC60-25-20B & 18VAC60-30-20B) include the exemption for volunteer practice in §54.1-2721 and §54.1-2727 of the Code of Virginia? The Regulatory-Legislative Committee recommends that these sections be amended to reference the exemptions as proposed by Elaine Yeatts. Upon the motion of Dr. Wyman, the Board agreed to amend the regulations as discussed.
3. Will the Board provide more regulatory guidance by including the CDC Guidelines for Dentistry or another such reference? The Regulatory-Legislative Committee voted to recommend adopting a guidance document to address safe and sanitary practice instead of incorporating the CDC Guidelines by reference in the regulations. It was noted that this is currently being addressed in GD 60-15 on Professional Conduct so Ms. Yeatts recommended that the Board defer this topic to the next meeting when it has the CDC Guidelines to review. Dr. Wyman's motion to defer to the next meeting was seconded and passed.

4. Does the Reportable Events regulation 18VAC60-21-100 apply to the use of local anesthesia? The Regulatory-Legislative Committee agreed to recommend that the term “anesthesia” as used in 18VAC60-21-100 should be interpreted to require reporting within 15 days of any emergency treatment related to local anesthesia. Following discussion, the Board agreed by consensus to adopt the Committee’s recommendation. Ms. Reen stated that no regulatory change would be needed based on this interpretation. Additionally, the Committee recommended that “or” should be inserted between sedation and anesthesia in this regulatory section. A motion by Ms. Russek to adopt the recommendation passed.
5. Licensees are concerned that the terms “gingival curettage” and “non-surgical” in 18VAC60-21-13, 18VAC60-21-140 and 18VAC60-25-40 are problematic and need to be replaced. Ms. Yeatts reported that she has not yet completed this. Dr. Watkins moved to defer this topic to the next business meeting. The motion was seconded and passed.
6. Clarification has been requested on the inconsistency in regulatory provisions addressing dental hygienists treating patients under sedation as addressed in 18VAC60-21-140, 18VAC60-25-40, 18VAC60-21-291 and 18VAC60-21-30 and GD 60-4. Ms. Yeatts reported that she has not yet completed this. Dr. Petticolas moved to defer this topic to the next business meeting. The motion was seconded and passed.

**REPORT ON CASE
ACTIVITY:**

Ms. Palmatier reviewed her report noting that during the first quarter of FY2017:

- A total of 58 patient care cases were received and 62 patient care cases were closed for a 107% clearance rate, which is up from 102% in Q4 of 2016.
- The current pending caseload older than 250 days is 27%, which is down from 29% in Q4 of 2016. This brings this figure closer to the Board’s goal of 20%.
- 75% of the patient care cases were closed within 250 days, the same as Q4 of 2016 and noted that the Board’s goal is 90%.

She added that, between August 30, 2016 and November 18, 2016, the Board summarily suspended one dental license. Ms. Palmatier also noted there is a new trend in informal conferences where the respondents are bringing their own expert witnesses, to discuss quality of care issues.

**EXECUTIVE
DIRECTOR’S**

Ms. Reen addressed her interest in possibly changing renewals from annually on March 31, to annually by birth month in order

REPORT/BUSINESS:

to spread out the workload. She noted this could be implemented with minimal financial impact on licensees. She requested approval to develop a proposal for implementing this change for consideration by the Board. Dr. Rizkalla requested a motion to have Ms. Reen investigate this further and report her findings at the next business meeting. Dr. Petticolas so moved and the motion was seconded and passed.

Ms. Reen said in preparation for the upcoming Exam Committee meeting she is:

- providing the 2016-2017 ADEA Snapshot of Dental Education for review, and
- recommending that the members consider which statutes and regulations they want to be addressed in the law exam.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 12:09 p.m.

Al Rizkalla, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

APPROVED MINUTES

**BOARD OF DENTISTRY
EXAMINATION COMMITTEE**

December 16, 2016

- TIME AND PLACE:** The Examination Committee convened on December 16, 2016, at 10:08 a.m., at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.
- PRESIDING:** James D. Watkins, D.D.S.
- MEMBERS PRESENT:** Nathaniel C. Bryant, D.D.S.
Patricia B. Bonwell, RDH, PhD
Carol R. Russek, JD
- OTHER BOARD MEMBERS PRESENT:** Al Rizkalla, D.D.S.
John M. Alexander, D.D.S.
Augustus Petticolas Jr., D.D.S.
Tammy C. Ridout, RDH
Bruce S. Wyman, D.M.D
- STAFF PRESENT:** Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Christine M. Houchens, Licensing Manager
- ESTABLISHMENT OF A QUORUM:** All members of the committee were present.
- PUBLIC COMMENT:** Dr. Watkins explained the parameters for public comment and opened the public comment period. No public comment was received.
- APPROVAL OF MINUTES:** Dr. Watkins asked if the Committee members had reviewed the February 13, 2015 minutes and asked if there were any corrections needed. Dr. Bonwell moved to accept the minutes as presented. The motion was seconded and passed.
- PATHWAYS TO LICENSURE- DR. RIZKALLA:** Dr. Rizkalla gave a brief slide presentation on Licensure Pathways, noting that mobility of licensees can be an issue because not all states accept all of the regional clinical examinations. He explained the relationship of the Commission on Dental Competency Assessments (CDCA) and ADEX. He then reviewed the Curriculum Integrated Format (CIF) now being used by testing agencies. He said the CIF allows students to be examined in sections during the fourth year of dental school instead of taking all parts of a clinical examination at the very end of the dental program.

He added that some states accept completion of a Post-Graduate Year Residency (PGY1) in lieu of a clinical examination and the ADA is developing an OSCE for use in determining competency for initial dental licensure in the United States. He concluded by noting the following issues to think about when considering clinical examination requirements: portability, ethical considerations when using patients for licensing examinations and if CIF is an acceptable compromise.

Discussion followed about accepting a Post-Graduate Year Residency in lieu of a clinical examination which has the advantages of the student having more patient experiences. Concerns were raised about the differences between GPR programs which are hospital based and AEGD programs that they can be affiliated with a hospital but can be stand alone. Quality control was also questioned. In response to questions from Board members, VCU School of Dentistry faculty members in the audience said a PGY1 graduate is more competent than a dental school graduate who completes a clinical exam and will be a better dentist with better training. Dr. Watkins asked for a motion if the Committee would like more information on accepting PGY1 programs in lieu of a clinical exam for the next meeting. A motion by Dr. Bonwell to get more information was made and passed.

**REPORT ON THE ADA 2016
OSCE DEVELOPMENT
FORUM:**

Dr. Rizkalla and Dr. Wyman expressed concern that the ADA is proceeding with its investigation of the feasibility of developing a non-patient based OSCE for licensure purposes despite the lack of support by the participants in the forum.

**PROPOSE A POSITION
STATEMENT ON CLINICAL
EXAMS FOR LICENSURES
OF DENTISTS AND
DENTAL HYGIENISTS:**

Ms. Reen said this topic is on the agenda for discussion so representatives of the Board have a clear message on where the Board stands when they are participating in the national and regional discussions of clinical examinations. Ms. Reen said that in the past the Board explored establishing a portfolio examination with VCU but concluded this exam model was not workable with only one dental school in the state Virginia. The Board has not discussed its position on clinical examinations since that effort. It was noted that the Board has always supported having patient based exams and has never been interested in any other exam models. Ms. Reen suggested that the Board could reaffirm its position of requiring live patient exams for all licensees. Ms. Russek made a motion to recommend reaffirming this position which was seconded and passed.

Discussion followed about examining and being members of the regional testing agencies whose exams are accepted by the Board. Dr. Watkins questioned if membership is needed since all the examination are essentially the same. The sense of the committee was that such membership and examining was desirable. Ms. Reen advised that Board Counsel should be included in this discussion because the testing agencies are in competition for

**IMPLEMENTING A LAW
EXAM FOR LICENSURE
APPLICANTS:**

business. Dr. Watkins decided to table this discussion so Board Counsel can participate.

Ms. Reen asked the Committee for guidance on structuring the law exam for licensure applicants and asked:

1. How many questions?
2. How to determine passage- all answers correct or a percentage correct?
3. Open book or not?
4. Are there other considerations to be addressed?

She explained that this information is needed so the IT Division can evaluate the system's capacity to meet the expectations.

The Committee agreed by consensus with Dr. Watkin's suggestion that the exam be open book. It was noted that the previous exam was 25 questions with an 80% or higher score to pass. Mrs. Palmatier said when the previous exam was ordered in discipline cases, the exam was open book and the licensee was limited to 1 hour to complete it. She stated that having a time limit means that they had to review the regulations prior to the exam and only needed to find the information again during the exam. The committee agreed by consensus to having a time limit of one hour.

Following further discussion, the committee also agreed by consensus to the following test parameters:

- Require completion of the exam in one attempt without the ability to pause and come back later;
- Each test would consist of 25 questions;
- Applicants for dental and dental hygiene licenses and for registration as a dental assistant II are required to take the exam;
- There should be 4 response options for each question; and
- a score of 80% or higher is required to pass.

Mrs. Palmatier explained the need for a bank of questions to draw from so that questions and sequencing can vary to limit the opportunities for cheating. She then reviewed a report on the most cited violations in the disciplinary cases that were closed this year to assist in formulating questions. She also noted that for each question there must be one clear answer.

Ms. Reen recommended that Ms. Palmatier develop a pool of questions and answers for review by the Committee. Dr. Watkins said he wants the Committee members to develop the questions then have Ms. Palmatier review them. He added that the Committee should meet as often as the Board meets in order to monitor the effectiveness of the exams and change the questions when needed. A VCU School of Dentistry faculty member said he believes the School would BETA test the examination with some of its students then

**Virginia Board of Dentistry
Examination Committee
December 16, 2016**

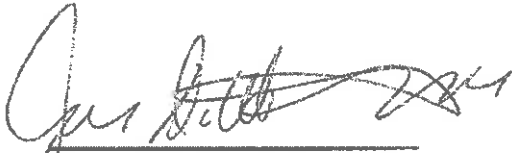
provide the Committee with an analysis.

Dr. Bryant moved to have the Committee members develop the exam questions. The motion was seconded and passed.


Dr. Watkins said the Committee should meet again before the next Board meeting, so that they can present the pool of questions each member has created, review and decide which questions to use and to also receive feedback from IT on what they are able to do. It was tentatively agreed that the Committee would meet on the reserved date of February 10, 2017.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 12:24pm.



James D. Watkins, D.D.S, Chair
2-10-17
Date



Sandra K. Reen, Executive Director
February 10, 2017
Date

UNAPPROVED MINUTES
BOARD OF DENTISTRY
EXAMINATION COMMITTEE
February 10, 2017

TIME AND PLACE: The Examination Committee convened on February 10, 2017, at 10:03 a.m., at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

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

MEMBERS PRESENT: Nathaniel C. Bryant, D.D.S.
Carol R. Russek, JD
Al Rizkalla, D.D.S., Ex-Officio

MEMBER ABSENT: Patricia B. Bonwell, R.D.H., PhD.

OTHER BOARD MEMBER PRESENT: Tonya A. Parris-Wilkins, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Christine M. Houchens, Licensing Manager
Sheila Beard, Executive Assistant

BOARD COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

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

PUBLIC COMMENT: Dr. Watkins explained the parameters for public comment and opened the public comment period. No public comment was received.

APPROVAL OF MINUTES: Dr. Watkins asked if the Committee members had reviewed the December 16, 2016 minutes and asked if there were any corrections needed. Dr. Rizkalla moved to accept the minutes as presented. The motion was seconded and passed.

DISCUSSION OF MEMBERSHIP IN REGIONAL TESTING AGENCIES: Ms. Reen said at its last meeting, the Committee expressed interest in becoming examiners and members of all the regional testing agencies administering clinical exams accepted by the Board. The topic was deferred to this meeting so that Board Counsel could be present. Mr.

Rutkowski recommended convening a closed session for discussion and to receive legal advice.

CLOSED MEETING:

Ms. Russek moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(7) of the Code of Virginia for consultation with legal counsel employed or retained by the Board regarding specific legal matters requiring the provision of legal advice by such counsel. Additionally she moved that Board Staff, Sandra Reen, Kelley Palmatier, Christine Houchens, Sheila Beard, and Board Counsel, James Rutkowski, attend the closed meeting because their presence is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

RECONVENE:

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

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

**IMPLEMENTING A
LAW EXAM FOR
LICENSURE
APPLICANTS-
DISCUSSION OF
IMPLEMENTATION:**

Mrs. Palmatier said the Committee decided at its last meeting that additional research and follow-up with IT was needed to determine the feasibility of implementing an online law examination for applicants using these parameters:

- Setting a time limit of one hour with the option to pause the examination and come back to finish at a later time or the option to “boot” applicants out of the examination once the time limit has been reached
- Requiring 80 percent of answers to be correct for passage
- Limiting the number of questions to 25
- Allowing the examination to be open book

Mrs. Palmatier reported she will meet with IT next week to determine which parameters are feasible. She said she received 15 questions from each Committee member which she compiled and sent to all the members for review. Discussion followed on whether to review the submitted questions at this meeting or allow additional time for members to review the recently submitted information. It was agreed that the questions would not be discussed at this meeting to allow additional time for review.

Dr. Watkins stated that the law examination is intended to be given to applicants, the majority of which are recent graduates. Therefore, he recommended not focusing on topics such as general anesthesia because the majority of applicants will have little to no experience with that topic. He said the questions should focus on information more applicable to general practice, including the violations that the Board sees most often in discipline cases.

Mrs. Palmatier agreed with Dr. Watkins and asked if the number of questions on less prevalent topics such as general anesthesia should be removed or reduced and more questions added on minimal or conscious/moderate sedation, or any other topics. Dr. Watkins asked the Committee members to consider this while reviewing the current draft questions and to provide their feedback to Mrs. Palmatier at a later date. The committee agreed.

Mrs. Palmatier agreed to compile the information for discussion at the next meeting. She also noted this will allow her to include information on IT's abilities to manage online administration of the examination as proposed. She suggested that the committee work to have the examination specifications finalized and ready to present to the Board at the June business meeting so a decision can be made on implementing the examination. The Committee decided to meet on April 28, 2017.

Dr. Watkins asked each member to review the current draft questions, and submit feedback and an additional 10 questions to Mrs. Palmatier by March 10, 2017.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 11:15a.m.

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

Sandra K. Reen, Executive Director

Date

Date

Reen, Sandra (DHP)

From: Bayley Milton <bmilton@dentalboards.org>
Sent: Thursday, January 12, 2017 10:44 AM
Subject: December 2016 AADB Monthly Report from Executive Director Richard Hetke

AADB Members ---

Happy New Year to all. I hope the Holiday season was an enjoyable one for everybody. Good time with family and friends. A minimal amount of stress. The last two weeks of December were rather quiet here in Chicago. However, we were open during the final two weeks of the year and handled a solid amount of requests and other business from Members and others. Highlights and updates for December are summarized below.

1. Mid-Year 2017 Meeting Reminder --- Our 2017 Mid-Year Meeting is slated for April 23 and 24 at the ADA Headquarters here in Chicago. As many of you well know, the AADB office is located on the 7th Floor of the ADA Building. Registration details will be released later this month. The Program Committee is busy assembling a program that should appeal to our Members. Stay tuned.
2. Membership Dues --- We are happy to announce that we have exceeded our membership dues revenue goal for Fiscal Year 2016-2017. At the present moment, we are about 2% above our projection in last year's budget. A few more dues payments may trickle into our office as well. Membership recruitment efforts may also add a few dollars. Good news.
3. Mid-Year Financial Report --- We are tracking our operating budget very closely. Revenue is slightly exceeding our forecast based upon a small surplus on membership dues and solid income gains from the query service. Expenses are slightly below budget and should remain so for the duration of Fiscal 2016-2017 (ending June 30, 2017). We would like to exceed our budget by at least \$30,000.
4. Tax-Exempt Organization Filing --- During the last quarter of 2016, AADB timely filed its IRS Form 990. This filing is used by tax-exempt organizations like AADB. We have maintained our tax-exempt status without any inquiries or challenges from the IRS.
5. Board of Director Meetings --- The AADB Board of Directors continues its practice of frequent meetings and interaction. A teleconference meeting was held on December 6, 2016 to summarize year-end results and discuss 1-Q 2017 activities. The Board will meet face-to-face on January 14 in Orlando for a few hours, taking advantage of the fact that virtually all Board members are attending the big CDCA meeting.
6. The 2017 Composite --- The 2017 Composite remains on target for its March 1 release. We have received 45 of 50 states' data and are promised two more submissions shortly. All of the data received to date has been input into the master draft with proofreading well under way. Thanks to all of the state boards for providing the necessary information.
7. The Clearinghouse --- Order entry into the AADB Clearinghouse is current. Once again, we ask all state boards to forward their orders on a quarterly basis to insure that the Clearinghouse remains a valuable resource to our Members.
8. The Queries --- We continue our 24-48 hour turnaround on all queries submitted to our office. A new part-time staff member has been fully trained, and she is doing an excellent job of maintaining our service. A second staffer is also proficient in the process and provides good backup.

9. Committee Formation --- We have made numerous efforts to enlist Members for AADB Committee work. Approximately 40 Members have expressed an interest in serving on an AADB Committee. During the next month, the Board will review the applications and begin to populate the Committees.
10. Membership Directory --- The membership directory has been updated on the AADB website. The database now more accurately reflects our current membership.
11. The Website --- A quarterly review of the new website is planned for late January. We will review the entire site on a page-by-page basis for additions, deletions, and corrections. Such reviews are essential in making the website a reliable source of information. All state boards should try to keep us informed of changes that should be reflected on our site.
12. Tele-Seminar Program --- We have received a small group of topical suggestions and a smaller group of volunteer presenters. Our goal is to present our first program sometime during the second quarter of 2017. Details will be coming soon.
13. 4-Q 2016 AADB Bulletin --- The 4-Q 2016 Bulletin will be released later this month. We did not want the publication lost in the holiday shuffle. Any state board updates or news may be submitted by January 20th for inclusion in the Bulletin.
14. Sponsor Search --- We are interested in adding a few more sponsors for the April Mid-Year Meeting. Sponsorships can be purchased for as little as \$2,000 and offer sponsors an excellent avenue for national exposure to key regulators and decision-makers. Please forward any good prospects to my attention.
15. Software/Hardware Upgrades --- Some new software was added to our server to minimize down time. We also added three new desktop computers to replace aging equipment. Total cost was quite reasonable, about \$2,500.
16. CDEL Meeting --- AADB representatives and I attended a CDEL meeting in early December. I gave a 10-minute overview of the AADB organization and current activities. I also provided the Board with a set of meeting notes.
17. January Meetings --- President Jill Burns and I attended a group of sessions during the annual meeting of the National Roundtable for Dental Collaboration at ADA Headquarters on January 6 and 7. Virtually every AADB Board Member is attending this week's CDCA meeting in Orlando. As a result, we are taking that opportunity to conduct a 2-3 hour Board meeting on January 14.
18. FARB Membership --- I recently joined the Federation of Associations of Regulatory Boards (FARB). FARB has a huge database of standard agreements that associations may use. The networking and information exchange opportunities are also attractive. We will explore on a one-year basis.

That's it for now. All the best for 2017.

Richard Hetke

**VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY ADVISORY PANEL
Discussion of the Prescribing of Opioids in the Practice of Dentistry
January 23, 2017**

TIME AND PLACE: The meeting of the Regulatory Advisory Panel was called to order at 9:20 a.m., on January 23, 2017, Department of Health Professions, 9960 Mayland Drive, Suite 201, Training Room 2, Henrico, Virginia 23233.

PRESIDING: John M. Alexander, D.D.S., Board Member, Board of Dentistry

**REGULATORY
ADVISORY PANEL**

MEMBERS PRESENT: A. Omar Abubaker, D.M.D., PhD, Oral & Maxillofacial Surgery
VCU School of Dentistry
B. Ellen Byrne, D.D.S., PhD, Professor of Endodontics
VCU School of Dentistry
Carol R. Russek, J.D., Board Member, Board of Dentistry

STAFF PRESENT: Kelley W. Palmatier, Deputy Executive Director, Board of Dentistry
Elaine J. Yeatts, DHP Senior Policy Analyst
Donna Lee, Discipline Case Manager, Board of Dentistry

OTHERS PRESENT: David E. Brown, D.C., DHP Director

**ESTABLISHMENT OF
A QUORUM:** With all Regulatory Advisory Panel members present, a quorum was established.

Ms. Palmatier read the emergency evacuation procedures.

**DISCUSSION ON THE
PRESCRIBING OF
OPIOIDS FOR ACUTE
AND CHRONIC DENTAL
RELATED PAIN:**

Dr. Alexander stated that the purpose of the meeting was to discuss the prescribing of opioids for acute and chronic dental pain, and to develop a guidance document and points to be addressed in emergency regulations.

Ms. Yeatts informed the Regulatory Advisory Panel ("Panel") that there are currently two bills at the General Assembly, when signed, the Board of Dentistry would have a statutory requirement to adopt regulations dealing with opioids for acute and chronic dental pain.

Ms. Yeatts explained the regulatory process regarding emergency regulations and that they are generally in effect 12-18 months before being replaced with permanent regulations. She also stated that one bill in the General Assembly is being amended to require a prescriber of opioids to check with the Prescription Monitoring Program for a prescription written for 7 days or more instead of the current law that states 14 days.

Dr. Brown stated that the goal of the emergency regulations and a guidance document regarding opioid prescribing is to provide clear guidance to practitioners so as to avoid overprescribing opioids to patients, recognizing that there may be unusual circumstances when a dentist may have to address chronic pain.

The Panel agreed that dentists should not have contracts with patients to treat chronic pain, but that a patient should be referred to a program for pain management where there are strict regulations that both the pain management doctor and patient have to follow.

The Panel reviewed the Board of Medicine's draft regulations for Governing Prescribing for Pain and Prescribing of Buprenorphine as a guideline to draft emergency regulations for the Board of Dentistry ("Board").

The Panel stated that the "Definitions" and the "Evaluation of the Patient" sections could read the same in the Board's draft emergency regulations as it does in the Board of Medicine's draft emergency regulations.

The Panel changed the title of the regulation "Treatment with Opioids" to read "Treatment of Acute Pain with Opioids" and the regulation to read as follows:

A. Initiation of opioid treatment for opioid naïve patients shall be with short-acting opioids.

B. Initiation of opioid treatment for all patients shall include the following:

1. A prescription for an opioid shall be a short-acting opioid in the lowest effective dose for the fewest number of days, not to exceed seven days.
2. The dentist shall carefully consider and document in the patient record the reasons to exceed 50 MME/day.

3. Prior to exceeding 120 MME/day, the dentist shall refer or consult with a pain management specialist.

C. If another prescription for an opioid is to be written beyond seven days, the dentist shall:

1. Re-evaluate the patient and document in the patient record the continued need for an opioid prescription; and
2. Check the patient's prescription history in the Prescription Monitoring Program.

The Panel also changed the title "Medical Records" to "Patient Record Requirement in Prescribing for Acute Pain" and the regulation to read as follows: The patient record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan and the medication prescribed (including date, type, dosage, strength, and quantity prescribed).

Also added were the following two regulations:

(1) Prescribing of opioids for chronic pain.

If a dentist treats a patient for whom an opioid prescription is necessary for chronic pain, he shall either:

1. Refer the patient to a medical doctor who has a specialty in pain management; or
2. Comply with regulations of the Board of Medicine, 18VAC85-21-10 et seq., if he chooses to manage the chronic pain with an opioid prescription.

(2) Continuing education required for prescribing.

A dentist who prescribes any Schedule II through V controlled substances during one renewal cycle shall obtain two hours of continuing education on pain management during the next renewal year. Continuing education hours required for prescribing of controlled substances may be included in the 15 hours required for renewal of licensure.

The Panel requested that Ms. Palmatier send the draft emergency regulations with the proposed changes discussed to each Panel member for review before they are presented to the Board at its meeting on March 10, 2017 for review and adoption.

Virginia Board of Dentistry
Regulatory Advisory Panel Meeting
January 23, 2017

The Panel also decided to not draft a guidance document at the present time, but let the Board determine at its March meeting if a guidance document is necessary.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 10:45 a.m.

John M. Alexander, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

**BOARD OF DENTISTRY
MINUTES OF REGULATORY--LEGISLATIVE COMMITTEE
Regulatory Advisory Panel Discussion on the
Education and Practice of Dental Assistants I & II**

January 5, 2017

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry and the Regulatory Advisory Panel (RAP) was called to order on January 5, 2017 at 9:07 a.m. at the Department of Health Professions, 9960 Maryland Drive, Suite 201, Board Room 4; Henrico, Virginia.

PRESIDING: Bruce S. Wyman, D.M.D., Chair

COMMITTEE MEMBERS PRESENT: John M. Alexander, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
Tammy C. Ridout, R.D.H

COMMITTEE MEMBERS ABSENT: Augustus A. Petticolos, Jr., D.D.S.

ESTABLISHMENT OF QUORUM: With four members of the committee present, a quorum was established.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Christine M. Houchens, Licensing Manager

ADVISORY PANEL MEMBERS PRESENT: Lori Turner, CDA - VCU School of Dentistry
Cheryl Evans, CDA, BSHA - Fortis College
Angela Smith - J. Sargeant Reynolds Community College
Misty Mesimer, RDH - Germanna Community College
Richard Taliaferro, D.D.S. - Past-President, Virginia Dental Association
Trish MacDougall, RDH - President, Virginia Dental Hygiene Association
Vickie Brett - ECPI University
Michelle Green-Wright, RN - Virginia Dept. of Education

PANEL MEMBERS ABSENT: Tina Bailey, CDA - Virginia Dental Assistants Association

OTHERS PRESENT: Elaine Yeatts, DHP Policy Analyst

PUBLIC COMMENT: None

DISCUSSION ON POSSIBLE REVISIONS TO THE REQUIREMENTS FOR DENTAL ASSISTANT II REGISTRATION: Dr. Wyman opened the meeting, indicating the RAP is asked to address the regulatory changes needed to establish competency based education requirements for Dental Assistants II (DAII). He then asked each member of the panel to state their recommendations for revising the requirements.

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Regulatory-Legislative Committee-RAP Meeting
January 5, 2017**

Ms. Mesimer recommended that the DAI curriculum be changed to competency based requirements. She also recommended revising the regulations for Dental Assistants I to require certification in Infection Control in addition to the requirement for radiation certification. She requested that the Board provide more details on the content for the didactic courses on "dental anatomy" and "operative dentistry" to specify the topics that must be covered so there is consistency across programs.

Ms. Smith recommended revising the regulations to include minimum education standards for Dental Assistants I. She agreed with changing to a competency based curriculum and recommended that the Board define who can teach the DAI programs.

Ms. Evans noted that she agrees with all of the recommendations stated by Ms. Smith and Ms. Mesimer. She added that schools need to know the Board's required credentials for those who can teach the DAI program. She also noted that she supports a competency based curriculum.

Ms. Turner said the regulations should be revised to require Dental Assistants I to hold the Certified Dental Assisting credential available through the Dental Assisting National Board. She recommended that Dental Assistants II be required to have training in all the delegable procedures. She also encouraged that the clinical experience be overseen by someone other than an employer and that it should be completed at the school rather than an employer's dental office.

Dr. Talliaferro stated he supports a competency based curriculum and recommended having independent clinical examinations for each procedure, especially composites and amalgams.

Ms. MacDougall agreed with all the recommendations of the previous speakers.

Mrs. Green-Wright supported the recommendations for a competency based curriculum and added that students completing the dental assisting programs offered through the Department of Education could feed into the programs offered by community colleges for career advancement. She offered assistance in developing a competency based curriculum.

Ms. Brett also agreed with changing to a competency based curriculum, noting this is essential. She said she is concerned about the limited availability of DAI programs and questioned whether they should be restricted to schools with CODA accredited

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Regulatory-Legislative Committee-RAP Meeting
January 5, 2017**

programs.

Dr. Wyman questioned if there is a need for DAsII and if changing the regulations will lead to more training programs. He then said a universal approach to revising the regulations is needed and facilitated a discussion of the recommendations. There was general agreement that:

- There are dentists and dental assistants who have reported interest in having a DAI program in their area.
- The requirement that DAI programs be offered by an educational institution that maintains a CODA accredited dental assisting, dental hygiene or dental program should be maintained.
- The didactic dental anatomy and operative dentistry coursework should be two courses and the content of each course should be specified for uniformity across programs.
- Requirements to teach DAI programs should be addressed in regulation. Instructors should be at or above the DAI level and have appropriate experience.
- The clinical experience component of the program should be supervised by a dentist who has successfully completed a calibration exercise.
- All the delegable duties should be taught to every enrolled student.
- Competence in each delegable duty should be established by completing a clinical examination.
- There is concern about the lack of uniformity across programs when a dentist who employs a student also supervises and evaluates clinical competence.
- Education requirements for DAsI should be established. The need for training in infection control was stressed and DANB was identified as the source for this training. There was support for requiring that CDA certification by DANB be obtained over a specified period of time so that all DAsI would be required to hold the credential. Concerns about the need for and cost of such a requirement were raised. The possibility of using work force development grants for training current DAsI was noted.
- Requirements for clinical experience settings DAsII should be addressed for consistency across programs. Options identified included not for profit settings, clinics that operate in conjunction with the CODA accredited program, and a hybrid program for completion at the school and in dental offices.
- The Board could elect to undertake program accreditation and set the standards to assure consistency across programs.
- Objective competency assessment tools should be established for consistency across programs.

**Virginia Board of Dentistry
Regulatory-Legislative Committee-RAP Meeting
January 5, 2017**

Dr. Wyman asked Ms. Reen to review the current regulations for the DAII program to identify the provisions where changes are recommended. During this review these additional items were also generally agreed to:

- The homework provision for laboratory training should be deleted. All training should be completed in the program's laboratory.
- Laboratory training should be mannequin based.
- The number of successful procedures required for the laboratory training in amalgam restorations and in composite resin restorations should be set for each class of restoration, with 12 required for Class I, 12 required for Class II, 5 required for Class III, 5 required for Class 4 and 5 required for Class V.
- The number of successful procedures for final impressions should be 4 and for the use non-epinephrine should be 2.
- The number of successful procedures required for the laboratory training in final cementation of crowns should be 5 and in final cementation of bridges should be 2.
- The number of hours for clinical experience should be reduced to a total of 120 hours and a required number of successful procedures should be set for each procedure.
- Strike the requirement for a practical examination at the conclusion of each module of laboratory training.

Ms. Reen said all the recommendations made today will be presented to the Regulatory-Legislative Committee for discussion. She said the ones addressing the DAII program requirements will be included in a discussion draft of the regulations which she will send to all the panel members for review in advance of the next meeting of the Committee. She invited their comments on the draft for the Committee's consideration.

NEXT MEETING:

TBD

ADJOURNMENT:

With all business concluded, Dr. Wyman thanked everyone for their contributions and adjourned the meeting at 12:12 pm.

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

Sandra K. Reen, Executive Director

Date

Date

**Agenda Item: Regulatory Actions - Chart of Regulatory Actions
(As of February 23, 2017)**

| Board | | Board of Dentistry |
|------------------|---|---|
| Chapter | Action / Stage Information | |
| [18 VAC 60 - 21] | Regulations Governing the Practice of Dentistry | <u>Credit for volunteer hours and extension of time for CE</u> [Action 4597] Fast-Track - Register Date: 12/26/16 Effective: 2/10/17 |
| [18 VAC 60 - 21] | Regulations Governing the Practice of Dentistry | <u>Administration of nitrous oxide only</u> [Action 4598] Fast-Track - Register Date: 12/26/16 Effective: 2/10/17 |
| [18 VAC 60 - 21] | Regulations Governing the Practice of Dentistry | <u>Posting of DEA registration</u> [Action 4682] Fast-Track - Register Date: 1/23/17 Effective: 3/9/17 |
| [18 VAC 60 - 21] | Regulations Governing the Practice of Dentistry | <u>Confirming rules to ADA guidelines on moderate sedation</u> [Action 4748] Fast-Track - fast-track process deemed inappropriate [Stage 7811] |
| [18 VAC 60 - 21] | Regulations Governing the Practice of Dentistry | <u>Requirement for capnography for monitoring anesthesia or sedation</u> [Action 4411] Final - At Governor's Office for 3 days |

Board of Dentistry Report of 2017 General Assembly

HB 1474 Dental hygienist; remote supervision.

Chief patron: Orrock

Dental hygiene; remote supervision. Eliminates the requirement that a dental hygienist providing dental hygiene services under remote supervision be employed by the supervising dentist; clarifies continuing education requirements for dental hygienists practicing under remote supervision; eliminates the requirement for written permission to treat a patient from a dentist who has treated the patient in the previous 12 months; and allows a dental hygienist practicing under remote supervision to treat a patient who provides verbal confirmation that he does not have a dentist of record whom he is seeing regularly. The bill eliminates the requirement that a dental hygienist practicing under remote supervision consult with the supervising dentist prior to providing further dental hygiene services if the patient is medically compromised or has periodontal disease and allows a dental hygienist practicing under remote supervision to provide further dental hygiene services in accordance with a written practice protocol developed and provided by the supervising dentist, which shall consider, at minimum, the medical complexity of the patient and the presenting signs and symptoms of oral disease. The bill requires a supervising dentist who conducts the examination of the patient or refers the patient to another dentist for examination following the 90-day period during which a dental hygienist is permitted to provide dental hygiene services under remote supervision to develop a diagnosis and treatment plan for the patient. The bill directs the Board of Dentistry to promulgate regulations to implement the provisions of the act within 280 days of its enactment.

HB 1748 Charity health care services; liability protection for administrators.

Chief patron: O'Bannon

Charity health care services; liability protection for administrators. Provides that persons who administer, organize, arrange, or promote the rendering of services to patients of certain clinics shall not be liable to patients of such clinics for any civil damages for any act or omission resulting from the rendering of such services unless the act or omission was the result of such persons' or the clinic's gross negligence or willful misconduct. This bill is identical to SB 981.

HB 1799 Controlled substances; use of FDA-approved substance upon publication of final rule, etc.

Chief patron: O'Bannon

Board of Pharmacy to deschedule or reschedule controlled substances. Authorizes the Board of Pharmacy (Board) to designate, deschedule, or reschedule as a controlled substance any substance 30 days after publication in the Federal Register of a final or interim final order or rule designating such substance as a controlled substance or descheduling or rescheduling such substance. Under current law,

the Board may act 120 days from such publication date. The bill also provides that a person is immune from prosecution for prescribing, administering, dispensing, or possessing pursuant to a valid prescription a substance approved as a prescription drug by the U.S. Food and Drug Administration on or after July 1, 2017, in accordance with a final or interim final order or rule despite the fact that such substance has not been scheduled by the Board. The immunity provided by the bill remains in effect until the earlier of (i) nine months from the date of the publication of the interim final order or rule or, if published within nine months of the interim final order or rule, the final order or rule or (ii) the substance is scheduled by the Board or by law. This bill is identical to SB 1403.

HB 1885 Opioids; limit on amount prescribed, extends sunset provision.

Chief patron: Hugo

Limits on prescription of controlled substances containing opioids. Requires a prescriber registered with the Prescription Monitoring Program (the Program) to request information about a patient from the Program upon initiating a new course of treatment that includes the prescribing of opioids anticipated, at the onset of treatment, to last more than seven consecutive days and exempts the prescriber from this requirement if the opioid is prescribed as part of treatment for a surgical or invasive procedure and such prescription is for no more than 14 consecutive days. Current law requires a registered prescriber to request information about a patient from the Program upon initiating a new course of treatment that includes the prescribing of opioids anticipated, at the onset of treatment, to last more than 14 consecutive days and exempts the prescriber from this requirement if the opioid is prescribed as part of a course of treatment for a surgical or invasive procedure and such prescription is not refillable. The bill extends the sunset for this requirement from July 1, 2019, to July 1, 2022.

HB 2164 Drugs of concern; drug of concern.

Chief patron: Pillion

Drugs of concern; gabapentin. Adds any material, compound, mixture, or preparation containing any quantity of gabapentin, including any of its salts, to the list of drugs of concern. This bill contains an emergency clause.

HB 2165 Opiate prescriptions; electronic prescriptions.

Chief patron: Pillion

Opiate prescriptions; electronic prescriptions. Requires a prescription for any controlled substance containing an opiate to be issued as an electronic prescription and prohibits a pharmacist from dispensing a controlled substance that contains an opiate unless the prescription is issued as an electronic prescription, beginning July 1, 2020. The bill defines electronic prescription as a written prescription that is generated on an electronic application and provides that Schedule II through V prescriptions must be transmitted in accordance with federal regulations. The bill requires the Secretary of Health and Human

Resources to convene a work group to review actions necessary for the implementation of the bill's provisions and to evaluate hardships on prescribers and the inability of prescribers to comply with the deadline for electronic prescribing and to make recommendations for any extension or exemption processes relative to compliance or disruptions due to natural or manmade disasters or technology gaps, failures, or interruptions of service. The bill requires the work group to report on its progress to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2017, and to issue a final report to such Chairmen by November 1, 2018.

HB 2167 Opioids and buprenorphine; Boards of Dentistry and Medicine to adopt regulations for prescribing.

Chief patron: Pillion

Boards of Dentistry and Medicine; regulations for the prescribing of opioids and buprenorphine. Directs the Boards of Dentistry and Medicine to adopt regulations for the prescribing of opioids and products containing buprenorphine. The bill requires the Prescription Monitoring Program at the Department of Health Professions to provide an annual report to the Joint Commission on Health Care on the prescribing of opioids and benzodiazepines in the Commonwealth. The bill contains an emergency clause.

HB 2470 Drug Control Act; Schedule II and Schedule V.

Chief patron: Jones

Drug Control Act; Schedule II and Schedule V. Adds thiafentanil to Schedule II of the Drug Control Act and Brivaracetam to Schedule V of the Drug Control Act.

SB 848 Naloxone; dispensing for use in opioid overdose reversal, etc.

Chief patron: Wexton

Dispensing of naloxone. Allows a person who is authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone for use in opioid overdose reversal and who is acting on behalf of an organization that provides services to individuals at risk of experiencing opioid overdose or training in the administration of naloxone for overdose reversal and that has obtained a controlled substances registration from the Board of Pharmacy pursuant to § 54.1-3423 to dispense naloxone to a person who has completed a training program on the administration of naloxone for opioid overdose reversal, provided that such dispensing is (i) pursuant to a standing order issued by a prescriber, (ii) in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, and (iii) without charge or compensation. The bill also provides that dispensing may occur at a site other than that of the controlled substance registration, provided that the entity possessing the controlled substance registration maintains records in accordance

with regulations of the Board of Pharmacy. The bill further provides that a person who dispenses naloxone shall not be liable for civil damages of ordinary negligence for acts or omissions resulting from the rendering of such treatment if he acts in good faith and that a person to whom naloxone has been dispensed pursuant to the provisions of the bill may possess naloxone and may administer naloxone to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. The bill contains an emergency clause. This bill is identical to HB 1453.

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 54.1-2722 of the Code of Virginia, relating to practice of dental hygiene; remote supervision.

[H 1474]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2722 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2722. License; application; qualifications; practice of dental hygiene.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of a dental hygiene program accredited by the Commission on Dental Accreditation and offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

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

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

57 A report of services provided by dental hygienists pursuant to such protocol, including their impact
58 upon the oral health of the citizens of the Commonwealth, shall be prepared and submitted by the
59 Department of Health to the Virginia Secretary of Health and Human Resources annually. Nothing in
60 this section shall be construed to authorize or establish the independent practice of dental hygiene.

61 F. For the purposes of this subsection, "remote supervision" means that a *supervising* dentist is
62 accessible and available for communication and consultation with a dental hygienist ~~employed by such~~
63 ~~dentist~~ during the delivery of dental hygiene services, but such dentist may not have conducted an initial
64 examination of the patients who are to be seen and treated by the dental hygienist and may not be
65 present with the dental hygienist when dental hygiene services are being provided.

66 Notwithstanding any other provision of law, a dental hygienist may practice dental hygiene under the
67 remote supervision of a dentist who holds an active, ~~unrestricted~~ license by the Board and who has a
68 dental ~~office~~ *practice* physically located in the Commonwealth. No dental hygienist shall practice under
69 remote supervision unless he has (i) completed a continuing education course *designed to develop the*
70 *competencies needed to provide care under remote supervision* offered by an accredited dental education
71 program or from a continuing education provider approved by the Board and (ii) at least two years of
72 clinical experience, consisting of at least 2,500 hours of clinical experience. A dental hygienist practicing
73 under remote supervision shall have professional liability insurance with policy limits acceptable to the
74 supervising dentist. A dental hygienist shall only practice under remote supervision at a ~~community~~
75 ~~health center~~, *federally qualified health center*; charitable safety net facility; free clinic; long-term care
76 facility; elementary or secondary school; Head Start program; or women, infants, and children (*WIC*)
77 program.

78 A dental hygienist practicing under remote supervision may (a) obtain a patient's treatment history
79 and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all
80 educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent
81 with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer topical
82 oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of
83 medicine or osteopathic medicine pursuant to subsection V of § 54.1-3408, and (h) perform any other
84 service ordered by the supervising dentist or required by statute or Board regulation. No dental hygienist
85 practicing under remote supervision shall administer local anesthetic or nitrous oxide.

86 Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote
87 supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement
88 disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for
89 the need for regular dental examinations by a dentist and (2) ~~verbal or written permission of any dentist~~
90 ~~who has treated the patient in the previous 12 months and can be identified by confirmation from the~~
91 ~~patient that he does not have a dentist of record whom he is seeing regularly.~~

92 After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote
93 supervision shall ~~consult with the supervising dentist prior to providing~~ *may provide* further dental
94 hygiene services if such patient is ~~medically compromised or has periodontal disease~~ *following a written*
95 *practice protocol developed and provided by the supervising dentist. Such written practice protocol shall*
96 *consider, at a minimum, the medical complexity of the patient and the presenting signs and symptoms of*
97 *oral disease.*

98 A dental hygienist practicing under remote supervision shall inform the supervising dentist of all
99 findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a
100 patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances,
101 shall either conduct an examination of the patient or refer the patient to another dentist to conduct an
102 examination. The supervising dentist shall develop a *diagnosis and* treatment plan for the patient, and
103 either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient. The
104 supervising dentist shall review a patient's records at least once every 10 months.

105 Nothing in this subsection shall prevent a dental hygienist from practicing dental hygiene under
106 general supervision whether as an employee or as a volunteer.

107 **2. That the Board of Dentistry shall promulgate regulations to implement the provisions of this act**
108 **to be effective within 280 days of its enactment.**

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend the Code of Virginia by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.4 and by adding in Article 2 of Chapter 29 of Title 54.1 a section numbered 54.1-2928.2, relating to Board of Dentistry and Medicine; regulations for the prescribing of opioids and buprenorphine.

[H 2167]

Approved

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.4 and by adding in Article 2 of Chapter 29 of Title 54.1 a section numbered 54.1-2928.2 as follows:

§ 54.1-2708.4. Board to adopt regulations related to prescribing of opioids.

The Board shall adopt regulations for the prescribing of opioids, which shall include guidelines for:

1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii) requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § 54.1-2522.1;

2. The treatment of chronic pain, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a treatment plan for the patient, (ii) an agreement for treatment signed by the provider and the patient that includes permission to obtain urine drug screens, and (iii) periodic review of the treatment provided at specific intervals to determine the continued appropriateness of such treatment; and

3. Referral of patients to whom opioids are prescribed for substance abuse counseling or treatment, as appropriate.

§ 54.1-2928.2. Board to adopt regulations related to prescribing of opioids and buprenorphine.

The Board shall adopt regulations for the prescribing of opioids and products containing buprenorphine. Such regulations shall include guidelines for:

1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii) requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § 54.1-2522.1;

2. The treatment of chronic pain, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a treatment plan for the patient, (ii) an agreement for treatment signed by the provider and the patient that includes permission to obtain urine drug screens, and (iii) periodic review of the treatment provided at specific intervals to determine the continued appropriateness of such treatment; and

3. The use of buprenorphine in the treatment of addiction, including a requirement for referral to or consultation with a provider of substance abuse counseling in conjunction with treatment of opioid dependency with products containing buprenorphine.

2. That an emergency exists and this act is in force from its passage.

3. That the Prescription Monitoring Program at the Department of Health Professions shall annually provide a report to the Joint Commission on Health Care on the prescribing of opioids and benzodiazepines in the Commonwealth that includes data on reporting of unusual patterns of prescribing or dispensing of a covered substance by an individual prescriber or dispenser or on potential misuse of a covered substance by a recipient, pursuant to § 54.1-2523.1.

§ 2.2-4011. Emergency regulations; publication; exceptions.

A. Regulations that an agency finds are necessitated by an emergency situation may be adopted by an agency upon consultation with the Attorney General, which approval shall be granted only after the agency has submitted a request stating in writing the nature of the emergency, and the necessity for such action shall be at the sole discretion of the Governor.

B. Agencies may also adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment and the regulation is not exempt under the provisions of subdivision A 4 of § 2.2-4006. In such cases, the agency shall state in writing the nature of the emergency and of the necessity for such action and may adopt the regulations. Pursuant to § 2.2-4012, such regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations.

C. All emergency regulations shall be limited to no more than 18 months in duration. During the 18-month period, an agency may issue additional emergency regulations as needed addressing the subject matter of the initial emergency regulation, but any such additional emergency regulations shall not be effective beyond the 18-month period from the effective date of the initial emergency regulation. If the agency wishes to continue regulating the subject matter governed by the emergency regulation beyond the 18-month limitation, a regulation to replace the emergency regulation shall be promulgated in accordance with this article. The Notice of Intended Regulatory Action to promulgate a replacement regulation shall be filed with the Registrar within 60 days of the effective date of the emergency regulation and published as soon as practicable, and the proposed replacement regulation shall be filed with the Registrar within 180 days after the effective date of the emergency regulation and published as soon as practicable.

D. In the event that an agency concludes that despite its best efforts a replacement regulation cannot be adopted before expiration of the 18-month period described in subsection C, it may seek the prior written approval of the Governor to extend the duration of the emergency regulation for a period of not more than six additional months. Any such request must be submitted to the Governor at least 30 days prior to the scheduled expiration of the emergency regulation and shall include a description of the agency's efforts to adopt a replacement regulation together with the reasons that a replacement regulation cannot be adopted before the scheduled expiration of the emergency regulation. Upon approval of the Governor, provided such approval occurs prior to the scheduled expiration of the emergency regulation, the duration of the emergency regulation shall be extended for a period of no more than six months. Such approval shall be in the sole discretion of the Governor and shall not be subject to judicial review. Agencies shall notify the Registrar of Regulations of the new expiration date of the emergency regulation as soon as practicable.

E. Emergency regulations shall be published as soon as practicable in the Register.

Agenda Item: Board Action on Draft Regulations for Opioid Prescribing

Included in your agenda package are:

A copy of the HB2167 of the 2017 General Assembly

A copy of the section in the Administrative Process Act authorizing adoption of an emergency regulation

A copy of regulations recommended by the Regulatory Advisory Panel at its meeting on January 23, 2017 (minutes of the RAP meeting are also included in your agenda package)

Staff Note:

Changes made since the RAP meeting are highlighted and are included for consistency with regulations adopted by the Board of Medicine

This action must be adopted as an emergency regulation.

Board action:

Adoption of Part III. Prescribing for pain management by an Emergency Action.

Board of Dentistry

Part III. Prescribing for pain management.

18VAC60-21-101. Definitions.

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

“Acute pain” shall mean pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months.

“Chronic pain” shall mean non-malignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months.

“Controlled substance” shall mean drugs listed in The Drug Control Act of the Code of Virginia in Schedules II through IV.

“MME” shall mean morphine milligram equivalent.

“Prescription Monitoring Program” shall mean the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

18VAC60-21-102. Evaluation of the patient in prescribing for acute pain.

A. Non-pharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the dentist shall follow the regulations for prescribing and treating with opioids in 18 VAC 60-21-103 and 18VAC60-21-104.

B. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the dentist shall perform a health history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient’s history and risk of substance abuse, and naïve or tolerant status as a part of the initial evaluation.

18VAC60-21-103. Treatment of acute pain with opioids.

A. Initiation of opioid treatment for opioid naïve patients shall be with short-acting opioids.

B. Initiation of opioid treatment for all patients with acute pain shall include the following:

1. A prescription for an opioid shall be a short-acting opioid in the lowest effective dose for the fewest number of days, not to exceed seven days as determined by the manufacturer’s directions for use, unless extenuating circumstances are clearly documented in the patient record.

2. The dentist shall carefully consider and document in the patient record the reasons to exceed 50 MME/day.

3. Prior to exceeding 120 MME/day, the dentist shall refer or consult with a pain management specialist and document in the patient record the reasonable justification for such dosage.

4. Naloxone shall be prescribed for any patient when any risk factor of prior overdose, substance abuse, doses in excess of 120 MME/day, or concomitant use of benzodiazepine is present.

B. If another prescription for an opioid is to be written beyond seven days, the dentist shall:

1. Re-evaluate the patient and document in the patient record the continued need for an opioid prescription; and

2. Check the patient's prescription history in the Prescription Monitoring Program.

C. Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the dentist shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

18VAC60-21-104. Patient record requirement in prescribing for acute pain.

The patient record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan and the medication prescribed (including date, type, dosage, strength, and quantity prescribed).

18VAC60-21-105. Prescribing of opioids for chronic pain.

If a dentist treats a patient for whom an opioid prescription is necessary for chronic pain, he shall either:

1. Refer the patient to a medical doctor who has a specialty in pain management; or

2. Comply with regulations of the Board of Medicine, 18VAC85-21-60 through 18VAC85-21-120, if he chooses to manage the chronic pain with an opioid prescription.

18VAC60-21-106. Continuing education required for prescribing.

A dentist who prescribes any Schedule II through IV controlled substances during one renewal cycle shall obtain two hours of continuing education on pain management during the next renewal cycle. Continuing education hours required for prescribing of controlled substances may be included in the 15 hours required for renewal of licensure.

Part III: IV. Direction and Delegation of Duties.

Part IV: V. Entry, Licensure, and Registration Requirements.

Part ~~V~~, VI. Licensure Renewal.

Part ~~VI~~, VII. ~~Controlled Substances, Sedation, and Anesthesia.~~

Part ~~VII~~, VIII. Oral and Maxillofacial Surgeons.

DRAFT

Agenda Item: Board action on Petitions for Rulemaking

Included in your agenda package are:

1) Copy of petition with attachments from Dr. Jacqueline Carney

A copy of the applicable sections of regulations

2) Copy of petition from Dr. Rodney Mayberry

A copy of comment on the petition

A copy of the applicable section of regulations

Board action:

Each petition will be discussed separately

- 1) To accept Dr. Carney's petition and initiate rulemaking with adoption of a NOIRA; or to deny the request to amend regulations (the reasons for declining to initiate rulemaking must be stated by the Board).**
- 2) To accept Dr. Mayberry's petition and initiate rulemaking with adoption of a NOIRA; or to deny the request to amend regulations (the reasons for declining to initiate rulemaking must be stated by the Board).**



COMMONWEALTH OF VIRGINIA

Board of Dentistry

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

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

Petition for Rule-making

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

| | | |
|---|--|-------------------|
| Please provide the information requested below. (Print or Type) | | |
| Petitioner's full name (Last, First, Middle Initial, Suffix,) Carney, Jacqueline | | |
| Street Address 536 Pantops Center #392 | Area Code and Telephone Number 434.760.0312 | |
| City Charlottesville | State VA | Zip Code 22911 |
| Email Address (optional) | Fax (optional) | |

Respond to the following questions:

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

18VAC60-21-280, 18VAC60-21-291, 18VAC60-21-301

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

See attached

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

Board of Dentistry is given power and duty to establish the regulations governing the practitioners licensed by the Board of Dentistry

Signature:

Date: 1/10/2017

I am hoping that some clarification can be provided for the guidelines regarding pre-operative, peri-operative and post-operative vital signs for the various levels of anxiolysis, sedation and anesthesia. I had thought this was under review along with the nitrous oxide/oxygen guidelines but upon review of the information that was presented to the governor and is now open for public comment, I do not see any information addressing my questions.

I have attached an excel file with the information I have compiled from Chapter 21 regulations for dentistry. This shows the information I have read and interpreted in order to meet the criteria for documentation. I have not been able to find a listing in every level of sedation/anesthesia across the 3 periods of time (pre-operative, peri-operative and post-operative). And, because the one level of sedation (minimal) that does document the requirements across all 3 time periods has different requirements for peri-op vs. pre and post-op, I do not want to make incorrect assumptions.

For moderate sedation, I only see specific vital signs listed for the peri-operative period. The information in this section tells me that vital signs must be taken for the other 2 segments of time but no specific vital signs are listed as required.

For deep sedation/general anesthesia, the pre-op requirements are listed but specific peri-op and post-op are not. Page 31, section E.3 says "monitoring shall take place continuously during administration..., the dental procedure and recovery." This implies the same vital signs during all phases. However, it is an incredible challenge/burden to keep/maintain monitoring on a recovering pediatric patient for EKG reading, blood pressure and temperature.

Could you also clarify one additional item for me? All of these guidelines state "until the patient is discharged" for monitoring. Does this mean until the patient is physically walked out of the facility or does this mean until the patient meets discharge criteria (such as an Aldrete scale or other form of assessment)?

Thank you,

Jacqueline Carney

DOCUMENTATION REQUIRED

NITROUS OXIDE

| | PRE OP | PERI OP | POST OP |
|-------------------|--------|---------|---------|
| BLOOD PRESSURE | X | | |
| OXYGEN SATURATION | | | X |
| RESPIRATORY RATE | | | |
| HEART RATE | X | | X |

MINIMAL SEDATION

| | PRE OP | PERI OP | POST OP |
|-------------------|--------|---------|---------|
| BLOOD PRESSURE | X | X | X |
| OXYGEN SATURATION | | X | |
| RESPIRATORY RATE | X | X | X |
| HEART RATE | X | X | X |

MODERATE SEDATION

| | PRE OP | PERI OP | POST OP |
|-------------------|--------|---------|---------|
| BLOOD PRESSURE | | X | |
| OXYGEN SATURATION | | X | |
| RESPIRATORY RATE | | | |
| HEART RATE | | X | |

PG 29 D.1 states "baseline vital signs shall be taken and recorded prior to administration" but doesn't list which vital signs
 pg 29 E.1 states "vital signs have been taken and recorded" but doesn't list which vital signs to record

GENERAL ANESTHESIA

| | PRE OP | PERI OP | POST OP |
|-------------------|--------|----------------|---------|
| TEMPERATURE | X | X ^o | |
| BLOOD PRESSURE | X | | |
| OXYGEN SATURATION | X | | |
| RESPIRATORY RATE | X | | |
| HEART RATE | X | | |
| EKG READING | | X | |

pg 31 E.2 says "vital signs and EKG readings shall be monitored, recorded every 5 minutes...throughout the administration of controlled drugs and recovery" but doesn't list which vital signs
 PG 31 E.2 says "vital signs and EKG readings shall be monitored, recorded every 5 minutes" but doesn't list which vital signs
 pg 31 E.3 says "monitoring shall take place continuously during administration, the dental procedure and recovery" but doesn't list which vital signs for recovery
 pg 32 G.1 says "discharged...until vital signs have been taken and recorded" but doesn't list which vital signs

18VAC60-21-279. Administration of only inhalation analgesia (nitrous oxide).

A. Education and training requirements. A dentist who utilizes nitrous oxide shall have training in and knowledge of:

1. The appropriate use and physiological effects of nitrous oxide, potential complications of administration, the indicators for complications, and the interventions to address the complications.
2. The use and maintenance of the equipment required in subsection D of this section.

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

C. Delegation of administration.

1. A qualified dentist may administer or use the services of the following personnel to administer nitrous oxide:

- a. A dentist;
- b. An anesthesiologist;
- c. A certified registered nurse anesthetist under his medical direction and indirect supervision;
- d. A dental hygienist with the training required by 18VAC60-25-90 B or C and under indirect supervision; or
- e. A registered nurse upon his direct instruction and under immediate supervision.

2. Preceding the administration of nitrous oxide, a dentist may use the services of the following personnel working under indirect supervision to administer local anesthesia to numb an injection or treatment site:

- a. A dental hygienist with the training required by 18VAC60-25-90 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or
- b. A dental hygienist, dental assistant, registered nurse, or licensed practical nurse to administer Schedule VI topical oral anesthetics.

D. Equipment requirements. A dentist who utilizes nitrous oxide only or who directs the administration by another licensed health professional as permitted in subsection C of this section shall maintain the following equipment in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Source of delivery of oxygen under controlled positive pressure;
2. Mechanical (hand) respiratory bag; and
3. Suction apparatus.

E. Required staffing.

When only nitrous oxide/oxygen is administered, a second person in the operatory is not required. Either the dentist or qualified dental hygienist under the indirect supervision of a dentist may administer the nitrous oxide/oxygen and treat and monitor the patient.

F. Monitoring requirements.

1. Baseline vital signs to include blood pressure and heart rate shall be taken and recorded prior to administration of nitrous oxide analgesia and prior to discharge, unless extenuating circumstances exist and are documented in the patient record.

2. Continual clinical observation of the patient's responsiveness, color, and respiratory rate and depth of ventilation shall be performed.

3. Once the administration of nitrous oxide has begun, the dentist shall ensure that a licensed health care professional or a person qualified in accordance with 18VAC60-21-260 I monitors the patient at all times until discharged as required in subsection G of this section.

4. Monitoring shall include making the proper adjustments of nitrous oxide/oxygen machines at the request of or by the dentist or by another qualified licensed health professional identified in subsection C of this section. Only the dentist or another qualified licensed health professional identified in subsection C of this section may turn the nitrous oxide/oxygen machines on or off.

5. Upon completion of nitrous oxide administration, the patient shall be administered 100% oxygen for a minimum of five minutes to minimize the risk of diffusion hypoxia.

G. Discharge requirements.

1. The dentist shall not discharge a patient until he exhibits baseline responses in a post-operative evaluation of the level of consciousness. Vital signs, to include blood pressure and heart rate shall be taken and recorded prior to discharge.

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

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

18VAC60-21-280. Administration of minimal sedation (~~anxiolysis or inhalation analgesia~~).

A. Education and training requirements. A dentist who utilizes minimal sedation shall have training in and knowledge of:

1. Medications used, the appropriate dosages, the potential complications of administration, the indicators for complications, and the interventions to address the complications.

2. Physiological effects of ~~nitrous oxide~~ minimal sedation, potential complications of administration, the indicators for complications, and the interventions to address the complications.

3. The use and maintenance of the equipment required in subsection D of this section.

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

C. Delegation of administration.

1. A qualified dentist may administer or use the services of the following personnel to administer minimal sedation:

- a. A dentist;
- b. An anesthesiologist;
- c. A certified registered nurse anesthetist under his medical direction and indirect supervision; or
- d. A dental hygienist with the training required by 18VAC60-25-90 B or C only for administration of nitrous oxide/oxygen and under ~~indirect~~ direct supervision; or
- e. A registered nurse upon his direct instruction and under immediate supervision.

2. Preceding the administration of minimal sedation, a dentist may use the services of the following personnel working under indirect supervision to administer local anesthesia to numb an injection or treatment site:

- a. A dental hygienist with the training required by 18VAC60-25-90 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or
- b. A dental hygienist, dental assistant, registered nurse, or licensed practical nurse to administer Schedule VI topical oral anesthetics.

3. If minimal sedation is self-administered by or to a patient 13 years of age or older before arrival at the dental office or treatment facility, the dentist may only use the personnel listed in subdivision 1 of this subsection to administer local anesthesia.

D. Equipment requirements. A dentist who utilizes minimal sedation or who directs the administration by another licensed health professional as permitted in subsection C of this section shall maintain the following equipment in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Blood pressure monitoring equipment;
2. Source of delivery of oxygen under controlled positive pressure;
3. Mechanical (hand) respiratory bag;
4. Suction apparatus; and
5. Pulse oximeter.

E. Required staffing.

~~1.~~ The treatment team for minimal sedation ~~other than just inhalation of nitrous oxide/oxygen~~ shall consist of the dentist and a second person in the operatory with the patient to assist the

dentist and monitor the patient. The second person shall be a licensed health care professional or a person qualified in accordance with 18VAC60-21-260 I; ~~or~~

~~2. When only nitrous oxide/oxygen is administered for minimal sedation, a second person is not required. Either the dentist or qualified dental hygienist under the indirect supervision of a dentist may administer the nitrous oxide/oxygen and treat and monitor the patient.~~

F. Monitoring requirements.

1. Baseline vital signs to include blood pressure, respiratory rate, and heart rate shall be taken and recorded prior to administration of sedation and prior to discharge.

2. Blood pressure, oxygen saturation, respiratory rate, and pulse shall be monitored intraoperatively continuously during the procedure.

3. Once the administration of minimal sedation has begun by any route of administration, the dentist shall ensure that a licensed health care professional or a person qualified in accordance with 18VAC60-21-260 I monitors the patient at all times until discharged as required in subsection G of this section.

4. If nitrous oxide/oxygen is used in addition to any other pharmacological agent, monitoring shall include making the proper adjustments of nitrous oxide/oxygen machines at the request of or by the dentist or by another qualified licensed health professional identified in subsection C of this section. Only the dentist or another qualified licensed health professional identified in subsection C of this section may turn the nitrous oxide/oxygen machines on or off.

5. If any other pharmacological agent is used in addition to nitrous oxide/oxygen and a local anesthetic, requirements for the induced level of sedation must be met.

G. Discharge requirements.

1. The dentist shall not discharge a patient until he exhibits baseline responses in a post-operative evaluation of the level of consciousness. Vital signs, to include blood pressure, respiratory rate, and heart rate shall be taken and recorded prior to discharge.

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

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

18VAC60-21-291. Requirements for Administration of Conscious/Moderate Sedation.

A. Delegation of administration.

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

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

- a. A dentist with the training required by 18VAC60-21-290 D 2 to administer by an enteral method;
- b. A dentist with the training required by 18VAC60-21-290 D 1 to administer by any method;
- c. An anesthesiologist;
- d. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1; or
- e. A registered nurse upon his direct instruction and under the immediate supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1.

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

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

- a. A dental hygienist with the training required by 18VAC60-25-100 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or
- b. A dental hygienist, dental assistant, registered nurse, or licensed practical nurse to administer Schedule VI topical oral anesthetics.

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

- a. All equipment required in subsection B of this section is present, in good working order, and immediately available to the areas where patients will be sedated and treated and will recover; and
- b. Qualified staff is on site to monitor patients in accordance with requirements of subsection D of this section.

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

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

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

D. Monitoring requirements.

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

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

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

E. Discharge requirements.

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

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

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

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

18VAC60-21-301. Requirements for Administration of Deep Sedation or General Anesthesia.

A. Preoperative requirements. Prior to the appointment for treatment under deep sedation or general anesthesia the patient shall:

1. Be informed about the personnel and procedures used to deliver the sedative or anesthetic drugs to assure informed consent as required by 18VAC60-21-260 F,

2. Have a physical evaluation as required by 18VAC60-21-260 C.

3. Be given preoperative verbal and written instructions including any dietary or medication restrictions.

B. Delegation of administration.

1. A dentist who does not meet the requirements of 18VAC60-21-300 shall only use the services of a dentist who does meet those requirements or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a

dentist shall use either a dentist who meets the requirements of 18VAC60-20-300, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist who meets the requirements of 18VAC60-20-300 may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

a. A dentist with the training required by 18VAC60-21-300 C;

b. An anesthesiologist; or

c. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-300 C.

3. Preceding the administration of deep sedation or general anesthesia, a dentist who meets the requirements of 18VAC60-20-300 may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

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

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

C. Equipment requirements. A dentist who administers deep sedation or general anesthesia shall have available the following equipment in sizes appropriate for the patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

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

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

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

6. Mechanical (hand) respiratory bag;

7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;

8. Appropriate emergency drugs for patient resuscitation;
9. EKG monitoring equipment;
10. Temperature measuring devices;
11. Pharmacologic antagonist agents;
12. External defibrillator (manual or automatic);
13. For intubated patients, an End-Tidal CO² monitor;
14. Suction apparatus;
15. Throat pack; and
16. Precordial or pretracheal stethoscope.

D. Required staffing. At a minimum, there shall be a three-person treatment team for deep sedation or general anesthesia. The team shall include the operating dentist, a second person to monitor the patient as provided in 18VAC60-21-260 K, and a third person to assist the operating dentist as provided in 18VAC60-21-260 J, all of whom shall be in the operatory with the patient during the dental procedure. If a second dentist, an anesthesiologist, or a certified registered nurse anesthetist administers the drugs as permitted in 18VAC60-21-301 B, such person may serve as the second person to monitor the patient.

E. Monitoring requirements.

1. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility to include: temperature, blood pressure, pulse, oxygen saturation, and respiration.
2. The patient's vital signs and EKG readings shall be monitored, recorded every five minutes, and reported to the treating dentist throughout the administration of controlled drugs and recovery. When depolarizing medications are administered, temperature shall be monitored constantly.
3. Monitoring of the patient undergoing deep sedation or general anesthesia is to begin prior to the administration of any drugs and shall take place continuously during administration, the dental procedure, and recovery from anesthesia. The person who administers the anesthesia or another licensed practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

F. Emergency management.

1. A secured intravenous line must be established and maintained throughout the procedure.
2. The dentist shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway, and cardiopulmonary resuscitation.

G. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge and vital signs have been taken and recorded.
2. Post-operative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number for the dental practice.
3. The patient shall be discharged with a responsible individual who has been instructed with regard to the patient's care.



COMMONWEALTH OF VIRGINIA

Board of Dentistry

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

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

Petition for Rule-making

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

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

Petitioner's full name (Last, First, Middle initial, Suffix,)

Mayberry, Rodney S

Street Address

112 Pleasant Street NW

Area Code and Telephone Number

703-281-2111

City

Vienna

State

VA

Zip Code

22180

Email Address (optional)

drmayberry@mayberrydental.com

Fax (optional)

703-281-0973

Respond to the following questions:

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

See attached letter.

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

See attached letter.

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

See attached letter.

Signature:

Rodney S. Mayberry DDS, DABDT

Date: 11-1-2016

To: The Commonwealth of Virginia, Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

My understanding is the Virginia Board of Dentistry is aware of the recent changes with regard to certification and recognition of dental specialty certifying organizations and that the American Dental Association has determined that the Virginia Board of dentistry may recognize the American Board of Dental Specialties authority to certify dental specialties not currently recognized by the American Dental Association.

As a result of this recent change in the position and policy of the American Dental Association, please accept this letter as a formal petition to the Commonwealth of Virginia Board of Dentistry requesting the immediate recognition of American Board of Dental Specialties as a bona fide dental specialty certifying organization with all the powers, authority and status previously granted to the specialty groups and organizations' previously recognized by the American Dental Association listed below.

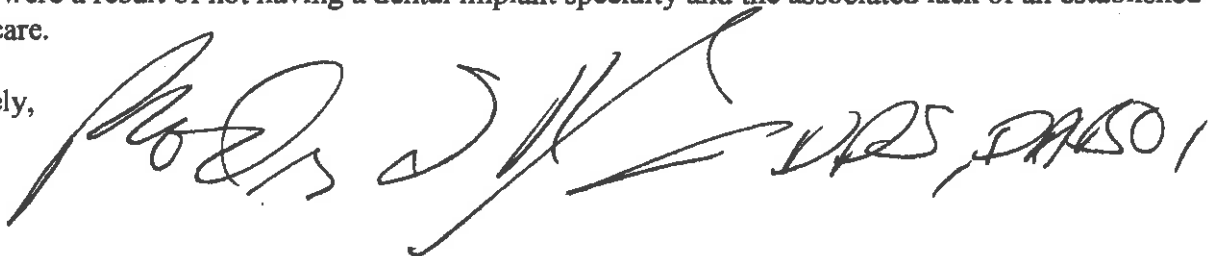
Oral and Maxillofacial Surgery
Dental Public Health
Endodontics
Oral and Maxillofacial Pathology
Oral and Maxillofacial Radiology
Orthodontics
Periodontics
Pediatric Dentistry
Prosthodontics

American Board of Dental Specialties
ADA Headquarters Building
211 E. Chicago Ave, Suite 750C
Chicago, IL 60611
312-818-2070

As part of this petition, it is requested that Diplomates, previously certified by the American Board of Oral Implantology/Implant Dentistry, which is a founding member of the ABDS, be immediately recognized as specialists in implant dentistry and be granted the unrestricted license to market, advertise and publish themselves as Dental Implant Specialists. Approval and acceptance of this petition would offer ABOI Diplomates in Virginia the same freedoms provided to ABOI Diplomates in Texas, and other states. The ability to advertise as dental implant specialists came about as a result of recent Federal Court decisions that will benefit all of dentistry.

My understanding is that the attorneys representing the Commonwealth of Virginia Board of Dentistry have already been made aware of these developments in Texas and the changes instituted by the American Dental Association. These changes are welcome and when fully instituted will better serve the public, establish a standard of care for implant dentistry, and help the Virginia Board of Dentistry clarify and provide guidance to the dentists in the Commonwealth. Most importantly, approval of these requested changes, recognition of the new dental implant specialty, will allow the Board to more fully protect the public, avoid some of the problems encountered in the past that were a result of not having a dental implant specialty and the associated lack of an established standard of care.

Most sincerely,

A handwritten signature in black ink, appearing to read 'Rodney S. Mayberry', with a stylized flourish at the end.

Rodney S. Mayberry DDS
Diplomate, American Board of Oral Implantology/Implant Dentistry

Virginia.gov

Agencies | Governor



Agency: Department of Health Professions

Board: Board of Dentistry

Chapter: Regulations Governing the Practice of Dentistry [18 VAC 60 - 21]

[Back to List of Comments](#)

Commenter: Charles Martin, DDS *

1/4/17 11:08 pm

New certifying board for dental specialties

In light of the recent decision of the ADA to no longer be the governing body of dental specialties because of FTC action since they are restraining trade, I support the recommendation to recognize the American Board of Dental Specialties as the new governing body. This is an organization created to monitor specialties just like a similar board in medicine. over this text and enter your comments here. You are limited to approximately 3000 words.

* Nonregistered public user

18VAC60-21-80. Advertising.

Get acquainted with our new Virginia State Law Portal! Law Help Center

Virginia Administrative Code
Title 18. Professional and Occupational Licensing
Agency 60. Board of Dentistry
Chapter 21. Regulations Governing the Practice of Dentistry

18VAC60-21-80. Advertising.

- A. Practice limitation. A general dentist who limits his practice to a dental specialty or describes his practice by types of treatment shall state in conjunction with his name that he is a general dentist providing certain services (e.g., orthodontic services).
- B. Fee disclosures. Any statement specifying a fee for a dental service that does not include the cost of all related procedures, services, and products that, to a substantial likelihood, will be necessary for the completion of the advertised services as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of fees for specifically described dental services shall not be deemed to be deceptive or misleading.
- C. Discounts and free offers. Discount and free offers for a dental service are permissible for advertising only when the nondiscounted or full fee, if any, and the final discounted fee are also disclosed in the advertisement. In addition, the time period for obtaining the discount or free offer must be stated in the advertisement. The dentist shall maintain documented evidence to substantiate the discounted fee or free offer.
- D. Retention of advertising. A prerecorded or archived copy of all advertisements shall be retained for a two-year period following the final appearance of the advertisement. The advertising dentist is responsible for making prerecorded or archived copies of the advertisement available to the board within five days following a request by the board.
- E. Routine dental services. Advertising of fees pursuant to this section is limited to procedures that are set forth in the American Dental Association's "Dental Procedures Codes," published in Current Dental Terminology in effect at the time the advertisement is issued.
- F. Advertisements. Advertisements, including but not limited to signage, containing descriptions of the type of dentistry practiced or a specific geographic locator are permissible so long as the requirements of §§ 54.1-2718 and 54.1-2720 of the Code are met.
- G. False, deceptive, or misleading advertisement. The following practices shall constitute false, deceptive, or misleading advertising within the meaning of subdivision 7 of § 54.1-2706 of the Code:
1. Publishing an advertisement that contains a material misrepresentation or omission of facts that causes an ordinarily prudent person to misunderstand or be deceived, or that fails to contain reasonable warnings or disclaimers necessary to make a representation not deceptive;
 2. Publishing an advertisement that fails to include the information and disclaimers required by this section;
 3. Publishing an advertisement that contains a false claim of professional superiority, contains a claim to be a specialist, or uses any terms to designate a dental specialty unless he is entitled to such specialty designation under the guidelines or requirements for specialties approved by the American Dental Association (Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, November 2013), or such guidelines or requirements as subsequently amended; or
 4. Representation by a dentist who does not currently hold specialty certification that his practice is limited to providing services in such specialty area without clearly disclosing that he is a general dentist.

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 32, Issue 05, eff. December 2, 2015.

Website addresses provided in the Virginia Administrative Code to documents incorporated by reference are for the reader's convenience only, may not necessarily be active or current, and should not be relied upon. To ensure the information incorporated by reference is accurate, the reader is encouraged to use the source document described in the regulation.

**VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY ADVISORY PANEL
Discussion of the Prescribing of Opioids in the Practice of Dentistry
January 23, 2017**

TIME AND PLACE: The meeting of the Regulatory Advisory Panel was called to order at 9:20 a.m., on January 23, 2017, Department of Health Professions, 9960 Mayland Drive, Suite 201, Training Room 2, Henrico, Virginia 23233.

PRESIDING: John M. Alexander, D.D.S., Board Member, Board of Dentistry

**REGULATORY
ADVISORY PANEL**

MEMBERS PRESENT: A. Omar Abubaker, D.M.D., PhD, Oral & Maxillofacial Surgery
VCU School of Dentistry
B. Ellen Byrne, D.D.S., PhD, Professor of Endodontics
VCU School of Dentistry
Carol R. Russek, J.D., Board Member, Board of Dentistry

STAFF PRESENT: Kelley W. Palmatier, Deputy Executive Director, Board of Dentistry
Elaine J. Yeatts, DHP Senior Policy Analyst
Donna Lee, Discipline Case Manager, Board of Dentistry

OTHERS PRESENT: David E. Brown, D.C., DHP Director

**ESTABLISHMENT OF
A QUORUM:** With all Regulatory Advisory Panel members present, a quorum was established.

Ms. Palmatier read the emergency evacuation procedures.

**DISCUSSION ON THE
PRESCRIBING OF
OPIOIDS FOR ACUTE
AND CHRONIC DENTAL
RELATED PAIN:**

Dr. Alexander stated that the purpose of the meeting was to discuss the prescribing of opioids for acute and chronic dental pain, and to develop a guidance document and points to be addressed in emergency regulations.

Ms. Yeatts informed the Regulatory Advisory Panel ("Panel") that there are currently two bills at the General Assembly, when signed, the Board of Dentistry would have a statutory requirement to adopt regulations dealing with opioids for acute and chronic dental pain.

Ms. Yeatts explained the regulatory process regarding emergency regulations and that they are generally in effect 12-18 months before being replaced with permanent regulations. She also stated that one bill in the General Assembly is being amended to require a prescriber of opioids to check with the Prescription Monitoring Program for a prescription written for 7 days or more instead of the current law that states 14 days.

Dr. Brown stated that the goal of the emergency regulations and a guidance document regarding opioid prescribing is to provide clear guidance to practitioners so as to avoid overprescribing opioids to patients, recognizing that there may be unusual circumstances when a dentist may have to address chronic pain.

The Panel agreed that dentists should not have contracts with patients to treat chronic pain, but that a patient should be referred to a program for pain management where there are strict regulations that both the pain management doctor and patient have to follow.

The Panel reviewed the Board of Medicine's draft regulations for Governing Prescribing for Pain and Prescribing of Buprenorphine as a guideline to draft emergency regulations for the Board of Dentistry ("Board").

The Panel stated that the "Definitions" and the "Evaluation of the Patient" sections could read the same in the Board's draft emergency regulations as it does in the Board of Medicine's draft emergency regulations.

The Panel changed the title of the regulation "Treatment with Opioids" to read "Treatment of Acute Pain with Opioids" and the regulation to read as follows:

A. Initiation of opioid treatment for opioid naïve patients shall be with short-acting opioids.

B. Initiation of opioid treatment for all patients shall include the following:

1. A prescription for an opioid shall be a short-acting opioid in the lowest effective dose for the fewest number of days, not to exceed seven days.

2. The dentist shall carefully consider and document in the patient record the reasons to exceed 50 MME/day.

3. Prior to exceeding 120 MME/day, the dentist shall refer or consult with a pain management specialist.

C. If another prescription for an opioid is to be written beyond seven days, the dentist shall:

1. Re-evaluate the patient and document in the patient record the continued need for an opioid prescription; and
2. Check the patient's prescription history in the Prescription Monitoring Program.

The Panel also changed the title "Medical Records" to "Patient Record Requirement in Prescribing for Acute Pain" and the regulation to read as follows: The patient record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan and the medication prescribed (including date, type, dosage, strength, and quantity prescribed).

Also added were the following two regulations:

(1) Prescribing of opioids for chronic pain.

If a dentist treats a patient for whom an opioid prescription is necessary for chronic pain, he shall either:

1. Refer the patient to a medical doctor who has a specialty in pain management; or
2. Comply with regulations of the Board of Medicine, 18VAC85-21-10 et seq., if he chooses to manage the chronic pain with an opioid prescription.

(2) Continuing education required for prescribing.

A dentist who prescribes any Schedule II through V controlled substances during one renewal cycle shall obtain two hours of continuing education on pain management during the next renewal year. Continuing education hours required for prescribing of controlled substances may be included in the 15 hours required for renewal of licensure.

The Panel requested that Ms. Palmatier send the draft emergency regulations with the proposed changes discussed to each Panel member for review before they are presented to the Board at its meeting on March 10, 2017 for review and adoption.

The Panel also decided to not draft a guidance document at the present time, but let the Board determine at its March meeting if a guidance document is necessary.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 10:45 a.m.

John M. Alexander, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

How Should the Board Address the Use of a Cavitron Device

Background:

Following an IFC, Dr. Watkins requested this item be added to the agenda for discussion of what might be misuse of cavitron devices by dental assistants for scaling of tartar and removal of dental cement and consideration of developing a guidance document.

How Should the Board Address the CDC Guidelines

Background:

At its December 9, 2016 meeting, the Board discussed a motion from the Regulatory-Legislative Committee to address the CDC Guidelines for Dental Settings in a guidance document instead of incorporating the CDC Guidelines by reference in regulations as had been recommended by a licensee. Discussion followed about incorporating by reference and the Committee motion was deferred for further discussion at the next meeting with the guidelines available for review.

Materials Provided:

- An excerpt from Guidance Document 60-15 on Professional Conduct where the CDC Guidelines are addressed
- CDC's Summary of Infection Prevention Practices in Dental Settings Basic Expectations for Safe Care

the dentist to recommend the product; providing the patient with written information about the product's contents and intended use as well as any directions and cautions that apply to its use; and, informing the patient if the product is available elsewhere.

- Do not misrepresent a product's value or necessity or the dentist's professional expertise in recommending products or procedures.

Relationships with Practitioners

- Upon completion of their care, specialists or consulting dentists are to refer back to the referring dentist, or if none, to the dentist of record for future care unless the patient expresses a different preference.
- A dentist who is rendering a second opinion regarding a diagnosis or treatment plan should not have a vested interest in the patient's case and should not seek to secure the patient for treatment unless selected by the patient for care.

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 HIPAA, OSHA, FDA, and the laws governing health practitioners in the Code of Virginia.
- Follow the applicable CDC infection control guidelines and recommendations.
- 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.

Advertising Ethics

- Do not hold out as exclusive any device agent, method, or technique if that representation would be false or misleading in any material respect to the public or patients.
- When you advertise, fees must be included stating the cost of all related procedures, services and products which to a substantial likelihood are necessary for the completion of the service as it would be understood by an ordinarily prudent person.
- Disclose the complete name of a specialty board or other organization which conferred certification or another form of credential.

Summary of Infection Prevention Practices in Dental Settings



Basic Expectations for Safe Care



Centers for Disease
Control and Prevention
National Center for Chronic
Disease Prevention and
Health Promotion

Note to Readers

This document is a summary guide of basic infection prevention recommendations for all dental health care settings. These include traditional settings such as private dental practices, dental clinics, dental schools and educational programs (including dental assisting, dental hygiene, and laboratory) and nontraditional settings that often use portable dental equipment such as clinics held in schools for sealant and fluoride placement and in other sites for humanitarian dental missions.

While the information included in this document reflects existing evidence-based guidelines produced by the Centers for

Disease Control and Prevention (CDC), it is not intended as a replacement for more extensive guidelines. This summary guide is based primarily upon elements of Standard Precautions and represents a summary of basic infection prevention expectations for safe care in dental settings as recommended in the *Guidelines for Infection Control in Dental Health-Care Settings—2003*. Readers are urged to use the Infection Prevention Checklist for Dental Settings (Appendix A), a companion to the summary; and to consult the full guidelines for additional background, rationale, and scientific evidence behind each recommendation.

Suggested Citation

Centers for Disease Control and Prevention. *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health; March 2016.

Adapted from: *Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care*
<http://www.cdc.gov/hai/settings/outpatient/outpatient-care-guidelines.html>

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Introduction

Transmission of infectious agents among patients and dental health care personnel (DHCP) in dental settings is rare. However, from 2003 to 2015, transmissions in dental settings, including patient-to-patient transmissions, have been documented.^{1–4} In most cases, investigators failed to link a specific lapse of infection prevention and control with a particular transmission. However, reported breakdowns in basic infection prevention procedures included unsafe injection practices, failure to heat sterilize dental handpieces between patients, and failure to monitor (e.g., conduct spore testing) autoclaves.^{2,3} These reports highlight the need for comprehensive training to improve understanding of underlying principles, recommended practices, their implementation, and the conditions that have to be met for disease transmission.

All dental settings, regardless of the level of care provided, must make infection prevention a priority and should be equipped to observe Standard Precautions and other infection prevention recommendations contained in CDC's *Guidelines for Infection Control in Dental Health-Care Settings—2003*.⁵ The *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care* summarizes current infection prevention recommendations and includes a checklist (Appendix A) that can be used to evaluate compliance.

The information presented here is based primarily upon the recommendations from the 2003 guideline and represents infection prevention expectations for safe care in dental settings. It is intended for use by anyone needing information about basic infection prevention measures in dental health care settings, but is not a replacement for the more extensive

guidelines. Readers are urged to consult the full guidelines for additional background, rationale, and scientific evidence behind each recommendation. Additional topics and information relevant to dental infection prevention and control published by CDC since 2003 in this document can be found in Appendix B including

- Infection prevention program administrative measures.
- Infection prevention education and training.
- Respiratory hygiene and cough etiquette.
- Updated safe injection practices.
- Administrative measures for instrument processing.

For the purposes of this document, DHCP refers to all paid and unpaid personnel in the dental health care setting who might be occupationally exposed to infectious materials, including body substances and contaminated supplies, equipment, environmental surfaces, water, or air. This includes

- Dentists.
- Dental hygienists.
- Dental assistants.
- Dental laboratory technicians (in-office and commercial).
- Students and trainees.
- Contractual personnel.
- Other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel).⁵

Objectives

By highlighting existing CDC recommendations, this summary guide

1. Provides basic infection prevention principles and recommendations for dental health care settings.
2. Reaffirms Standard Precautions as the foundation for preventing transmission of infectious agents during patient care in all dental health care settings.
3. Provides links to full guidelines and source documents that readers can reference for more detailed background and recommendations.

For additional references, background information, rationale, and evidence, readers should consult the references and resources listed in Appendix C. Detailed recommendations for dental health care settings can be found in the compendium document, *Recommendations from the Guidelines for Infection Control in Dental Health-Care Settings—2003*.

References

1. Redd JT, Baumbach J, Kohn W, et al. Patient-to-patient transmission of hepatitis B virus associated with oral surgery. *J Infect Dis*. 2007;195(9):1311–1314.
2. Radcliffe RA, Bixler D, Moorman A, et al. Hepatitis B virus transmissions associated with a portable dental clinic, West Virginia, 2009. *J Am Dent Assoc*. 2013;144(10):1110–1118.
3. Oklahoma State Department of Health. Dental Healthcare-Associated Transmission of Hepatitis C: Final Report of Public Health Investigation and Response, 2013. Available at: http://www.ok.gov/health2/documents/Dental%20Healthcare_Final%20Report_2_17_15.pdf.
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5. Centers for Disease Control and Prevention. Guidelines for infection control in dental health-care settings—2003. *MMWR Recomm Rep* 2003;52(RR-17):1–61. Available at: www.cdc.gov/mmwr/PDF/rr/rr5217.pdf.

Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Dental Settings

Administrative Measures

Infection prevention must be made a priority in any dental health care setting. At least one individual with training in infection prevention—the infection prevention coordinator—should be responsible for developing written infection prevention policies and procedures based on evidence-based guidelines, regulations, or standards. Policies and procedures should be tailored to the dental setting and reassessed on a regular basis (e.g., annually) or according to state or federal requirements. Development should take into consideration the types of services provided by DHCP and the patient population served, extending beyond the Occupational Safety and Health Administration

(OSHA) bloodborne pathogens standard to address patient safety. The infection prevention coordinator should ensure that equipment and supplies (e.g., hand hygiene products, safer devices to reduce percutaneous injuries, and personal protective equipment) are available and should maintain communication with all staff members to address specific issues or concerns related to infection prevention. In addition, all dental settings should have policies and protocols for early detection and management of potentially infectious persons at initial points of patient encounter.

Key ADMINISTRATIVE RECOMMENDATIONS for Dental Settings

1. Develop and maintain infection prevention and occupational health programs
2. Provide supplies necessary for adherence to Standard Precautions (e.g., hand hygiene products; safer devices to reduce percutaneous injuries; personal protective equipment)
3. Assign at least one individual trained in infection prevention responsibility for coordinating the program
4. Develop and maintain written infection prevention policies and procedures appropriate for the services provided by the facility and based on evidence-based guidelines, regulations, or standards.
5. Facility has system for early detection and management of potentially infectious persons at initial points of patient encounter.

Infection Prevention Education and Training

Ongoing education and training of DHCP are critical for ensuring that infection prevention policies and procedures are understood and followed. Education on the basic principles and practices for preventing the spread of infections should be provided to all DHCP. Training should include both DHCP safety (e.g., OSHA bloodborne pathogens training) and

patient safety (e.g., emphasizing job- or task-specific needs). Education and training should be provided during orientation to the setting, when new tasks or procedures are introduced and at a minimum, annually. Training records should be maintained according to state and federal requirements.

Key Recommendations for EDUCATION AND TRAINING in Dental Settings

1. Provide job- or task-specific infection prevention education and training to all DHCP.
 - a. This includes those employed by outside agencies and available by contract or on a volunteer basis to the facility.
2. Provide training on principles of both DHCP safety and patient safety.
3. Provide training during orientation and at regular intervals (e.g., annually).
4. Maintain training records according to state and federal requirements.

Dental Health Care Personnel Safety

Infection prevention programs should also address occupational health needs, including vaccination of DHCP, management of exposures or infections in personnel requiring post-exposure prophylaxis or work restrictions, and compliance with OSHA bloodborne pathogens standard. Referral arrangements for medical services can be made with qualified health care professionals in an occupational health program of a hospital, with educational institutions, or with health care facilities that offer personnel health services.

Recommendations for prevention of infections in DHCP can be found in the following documents—*Guidelines for Infection Control in Dental Health-Care Settings—2003* (available at: www.cdc.gov/mmwr/PDF/rr/rr5217.pdf), *Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP)* (available at: <http://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf>), and *OSHA Bloodborne Pathogens and Needlestick Prevention* (available at: <http://www.osha.gov/SLTC/bloodbornepathogens/index.html>).

Key Recommendations for DENTAL HEALTH CARE PERSONNEL SAFETY

1. Current CDC recommendations for immunizations, evaluation, and follow-up are available. There is a written policy regarding immunizing DHCP, including a list of all required and recommended immunizations for DHCP (e.g., hepatitis B, MMR (measles, mumps, and rubella), varicella (chickenpox), Tdap (tetanus, diphtheria, pertussis)).
2. All DHCP are screened for tuberculosis (TB) upon hire regardless of the risk classification of the setting.
3. Referral arrangements are in place to qualified health care professionals (e.g., occupational health program of a hospital, educational institutions, health care facilities that offer personnel health services) to ensure prompt and appropriate provision of preventive services, occupationally-related medical services, and postexposure management with medical follow-up.
4. Facility has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions.

Program Evaluation

A successful infection prevention program depends on

- Developing standard operating procedures.
- Evaluating practices and providing feedback to DHCP.
- Routinely documenting adverse outcomes (e.g., occupational exposures to blood) and work-related illnesses in DHCP.
- Monitoring health care associated infections in patients.

Strategies and tools to evaluate the infection prevention program can include periodic observational assessments, checklists to document

procedures, and routine review of occupational exposures to bloodborne pathogens. The Infection Prevention Checklist for Dental Settings found in Appendix A is one tool DHCP can use to evaluate their infection prevention program. Evaluation offers an opportunity to improve the effectiveness of both the infection-prevention program and dental practice protocols. If deficiencies or problems in the implementation of infection prevention procedures are identified—further evaluation and feedback, corrective action, and training (if applicable) is needed to eliminate the problems.

Key Recommendation for PROGRAM EVALUATION in Dental Settings

1. Establish routine evaluation of the infection prevention program, including evaluation of DHCP adherence to infection prevention practices.

Standard Precautions

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. These practices are designed to both protect DHCP and prevent DHCP from spreading infections among patients. Standard Precautions include—

1. Hand hygiene.
2. Use of personal protective equipment (e.g., gloves, masks, eyewear).
3. Respiratory hygiene/cough etiquette.
4. Sharps safety (engineering and work practice controls).
5. Safe injection practices (i.e., aseptic technique for parenteral medications).
6. Sterile instruments and devices.
7. Clean and disinfected environmental surfaces.

Each element of Standard Precautions is described in the following sections. Education and training are

critical elements of Standard Precautions, because they help DHCP make appropriate decisions and comply with recommended practices.

When Standard Precautions alone cannot prevent transmission, they are supplemented with Transmission-Based Precautions. This second tier of infection prevention is used when patients have diseases that can spread through contact, droplet or airborne routes (e.g., skin contact, sneezing, coughing) and are always used in addition to Standard Precautions. Dental settings are not typically designed to carry out all of the Transmission-Based Precautions (e.g., Airborne Precautions for patients with suspected tuberculosis, measles, or chickenpox) that are recommended for hospital and other ambulatory care settings. Patients, however, do not usually seek routine dental outpatient care when acutely ill with diseases requiring Transmission-Based Precautions. Nonetheless, DHCP should develop and carry out systems for early detection and management of

potentially infectious patients at initial points of entry to the dental setting. To the extent possible, this includes rescheduling non-urgent dental care

until the patient is no longer infectious or referral to a dental setting with appropriate infection prevention precautions when urgent dental treatment is needed.

Hand Hygiene

Hand hygiene is the most important measure to prevent the spread of infections among patients and DHCP. Education and training programs should thoroughly address indications and techniques for hand hygiene practices before performing routine and oral surgical procedures.

For routine dental examinations and nonsurgical procedures, use water and plain soap (hand washing) or antimicrobial soap (hand antisepsis) specific for health care settings or use an alcohol-based hand rub. Although alcohol-based hand rubs are effective for hand hygiene in health care settings, soap and water

should be used when hands are visibly soiled (e.g., dirt, blood, body fluids). For surgical procedures,¹ perform a surgical hand scrub before putting on sterile surgeon's gloves. For all types of hand hygiene products, follow the product manufacturer's label for instructions. Complete guidance on how and when hand hygiene should be performed, including recommendations regarding surgical hand antisepsis and artificial nails can be found in the *Guideline for Hand Hygiene in Health-Care Settings* (available at: <http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf>).

Key Recommendations for HAND HYGIENE in Dental Settings

1. Perform hand hygiene—
 - a. When hands are visibly soiled.
 - b. After barehanded touching of instruments, equipment, materials, and other objects likely to be contaminated by blood, saliva, or respiratory secretions.
 - c. Before and after treating each patient.
 - d. Before putting on gloves and again immediately after removing gloves.
2. Use soap and water when hands are visibly soiled (e.g., blood, body fluids); otherwise, an alcohol-based hand rub may be used.

Personal Protective Equipment

Personal protective equipment (PPE) refers to wearable equipment that is designed to protect DHCP from exposure to or contact with infectious agents. PPE that is appropriate for various types of patient interactions and effectively covers personal clothing and skin likely to be soiled with blood, saliva, or other potentially infectious materials (OPIM) should be available. These include gloves, face masks, protective eye wear, face shields, and protective clothing (e.g., reusable or

disposable gown, jacket, laboratory coat). Examples of appropriate use of PPE for adherence to Standard Precautions include—

- Use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, non-intact skin (e.g., exposed skin that is chapped, abraded, or with dermatitis) or OPIM.
- Use of protective clothing to protect skin and clothing during procedures or activities where

¹ Definition from 2003 CDC Dental Guidelines—Oral surgical procedures involve the incision, excision, or reflection of tissue that exposes the normally sterile areas of the oral cavity. Examples include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth (e.g., removal of erupted or nonerupted tooth requiring elevation of mucoperiosteal flap, removal of bone or section of tooth, and suturing if needed).

- contact with blood or body fluids is anticipated.
- Use of mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids.

DHCP should be trained to select and put on appropriate PPE and remove PPE so that the chance for skin or clothing contamination is reduced. Hand hygiene is always the final step after removing and disposing of PPE. Training should also stress preventing further spread of contamination while wearing PPE by:

- Keeping hands away from face.
- Limiting surfaces touched.
- Removing PPE when leaving work areas.
- Performing hand hygiene.

The application of Standard Precautions and guidance on appropriate selection and an example of putting on and removal of personal protective equipment is described in detail in the *2007 Guideline for Isolation Precautions* (available at: <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>).

Key Recommendations for PERSONAL PROTECTIVE EQUIPMENT (PPE) in Dental Settings

1. Provide sufficient and appropriate PPE and ensure it is accessible to DHCP.
2. Educate all DHCP on proper selection and use of PPE.
3. Wear gloves whenever there is potential for contact with blood, body fluids, mucous membranes, non-intact skin, or contaminated equipment.
 - a. Do not wear the same pair of gloves for the care of more than one patient.
 - b. Do not wash gloves. Gloves cannot be reused.
 - c. Perform hand hygiene immediately after removing gloves.
4. Wear protective clothing that covers skin and personal clothing during procedures or activities where contact with blood, saliva, or OPIM is anticipated.
5. Wear mouth, nose, and eye protection during procedures that are likely to generate splashes or spattering of blood or other body fluids.
6. Remove PPE before leaving the work area.

Respiratory Hygiene/Cough Etiquette

Respiratory hygiene/cough etiquette infection prevention measures are designed to limit the transmission of respiratory pathogens spread by droplet or airborne routes. The strategies target primarily patients and individuals accompanying patients to the dental setting who might have undiagnosed transmissible respiratory infections, but also apply to anyone (including DHCP) with signs of illness including cough, congestion, runny nose, or increased production of respiratory secretions.

DHCP should be educated on preventing the spread of respiratory pathogens when in contact with symptomatic persons. Respiratory hygiene/cough etiquette measures were added to Standard Precautions in 2007. Additional information related to respiratory hygiene/cough etiquette can be found in the *2007 Guideline for Isolation Precautions* (available at: <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>). Recommendations for preventing the spread of influenza are available at: <http://www.cdc.gov/flu/professionals/infectioncontrol/>.

Key Recommendations for RESPIRATORY HYGIENE/COUGH ETIQUETTE in Dental Settings

1. Implement measures to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection, beginning at point of entry to the facility and continuing throughout the visit.
 - a. Post signs at entrances with instructions to patients with symptoms of respiratory infection to —
 - i. Cover their mouths/noses when coughing or sneezing.
 - ii. Use and dispose of tissues.
 - iii. Perform hand hygiene after hands have been in contact with respiratory secretions.
 - b. Provide tissues and no-touch receptacles for disposal of tissues.
 - c. Provide resources for performing hand hygiene in or near waiting areas.
 - d. Offer masks to coughing patients and other symptomatic persons when they enter the dental setting.
 - e. Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these patients in a separate area while waiting for care.
2. Educate DHCP on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens when examining and caring for patients with signs and symptoms of a respiratory infection.

Sharps Safety

Most percutaneous injuries (e.g., needlestick, cut with a sharp object) among DHCP involve burs, needles, and other sharp instruments. Implementation of the OSHA Bloodborne Pathogens Standard has helped to protect DHCP from blood exposure and sharps injuries. However, sharps injuries continue to occur and pose the risk of bloodborne pathogen transmission to DHCP and patients. Most exposures in dentistry are preventable; therefore, each dental practice should have policies and procedures available addressing sharps safety. DHCP should be aware of the risk of injury whenever sharps are exposed. When using or working around sharp devices, DHCP should take precautions while using sharps, during cleanup, and during disposal.

Engineering and work-practice controls are the primary methods to reduce exposures to blood and OPIM from sharp instruments and needles.

Whenever possible, engineering controls should be used as the primary method to reduce exposures to bloodborne pathogens. Engineering controls remove or isolate a hazard in the workplace and are frequently technology-based (e.g., self-sheathing anesthetic needles, safety scalpels, and needleless IV ports). Employers should involve those DHCP who are directly responsible for patient care (e.g., dentists, hygienists, dental assistants) in identifying, evaluating and selecting devices with engineered safety features at least annually and as they become available. Other examples of engineering controls include sharps containers and needle recapping devices.

When engineering controls are not available or appropriate, work-practice controls should be used. Work-practice controls are behavior-based and are intended to reduce the risk of blood exposure by changing the way DHCP perform tasks, such as using

a one-handed scoop technique for recapping needles between uses and before disposal. Other work-practice controls include not bending or breaking needles before disposal, not passing a syringe with an unsheathed needle by hand, removing burs before disassembling the handpiece from the dental unit, and using instruments in place of fingers for tissue retraction or palpation during suturing and administration of anesthesia.

All used disposable syringes and needles, scalpel blades, and other sharp items should be placed in appropriate puncture-resistant containers located

close to the area where they are used. Sharps containers should be disposed of according to state and local regulated medical waste rules.

For more information about sharps safety, see the *Guidelines for Infection Control in Dental Health-Care Settings—2003* (available at: www.cdc.gov/mmwr/PDF/rr/rr5217.pdf), the CDC *Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program* (available at: www.cdc.gov/sharpsafety/), and the CDC Sample Screening and Device Evaluation Forms for Dentistry (available at: www.cdc.gov/OralHealth/infectioncontrol/forms.htm).

Key Recommendations for SHARPS SAFETY in Dental Settings

1. Consider sharp items (e.g., needles, scalars, burs, lab knives, and wires) that are contaminated with patient blood and saliva as potentially infective and establish engineering controls and work practices to prevent injuries.
2. Do not recap used needles by using both hands or any other technique that involves directing the point of a needle toward any part of the body.
3. Use either a one-handed scoop technique or a mechanical device designed for holding the needle cap when recapping needles (e.g., between multiple injections and before removing from a non-disposable aspirating syringe).
4. Place used disposable syringes and needles, scalpel blades, and other sharp items in appropriate puncture-resistant containers located as close as possible to the area where the items are used.

Safe Injection Practices

Safe injection practices are intended to prevent transmission of infectious diseases between one patient and another, or between a patient and DHCP during preparation and administration of parenteral (e.g., intravenous or intramuscular injection) medications. Safe injection practices are a set of measures DHCP should follow to perform injections in the safest possible manner for the protection of patients. DHCP most frequently handle parenteral medications when administering local anesthesia, during which needles and cartridges containing local anesthetics are used for one patient only and the

dental cartridge syringe is cleaned and heat sterilized between patients. Other safe practices described here primarily apply to use of parenteral medications combined with fluid infusion systems, such as for patients undergoing conscious sedation. Unsafe practices that have led to patient harm include 1) use of a single syringe—with or without the same needle—to administer medication to multiple patients, 2) reinsertion of a used syringe—with or without the same needle—into a medication vial or solution container (e.g., saline bag) to obtain additional medication for a single patient and then

using that vial or solution container for subsequent patients, and 3) preparation of medications in close proximity to contaminated supplies or equipment.

Safe injection practices were covered in the Special Considerations section (Aseptic Technique for Parenteral Medications) of the 2003 CDC dental guidelines. However, because of reports of transmission of infectious diseases by inappropriate handling of injectable medications, CDC now considers safe injection practices to be a formal element of Standard Precautions. Complete guidance on safe injection practices can be found in the 2007

Guideline for Isolation Precautions (available at: <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>). Additional materials, including a list of frequently asked questions from providers and a patient notification toolkit, are also available (<http://www.cdc.gov/injectionsafety/>). The *One & Only Campaign* is a public health effort to eliminate unsafe medical injections. The campaign is led by CDC and the Safe Injection Practices Coalition (SIPC). To learn more about safe injection practices and access training videos and resources, please visit <http://www.oneandonlycampaign.org/>.

Key Recommendations for SAFE INJECTION PRACTICES in Dental Settings

1. Prepare injections using aseptic technique² in a clean area.
2. Disinfect the rubber septum on a medication vial with alcohol before piercing.
3. Do not use needles or syringes^{*} for more than one patient (this includes manufactured prefilled syringes and other devices such as insulin pens).
4. Medication containers (single and multidose vials, ampules, and bags) are entered with a new needle and new syringe, even when obtaining additional doses for the same patient.
5. Use single-dose vials for parenteral medications when possible.
6. Do not use single-dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution for more than one patient.
7. Do not combine the leftover contents of single-use vials for later use.
8. The following apply if multidose vials are used —
 - a. Dedicate multidose vials to a single patient whenever possible.
 - b. If multidose vials will be used for more than one patient, they should be restricted to a centralized medication area and should not enter the immediate patient treatment area (e.g., dental operator) to prevent inadvertent contamination.
 - c. If a multidose vial enters the immediate patient treatment area, it should be dedicated for single-patient use and discarded immediately after use.
 - d. Date multidose vials when first opened and discard within 28 days, unless the manufacturer specifies a shorter or longer date for that opened vial.
9. Do not use fluid infusion or administration sets (e.g., IV bags, tubings, connections) for more than one patient.

² A technique that prevents or reduces the spread of microorganisms from one site to another, such as from patient to DHCP, from patient to operatory surfaces, or from one operatory surface to another.

^{*} A Note about Administering Local Dental Anesthesia: When using a dental cartridge syringe to administer local anesthesia, do not use the needle or anesthetic cartridge for more than one patient. Ensure that the dental cartridge syringe is appropriately cleaned and heat sterilized before use on another patient.

Sterilization and Disinfection of Patient-Care Items and Devices

Instrument processing requires multiple steps using specialized equipment. Each dental practice should have policies and procedures in place for containing, transporting, and handling instruments and equipment that may be contaminated with blood or body fluids. Manufacturer's instructions for reprocessing reusable dental instruments and equipment should be readily available—ideally in or near the reprocessing area. Most single-use devices are labeled by the manufacturer for only a single use and do not have reprocessing instructions. Use single-use devices for one patient only and dispose of appropriately.

Cleaning, disinfection and sterilization of dental equipment should be assigned to DHCP with training in the required reprocessing steps to ensure reprocessing results in a device that can be safely used for patient care. Training should also include the appropriate use of PPE necessary for safe handling of contaminated equipment.

Patient-care items (e.g., dental instruments, devices, and equipment) are categorized as critical, semicritical, or noncritical, depending on the potential risk for infection associated with their intended use.

- Critical items, such as surgical instruments and periodontal scalers, are those used to penetrate soft tissue or bone. They have the greatest risk of transmitting infection and should always be sterilized using heat.
- Semicritical items (e.g., mouth mirrors, amalgam condensers, reusable dental impression trays) are those that come in contact with mucous membranes or non-intact skin (e.g., exposed skin that is chapped, abraded, or has dermatitis). These items have a lower risk of transmission. Because the majority of semicritical items in dentistry are heat-tolerant, they should also be sterilized using heat. If a semicritical item is heat-sensitive, DHCP should replace it with a heat-tolerant or disposable alternative. If none are available, it should, at a minimum,

be processed using high-level disinfection.

Note: Dental handpieces and associated attachments, including low-speed motors and reusable prophylaxis angles, should always be heat sterilized between patients and not high-level or surface disinfected. Although these devices are considered semicritical, studies have shown that their internal surfaces can become contaminated with patient materials during use. If these devices are not properly cleaned and heat sterilized, the next patient may be exposed to potentially infectious materials.

Digital radiography sensors are also considered semicritical and should be protected with a Food and Drug Administration (FDA)-cleared barrier to reduce contamination during use, followed by cleaning and heat-sterilization or high-level disinfection between patients. If the item cannot tolerate these procedures then, at a minimum, protect with an FDA-cleared barrier. In addition, clean and disinfect with an Environmental Protection Agency (EPA)-registered hospital disinfectant with intermediate-level (i.e., tuberculocidal claim) activity between patients. Because these items vary by manufacturer and their ability to be sterilized or high-level disinfected also vary, refer to manufacturer instructions for reprocessing.

- Noncritical patient-care items (e.g., radiograph head/cone, blood pressure cuff, facebow) are those that only contact intact skin. These items pose the least risk of transmission of infection. In the majority of cases, cleaning, or if visibly soiled, cleaning followed by disinfection with an EPA-registered hospital disinfectant is adequate. Protecting these surfaces with disposable barriers might be a preferred alternative.

Cleaning to remove debris and organic contamination from instruments should always occur before disinfection or sterilization. If blood, saliva, and other contamination are not removed, these materials can shield microorganisms and potentially compromise

the disinfection or sterilization process. Automated cleaning equipment (e.g., ultrasonic cleaner, washer-disinfector) should be used to remove debris to improve cleaning effectiveness and decrease worker exposure to blood. After cleaning, dried instruments should be inspected, wrapped, packaged, or placed into container systems before heat sterilization. Packages should be labeled to show the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date. This information can help in retrieving processed items in the event of an instrument processing/sterilization failure.

The ability of a sterilizer to reach conditions necessary to achieve sterilization should be monitored using a combination of biological, mechanical, and chemical indicators. Biological indicators, or spore tests, are the most accepted method for monitoring the sterilization process because they assess the sterilization process directly by killing known highly resistant microorganisms (e.g., *Geobacillus* or *Bacillus* species). A spore test should be used at least weekly to monitor sterilizers. However, because spore tests are only performed periodically (e.g., once a week, once a day) and the results are usually not obtained immediately, mechanical and chemical monitoring should also be performed.

Mechanical and chemical indicators do not guarantee sterilization; however, they help detect procedural errors and equipment malfunctions. Mechanical monitoring involves checking the sterilizer gauges, computer displays, or printouts; and documenting the sterilization pressure, temperature, and exposure time in your sterilization records. Since these parameters can be observed during the sterilization cycle, this might be the first indication of a problem.

Chemical monitoring uses sensitive chemicals that change color when exposed to high temperatures or combinations of time and temperature. Examples include chemical indicator tapes, strips or tabs, and special markings on packaging materials. Chemical monitoring results are obtained immediately following the sterilization cycle and therefore can provide more

timely information about the sterilization cycle than a spore test. A chemical indicator should be used inside every package to verify that the sterilizing agent (e.g., steam) has penetrated the package and reached the instruments inside. If the internal chemical indicator is not visible from the outside of the package, an external indicator should also be used. External indicators can be inspected immediately when removing packages from the sterilizer. If the appropriate color change did not occur, do not use the instruments. Chemical indicators also help to differentiate between processed and unprocessed items, eliminating the possibility of using instruments that have not been sterilized.

Note: A single-parameter internal chemical indicator provides information regarding only one sterilization parameter (e.g., time or temperature). Multiparameter internal chemical indicators are designed to react to ≥ 2 parameters (e.g., time and temperature; or time, temperature, and the presence of steam) and can provide a more reliable indication that sterilization conditions have been met.

Sterilization monitoring (e.g., biological, mechanical, chemical monitoring) and equipment maintenance records are an important component of a dental infection prevention program. Maintaining accurate records ensures cycle parameters have been met and establishes accountability. In addition, if there is a problem with a sterilizer (e.g., unchanged chemical indicator, positive spore test), documentation helps to determine if an instrument recall is necessary.

Ideally, sterile instruments and supplies should be stored in covered or closed cabinets. Wrapped packages of sterilized instruments should be inspected before opening and use to ensure the packaging material has not been compromised (e.g., wet, torn, punctured) during storage. The contents of any compromised packs should be reprocessed (i.e., cleaned, packaged, and heat-sterilized again) before use on a patient.

Recommendations for the cleaning, disinfection, and sterilization of dental equipment can be found in the *Guidelines for Infection Control in Dental*

Health-Care Settings—2003 (available at: www.cdc.gov/mmwr/PDF/rr/rr5217.pdf). Recommendations for the cleaning, disinfection, and sterilization of medical equipment are available in the *Guideline for Disinfection and Sterilization in Healthcare Facilities* (available at: [\[hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf\]\(http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf\)\). FDA regulations on reprocessing of single-use devices are available at: <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm071434>.](http://www.cdc.gov/</p></div><div data-bbox=)

Key Recommendations for STERILIZATION AND DISINFECTION OF PATIENT-CARE DEVICES for Dental Settings

1. Clean and reprocess (disinfect or sterilize) reusable dental equipment appropriately before use on another patient.
2. Clean and reprocess reusable dental equipment according to manufacturer instructions. If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use.
 - a. Have manufacturer instructions for reprocessing reusable dental instruments/equipment readily available, ideally in or near the reprocessing area.
3. Assign responsibilities for reprocessing of dental equipment to DHCP with appropriate training.
4. Wear appropriate PPE when handling and reprocessing contaminated patient equipment.
5. Use mechanical, chemical, and biological monitors according to manufacturer instructions to ensure the effectiveness of the sterilization process. Maintain sterilization records in accordance with state and local regulations.

Environmental Infection Prevention and Control

Policies and procedures for routine cleaning and disinfection of environmental surfaces should be included as part of the infection prevention plan. Cleaning removes large numbers of microorganisms from surfaces and should always precede disinfection. Disinfection is generally a less lethal process of microbial inactivation (compared with sterilization) that eliminates virtually all recognized pathogenic microorganisms but not necessarily all microbial forms (e.g., bacterial spores).

Emphasis for cleaning and disinfection should be placed on surfaces that are most likely to become contaminated with pathogens, including clinical contact surfaces (e.g., frequently touched surfaces such as light handles, bracket trays, switches on dental units, computer equipment) in the patient-care area. When these surfaces are touched, microorganisms can be transferred to other surfaces, instruments

or to the nose, mouth, or eyes of DHCP or patients. Although hand hygiene is the key to minimizing the spread of microorganisms, clinical contact surfaces should be barrier protected or cleaned and disinfected between patients. EPA-registered hospital disinfectants or detergents/disinfectants with label claims for use in health care settings should be used for disinfection. Disinfectant products should not be used as cleaners unless the label indicates the product is suitable for such use. DHCP should follow manufacturer recommendations for use of products selected for cleaning and disinfection (e.g., amount, dilution, contact time, safe use, and disposal). Facility policies and procedures should also address prompt and appropriate cleaning and decontamination of spills of blood or other potentially infectious materials. Housekeeping surfaces, (e.g., floors, walls, sinks) carry less risk of disease transmission than clinical contact

surfaces and can be cleaned with soap and water or cleaned and disinfected if visibly contaminated with blood.

Additional guidance for the cleaning and disinfection of environmental surfaces—including for cleaning blood or body substance spills—is available

in the *Guidelines for Environmental Infection Control in Health-Care Facilities* (available at: http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf) and the *Guideline for Disinfection and Sterilization in Healthcare Facilities* (available at: http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf).

Key Recommendations for ENVIRONMENTAL INFECTION PREVENTION AND CONTROL in Dental Settings

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| <ol style="list-style-type: none">1. Establish policies and procedures for routine cleaning and disinfection of environmental surfaces in dental health care settings.<ol style="list-style-type: none">a. Use surface barriers to protect clinical contact surfaces, particularly those that are difficult to clean (e.g., switches on dental chairs, computer equipment) and change surface barriers between patients.b. Clean and disinfect clinical contact surfaces that are not barrier-protected with an EPA-registered hospital | <p>disinfectant after each patient. Use an intermediate-level disinfectant (i.e., tuberculocidal claim) if visibly contaminated with blood.</p> <ol style="list-style-type: none">2. Select EPA-registered disinfectants or detergents/disinfectants with label claims for use in health care settings.3. Follow manufacturer instructions for use of cleaners and EPA-registered disinfectants (e.g., amount, dilution, contact time, safe use, disposal). |
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Dental Unit Water Quality

Dental unit waterlines (i.e., plastic tubing that carries water to the high-speed handpiece, air/water syringe, and ultrasonic scaler) promote bacterial growth and development of biofilm due to the presence of long narrow-bore tubing, inconsistent flow rates, and the potential for retraction of oral fluids. Dental health care personnel and patients could be placed at risk of adverse health effects if water is not appropriately treated.

All dental units should use systems that treat water to meet drinking water standards (i.e., ≤ 500 CFU/mL of heterotrophic water bacteria). Independent reservoirs—or water-bottle systems—alone are not sufficient. Commercial products and devices are available that can improve the quality of water used

in dental treatment. Consult with the dental unit manufacturer for appropriate water maintenance methods and recommendations for monitoring dental water quality. During surgical procedures,¹ use only sterile solutions as a coolant/irrigant using an appropriate delivery device, such as a sterile bulb syringe, sterile tubing that bypasses dental unit waterlines, or sterile single-use devices.

Guidance on dental unit water quality can be found in the *Guidelines for Infection Control in Dental Health-Care Settings—2003* (available at: www.cdc.gov/mmwr/PDF/rr/rr5217.pdf), and the CDC Boil-Water Advisories and the Dental Office Fact Sheet (available at: <http://www.cdc.gov/oralhealth/infectioncontrol/faq/dentalunitwaterquality.htm>).

Key Recommendations for DENTAL UNIT WATER QUALITY in Dental Settings

1. Use water that meets EPA regulatory standards for drinking water (i.e., ≤ 500 CFU/mL of heterotrophic water bacteria) for routine dental treatment output water.
2. Consult with the dental unit manufacturer for appropriate methods and equipment to maintain the quality of dental water.
3. Follow recommendations for monitoring water quality provided by the manufacturer of the unit or waterline treatment product.
4. Use sterile saline or sterile water as a coolant/irrigant when performing surgical procedures.

Risk Assessment

Facilities are encouraged to use the Infection Prevention Checklist for Dental Settings (Appendix A)—a companion to the summary guide—to periodically assess practices in their facility and ensure they are meeting the minimum expectations for safe care. In the course of auditing practices, facilities may identify lapses in infection control. If such lapses are identified, efforts should be made to correct the practices, appropriately educate DHCP (if applicable), and determine why the correct practice was not being performed. In addition, consideration should also be made for determining the risk posed to patients by the deficient practices. Certain infection control lapses (e.g., reuse of syringes on more than one patient or to access a medication container that is used for subsequent patients, reuse of lancets) have resulted in bloodborne pathogen transmission and should

be halted immediately. Identification of such lapses warrants immediate consultation with the state or local health department and appropriate notification and testing of potentially affected patients. Additional resources describing approaches to evaluation and management of infection control breaches identified in health care settings—including those involving lapses related to reprocessing of medical devices—can be found in CDC's Steps for Evaluating an Infection Control Breach (available at: http://www.cdc.gov/hai/outbreaks/steps_for_eval_IC_breach.html). In addition, for circumstances warranting patient notification, CDC has developed a Patient Notification Toolkit (available at: <http://www.cdc.gov/injectionsafety/pntoolkit/index.html>) to assist health care facilities with conducting a patient notification.

Conclusions

The information presented in this document represents basic infection prevention expectations for safe care in dental health care settings. This guidance is not all-encompassing. DHCP and others are encouraged to refer to the original source documents, which provide more detailed guidance

and references for the information included in this guide. DHCP are also encouraged to visit the main CDC Web page (www.cdc.gov) for the most current infection prevention information about emerging pathogens and updated information about existing recommendations.

Source Documents

Dental Infection Prevention Guidelines

Guidelines for Infection Control in Dental Health-Care Settings---2003
www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

General Infection Prevention Guidelines

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008
www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

Guideline for Hand Hygiene in Health-Care Settings, 2002
www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

Guideline for Infection Control in Healthcare Personnel, 1998
www.cdc.gov/hicpac/pdf/InfectControl98.pdf

Guidelines for Environmental Infection Control in Health-Care Facilities, 2003
www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005
www.cdc.gov/mmwr/pdf/rr/rr5417.pdf

Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization, 2011
www.cdc.gov/mmwr/pdf/rr/rr6007.pdf

Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006
www.cdc.gov/hicpac/pdf/guidelines/MDROGuideline2006.pdf

Key Links for Additional Information

CDC Division of Oral Health
www.cdc.gov/oralhealth

CDC/Healthcare Infection Control Practices Advisory Committee (HICPAC) Guidelines for Prevention of Healthcare Associated Infections
www.cdc.gov/hicpac/pubs.html

CDC Web site on Hand Hygiene
www.cdc.gov/handwashing

CDC Web site on Influenza
www.cdc.gov/flu

CDC Web site on Injection Safety
www.cdc.gov/injectionsafety

Appendix A

Infection Prevention Checklist for Dental Settings: Basic Expectations for Safe Care

The following is a companion to the *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*. The checklist should be used—

1. To ensure the dental health care setting has appropriate infection prevention policies and practices in place, including appropriate training and education of dental health care personnel (DHCP) on infection prevention practices, and adequate supplies to allow DHCP to provide safe care and a safe working environment.
2. To systematically assess personnel compliance with the expected infection prevention practices and to provide feedback to DHCP regarding performance. Assessment of compliance should be conducted by direct observation of DHCP during the performance of their duties.

DHCP using this checklist should identify all procedures performed in their setting and refer to appropriate sections of this checklist to conduct their evaluation. Certain sections may not apply (e.g., some settings may not perform surgical procedures or use medications in vials, such as for conscious sedation). If the answer to any of the applicable listed questions

is no, efforts should be made to determine why the correct practice was not being performed, correct the practice, educate DHCP (if applicable), and reassess the practice to ensure compliance. Consideration should also be made to determine the risk posed to patients by the deficient practice. Certain infection prevention and control lapses (e.g., re-use of syringes on more than one patient, sterilization failures) can result in bloodborne pathogen transmission and measures to address the lapses should be taken immediately. Identification of such lapses may warrant immediate consultation with the state or local health department and appropriate notification and testing of potentially affected patients.

Section I lists administrative policies and dental setting practices that should be included in the site-specific written infection prevention and control program with supportive documentation. Section II describes personnel compliance with infection prevention and control practices that fulfill the expectations for dental health care settings. This checklist can serve as an evaluation tool to monitor DHCP compliance with the CDC's recommendations and provide an assurance of quality control.

Infection Prevention Checklist

Section I: Policies and Practices

I.1 Administrative Measures

| |
|---------------------|
| Facility name:..... |
| Completed by:..... |
| Date:..... |

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|-------------------------|------------|-----------------------------|
|-------------------------|------------|-----------------------------|

A. Written infection prevention policies and procedures specific for the dental setting are available, current, and based on evidence-based guidelines (e.g., CDC/Healthcare Infection Control Practices Advisory Committee [HICPAC]), regulations, or standards

Yes No

Note: Policies and procedures should be appropriate for the services provided by the dental setting and should extend beyond the Occupational Safety and Health Administration (OSHA) bloodborne pathogens training.

B. Infection prevention policies and procedures are reassessed at least annually or according to state or federal requirements, and updated if appropriate

Yes No

Note: This may be performed during the required annual review of the dental setting's OSHA Exposure Control Plan.

C. At least one individual trained in infection prevention is assigned responsibility for coordinating the program

Yes No

D. Supplies necessary for adherence to Standard Precautions are readily available

Yes No

Note: This includes, but is not limited to hand hygiene products, safer devices to reduce percutaneous injuries, and personal protective equipment (PPE).

E. Facility has system for early detection and management of potentially infectious persons at initial points of patient encounter

Yes No

Note: System may include taking a travel and occupational history, as appropriate, and elements described under respiratory hygiene/cough etiquette.

I.2 Infection Prevention Education and Training

| Elements To Be Assessed | Assessment | Notes / Areas For Improvement |
|---|---|-------------------------------|
| <p>A. DHCP receive job or task-specific training on infection prevention policies and procedures and the OSHA bloodborne pathogens standard—</p> <ul style="list-style-type: none"> a. upon hire b. annually c. when new tasks or procedures affect the employee's occupational exposure d. according to state or federal requirements <p>Note: This includes those employed by outside agencies and available by contract or on a volunteer basis to the dental setting.</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>B. Training records are maintained in accordance with state and federal requirements</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

I.3 Dental Health Care Personnel Safety

| Elements To Be Assessed | Assessment | Notes / Areas For Improvement |
|---|---|-------------------------------|
| <p>A. Facility has an exposure control plan that is tailored to the specific requirements of the facility (e.g., addresses potential hazards posed by specific services provided by the facility)</p> <p>Note: A model template that includes a guide for creating an exposure control plan that meets the requirements of the OSHA Bloodborne Pathogens Standard is available at: https://www.osha.gov/Publications/osha3186.pdf.</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>B. DHCP for whom contact with blood or OPIM is anticipated are trained on the OSHA Bloodborne Pathogens Standard:</p> <ul style="list-style-type: none"> a. upon hire b. at least annually | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>C. Current CDC recommendations for immunizations, evaluation, and follow-up are available. There is a written policy regarding immunizing DHCP, including a list of all required and recommended immunizations for DHCP (e.g., hepatitis B, MMR (measles, mumps, rubella), varicella (chickenpox), Tdap (tetanus, diphtheria, pertussis))</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

CONTINUED

I.3 Dental Health Care Personnel Safety

| Elements To Be Assessed | Assessment | Notes/ Areas For Improvement |
|--|---|------------------------------|
| <p>D. Hepatitis B vaccination is available at no cost to all employees who are at risk of occupational exposure to blood or other potentially infectious material (OPIM)</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>E. Post-vaccination screening for protective levels of hepatitis B surface antibody is conducted 1-2 months after completion of the 3-dose vaccination series</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>F. All DHCP are offered annual influenza vaccination</p> <p>Note: <i>Providing the vaccination at no cost is a strategy that may increase use of this preventive service.</i></p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>G. All DHCP receive baseline tuberculosis (TB) screening upon hire regardless of the risk classification of the setting</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>H. A log of needlesticks, sharps injuries, and other employee exposure events is maintained according to state or federal requirements</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>I. Referral arrangements are in place to qualified health care professionals (e.g., occupational health program of a hospital, educational institutions, health care facilities that offer personnel health services) to ensure prompt and appropriate provision of preventive services, occupationally-related medical services, and postexposure management with medical follow-up</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>J. Following an occupational exposure event, postexposure evaluation and follow-up, including prophylaxis as appropriate, are available at no cost to employee and are supervised by a qualified health care professional</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>K. Facility has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions. These policies include—</p> | | |
| <p>a. work-exclusion policies that encourage reporting of illnesses and do not penalize staff with loss of wages, benefits, or job status</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>b. education of personnel on the importance of prompt reporting of illness to supervisor</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

1.4 Program Evaluation

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|--|-----------------------------|
| A. Written policies and procedures for routine monitoring and evaluation of the infection prevention and control program are available | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. Adherence with certain practices such as immunizations, hand hygiene, sterilization monitoring, and proper use of PPE is monitored and feedback is provided to DHCP | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

1.5 Hand Hygiene

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|--|-----------------------------|
| A. Supplies necessary for adherence to hand hygiene for routine dental procedures (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible to DHCP | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <p>a. If surgical procedures are performed, appropriate supplies are available for surgical hand scrub technique (e.g., antimicrobial soap, alcohol-based hand scrub with persistent activity)</p> <p>Note: <i>Examples of surgical procedures include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth.</i></p> | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. DHCP are trained regarding appropriate indications for hand hygiene including handwashing, hand antisepsis, and surgical hand antisepsis | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Note: <i>Use soap and water when hands are visibly soiled (e.g., blood, body fluids). Alcohol-based hand rub may be used in all other situations.</i> | | |

1.6 Personal Protective Equipment (PPE)

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| A. Sufficient and appropriate PPE is available (e.g., examination gloves, surgical face masks, protective clothing, protective eyewear/face shields, utility gloves, sterile surgeon's gloves for surgical procedures) and readily accessible to DHCP | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. DHCP receive training on proper selection and use of PPE | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

I.7 Respiratory Hygiene/Cough Etiquette

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|---|-----------------------------|
| <p>A. Policies and procedures to contain respiratory secretions in people who have signs and symptoms of a respiratory infection, beginning at point of entry to the dental setting have been implemented. Measures include—</p> <ul style="list-style-type: none"> a. posting signs at entrances (with instructions to patients with symptoms of respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions) b. providing tissues and no-touch receptacles for disposal of tissues c. providing resources for patients to perform hand hygiene in or near waiting areas d. offering face masks to coughing patients and other symptomatic persons when they enter the setting e. providing space and encouraging persons with respiratory symptoms to sit as far away from others as possible—if possible, a separate waiting area is ideal | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>B. DHCP receive training on the importance of containing respiratory secretions in people who have signs and symptoms of a respiratory infection</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

I.8 Sharps Safety

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|---|-----------------------------|
| <p>A. Written policies, procedures, and guidelines for exposure prevention and postexposure management are available</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>B. DHCP identify, evaluate, and select devices with engineered safety features (e.g., safer anesthetic syringes, blunt suture needle, safety scalpels, or needleless IV systems)—</p> <ul style="list-style-type: none"> a. at least annually b. as they become available in the market <p>Note: <i>If staff inquire about the availability of new safety devices or safer options and find none are available, DHCP can document these findings in their office exposure control plan.</i></p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

I.9 Safe Injection Practices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| A. Written policies, procedures, and guidelines for safe injection practices (e.g., aseptic technique for parenteral medications) are available | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. Injections are required to be prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

I.10 Sterilization and Disinfection of Patient-Care Items and Devices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| A. Written policies and procedures are available to ensure reusable patient care instruments and devices are cleaned and reprocessed appropriately before use on another patient | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. Policies, procedures, and manufacturer reprocessing instructions for reusable instruments and dental devices are available, ideally in or near the reprocessing areas | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. DHCP responsible for reprocessing reusable dental instruments and devices are appropriately trained— | | |
| a. upon hire | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. at least annually | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| c. whenever new equipment or processes are introduced | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| D. Training and equipment are available to ensure that DHCP wear appropriate PPE (e.g., examination or heavy duty utility gloves, protective clothing, masks, eye protection) to prevent exposure to infectious agents or chemicals | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Note: <i>The exact type of PPE depends on infectious or chemical agent and anticipated type of exposure.</i> | | |
| E. Routine maintenance for sterilization equipment is— | | |
| a. performed according to manufacturer instructions | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. documented by written maintenance records | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

CONTINUED

I.10 Sterilization and Disinfection of Patient-Care Items and Devices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|--|-----------------------------|
| F. Policies and procedures are in place outlining dental setting response (e.g., recall of device, risk assessment) in the event of a reprocessing error/failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

I.11 Environmental Infection Prevention and Control

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| A. Written policies and procedures are available for routine cleaning and disinfection of environmental surfaces (i.e., clinical contact and housekeeping) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. DHCP performing environmental infection prevention procedures receive job-specific training about infection prevention and control management of clinical contact and housekeeping surfaces— | | |
| a. upon hire | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. when procedures/policies change | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| c. at least annually | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. Training and equipment are available to ensure that DHCP wear appropriate PPE (e.g., examination or heavy duty utility gloves, protective clothing, masks, and eye protection) to prevent exposure to infectious agents or chemicals | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| D. Cleaning, disinfection, and use of surface barriers are periodically monitored and evaluated to ensure that they are consistently and correctly performed | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| E. Procedures are in place for decontamination of spills of blood or other body fluids | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

I.12 Dental Unit Water Quality

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| A. Policies and procedures are in place for maintaining dental unit water quality that meets Environmental Protection Agency (EPA) regulatory standards for drinking water (i.e., ≤ 500 CFU/mL of heterotrophic water bacteria) for routine dental treatment output water | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B: Policies and procedures are in place for using sterile water as a coolant/irrigant when performing surgical procedures Note: <i>Examples of surgical procedures include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. Written policies and procedures are available outlining response to a community boil-water advisory | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Infection Prevention Checklist

Section II: Direct Observation of Personnel and Patient-Care Practices

II.1 Hand Hygiene is Performed Correctly

| |
|---------------------|
| Facility name:..... |
| Completed by:..... |
| Date:..... |

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| A. When hands are visibly soiled | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. After barehanded touching of instruments, equipment, materials and other objects likely to be contaminated by blood, saliva, or respiratory secretions | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. Before and after treating each patient | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| D. Before putting on gloves | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| E. Immediately after removing gloves | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| F. Surgical hand scrub is performed before putting on sterile surgeon's gloves for all surgical procedures | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Note: Examples of surgical procedures include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth. | | |

II.2 Personal Protective Equipment (PPE) is Used Correctly

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| A. PPE is removed before leaving the work area (e.g., dental patient care, instrument processing, or laboratory areas) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. Hand hygiene is performed immediately after removal of PPE | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. Masks, Protective Eyewear, and Face Shields | | |
| a. DHCP wear surgical masks during procedures that are likely to generate splashes or sprays of blood or other body fluids | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. DHCP wear eye protection with solid side shields or a face shield during procedures that are likely to generate splashes or sprays of blood or other body fluids | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| c. DHCP change masks between patients and during patient treatment if the mask becomes wet | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

CONTINUED

II.2 Personal Protective Equipment (PPE) is Used Correctly

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| D. Gloves | | |
| a. DHCP wear gloves for potential contact with blood, body fluids, mucous membranes, non-intact skin, or contaminated equipment | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. DHCP change gloves between patients; do not wear the same pair of gloves for the care of more than one patient | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| c. DHCP do not wash examination or sterile surgeon's gloves for the purpose of reuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| d. DHCP wear puncture- and chemical-resistant utility gloves when cleaning instruments and performing housekeeping tasks involving contact with blood or OPIM | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| e. DHCP wear sterile surgeon's gloves for all surgical procedures | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Note: <i>Examples of surgical procedures include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth.</i> | | |
| f. DHCP remove gloves that are torn, cut, or punctured and perform hand hygiene before putting on new gloves | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <hr/> | | |
| E. Protective Clothing | | |
| a. DHCP wear protective clothing (e.g., reusable or disposable gown, laboratory coat, or uniform) that covers personal clothing and skin (e.g., forearms) likely to be soiled with blood, saliva, or OPIM | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. DHCP change protective clothing if visibly soiled and immediately or as soon as possible if penetrated by blood or other potentially infectious fluids | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

II.3 Respiratory Hygiene/Cough Etiquette

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|--|-----------------------------|
| A. Signs are posted at entrances (with instructions to patients with symptoms of respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

CONTINUED

II.3 Respiratory Hygiene/Cough Etiquette

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| B. Tissues and no-touch receptacles for disposal of tissues are provided | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. Resources are provided for patients to perform hand hygiene in or near waiting areas | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| D. Face masks are offered to coughing patients and other symptomatic persons when they enter the setting | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| E. Persons with respiratory symptoms are encouraged to sit as far away from others as possible. If possible, a separate waiting area is ideal | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

II.4 Sharps Safety

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|--|-----------------------------|
| A. Engineering controls (e.g., self-sheathing anesthetic needles, safety scalpels, needleless IV ports) are used to prevent injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. Work practice controls (e.g., one-handed scoop technique for recapping needles, removing burs before disconnecting handpieces) are used to prevent injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. DHCP do not recap used needles by using both hands or any other technique that involves directing the point of a needle toward any part of the body | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| D. DHCP use either a one-handed scoop technique or a mechanical device designed for holding the needle cap when recapping needles (e.g., between multiple injections and before removing from a reusable aspirating syringe) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| E. All sharps are disposed of in a puncture-resistant sharps container located as close as possible to the area in which the items are used | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| F. Sharps containers are disposed of in accordance with federal, state and local regulated medical waste rules and regulations | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

II.5 Safe Injection Practices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|---|-----------------------------|
| <p>A. Injections are prepared using an aseptic technique in a clean area free from contaminants or contact with blood, body fluids, or contaminated equipment</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>B. Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and other devices such as insulin pens)</p> <p>Note: <i>When using a dental cartridge syringe to administer local anesthesia, do not use the needle, syringe, or anesthetic cartridge for more than one patient. Ensure that the dental cartridge syringe is appropriately cleaned and heat sterilized before use on another patient.</i></p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>C. The rubber septum on a medication vial is disinfected with alcohol before piercing</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>D. Medication containers (single and multidose vials, ampules, and bags) are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>E. Single-dose (single-use) vials, ampules, and bags or bottles of intravenous solutions are used for only one patient</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>F. Leftover contents of single-dose vials, ampules, and bags of intravenous solutions are not combined for later use</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>G. Single-dose vials for parenteral medications are used when possible</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

CONTINUED

II.5 Safe Injection Practices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|--|-----------------------------|
| H. When using multidose medication vials | | |
| a. multidose vials are dedicated to individual patients whenever possible | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| b. multidose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., dental operator) to prevent inadvertent contamination of the vial | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Note: <i>If a multidose vial enters the immediate patient treatment area it should be dedicated for single-patient use and discarded immediately after use.</i> | | |
| c. multidose vials are dated when first opened and discarded within 28 days unless the manufacturer specifies a shorter or longer date for that opened vial | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Note: <i>This is different from the expiration date printed on the vial.</i> | | |
| ----- | | |
| I. Fluid infusion and administration sets (i.e., IV bags, tubings, and connections) are used for one patient only and disposed of appropriately | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ----- | | |

II.6 Sterilization and Disinfection of Patient-Care Items and Devices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|--|-----------------------------|
| A. Single-use devices are discarded after one use and not used for more than one patient | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| B. Reusable critical and semicritical dental items and devices are cleaned and heat-sterilized according to manufacturer instructions between patient use Note: <i>If the manufacturer does not provide reprocessing instructions, the item or device may not be suitable for multi-patient use.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| C. Items are thoroughly cleaned according to manufacturer instructions and visually inspected for residual contamination before sterilization | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| D. Food and Drug Administration (FDA)-cleared automated cleaning equipment (e.g., ultrasonic cleaner, instrument washer, washer-disinfector) is used to remove debris to improve cleaning effectiveness and decrease worker exposure to blood | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| E. Work-practice controls that minimize contact with sharp instruments (e.g., long-handled brush) are used and appropriate PPE is worn (e.g., puncture- and chemical-resistant utility gloves) if manual cleaning is necessary | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| F. After cleaning and drying, instruments are appropriately wrapped/packaged for sterilization (e.g., package system selected is compatible with the sterilization process being performed, hinged instruments are open, instruments are disassembled if indicated by the manufacturer) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| G. A chemical indicator is used inside each package. If the internal indicator is not visible from the outside, an exterior chemical indicator is also used on the package Note: <i>The chemical indicators may be integrated into the package design.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| H. Sterile packs are labeled at a minimum with the sterilizer used, the cycle or load number, the date of sterilization, and if applicable an expiration date | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

CONTINUED

II.6 Sterilization and Disinfection of Patient-Care Items and Devices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|--|-----------------------------|
| I. FDA-cleared medical devices for sterilization are used according to manufacturer's instructions | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| J. A biologic indicator (i.e., spore test) is used at least weekly and with every load containing implantable items | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| K. Logs for each sterilizer cycle are current and include results from each load and comply with state and local regulations | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| L. After sterilization, dental devices and instruments are stored so that sterility is not compromised | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| M. Sterile packages are inspected for integrity and compromised packages are reprocessed before use | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| N. Instrument packs are not used if mechanical (e.g., time, temperature, pressure) or chemical indicators indicate inadequate processing (e.g., color change for chemical indicators) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| O. The instrument processing area has a workflow pattern designed to ensure that devices and instruments clearly flow from high contamination areas to clean/sterile areas (i.e., there is clear separation of contaminated and clean workspaces) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| P. Reusable heat sensitive semicritical items that cannot be replaced by a heat stable or disposable alternative are high-level disinfected according to manufacturer's instructions | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q. High-level disinfection products are used and maintained according to manufacturer instructions | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| R. Dental handpieces (including the low-speed motor) and other devices not permanently attached to air and waterlines are cleaned and heat-sterilized according to manufacturer instructions | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

CONTINUED

II.6 Sterilization and Disinfection of Patient-Care Items and Devices

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|--|---|-----------------------------|
| <p>S. If digital radiography is used in the dental setting—</p> <p>a. FDA-cleared barriers are used to cover the sensor and barriers are changed between patients</p> <p>b. after the surface barrier is removed, the sensor is ideally cleaned and heat sterilized or high-level disinfected according to the manufacturer's instructions. If the item cannot tolerate these procedures, then at a minimum, the sensor is cleaned and disinfected with an intermediate-level, EPA-registered hospital disinfectant</p> <p>Note: Consult with manufacturers regarding compatibility of heat sterilization methods and disinfection products.</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

II.7 Environmental Infection Prevention and Control

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|---|-----------------------------|
| <p>A. Clinical contact surfaces are either barrier-protected or cleaned and disinfected with an EPA-registered hospital disinfectant after each patient. An intermediate-level (i.e., tuberculocidal claim) disinfectant is used if visibly contaminated with blood</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>B. Surface barriers are used to protect clinical contact surfaces that are difficult to clean (e.g., switches on dental chairs, computer equipment, connections to hoses) and are changed between patients</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>C. Cleaners and disinfectants are used in accordance with manufacturer instructions (e.g., dilution, storage, shelf-life, contact time, PPE)</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>D. Regulated medical waste is handled and disposed of according to local, state, and federal regulations</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>E. DHCP engaged in environmental cleaning wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection)</p> <p>Note: The correct type of PPE depends on infectious or chemical agent and anticipated type of exposure.</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

II.8 Dental Unit Water Quality

| Elements To Be Assessed | Assessment | Notes/Areas For Improvement |
|---|---|-----------------------------|
| <p>A. Dental unit waterline treatment products/devices are used to ensure water meets EPA regulatory standards for drinking water (i.e., ≤ 500 CFU/mL of heterotrophic water bacteria) for routine dental treatment output water</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>B. Product manufacturer instructions (i.e., waterline treatment product, dental unit manufacturer) are followed for monitoring the water quality</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |
| <p>C. Sterile saline or sterile water is used as a coolant/irrigant when performing surgical procedures</p> <p>Note: Use devices specifically designed for delivering sterile irrigating fluids (e.g., sterile bulb syringe, single-use disposable products, and sterilizable tubing).</p> <p>Note: Examples of surgical procedures include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth.</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

Appendix B

Relevant Recommendations Published by CDC Since 2003

Administrative Measures

1. Develop and maintain written infection prevention policies and procedures appropriate for the services provided by the facility and based upon evidence-based guidelines, regulations, or standards.
2. Infection prevention policies and procedures are reassessed at least annually or according to state or federal requirements.
3. Assign at least one individual trained in infection prevention responsibility for coordinating the program.
4. Provide supplies necessary for adherence to Standard Precautions (e.g., hand hygiene products, safer devices to reduce percutaneous injuries, personal protective equipment).
5. Facility has system for early detection and management of potentially infectious persons at initial points of patient encounter.

References

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care
<http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html>

Infection Prevention Education and Training

1. Maintain training records according to state and federal requirements.

Reference

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Respiratory Hygiene/Cough Etiquette

1. Implement measures to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection, beginning at point of entry to the facility and continuing throughout the visit.
2. Post signs at entrances with instructions to patients with symptoms of respiratory infection to—
 - Cover their mouths/noses when coughing or sneezing.
 - Use and dispose of tissues.
 - Perform hand hygiene after hands have been in contact with respiratory secretions.
3. Provide tissues and no-touch receptacles for disposal of tissues.
4. Provide resources for performing hand hygiene in or near waiting areas.
5. Offer masks to coughing patients and other symptomatic persons when they enter the dental setting.
6. Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these patients in a separate area while waiting for care.
7. Educate DHCP on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens when examining and caring for patients with signs and symptoms of a respiratory infection.

Reference

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Safe Injection Practices

1. Prepare injections using aseptic technique in a clean area.
2. Disinfect the rubber septum on a medication vial with alcohol before piercing.
3. Do not reuse needles or syringes to enter a medication vial or solution, even when obtaining additional doses for the same patient.
4. Do not use single-dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution for more than one patient.
5. Dedicate multidose vials to a single patient whenever possible.
6. If multidose vials will be used for more than one patient, they should be kept in a centralized medication area and should not enter the immediate patient treatment area to prevent inadvertent contamination.
7. If a multidose vial enters the immediate patient treatment area it should be dedicated for single-patient use and discarded immediately after use.
8. Date multidose vials when first opened and discard within 28 days unless the manufacturer specifies a shorter or longer date for that opened vial.

References

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

CDC: Injection Safety, Information for Providers

www.cdc.gov/injectionsafety/providers.html

Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care

<http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html>

Sterilization and Disinfection of Patient-Care Items and Devices

1. Have manufacturer instructions for reprocessing reusable dental instruments/equipment readily available, ideally in or near the reprocessing area.
2. Label sterilized items with the sterilizer used, the cycle or load number, the date of sterilization, and (if applicable) the expiration date.
3. Ensure routine maintenance for sterilization equipment is performed according to manufacturer instructions and maintenance records are available.

Reference

Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008

www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

Appendix C

Selected References and Additional Resources by Topic Area

Administrative Measures

Guidelines for Infection Control in Dental Health-Care Settings—2003

www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Table 1: Suggested work restrictions for health care personnel infected with or exposed to major infectious diseases in health care settings, in the absence of state and local regulations

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Guideline for Infection Control in Healthcare Personnel, 1998

www.cdc.gov/hicpac/pdf/InfectControl98.pdf

Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP)

www.cdc.gov/mmwr/pdf/rr/rr6007.pdf

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis

<http://stacks.cdc.gov/view/cdc/20711>

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis

www.cdc.gov/mmwr/PDF/rr/rr5011.pdf

CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management

www.cdc.gov/mmwr/PDF/rr/rr6210.pdf

Infection Prevention Education and Training

Guidelines for Infection Control in Dental Health-Care Settings—2003

www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Organization for Safety, Asepsis, and Prevention (OSAP) Knowledge Center

<http://www.osap.org/?page=KnowledgeCenter>

Association for Professionals in Infection Control and Epidemiology (APIC)

Practice Guidance for Infection Prevention

<http://apic.org/Professional-Practice/Overview>

Dental Health Care Personnel Safety

Guidelines for Infection Control in Dental Health-Care Settings—2003

www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Guideline for Infection Control in Healthcare Personnel, 1998

www.cdc.gov/hicpac/pdf/infectControl98.pdf

Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP)
www.cdc.gov/mmwr/pdf/rr/rr6007.pdf

Influenza Vaccination of Health-Care Personnel
www.cdc.gov/mmwr/PDF/rr/rr55e209.pdf

Influenza Vaccination Information for Health Care Workers
www.cdc.gov/flu/healthcareworkers.htm

Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005
www.cdc.gov/mmwr/pdf/rr/rr5417.pdf

Occupational Safety & Health Administration (OSHA) Bloodborne Pathogens and Needlestick Prevention Standards
www.osha.gov/SLTC/bloodbornepathogens/index.html

Program Evaluation

Guidelines for Infection Control in Dental Health-Care Settings—2003
www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Table 5: Examples of methods for evaluating infection control programs

Example of an audit tool used by federal surveyors in ambulatory surgical centers (including dental)
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_351.pdf

Measuring Hand Hygiene Adherence: Overcoming the Challenges
www.cdc.gov/handhygiene/Measurement.html

Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care
www.cdc.gov/oralhealth/infectioncontrol/index.htm

Appendix A: Infection Prevention Checklist for Dental Settings: Basic Expectations for Safe Care

Standard Precautions

Guidelines for Infection Control in Dental Health-Care Settings—2003
www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006
www.cdc.gov/hicpac/pdf/guidelines/MDROGuideline2006.pdf

Harte JA. Standard and transmission-based precautions: An update for dentistry. *J Am Dent Assoc.* 141(5):572-581; 2010.
[jada.ada.org/article/S0002-8177\(14\)61533-6/abstract](http://jada.ada.org/article/S0002-8177(14)61533-6/abstract)

Hand Hygiene

Guidelines for Infection Control in Dental Health-Care Settings—2003
www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Table 2: Hand-hygiene methods and indications

Guideline for Hand Hygiene in Health-Care Settings
www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

CDC Hand Hygiene in Healthcare Settings Educational Materials
www.cdc.gov/handhygiene/

Personal Protective Equipment

Guidelines for Infection Control in Dental Health-Care Settings—2003
www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

Guidance for the Selection and Use of Personal Protective Equipment in Healthcare Settings: Slides and Posters
www.cdc.gov/hai/prevent/ppe.html

Respiratory Hygiene/Cough Etiquette

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

CDC Influenza (Flu) Resources for Health Care Facilities
www.cdc.gov/flu/professionals/infectioncontrol/

CDC Respiratory Hygiene/Cough Etiquette in Healthcare Settings
www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm

Sharps Safety

Guidelines for Infection Control in Dental Health-Care Settings—2003
www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program
www.cdc.gov/sharpsafety

CDC Sample Screening and Device Evaluation Forms for Dentistry
www.cdc.gov/OralHealth/infectioncontrol/forms.htm

Safe Injection Practices

Guidelines for Infection Control in Dental Health-Care Settings—2003
www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

CDC Injection Safety: Information for Providers—includes a list of frequently asked questions for providers and injection safety training video.
www.cdc.gov/injectionsafety

One and Only Campaign
www.oneandonlycampaign.org

Sterilization and Disinfection of Patient-Care Items and Devices

Guidelines for Infection Control in Dental Health-Care Settings—2003

www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Table 4: Infection-control categories of patient-care instruments

Appendix C: Methods for Sterilizing and Disinfecting Patient-Care Items and Environmental Surfaces

Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008

www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

Resources to assist in the event of a reprocessing error/failure

CDC Health Care Associated Infections, Outbreaks and Patient Notifications

www.cdc.gov/hai/outbreaks/outbreak-resources.html

Patel PR, Srinivasan A, Perz JF. Developing a broader approach to management of infection control breaches in health care settings. *Am J Infect Control*. 2008;36:685–690.

Rutala WA, Weber DJ. How to assess risk of disease transmission to patients when there is a failure to follow recommended disinfection and sterilization guidelines. *Infect Control Hosp Epidemiol* 2007;28:146—155.

Environmental Infection Prevention and Control

Guidelines for Infection Control in Dental Health-Care Settings—2003

www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Guidelines for Environmental Infection Control in Health-Care Facilities

www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008

www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

EPA Medical Waste Frequent Questions

www.epa.gov/osw/nonhaz/industrial/medical/mwfaqs.htm

EPA Where You Live—State Medical Waste Programs and Regulations

www.epa.gov/osw/nonhaz/industrial/medical/programs.htm

Dental Unit Water Quality

Guidelines for Infection Control in Dental Health-Care Settings—2003

www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

CDC Boil-Water Advisories and the Dental Office

<http://www.cdc.gov/oralhealth/infectioncontrol/faq/dentalunitwaterquality.htm>

For more information please contact

Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30329-4027
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348
E-mail: cdeinfo@cdc.gov
Web: www.cdc.gov/oralhealth
Publication date: March 2016

Continuing Education Tracking Services

Background:

After talking with an exhibitor who offers continuing education tracking services at the October AADB meeting, Dr. Rizkalla asked that this topic be included on the agenda of an upcoming meeting of the Board for discussion.

Materials Provided:

- Florida Board of Dentistry Continuing Education web page explaining the mandated tracking system provided by CE Broker.
- Kentucky Board of Dentistry Continuing Education web page explaining the mandated tracking system provided by The Dental Exchange.



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The Department of Health, Division of Medical Quality Assurance, will now review your continuing education records in the electronic tracking system at the time of renewal. It will happen automatically when you renew your license, but it is important that you understand how this simple change will affect the way you renew your license in the future.

If the practitioner’s continuing education records **are complete**, they will be able to renew their license without interruption.

If the practitioner’s continuing education records **are not complete**, they will be prompted to enter their remaining continuing education hours before proceeding with their license renewal.

Continuing Education Reporting Account Types

The Department’s Continuing Education Tracking system is powered by CEBroker

FREE “Just The Basics” Account – This account provides all the necessary tools for you to comply with the departments reporting requirements. You can view your basic course history, which will list the course name, educational provider name, date of completion and hours reported. It would then be up to you to determine whether all of the courses that have been reported will complete all of your specific continuing education requirements. You can also self-report any continuing education that may be missing.

[Free Account](#) →

Professional Account (*Paid Subscription – Optional*) – This account provides you with all of the tracking tools that CE Broker offers. Your transcript will display what your specific CE requirements are and will calculate what requirements have been met and what may still be outstanding. A Professional Account is a subscription service and is not a requirement but it can be a useful tool in managing your Florida continuing education requirements should you chose to subscribe. *This account offers a 7 day Free Trial. This is NOT the FREE account.*

[Professional Account](#) →

Please refer to Rule [64B5-12, F.A.C.](#) for additional continuing education information.

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Is my CE information in the electronic CE tracking system a public record?

Yes.

What is the difference in viewing my course history for free or subscribing to the continuing education tracking system?

With a free **Basic Account** you can view your basic course history, which will list the course name, educational provider name, date of completion and hours reported. It would then be up to you to determine whether all of the courses that have been reported will complete all of your specific continuing education requirements. You can also self-report any continuing education that may be missing. The Basic Account provides all the necessary tools for you to comply with the departments reporting requirements.

A Professional Account (paid subscription) provides you with all of the tracking tools that CE Broker offers. Your transcript will display what your specific CE requirements are and will calculate what requirements have been met and what may still be outstanding. A Professional Account is a subscription service and is not a requirement but it can be a useful tool in managing your Florida continuing education requirements should you chose to subscribe.

How will I know what has been reported?

You will be able to view your course history free of charge. Your course history will show all the courses that have been reported.

Do I have to subscribe to the electronic tracking system?

No, subscriptions remain optional. There are a number of services you can receive by subscribing, however, it is optional. You can always search for courses, report your hours, and view your course history free of charge by creating a Basic Account

Do I have to wait until license renewal to report my continuing education credits to the electronic tracking system?

No, you can report your hours free of charge anytime during the biennium. For more information please visit www.CEatRenewal.com. Please note, if you take a course from a Florida Board approved Provider they are required to report on your behalf. If you take a course from a National organization it is your responsibility to report completion. There may be other ways for you to obtain credit towards

continuing education required for license renewal. For specific approved methods of obtaining continuing education for your profession please review the Board rules by visiting www.flhealthsource.gov.

What will happen if I do not have the required continuing education for renewal?

Beginning in 2015 you will not be able to renew a license without having your continuing education reported into the continuing education tracking system. If you do not have the hours to report, your license will move to a delinquent status at expiration. In order to renew a delinquent license you will be required to complete the continuing education requirements. Additional fees may apply.

When will this change become effective?

Beginning with licenses expiring May 31, 2013, practitioners will be prompted to report continuing education credits during the renewal process.

Why is continuing education being verified at renewal?

Continuing Education is a requirement to renew a professional license. Section 456.025(7), F.S. requires the Department to implement an electronic continuing education tracking system for each biennial renewal cycle and to integrate such system into the licensure and renewal system.

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Continuing Education Requirements

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Reporting Continuing Education

All dentists and dental hygienists are required to complete 30 hours of continuing education every two years. If you are also licensed in another state, you must adhere to Kentucky Continuing Education requirements as well as the requirements of any state that you are licensed in. You must contact the other state licensing agencies regarding their requirements.

All dentists and dental hygienists must report their Continuing Education requirements through My CE Tool (<https://www.thedentalexchange.com/kentucky.html>).

[MY CE TOOL \(HTTPS://WWW.THEDENTALEXCHANGE.COM/KENTUCKY.HTML\)](https://www.thedentalexchange.com/kentucky.html)

Graduating During a Renewal Year

A student who graduates during a renewal year (i.e., Graduation Date June 2014 and Renewal is December 2014) are not required to complete additional continuing education. If a student graduates during a non-renewal year of that renewal cycle, (i.e., Graduation Date June 2014 and Renewal is December 2015) they are required to complete 15 continuing education hours.

Requirements for Dentists Under HB1

As a result of HB1, all licensed dentists in Kentucky must complete 3 hours of continuing education that relates to the use of the electronic monitoring system, pain management or addiction disorders prior to renewing their license December 31st of each renewal cycle (dentists renew on odd numbered years). The hours may be included in the 30 required hours and are not required additional hours.

Free Training

View online videos that fulfill 3 hours of continuing education requirement for HB1:

<http://www.cecentral.com/addictionky> (<http://www.cecentral.com/addictionky>)

Certificate Requirements

Licensees are required to obtain a certificate of attendance or completion to verify all continuing education hours, and to submit it to the Board if audited. These certificates must contain the following information:

- Signature of or verification by the provider
- Name of the licensee in attendance
- Title of the course or meeting attended or completed
- Date of attendance or completion
- Number of hours earned (based on clock hours of attendance)
- Evidence of the method of delivery if the course was taken in a live interactive presentation format.

Please see the following example if you have questions about what information should be in a continuing education certificate.

SAMPLE FORM (/DOCUMENTS/CESAMPLECERTIFICATE.PDF)

Frequently Asked Questions

Q: I wasn't aware of the new regulations. How were the dentists in Kentucky informed?

A: An email was sent to all dentists by KASPER and the Cabinet for Health and Family Services. The Kentucky Board of Dentistry supplied the KASPER office with all emails that were on file at the time for the dentists in the state.

Q: When did this law become effective?

A: The law became effective on July 20, 2012. There is a grace period that ends September 15, 2012 for all dentists to be registered with KASPER.

Q: I don't have a computer in my office, what do I do?

A: It is required by law that each office must have one computer with internet capabilities to access the KASPER website and run the KASPER report as well as a printer to print the KASPER results.

Q: When am I required to run a KASPER?

A: A KASPER report is required for all patients that a dentist prescribes schedule II, schedule III and specific schedule IV controlled substances (see Q# 6 below re exception for oral surgery).

Q: How often do I have to run a KASPER report to update a previous report?

A: KASPER reports should be updated every three months.

Q: What do I do if my patient is in pain?

A: If a dentist has performed oral surgery on a patient, they can prescribe a schedule III or schedule IV controlled substance for up to 72 hours without querying KASPER. In all other situations, a dentist must obtain a KASPER report before prescribing any schedule II, III and specific schedule IV medications to a patient.

Q: Is the dentist required to inform the patient that a KASPER report will be generated?

A: No.

Q: Are dentists required to keep the KASPER report in the patient record?

A: It is not a requirement, however it is recommended for documentation purposes. Additionally, if the patient is seen in the office more than one time during a three month period, the same KASPER report can be used. Updated 8/6/2015

Q: Informed Consents are required to be signed by patients. Is there a separate Informed Consent that is required for prescriptions given to patients?

A: Patients must consent to their treatment, which includes the medication being prescribed. This can be included on the same Informed Consent form.

Q: Is it required that post treatment instructions are included in the patient record?

A: It is not a requirement; however it is recommended in the event the dentist is asked to provide proof that it was provided at a later date.

Q: I'm a licensed Kentucky dentist, however I am in the military. Do I still need to register?

A: Yes, currently the law requires every Kentucky dentist who holds a DEA license to register with KASPER, whether or not you are currently practicing dentistry in Kentucky.

Q: Am I required to complete any continuing education requirements regarding these changes in House Bill 1?

A: Dentists are required to complete 3 hours of continuing education that relates to the use of the electronic monitoring system, pain management or addiction disorders prior to renewing their license December 31, 2013.

Q: Can an associate dentist write a refill for a patient if the associate dentist that treated the patient is not present?

A: Yes, provided the partner or associate perform an exam on the patient prior to prescribing the controlled substance. Additionally, if the KASPER is older than three months, an updated KASPER would need to also be obtained.

Q: I am a licensed dentist in Kentucky and am adhering to the new HB1 law. Occasionally the KASPER report takes an extended amount of time to process. Do you have any recommendations for this situation?

A: Although not a requirement, it is permissible to designate a staff member to obtain the KASPER reports in advance of the patient's appointment to alleviate this problem.

Q: If I run a KASPER on a patient and I feel that the patient may be abusing drugs, what should I do?

A: Speak to the patient in private. Explain to them that you have concerns about their health and welfare as a result of the information that was generated on the KASPER. You have the right to refuse to prescribe them a controlled substance. You can also contact the local law enforcement agency if you feel the need to do so.

Contact (<http://dentistry.ky.gov/Pages/contact.aspx>)

Site Map (<http://dentistry.ky.gov/Pages/sitemap.aspx>)

Board Member Access (<https://documentlibrary-edit.ky.gov/Dentistry%20Board%20Members/Forms/AllItems.aspx>)

Policies (<http://kentucky.gov/policies/Pages/default.aspx>)

Security (<http://kentucky.gov/policies/Pages/security.aspx>)

Disclaimer (<http://kentucky.gov/policies/Pages/disclaimer.aspx>)

Accessibility (<http://kentucky.gov/policies/Pages/accessibility.aspx>)



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Kentucky.gov (<http://www.kentucky.gov>)

Disciplinary Board Report for March 10, 2017

Today's report reviews the 2017 calendar year case activity then addresses the Board's disciplinary case actions for the second quarter of fiscal year 2017 which includes the dates of October 1, 2016 through December 31, 2016.

Calendar Year 2017

The table below includes all cases that have received Board action since January 1, 2017 through February 23, 2017.

| Calendar 2017 | Cases Received | Cases Closed No/Violation | Cases Closed W/Violation | Total Cases Closed |
|---------------|----------------|---------------------------|--------------------------|--------------------|
| January | 36 | 12 | 7 | 19 |
| February 23rd | 9 | 7 | 5 | 12 |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Totals | 45 | 19 | 12 | 31 |

Q2 FY 2017

For second quarter of 2017, the Board received a total of 37 patient care cases. The Board closed a total of 58 patient care cases for a 171% clearance rate, which is up from 107% in Q1 of 2017. The current pending caseload older than 250 days is 28%, which is up from 27% in Q1 of 2017. The Board's goal is 20%. In Q2 of 2017, 84 % of the patient care cases were closed within 250 days, whereas 75% of the patient care cases were closed within 250 days in Q1 of 2017. The Board's goal is 90% of patient care cases closed within 250 days.¹

License Suspensions

Between November 19, 2016 and February 23, 2017, the Board did not suspend any licenses or registrations.

¹ The Agency's Key Performance Measures.

- DHP's goal is to maintain a 100% clearance rate of allegations of misconduct through the end of FY 2017.
- The goal is to maintain the percentage of open patient care cases older than 250 business days at no more than 20% through the end of FY 2017.
- The goal is to resolve 90% of patient care cases within 250 business days through the end of FY 2017.

Board Member concerns

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

Virginia Department of Health Professions

Patient Care Disciplinary Case Processing Times:

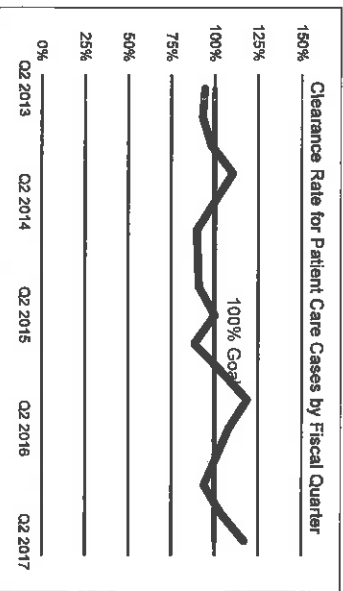
Quarterly Performance Measurement, Q2 2013 - Q2 2017

David E. Brown, D.C.
Director

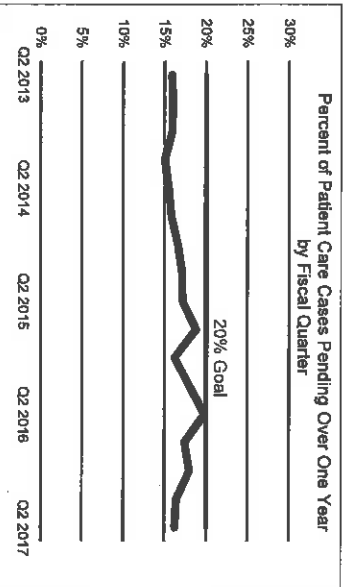
"To ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."
DHP Mission Statement

In order to uphold its mission relating to discipline, DHP continually assesses and reports on performance. Extensive trend information is provided on the DHP website, in biennial reports, and, most recently, on Virginia Performs through Key Performance Measures (KPMs). KPMs offer a concise, balanced, and data-based way to measure disciplinary case processing. These three measures, taken together, enable staff to identify and focus on areas of greatest importance in managing the disciplinary caseload: Clearance Rate, Age of Pending Caseload and Time to Disposition uphold the objectives of the DHP mission statement. The following pages show the KPMs by board, listed in order by caseload volume: volume is defined as the number of cases received during the previous 4 quarters. In addition, readers should be aware that vertical scales on the line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

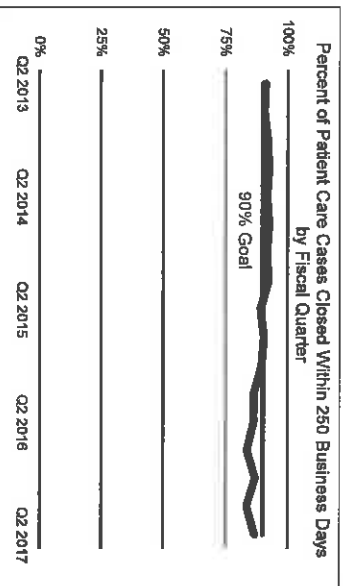
Clearance Rate - the number of closed cases as a percentage of the number of received cases. A 100% clearance rate means that the agency is closing the same number of cases as it receives each quarter. DHP's goal is to maintain a 100% clearance rate of allegations of misconduct. The current quarter's clearance rate is 117%, with 914 patient care cases received and 1069 closed.



Age of Pending Caseload - the percent of open patient care cases over 250 business days old. This measure tracks the backlog of patient care cases older than 250 business days to aid management in providing specific closure targets. The goal is to maintain the percentage of open patient care cases older than 250 business days at no more than 20%. The current quarter shows 16% patient care cases pending over 250 business days with 2,504 patient care cases pending and 406 pending over 250 business days.



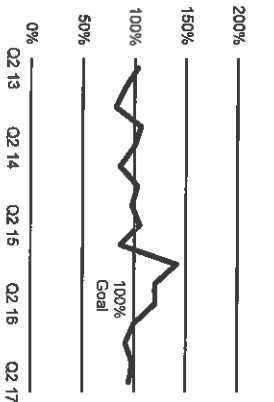
Time to Disposition - the percent of patient care cases closed within 250 business days for cases received within the preceding eight quarters. This moving eight-quarter window approach captures the vast majority of cases closed in a given quarter and effectively removes any undue influence of the oldest cases on the measure. The goal is to resolve 90% of patient care cases within 250 business days. The current quarter shows 87% percent of patient care cases being resolved within 250 business days with 1032 cases closed and 895 closed within 250 business days.



Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

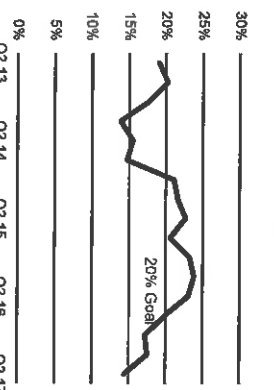
Medicine - In Q2 2017, the clearance rate was 95%, the Pending Caseload older than 250 business days was 14% and the percent closed within 250 business days was 95%.

Q2 2017 Caseloads:
 Received=305, Closed=290
 Pending over 250 days=84
 Closed within 250 days=266

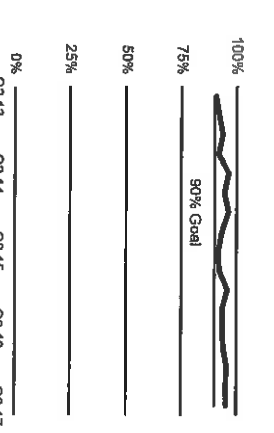


Clearance Rate

Age of Pending Caseload
 (percent of cases pending over one year)

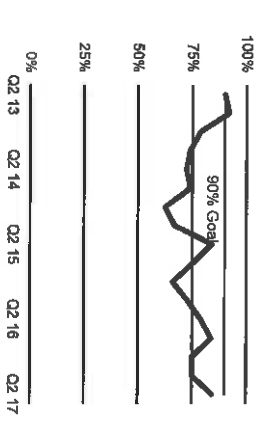
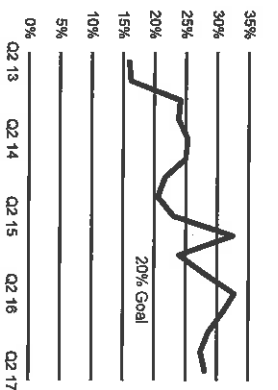
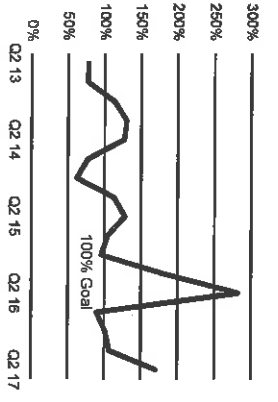


Percent Closed In 250 Business Days



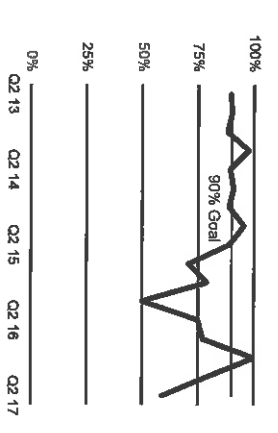
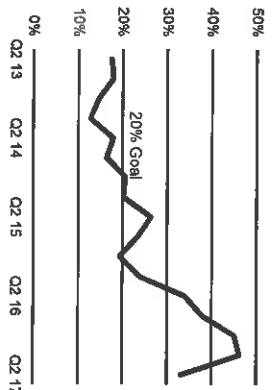
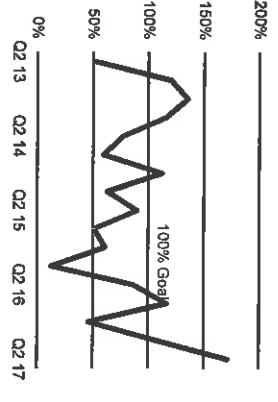
Dentistry - In Q2 2017, the clearance rate was 171%, the Pending Caseload older than 250 business days was 28% and the percent closed within 250 business days was 84%.

Q2 2017 Caseloads:
 Received=34, Closed=58
 Pending over 250 days=50
 Closed within 250 days=43



Pharmacy - In Q2 2017, the clearance rate was 172%, the Pending Caseload older than 250 business days was 33% and the percent closed within 250 business days was 59%.

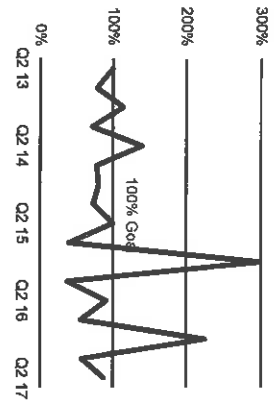
Q2 2017 Caseloads:
 Received=32, Closed=55
 Pending over 250 days=47
 Closed within 250 days=26



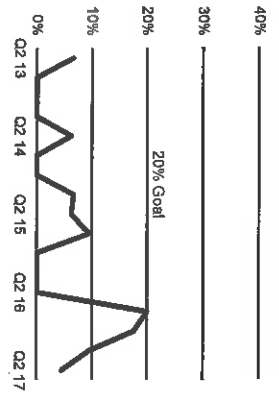
Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Clearance Rate

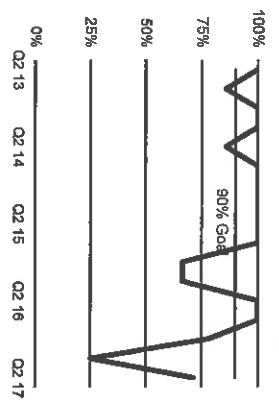
Physical Therapy - In Q2 2017, the clearance rate was 57%, the Pending Caseload older than 250 business days was 10% and the percent closed within 250 business days was 25%.
Q2 2017 Caseloads:
 Received=7, Closed=4
 Pending over 250 days=2
 Closed within 250 days=1



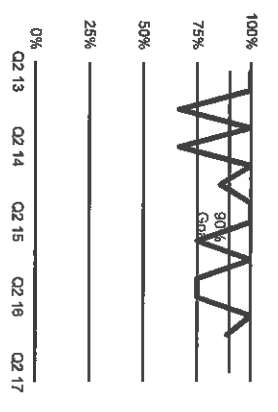
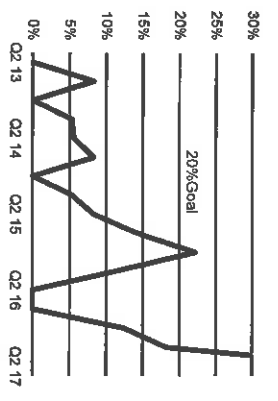
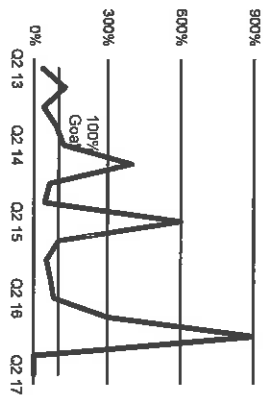
Age of Pending Caseload
(Percent of cases pending over one year)



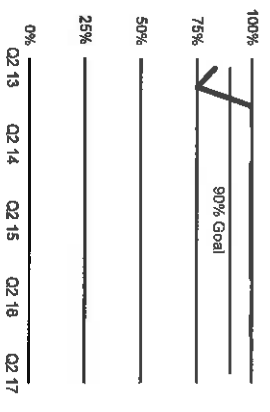
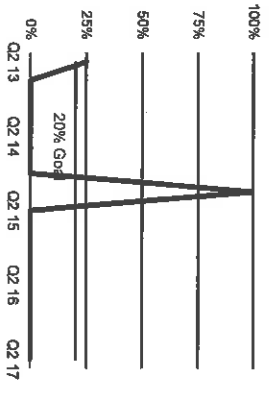
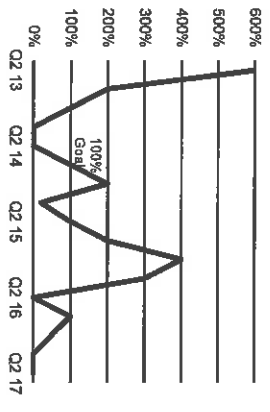
Percent Closed in 250 Business Days



Funeral - In Q2 2017, the clearance rate was 0%, the Pending Caseload older than 250 business days was 18% and the percent closed within 250 business days was N/A.
Q2 2017 Caseloads:
 Received=3, Closed=0
 Pending over 250 days=2
 Closed within 250 days=0



Audiology - In Q2 2017, the clearance rate was 0% the Pending Caseload older than 250 business days was 0% and the percent closed within 250 business days was N/A.
Q2 2017 Caseloads:
 Received=1, Closed=0
 Pending over 250 days=0
 Closed within 250 days=0



Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

62nd Southern Conference of Dental Deans and Examiners

1. This conference provided a platform for creative thinking by exploring technological advances that will facilitate learning and integrated digital curriculum development. Digital dentistry and computer-assisted learning represents cutting edge technologies that can vastly improve student restorative dentistry skills when imbedded in a comprehensive education program. These technologies provide computer-assisted assessments and immediate feedback which can optimize learning and educational outcomes. These technologies make truly objective assessments of student's performance.

This new approach is named "gamification." The **gamification** of learning is an educational approach to motivate students to learn by using video game design and game elements in learning environments. The goal is to maximize enjoyment and engagement through capturing the interest of learners and inspiring them to continue learning.

2. This conference also covered the factors and trends on dental education and practice for the future. For example, the average 2016 educational debt is approximately \$262,119 which is the sum of education debt incurred before and during dental school. For all students, including those with no debt the sum is \$219,463.

For the 2016 dental school graduating class, approximately 50.5% intended to go into private practice- 42% as an associate dentist in an existing private practice with a sole proprietor and 14.5% employed in a corporate-owned group practice. Further, 33.8% of 2016 dental school graduates intended to continue on to a dental graduate program.

In 2015-16, the first-year enrollment in accredited allied dental education programs consisted of 6875 in dental assisting and 8279 in dental hygiene.

3. Finally, another discussion was had about the pathways to licensure widening and how the ADEA strongly supports continued efforts to increase the portability of licensure and to promote the adoption of alternative pathways to licensure that eliminate the patient-based component of the licensure exam.

Correspondence to DOCS

Background:

After conferring with Board Counsel and the Board President, Ms. Reen sent a request to DOCS Education asking for immediate action to correct misinformation contained in the recent advertisement DOCS targeted to dentists in Virginia. Essentially, DOCS falsely claims that its 24-hour course offering still meets the BOD's education requirement for obtaining an enteral conscious/moderate sedation permit in Virginia. DOCS has been asked to provide the BOD with a copy of the corrective action it takes. In addition, a notice has been added to the BOD's Applications and Forms web page stating the current education requirement is addressed in the October 2016 ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.

Materials Provided:

A document which includes the DOCS course announcement and the request that DOCS take steps to address the misinformation.

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Friday, February 24, 2017 12:10 PM
To: 'John Bitting'
Subject: Request for Correction of Misinformation

Importance: High

Dr. Silverman and Mr. Bitting:

On behalf of the Virginia Board of Dentistry, I am requesting that you take immediate steps to correct misinformation contained in the DOCS Education Course advertisement below which was issued on behalf of Dr. Silverman for dentists in Virginia. The current Virginia **Regulations Governing the Practice of Dentistry** require applicants for a conscious/moderate sedation permit to administer by only an enteral method to meet the education requirement in section 18VAC60-21-290.D.2 which states as follows:

Enteral administration only. A dentist may be issued a conscious/moderate sedation permit to administer only by an enteral method if he has completed a continuing education program that meets the requirements of 18VAC60-21-250 and consists of not less than 18 hours of didactic instruction plus 20 clinically oriented experiences in enteral or a combination of enteral and nitrous oxide/oxygen conscious/moderate sedation techniques. The course content shall be consistent with the ADA's Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry in effect at the time the training occurred. The certificate of completion and a detailed description of the course content must be maintained.

I have highlighted the sentence that expressly requires courses to be consistent with the ADA Guidelines in effect at the time the training occurs which means any moderate sedation course taken after October 2016 must meet the course requirements of the October 2016 Guidelines. This means the information in the first two paragraphs in the DOCS Education Course advertisement below is not correct. The advertisement fails to consider and address the current regulations of the Virginia Board of Dentistry which will be applied to applicants for a conscious/moderate sedation permit. Please take immediate action and send me a copy of the corrective action you take in this matter.

Also, please be aware that the following notice is now posted on the Applications and Forms page of the Board of Dentistry's website.

NOTICE: The [Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students](#) adopted by the American Dental Association in October 2016 detail the current education standards for a moderate sedation course. The October 2016 Guidelines no longer include provisions for a course to administer only by an enteral method. Any moderate sedation course taken on or after November 1, 2016 must meet the October 2016 Guidelines in order for an applicant to qualify for a conscious/moderate sedation permit in Virginia. These Guidelines must be met to qualify to administer by any method and to qualify to administer by an enteral method only. Please download the Guidelines [using this link](#).

Please contact me by return email if you have any questions about Virginia's requirements for a conscious/moderate sedation permit.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, VA. 23233

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From: mailer@infusionmail.com [mailto:mailer@infusionmail.com] **On Behalf Of** Michael Silverman
Sent: Monday, February 13, 2017 12:05 PM
To: Reen, Sandra (DHP) <Sandra.Reen@DHP.VIRGINIA.GOV>
Subject: Sedation Dentistry may be changing forever

Regulatory Compliance Alert for VA Dentists

On October 24th, the ADA House of Delegates voted to *demolish* oral sedation dentistry with new guidelines eliminating moderate oral sedation. If adopted by the Virginia dental board, dentists will be required to take a 60-hour course plus 20 live patient experiences to continue to offer this care.

WHAT CAN YOU DO? For a limited time the new ADA guidelines provide a **grandfather clause** allowing dentists who complete training under the previous guidelines (24 credit hour course with 3 live patients plus ACLS certification) to be fully credentialed without a new 60-hour course.

Attend a DOCS Education Course before it's too late!

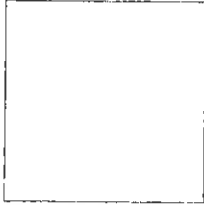
Clinically-tested and up-to-date minimal and moderate oral sedation techniques are being taught at training programs in Reston, VA (May 19-21, 2017) to meet these requirements.

These AGD PACE-approved courses provide a total of at least 24 hours of CE per location and may be used to fulfill CE requirements for license renewal.

REGISTER NOW: 877-719-5259 or DOCSeducation.org

To learn more and receive alerts on regulation changes in your state, go to SedationRegulations.com/VA.

This announcement is a service of DOCS Education to dentists in Virginia



**DOCS Education
106 Lenora Street
Seattle, WA 98129
T: 877-719-5259**

If you no longer wish to receive our emails, click the link below:

[Unsubscribe](#)

Strategic Dentistry 106 Lenora Street Seattle, Washington 98121 United States