

VIRGINIA BOARD OF DENTISTRY

December 14, 2018 AGENDA

Department of Health Professions

Perimeter Center - 2nd Floor Conference Center, Board Room 4

9960 Mayland Drive, Henrico, Virginia 23233

Board Business

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9:00 a.m. Call to Order – Dr. Tonya A. Parris-Wilkins, President	
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Public Comment – Dr. Parris-Wilkins	
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- **Status of Regulatory Actions** **PG. 84**
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 - **Adoption of proposed regulations for use of dental specialties** **PG. 153**
 - **Adoption of proposed regulations for change in renewal schedule** **PG. 256**
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 - **Adoption of NOIRA for required content of examination** **PG. 291**
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- **Public Comment**
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 - **60-15 – Standards for Professional Conduct in the Practice of Dentistry** **PG. 314**
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Deputy Executive Report/Business – Ms. Palmatier

- **Disciplinary Activity Report** **PG. 323**

Board Counsel Report– Jim Rutkowski

- **A1C Diabetes Testing**

Executive Director’s Report/Business – Ms. Reen

Calibration Exercise

Service Recognition Lunch

14259 Riverside Dr,
Ashland, Va, 23005

9-11-18

Dr. John Alexander and
Board of Dental Examiners
State of Virginia
9960 Magland, Dr.
Henrico, Va 23233

RECEIVED
SEP 11 2018
Virginia Board of Dentistry

~~Dear John and Board:~~
^{PAGE 1}

On Dec 15, 2017 I made a presentation to the Board asking for the endorsement of periodic testing to help diagnose and prevent the problem of 440,000 deaths by errors in U.S. hospitals. I have not had any reply. If the Board does not like the concept of periodic testing I would like to know why.

Periodic testing has worked well for commercial airlines, and in 2017 they did not have one crash in the entire world. This is in contrast to healthcare errors which cause the equivalent of ten 737 crashes a day in the USA alone.

I also made the same plea before the Board 18 years ago. How many more must die before something proven to work will be tried?

2.

Ignoring the problem is not a solution. Ignoring the opioid problem for years didn't solve that problem, and instead, made it into a tragic epidemic.

Ignoring the error death problem seems more like a dereliction of duty and an irresponsibility to protect the public. We can't abandon the patients to errors for another 18 years and call ourselves a profession.

To help focus your priorities, try to think of what you are currently working on that is more important than 440,000 lives.

How has something so huge and visible to the public managed to escape the scrutiny of the State Board for 18 years?

It would help with the problem if the Board members could list why they do not like periodic testing and sign, so I can get back with the individuals to correct any misconceptions.

Sincerely,
John W. Wittrock

From: McGraw, Marina D. <mmcgraw@nvcc.edu>
Sent: Tuesday, July 24, 2018 6:08 PM
To: sandra.reen@dhp.virginia.gov
Subject: Blood Glucose testing letter of support

Hi Sandra,

Please find attached a letter of support for chairside Blood Glucose testing as well as an article stating the connection between periodontal disease and diabetes.

Thanks

Ms. Marina D. McGraw, RDH, BSHS, MHA
Program Director- Dental Hygiene
Northern Virginia Community College

July 12, 2018

To whom it may concern:

I am writing in reference to Dr. Marioneaux's petition to the Board of Dentistry regarding the chairside Blood Glucose screening. I concur that this additional measure would prove to be integral for comprehensive, quality and safe care for the patients of the Commonwealth of Virginia.

As a Registered Dental Hygienist with 18 ½ years' experience in private practice and now as an educator of future Registered Dental Hygienists, having knowledge of a patient's health status is vitally important for oral healthcare providers. This knowledge of the patient's health status wouldn't only allow for a customized treatment plan to meet their oral health needs; it would lend itself to improving over-all wellness by potentially improving early diagnosis rates. In addition to this, it could potentially prevent any unnecessary medical emergencies occurring during treatment of diabetic patients when Blood Glucose levels are either elevated or low.

In our curriculum at Northern Virginia Community College, treatment of the diabetic population is discussed in the following, but not limited to, DNH 120, DNH 145, DNH 146, DNH 235, DNH 244, DNH 245. In addition to the topic being discussed in these courses, the program also has Student Learning Outcomes applicable to the care of diabetic patients such as: Plan and document a patient's treatment needs, Evaluate the outcomes of treatment for determining a patient's subsequent treatment needs and Communicate the provision of oral health care services with diverse population groups.

Research has shown a correlation between periodontal disease and diabetes, it is imperative oral health care providers have every opportunity to provide the most comprehensive care to yield the best opportunity for health, oral and overall for this population. The Blood Glucose screening would improve this opportunity.

I have provided in this letter an example of what is taught in DNH 244, see below. Also, I have included with this letter an article detailing the relationship between periodontal disease and diabetes.

I appreciate your consideration of this petition so that oral healthcare providers in Virginia have the opportunity to offer detailed comprehensive care to improve the health of the patients of the Commonwealth.

Sincerely,



Marina D. McGraw, RDH, BSHS, MHA

DNH 244

The patient with diabetes mellitus

1. Identify and define key terms and concepts related to diabetes.
2. Explain the function and effects of insulin.
3. Identify risk factors for diabetes.
4. List etiologic classifications, signs and symptoms, diagnostic procedures, complications, and common medical treatment for diabetes.
5. Relate the appropriate management of a diabetic emergency.
6. Explain the relationship between diabetes and oral health.
7. Plan dental hygiene care and oral hygiene instructions for patients with diabetes.

The Diabetes Patient

A. Diabetes Mellitus

1. Definition
2. Impact

B. Insulin

1. Definition
2. Description
3. Functions
4. Effects of Decreased Insulin (Type 1 Diabetes)
5. Effects of Decreased Action of Insulin (Type 2 Diabetes)
6. Insulin Complications

C. Diabetes Mellitus Etiologic Classification

1. Type 1
2. Type 2
3. Gestational Diabetes Mellitus
4. Other Specific Types of Diabetes

D. Diagnosis of Diabetes

1. Symptoms Suggestive of Diabetes
2. Diagnostic Tests

E. Complications of Diabetes

1. Infection
2. Peripheral Neuropathy
3. Autonomic Neuropathy
4. Nephropathy
5. Retinopathy
6. Cardiovascular Disease
7. Amputation
8. Pregnancy Complications
9. Psychosocial
10. Silent Killer

F. Medical Treatment and Modifications for Diabetes Control

1. General Procedures
2. Instruction
3. Exercise
4. Diet
5. Habits

G. Medications

1. Insulin Therapy
2. Oral Hypoglycemic Agents

H. Pancreas Transplantation

I. Blood Glucose Testing

1. Self-Administered Tests
2. Laboratory Test

J. Oral Relationships

1. Periodontal Involvement
2. Other Oral Findings
3. Endodontic Infections
4. Dental Implants

K. Dental Hygiene Care Plan

1. Patient History
2. Consultation with Physician

3. **Appointment Planning**
4. **Clinical Procedures**
5. **Maintenance Phase**

From: Baumann, Cathy [mailto:baumannca@ada.org]

Sent: Friday, June 29, 2018 7:56 AM

To: denbd@dhp.virginia.gov

Subject: Communication from the National Commission on Recognition of Dental Specialties and Certifying Boards

Good Morning-

The National Commission on Recognition of Dental Specialties and Certifying Boards held its inaugural meeting on May 9-10, 2018. At this meeting, the National Commission adopted formal policies and procedures related to all aspects of the recognition process.

Please find attached communication from Dr. Charles Norman, chair, National Commission on Recognition of Dental Specialties and Certifying Boards related to the roles and duties of the National Commission with regard to the recognition of dental specialties and their respective certifying boards.

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

Cathy

Catherine Baumann, M.A.P.S. baumannca@ada.org

Director, National Commission on Recognition of Dental Specialties and Certifying Boards

Education

312.440.2697

American Dental Association 211 E. Chicago Ave. Chicago, IL 60611 www.ada.org



National Commission on Recognition of Dental Specialties and Certifying Boards

June 29, 2018

Dr. John Alexander
President
Virginia Board of Dentistry
9960 Maryland Drive, Suite 300
Henrico, VA 23233

Dear Dr. Alexander,

As you are aware, in late 2016, the American Dental Association (ADA) Board of Trustees charged the Task Force on Specialty and Specialty Certifying Board Recognition to evaluate the process and criteria by which specialties and specialty certifying boards were recognized. The ADA Board of Trustees agreed with the findings of the Task Force that the establishment of the National Commission on Recognition of Dental Specialties and Certifying Boards would enhance the recognition program that sets requirements designed to help dentists excel throughout their careers and the public ascertain the importance of educated and board certified dental specialists.

With adoption of the ADA Board of Trustees Report 7 to the ADA House of Delegates and Resolution 30H-2017, the House of Delegates established the National Commission on Recognition of Dental Specialties and Certifying Boards. In Resolution 30H-2017, the ADA House of Delegates adopted the following roles of the National Commission:

- Establishment of the National Commission reduces the potential or perceived bias or conflict of interest in the decision-making process for recognizing dental specialties and is intended to emulate the process for the recognition of specialties and certifying boards in other health professions.
- The National Commission will set requirements designed to help dentists excel throughout their careers. Those requirements will also be designed to help the public ascertain the importance of educationally qualified and board certified dental specialists.
- The duties of the National Commission are specific to the recognition of dental specialties and certifying boards and in accord with the *ADA Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialties* and provisions for appealing an adverse action.

The National Commission on Recognition of Dental Specialties and Certifying Boards held its inaugural meeting May 9-10, 2018. At this meeting, the National Commission adopted formal policies and procedures related to, all aspects of the recognition process. The *Rules* of the National Commission, along with the *Policy and Procedure Manual*, are attached and will be posted on the National Commission's website.

211 E. Chicago Avenue, Suite 600, Chicago, IL 60611
Main: 312-440-2897 ADA.org/NCRDSCB

From: nbexams <nbexams@ada.org>

Sent: Wednesday, July 18, 2018 3:05 PM

Subject: Formal Notification of the INBDE, on behalf of Dr. Lisa Heinrich-Null

The attached communication is a formal notification that the Integrated National Board Dental Examination (INBDE) will be available for administration beginning on August 1, 2020. The NBDE Part I will be discontinued on July 31, 2020, and the NBDE Part II will be discontinued on August 1, 2022.

The JCNDE requests your assistance in communicating relevant INBDE information to those who would benefit from this information. Any questions regarding this notification can be directed to the Joint Commission via nbexams@ada.org.

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

Date: July 18, 2018
To: Stakeholders and Communities of Interest
From: Dr. Lisa Heinrich-Null, Chair, Joint Commission on National Dental Examinations
Subject: Notice of INBDE Implementation and NBDE Discontinuation

In 2009, the Joint Commission on National Dental Examinations ("Joint Commission") initiated formal efforts to begin development of an examination program that integrates content from the biomedical, behavioral, and clinical sciences, to replace National Board Dental Examination (NBDE) Parts I and II. The purpose of the Integrated National Board Dental Examination (INBDE) mirrors that of the NBDE Program: to assist dental boards in determining the qualifications of individuals who seek licensure to practice dentistry. Throughout its development the INBDE has been focused on the clinical relevance of examination content, and the corresponding clinical relevance of the biomedical sciences. The INBDE is the product of a comprehensive strategic planning process, and years of rigorous psychometric research that have resulted in a substantial amount of evidence that supports usage of this examination in the licensure decision making process of dental boards.

This communication provides the Joint Commission's official notification to your organization that the INBDE will be available for administration beginning on August 1, 2020. Concomitantly, the NBDE Part I will be discontinued as of the day prior (July 31, 2020). The NBDE Part II will be discontinued two years later, on August 1, 2022. No further administrations of the NBDE will be provided after the aforementioned dates. The Joint Commission first announced anticipated details of the INBDE Implementation Plan on March 13, 2016, and the current schedule of activity is in accordance with those announced details. The Joint Commission's website (www.ada.org/JCNDE/INBDE) contains the INBDE Implementation Plan, as well as a tremendous amount of information concerning validity evidence for the INBDE, activity timelines, etc.

The INBDE Implementation Plan provides information concerning the dates of implementation, how implementation will occur, and general guidance on how best to prepare. In reviewing this plan, the Joint Commission recommends your organization take into consideration any modifications and/or adjustments that may be necessary to accommodate the discontinuation of NBDE Parts I and II. This Implementation Plan will be updated regularly so it remains current, as the Joint Commission responds to inquiries and releases any additional information to help stakeholders and communities of interest with the transition.

The INBDE Retest Policy and Candidate Eligibility document provides an example of a document that was created to help facilitate the transition to the INBDE. This document provides additional guidance through the clarification of retest policies and unique issues that will be present during the transition period. Candidates are advised to consider their available options well in advance of testing. Dental school faculty will also find this information useful in advising students and considering administrative or academic policy changes that may be needed.

JCNDE JOINT COMMISSION
ON NATIONAL
DENTAL EXAMINATIONS

The Joint Commission requests your assistance in communicating relevant INBDE information to those who would benefit from this information. The Joint Commission will continue to provide updates to help facilitate this transition as information becomes available. Please review and monitor INBDE information on the Joint Commission's website (www.ada.org/JCNDE/INBDE). Any questions regarding this notification can also be directed to the Joint Commission via nbexams@ada.org.

Sincerely yours,



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

Integrated National Board Dental Examination (INBDE) Quick Facts

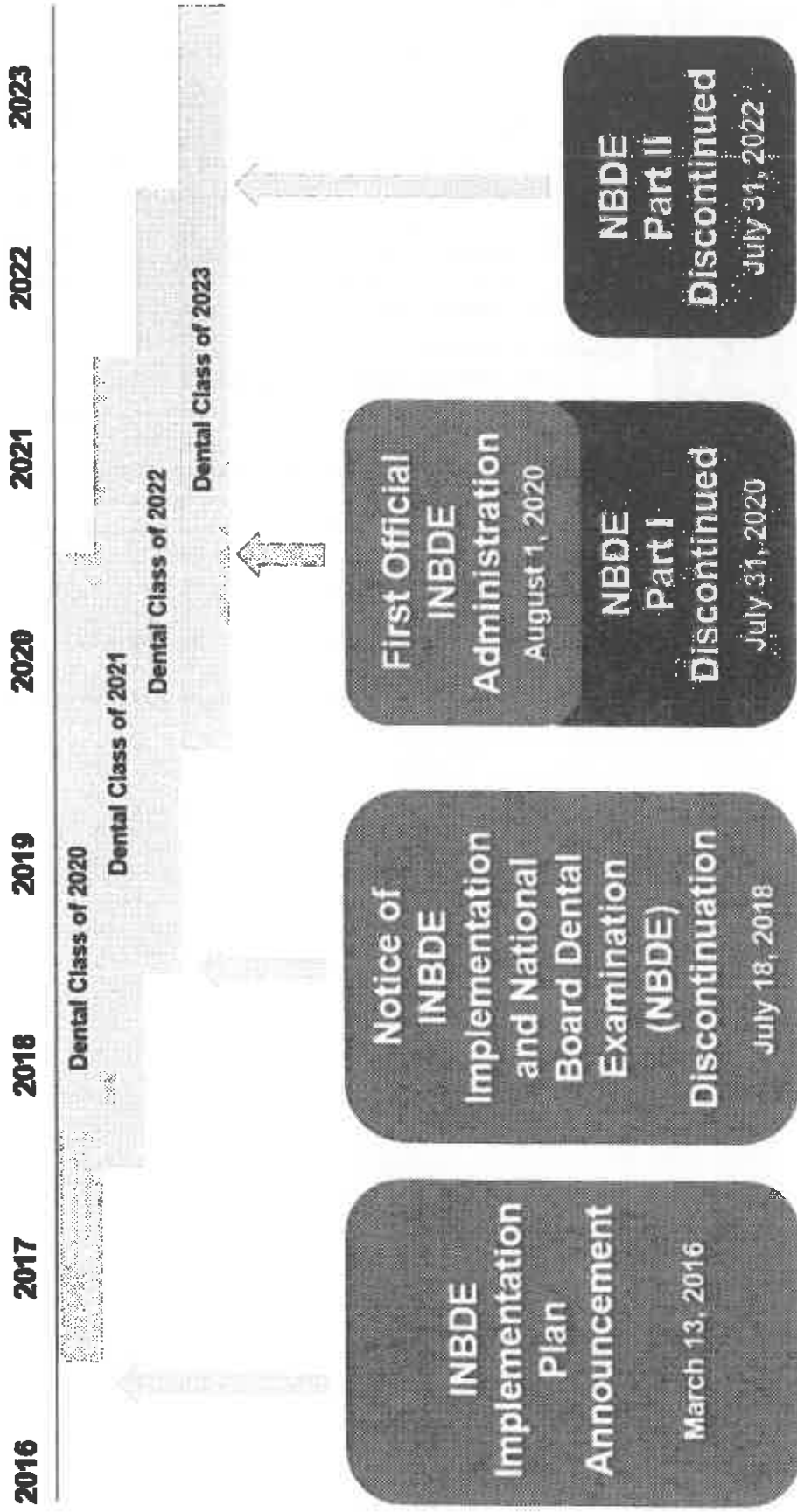
Name of Examination	<p>As presented on the JCNDE website, for purposes of administering the examination:</p> <p>Prior to Aug. 1, 2022:</p> <p style="text-align: center;">The Integrated National Board Dental Examination</p> <p>Aug. 1, 2022 and beyond:</p> <p style="text-align: center;">The National Board Dental Examination (NBDE)</p> <p>As presented on the Department of Testing Services' Results Reporting Hub ("DTS Hub"), for purposes of reporting candidate results to dental boards and schools:*</p> <p style="text-align: center;">The National Board Dental Examination (NBDE)</p> <p>*The DTS Hub will make no distinction between the NBDE and the INBDE.</p>
First Date of Availability	<p>August 1, 2020*</p> <p>*NBDE Parts I and II will be discontinued July 31, 2020 and July 31, 2022, respectively.</p>
Content Domain and Test Specifications	<p>The INBDE is designed to evaluate dental candidate cognitive skills based on the JCNDE's Domain of Dentistry: https://www.ada.org/~media/JCNDE/pdfs/domain_of_dentistry_july2018.pdf?la=en</p> <p>The INBDE Test Specifications can be downloaded here: https://www.ada.org/~media/JCNDE/pdfs/inbde_test_specs_july2018.pdf?la=en</p>
Sample Questions	<p>Sample INBDE questions can be obtained here: http://www.ada.org/~media/JCNDE/pdfs/INBDE_practice_questions.pdf?la=en</p>
Eligibility	<p>INBDE eligibility rules for students of U.S. dental schools accredited by the Commission on Dental Accreditation (CODA) are determined by each dental school. Each school at its discretion may also institute its own specific requirements pertaining to the examination.</p>
Administration	<p>The INBDE will contain 500 questions and require 1 ½ days to administer. Administrations will occur at professional testing centers located throughout the US and Canada. The INBDE Candidate Guide will be made available December 2019. The INBDE Candidate Guide will also provide information concerning the test administration vendor.</p>
Cost of Administration	<p>The cost of administration will be communicated in December 2019.</p>

<p>General Policies and Procedures</p>	<p>Unless stated otherwise, INBDE policies and procedures are anticipated to be fully consistent with the policies and procedures of the National Board Dental Examination and National Board Dental Hygiene Examination. This includes, for example, policies concerning examination conduct and appeals.</p>
<p>Results Reporting</p>	<p>Candidate Results. INBDE results will be reported as Pass/Fail. For remediation purposes, candidates who fail the examination will be provided with information concerning their performance in the following areas:</p> <ul style="list-style-type: none"> • Overall results • Diagnosis and Treatment Planning • Oral Health Management • Practice and Profession • Molecular, biochemical, cellular, and systems-level development, structure and function • Physics and chemistry to explain normal biology and pathobiology • Physics and chemistry to explain the characteristics and use of technologies and materials • Principles of genetic, congenital and developmental diseases and conditions and their clinical features to understand patient risk • Cellular and molecular bases of immune and non-immune host defense mechanisms • General and disease-specific pathology to assess patient risk • Biology of microorganisms in physiology and pathology • Pharmacology • Sociology, psychology, ethics and other behavioral sciences • Research methodology and analysis, and informatics tools <p>School Results. Candidates' pass/fail status will be reported through the DTS Hub. Monthly and annual school reports will also be available through the DTS Hub.</p> <p>State Board Results. Candidates' pass/fail status will be reported through the DTS Hub. The DTS Hub will indicate whether a candidate has met or not met the National Board Dental Examination cognitive skills requirements for dentistry (i.e., no distinction will be made among Part I, Part II, or the INBDE).</p>
<p>Retesting Policy (Transition Policy)</p>	<p>The INBDE Retest Policy is available here: http://www.ada.org/~media/JCNDE/pdfs/inbde_retest_policy_and_eligibility.pdf?la=en</p> <p>The focal aspects of the policy are as follows:</p> <ul style="list-style-type: none"> • Candidates who have passed may not retake the examination unless required by a state board or relevant regulatory agency. • Candidates who have not passed may apply for re-examination. An examination attempt is defined as any examination administration where the candidate has been seated at a computer at a test center, and electronically agreed to the confidentiality statement to start the examination. • Candidates must wait a minimum of 90 days between test attempts. • Candidates are encouraged to seek formal remediation before re-examination. • Under the JCNDE's 5 Years/5 Attempts Eligibility Rule, candidates must pass the examination within a) five years of their first attempt or b) five examination attempts, whichever comes first. Subsequent to the fifth year or fifth attempt, failing candidates may test once every 12 months after their most recent attempt.

JCNDE JOINT COMMISSION
ON NATIONAL
DENTAL EXAMINATIONS

Dental Boards	Candidates should contact the dental boards of each state to understand state requirements and the acceptability of the INBDE. With respect to administration timing, the JCNDE has received informal feedback suggesting a general preference for candidates to complete the examination in close proximity to when they are applying for licensure.
History of Development	<p>INBDE development was initiated in 2009 with the formation of a Committee for an Integrated Examination (CIE). The INBDE has made steady and consistent progress since that time. Background information on INBDE development is available here: http://www.ada.org/en/jcnde/inbde</p> <p>A specific timeline of activity can be found here: http://www.ada.org/en/jcnde/inbde/inbde-timeline</p>
Validity and Technical Information	The INBDE Technical Report will be available in the coming months.
Additional Information	<p>Please see the INBDE website: http://www.ada.org/jcnde/inbde</p> <p>The JCNDE can also be reached via the following email address: nbexams@ada.org</p>

INBDE Implementation Plan (Final)



PPT: July 2018



October 17, 2018

Virginia Board of Dentistry, Department of Health Professions
Attn: Sandra Reen, Executive Director; Elaine Yeatts, Senior Policy Analyst
Via Email

Re: Diabetes screening by dental professionals

The Virginia Dental Hygienists Association (VDHA) supports adding to the permitted duties of a dentist and dental hygienist the ability to perform the necessary screening tests to identify those at risk for diabetes. Oral health is a crucial part of overall health. Dentists and dental hygienists serve an important role in regular preventive interactions with patients. We are uniquely positioned to collaborate with other health professionals in screening for possible chronic medical conditions and referring at-risk patients to appropriate medical care.

One of the most common preventable chronic diseases is diabetes. According to the Centers for Disease Control and Prevention (CDC), more than 100 million U.S. adults are now living with diabetes or prediabetes. As of 2015, 30.3 million Americans have diabetes. Another 84.1 million have prediabetes, a condition that if not treated often leads to type 2 diabetes within five years. Diabetes was the seventh leading cause of death in the U.S. in 2015.

At the same time, many people – including at-risk individuals – who do not seek regular primary health care do, however, seek dental care. Dentists and dental hygienists under their supervision have extensive experience in certain medical screenings and are alert to clinical evidence that indicates possible illness. Dental hygienists are at the front lines of patient interaction in dental care. In addition to the standard procedures dental hygienists perform, we provide direct support to dentists as they perform any necessary screenings and procedures. Dental hygiene students receive training in screening tests and directly assist dentists in the collection of screening data and patient information.

As you know, screening procedures are not diagnostic but rather aim to determine the likelihood of already high-risk patients of having a certain disease. Early detection is critical in prevention and reduction of morbidity or mortality. Patients who have a positive result from screening tests are referred to appropriate medical professionals for further evaluation, diagnosis and treatment.

We understand the Virginia Dental Association (VDA) has also submitted a statement of support. We have reiterated and associate ourselves with the VDA's comments, and join our dental colleagues in urging the Board of Dentistry to allow dentists and dental hygienists the ability to perform the necessary screening tests to identify those individuals at risk for diabetes.

Please contact us with any questions or for more information. Thank you for your consideration.

Sincerely,

Emilie Bonovitch,
VDHA President

Cc: Cal Whitehead and Mark Hickman, Commonwealth Strategy Group



September 3, 2018

Terry Dickinson, DDS
Virginia Dental Association
3460 Mayland Court, #110
Henrico, VA 23233

Dear Dr. Dickinson:

The Virginia Diabetes Council is writing to express the unanimous support of its Board of Directors for the Virginia Dental Association's effort to add diabetes pre-screening to the permitted duties of dentists and dental hygienists. We understand that the VDA will be seeking this authority at the September 2018 meeting of the Board of Dentistry, and as an organization dedicated to lifting the burden of diabetes across the State of Virginia, we are in complete concurrence with your proposal.

As you have indicated in your request to the Board of Dentistry, 30 million Americans have diabetes, and approximately one in four of these individuals is unaware of the debilitating health condition that lies undiagnosed. While many of these individuals do not have a primary medical care provider, they do seek dental care. This enables dental care providers to be the first line of defense for many who are at risk of diabetes with a simple screening test. When individuals with positive screenings are identified, they can be referred for further evaluation to the appropriate health care professional, thereby lessening the chance of suffering from the multitude of debilitating health issues brought about by diabetes.

The Virginia Diabetes Council (www.virginiadiabetes.org) is an organization of volunteers composed of diabetes educators, health care providers, and community agencies offering diabetes prevention and other educational programs. Our members are ready to assist the VDA as they move forward with this critical, life-saving endeavor, should the Board of Dentistry approve this request.

If we can provide further information, or be of support to the Virginia Dental Association, please do not hesitate to contact me.

Sincerely yours,

Julia M. Groom

Julia M. Groom
Executive Director,
Virginia Diabetes Council

julia@virginiadiabetes.org
804.837.7442



American Medical College's Center for Workforce Studies estimates that by 2020, the United States will face a shortage of 45,000 primary care physicians and 45,100 medical specialists. These workforce estimates take into account an aging physician workforce.

Rural and urban inner-city areas already have an inadequate physician workforce or are experiencing difficulty with access. Across the United States there are 5,800 designated medical primary care Health Professional Shortage Areas (HPSA) according to 2013 U.S. Department of Health and Human Services data. Since the primary care physician workforce is projected to be inadequate to meet demand in 2020, the dental profession may be positioned with an opportunity to practice at its full scope. The dental setting could serve as an early resource for identification of patients at increased risk of chronic diseases and serve as an entry point in the medical care system.

Prevalence of Chronic Disease: Chronic conditions and diseases are the leading cause of death and disability in the United States. The most common, costly and preventable chronic diseases are diabetes, obesity, heart disease, stroke, cancer and arthritis. Forty-seven percent of U.S. adults had at least one of the risk factors for heart disease or stroke (uncontrolled high blood pressure, high Low-Density Lipoprotein (LDL) cholesterol or smoking). As of 2012, 50% of all adults (17 million people) had one or more chronic health conditions. One in four Americans has multiple chronic disease conditions, requiring ongoing medical attention. That number increases to three in four Americans aged 65 and older. Having multiple chronic conditions is also associated with substantial health care costs. Approximately 71% of the total health care spending in the United States is associated with care for Americans with more than one chronic condition.

According to the Centers for Disease Control and Prevention's (CDC's) 2014 National Diabetes Statistics Report, 29.1 million Americans, or one out of every eleven people have diabetes, and, of these, one out of four people do not know they have diabetes. The CDC states 86 million people have pre-diabetes, or more than one out of three adults; of these, nine out of ten do not know they have pre-diabetes. Fifteen to thirty percent of the people with pre-diabetes will develop Type 2 diabetes within five years. A recent ADA study found that federal and state health care savings could reach \$42.4 million to \$102.6 million each year by having dentists conduct screenings for diabetes, high blood pressure and cholesterol in the dental practice. The estimated health care savings was dependent on patients completing their referral to a physician and starting pharmacological treatment.

The Virginia Dental Association believes its members could, and should, be a part of this effort to identify those with pre-diabetes in particular and in those who are currently undiagnosed with frank diabetes. We would urge this board to add to the permitted duties of a dentist and dental hygienist the ability to perform the necessary screening tests to identify those at risk and refer to the appropriate medical professional.

Terry D. Dickinson, D.D.S.
Executive Director, VDA



Virginia Dental
ASSOCIATION

ADA

3480 Mayland Court, Unit 110
Henrico, Virginia 23233
804.288.5750 F 804.288.1680 www.vadental.org

To: The Virginia Board of Dentistry

Health care providers, the public health community, payers and health services researchers are increasingly recognizing oral health as a crucial component of the medical home. The increasing evidence of the link between oral and systemic health has increased the potential role of dentists in early identification and referral of patients with possible chronic medical conditions and collaboration with other health professionals for comprehensive patient care.

Health Screening:

Diseases frequently begin long before symptoms occur. The goal of screening is to reduce morbidity or mortality from a disease by detecting it in its earliest stages, when treatment is usually more successful. Screening refers to the medical procedure or test of individuals whom have no symptoms of a particular disease, for the purpose of determining their likelihood of having the disease. Screening procedures are not diagnostic procedures. Persons with a positive result from a screening test will need further evaluation and referral for subsequent diagnostic tests or procedures. Screenings should target a subset of the population that is likely to have a higher prevalence of a disease. The utilization of health risk appraisals targets the individuals who are at higher risk of developing the disease.

Dentists have assumed responsibility for some patient medical screenings for many years. Practicing 28 dentists are treating an ever-aging population with significant medical issues. Detailed patient medical histories are routinely taken and reviewed to assess the relative risks of medical comorbidities and patient medications during dental care. Dentists are alert to clinical evidence that indicates a possible underlying, undiagnosed illness. Blood pressure, oral cancer and nutritional screenings are performed regularly in dental offices with referral to primary health providers for medical evaluation and diagnosis when appropriate. Dentists also offer counseling to patients for smoking cessation.

The 2008 Medical Expenditure Panel Survey (MEPS) indicated that of the 26 percent of children and 24.1 percent of adults who did not have contact with a general health care provider, a sizable proportion (34.7 percent of children and 23.1 percent of adults) visited a dental practice that year. These groups are estimated to represent 19.5 million individuals. The majority of these adults and children had some form of health insurance. This suggests that many of those who did not interact with a general health care provider may have had access to general health care but opted not to seek this care. For these and other individuals, dentists are in a key position to assess and detect oral signs and symptoms of systemic health disorders that may otherwise go unnoticed. Other research demonstrates high dental care utilization among key populations such as smokers, individuals at elevated risk for HIV, and individuals at risk for diabetes. Many at-risk individuals use dental services even when they do not regularly receive primary medical care services.

Demand for medical primary care services is projected to increase through 2020, largely because of population aging, population growth and insurance coverage for the uninsured. The Association of

UNAPPROVED - DRAFT

**BOARD OF DENTISTRY
MINUTES of the NOMINATING COMMITTEE MEETING**

Friday, May 18, 2018

**Perimeter Center
9960 Mayland Drive, Suite 200
Richmond, VA 23233
Hearing Room 3**

- CALL TO ORDER:** The meeting was called to order at 12:40 p.m.
- PRESIDING:** John M. Alexander, D.D.S., Chair
- MEMBER PRESENT:** James D. Watkins, D.D.S.,
- STAFF PRESENT:** Sandra K. Reen, Executive Director for the Board
- QUORUM:** With two members present, a quorum was established.
- NOMINATIONS:** The Committee discussed possible candidates and agreed by consensus to nominate Dr. Parris-Wilkins for president, Dr. Petticoles for vice-president and Dr. Catchings for secretary.
- APPROVAL OF MINUTES:** Ms. Reen requested approval of the June 30, 2017 meeting minutes. The Committee agreed by consensus to approve these minutes.
- ADJOURNMENT:** With all business concluded, the Committee adjourned at 1:05 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

**VIRGINIA BOARD OF DENTISTRY
FULL BOARD MINUTES**

June 8, 2018

Department of Health Professions

Henrico, VA 23233

- CALL TO ORDER:** Dr. Alexander called the meeting of the Board to order at 9:34AM. With 10 Board members present, a quorum was established.
Ms. Reen provided the emergency egress procedures for Board Room 4.
- MEMBERS PRESENT:** John M. Alexander, D.D.S., President
Tonya A. Parris-Wilkins, D.D.S., Vice-President
Augustus A. Petticolas, Jr., D.D.S., Secretary
Tammy C. Ridout, R.D.H.
Sandra J. Catchings, D.D.S.
James D. Watkins, D.D.S.
Carol R. Russek, JD
Jamiah Dawson, D.D.S.
Patricia B. Bonwell, R.D.H., PhD
Nathaniel C. Bryant, D.D.S.
- STAFF PRESENT:** Sandra K. Reen, Executive Director of the Board
Kelley W. Palmatier, Deputy Executive Director of the Board
Sheila Beard, Executive Assistant
Connie McHale, Licensing Manager
David Brown, DC, DHP Director
Barbara Allison-Bryan, MD, DHP Chief Deputy Director
Elaine Yeatts, DHP Policy Analyst
- COUNSEL PRESENT:** James E. Rutkowski, Assistant Attorney General
- PUBLIC COMMENT:** Charles Gaskin, D.D.S. – Charles Gaskin, D.D.S. spoke to the board about evidence-based dentistry (EBD) He cited an article by Dr. David W. Chambers entitled “Evidence-Based Overreach” which appeared in the Journal of the American College of Dentists, Volume 84, Number 4, 2017.

Dr. Gaskin asked the Board to be cautious and to be aware of perceived bias in relating EBD to standard of care.
- APPROVAL OF MINUTES:** With one change noted in the March 9, 2018 minutes, Dr. Petticolas made a motion to adopt the 3 sets minutes. The motion was seconded and passed.

DHP DIRECTOR'S REPORT

Dr. Brown informed the Board that the agency has completed the move of the reception area renovation to the first floor and the move of the Board of Dentistry to its new space on the 3rd floor. Additional changes included informing the Board of new agency ID badges with the agency logo for staff and board members. In addition, the Medicaid expansion implementation will happen in January. Dr. Brown informed the board that the Board of Pharmacy will monitor production of the THC oils, monitoring who and what can be prescribed and allowing five processors to get a permit.

Dr. Brown informed the Board that there is underway an evaluation of the need for community health workers to be regulated. Lastly, there is a bill that may require ER doctors to check with PMP before prescribing narcotics and evaluate the need for the availability of naloxone for patients receiving narcotic medications.

Dr. Allison-Bryan informed the Board that presently, security measures for staff and board members are being reviewed for the building. In addition, she provided a recap regarding the opioid epidemic. She also mentioned the presentation made by Dr. Abubaker at the staff development day.

CONFERENCE REPORTS

AADB – Dr. Dawson submitted a report to the Board, which is included in the agenda package, referencing her attendance to the AADB meeting held in Chicago, IL in April. She thanked the Board for the opportunity to attend.

Dr. Petticolas was also in attendance at the AADB meeting stating the meeting was very beneficial and enlightening. Some of the topics discussed included curriculum assessments, corporate dentistry, dental education today and a case study on dentist administering the flu vaccine.

COMMITTEE REPORTS

Dr. Watkins made the following reports:

- **SRTA** – Dr. Watkins stated the application has been submitted for SRTA rejoining ADEX for the development of licensure exams. What may still pose to be a hindrance is that ADEX is assessing a \$20k fee for rejoining. There will be more information to come on this decision.
- **BHP** - BHP has not met since our last board meeting. The next meeting is scheduled this month.
- **Exam Committee** – The Exam Committee has not met since our last board meeting.

Dr. Petticolas made the following report:

- **Regulatory-Legislative Committee** – Dr. Petticolas informed the Board that the committee is scheduled to meet on June 29, 2018. Currently on the agenda, the committee will be discussing recovery of disciplinary costs.

Dr. Bryant made the following report:

- **2018 National Dental Educator's Advisory Forum** – Dr. Bryant will be representing the Board at the upcoming forum being held in Chicago, IL. This forum will deal with the process of changing its examination to the Integrated National Board Dental Examination and recommended actions dental boards should take to prepare for the change.
- **ADEX** – Dr. Bryant will be attending the conference August 10-12, 2018.

Dr. Alexander made the following reports:

- **Advisory Panel on Opioids** – Dr. Alexander informed the Board that the final regulation is still pending. He will be working on a patient education statement with Dr. Abubaker regarding usage and proper disposal of opioids.
- **Executive Committee Meeting** - Dr. Alexander informed the Board that the Executive Committee met on March 8, 2018. Revisions for the By-Laws were discussed. The meeting minutes and the proposed revisions were in the agenda package. Ms. Reen reviewed the proposed changes. Striking the word “treasurer” throughout the by-laws was suggested. A motion was made by Ms. Ridout to approve the changes made to the by-laws. Dr. Catchings seconded the motion and it passed.
- **Nominating Committee** - Dr. Alexander also informed the Board that the Nominating Committee met on May 18, 2018. The minutes have been included in the agenda package. The Committee has recommended Dr. Parris-Wilkins for President, Dr. Petticolas for Vice – President and Dr. Catchings as Secretary. He said the elections would be held at the September meeting.

LEGISLATION AND REGULATORY ACTIONS

Ms. Yeatts gave a report that all regulatory actions for dentistry are currently pending in the Governor’s office.

Ms. Yeatts provided a status report on the following regulatory actions:

- **Conforming rules to ADA guidelines on moderate sedation** –the comment period ended on February 23, 2018 so the Board can adopt these for publication as a final action. Ms. Russek made the motion to adopt as a final action. The motion was seconded and passed.
- **Continuing education for practice by remote supervision** – Ms. Yeatts said the emergency regulation is in effect and needs to be replaced with final regulations by May 12, 2019. She requested adoption of these regulations as proposed final regulations to be released for public comment. Dr. Bonwell made the motion to adopt the proposed regulations. The motion was seconded and passed.

BOARD DISCUSSIONS

Acknowledgment of Public Comments – There were no comments or discussion regarding public comment.

Guidance Documents – The Board discussed the following Guidance Documents:

- **60-1 Confidential Consent Agreements** - This Guidance document has been identified for Board review based on its age to consider revision, re-adoption or withdrawal. If re-adopted, consider removing violations of “terms of probation” in item number 2 as a matter that could be addressed in a CCA. Dr.

Petticolas made a motion to adopt the change and to re-adopt this guidance document as revised. The motion was seconded and passed.

- **60-7 - Delegation to Dental Assistants** - Identified for Board review based on its age to consider revision, re-adoption or withdrawal. Staff did not identify any needed changes or additions. Dr. Watkins made a motion to re-adopt. The motion was seconded and passed.
- **60-9 - Code of Conduct for Members** - Identified for Board review based on its age to consider revision, re-adoption or withdrawal. Staff did not identify any needed changes or additions. Dr. Bonwell made a motion to re-adopt. The motion was seconded and passed.
- **60-11 - Guidance on Completion of Treatment if Patient Has Not Paid Fees** - Identified for Board review based on its age to consider revision, re-adoption or withdrawal. If the Board wishes to retain this guidance, staff recommends withdrawing this guidance document and addressing it in the Practitioner Responsibility section of Guidance Document 60-15 by adding this provision. A motion was made by Dr. Petticolas to withdraw the guidance document. The motion was seconded and passed.
- **60-12 - Administration of Topical Oral Fluorides by Dental Hygienists under Standards adopted by the Virginia Department of Health** - Identified for Board review based on its age to consider revision, re-adoption or withdrawal. Staff recommends withdrawal of this guidance document because the substance of this guidance is more fully addressed in Guidance Document 60-13 Practice of Dental Hygienists under Remote Supervision, which is the next document in the agenda package. Dr. Watkins moved to withdraw this guidance document. The motion was seconded and passed.
- **60-13 - Practice of Dental Hygienists under Remote Supervision** - The Virginia Dental Hygienists' Association has requested that the Board make two revisions to this guidance document to conform to language in the governing statutes. Staff has drafted language to address this request for review by the Board and added language addressing §54.1-3408 provisions. Attachments also provided are:
 - * The email sent by the VDHA
 - * §54.1-2722 of the Code of Virginia
 - * An excerpt from the Drug Control Act, §54.1-3408, with subsections J. and VThis guidance document has been tabled until the next board meeting and referred to the Regulatory-Legislative Committee for review.
- **60-15 - Adding an unpaid fee provision in the Practitioner Responsibility section Standards for Professional Conduct in the Practice of Dentistry.** Ms. Russek moved to accept the document with adding "30 day notice period". The motion was seconded and approved
- **60-19 – Dental Laboratory Subcontractor Work Order Form** - Identified for Board review based on its age to consider revision, re-adoption or withdrawal. Staff did not identify any needed changes or additions. This form has been deferred to the Regulatory-Legislative Committee for review.

BOARD COUNSEL REPORT

Mr. Rutkowski had nothing to report to Board.

DISCIPLINE AND DEPUTY EXECUTIVE DIRECTOR REPORT

- **Disciplinary Activity Report**

Ms. Palmatier reviewed her report noting for the third quarter of 2018, the Board received a total of 65 patient care cases. The Board closed a total of 75 patient care cases for a 115% clearance rate, which is down from 122% in Q2 of 2018. The current pending caseload older than 250 days is 25%, while the Board's goal is 20%. In Q3 of 2018, 89 % of the patient care cases were closed within 250 days. There was one mandatory suspension of a dental license and one voluntary surrender for indefinite suspension by the Board between February 21, 2018 and May 25, 2018.

EXECUTIVE DIRECTORS REPORT –

- **Oral Health Providers Overview**

Ms. Reen shared an article with the Board with information referencing dental hygienists and dental therapists with direct access of prescriptive authority.

- **Virginia DEQ Dental Rule FAQ for Dentists**

Ms. Reen shared the Dental Rule FAQ sheet with the Board, indicating that it would be added in the announcements section of the Board's webpage.

- **New Staff Member Introduction**

Ms. Reen introduced and welcomed the new Licensing Manger, Connie McHale to the Board.

EXECUTIVE ASSISTANTS REPORT –

- Ms. Beard discussed travel policy and procedures with the Board to assist in understanding policies and reimbursement procedures. A travel information sheet as well as the travel regulations were provided.

CALIBRATION EXERCISE –

- The Board participated in a calibration exercise related to probable cause decisions.

ADJOURNMENT: With all business concluded, Dr. Alexander adjourned the meeting at 12:18 PM.

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

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
June 08, 2018**

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 1:01 p.m., on June 08, 2018 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

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

MEMBERS PRESENT: August A. Petticolas Jr., D.D.S.
Tammy C. Ridout, R.D.H.
Sandra J. Catchings, D.D.S.
Jamiah Dawson, D.D.S.
Patricia B. Bonwell, R.D.H., PhD
Tonya A. Parris-Wilkins, D.D.S.
James D. Watkins, D.D.S.
Carol R. Russek, JD
Nathanial C. Bryant, D.D.S.

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

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT: James E. Schliessmann, Senior Assistant Attorney General
Shevaun Roukous, Adjudication Specialist
Juan Ortega, Court Reporter
Peter Baruch, Esquire, Respondent's Counsel

ESTABLISHMENT OF A QUORUM: With 10 Board members present, a quorum was established.

Jennifer Combs, R.D.H. Ms. Combs was present with legal counsel in accordance with the Notice of the Board dated October 2, 2017.

Case No. 181096 Dr. Alexander swore in the witnesses.

Ms. Combs stated that she was familiar with the order of proceedings. There were no preliminary matters discussed.

Following Mr. Schliessmann's opening statement; Dr. Alexander admitted into evidence Commonwealth's exhibits 1-5.

Following Mr. Baruch's opening statement;
Dr. Alexander admitted into evidence Respondent's Exhibit
A.

Testifying on behalf of the Commonwealth was Gayle Miller, DHP
Senior Investigator, Dr. Lawrence, Alyssa Adkins, and Rebecca
Britt, HPMP Case Manager.

Testifying on behalf of the Respondent was Dawn C. Rigler and
Jennifer Combs testified on her own behalf.

Mr. Schlessmann and Mr. Baruch provided closing statements.

Closed Meeting:

Dr. Parris-Wilkins moved that the Board enter into a closed
meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of
the Code of Virginia for the purpose of deliberation to reach a
decision in the matter of Jennifer Combs, R.D.H. Additionally,
she moved that Board staff, Ms. Reen, Ms. Lee, and Board
counsel, Mr. Rutkowski attend the closed meeting because their
presence in the closed meeting was deemed necessary and
would aid the Board in its deliberations. The motion was
seconded and passed.

Reconvene:

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

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

Decision:

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

Mr. Rutkowski reported that Jennifer Combs, R.D.H. is continued on
Indefinite Suspension until such time she can come before the
Board and prove that she is safe and competent to practice.

Virginia Board of Dentistry
Formal Hearing
June 8, 2018

Dr. Parris-Wilkins moved the adoption of the sanction imposed as read by Mr. Rutkowski. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 3:46 p.m.

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

Sandra K. Resn, Executive Director

Date

Date

UNAPPROVED

**VIRGINIA BOARD OF DENTISTRY
PUBLIC HEARING
July 27, 2018**

TIME AND PLACE: The Virginia Board of Dentistry convened a Public Hearing at 9:00 a.m., on July 27, 2018 in Hearing Room 4 to receive comments on proposed Regulations on Prescribing Opioids for pain management

PRESIDING: Tonya A. Parris-Wilkins, D.D.S

MEMBERS PRESENT: None

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

QUORUM: Not Required

PUBLIC COMMENT: Zachary Hairston, DDS – In support of regulations. Recommended addressing the use of electronic health records and the PMP when prescribing opioids.

Dr. Parris-Wilkins announced the deadline for submitting written comments is September 7, 2018, and indicated that the Board will consider all comments received before adoption of final Regulations on September 14, 2018.

ADJOURNMENT: The public hearing concluded at 9:32 a.m.

Tonya A. Parris-Wilkins, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
NEW MEMBER ORIENTATION
July 30, 2018**

TIME AND PLACE: The meeting was called to order at 8:30 a.m., on Monday, July 30, 2018 in Training Room 2, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Tonya A. Parris-Wilkins, D.D.S., President

MEMBERS PRESENT: Perry E. Jones, D.D.S.

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

OTHER PRESENT: James E. Rutkowski, Assistant Attorney General, Board Counsel

ORIENTATION: Dr. Parris-Wilkins welcomed Dr. Jones and reviewed the Board's current issues involving Sedation, DA II, and remote supervision.

Ms. Reen went over the laws, regulations and policies in the Board Member's notebook to include the bylaws and Code of Conduct for the members. She then explained the Board's three areas of work; licensure, regulation, and discipline. She gave an overview of the Board's structure, staffing, and memberships in AADB, SRTA and ADEX.

Mr. Rutkowski explained his role with the Board and discussed the powers and duties of health regulatory boards, the Administrative Process Act, the Freedom of Information Act, and the Conflict of Interest provisions.

Ms. Beard reviewed the state's policies on travel, per diems and reimbursements then directed Dr. Jones on how to complete the conflict of Interest training.

Ms. Palmatier explained the disciplinary case process and the Probable Cause Review form and discussed the information needed to close a case and to move a case forward for issuance of an advisory letter, confidential consent agreement, pre-hearing consent order and notice for an informal conference. She also reviewed the guide for case reviews, probable cause decisions

**Virginia Board of Dentistry
New Member Orientation
July 30, 2018**

and disciplinary action. She encouraged Dr. Jones to use it when reviewing cases and to call staff with any questions about a case.

ADJOURNMENT: The training was adjourned at 11:45 a.m.

Tonya A. Parris-Wilkins, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES

SPECIAL SESSION – TELEPHONE CONFERENCE CALL

- CALL TO ORDER:** The meeting of the Board of Dentistry was called to order at 5:18 p.m., on November 6, 2018, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 4, 9960 Mayland Drive, Henrico, VA 23233.
- PRESIDING:** Tonya A. Parris-Wilkins, D.D.S., President
- MEMBERS PRESENT:** Patricia B. Bonwell, R.D.H., PhD
Jamiah Dawson, D.D.S.
Perry E. Jones, D.D.S.
Augustus A. Petticoles, Jr., D.D.S.
James D. Watkins, D.D.S.
- MEMBERS ABSENT:** Nathaniel C. Bryant, D.D.S.
Sandra J. Catchings, D.D.S.
Tammy C. Riddout, R.D.H.
Carol R. Russek, J.D.
- QUORUM:** With six members present, a quorum was established.
- STAFF PRESENT:** Kelley W. Palmatier, Deputy Executive Director
Donna M. Lee, Discipline Case Manager
- OTHERS PRESENT:** James E. Rutkowski, Assistant Attorney General, Board Counsel
- James N. Rhodes, D.D.S.
Case No.: 188872** The Board received information from Ms. Palmatier regarding a Consent Order signed by Dr. Rhodes as a settlement proposal for the resolution of his case in lieu of proceeding with the scheduled Formal Hearing.
- Closed Meeting:** Dr. Petticoles moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of James N. Rhodes. Additionally, Dr. Petticoles moved that Ms. Palmatier, Ms. Lee and Mr. Rutkowski attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.
- Reconvene:** Dr. Petticoles moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION:

Dr. Bonwell moved that the Board accept the Consent Order that was signed by Dr. Rhodes in lieu of proceeding with the Formal Hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT:

With all business concluded, the Board adjourned at 5:30 p.m.

Tonya A. Parris-Wilkins, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

43rd ANNUAL SOUTHERN REGIONAL TESTING AGENCY CONVENTION

THIS MEETING WAS HELD FROM AUGUST 2-4, 2018 AT THE SHERATION AIRPORT HOTEL IN CHARLOTTE, NC.

I REPRESENTED OUR BOARD AS A MEMBER OF THE SRТА BOARD OF DIRECTORS; SRТА DENTAL CALIBRATION COMMITTEE; SRТА DENTAL EXAMINATION COMMITTEE; SRТА DENTAL EXAMINER REVIEW COMMITTEE AND SRТА NOMINATING COMMITTEE.

—The Dental Calibration committee:

Met at 8am on Thursday morning with the committee chair, Dr. Glenn Young (VA) opening the meeting by having the SRТА president, Dr. Susan King (KY) give the committee members an update on the SRТА application to ADEX. There was a motion made after considerable discussion that SRТА eliminate the necessity for candidates to declare the type of Class II composite restoration they will perform (either conventional or slot prep). Also, some minor changes were made to the criteria sections in the Class III restoration and to clarify the removal of calculus and stains in the Periodontal section of the exam. The committee has been working over the past year with Mr. Jeff Scott of Acadental in the development of a new tooth to be used in mock board exams. This new tooth has caries and a pulp and cuts more like a natural tooth. Two of our Faculty advisors had made preparations with the tooth and submitted photos and samples of the prepped teeth to the committee. The committee recommended the teeth be used in the 2019 examination cycle.

—The Dental Examination committee:

Met at 8am on Friday morning with the committee chair, Dr. Van Morgan (SC), proposing that SRТА incorporate an Orofacial Assessment for the Periodontal section of the SRТА exam. The state of South Dakota requested that assessment in order for their state to accept the SRТА exam results for licensure. The committee members reviewed an assessment worksheet and proposed the assessment for the 2019 exam. Additionally, the committee discussed introducing probing depth measurements for two teeth that are recorded and graded during the Perlo exam. The committee has received nothing but positive feedback from the schools and candidates on the use of pre-approval of lesions for the past examination year and will continue to use it. The committee voted to accept the changes to the manual for the Class II composite restoration, the Class III restoration and the Periodontal section; as proposed by the Calibration committee. The committee proposes that there be at least two examiner alternates for each exam in case an examiner has an emergency and cannot attend an assigned exam. President-elect, Dr. George Martin (AR) gave an update on the ADEX application.

—The Nominating committee:

Committee met and presented the following slate of officers for 2018-2019:

- Dr. George Martin (AR): President**
- Dr. Gerald Walker (AL): President-elect**
- Dr. Robert Hall (VA): Treasurer**
- Ms. BethAnn Casey-Thompson, RDH (TN): Secretary**

—All examiners and Board of Directors met at 1pm on Friday to receive a report from the newly formed SRТА Quality Assurance Committee, which is chaired by Dr. John Dixon (WVA). This committee recommends the following:

- 1. SRТА photograph all dental failures on both the manikin and patient procedures with the approved SRТА camera.**

2. **SRTA reinstate implementation of dental and dental hygiene CFM/CFC/SAC/DA and DHA training prior to each new exam cycle.**
3. **SRTA amend the bylaws to specify a separate dental hygienist position/member as a part of the Quality Assurance Committee.**

---The SRTA Board of Directors:

Met at 5pm on Friday with the SRTA president, Dr. Susan King, presiding. The BOD reviewed all committee reports to be presented to the assembly. The president gave the following report: the SRTA has completed its 2017-18 examination cycle. SRTA has had a significant decrease in the number of candidates taking both the dental and dental hygiene exams over the previous year's numbers. This year, the combined total of initial and sectional dental examination candidates totaled 189, down from the 270 in the 2016-17 cycles. An even larger change was seen in the number of candidates taking the dental hygiene examination. There were 187 first-time and repeat candidates for the dental hygiene examination, down from 373. These numbers represent a 30% decrease in the number of dental candidates and a 49% decrease in the number of dental hygiene candidates from the last year. The BOD feels that this downturn in numbers is a result of candidates choosing other examination platforms that they believe offer them more licensure PORTABILITY than the SRTA examination. SRTA has paid to ADEX the \$30K that they perceived was owed to them when SRTA withdrew from ADEX. SRTA has submitted its application to rejoin ADEX along with their \$20K application fee and awaits the ADEX decision which is assumed will be made next week when ADEX holds its annual session. Dr. King is very OPTIMISTIC that our application will be accepted.

THE SRTA GENERAL ASSEMBLY MET AT 8am ON SATURDAY, AUGUST 4, 2018

---The GA was called to order by SRTA president, Dr. Susan King.

---A state roll call was held by the Secretary, Ms. Tanya Riffe, RDH (SC) and a quorum was established.

---A moment of silence was held in memory of the passing of Dr. Wendell Garrett (AR), who had been a SRTA member who worked many years for the organization, especially with updating the dental examination manuals.

---All committee reports were presented and voted on by the general assembly.

---The majority of the conversation revolved around the future of the SRTA organization. This led to a motion that was unanimously passed that SRTA pursue and accept the ADEX status and aggressively pursue merger opportunities with other testing agencies.

---New officers were elected.

---New SRTA President, Dr. George Martin, addressed the assembly. He stated that the site and dates of the next annual meeting will be determined later. SRTA may consider changing its annual meeting dates to AFTER the ADEX annual meeting so as to be able to institute changes that may occur in the ADEX exam after its annual meeting. Any changes to the exam that may be made, especially if the ADEX status is achieved for 2019, will be made at a special session of the Dental and Dental Hygiene Examination committees at a place and time to be determined later.

MEETING ADJOURNED.

**THANKS TO THE DHP DIRECTOR AND THE BOARD FOR ALLOWING MY ATTENDANCE AT THIS MEETING.
JAMES D. WATKINS, DDS**

**SRTA Annual Meeting
August 2-4, 2018
Report Presented by Dr. Patricia Bonwell, RDH, PhD
Virginia Board of Dentistry Member**

Thursday, August 2, 2018

A. Dental Hygiene Examination Development Committee

1. Thorough page by page review of the Examiner Manual and Candidate Guide
 - a. Spelling and grammatical errors corrected
 - b. Suggestions to be made to the Dental Hygiene Examination Committee
 1. Verbiage regarding radiographs change "diagnostic" to "required"; Panorex or FMX within 4 years and 4 BW x-rays within 2 years
 2. Clarifying the selection of Primary and Secondary quadrants
 3. Share exam results the end of day of the last testing day at a site
 4. Numbering the candidate forms to aid with clarifying what form goes where or to whom
 5. Reviewed 10 "most missed" questions on computer portion of exam
 6. Proof showing certified to administer local anesthesia
 7. Working with Dental Exam Committee on BP standards
2. Presentation shared by Ms. Southall focusing on licensure requirements.
 - a. Beneficial to share with students licensure requirements for the state their school is located
 - b. Advise students to find out in advance what is required in whatever state they decide to practice in.

Friday, August 3, 2018

A. Dental Hygiene Examination Committee Meeting

1. Nominated and voted on BOD Dental Hygiene Representative
2. Discussed and voted on proposed changes
3. Educators report shared
 - a. Educators shared they would like to see the computer segment exam questions before the exam.
 - b. Want scoring areas when at all possible
 - c. Discussed relationship building with State Dental Boards
 - d. Shared and idea accepted/supported to create and share with students licensure requirement presentations for the state where their school is located
 - 1) Advise students to find out in advance what is required in whatever state they decide to practice in.
4. Reviewed 10 "most missed" test questions with educators present
 - a. asked for input/provision of more questions from educators

Saturday, August 4, 2018 - General Assembly

Discussion focused primarily on SRTA re-joining and working with ADEX for administering clinical board exams. Outgoing president shared that she and other Board members were hopeful for a positive report of application acceptance coming out of the ADEX annual meeting, being held this coming weekend.

Exploring options of working with/collaborating with other testing agencies such as CITA, etc.

Amended by-laws were reviewed and accepted via vote.

From: Dr Nathaniel Bryant

To: Virginia Dental Board

Subj: Report on the ADEX and JCNDE Meetings

ADEX

The meeting was held on August 10, 2018 in Chicago, IL. As an overview, the meeting started with a welcome by the president. Following the welcome each participant met with their respective subcommittees to discuss any changes that were proposed by the Executive Committee. The subcommittees in each of the testing disciplines presented their recommendations to the general assembly for voting. There were some changes proposed in some of the sections of the examination, which if finalized and adopted will go into effect during the 2019-2020 test cycle. No major changes were made at the meeting as far as administration of the exam. There was also no decision announced concerning the status of the SRTA application to administer the ADEX exam.

JCNDE

The Meeting was held on June 20, 2018 in Chicago IL, at the ADA headquarters. The meeting was designed to update the attending State Board members, in addition to the other members of different organizations, on the changes to the National Board exam for dental and dental hygiene. The Integrated Board Exam will combine Part I and II. This will go into effect in August 2020, with full implementation and elimination of the two separate parts to the exam in 2022. Beta testing has occurred around the country, and the results have been favorable.



- The JCNDE exists to provide information to dental boards to inform licensure decision concerning dental and dental hygiene candidates.
- Dental boards have the critical task of using this information to understand whether a candidate has the skills necessary to safely practice.
- The actions of dental boards are vital to the oral health and general health of the public.
- The JCNDE extends its thanks to dental boards and dental board members for their work in protecting the public health.
- The JCNDE appreciates the opportunity to be of service to boards, in providing important information concerning candidate qualifications for licensure.
- **The JCNDE recognizes the importance of its task and shares dental boards concern for the protection of the public.**
- **This is why we're all here today!**

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- **Welcome!**
- **The purpose of the JCNDE**
- **The purpose of NDEAF**
- **The JCNDE and its activities**
 - JCNDE background and policy updates
 - JCNDE examination programs and implementation
 - Standard setting activities
 - Administration volume and failure rates
- **The Integrated National Board Dental Examination (Dr. Mark Christensen)**
- **Q & A**

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- **NDEAF was created to encourage dialogue between the JCNDE and dental board members**
- **The JCNDE's National Board Dental and Dental Hygiene Examinations are designed to help dental boards understand whether a candidate possesses the necessary cognitive skills to safely practice.**
 - The content outline for these examinations is available online in Candidate Guides and Technical Reports.
 - Dental board members can use this material to understand the nature of the cognitive skill evaluation, and the validity evidence that supports use of these examinations.
- **NDEAF provides an opportunity for the JCNDE to interact face-to-face (or remotely) with board members, to understand their unique perspectives and identify any areas for improvement concerning the National Board Examinations**

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- **NDEAF is being approached a new way to facilitate direct engagement between members of the JCNDE and communities of interest.**
- **In attendance today we have:**
 - **Members of dental boards**
 - In-person
 - Remote attendees
 - **Members of the JCNDE**
 - In-person
 - Remote attendees
 - **Members of the Committee for an Integrated Examination (CIE)**
 - **Invited guests and observers from the AADS, ADA Board of Trustees, ADEA, ASDA, ADHA**
 - **Staff who work closely with the JCNDE's examination programs**

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The JCNDE Bylaws indicate that the purpose of the JCNDE is:

- **to provide and conduct examinations to assist state boards in determining qualifications of dentists and dental hygienists who seek licensure.**
- **to make rules and regulations for the conduct of National Board examinations and certificates.**
- **to serve as a resource for the dental profession in the development of examinations.**

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"The JCNDE develops and conducts highly reliable, state of the art cognitive examinations that assist regulatory agencies in making valid decisions regarding licensure of oral health care professionals, develops and implements policy for the orderly, secure, and fair administration of its examinations, and is a leader and resource in assessment for the oral health care profession."

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Appointing Organizations	Number of Members	Term Lengths (in years)
Voting Members		
AADB	1	4
ADIA	3	4
ADA	3	4
ADHA	1	4
ASDA	1	1
Public	1	4
Non-voting Members		
ADA Observer	1	1*
ADA BOT Liaison	1	1

* The ASDA Observer transitions to a Commissioner role in their second year.

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Philosophical foundation of Commissions:

- ✓ **Consistent and free from bias/conflict of interest – remain objective.**
- ✓ **No single community of interest can have undue influence in the decision-making process, including the ADA.**
- ✓ **Quality assurance is necessary to protect the public and ensure long-term viability of the profession.**
- ✓ **Integrity, confidentiality, due process.**

- **Subject to ADA Bylaws and Standing Rules, while maintaining own Bylaws and Rules in accordance with mission and with HOD approval.**
- **Commissions maintain independent authority to carry out their program.**

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History of the National Board Dental Examination:

1922: National Board of Dental Examiners established as a standing committee of the ADA for the purpose of providing & conducting written examinations for use by the state boards of dentistry in licensing dentists.

1923/1934: National Board Dental Examinations first administered.

1949: NBDDE first administered.

1973: NBDDE inserts a comprehensive examination.

1989: National Board of Dental Examiners was restructured as the 15 member JCNDE.

1992: Part 2 inserts a comprehensive examination.

2003: Part 2 became a comprehensive examination.

2004: All National Boards are computer-based examinations.

Present: All U.S. licensing jurisdictions accept the NBDDE and NBDDE as fulfillment of the written examination requirement for licensure.

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Year	Event
1922	National Board of Dental Examiners established as a standing committee of the ADA for the purpose of providing & conducting written examinations for use by the state boards of dentistry in licensing dentists.
1923/1934	National Board Dental Examinations first administered.
1949	NBDDE first administered.
1973	NBDDE inserts a comprehensive examination.
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- **The composition of the JCNDE reflects the important perspectives that must be considered in the building and implementing of National Board Examinations, with particular emphasis given to dental boards.**
- **The JCNDE has a long track record of helping dental boards identify those who are not qualified to safely practice.**
- **The JCNDE monitors administration through internal procedures and close collaboration with key vendors (Prometric and Pearson VUE)**
- **The JCNDE monitors examination and examinee performance closely and regularly, and reviews examination policy on an ongoing basis to address any issues that arise.**
- **The JCNDE updates examination content and programs to ensure clinical relevance and to help ensure consistent, accurate identification of those who do not possess the cognitive skills necessary to safely practice.**
- **The Integrated National Board Dental Examination benefits from and will help continue this strong record of performance**

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- The Joint Commission on National Dental Examinations (JCNDE) met June 2017 and took the actions reported in the Unofficial Report of Major Actions.
- These actions are posted here: <https://www.nade.org/jcnnde/news-resources/unofficial-reports>

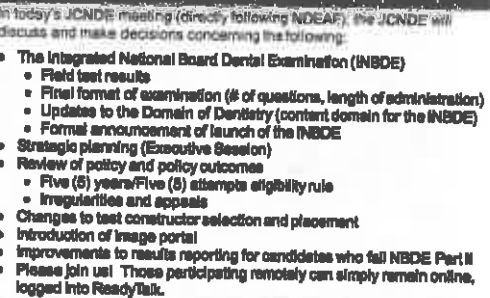


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In today's JCNDE meeting (directly following NDAEF), the JCNDE will discuss and make decisions concerning the following:

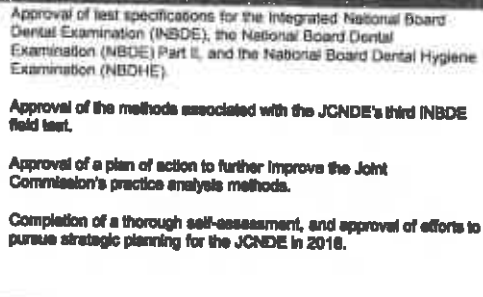
- The Integrated National Board Dental Examination (INBDE)
 - Final test results
 - Final format of examination (# of questions, length of administration)
 - Updates to the Domain of Dentistry (content domain for the INBDE)
 - Formal announcement of launch of the INBDE
- Strategic planning (Executive Session)
- Review of policy and policy outcomes
 - Five (5) years/Five (5) attempts eligibility rule
 - Irregularities and appeals
- Changes to test constructor selection and placement
- Introduction of image portal
- Improvements to results reporting for candidates who fail NBDE Part II

Please join us! Those participating remotely can simply remain online, logged into ReadyTalk.



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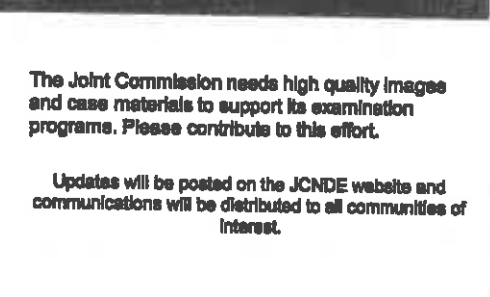
- Approval of test specifications for the Integrated National Board Dental Examination (INBDE), the National Board Dental Examination (NBDE) Part II, and the National Board Dental Hygiene Examination (NBDHE).
- Approval of the methods associated with the JCNDE's third INBDE field test.
- Approval of a plan of action to further improve the Joint Commission's practice analysis methods.
- Completion of a thorough self-assessment, and approval of efforts to pursue strategic planning for the JCNDE in 2018.



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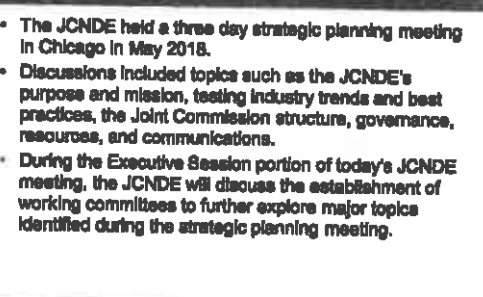
The Joint Commission needs high quality images and case materials to support its examination programs. Please contribute to this effort.

Updates will be posted on the JCNDE website and communications will be distributed to all communities of interest.



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- The JCNDE held a three day strategic planning meeting in Chicago in May 2018.
- Discussions included topics such as the JCNDE's purpose and mission, testing industry trends and best practices, the Joint Commission structure, governance, resources, and communications.
- During the Executive Session portion of today's JCNDE meeting, the JCNDE will discuss the establishment of working committees to further explore major topics identified during the strategic planning meeting.




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- The Standards were developed by the American Educational Research Association (AERA), American Psychological Association (APA), and the National Council on Measurement in Education (NCME).
- The Standards provide considerations for developing, implementing, and evaluating tests.
- The Standards and industry best practices help guide JCND E and DTS activities as it designs, constructs, and implements the assessments under its care.
- The JCND E's primary focus is on validity, the evidence that supports the interpretation and use of NBE results



JCND E

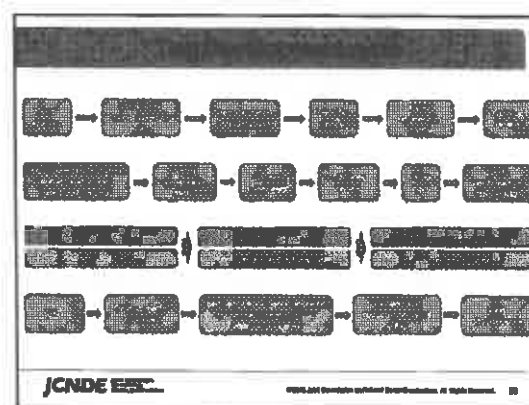
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The JCND E oversees the following licensure testing programs:

- ✓ National Board Dental Examination Part I (NBDE Part I)
- ✓ National Board Dental Examination Part II (NBDE Part II)
- ✓ National Board Dental Hygiene Examination (NBDHE)
- ✓ Integrated National Board Dental Examination (INBDE)
 - Under development. Will replace NBDE Part I in 2020 and NBDE Part II in 2022.

JCND E

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Examination Content, Scoring, Analysis, Now Development		
Test Development Develops test construction forms (TCF) including all exam administration programs (e.g., TestCenter software).	Research & Development Requirements Conducts research and testing of candidate test (CAT) construction requirements, and develops a prototype of proposed program.	Item Preparation/Development Provides construction support in the development of test writing programs.
TEST CENTER		
Test Administration Oversees test center operations and test center administration (e.g., CAT) administration.	Test Security and Identification Develops and administers security, identification and security aspects of the examination.	Construction Provides construction for candidates and construction materials.
Response to Inquiries Responds to state calls, test center contact, and inquiry (CAT) inquiries.	Interview and Meeting Coordination Conducts interview activities and meeting support for CAT and governance meetings.	
Research and Development Projects Provides management and technical support for research and development projects.		

JCND E

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- Administer 48,000+ examinations
- Phone calls, live chat, email and fax correspondence
- DENTPIN requests/updates
- Examination guides, website updates
- Examination/test applications including the waiver requests and testing accommodations
- Score reporting
 - Fulfill additional score report requests (30,000+)
 - Fulfill orders for NBDHE released form sets and National Board certificates.
- Resolve issues/problems with testing (emergencies, ID problems, testing conditions)
- Conduct 80+ test construction committee meetings
- Booking and research services for contracted clients
- JCND E and DAT publication and website updates
- R&D staff research publications and presentations
- Activities conducted by professionally trained staff, many with advanced degrees

JCND E

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- The National Board Examinations are criterion-referenced and not norm-referenced examinations.
- Subject matter experts identify standards (pass/fail points) following established procedures and criteria that reference specific skill level requirements, NOT by the process sometimes known as "grading on a curve."
 - All candidates who demonstrate the necessary skill level through their examination performance will pass the examination (it is NOT the case that scoring is established to fail a certain percentage of examinees).
 - All candidates who do NOT demonstrate the necessary skill level through their examination performance will fail the examination.
- Based on standard setting activities, the JCNDE has recently INCREASED STANDARDS across all of its examination programs.
- The new standards for the NBDE Part I, NBDHE, and NBDE Part II were separately reviewed & approved by the Joint Commission, and implemented in November 2016, January 2017, and March 2017, respectively.

JCNDE Joint Commission on National Dental Examinations

*** A new standard was introduced this year, based on updated standard setting activities.**

JCNDE Joint Commission on National Dental Examinations

- The following slides present information concerning examinee volume and performance for a 10-year period.
- Examinee volume data includes all individuals (first time, repeaters, accredited, non-accredited) completing the National Board Dental Examinations (Part I and Part II) and the National Board Dental Hygiene Examination.
- Performance trend data include candidates enrolled in accredited schools in the U.S and Canada who took the examination for the first time.

JCNDE Joint Commission on National Dental Examinations

Figure 2: NBDE Part II Administrations (2008-2017)

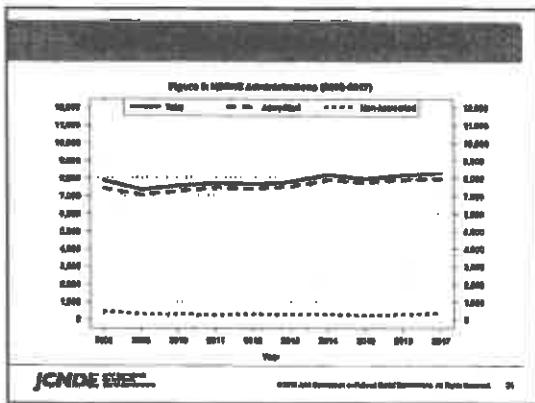
JCNDE Joint Commission on National Dental Examinations

Figure 1: NBDE Part I Administrations (2008-2017)

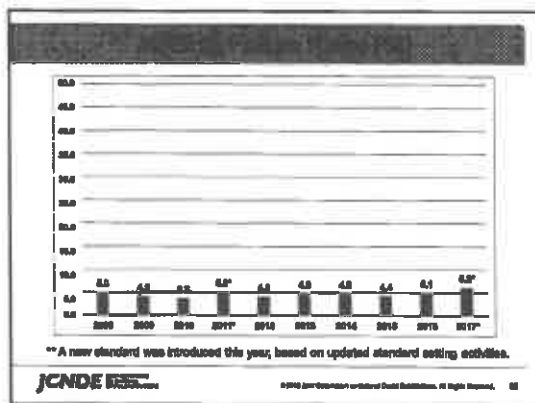
JCNDE Joint Commission on National Dental Examinations

**** A new standard was introduced this year, based on updated standard setting activities.**

JCNDE Joint Commission on National Dental Examinations



- In 2009, the JCNDE appointed a Committee for an Integrated Examination (CIE) to develop and validate a new examination instrument for dentistry that integrates the biomedical, behavioral, and clinical sciences to assess entry level competency in dental practice, to supplant NBDE Part I and Part II.
- The integrated examination retains the same fundamental purpose as NBDE Part I and Part II – to assist state boards of dentistry in determining qualifications of dentists who seek licensure to practice in the U.S.



- A convergence of factors led to the INBDE, which was designed to better serve communities of interest by:
 - Improving test content to make it more appropriate and relevant to the practice of dentistry and contemporary dental education
 - Improving processes and candidates' experiences in taking the examination
 - Better assisting regulatory agencies
- Examination content trends and the movement toward integrated content and clinical relevance also were considered.



- The members of the ad hoc CIE are well acquainted with the Joint Commission's mission and workings.
- | | |
|---|---|
| <p>Mark Christensen, DDS (Chair)
(AADE 2008-2008)
Vice-Chair – JCNDE (2008)
Chair – Administration (2008)
Chair – Dental Hygiene (2008 & 2007)</p> | <p>Andrew Spielman, DMD, MS, Ph.D.
(ADEA 2008-2011)
Chair – JCNDE (2011)
Chair – Examination Development (2008)</p> |
| <p>Bruce D. Herr, DDS
(AADE 2007-2010)
Chair – JCNDE (2010)
Chair – Administration (2008)
Chair – Dental Hygiene (2008)</p> | <p>Ron J. Sneling, DDS
(ADA 2007-2010)
Chair – JCNDE (2009)
Chair – Examination Development (2008)</p> |
| <p>B. Ellen Byrne, DDM, Ph.D.
(ADEA 2008-2011)
Chair – Research & Development (2012)
Chair – Administration (2011)</p> | <p>Stephen T. Rodick, BS, DMD
(ADA 2008-2011)
Chair – Research & Development (2010 & 2011)
Vice-Chair – JCNDE (2010)</p> |

2017-2018 Appointments

The Joint Commission Chair and NBDE Standing Committee Chairs serve as ex-officio members of the CIE.

Lisa Heltrich-Hall, DDS Chair – JCNDE (2018) Chair – Research & Development (2017) Chair – Administration (2016)	William F. Robinson, DDS Vice Chair – JCNDE (2018) Chair – Research & Development (2018) Chair – Administration (2017)
Nader Maderwahh, DDS, MBA, EdD Chair – Administration (2018) Chair – Examination Development (2017)	Osbaldo W. Leone, DMD, DABSO, FRCR Chair – Examination Development (2018)

The Joint Commission Chair has also made additional, one-year appointments.

Dale R. Charabertain, DDS JCNDE Commissioner	Steven D. Vincent, DDS, MS JCNDE Test Construction Team member
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- The Public
- Dental boards (states, territories)
- The JCNDE
- The CIE
- INBDE working committees
 - INBDE Science Panels
 - Test Specification Review Panels
- Test Construction Teams
- Department of Testing Services
- Dental programs
- Dental students
- Associations (ADA, AADB, ADEA, ASDA, ATP, etc.)
- Vendors (test administration, item bank)

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Year	Key Tasks and Activities
2005	ADEA Commission on Change and Innovation (CCI) recommended changes to dental education and assessment.
2006-2007	JCNDE monitored and considered CCI progress and recommendations.
2008	JCNDE created ad hoc Committee on Strategic Planning, conducted environmental scans, and considered the future.
2009	JCNDE resolved to create an integrated examination, and appointed members to the ad hoc Committee for an Integrated Examination (CIE).
2010	CIE worked to lay the content foundation for the exam.
2011	Practice analysis and advice panels conducted using content foundation.
2012	General test specifications developed.

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Read: Key Take-Away Activities

2012	Details about item development and approach were outlined. Resolutions were created to enhance communication and alignment between the Joint Commission and the CDE.
2014	Approach was refined, and first INBDE Test Construction Committees were formed. Item writing began.
2015	Item writing and automatic item generation. Sample item survey conducted. Development of Implementation Plan. Refinement of practice analysis clinical content areas.
2016	Short Form Field Test (Sept). Item writing. Retest policy. Refinement of approaches.
2017	Mid-length Field Test (Nov). Item writing. Refinement of test areas and approaches.
2018	Field test results review. Item writing. Formal announcement of implementation.

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- The Joint Commission has established 66 "clinical content areas" that represent the tasks entry-level general dentists must be able to perform to practice safely.
 - The clinical content areas were based on ADEA's 2008 *Competencies for the New General Dentist*.
 - The 66 clinical content areas are classified into three component sections:
 - 1) Diagnosis and Treatment Planning
 - 2) Oral Health Management
 - 3) Practice and Profession
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- Clinical relevance and alignment with test purpose are the key considerations in establishing content and the items that appear on the INBDE.
 - Integration is viewed as a means of implementing and promoting this perspective; as such, integration is secondary to clinical relevance and alignment with test purpose.
 - In summary, examination purpose drives all considerations, clinical relevance is the best way to achieve the exam purpose, and integration provides a strong means of achieving clinical relevance.
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Continuum of Oral Health Management

1. Obtain patient information and medical history to assess and manage patients.
2. Identify chief complaint and understand the underlying factors.
3. Perform history and oral and extraoral examinations, interpreting and analyzing the overall findings.
4. Use history and examination data to develop and establish a program for dental diagnosis and planning.
5. Integrate the history and examination data with management decisions that require further diagnostic investigation.
6. Provide the most likely diagnosis with the greatest possible patient information.
7. Inform patient results to allow understanding of the primary condition.
8. Manage the management of clinical issues and oral disease and its management may affect the delivery of dental care.
9. Manage the interrelationship between oral health and systemic disease and implement strategies for managing overall health.
10. Select the diagnosis most readily to establish or modify the diagnosis.
11. Select treatment. Plan, monitor, coordinate, adjust, re-evaluate, and other healthcare professionals to ensure treatment success.
12. Provide a comprehensive diagnosis and treatment plan for patient management.
13. Monitor ongoing treatment effectiveness and progress and provide to the patient and other healthcare professionals according to the management of oral health.

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- A "content domain" is the set of behaviors, knowledge, skills, abilities that a test measures.
 - In establishing the INBDE content domain, the Joint Commission focused on two key questions:
 - 1) What tasks must entry-level general dentists be able to perform to practice safely?
 - 2) What knowledge, skills and abilities underlie the performance of those tasks?
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1	Obtain patient information and medical history to assess and manage patients.
2	Identify chief complaint and understand the underlying factors.
3	Perform history and oral and extraoral examinations, interpreting and analyzing the overall findings.
4	Use history and examination data to develop and establish a program for dental diagnosis and planning.
5	Integrate the history and examination data with management decisions that require further diagnostic investigation.
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65	Monitor ongoing treatment effectiveness and progress and provide to the patient and other healthcare professionals according to the management of oral health.
66	Obtain patient information and medical history to assess and manage patients.

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Foundational Knowledge Areas

The successful entry-level general practitioner is based on the prevention, diagnosis, and management of oral disease, and the promotion and maintenance of general health. This requires application of knowledge in the following areas:

- 1. Oral anatomy and histology
- 2. Oral pathology and radiology
- 3. Oral medicine and surgery
- 4. Oral diagnosis and treatment planning
- 5. Oral surgery and anesthesia
- 6. Oral medicine and geriatrics
- 7. Oral medicine and pediatrics
- 8. Oral medicine and obstetrics/gynecology
- 9. Oral medicine and infectious diseases
- 10. Oral medicine and immunology
- 11. Oral medicine and endocrinology
- 12. Oral medicine and neurology
- 13. Oral medicine and psychiatry
- 14. Oral medicine and psychology
- 15. Oral medicine and sociology
- 16. Oral medicine and anthropology
- 17. Oral medicine and linguistics
- 18. Oral medicine and law
- 19. Oral medicine and ethics
- 20. Oral medicine and public health
- 21. Oral medicine and environmental health
- 22. Oral medicine and occupational health
- 23. Oral medicine and safety
- 24. Oral medicine and quality improvement
- 25. Oral medicine and patient care
- 26. Oral medicine and communication
- 27. Oral medicine and leadership
- 28. Oral medicine and teamwork
- 29. Oral medicine and professional development
- 30. Oral medicine and continuing education
- 31. Oral medicine and research
- 32. Oral medicine and evidence-based practice
- 33. Oral medicine and clinical practice
- 34. Oral medicine and patient education
- 35. Oral medicine and patient assessment
- 36. Oral medicine and patient history
- 37. Oral medicine and patient examination
- 38. Oral medicine and patient diagnosis
- 39. Oral medicine and patient treatment
- 40. Oral medicine and patient follow-up
- 41. Oral medicine and patient satisfaction
- 42. Oral medicine and patient compliance
- 43. Oral medicine and patient adherence
- 44. Oral medicine and patient cooperation
- 45. Oral medicine and patient participation
- 46. Oral medicine and patient involvement
- 47. Oral medicine and patient empowerment
- 48. Oral medicine and patient engagement
- 49. Oral medicine and patient activation
- 50. Oral medicine and patient self-management
- 51. Oral medicine and patient self-care
- 52. Oral medicine and patient self-monitoring
- 53. Oral medicine and patient self-reporting
- 54. Oral medicine and patient self-evaluation
- 55. Oral medicine and patient self-reflection
- 56. Oral medicine and patient self-regulation
- 57. Oral medicine and patient self-education
- 58. Oral medicine and patient self-improvement
- 59. Oral medicine and patient self-motivation
- 60. Oral medicine and patient self-direction
- 61. Oral medicine and patient self-actualization
- 62. Oral medicine and patient self-fulfillment
- 63. Oral medicine and patient self-actualization
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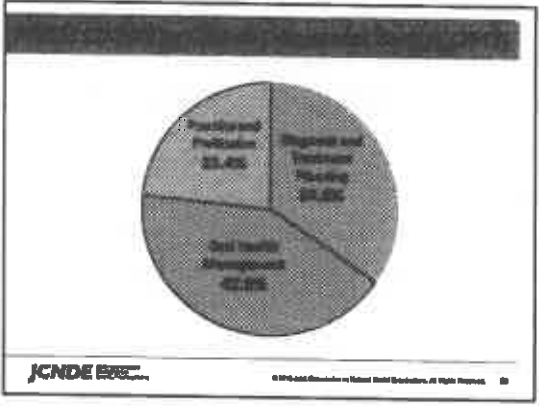
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Foundational Knowledge Areas

The successful entry-level general practitioner is based on the prevention, diagnosis, and management of oral disease, and the promotion and maintenance of general health. This requires application of knowledge in the following areas:

- 1. Oral anatomy and histology
- 2. Oral pathology and radiology
- 3. Oral medicine and surgery
- 4. Oral diagnosis and treatment planning
- 5. Oral surgery and anesthesia
- 6. Oral medicine and geriatrics
- 7. Oral medicine and pediatrics
- 8. Oral medicine and obstetrics/gynecology
- 9. Oral medicine and infectious diseases
- 10. Oral medicine and immunology
- 11. Oral medicine and endocrinology
- 12. Oral medicine and neurology
- 13. Oral medicine and psychiatry
- 14. Oral medicine and psychology
- 15. Oral medicine and sociology
- 16. Oral medicine and anthropology
- 17. Oral medicine and linguistics
- 18. Oral medicine and law
- 19. Oral medicine and ethics
- 20. Oral medicine and public health
- 21. Oral medicine and environmental health
- 22. Oral medicine and occupational health
- 23. Oral medicine and safety
- 24. Oral medicine and quality improvement
- 25. Oral medicine and patient care
- 26. Oral medicine and communication
- 27. Oral medicine and leadership
- 28. Oral medicine and teamwork
- 29. Oral medicine and professional development
- 30. Oral medicine and continuing education
- 31. Oral medicine and research
- 32. Oral medicine and evidence-based practice
- 33. Oral medicine and clinical practice
- 34. Oral medicine and patient education
- 35. Oral medicine and patient assessment
- 36. Oral medicine and patient history
- 37. Oral medicine and patient examination
- 38. Oral medicine and patient diagnosis
- 39. Oral medicine and patient treatment
- 40. Oral medicine and patient follow-up
- 41. Oral medicine and patient satisfaction
- 42. Oral medicine and patient compliance
- 43. Oral medicine and patient adherence
- 44. Oral medicine and patient cooperation
- 45. Oral medicine and patient participation
- 46. Oral medicine and patient involvement
- 47. Oral medicine and patient empowerment
- 48. Oral medicine and patient engagement
- 49. Oral medicine and patient activation
- 50. Oral medicine and patient self-management
- 51. Oral medicine and patient self-care
- 52. Oral medicine and patient self-monitoring
- 53. Oral medicine and patient self-reporting
- 54. Oral medicine and patient self-evaluation
- 55. Oral medicine and patient self-reflection
- 56. Oral medicine and patient self-regulation
- 57. Oral medicine and patient self-education
- 58. Oral medicine and patient self-improvement
- 59. Oral medicine and patient self-motivation
- 60. Oral medicine and patient self-direction
- 61. Oral medicine and patient self-actualization
- 62. Oral medicine and patient self-fulfillment
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JCNDE Content, by Foundation Knowledge Area*

Foundation Knowledge Area	Percentage
1. Anatomy, histological, cellular, and histological development, structure and function	12.5%
2. Physics and chemistry to explain normal biology and pathology	4.2%
3. Physics and chemistry to explain the interactions and use of biomaterials and materials	3.8%
4. Principles of genetic, congenital and developmental diseases and conditions and their clinical features to understand patient risk	10.0%
5. Cellular and molecular bases of immune and non-immune host defense mechanisms	1.5%
6. General and disease-specific pathology to assess patient risk	15.0%
7. Biology of microorganisms in physiology and pathology	12.0%
8. Pharmacology	10.0%
9. Toxicology, epidemiology, etiology and other interrelated sciences	10.0%
10. Research methodology, data analysis, and information tools	8.0%

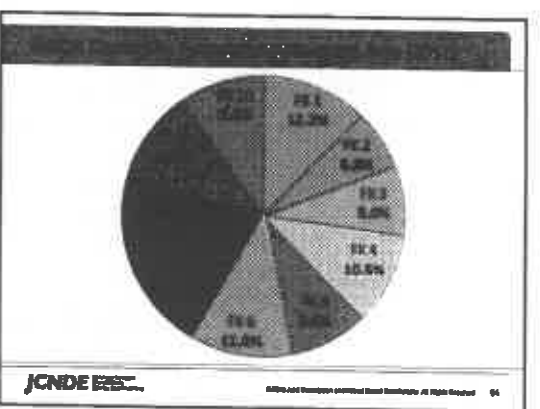
* PK 8 and 10 contain minor skills that are currently pending JCNDE approval.

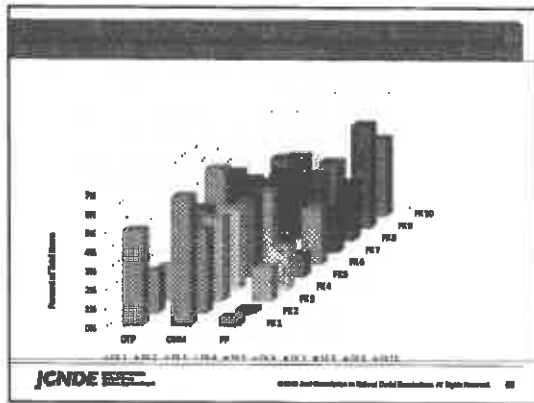
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Continental Practice

- 1. Oral anatomy and histology
- 2. Oral pathology and radiology
- 3. Oral medicine and surgery
- 4. Oral diagnosis and treatment planning
- 5. Oral surgery and anesthesia
- 6. Oral medicine and geriatrics
- 7. Oral medicine and pediatrics
- 8. Oral medicine and obstetrics/gynecology
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Answer
Female, 30 years old

Chief Complaint
"My front teeth have been gradually loosening and have not responded when I touch the edges or try to eat."

Background and History
A field orthodontic appliance was recently installed in the maxillary arch.
Advise the patient to return to your office for evaluation of her maxillary anterior teeth.
Medications
None
Relevant Findings
Occlusion: full on maxillary arches. Missing teeth anterior to 7, 8, 9, and 10, especially at buccal edges. Small enamel chip to a horizontal of buccal enamel of 8 and 9



The orthodontic brackets and arch wire are removed prior to professionally restoring teeth 8 and 9. What is the most likely cause of the patient's condition?

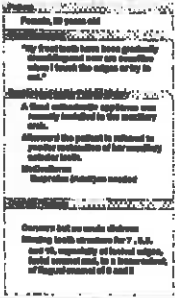
A. Habitual chewing on parotid excess
B. Grinding of her anterior teeth
C. Sucking on lingers and liners
D. Sucking soft drinks before swallowing

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- INBDE Test Construction Teams (TCTs) have been formed for each clinical content section.
 - Diagnosis and Treatment Planning
 - Oral Health Management
 - Practice and Profession
 - TCTs meet within their 5-person groups and also as a full unit (15 members) during item reviews.
 - INBDE TCTs have drafted over 2,000 items to date in support of field testing efforts.
 - Additional INBDE TCTs have focused tasks:
 - Case Development, Clinical Reference Review, Form Review
- JCNDE ESE
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- The JCNDE has conducted three separate INBDE Field Tests
 - INBDE Sample Item Survey (July 2016 - September 2016)
 - 170 NBDE Part I candidates
 - INBDE Short Form Field Test (October 2016 - January 2017)
 - 840 NBDE Part II candidates from accredited dental schools
 - 2017-2018 INBDE Field Test (November 2017 - January 2018)
 - Approximately 1,400 NBDE Part II candidates from accredited dental schools
 - Results from INBDE field testing provide validity evidence in support of the intended use and interpretation of INBDE results
 - Overall, the INBDE has been viewed by field test candidates as an improvement over the NBDE Part II in many ways
- JCNDE ESE
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- The Patient Box includes all relevant information a candidate needs to know in order to properly diagnose or treat a patient
 - Patient's basic demographic information (gender and age)
 - Chief Complaint: reason for the visit
 - Background and/or Patient History: dental and medical history, current medications, etc.
 - Current Findings: any additional information regarding pre-treatment or diagnosis obtained during the current visit



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- INBDE field testing efforts have been successful to date.
 - The Joint Commission is on track for an August 2020 release of the INBDE.
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On June 20, 2018 the JCNDP will vote on release of the formal notice concerning INBDE implementation and NBDE discontinuation.

JCNDP

- Information concerning the INBDE is available via the Joint Commission's website (www.jca.org/JCNDP/INBDE).
- The following information is currently available and is updated as changes occur:
 - INBDE background
 - INBDE FAQs
 - Domain of Dentistry and general validity evidence
 - Test specifications
 - Preliminary sample questions
 - INBDE retake policy and candidate eligibility
 - INBDE draft item development guide
 - INBDE practice test questions
- The following information will be posted as soon as it becomes available:
 - Technical report(s) providing detailed information concerning validity.

JCNDP

**AADB 135th Annual Meeting Report
September 22-23, 2018
Chicago, Illinois**

Themes:

- 1. Messages from Organizational Leaders**
- 2. Collaborative Practice Among Healthcare Professionals**
- 3. Testing**
- 4. Dental Support Organizations (DSOs)**
- 5. Licensure**

I. Messages from Organizational Leaders

Richard Hetke, AADB Executive Director's Report

Goals of the organization:

Provide valuable services for membership

Build membership

Provider strong mid-year and annual meetings

Facilitate open and professional conversations

Develop new sources of revenue

Advocate

Increase revenue from services and sponsors

Balance the budget

Joseph P. Crowley, President, American Dental Association

Current Initiatives:

Support mandatory drug education and use of PMP

Jeffrey Kerst, Vice-President, American Student Dental Association

Current Initiatives:

Tackling increasing student loan debt

Licensure reform (No clinical patients), Pro-OSCE

Oppose Mid-Level Providers

II. Interprofessional Education for Collaborative Practice

Tenets:

- Students from 2 or more healthcare professions learn about, from and with each other
- Able to significantly improve health of patient
- Decrease per capital costs of healthcare
- Create support systems
- Create collective identity and shared responsibility for a patients
- Foster a common vision for team based care
- Defines roles/responsibilities for care providers in the group
- Facilitates communication with patient's family and community but within the group

IPE goals are reflected in the Commission on Dental Accreditation (CODA) standards.

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

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

Intent:

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

For more information please visit www.ada.org/coda.

III. Testing

Introduces standardization and allows for more reliable skill assessment.

Steps for Testing:

1. Planning
2. Content Definition
3. Test Specifications
4. Items or station development
5. Test Design and assembly
6. Test Production
7. Test Administration
8. Test Scoring
9. Standard setting
10. Reporting Test Results
11. Item Banking
12. Technical Reports/Standardization

Validity-The most important fundamental consideration of developing a test.

Reliability-Consistency and precision of score across replications of a testing procedure.

All of the above must be considered when developing a Dental Licensure OSCE (DLOSCE).

In 2017, the ADA Board of Trustees authorized the ADA Department of Testing Services to begin the process of developing a clinical dental licensure exam which will not require performance of procedures on patients. A Steering Committee has been charged by the Board of Trustees with direct oversight of the development of the OSCE, and includes two members from the Board of Trustees, two members from the practicing community, two members from the education community and two members who currently serve on a state dental board.

IV. Dental Support Organizations (DSOs)-Independent business support centers that contract with dental practices in the United States. They provide critical business management and support to dental practices, including non-clinical operations.

Goal: Supporting dentists to increase access to quality affordable care.

Why Dentists Choose Dental Support Organizations (DSOs)

- Bookkeeping
- IT support
- Billing and Collections
- Payroll
- Banking
- Financial Reports and Accounting
- Marketing

V. Licensure

- A public protection and barrier to entry
 - Substantial variation across states in the strictness of licensing rules
 - Many licensing requirements not plausibly linked to safety
 - Licensed workers enjoy wage and non-wage advantages over non-licensed workers
 - Substantial wage gap between licensed and unlicensed workers
- *****25% of licensed workers are in healthcare industry.*****

Occupational Licensure

- 20% of all employed 25-64 year old workers are licensed.
- Licensure is defined as a credential required to maintain employment.

Licensed v. Un-Licensed Workers

- Hours (Work More), More likely to work FT hours than PT hours
- Higher Tenure
- Unemployment Rates Lower

Options to Enhance Occupational Licensure and Portability

- Can be high barrier for multi-state practice (telehealth) and military spouses
- State compacts
- Model Laws
- Interstate Medical Licensure Compact
- Harmonization of Licensure Requirements

I would like to express my sincere thanks to the Department of Health Professions and the Board of Dentistry for allowing me to travel on their behalf and broaden my professional horizons.

Respectfully submitted,
Tonya A. Parris-Wilkins, DDS

Report on AADB 135th Meeting September 22-23rd, 2018

Sandra J Catchings DDS

This is a report on some of my thoughts and impressions of the AADB Meeting held on September 22-23, 2018 in Chicago

Opening: The meeting started off on a very positive note. We heard an address from the ADA President, which expressed a relatively good working relationship with the AADB.

ASDA: We heard from the President of the American Student Dental Association. The issues that concern the students are: midlevel providers, licensure reform, and dental student debt.

Debt: reduced interest rate, increased tax deductibility for interest, for loans, and an increase in loan forgiveness programs. They support H.R. 649, The Student Loan Refinancing Act and H.R. 4223, the POST Grad Act.

Licensure: Students would like to see a universally accepted exam that does not use live patients and is reliably assessable. They would prefer manikins and submission of a portfolio of comprehensive patient care for testing.

Midlevel Providers: ASDA is engaged in a fight against midlevel providers and believes that only a dentist should: prescribe medications or work authorizations, perform irreversible treatment, and perform exam, diagnosis, and treatment planning.

Corporate Dentistry: There was a panel presentation on Corporate Dentistry. This was an eye opening experience for me. On the panel were executives and dentists from three large corporate dental companies: Heartland Dental, Pacific Dental Services, and Decision One Dental Partners. I was able to see how this is marketed to dentists to sound so alluring to them. And then by observing the questions from the floor, see how deceiving the relationships actually are. The executives from Heartland did most of the speaking and they were very polished and practiced in their "non-answers". It is hard to put into words just how "slick" they were. Here are a few examples:

Question: What happens when a dentist wants to sell a practice?

Answer: "So, the dentist wants to sell the practice. That's it."

Question: "If dentists in your programs are so well mentored and advised, then why is it that they have a high rate of disciplinary action and we see more cases involving them coming to the boards?"

Answer: "I don't believe that that information is true or correct."

Question: “What about the cases where dentists are unable to get out of their contracts and law suits have been brought up against Heartland in order to break free from it?”

Answer from Heartland: “I am not aware of any lawsuits.”

The whole presentation left me very concerned and saddened that this is happening in our field. I was concerned for both the dentist and the patient that would be involved in this type of setting.

O.S.C.E.: There was a lecture on the ADA’s O.S.C.E. Exam. The ADA has invested a lot of money in developing this exam. And I believe they are going to push hard for it. I am concerned that the wealth and political strength of the ADA will be hard to fight against, as it often is. I do not believe that the ADA should be in the business of licensure or examinations. O.S.C.E. stands for Objective Structured Clinical Examinations. O.S.C.E. Exams have been in use in the medical field for quite some time. The objective of creating this exam was to provide an exam without a live patient that would have a reliable and predictable method of assessment with improved perception of fairness by candidates and a decreased possibility to endanger patient health, while assessing a wide range of capabilities.

F.T.C.: The last section of the conference that I was interested in was the FTC’s presentations on fair competition and came in 2 different lectures. I was unable to stay for the second portion as I had to get to the airport. I was very happy to find that the lecture slides were available online after the meeting and awaited their availability to finish this report. There was information about telehealth, direct supervision, and indirect supervision in field positions and their effect on limiting access to care and their use to unfairly control competition. The FTC looks for and considers safety in whether or not supervision is actually needed or if it is used as a competition control method.

Floor Comments: I found comments from the floor helpful and informative for the most part. Especially pertinent was a statement from CODA that it has moved away from using the word “specialist” and is now using “advanced education in specific interests”. Two individuals opposed my memory of this terminology at the Legislative Committee Meeting for the VBOD on October 25, 2018. I made sure to call CODA later and check on that terminology and confirmed that it was “advanced education in specific interests”. I am sure that this will come out in other lectures and papers, which I believe it probably did later in the day after I had departed. I do think that this terminology is lengthy and is likely to get shortened and abbreviated for ease of use.

New Member Orientation: I also attended the New Member Orientation before the general meeting. The organization’s Executive Director stated that only three states were not members of the AADB and that Virginia is one of those states. I asked questions of the Executive Director and some of the AADB Board Members and it is my opinion that Ms. Reen’s position that the board level membership is not a good value is a sound one. Fiscally, it is more responsible to pay the individual membership and meeting fees for a few board members than to pay a board fee in addition to that. Dental boards don’t really get anything for this fee. I did make an attempt to explain this point of view, with which I agree, to the

Executive Director of AADB. I am an individual member of my own accord and financing and will probably remain so for the information available from this organization. It is important to clarify that the information and participation at this meeting was valuable. I needed and appreciated the information provided and obtained through my attendance. If I can figure out how to help make a board level membership a more valuable and attractive thing for Virginia, then I will be sure to present that to the AADB director.

General Comments: Also enlightening was the observance of the general membership. The AADB is an unusual organization. Represented in the room were dental professionals of all ages, from all areas of expertise, and all kinds of board formats. Some boards were independent and some were not. The differences are too much to go into for this report, however, it is significant to point out that it did mature and develop my understanding and appreciation of our board here in Virginia.

As an interesting note, the hotel workers were on strike and picketing outside the hotel.

Board of Health Professions
Full Board Meeting**August 23, 2018**
10:00 a.m. - Board Room 4
9960 Mayland Dr, Henrico, VA
23233**In Attendance**

Kevin Doyle, EdD, LPC, LSATP, Board of Counseling
Allen R. Jones, Jr., DPT, PT, Board of Physical Therapy
Derrick Kendall, NHA, Board of Long-Term Care Administrators
Trula E. Minton, MS, RN, Board of Nursing
Kevin P. O'Connor, Board of Medicine
Martha S. Perry, MS, Citizen Member
Herb Stewart, PhD, Board of Psychology
Jacquelyn Tyler, RN, Citizen Member
Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language Pathology
James Wells, RPh, Citizen Member

Absent

Lisette P. Carbajal, Citizen Member
Helene D. Clayton-Jeter, OD, Board of Optometry
Mark Johnson, DVM, Board of Veterinary Medicine
Ryan Logan, RPh, Board of Pharmacy
Maribel E. Ramos, Citizen Member
James D. Watkins, DDS, Board of Dentistry
Vacant – Board of Social Work

DHP Staff

Vacant – Board of Funeral Directors and Embalmers
Barbara Allison-Bryan, Deputy Director, DHP
David Brown, Director, DHP
Elizabeth A. Carter, Ph.D., Executive Director BHP
Jaime Hoyle, Executive Director Behavioral Sciences Boards, DHP
Laura L. Jackson, MSHSA, Operations Manager, BHP
Elaine Yeatts, Senior Policy Analyst DHP
Diane Powers, Communications Director, DHP
Corle Tillman Wolf, Executive Director, Boards of Funeral Directors and Embalmers, Physical Therapy, Long-Term Care Directors, DHP

OAG Representative

Charise Mitchell

Presenters	Amy Marschean, DARS Dr. Richard Lindsay, Lindsay Institute for Innovations in Caregiving Christine Jensen, PhD, Riverside Stephanie Willinger, Deputy Director, Stephanie Willinger, Deputy Executive Director Licensing, Board of Nursing Na'im Campbell, Backgrounds Investigation Supervisor, CBC Unit DHP
Speakers	No speakers signed-in
Observers	Sarah Deaver, AATA Kandra Orr Terri Giller, VATA Darlene Green, VATA Carol Olson, VATA Gretchen Graves, VATA
Media	Katie O'Connor, Virginia Mercury
Emergency Egress	Dr. Carter

Call to Order

Acting Chair: Dr. Jones, Jr. **Time** 10:02 a.m.
Quorum Established

Public Comment

Discussion

There was no public comment

Approval of Minutes

Presenter Dr. Jones, Jr.

Discussion

The June 26, 2018 Full Board meeting minutes were approved with no revisions. All members in favor, none opposed.

Welcome

Presenter Dr. Jones, Jr.

Dr. Allen R. Jones, Jr. was acting Chair for this meeting as Dr. Clayton-Jeter is out of the state on business. He thanked the board members for their commitment to the Commonwealth and thanked staff for their work and dedication to DHP.

Directors Report

Presenter Dr. Brown**Discussion**

Dr. Brown stated that the agency is gearing up for the 2019 legislative session.

In follow-up to the 2018 session:

- Dr. Brown briefed the Board on an upcoming e-prescribing meeting;
- Dr. Allison-Bryan will be meeting with stakeholders to take a preliminary look into regulating community health workers;
- DHP will be convening a meeting of the Behavioral Sciences Unit, Board of Nursing and Board of Medicine to come up with a common set of regulations regarding conversion therapy for minors;
- A workgroup will be convening to see how the PMP may be automated for greater efficiency in ER physicians notifying prescribers of a patient overdose;
- In lieu of yearly board member orientation, DHP will be initiating at the board level, 45 minute board member orientation sessions to train board members on changes relevant to the board and the agency;
- Ms. Hahn and Dr. Allison-Bryan are continuing to work with Virginia State Police and the Henrico County Crime Prevention Environmental Divide Unit to establish agency safety protocol.

Invited Presentations

Presenter Ms. Marschean**Virginia Family Caregivers**

Dr. Richard Lindsay provided a PowerPoint presentation on the status of today's caregiving community. Ms. Marschean followed up with an overview of the Virginia Department for Aging and Rehabilitative Services report on Recommendations for Improving Family Caregiver Support in Virginia 2018. Dr. Jenson provided details of different approaches Riverside is taking to support their staff of caregivers.

Criminal Background Checks

Presenter Ms. Willinger

Discussion

Ms. Willinger provided a PowerPoint presentation on how the Virginia Board of Nursing obtained authority and the methods and impact on public safety of criminal background checks. The Board of Pharmacy is also utilizing CBCs for applicants seeking a Pharmaceutical Processor permit. *Attachment 1*

***Break**

Regulatory Research Committee - Art Therapist Study Recommendation

Presenter Mr. Wells

Discussion

Mr. Wells provided information regarding the Committee's recommendation to license Art Therapists in Virginia. He stated that the burden of regulation was justified and proof of The Criteria was supported.

Motion

A motion was made to accept the recommendation of the Regulatory Research Committee to license Art Therapists in Virginia was made and by a vote of eight (8) members in favor, one (1) opposed, was properly seconded.

Legislative and Regulatory Report

Presenter Ms. Yeatts

Discussion

Ms. Yeatts advised the Board that there are 13 proposals to move forward in the 2019 legislative session. Updates to regulations and General Assembly legislative actions relevant to DHP were also provided. *Attachment 2*

***Lunch**

Executive Directors Report

Presenter Dr. Carter

Board Budget

Dr. Carter stated that the Board is operating within budget.

Agency Performance

Dr. Carter reviewed the agencies performance measures in relation to clearance rate, age of pending caseload and time to disposition.

Sanction Reference Points (SRP) - Update

Dr. Carter advised that the Board of Long Term Care had just completed its latest SRP revisions, and the Board of Dentistry is next.

Policies and Procedures

Dr. Carter discussed the updating of the Board's sunrise policies and procedures guidance document, and that the matter will be placed on the December agenda for the full Board's consideration and vote.

New FTE Allocation

Dr. Carter advised the Board of a new FTE to the unit. Dr. Allison-Bryan added that the agency's statistical analysis and data reporting functions are returning to BHP. The new data analyst position will focus on data validation, analysis and reporting, methods documentation, and providing technical analytic support related to agency performance measures, strategic planning, and support for DHP HWDC increasing users.

Healthcare Workforce Data Center (HWDC)

Presenter Dr. Carter

Discussion

Dr. Carter stated that all 2017 profession workforce surveys have been approved by the respective Board and are posted on the agencies website. HWDC collaboration with VLDS is still ongoing. The HWDC released its first newsletter in August with quarterly reports to follow.

Board Reports

Presenter Dr. Jones, Jr.

Board of Audiology & Speech Language Pathology

Ms. Verdun was not in attendance.

Board of Counseling

Dr. Doyle stated that the Board of Counseling is convening a Supervisor's Summit on September 7, 2018 that will allow an opportunity to explain the laws and regulations around supervision. He stated that the board is also registering Qualified Mental Health Professionals. With the additional of QMHPs, the Board of Counseling now has an applicant count of over 24,000. He stated that the Behavioral Sciences Boards would also be participating in the conversion therapy for minor's workgroup.

Board of Dentistry

Dr. Watkins was not in attendance.

Board of Funeral Directors & Embalmers

The seat for this Board is currently vacant.

Board of Long Term Care Administrators

Mr. Kendall stated that the Board has finalized its revisions to the Sanction Reference Point manual and that the periodic review of the Regulations Governing the Practice of Nursing Home Administrators was in its final stage at the Secretary's Office. He was happy to announce that the Board has no vacancies at this time.

Board of Medicine

Dr. O'Connor reported that the board has five (5) new members. The Executive Committee met August 3, 2018 and discussed autonomous practice for Nurse Practitioners; the Board is currently undergoing a periodic review of regulations; and the Board of Medicine will be participating in the conversion therapy for minor's workgroup.

Board of Nursing

Ms. Minton attended the 40th annual NCSBN national meeting and was very excited to announce that Ms. Douglas, Executive Director for the Board of Nursing, has been appointed to the NCSBN Board. She also advised that the NCSBN is working to address the role of nurses working with patients who use medical marijuana. She also discussed that "Nursing Now" is a global campaign that aims to improve health by raising the profile of nursing worldwide.

Board of Optometry

Dr. Jones, Jr. provided the report as follows:

*Next meeting is scheduled for July 13, 2018.

Complaints FY2016: Received 13

Complaints FY2017: Received 36

Licenses (In state/out of state based on address of record provided by licensee)

FY2017: Total – 1,921 TPA – 1,148/390 DPA – 27/90 Professional Designations – 266

Y-T-D FY2018: Total – 1,929 TPA – 1,168/400 DPA – 20/84 Professional Designations – 257

Continuing Education: Audit has not yet commenced.

Regulatory Changes: The Board adopted emergency regulations for the prescribing of opioids, which became effective on 10/30/17. The final replacement regulations under review in the Secretary's office. In addition, a periodic review is in the proposed stage and is still under consideration by the administration.

In response to a petition for rulemaking, the Board moved forward with a NOIRA to add inactive licenses to the regulations.

Board of Pharmacy

Mr. Logan was not in attendance.

Board of Physical Therapy

Dr. Jones, Jr., reported that he is no longer the President of the Board, that Arkena Dally was appointed President at the August 16, 2018 meeting. He stated that the Virginia Board of Physical Therapy was chosen as one of two Boards across the country to receive the 2018 Excellence in Regulation Award from the Federation of State Boards of Physical Therapy (FSBPT). The Board's guidance documents have been reviewed and updated. The Board voted to pursue legislation to enact the Physical Therapy Licensure Compact.

Board of Psychology

Dr. Stewart stated they have approximately 6,500 applicants. The Board has a member seat specific to applied psychologist and due to the low number in the profession, this seat has been vacant for an extended period of time. The board is considering requesting reallocation of the seat. The Board is performing a top to bottom review of existing regulations and has submitted for a one-time fee reduction. The Board of Psychology will also be participating in the conversion therapy for minor's workgroup. In July, the Board voted to endorse PSYPAC and it has been added to 2019 legislation.

Board of Social Work

The seat for this Board is currently vacant.

Board of Veterinary Medicine

Dr. Johnson was not in attendance.

New Business

Presenter Dr. Jones, Jr.

There was no new business to discuss.

Next Full Board Meeting – December 4, 2018

Presenter Dr. Jones, Jr.

Dr. Jones, Jr. announced the next Full Board meeting date as December 4, 2018.

Adjourned 1:26 p.m.

Acting Chair Allen R. Jones, Jr., DPT, PT

Signature: _____ **Date:** ____/____/____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ **Date:** ____/____/____

UNAPPROVED
MINUTES

BOARD OF DENTISTRY
EXAMINATION COMMITTEE
August 10, 2018

- TIME AND PLACE:** The Examination Committee convened on August 10, 2018, at 1:06p.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:** Jamiah Dawson, D.D.S.
Patricia B. Bonwell, R.D.H., PhD
Tonya A. Parris-Wilkins, D.D.S.
- MEMBER ABSENT:** Nathaniel C. Bryant, D.D.S.
Carol R. Russek, J.D.
- STAFF PRESENT:** Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Sheila Beard, Executive Assistant
- BOARD COUNSEL PRESENT:** James E. Rutkowski, Assistant Attorney General
- ESTABLISHMENT OF A QUORUM:** With three members of the Committee present, a quorum was established.
- PUBLIC COMMENT:** There were no public comments.
- APPROVAL OF MINUTES:** Dr. Watkins asked if the Committee members had reviewed the February 2, 2018 minutes and asked if there were any corrections needed. Dr. Bonwell moved to accept the minutes presented. The motion was seconded and passed.
- DISCUSSION:** Letter from JCNDE - The letter included in the agenda package from JCNDE was accepted for informational purposes.

Acceptance of Clinical Examinations

ADHA - Dr. Bonwell acknowledged the letter included in the agenda package and shared the information presented at the recent SRTA meeting. Extensive conversation went forth surrounding ADHA's support to eliminate clinical exams.

ADEA - Ms. Reen informed the Committee that this matter continues to come before the Board and should be addressed by the Committee. Ms. Reen stated when licensing by credentials the Board must be aware what will be good for Virginia. The information for ADHA and ADEA will be added to the September Board Meeting package.

Acceptance of Regional Exams - Ms. Reen informed the Committee that it must review the examinations of all the regional testing agencies and recommend to the Board which examinations are acceptable. Ms. Reen stated there are inconsistencies between regional exams and how results are reported, which seem to change year to year. Currently, the prosthodontics section of the WREB exam is optional and is a required section of all other regional exams. There is a concern that many applicants are applying with no intention to practice in Virginia.

Dr. Watkins asked if it would be beneficial for a Board representative to be part of each exam agency in order to keep up with the changes that take place.

Ms. Reen informed the Committee that Guidance Document 60-25, as currently written, cannot be enforced. Ms. Reen suggested that consideration should be given to possibly accepting ADEX exams only and that the Board put a new policy in place. The Board can make changes to this Guidance Document in September. Mr. Rutkowski reminded the Committee that guidance documents are not enforceable as law and recommended a regulatory change. Ms. Reen stated the Board can choose to adopt a fast-track regulatory action at the September Board meeting.

Dr. Dawson made a motion to change Guidance Document 60-25 to read "All examinations taken after January 1, 2019 must include, at a minimum, sections on Endodontics; Prosthodontics; operative dentistry consisting of a Posterior Class II and Anterior Class III restorations; and a Periodontal section" for dental licensure applicants by examination or credentials. This motion was seconded by Dr. Bonwell and passed.

Dr. Bonwell made a motion to adopt a regulatory action to change the policy for exam acceptance under the section of licensure by examinations and credentials.

The next Exam Committee meeting is being considered for September 13, 2018.

ADJOURNMENT:

With all business concluded, the meeting adjourned at 2:54pm

**Virginia Board of Dentistry
Examination Committee
August 10, 2018**

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

Sandra K. Keen, Executive Director

Date

Date

UNAPPROVED

**VIRGINIA BOARD OF DENTISTRY
REGULATORY-LEGISLATIVE COMMITTEE MINUTES**

June 29, 2018

Department of Health Professions

Henrico, VA 23233

CALL TO ORDER: Dr. Augustus A. Petticolas, Jr. called the meeting of the Regulatory-Legislative Committee to order at 10:04AM. With 8 Board members present, a quorum was established.

MEMBERS PRESENT: Augustus A. Petticolas, Jr., D.D.S., Chair
Tonya A. Parris-Wilkins, D.D.S.
Tammy C. Ridout, R.D.H.
Sandra J. Catchings, D.D.S.
James D. Watkins, D.D.S.

OTHER BOARD MEMBERS PRESENT: Patricia Bonwell, R.D.H., Ph.D.
John M. Alexander, D.D.S.
Carol Russek, JD

STAFF PRESENT: Sandra K. Reen, Executive Director
Sheila Beard, Executive Assistant
Elaine Yeatts, DHP Policy Analyst

PUBLIC COMMENT: Emily Bonovitch, VDHA – Thanked the Board for reviewing Guidance Documents “Practice of Dental Hygienist under Remote Supervision”, and “Administration of Topical Fluorides”, to address how they align with current Code and regulatory provisions. She asked that the Remote Supervision Guidance Document, be amended to remove the age restriction in #7(g) and #8.

Terry Dickenson, D.D.S., Executive Director, VDA – Supports the position of the VDHA regarding removing the age restriction for the application of fluoride.

Michelle McGregor, VCU Dental Hygienist – Supports allowing dentists to do the A1C finger prick screening. Requested dental hygienists be included since students are trained for this.

Terry Dickenson, D.D.S., Executive Director, VDA – Said the VDA also supports allowing dentists and dental hygienists to do A1C screening.

APPROVAL OF MINUTES:

Ms. Ridout moved to accept the minutes of March 8, 2018 as written. The motion was seconded and passed.

LEGISLATION AND REGULATORY

Ms. Yeatts informed the Committee that all regulatory actions are still pending in the Governor’s office. She added that she expects the 60-day comment period on the proposed regulations to replace the emergency regulations for opioid prescribing will take place between 7/9/2018 and 9/7/2018.

COMMITTEE DISCUSSIONS:

A1C Test and Diabetes -

At the June 8, 2018 Board meeting, Dr. Alexander referred this matter to the Regulatory- Legislative Committee for review to consider if legislative action is required to allow dentists and dental hygienists to perform skin pricks. Ms. Reen advised that in prior discussion with Board Council, she was advised that the Code definition of dentistry would require amendment to include A1C screening. The Committee decided to ask Board Council to reconsider his advice given the current research on A1C and how it relates to the profession of dentistry in making decisions about treatment and sedation.

Guidance Documents -

The committee discussed the following Guidance Documents:

- **60-12 Administration of Topical Oral Fluorides by Dental Hygienists Under Standards adopted by the Virginia Department of Health –** This Guidance document has been identified for the committee to consider revision, re-adoption, or withdrawal. Ms. Ridout made the motion to recommend withdrawing guidance document 60-12. The motion was seconded and passed.
- **60-13 Practice of a Dental Hygienist under Remote Supervision-** The Committee discussed the difference in provisions for dental hygienists to possess and administer topical fluorides, topical anesthetics, antimicrobial agents or other Schedule VI topical drug while practicing under remote supervision to and while practicing under general supervision. Ms. Yeatts advised that legislative action was needed to address the Committee’s interest in having the provisions for general supervision apply to remote supervision. She added that to have this change included in the Board’s legislative proposal a decision on this could not wait for Board action at the September meeting. She said DHP Director Dr. Brown could make this change at the request of the Committee. A motion was made by Ms. Ridout to ask Dr. Brown to amend the Board’s legislative proposal to add “or remote” supervision to §54.1-3408(J) and to add the Schedule VI topical drugs addressed in §54.1-3408 (J) to §54.1-2722 F(g). The motion was seconded and passed. Ms. Ridout made a motion to recommend adoption of guidance document 60-13 as proposed. The motion was seconded and passed.

- **60-17 Recovery of Disciplinary Costs** – In response to Dr. Brown’s concern about the Board’s policy on disciplinary cost recovery, Dr. Alexander asked the Committee to consider the options of eliminating or reducing such costs or reducing the costs for dental hygienist and to make a recommendation to the Board. A motion was made by Dr. Watkins to recommend dismissing the costs for first time offenders and to continue recovering costs for repeat offenders; additionally, to recommend maintaining the maximum cost assessment of \$5,000.00 for dentists and establishing the maximum cost assessment at \$1,250.00 for dental hygienists. The motion was seconded and passed.
- **60-19 Dental Laboratory Subcontractor Work Order Form** – Ms. Reen informed the Board after review of this document, she recommends to re-adopt the form. There is no license number associated with the subcontractor form; therefore, the form presented is the correct form for use. Ms. Ridout made a motion to recommend that the Board re-adopt the guidance as is. The motion was seconded and passed.

ADJOURNMENT:

With all business concluded, Dr. Petticolas adjourned the meeting at 11:58AM.

Augustus A. Petticolas, Jr., D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY
REGULATORY-LEGISLATIVE COMMITTEE MINUTES

October 26, 2018

Department of Health Professions

Henrico, VA 23233

CALL TO ORDER: Dr. Petticolas called the meeting of the Regulatory-Legislative Committee to order at 9:02AM. All Committee members were present.

MEMBERS PRESENT: Augustus A. Petticolas, Jr., D.D.S., Chair
Tonya A. Parris-Wilkins, D.D.S.
Tammy C. Ridout, R.D.H.
Sandra J. Catchings, D.D.S.
James D. Watkins, D.D.S.
Carol Russek, JD

OTHER BOARD MEMBERS PRESENT: Patricia Bonwell, R.D.H., Ph.D.
Nathaniel C. Bryant, D.D.S.
Jamiah Dawson, D.D.S.
Perry Jones, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director
Sheila Beard, Executive Assistant
Elaine Yeatts, DHP Policy Analyst
Barbara Allison-Bryan, DHP Chief Deputy

COUNSEL PRESENT: Jim E. Rutkowski, Asst. Attorney General

PUBLIC COMMENT: Dr. Petticolas announced the public comment period and no comments were forthcoming.

APPROVAL OF MINUTES: Dr. Watkins moved to accept the minutes from June 29, 2018 as presented. The motion was seconded and passed.

LEGISLATION AND REGULATORY: Ms. Yeatts provided a status report on the following regulatory actions:

- **Change in renewal schedule** – Comment period closed on 9/5/18
- **Amendment to restriction on advertising dental specialties** – Comment period closed on 9/5/18
- **Administration of sedation and anesthesia** – Comment period closed on 9/5/18
- **Prescribing opioids for pain management** – Comment period closed on 9/7/18

- **Conforming rules to ADA guidelines on moderate sedation** – Published as final regulations on October 19, 2018
- **Continuing education for practice by remote supervision** – became effective on 9/20/2018
- **Education and training for dental assistants II** – Comment period closed 9/5/18

**COMMITTEE
DISCUSSIONS:**

Ms. Yeatts reviewed and facilitated discussion of the following actions:

- **Education & Training of Dental Assistants II** – The substance of the proposed regulation needs to be reviewed to finalize proposed language in response to public comment. Staff recommended convening an ad hoc committee from the members of the Regulatory Advisory Panel for that purpose with the recommendations to be reported to the Board prior to the December Board meeting. Dr. Catchings made a motion to have staff convene an ad hoc committee to review and finalize recommendations on language for the proposed regulation. The motion was seconded and passed.
- **Petition for rulemaking from Dr. Ilchyshyn** – A copy of the petition from Dr. Ilchyshyn was reviewed by committee for consideration of granting continuing education credits for volunteer dentists who serve as preceptors to dental students volunteering at community/free clinics. The committee might recommend initiating rulemaking to make the regulatory change or recommend denying the petitioner’s request. Following discussion, Ms. Ridout made a motion to recommend denying the request of the petitioner. The motion was seconded and passed.
- **Regulations for Opioid Prescribing** – A recommendation for adoption of the final regulation to replace the emergency regulation is needed. The Committee might recommend the proposed regulation with or without changes in response to public comment. A motion was made by Ms. Ridout to recommend adoption of the final regulations as proposed. The motion was seconded and passed.
- **Administration of sedation & anesthesia** – The Committee discussed the regulatory language proposed by a Regulatory Advisory Panel and the public comments received on that language. Ms. Reen stated the Board has worked on this set of regulations a number of times to address the concerns of dentists. The following sections were discussed:
 - In 18VAC6021-260.E, replacing “for or to be administered” with “for administration”
 - In 18VAC60-21-279.B, replacing “for or to be administered” with “for administration.”

Ms. Yeatts’s offer to make this change every place this language appears in subsequent sections was accepted.

 - In 18VAC60-21-280.F(4), changing this section to read “If nitrous oxide/oxygen is used in addition to any other pharmacological agent and deeper levels of sedation or general anesthesia are produced, “then the” regulations for the induced level shall be followed.

- In 18VAC60-21-291 sections A(1) and A(2)(d) were discussed to draft appropriate language for certified registered nurse anesthetists. It was agreed that Ms. Reen and Ms. Yeatts would meet with the Executive Director of the Board of Nursing to determine if and how the current language should be revised.
- Comment received on 18VAC60-21-290.C against requiring a three-person treatment team for moderate sedation was considered. The Committee decided to recommend advancing the proposal to require a three-person treatment team.

Ms. Yeatts said the Committee might recommend keeping the proposed regulations as originally drafted or as amended. Dr. Watkins made a motion to recommend the regulations as amended by the Committee. The motion was seconded and passed.

- **Use of dental specialties** – The Committee can recommend advancing the regulation as proposed or take another action. Opposition to the proposed regulation was considered. Mr. Rutkowski advised recommending the proposed regulation. He also noted that a legislative change could also be proposed. Dr. Watkins made a motion to recommend advancing the proposed regulation. The motion was seconded and passed.
- **Change in renewal schedule** - The comment on the proposal to change the renewal schedule from March 31 each year to renewal by birth month beginning in 2021 was considered. It was noted that a one-time fee reduction was also proposed to minimize the financial impact on licensees. Dr. Watkins moved to recommend advancing the proposed regulation to change the renewal schedule to birth month. The motion was seconded and passed.
- **Content of Examination** – Ms. Yeatts asked the Committee to review the minutes of the August Examination Committee meeting and the current Guidance document 60-25 and consider if a regulatory action should be recommended as proposed by the Examination Committee. She said regulatory action is needed to establish content requirements for clinical exams because the Board's guidance document cannot be enforced. Ms. Yeatts added that the committee should decide if this should be a fast-track action. Ms. Reen commented on the problems that have occurred with applicants regarding acceptance of exams. Ms. Ridout made motion to recommend the draft regulation be issued as a Notice of Intended Regulatory Action and not a fast-track. The motion was seconded and passed.

ADJOURNMENT:

With all business concluded, Dr. Petticolas adjourned the meeting at 11:33AM.

Augustus A. Petticolas, Jr., D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

DRAFT Legislation

2019 Session of the General Assembly

A BILL to amend the *Code of Virginia* by amending §§ 54.1-2722 and 54.1-3408 of the Code of Virginia relating to administration of Schedule VI drugs by dental hygienists.

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2722 and 54.1-3408 of the *Code of Virginia* are 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 Lenowisco Health Districts; (ii) dental hygienists employed by the Department of Health; (iii) the Director of the Dental Health Division of the Department of Health; (iv) one representative of the Virginia Dental Association; and (v) one representative of the Virginia Dental Hygienists' Association. Such protocol shall be adopted by the Board as regulations.

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

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

Notwithstanding any other provision of law, a dental hygienist may practice dental hygiene under the remote supervision of a dentist who holds an active license by the Board and who has a dental practice physically located in the Commonwealth. No dental hygienist shall practice under remote supervision unless he has (i) completed a continuing education course designed to develop the competencies needed to provide care under remote supervision offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of

clinical experience. A dental hygienist practicing under remote supervision shall have professional liability insurance with policy limits acceptable to the supervising dentist. A dental hygienist shall only practice under remote supervision at a federally qualified health center; charitable safety net facility; free clinic; long-term care facility; elementary or secondary school; Head Start program; or women, infants, and children (WIC) program.

A dental hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine pursuant to subsections J or V of § 54.1-3408, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation. No dental hygienist practicing under remote supervision shall administer local anesthetic or nitrous oxide.

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

After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision may provide further dental hygiene services following a written practice protocol developed and provided by the supervising dentist. Such written practice protocol shall consider, at a minimum, the medical complexity of the patient and the presenting signs and symptoms of oral disease.

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

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

§ 54.1-3408. Professional use by practitioners.

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine or a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to

§ 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause drugs or devices to be administered by:

1. A nurse, physician assistant, or intern under his direction and supervision;
2. Persons trained to administer drugs and devices to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the Department of Behavioral Health and Developmental Services who administer drugs under the control and supervision of the prescriber or a pharmacist;
3. Emergency medical services personnel certified and authorized to administer drugs and devices pursuant to regulations of the Board of Health who act within the scope of such certification and pursuant to an oral or written order or standing protocol; or
4. A licensed respiratory therapist as defined in § 54.1-2954 who administers by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine and oxygen for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines.

Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any school nurse, school board employee, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education, or any employee of a private school that is accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education

who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a public institution of higher education or a private institution of higher education who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order issued by the prescriber within the course of his professional practice, an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services may possess and administer epinephrine, provided such person is authorized and trained in the administration of epinephrine.

Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize pharmacists to possess epinephrine and oxygen for administration in treatment of emergency medical conditions.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed athletic trainers to possess and administer topical corticosteroids, topical lidocaine, or other Schedule VI topical drugs; oxygen for use in emergency situations; and epinephrine for use in emergency cases of anaphylactic shock.

G. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § 32.1-50.2, such prescriber may authorize registered nurses or licensed practical nurses under the supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated based on protocols and policies established by the Department of Health.

H. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, or (iii) a private school accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a public institution of higher education or a private institution of higher education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administration of glucagon to a student diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services to assist with the administration of insulin or to administer glucagon to a person diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia, provided such employee or person providing services has been trained in the administration of insulin and glucagon.

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

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

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

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

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

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

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

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

N. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

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

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

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

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

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

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

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

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

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

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

X. Notwithstanding the provisions of § 54.1-3303, pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee

authorizing the dispensing of naloxone or other opioid antagonist used for overdose reversal in the absence of an oral or written order for a specific patient issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, a pharmacist may dispense naloxone or other opioid antagonist used for overdose reversal and a person may possess and administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. Law-enforcement officers as defined in § 9.1-101, employees of the Department of Forensic Science, employees of the Office of the Chief Medical Examiner, employees of the Department of General Services Division of Consolidated Laboratory Services, and firefighters who have completed a training program may also possess and administer naloxone in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Y. Notwithstanding any other law or regulation to the contrary, 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 an 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 may dispense naloxone to a person who has completed a training program on the administration of naloxone for opioid overdose reversal approved by the Department of Behavioral Health and Developmental Services, 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 dispensing may occur at a site other than that of the controlled substance registration provided the entity possessing the controlled substances registration maintains records in accordance with regulations of the Board of Pharmacy. A person to whom naloxone has been dispensed pursuant to this subsection 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.

Z. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, or (iii) a private school accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is trained in the administration of injected medications for the treatment of adrenal crisis resulting from a condition causing adrenal insufficiency to administer such medication to a student diagnosed with a condition causing adrenal insufficiency when the student is believed to be experiencing or about to experience an adrenal crisis. Such authorization shall be effective only when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Agenda Item: Regulatory Actions - Chart of Regulatory Actions

Board		Board of Dentistry
Chapter	Action / Stage Information	
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	<p><u>Change in renewal schedule</u> [Action 4975]</p> <p>NOIRA - Register Date: 8/6/18 Adoption of proposed on Dec. 14th</p>
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	<p><u>Amendment to restriction on advertising dental specialties</u> [Action 4920]</p> <p>NOIRA - Register Date: 8/6/18 Adoption of proposed on Dec. 14th</p>
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	<p><u>Administration of sedation and anesthesia</u> [Action 5056]</p> <p>NOIRA - Register Date: 8/6/18 Adoption of proposed on Dec. 14th</p>
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	<p><u>Prescribing opioids for pain management</u> [Action 4778]</p> <p>Proposed - Register Date: 7/9/18 Adoption of final on Dec. 14th</p>
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	<p><u>Conforming rules to ADA guidelines on moderate sedation</u> [Action 4748]</p> <p>Final - Register Date: 10/29/18 Effective: 11/28/18</p>
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	<p><u>Education and training for dental assistants II</u> [Action 4916]</p> <p>NOIRA - Register Date: 8/6/18 Regulatory Advisory Panel – 11/27/18</p>

Agenda Item: Board Action on Regulations for Opioid Prescribing

Included in your agenda package are:

A copy of proposed regulations which were published on 7/9/18 with comment until 9/7/18

A copy of comments on the proposed regulations to replace emergency regulations

Board action:

Adoption of a final regulation to replace the emergency regulation, identical to the proposed regulation, as recommended by the Regulation Committee.

Project 5064 - Other Action

BOARD OF DENTISTRY

Prescribing opioids for pain management

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" means 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" means nonmalignant 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" means drugs listed in The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) in Schedules II through IV.

"MME" means morphine milligram equivalent.

"Prescription Monitoring Program" means 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. Nonpharmacologic 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 18VAC60-21-103 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.

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

A. 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 per day.

3. Prior to exceeding 120 MME per day, the dentist shall refer the patient to 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 there is any risk factor of prior overdose, substance abuse, or doses in excess of 120 MME per day, and shall be considered when concomitant use of benzodiazepine is present.

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

1. Reevaluate 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 patient record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

18VAC60-21-104. Patient recordkeeping 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, the dentist shall either:

1. Refer the patient to a medical doctor who is a pain management specialist; or
2. Comply with regulations of the Board of Medicine, 18VAC85-21-60 through 18VAC85-21-120, if the dentist chooses to manage the chronic pain with an opioid prescription.

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

Any dentist who prescribes Schedules II through IV controlled substances after April 24, 2017, shall obtain two hours of continuing education on pain management, which must be taken by March 31, 2019. Thereafter, any dentist who prescribes Schedules II through IV controlled substances shall obtain two hours of continuing education on pain management every two years. Continuing education hours required for prescribing of controlled substances may be included in the 15 hours required for renewal of licensure.



Logged in as
Elaine J. Yeatts

Department of Health Professions

Board of Dentistry

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

Action	<u>Prescribing opioids for pain management</u>
Stage	<u>Proposed</u>
Comment Period	Ends 9/7/2018

All good comments for this forum [Show Only Flagged](#)

[Back to List of Comments](#)

Commenter: Dr.Edward H. Radcliffe

7/13/18 10:03 am

Personal use of Opioids prescribed by a Physician

I, when a practicing Dentist and after retiring from active practice of dentistry, was prescribed and I used prednisone for several years in an attempt to obtain relief from physical pain. this pain was a result of some injuries which were received in my earlier life. This was very helpful, physically, and I am certain that my knowledge of the possible harmful effects of continuing to use this over a long period of time avoided an addiction problem.

Commenter: Jonathan L Wong, Coastal Pediatric Dental & Anesthesia

7/31/18 3:06 pm

MMEs and naloxone

The opioid epidemic has been a hot topic both in medicine and dentistry. Although it has cost many individuals their lives, and cost their families and our communities countless amounts, I can only partially applaud this effort. Dentist should be prescribing opioids in a fashion that uses the lowest possible dose for the lowest possible time period. Extended release oral opioids have very few places in dentistry, especially for typical surgical procedures such as surgical extractions and implants. Most dental procedures also do not typically require opioid prescriptions for greater than 7 days. In addition, the consideration of non opioid pain management is considered standard of care in pain management. A multimodal approach has far greater efficacy in the management of both acute and chronic pain.

Where I tend to disagree with the proposal is the practicality of the use of MMEs for most practitioners. MMEs were designed as a way to transition patients from parenteral to enteral opioids. Many dentists are not familiar with this concept, and although it has been adopted by the CDC as a determining factor for when patients are at higher risk for overdose, it does little for the average prescribing dentist.

In addition, the widespread use of naloxone is not a solution to this problem. The demand for naloxone has caused an astronomical increase in the price of this medication. Although most commonly describe this medication as a harmless reversal for opioid overdose, it is simply a

temporary reversal of respiratory depression. There is no question that this medication has saved lives, but the blanket use of naloxone for any patient with "any risk factor of prior overdose, substance abuse, or doses in excess of 120 MME." There are numerous risk factors for substance abuse, and this regulation will likely result in the unnecessary overuse of naloxone.

Regulation and the policy of stressing the importance of pain scores and patient satisfaction helped create the opioid epidemic. Addressing the core issue of over prescription and over use of opioids is important and this regulatory action may help the issue, however the use of MMEs and naloxone for "any risk factor of prior overdose, substance abuse ..." is not likely to change the current situation. In fact, it may lead to excessive waste of resources. Finally, the requirement of CE in controlled substances has long been required in NY, where I had also held a license. The coursework has been ineffective in the curtailing of the opioid epidemic.

Jonathan L Wong, DMD, DADBA, DNDBA, FADSA

Diplomate, American Dental Board of Anesthesia

Diplomate, National Dental Board of Anesthesia

Fellow, American Dental Society of Anesthesia

Commenter: Cynthia Williams, Riverside Health System

8/23/18 8:19 am

Comments on Dept of Dentistry Prescribing of Opioids

My suggestion is that the Board of Dentistry regulation mirror exactly the board of medicine related to requirements for treatment of acute pain. It appears there are differences between the required co-prescribing of naloxone. I also support the mandated check of the PMP for all opioid prescriptions written, not just for second prescription.

Commenter: Walter E Saxon, Jr.

9/7/18 5:16 pm

Clarification, etc.

Under 18VAC60-21-102 B. "conduct an assessment of the patient's history and risk of substance abuse" is stated. That is a nebulous statement. I'd appreciate more guidance.

Under 18VAC60-21-106 I am against the addition of 2 hours CE for pain management every 2 years. There are dentists who don't prescribe. There are those of us who've had a very long history of very few prescriptions filled per month, etc. Making us take 2 hours every 2 years is only good for PR and will not cause us to write fewer prescriptions. Remember, it was the DEA that reclassified most Class III to Class II and as a result, a patient who leaves my office after surgery now must get a prescription for a narcotic (if I feel OTC's, etc. will not be sufficient), as they will have to come back to the office to get one and many live an hour away and it's likely to be after hours. I can no longer call or fax one to their pharmacy. When I asked at a study club how many dentists were writing more scripts than before the DEA action, all hands of those who prescribed went up. However, we've done an excellent job in educating our patients and few of the prescriptions are actually filled.

I personally don't like or tolerate the narcotics and have tried to keep patients away from them. Don't add 2 hours of CE for every 2 years. There must be a threshold for it. Also, unless there is new information or proof that there is a problem with dentists prescribing narcotics, the board of dentistry should not require this additional CE. They have the ability to revisit this issue if a problem is identified and then they could enact emergency regulations to address the specific problem.

Agenda Item: Board action on administration of sedation & anesthesia

Included in your agenda package are:

Minutes of Regulatory Advisory Panel (met on 12/1/17 and 2/2/18)

Minutes of Regulatory/Legislative Committee – 3/8/18

Copy of NOIRA

Copy of comments on the NOIRA

Copy of amended regulation as recommended by the Regulation Committee

Board action:

To adopt the proposed regulation as recommended by the Regulation Committee or other action.

APPROVED

**BOARD OF DENTISTRY
MINUTES OF THE REGULATORY ADVISORY PANEL ON THE
CONTROLLED SUBSTANCES, SEDATION AND ANESTHESIA REGULATIONS
Friday, December 1, 2017**

TIME AND PLACE: The meeting of the Regulatory Advisory Panel (RAP) of the Board of Dentistry was called to order on December 1, 2017 at 1:45 p.m. at the Department of Health Professions, 9960 Maryland Drive, Suite 201, Training Room 1; Henrico, Virginia.

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

PANEL MEMBERS PRESENT: David Sarrett, D.D.S.
Malinda Hesson, D.D.S.
Jacques Riviere, D.D.S.
Carol Russek, JD

ESTABLISHMENT OF QUORUM: All members of the Panel were present.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Shella Beard, Executive Assistant
Elaine Yeatts, DHP Policy Analyst

Ms. Reen gave the instructions for evacuating the building in case of emergency.

OPEN FORUM: Dr. Alexander explained the Forum is an opportunity for speakers to address their questions, concerns and recommendations for the Board of Dentistry's regulations. He noted that speakers have about five minutes to address their concerns. He then called on members of the audience who had signed the attendance sheet to make their comments. Other members of the audience also made comments. The transcript of the comments received are attached to these minutes.

PANEL DISCUSSION: Following a brief break, Dr. Alexander asked the panel how it would like to proceed with its review. Discussion followed about topics that should be considered in addition to the ones identified by the public.

Ms. Yeatts suggested the panel take time to go over the ADA guidelines and our current regulations along with the transcript from the open forum.

After identifying a number of topics of interest, the panel agreed to defer discussion of regulatory changes to a subsequent meeting in order to review all the comments received. In addition, staff was asked to send the full text of the Regulations Governing the Practice of Dentistry, the American Academy of Pediatric Dentistry sedation guidelines and the American Society of Anesthesiologists practice guidelines.

**Virginia Board of Dentistry
Regulatory Advisory Panel Meeting
December 1, 2017**

2

NEXT MEETING: Ms. Reen noted that Friday, February 2, 2018 had been reserved if a second meeting was needed. The Panel agreed to meet that day.

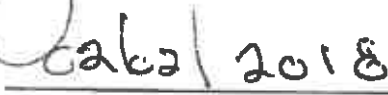
ADJOURNMENT: With all business concluded, Dr. Alexander adjourned the meeting at 3:44 p.m.



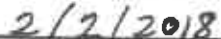
John M. Alexander, D.D.S., Chair



Sandra K. Reen, Executive Director



Date



Date

VIRGINIA BOARD OF DENTISTRY

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

TIME AND PLACE: The meeting of the Regulatory Advisory Panel (RAP) of the Board of Dentistry (Board) was called to order on February 2, 2018 at 1:56 p.m., at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.

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

PANEL MEMBERS PRESENT: Malinda Husson, D.D.S.
Carol Russek, J.D.
David Sarrett, D.D.S.

PANEL MEMBERS ABSENT: Jacques Riviere, D.D.S.

OTHERS PRESENT: Augustus A. Petticolas, Jr., D.D.S.

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

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

Ms. Reen read the emergency evacuation procedure.

APPROVAL OF MINUTES: The December 1, 2017 minutes were accepted as presented by consensus.

PUBLIC COMMENT: Catherine Harrison, CRNA, stated that she was present to clarify any questions concerning sedation provided by CRNAs in dental practices.

PANEL DISCUSSION: Dr. Alexander expressed his appreciation for the information and recommendations the RAP received at the December 1, 2017 Open Forum. He explained that the draft of Part VI of the Regulations Governing the Practice of Dentistry provided for discussion includes the recommendations received throughout the text as well as the notes that he and Dr. Sarrett had added.

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

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

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

NEXT STEPS:

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

ADJOURNMENT:

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

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

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

**VIRGINIA BOARD OF DENTISTRY
REGULATORY-LEGISLATIVE COMMITTEE MINUTES**

March 8, 2018

Department of Health Professions

Henrico, VA 23233

- CALL TO ORDER:** Dr. Augustus A. Petticolas, Jr. called the meeting of the Regulatory-Legislative Committee to order at 9:11AM. With 5 Board members present, a quorum was established.
- MEMBERS PRESENT:** Augustus A. Petticolas, Jr., D.D.S., Chair
Tonya A. Parris-Wilkins, D.D.S.
Tammy C. Ridout, R.D.H.
Sandra J. Catchings, D.D.S.
John M. Alexander, D.D.S.
- MEMBERS ABSENT:** James D. Watkins, D.D.S.
- STAFF PRESENT:** Sandra K. Reen, Executive Director
Sheila Beard, Executive Assistant
Elaine Yeatts, DHP Policy Analyst
- PUBLIC COMMENT:** Benita A. Miller, DDS – Objecting to fast track action to amend the restriction on advertising dental specialties
Karen McAndrew, DMD, MS - Objecting to fast track action to amend the restriction on advertising dental specialties
Kassie Schroth, McGuire Woods Consulting – Asking that the Board conforms its regulations to more closely reflect the statute addressing the requirement for permits for sedation and anesthesia; specifically, who can provide or administer sedation.
Frank Iuorno, DDS, MS - Objecting to fast track action to amend the restriction on advertising dental specialties
Stephanie Voth - Objecting to fast track action to amend the restriction on advertising dental specialties
Thomas Glazier, DDS, MSD - Objecting to fast track action to amend the restriction on advertising dental specialties
Ben Ross, DMD - Objecting to fast track action to amend the restriction on advertising dental specialties
Ursula Klostermyer, DDS, PhD - Objecting to fast track action to amend the restriction on advertising dental specialties
Tamika Atkins - Objecting to fast track action to amend the restriction on advertising dental specialties

Danielle McCormick, DDS, MS - Objecting to fast track action to amend the restriction on advertising dental specialties

Sorin Uram-Tuculescu, DDS – Objecting to adding PGY-1 Pathway for Licensure.

Daniel Bartling, DDS - Objecting to fast track action to amend the restriction on advertising dental specialties

APPROVAL OF MINUTES:

Dr. Catchings moved to accept the minutes of June 30, 2017 as written. The motion was seconded and passed.

LEGISLATION AND REGULATORY

Ms. Yeatts explained to the Committee that due to the change in administration, all regulatory actions waiting to be signed were sent back to the Secretary's office for review, which will not take place until the current session of the General Assembly is ended. A more detailed regulatory report will be provided at the Full Board Business Meeting on March 9, 2018.

A status report was provided about following regulatory actions:

- **Change in renewal schedule** – *waiting for Secretary Action.*
- **Conforming rules to ADA guidelines on moderate sedation** – *propose that the Board adopt as final.*
- **Reduction in renewal fees** – *In effect on February 21, 2018.*
- **Continuing education for practice by remote supervision** – *proposed regulation is in effect; final regulations need to be in place by May 12, 2019.*

COMMITTEE DISCUSSIONS:

Amending the restriction on Advertising Dental Specialties -

Ms. Yeatts advised that given the comments received on this action, the standard process will need to be followed. The Committee adopted a motion for the Board that this regulatory action be withdrawn as a Fast Track Action and that a NOIRA be submitted to start the standard regulatory process.

C.E. Credit for attending Board Meetings –

At the December 15, 2017 Board meeting, Dr. Alexander referred consideration of granting C.E. credit for attending Board meetings to the Regulatory-Legislative Committee for review. The Committee was not in favor of pursuing granting C.E. Credit for attending Board meetings and adopted a motion for the Board that the Board not pursue this.

Adding PGY-1 Pathway for Licensure –

Questions were raised at the December 15, 2017 Board meeting about eliminating the clinical exam requirement for applicants who have completed an advanced general dentistry or specialty program since the Board only issues general dental licenses. The Board referred this proposal to the Regulatory-

Legislative Committee for further discussion. The Committee adopted a motion for the Board that the Board not pursue adding PGY-1 as a pathway to licensure.

**Regulatory-Advisory Panel Recommendations on Sedation
Recommendations-**

Proposed changes to Part VI of the Regulations Governing the Practice of Dentistry from the RAP was reviewed by the Committee. Ms. Reen explained to the Committee the intention of the RAP is to assist the Board in understanding changes needed to clarify the regulations. This process is a “pre” regulatory process. The regulatory process will begin once a NOIRA has been adopted.

After review of the panel’s recommendations, the Committee adopted a motion for the Board that the Board issue a NOIRA to revise the Sedation Regulations.

ADJOURNMENT: With all business concluded, Dr. Petticolas adjourned the meeting at 10:32AM.

Augustus A. Petticolas, Jr., D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

NOTICES OF INTENDED REGULATORY ACTION

TITLE 12. HEALTH

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Behavioral Health and Developmental Services intends to consider amending 12VAC35-105, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services. The purpose of the proposed action is to comply with the quality and risk management system requirements of the U.S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG) and develop and implement a system to ensure that individuals in the Settlement Agreement population who are receiving services in Virginia's public system of services receive a level of care that is good quality, meets individuals' needs, and helps individuals achieve positive outcomes. Quality improvement measures are required of community services boards for services they provide, but those services are not currently in the Department of Behavioral Health and Developmental Services (DBHDS) licensing regulations for providers. The proposed amendments will clarify and expand the requirements for the quality practices for the health, safety, care, and treatment for adults who receive services from DBHDS service providers.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 37.2-302 and 37.2-400 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Emily Bowles, Legal Coordinator, Office of Licensing, Department of Behavioral Health and Developmental Services, 1220 Bank Street, P.O. Box 1797, Richmond, VA 23218, telephone (804) 225-3281, FAX (804) 692-0066, TTY (804) 371-8977, or email emily.bowles@dbhds.virginia.gov.

V.A.R. Doc. No. R18-4381; Filed July 12, 2018, 9:52 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-21, Regulations Governing the Practice of Dentistry. The purpose of the proposed action is to replace regulatory provisions specific to the advertising of dental specialties with reference to the statutory language regarding the use of trade names. Specifically being considered for removal are provisions prohibiting (i) advertising a claim of a dental specialty unless it is approved by the National Certifying Boards for Dental Specialists of the American Dental Association and (ii) representation by a dentist who does not hold specialty certification that his practice is limited to providing services in such specialty area without disclosing that he is a general dentist. The prohibition of a claim of professional superiority remains in the regulation.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

V.A.R. Doc. No. R18-5206; Filed July 5, 2018, 5:12 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-21, Regulations Governing the Practice of Dentistry. The purpose of the proposed action is to amend regulations relating to administration of sedation or anesthesia in dental offices. The goals of the proposed action are greater consistency and clarity of the requirements, depending on the level of sedation and the risk to the patient, and closer alignment with the American Dental Association Guidelines for the Use of Sedation and General Anesthesia. The board intends to amend provisions that are problematic to dentists, such as compliance with current regulations regarding special needs patients. The board intends to incorporate guidelines and best practices for sedation and anesthesia, such as the use of a three-person team in the operatory during administration of moderate sedation.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.



August 23, 2018

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

**Re: Public Comment in response to the Notice of Intended Regulatory Action (NOIRA)
Regarding the Regulations Governing the Practice of Dentistry Related to Administration
of Sedation and Anesthesia (18 VAC 60-21)**

Dear Ms. Reen,

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

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

VANA applauds the Board of Dentistry for addressing these issues and for proposing important changes to the regulations. We are pleased to see the Board has proposed an increase for the treatment team from two to three and believe this is an important step toward increased anesthesia safety. However, we remained concerned that the proposed language continues to allow dentists to administer sedation and anesthesia in a dental office without a permit, which is a violation of Virginia Code §54.1-2709.5.

Delegation of Administration (18VAC60-21-291 and 18VAC60-21-301) – The Proposed Regulations Continue to Contradict Virginia Code § 54.1-2709

The language under 18VAC60-21-291(A)(1) and 18VAC60-21-301(A)(1) contradict the changes proposed under 18VAC60-21-290 and 18VAC60-21-300 and exceed statutory authority by allowing a

dentist who does not hold a permit to administer conscious/moderate or deep sedation or general anesthesia by delegating the administration to an anesthesiologist.

VANA requests the following amendment to 18VAC60-21-291(A)(1) and 18VAC60-21-301(A)(1) based on the explanation below.

1. A dentist who does not hold a permit to administer conscious/moderate sedation ~~may not provide or administer conscious/moderate sedation, 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 a qualified dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer such sedation.~~

Virginia Code §54.1-2709.5 states:

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

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

"C. This section shall not apply to:

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

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

The statute is clear that any dentist who provides or administers conscious/moderate or deep sedation or general anesthesia in a dental office must obtain either a conscious/moderate sedation permit or a deep sedation/general anesthesia permit. The statute does not provide an exception for dentists who do not hold a permit to use the services of an anesthesiologist to administer sedation. The only instances where a



permit is not required is specific to oral and maxillofacial surgeons or the administration of anxiolysis for minimal sedation.

We thank you for your efforts to update the regulations and we look forward to continuing to work with you.

Sincerely,

/s/ Myra Branch

**Myra Branch
President
Virginia Association of Nurse Anesthetists**

**cc: Dr. David Brown, Director, Virginia Department of Health Professions
Ms. Elaine Yeatts, Virginia Department of Health Professions
Ms. Jay Douglas, Executive Director, Board of Nursing
Ms. Michele Satterfund, McGuireWoods Consulting
Ms. Kassie Schroth, McGuireWoods Consulting**

VIRGINIA.GOV Agencies | Governor



Logged in as

Elaine J. Yeatts

Agency: **Department of Health Professions**

Board: **Board of Dentistry**

Chapter: **Regulations Governing the Practice of Dentistry [18 VAC 80 - 21]**

Action	Administration of sedation and anesthesia
Stage	NOIRA
Comment Period	Ends 9/5/2018

All good comments for this forum [Show Only Flagged](#)

[Back to List of Comments](#)

Commenter: jefferson t Blackburn

8/8/18 8:44 am

sedation regulatulations

This comment is in response to the possible requirement of a 3rd person needed in the room during sedation. This is an absolutely absurd recommendation. In fact it would actually increase potential problems and distractions. I only allow sedation certified assistants with me in the room during a procedure and have never had the need for a 3rd person. This also is an increase in overhead to us and our patient. Properly trained personnel can do the job!!!!!!!

If a dentist wants a 3rd person in the operatory then they can do that. The mandateing of this is what I am totally opposed to.

Jeff Blackburn

Commenter: Dr. Thomas B Padgett

8/8/18 8:57 am

Strike thru may have been missed

Section 18VAC60-21-291

Paragraph A, section 2, Line d: medical has not been struck thru as in other sections

Commenter: John H Unkel DDS MD, Bon Secours Pediatric Dental Associates

8/8/18 5:07 pm

2. Administration of Sedation and Anesthesia

The last sentence states - "...a three-person team in the operatory during administration of Moderate sedation". This is incorrect per many national guidelines. It should state 3 individuals for Deep sedation. Therefore, the statement should be changed to reflect and be congruent with national guidelines.

Commenter: Chris R. Richardson, DMD, MS

8/8/18 10:13 pm

Clarification of ASA and Associated ADA Sedation Guidelines-OPPOSED TO 3-PERSON RECOMMENDATION

This will be very simple. I have a letter from Dr. James Toms, DDS, MS, FACD. Dr. Toms serves as both the American Dental Association (ADA) and American Society of Dentists Anesthesiologists (ASDA) representative to the American Society of Anesthesiologists (ASA) Task Force on the 2018 PRACTICE GUIDELINES FOR MODERATE PROCEDURAL SEDATION AND ANALGESIA. The letter clearly states that the current two-person delivery of IV Moderate Conscious Sedation is NOT, I REPEAT, NOT being changed in the ADA nor ASA guidelines. This letter is of public record and I have copied it here. PLEASE READ and appreciate the contents:

April 25, 2018

As both the American Dental Association (ADA) and American Society of Dentists Anesthesiologists (ASDA) representative to the American Society of Anesthesiologists (ASA) Task Force on the 2018 *Practice Guidelines for Moderate Procedural Sedation and Analgesia*, I want to make exceedingly clear the intent and recommendations on specific language in a section of the *Guidelines* that is entitled "Availability of an Individual Responsible for Patient Monitoring" (pg. 443, second column).

In regards to the first bullet-point stipulated in the recommendation, where in the *Guidelines* it states,

- The individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction and be authorized to seek additional help.

We agree that this responsibility is fulfilled by any dental assistant with basic life support (BLS) training. Recognition of unconsciousness, apnea, airway obstruction, cardiac arrest, and the summoning of emergency medical services has been a long held competency in all current BLS certificate courses. A dental assistant, whether a registered dental assistant or otherwise, by virtue of BLS training and certification, can adequately perform these tasks.

Secondly, in regards to the subsequent bullet-point in the *Guidelines* which state,

- The designated individual should not be a member of the procedural team but may assist with minor, interruptible tasks once the patient's level of sedation/analgesia and vital signs have stabilized, provided that adequate monitoring for the patient's level of sedation is maintained.

The intent of this statement is to assure that at least one individual can assist the operating dentist in monitoring the moderately sedated patient AND concurrently be involved in minor, interruptible tasks such as suctioning, light-curing, tissue or tongue retraction, etc. Note carefully that this statement contains a "should" statement that is emphasizing that this individual should not be involved with the conduct of the procedure or surgery, but instead act in a supplemental role that assists in patient monitoring and minor surgical/procedural tasks. Akin to Commission on Dental Accreditation (CODA) standards, a "should" statement is NOT a requirement, but rather presents an intent statement that implies "highly desirable, but not mandatory" as per CODA definition of terms.

We discussed this issue at great length at the ASA Task Force meetings to ensure that not only the dental profession can continue to practice to current ADA Moderate Sedation Guidelines which only require the presence of one other individual beside the operating dentist to assist in monitoring, but also that various other physician disciplines may operate in settings where the physician providing the moderate sedation can rely on the assistance of only one nurse, respiratory therapist, physician's assistant, etc.

When I presented the draft document to the ADA for scrutiny, it was carefully examined for this exact issue and found to be congruent with existing 2017 ADA Guidelines, which explicitly state:

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

With this understanding, the ADA gave expressed sponsorship and published endorsement of the 2018 ASA Guidelines as reinforcing and supporting past and present dental moderate sedation guidelines. The 2018 ASA Guidelines also concur with the American Academy of Pediatrics/American Academy of Pediatric Dentistry (AAP/AAPD) *Guideline for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016* wherein the authors (one of which is also an author of the ASA Guidelines) state the following:

- **Support personnel.** The use of moderate sedation shall include the provision of a person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration, such as holding an instrument or troubleshooting equipment. (AAP/AAPD p. 223)

To clarify even more and remove all ambiguity, the ASA Guideline document includes a "Summary of Recommendations" found in Appendix 1 (pg. 450, column two). Within the section found on page 450 and continuing on to page 451, within the subheading of "Availability of an Individual Responsible for Patient Monitoring," language is clear in requiring only "a designated individual other than the practitioner performing the procedure is present to monitor the patient throughout the procedure." Further, this individual is only responsible for monitoring the patient for signs of apnea and airway obstruction AND "may assist with minor, interruptible tasks." The summary removes the "should" statement and for brevity and clarity, and stipulates only one additional person other than the practitioner needs to be present to assist in monitoring.

I wanted to assure you and others that the traditional dental model of only requiring one dental assistant while the operating dentist performs the procedure and administers moderate sedation is strongly supported by these ASA Guidelines. As a dental educator that provides a long-standing parenteral moderate sedation certification course for general practitioners and dental specialists from all over the nation, I made great efforts to promote the safety and continued use of this practice model to the ASA Task Force.

There is no effort underway or planned to require a third individual to be a sole monitor in moderate sedation practice in dentistry or medicine.

Please feel free to contact me at any time regarding this issue or any other issues involving patient safety, sedation, or anesthesia in general dental or specialty dental practice.

Respectfully,

Jimmy

James Tom DDS, MS, FACD
Dentist Anesthesiologist
Diplomate, American Dental Board of Anesthesiology
Diplomate, National Dental Board of Anesthesiology
President, American Society of Dentist Anesthesiologists
Associate Clinical Professor
Herman Ostrow School of Dentistry
University of Southern California
Division of Endodontics, General Practice Residency, and Orthodontics 925 W. 34th Street RM
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(213) 740-1081 jtom@usc.edu

Improving Access to Care for Dental Patients and Their Dentists

4411 Bee Ridge Road, #172 ? Sarasota, FL 34233 ? (phone) 312.624.9591 ? (fax) 773.304.9894 ? www.asdahq.org

Commenter: Jonathan L Wong, Coastal Pediatric Dental & Anesthesia

8/9/18 6:28 pm

Difficulty for the public to truly review proposed changes

I would like to make a technical comment, which will be separate from my professional comment, on this proposal. I believe that it has been made unnecessarily difficult for the general public to ascertain the true changes that are being made to the regulations because there is currently the "Conforming rules to ADA guidelines on moderate sedation" changes that are also in their final stage and Governor's review. These changes also affect the definitions in the proposal made that is up for commentary. As such, it takes a careful review of the definitions minimal and moderate sedation to completely grasp the meaning of the proposed text that we have been asked to comment on.

As such, I would strongly encourage anyone to also read and incorporate the changes from "Conforming rules to ADA guidelines on moderate sedation" into their read of this proposal. The final text is available here: <http://townhall.virginia.gov/L/ViewXML.cfm?textid=12406>

Thank you,

Jonathan L Wong, DMD, DADBA, DNDBA, FADSA *

Diplomate, American Dental Board of Anesthesia

Diplomate, National Dental Board of Anesthesia

Fellow, American Dental Society of Anesthesia

* The ADA does not recognize Dentist Anesthesiologists as specialists, therefore anesthesiology services are rendered as a general dentist with a general anesthesia permit.

Commenter: Lillie Pitman, DMD

8/10/18 9:27 am

Correction needed

The last sentence states - "...a three-person team in the operatory during administration of Moderate sedation.". This is incorrect per many national guidelines. It should state 3 individuals for Deep sedation. Therefore, the statement should be changed to reflect and be congruent with national guidelines.

Commenter: Benjamin T. Watson DDS, MAGD

8/10/18 11:59 am

Sedation Regulation

I started providing oral conscious sedation in 2001-2002. At that time there were virtually no regulations except have a DDS or DMD degree. As more dentists began to use oral sedation regulations were developed to ensure safety of the patient. These regulations included courses designed in airway management as well as sedation procedures. I fully supported these

regulations as patient safety cannot be jeopardized. Then in about 2011 or there about, more regulations were made. You had to have taken a 3 day course in sedation. Well because my original course was only 2 days I had to go back and retake a whole new course even though I had been doing oral sedation for 10 years. Also, because The Board could not guarantee that my 3 day course would be approved (it eventually was) I had to take another course by a dental anesthesiologist to insure it would be accepted. Then came the Moderate Sedation Permit. I got the permit even though virtually all my sedations are "minimal sedation." I kept the permit so my patient's would know that I went through the training to perform oral sedation and just in case The Board questions at some time if a patient was minimal or moderate. I can see where The Board is trying to go, that is eventually requiring any dentist doing any kind of sedation to have an IV permit. This would be totally absurd. I go all out (as most dentists) in making sure my patients under sedation are safe. It starts with a complete health history and medications they are on. The meds are run through Lexicomp for any possible interactions. I then do what I call a sedation pre-assessment which includes all vital signs, Malampati, tonsils, ASA classification, height, weight, BMI, as well as listening to their lungs. If there are any questions as to health concerns then I don't sedate or at minimum have a medical consult. I have all the required medical equipment. I use a pulse ox as well as capnography on each patient. You can see I go above and beyond what The Board requires. My patients appreciate the fact that I offer oral sedation. It has benefited many patients who would not have had dentistry. I have invested many years and finances in oral sedation. Regulations are good, I endorse most but the direction The Board is going (example requiring a 3 member team) is simply wrong. I sincerely hope The Board uses common sense in what they require. If you are heading in the direction of requiring all sedations to have an IV permit (which is what I have heard) I hope you change course. This would hurt so many patients who would benefit from oral sedation.

Commenter: James W Tom

8/10/18 3:52 pm

Further clarification of number of personnel needed for moderate ("conscious") sedation

August 10th, 2018

Dear Virginia Board of Dentistry,

In reference to a copy of a letter I drafted to clarify some misconceptions regarding the mandate of a 3rd individual being present during the performance of moderate sedation in a dental office-based setting, I was asked to re-iterate some of the points that currently exist in not only the American Society of Anesthesiologists (ASA) 2018 Moderate Procedural Sedation and Analgesia Guidelines, but also in the newly affirmed American Academy of Pediatrics/American Academy of Pediatric Dentistry (AAP/AAPD) Guideline for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016.

I've maintained and continue to maintain that the intent and goals of all of the authors of the ASA 2018 Guidelines, which were comprised of not only dentists, but also pediatric physician anesthesiologists, a gastroenterologist, a cardiologist, an emergency medicine physician, an interventional radiologist, and other physician anesthesiologists, were to establish the two-person model of moderate sedation provision as the de facto standard of care, regardless of the setting.

If the sedation provider truly intends for the patient to be in moderate sedation, in which patients purposefully respond to verbal stimulation and are awake during the procedure, you, in essence, already have three individuals present to ensure a minimum level of safety in monitoring and response: 1) The treating dentist, who is providing the sedation, 2) the dental assistant, who is monitoring the patient along with the treating dentist, and 3) the patient themselves who is providing verbal and purposeful response to the dentist and assistant during the procedure to indicate safe levels of sedation.

I would respectfully urge the Virginia Board of Dentistry to reconsider the proposed language to mandate 3 individuals needed for the safe provision of moderate sedation as unnecessarily

exceeding established and researched national guidelines. Given the greater context of patients undergoing procedural moderate sedation in different healthcare venues outside of dentistry, the proposed mandate goes well beyond the intent of guideline committees specifically tasked to examine this matter.

As others have already stated, 3 individuals are required for the delivery of *deep sedation and/or general anesthesia* in a dental setting. The current ASA, ASDA, and AAP/AAPD positions on deep sedation/general anesthesia for pediatric patients in dental settings require the third individual to be a dedicated and independent anesthesia provider (DDS, MD/DO, or CRNA) not involved in the conduct of the procedure. (see: [https://www.csahq.org/docs/default-source/default-document-library/asa-statement-on-sedation-anesthesia-administration-in-dental-office-based-settings-\(1\).pdf?sfvrsn=0](https://www.csahq.org/docs/default-source/default-document-library/asa-statement-on-sedation-anesthesia-administration-in-dental-office-based-settings-(1).pdf?sfvrsn=0) and http://www.aapd.org/media/Policies_Guidelines/BP_AnesthesiaPersonnel.pdf)

Respectfully submitted by request,

Jimmy

James Tom DDS, MS, FACD

President, American Society of Dentist Anesthesiologists

Associate Professor

Herman Ostrow School of Dentistry

University of Southern California

Commenter: Jonathan Wong, DMD; Coastal Pediatric Dental & Anesthesia

8/12/18 12:25 pm

Comments and rationale for modification of proposed changes

Thank you for the efforts to update the sedation and anesthesia guidelines for the Commonwealth of Virginia. Although I agree with a majority of the changes in the proposed text, there are some additional comments I wish the Board to consider.

First under the definitions in 18VAC80-21-10 I would ask that you consider the following changes:

- 1) Under section D, it may not be necessary to delete the definition of enteral. Although moderate sedation is changing in order to not distinguish between enteral and parenteral routes of administration (and appropriately so), the definition of enteral may still come into play, especially when discussing maximum recommended doses in minimal sedation.
- 2) A point of clarification is that under Deep Sedation and General Anesthesia, the definitions mention "ventilator functions", this should state ventilatory function. A ventilator is the mechanical machine that provides ventilatory support, the body has ventilatory and cardiovascular functions in these two definitions.
- 3) Please consider defining the "maximum recommended dose" as this will be a very debatable definition that practitioners will argue when defining the line between minimal and moderate sedation, as stated in 18VAC80-21-280 Section F 4. The ADA defines this in their guidelines as follows: "maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use." As a point of comment - this definition even by the ADA may be challenged by some providers as Xanax (alprazolam) allows for a higher FDA recommended maximum dose if titrated by the practitioner over time to the desired effect. Some may choose to use the actual highest dosage allowed of 10mg per day, even though the FDA recommends dosing increases at intervals of 3-4 days and when increased should not be increased more than 1mg per day.

Under 18VAC60-21-260 General Provisions

1) Section K1 - It allows delegation of monitoring to "another dentists, anesthesiologists, or certified registered nurse anesthetist (CRNA)." In all other instances where a CRNA is mentioned, it is under the direction of the dentist, but in this single instance it is not. According to the regulations, the CRNA must practice under the direction of a dentist with the appropriate level of sedation / anesthesia permit. Therefore, a CRNA should also be under the direction of the dentist like the aforementioned assistant, hygienist, or nurse in this section.

2) Section M - Instead of "Special needs patients", this should read "Patients with Special Healthcare Needs". This is a matter of political correctness. In addition, the provisions here should also apply to pediatric patients that are uncooperative for IV placement prior to induction. Although this is mentioned in the section, the section heading makes it sound as if it only applies to Patients with Special Healthcare Needs.

18VAC60-21-279 Under section D - this section mentions the required equipment that shall be in working order and available, therefore item # 5 should not allow a pulse oximeter to not be available in the facility, therefore the section should simply read pulse oximeter.

18VAC60-21-290 Section 4.b - I would encourage the Board to consider changing the language of "at the timing that training occurred." The ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students have been developed to increase patient safety by ensuring that training and update / refresher courses meet the new standards, especially in terms of the competency in rescuing the airway and establishing parenteral access. The American Society of Anesthesiologists' 2018 Task Force on Procedural Sedation found that it was critical that a member of the team be competent in IV access.

(<http://anesthesiology.pubs.asahq.org/article.aspx?articleid=2670190>) Practitioners should be held responsible for updating their training, especially in sedation and anesthesia as that person is responsible for the safety of the patient's life and the management of any complication that might arise.

Under 18VAC60-21-291

1) Section B.11 does not need to state parenteral administration any longer as this is all part of moderate sedation now and ECG should be required.

2) Section C - there is already a lot on input regarding this, but I would like the Board to consider verbiage such as this. "There shall be a two person team in the room with the patient at all times." I believe the Board's intent was to ensure that two people were always present at the time, and as the AAPD and ADA guidelines state, the person monitoring the patient may have minor interruptible tasks. In many practices, this might include an immediately available third assistant to function as a "circulator" much like a circulating nurse in the OR. Nevertheless, the established standard is a two person team. The only other explanation I have heard to justify this is the AAOMS Parameters of Care that state in Deep Sedation or GA that if the person monitoring the patient have no other responsibilities. However, this is Deep Sedation or GA.

Finally, it may be prudent for the Board to consider when a patient may be considered adequately recovered for these teams to leave the room with a designated staff member. Unfortunately there have been numerous reports and associated morbidity and mortality when the sedation or anesthesia provider moves on to the next patient and leaves a patient with an "monitoring assistant." The ADA guidelines require that the patient return to a state of minimal sedation prior to leaving them with a dental assistant. This may vary if the delegated individual were say an RN or a CRNA whom is licensed and has the adequate training to thoroughly monitor say the moderately sedated patient in recovery.

Thank you for your time and consideration of the above comments,

Jonathan L Wong, DMD, DADBA, DNDBA, FADSA

Diplomate, American Dental Board of Anesthesia *

Diplomate, National Dental Board of Anesthesia *

Fellow, American Dental Society of Anesthesiology *

*The ADA does not recognize Dentist Anesthesiologists as specialists, therefore anesthesiology services and expertise are rendered as a general dentist with a general anesthesia permit.

Commenter: Aaron Stump DDS Charlottesville Pediatric Dentistry

8/17/18 11:32 am

Clarification

Under section 18VAC60-21-260 K.2e there is no clarification on when, what type, and duration of vital sign monitoring is needed for minimal sedation. Please clarify.

Commenter: Uniforce

8/22/18 1:28 am

Effects on cardiorespiratory function

Dexmedetomidine can have deleterious effects on cardiorespiratory function. In a study of adult patients undergoing vascular surgery, Venn *et al.* reported that 18 of the 66 patients who received dexmedetomidine experienced adverse hemodynamic effects including hypotension.. Dr. Alex Carros

Commenter: Jonathan L Wong, Coastal Pediatric Dental & Anesthesia

8/26/18 7:00 pm

NFPA 99 Considerations while updating sedation regulations

The National Fire Protection Association has had national standards on medical gas systems which are codified in the NFPA 99. NFPA 99 has included dental offices performing any form of sedation, anesthesia, and anxiolysis since at least 1996. However, these rules have been seldomly enforced in dental offices. In a discussion with members of the Virginia Society of Oral and Maxillofacial Surgeons, I was made aware that they have now made certification by an American Society of Sanitary Engineers (ASSE) 6030: medical gas verifier as part of their anesthesia self inspections for any new or renovated gas system. Given the unfortunate issues that have arisen in the past in Virginia, I would ask that the Board also consider these National Safety Standards when updating the sedation and anesthesia regulations.

In addition, the Dental Board has included by reference the American Academy of Pediatric Dentistry's (AAPD) Guidelines on Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures. However, there is no reference to AAPD Policy on the Use of Deep Sedation and General Anesthesia in the Pediatric Dental Office. In this policy it states, "The pediatric dentist is also responsible for establishing a safe environment that complies with local, state, and federal rules and regulations, as well as the Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures for the protection of the patient." The NFPA 99 is the ANSI (Federal) standard for medical gas systems. In addition it is also adopted by reference in the International Plumbing Code and International Fire Code, which are adopted by the Statewide Building Code (State). Local enforcement of this has been variable, but the policy set forth by the AAPD and now by VSOMS suggests that the dentist is responsible for ensuring this step toward compliance is followed.

In addition, such great concern for patient safety in dentistry from lack of compliance with NFPA 99 exists, that the NFPA has included a new chapter in the 2018 revision of the NFPA 99 code. This chapter, Chapter 15, is solely about dental offices.

I would ask that the Board consider these issues when changing the regulations on sedation and anesthesia. They may not be currently enforced in dentistry, but with the new 2018 changes they certainly will be in the future. I am uncertain if this is something that the Board of Dentistry wishes to address at this time while comment is open on these regulations, or if this should be left to Building Inspectors and Fire Marshals. Nevertheless, I believe it prudent to consider.

Sincerely,

Jonathan L Wong, DMD, DADBA, DNDBA, FADSA *

Diplomate, American Dental Board of Anesthesia

Diplomate, National Dental Board of Anesthesia

Fellow, American Dental Society of Anesthesia

* The ADA does not recognize Dentist Anesthesiologists as specialists, therefore anesthesiology services are rendered as a general dentist with a general anesthesia permit.

Commenter: Josh Hanson

8/26/18 7:49 pm

clarification needed

Under section 18VAC60-21-260 K.2e and under Under section 18VAC60-21-291 D.2e we need clarification as to how often the vital signs has to be recorded. You cant record blood pressure every second, the machine takes longer than that to take it. Why did you get rid of the every 5 minutes. It is impossible to do it every second. You need a time measure, every 5 min for instance. If you dont have a specified time measure you open yourself up to people doing it every 10 min, 15 min etc.

Under section 18VAC60-21-260 C required staffing. I agree with the other commenters. For this level of sedation 2 people is sufficient. Requiring 3 people is against other national guidelines and would mean the dental board of Virginia is establishing their own national guidelines. The ada guidelines also only support a 2nd person not a 3rd.

Commenter: Dr. Kim Kitchen, Old Town Smiles

8/28/18 1:27 pm

Minimal Sedation Restriction Proposal

Drs., I am writing to voice my strong opinion on what your proposal to limit our sedation options. Oral Sedation has been proven to be one of the safest modalities. The ADA guidelines and the commonwealth states don't have as restrictive guidelines that you are proposing. My whole team has been ACLS certified and I have gone to multiple DOCS courses to prepare us for oral conscious sedation. Our patients feel that this is a huge benefit for them. Frankly, some of them wouldn't be seeing a dentist unless this is an option. These are the dental and needle phobic patients that depend on being sedated to have their work done. I am taking time to write you for you to please reconsider your proposal. This would impact so many of my needy patients.

Sincerely, Dr. Kim Kitchen

Commenter: Dr. Austin Westover

8/28/18 4:48 pm

This will negatively affect the patients who need it the most

Making it more difficult to provide minimal sedation will harm the patients who need it the most. We have many patients whose finances are tight, and who are terrified of the dentist. The cheapest method of sedation available is for them to pick up a valium at the local pharmacy and take it a few hours before their appointment. Many of these patients arrive still very fearful and need something further. This leaves us with 2 options. Option 1 is to add some nitrous, which allows us to quickly titrate them to a precise mild sedation level. It's safe, effective, fast, and expelled from the body quickly. Option 2 is to add more pills, which is harder to titrate, slow, and requires significant post op observation time. It also carries an increased risk of oversedation that is much more difficult to correct. This increases the overall cost of the visit, which eliminates dental care for many of the needy. Making mild sedation more expensive and difficult will decrease the overall public's oral health, increase dental ER visits, and reduce access to care. Please do not make VA the most difficult state in the US to offer minimal sedation.

Commenter: Tontra Lowe, DDS

8/28/18 7:57 pm

Opposition to Minimal Sedation Restrictions Proposal

First, thank you for listening to my comments. As a practicing general dentist who includes sedation dentistry as a part of my practice to help those in fear of the dentist, I implore you to reconsider the restrictions being proposed for MINIMAL sedation. Having a fear of the dentist is like having a fear of snakes. Could you imagine being in a den of slithering snakes and you hate snakes? That is what patients have described as the heart-pounding experience they have even from simply picking up the phone to call our office. These patients are dying inside from their lack of oral care and all is compounded by systemic disease working in synergy to their early demise. They need our help to SAFELY and EASILY gain access to care through sedation.

Your proposal would require IV sedation equivalent training for perhaps only a quadrant of dentistry. I am a fan of continual learning, but it has to make sense. Oral sedation is already proven to be the most safe method for helping phobic patients. If the ADA guidelines are not this restrictive, why are Virginia's? The best way to increase patient safety is not with arbitrary regulation and dosage requirements, but with adequate training, equipment, and patient monitoring. How does IV sedation training equate to safer oral sedation administration? My goal is minimal sedation if at all possible, but the patient has to be comfortable. Nitrous oxide in addition to the sedative is key to realizing lower dosages of medications. However, some patients just will need more than this proposal allows, and that is bad for the patient if this regulation passes.

Tooth pain is real and so is the fear of the dentist. Please do not pass these restrictions that will make it even harder for patients to receive and afford these services to improve their health. If dentists are required to attend these expensive courses for additional, unnecessary training, the cost is passed along to the patients. Patients can be safe and healthy WITHOUT these hefty restrictions and extra fees. My colleagues should be able to perform minimal sedation including nitrous oxide safely to improve access to care without arbitrary dose requirements. Please reconsider, and thank you for your time.

Commenter: Smiles for Life Dental Care - Dr Joseph McIntyre DDS

8/29/18 7:38 am

Proposed regulations changing the guidelines for oral sedation

Dear VA Dental
Board,

August 29, 2018

Regulations Governing the Practice of Dentistry [18 VAC 60 ? 21]

I am writing to voice my opposition to the proposed changes with oral conscious sedation. Our office has been oral sedation certified for almost 3 years and we have treated over 150 sedation patients without any incident. This is already a proven safe modality of treatment when the current regulations are followed. These patients are people that have avoided dental treatment for years – sometimes decades – due to their great fear of dentistry and often of needles. The availability of oral sedation has made it possible for them to move forward with care to improve their health and eliminate infection.

We generally use a combination of nitrous and Triazolam – generally about .5mg of Triazolam and sometimes up to .75mg if the patient is large. The proposed limiting of dosage and limiting sedation to just one medicine would limit the successfulness of sedation. The dosage of Triazolam that is needed for sedation varies according to the patient's size, other medicines they are taking and their reaction to the sedation medicine. However, by using nitrous in combination with Triazolam, we don't have to use as much Triazolam. By limiting the dosage or only allowing one of the meds, that will mean some patients are not adequately sedated to eliminate their anxiety about dental care and they will not have a comfortable, positive experience.

Our patients mostly choose oral sedation because they don't like an IV needle and the cost for oral sedation is significantly lower which makes access to dental care more affordable. If there are concerns about any specific incidents, then that office should be visited to make sure the current guidelines are being adhered to. If more training is needed, then more training is a better way to increase patient safety rather than restricting the dosage of sedation meds. When the current guidelines are correctly followed, oral sedation is safe and allows access to care for many people that otherwise wouldn't get dental care.

I would like to voice my feeling that this regulation would actually limit patient safety because people may not seek needed dental care if they have to have IV sedation. I feel these restrictive guidelines are not needed and do not increase patient safety and add a barrier to access of care for many people.

Thank You,

Dr Joseph McIntyre DDS
Smiles for Life Dental Care
115 Oakwood Drive
Bridgewater, VA 22812
540-828-2312

Commenter: Bryant Ash DDS, Smiles For Life

8/29/18 8:24 am

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

Dear VA Dental Board,

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

I am writing to voice my opposition to the proposed changes with oral conscious sedation. Our office has been oral sedation certified for almost 3 years and we have treated over 150 sedation patients without any incident. This is already a proven safe modality of treatment when the current

regulations are followed. These patients are people that have avoided dental treatment for years – sometimes decades - due to their great anxiety associated with dentistry and needles. I fear that without this option we will create an unnecessary barrier to care preventing patients from receiving the help they need. The availability of oral sedation has made it possible for many patients to move forward with care.

In our office, we generally use a combination of nitrous and Triazolam – generally about .5mg of Triazolam and sometimes up to .75mg if the patient is large. The proposed limiting of dosage and limiting sedation to just one medicine would limit the successfulness of sedation as one dose does not fit all patients. The dosage of Triazolam that is needed for sedation varies according to the patient's size, other medicines they are taking and their reaction to the sedation medicine. However, by using nitrous in combination with Triazolam, we don't have to use as much Triazolam. By limiting the dosage or only allowing one of the medications, that will mean some patients are not adequately sedated to eliminate their anxiety about dental care and they will not have a comfortable, positive experience.

Our patients mostly choose oral sedation over IV sedation because they don't like an IV needle. Additionally the cost for oral sedation is significantly less than IV sedation allowing access to dental care to many who more are financially challenged. If there are concerns about any specific incidents, then that office should be visited to make sure the current guidelines are being adhered. A much better way to increase patient safety is to do more training rather than restricting the dosage of sedation medications. When the current guidelines are correctly followed, time has proven oral sedation is safe and allows access to care for many people that otherwise wouldn't get dental care. If we hope to improve public dental health we should be aware of our patients needs and the barriers they face when seeking treatment.

I would like to voice my feeling that this regulation would actually limit patient safety because people may not seek needed dental care, perpetuating a state of unhealthiness if their only option is to have IV sedation. I feel these restrictive guidelines are not the answer, not needed, and do not increase patient safety.

Best,

Bryant Ash, DDS

Smiles for Life

115 Oakwood Dr. Bridgewater VA, 22812

Commenter: Nadia Armentrout

8/29/18 8:36 am

Minimal Sedation

To Whom It May Concern:

I would respectfully request that the board reconsider the suggested provision to minimal sedation. This new provision is more restrictive than in any other state & the ADA guidelines. Being able to provide our patients with minimal sedation greatly improves their access to care, especially for phobic patients. Some patients simply need more than this proposed dosage restriction allows and fear will keep them from seeking the treatment they need. These patients will continue to bombard ERs and Urgent care as they avoid treatment due to fear and the excessive cost associated with IV and General Anesthesia. Oral sedation is incredibly safe & I believe that the best way to increase patient safety is via training, equipment, team, and monitoring, not with arbitrary dosage restrictions.

Thank you for your time and consideration

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Commenter: Nadia Armentrout DDS,FAGD**8/29/18 8:39 am****Minimal Sedation****o Whom it May Concern:**

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Thank you for your time and consideration,

Nadia Armentrout DDS, FAGD

Commenter: Smiles for Life Dental Care - Dr Daniel Whiting DMD**8/29/18 9:05 am****Proposed regulations changing the guidelines for oral sedation****Regulations Governing the Practice of Dentistry [18 VAC 60 - 21]**

I am writing to voice my opposition to the proposed changes with oral conscious sedation. Our office has been oral sedation certified for almost 3 years and we have treated over 150 sedation patients without any incident. This is already a proven safe modality of treatment when the current regulations are followed. These patients are people that have avoided dental treatment for years – sometimes decades - due to their great anxiety associated with dentistry and needles. I fear that without this option we will create an unnecessary barrier to care preventing patients from receiving the help they need. The availability of oral sedation has made it possible for many patients to move forward with care.

In our office, we generally use a combination of nitrous and Triazolam – generally about .5mg of Triazolam and sometimes up to .75mg if the patient is large. The proposed limiting of dosage and limiting sedation to just one medicine would limit the successfulness of sedation as one dose does not fit all patients. The dosage of Triazolam that is needed for sedation varies according to the patient's size, other medicines they are taking and their reaction to the sedation medicine. However, by using nitrous in combination with Triazolam, we don't have to use as much Triazolam. By limiting the dosage or only allowing one of the medications, that will mean some patients are not adequately sedated to eliminate their anxiety about dental care and they will not have a comfortable, positive experience.

Our patients mostly choose oral sedation over IV sedation because they don't like an IV needle. Additionally the cost for oral sedation is significantly less than IV sedation allowing access to dental care to many who more are financially challenged. If there are concerns about any specific

incidents, then that office should be visited to make sure the current guidelines are being adhered. A much better way to increase patient safety is to do more training rather than restricting the dosage of sedation medications. When the current guidelines are correctly followed, time has proven oral sedation is safe and allows access to care for many people that otherwise wouldn't get dental care. If we hope to improve public dental health we should be aware of our patient's needs and the barriers they face when seeking treatment.

I am opposed to the proposed guideline of having 3 people in the sedation operatory. We always have 2 people there but a third person is not needed. The ADA guidelines just recommend 2 people. There are always others in the office that are close by and could come to the room if needed.

I would like to voice my feeling that this regulation would actually limit patient safety because people may not seek needed dental care, perpetuating a state of unhealthiness if their only option is to have IV sedation. I feel these restrictive guidelines are not the answer, not needed, and do not increase patient safety.

Best,

Daniel Whiting DMD

Smiles for Life Dental Care

115 Oakwood Dr. Bridgewater VA, 22812

Commenter: Smiles for Life Dental Care -Dr Joseph McIntyre DDS

8/29/18 9:08 am

Proposed regulations changing the guidelines for oral sedation

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

I am writing to voice my opposition to the proposed changes with oral conscious sedation. Our office has been oral sedation certified for almost 3 years and we have treated over 150 sedation patients without any incident. This is already a proven safe modality of treatment when the current regulations are followed. These patients are people that have avoided dental treatment for years – sometimes decades – due to their great anxiety associated with dentistry and needles. I fear that without this option we will create an unnecessary barrier to care preventing patients from receiving the help they need. The availability of oral sedation has made it possible for many patients to move forward with care.

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I would like to voice my feeling that this regulation would actually limit patient safety because people may not seek needed dental care, perpetuating a state of unhealthiness if their only option is to have IV sedation. I feel these restrictive guidelines are not the answer, not needed, and do not increase patient safety.

Best,

Dr. Joseph McIntyre DDS

Smiles for Life Dental Care

115 Oakwood Dr. Bridgewater VA, 22812

Commenter: Christopher Salas DDS

8/30/18 11:46 am

Reconsider provision to minimal sedation

This email is written for a request to reconsider the change in the provision for minimal sedation. There are no states with a minimal sedation provision this restrictive. The ADA guidelines, also, do not have a provision as restrictive.

This provision will take away an option to many patients who seek comfort and anxiety relief from the dental environment. It will deter patients from seeking care for simple routine treatment which will eventually lead to more invasive and costly procedures in the future.

Commenter: Jonathan L Wong

8/30/18 4:39 pm

Oral sedation dissent goes against the ADA Standard of Care

In regards to others claiming that the changes to minimal sedation and the concern that patients will be restricted in their access to care because of the restrictive regulations. These updates are simply conforming with the already established standard of care from the 2016 ADA update to the sedation guidelines. By not updating these regulations to include this terminology, we are stating that Virginia dentists should be allowed to practice below the ADA stated standard of care.

Commenter: Mesfin Zelleke, Mesfin Zelleke PC

8/31/18 7:44 am

Minimal sedation proposal

I oppose the new proposal to limit minimal sedation by the board. I believe it compromises patient

safety by restricting access to care for many anxious patients.

Commenter: John Bitting, Regulatory Counsel, DOCS Education

8/31/18 4:02 pm

18VAC60-21-280. Administration of minimal sedation.

Dear Virginia Board of Dentistry,

The concern of Virginia oral sedation dentists centers around the dosage restrictions being proposed for minimal sedation: Dentists would be limited to the MRD of a single sedative with or without nitrous. This dosage restriction was obviously copied from the American Dental Association's October 2016 sedation guidelines, which were the result of a great deal of controversy from dentists and stakeholders. The 2007 to 2015 iterations of the ADA guidelines contained a minimal sedation provision that allowed for up to 1.5x the MRD of a single sedative with or without nitrous, but the Virginia Board of Dentistry never bothered to adopt that provision during those eight years. No patients were harmed during that time with either minimal or moderate oral sedation *by dentists who had formal training required by the board since 2005 (18 to 24 hours + ACLS + 4 hours q 2 years of renewal CE)*. And yet, one has to wonder what the political motivations are behind the current push to adopt this grossly over-restrictive proposal now.

It should be noted that some states have adopted an "unrestricted" minimal sedation concept that is consistent with the American Society of Anesthesiology's own guidelines whereby the intended and resulting level of sedation governs. This has been implemented in Colorado, Illinois, Massachusetts, Minnesota, Nebraska, New York, Oregon, Rhode Island, South Carolina, Utah, Virginia (until now), and Washington when those dental boards revised their sedation rules over the past several years. I will elaborate below:

It should be noted that the full definition of "MRD" is "manufacturer's maximum recommended dose for at-home unmonitored use."

1. **Manufacturer's:** The common misconception here is that the MRD is set by the US FDA. It is not. In fact, the FDA's dosage limits appear on a chart called the MRTD, or maximum recommended therapeutic dose, which is actually MUCH higher than the MRD...higher than any of us would ever recommend or administer.
2. **At-home:** The MRD applies to at-home self-administration, not a dental or other healthcare office.
3. **Unmonitored:** This is most important. The MRD contemplates that the patient is unmonitored. Even during minimal sedation, this would not be standard of care. DOCS teaches that, even during minimal sedation, the patient would be monitored with pulse oximetry, an assistant would be present to assist the dentist with monitoring, the operatory would be equipped with standard of care equipment, and the appropriate unexpired emergency drugs would be readily available.
 1. Patients react differently to different drugs and a dentist must be able to adapt the drugs administered to the patient's particular circumstances.
 2. Certain drugs may work better in combination with other agents, reducing the overall volume of sedatives required or permitting the time that a patient is under sedation to be reduced. For example, hydroxyzine administered together with a traditional short-half-life benzodiazepine sedative will permit more effective sedation at lower overall sedative volumes and will, in addition, help to reduce saliva volumes and gagging during procedures and increase sedative effectiveness in patients who are smokers.
 3. The ability to incrementally dose sedatives allows sedative levels to be kept to the minimum amount necessary. If a sedative can only be administered up to the MRD, dentists will have little option but to administer a bolus MRD just to achieve minimal

sedation.

4. The provision in the ADA guidelines dealing with supervision of sedated patients by Qualified Anesthesia Monitors, and the requirements for available facilities, including reversal agents, provide protection for patients.
5. Allowing dentists to incrementally administer sedatives also protects patients by permitting the dentist to administer the minimum amount of medication required at each appointment, which may vary for each patient and on each day that that patient is sedated.
6. NOTE: DOCS adheres to a policy that the MRD should never be exceeded for pediatric patients (in Virginia, <13yo) under any circumstances. Patients under age 5yo should be referred to hospital-based dentistry, if necessary.

The problem with dosage restrictions for minimal sedation is that they handcuff both the dentist and the patient. One size simply does not fit all. Sometimes 0.25mg of triazolam is enough to get Patient A into minimal sedation. Sometimes more than 0.5mg is necessary for Patient B to achieve minimal sedation.

A misconception about the DOCS incremental protocols is that they are intended to induce moderate or even deep sedation. This is simply not true. The incremental protocols are primarily intended to induce AND MAINTAIN minimal sedation. They were primarily created to assist dentists with long appointments for patients who have neglected their dental care for years or even decades. This is both safer and more cost-effective for the patient.

As such, DOCS training and the incremental protocols are intended to foster access to care...safe and effective dental care.

RECOMMENDATION:

While we agree that a maximum dose limitation is required, an overall maximum of the MRD of a single sedative may be too low for many otherwise healthy (ASA I and some ASA II) patients. An alternative suggestion would be to tie the dosages for the various widely-used sedatives to the patient's body weight, such as:

1. Total overall prescribed dose of triazolam in mg (to a maximum of 2.0 mg) = body weight in lbs/100 (drug quotient factor for triazolam). This is only for ADULT patients (≥18yo) AND is rounded down AND is cut in half for medically-complex patients or patients over the age of 64;
 1. E.g. 180 lb patient (180 lb/100 qf) = 1.8 = 1.75 mg triazolam.
2. Total Overall Prescribed dose of lorazepam in mg (to a maximum of 8.0mg) = body weight in lbs/25 (drug quotient factor for lorazepam). This is only for ADULT patients (≥18yo) AND is rounded down AND is cut in half for medically-complex patients or patients over the age of 64.
 1. E.g. 180 lb patient (180 lb/25 qf) = 7.2 = 7 mg triazolam.

Minimal Sedation is a vital component of modern general dentistry and the availability of affordable sedation options is absolutely necessary for a significant portion of the general public to be able to access dental services and maintain their oral health.

The goal of the Board must, therefore, be to establish a system which allows reasonable and cost-effective access to Minimal Sedation services for the patients who need them, while preserving reasonable standards of training for the dentist and dental auxiliaries to provide the safest services with reasonable requirements for the facilities in which the services are provided.

Thank you as always for your time and consideration.

Respectfully submitted,

John P. Blitting, Esq.

Regulatory and CE Counsel

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Commenter: Julie Hawley, DDS

9/4/18 4:32 pm

minimal changes.

The changes to the minimal sedation regulations are overburdensome and will only serve to limit access to care for anxiety ridden patients.

Higher than max recommended doses (which are developed for at home self administration) can be used successfully under the supervision of a licensed DDS or DMD to achieve minimal sedation, and should be based on the patient. Combinations of drugs can also be used successfully to produce a minimum level of sedation with often times lower dosages of each drug.

I oppose this regulation change.

Respectfully,

Commenter: Benjamin T Watson DDS

9/4/18 7:59 pm

Oral Sedation Proposaly

It appears to me that the proposal that is being recommended has not been thought out very well and is not supported by sound data. Minimal sedation cannot be defined by an amount of drug; it is a state of consciousness. Some patients may take one amount and others may require a higher amount.. By setting a certain amount of drug you are hindering safety instead of promoting it. Adding hydroxyzine or N2O to triazolam allows us to use a smaller amount of triazolam.

Furthermore if one cannot use multiple doses, one will just give the higher dose when it may not be necessary. I have researched the sedation emergencies in Virginia and cannot find anywhere when safe protocols are followed there have been a death. Yes, there are a few cases where there have been a problem but it was not due to an amount of drug but instead an underlying medical condition. The same thing could happen with other drugs we use including lidocaine. So why then is Virginia looking to have one of the most restrictive regulation? What politics is behind this? I have been doing oral sedation safely since 2001-2002. I have always been in agreement with regulations to promote safety but cannot support this one. I have always gone above the Board in what I provide. By this proposed regulation you are robbing many patients in receiving the dentistry they would otherwise not get. Please rethink this. Thank you.

Commenter: Dr Damon Thompson

9/4/18 9:05 pm

Support for Moderate Oral Conscious Sedation for Anxious Dental Patients

To Whom It May Concern:

I am writing to request a review and reconsideration of the restrictions being considered for Oral Conscious Sedation in the State of Virginia. The proposed restrictions of oral conscious sedation for Dental procedures will have a detrimental effect upon the access and success of Dental care. "One size does NOT fit all" ...limiting dosing to a single dose without the assistance of nitrous oxide will cause many patients to simply not achieve the level of Sedation they require for even basic dental care. It is inconsiderate and cold-hearted to say to a fearful patient "that is all I can give you...you will have to be brave from here." Just as we would not perform general surgery upon a patient inadequately sedated, it is bad practice to do the same for an anxious, often damaged from previous bad experiences, patient. We will have a GREATER Dental health crisis on our hands if we cannot provide these patients the opportunity to receive adequate care. The teachers of Oral Conscious Sedation have gone above and beyond the requirements to teach and train dentists like myself to provide excellent service for fearful patients. They have research on their side. Unfortunate outcomes do happen, which require oversight and regulation...but to swing into an area of being the most restrictive on oral Sedation in all of the USA is not showing the State of Virginia Dentistry in the best light. We need to be courageous leaders bringing the best of dentistry to the community. Please reconsider this course and direction of action. Please do not allow singular interests or personal pride get in the way of safe dental practice for a whole class of patients in our communities. Thank you.

Project 5513 - Proposed

BOARD OF DENTISTRY

Administration of sedation and anesthesia

Part I

General Provisions

18VAC60-21-10. Definitions.

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

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

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

"ADA" means the American Dental Association.

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

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

"Code" means the Code of Virginia.

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

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

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

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

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

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

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

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

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

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

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

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist, or a dental assistant, or a certified registered nurse anesthetist who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, or (iii) preparing the patient for dismissal following treatment, (iv) or administering topical local anesthetic, sedation or anesthesia, as authorized by law or regulation.

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

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

"Analgesia" means the diminution or elimination of pain.

"Continual" or "continually" means repeated regularly and frequently in a steady succession.

"Continuous" or "continuously" means prolonged without any interruption at any time.

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

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

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

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

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

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes "anxiolysis" (the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness)

and includes "inhalation analgesia" when used in combination with any anxiolytic agent administered prior to or during a procedure.

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

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

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

"Provide" means, in the context of regulations for moderate sedation or deep sedation/general anesthesia, to supply, give, or issue sedating medications. A dentist who does not hold the applicable permit cannot be the provider of moderate sedation or deep sedation/general anesthesia.

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

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

Part VI

Controlled Substances, Sedation, and Anesthesia

18VAC60-21-260. General provisions.

A. ~~Application of Part VI.~~ Part VI of this chapter:

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

2. ~~Addresses the minimum requirements for administration to patients of any age. Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures, issued by the American Academy of Pediatrics and American Academy of Pediatric Dentistry should be consulted when practicing pediatric dentistry.~~

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

C. Patient evaluation required.

1. ~~An appropriate medical history and patient evaluation including medication use and a focused physical exam shall be performed before the decision to administer controlled drugs for dental treatment is made.~~ The decision to administer controlled drugs for dental treatment must be based on a documented evaluation of the health history and current medical condition of the patient in accordance with the Class I through V risk category classifications of the American Society of Anesthesiologists (ASA) in effect at the time of

treatment. The findings of the evaluation, the ASA risk assessment class assigned, and any special considerations must be recorded in the patient's record.

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

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

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

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

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

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

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

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

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

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

1. Notation of the patient's American Society of Anesthesiologists classification;
2. Review of medical history and current conditions, including the patient's weight and height or, if appropriate, the body mass index;
3. Written informed consent for administration of sedation and anesthesia and for the dental procedure to be performed;
4. Preoperative vital signs;
5. A record of the name, dose, and strength of drugs and route of administration including the administration of local anesthetics with notations of the time sedation and anesthesia were administered;
6. Monitoring records of all required vital signs and physiological measures recorded every ~~five-minutes~~ continually; and
7. A list of staff participating in the administration, treatment, and monitoring including name, position, and assigned duties.

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

F. Informed written consent. Prior to administration of any level of sedation or general anesthesia, the dentist shall discuss the nature and objectives of the planned level of sedation or general anesthesia along with the risks, benefits, and alternatives and shall obtain informed,

written consent from the patient or other responsible party for the administration and for the treatment to be provided. The written consent must be maintained in the patient record.

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

H. Emergency management.

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

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

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

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

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

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

K. Patient monitoring.

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

2. The person monitoring the patient shall:

- a. Have the patient's entire body in sight;**
- b. Be in close proximity so as to speak with the patient;**
- c. Converse with the patient to assess the patient's ability to respond in order to determine the patient's level of sedation;**
- d. Closely observe the patient for coloring, breathing, level of physical activity, facial expressions, eye movement, and bodily gestures in order to immediately recognize**

and bring any changes in the patient's condition to the attention of the treating dentist;
and

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

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

1. The equipment for administration and monitoring, as required in subsection B of 18VAC60-21-291 or subsection C of 18VAC60-21-301, is readily available and in good working order prior to performing dental treatment with anesthesia or sedation. The equipment shall either be maintained by the dentist in his office or provided by the anesthesia or sedation provider; and
2. The person administering the anesthesia or sedation is appropriately licensed and the staff monitoring the patient is qualified.

M. Special needs patients.

If a patient is mentally or physically challenged, and it is not possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care, the dentist is responsible for documenting in the patient record the reasons preventing the recommended preoperative management. In selected circumstances, sedation or general anesthesia may be utilized without establishing an intravenous line. These selected circumstances include very brief procedures or periods of time, which may occur in some patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

18VAC60-21-270. Administration of local anesthesia.

A dentist may administer or use the services of the following personnel to administer local anesthesia:

1. A dentist;
2. An anesthesiologist;
3. A certified registered nurse anesthetist under his ~~medical~~ direction and indirect supervision;
4. 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 under his indirect supervision;
5. A dental hygienist to administer Schedule VI topical oral anesthetics under indirect supervision or under his order for such treatment under general supervision; or
6. A dental assistant or a registered or licensed practical nurse to administer Schedule VI topical oral anesthetics under indirect supervision.

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

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, the 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 administration ~~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 18VAC60-25-100 B 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 18VAC60-25-100 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.

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. Blood pressure monitoring equipment;
2. Source of delivery of oxygen under controlled positive pressure;
3. Mechanical (hand) respiratory bag; and

4. Suction apparatus; and

5. Oxygen saturation with pulse oximeter, unless extenuating circumstances exist and are documented in the patient's record.

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, intraoperatively as necessary, and prior to discharge, unless extenuating circumstances exist and are documented in the patient's record.

2. Continual clinical observation of the patient's responsiveness, color, 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, unless extenuating circumstances exist and are documented in the patient's record.

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.

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

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

2. The physiological effects of minimal sedation, the 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 administration ~~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;
- d. A dental hygienist with the training required by 18VAC60-25-100 C B only for administration of nitrous oxide/oxygen with the dentist present in the operatory under indirect 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 18VAC60-25-100 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.

~~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. The treatment team for minimal sedation 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.

F. Monitoring requirements.

1. Baseline vital signs to include blood pressure, respiratory rate, and heart rate, and oxygen saturation 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 continuously continually during the procedure unless extenuating circumstances exist and are documented in the patient's record.
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 Nitrous oxide/oxygen is may be used in addition to any with one other pharmacological agent in the recommended dosage for minimal sedation. , ~~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~~ If deeper levels of sedation or general anesthesia are produced, the regulations for the induced level shall be followed. The administration of one drug in excess of the maximum recommended dose or of two or more drugs, with or without nitrous oxide, exceeds minimal sedation and requires compliance with the regulations for the level of sedation induced.~~

5. 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.

5.6. 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, and oxygen saturation shall be taken and recorded prior to discharge unless extenuating circumstances exist and are documented in the patient's record.

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.

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

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

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

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

1. A completed application form;
2. The application fee as specified in 18VAC60-21-40;
3. A copy of a transcript, certification, or other documentation of training content that meets the educational and training qualifications as specified in subsection D of this section; and
4. A copy of current certification in advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) as required in subsection E of this section.

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

1. Completion of training for this treatment modality according to the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students in effect at the time the training occurred, while enrolled in an accredited dental program or while enrolled in a post-doctoral university or teaching hospital program; or
2. Completion of a continuing education course that meets the requirements of 18VAC60-21-250 and consists of (i) 60 hours of didactic instruction plus the management of at least 20 patients per participant, (ii) demonstration of competency and clinical experience in moderate sedation, and (iii) management of a compromised airway. The course content shall be consistent with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students in effect at the time the training occurred.

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

1. Hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers, such as ACLS or PALS as evidenced by a certificate of completion posted with the dental license; and
2. Have current training in the use and maintenance of the equipment required in 18VAC60-21-291.

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

A. Delegation of administration.

1. A dentist who does not hold a permit to provide or administer moderate sedation shall only use utilize 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 provide or administer moderate sedation shall use utilize 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 moderate sedation:

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

b. An anesthesiologist;

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

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

~~3. If minimal sedation is self-administered by or to a patient 13 years of age or older before arrival at the dental office, the dentist may only use the personnel listed in subdivision 2 of this subsection to administer local anesthesia. No sedating medication shall be prescribed for administration 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 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 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 provides or administers or who utilizes a qualified anesthesia provider to administer 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~~ Airway protective device;
16. Precordial or pretracheal stethoscope; and
17. An end-tidal carbon dioxide monitor (capnograph); and
18. Equipment necessary to establish intravenous or intraosseous access.

C. Required staffing. At a minimum, there shall be a ~~two-person~~ three-person treatment team for moderate sedation. The team shall include the operating dentist ~~and a second~~ one person to monitor the patient as provided in 18VAC60-21-260 K, and one person to assist the operating dentist as provided in 18VAC60-21-260 J, ~~both~~ all 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 subsection A of this section, such person may monitor the patient.

D. Monitoring requirements.

1. Baseline vital signs ~~to include blood pressure, oxygen saturation, respiratory rate and heart rate~~ 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 end-tidal carbon dioxide, ~~and pulse~~ shall be monitored continually during the administration and recorded ~~every five minutes~~ unless precluded or invalidated by the nature of the patient, procedure or equipment.

3. Monitoring of the patient under 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 blood pressure and heart rate 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.

4. If a separate recovery area is utilized, oxygen and suction equipment shall be immediately available in that area.

5. Since re-sedation may occur once the effects of the reversal agent have waned, the patient shall be monitored for a longer period than usual when a pharmacological reversal agent has been administered before discharge criteria have been met.

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.

18VAC60-21-300. Requirements for a deep sedation/general anesthesia permit.

~~A. After March 31, 2013, no~~ **No dentist may employ or use provide or administer deep sedation or general anesthesia in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in AAOMS and who provides the board with reports that result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.**

B. To determine eligibility for a deep sedation/general anesthesia permit, a dentist shall submit the following:

- 1. A completed application form;**
- 2. The application fee as specified in 18VAC60-21-40;**
- 3. A copy of the certificate of completion of a CODA accredited program or other documentation of training content which meets the educational and training qualifications specified in subsection C of this section; and**
- 4. A copy of current certification in Advanced Cardiac Life Support for Health Professionals (ACLS) or Pediatric Advanced Life Support for Health Professionals (PALS) as required in subsection C of this section.**

C. Educational and training qualifications for a deep sedation/general anesthesia permit.

- 1. Completion of a minimum of one calendar year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program in conformity with the ADA's Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry in effect at the time the training occurred; or**

2. Completion of an CODA accredited residency in any dental specialty that incorporates into its curriculum a minimum of one calendar year of full-time training in clinical anesthesia and related clinical medical subjects (i.e., medical evaluation and management of patients) comparable to those set forth in the ADA's Guidelines for Graduate and Postgraduate Training in Anesthesia in effect at the time the training occurred; and
3. Current certification in advanced resuscitative techniques with hands-on simulated airway and megacode training for health care providers, including basic electrocardiographic interpretations, such as courses in ACLS or PALS; and
4. Current training in the use and maintenance of the equipment required in 18VAC60-21-301.

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 utilize 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 utilize either a dentist who meets the requirements of

18VAC60-21-300, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist who meets the requirements of 18VAC60-21-300 may administer or use utilize 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 or under the supervision of a doctor of medicine or osteopathic medicine in accordance with a practice agreement for such practice.

3. Preceding the administration of deep sedation or general anesthesia, a dentist who meets the requirements of 18VAC60-21-300 may use utilize 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 or utilizes the services of a qualified anesthesia provider to administer 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. Blood pressure monitoring equipment;
- ~~8-9.~~ Appropriate emergency drugs for patient resuscitation;
- ~~9-10.~~ EKG monitoring equipment;
- ~~10-11.~~ Temperature measuring devices;
- ~~11-12.~~ Pharmacologic antagonist agents;
- ~~12-13.~~ External defibrillator (manual or automatic);
- ~~13-14.~~ An end-tidal carbon dioxide monitor (capnograph);
- ~~14-15.~~ Suction apparatus;
- ~~15-16.~~ Throat pack Airway protective device; and
- ~~16-17.~~ Precordial or pretracheal stethoscope; and
18. Equipment necessary to establish intravenous or intraosseous access.

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 subsection B of this section, 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, EKG, and respiration.

2. The patient's vital signs, end-tidal carbon dioxide (unless precluded or invalidated by the nature of the patient, procedure, or equipment), and EKG readings, blood pressure, pulse, oxygen saturation, temperature, and respiratory rate shall be monitored, continually, and recorded every five minutes, and reported to the treating dentist throughout the administration of controlled drugs and recovery. When a depolarizing medications medication or inhalation agent other than nitrous oxide are is administered, temperature shall be monitored ~~constantly~~ continuously.

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~~ continually 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. If a separate recovery area is utilized, oxygen and suction equipment shall be immediately available in that area.

4-2. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, and circulation blood pressure, and heart rate are satisfactory for discharge and vital signs have been taken assessed and recorded, unless extenuating circumstances exist and are documented in the patient's record.

3. Since re-sedation may occur once the effects of the reversal agent have waned, the patient shall be monitored for a longer period than usual before discharge if a pharmacological reversal agent has been administered before discharge criteria have been met.

2-4. 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.

3-5. The patient shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

Agenda Item: Board action on use of dental specialties

Included in your agenda package are:

Copy of NOIRA

Copy of amended regulation as originally adopted by the Board as a fast-track action

Copy of applicable Code section

Copy of comments on the NOIRA

Board action:

To accept the recommendation of the Regulation Committee for proposed regulations.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 12. HEALTH

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Behavioral Health and Developmental Services intends to consider amending 12VAC35-105, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services. The purpose of the proposed action is to comply with the quality and risk management system requirements of the U.S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG) and develop and implement a system to ensure that individuals in the Settlement Agreement population who are receiving services in Virginia's public system of services receive a level of care that is good quality, meets individuals' needs, and helps individuals achieve positive outcomes. Quality improvement measures are required of community services boards for services they provide, but those services are not currently in the Department of Behavioral Health and Developmental Services (DBHDS) licensing regulations for providers. The proposed amendments will clarify and expand the requirements for the quality practices for the health, safety, care, and treatment for adults who receive services from DBHDS service providers.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 37.2-302 and 37.2-400 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Emily Bowles, Legal Coordinator, Office of Licensing, Department of Behavioral Health and Developmental Services, 1220 Bank Street, P.O. Box 1797, Richmond, VA 23218, telephone (804) 225-3281, FAX (804) 692-0066, TTY (804) 371-8977, or email emily.bowles@dbhds.virginia.gov.

VA.R. Doc. No. R18-4381; Filed July 12, 2018, 9:52 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-21, Regulations Governing the Practice of Dentistry. The purpose of the proposed action is to replace regulatory provisions specific to the advertising of dental specialties with reference to the statutory language regarding the use of trade names. Specifically being considered for removal are provisions prohibiting (i) advertising a claim of a dental specialty unless it is approved by the National Certifying Boards for Dental Specialists of the American Dental Association and (ii) representation by a dentist who does not hold specialty certification that his practice is limited to providing services in such specialty area without disclosing that he is a general dentist. The prohibition of a claim of professional superiority remains in the regulation.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dbp.virginia.gov.

VA.R. Doc. No. R18-5206; Filed July 5, 2018, 9:12 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-21, Regulations Governing the Practice of Dentistry. The purpose of the proposed action is to amend regulations relating to administration of sedation or anesthesia in dental offices. The goals of the proposed action are greater consistency and clarity of the requirements, depending on the level of sedation and the risk to the patient, and closer alignment with the American Dental Association Guidelines for the Use of Sedation and General Anesthesia. The board intends to amend provisions that are problematic to dentists, such as compliance with current regulations regarding special needs patients. The board intends to incorporate guidelines and best practices for sedation and anesthesia, such as the use of a three-person team in the operatory during administration of moderate sedation.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Project 5206 - Proposed

BOARD OF DENTISTRY

Amendment to restriction on advertising dental specialties

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~~ an unsubstantiated 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~~ Publishing an advertisement that is not in compliance with § 54.1-2718 of the Code of Virginia.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 27. Dentistry

§ 54.1-2718. Practicing under firm or assumed name.

A. No person shall practice, offer to practice, or hold himself out as practicing dentistry, under a name other than his own. This section shall not prohibit the practice of dentistry by a partnership under a firm name, or a licensed dentist from practicing dentistry as the employee of a licensed dentist, practicing under his own name or under a firm name, or as the employee of a professional corporation, or as a member, manager, employee, or agent of a professional limited liability company or as the employee of a dental clinic operated as specified in subsection A of § 54.1-2715.

B. A dentist, partnership, professional corporation, or professional limited liability company that owns a dental practice may adopt a trade name for that practice so long as the trade name meets the following requirements:

1. The trade name incorporates one or more of the following: (i) a geographic location, e.g., to include, but not be limited to, a street name, shopping center, neighborhood, city, or county location; (ii) type of practice; or (iii) a derivative of the dentist's name.
2. Derivatives of American Dental Association approved specialty board certifications may be used to describe the type of practice if one or more dentists in the practice are certified in the specialty or if the specialty name is accompanied by the conspicuous disclosure that services are provided by a general dentist in every advertising medium in which the trade name is used.
3. The trade name is used in conjunction with either (i) the name of the dentist or (ii) the name of the partnership, professional corporation, or professional limited liability company that owns the practice. The owner's name shall be conspicuously displayed along with the trade name used for the practice in all advertisements in any medium.
4. Marquee signage, web page addresses, and email addresses are not considered to be advertisements and may be limited to the trade name adopted for the practice.

Code 1950, § 54-184; 1970, c. 639; 1975, c. 479; 1988, c. 765; 1992, c. 574; 2004, c. 48; 2005, cc. 505, 587.

Virginia.gov Agencies | Governor



Logged In as

Elaine J. Yeatts

Agency Department of Health Professions

Board

Board of Dentistry

Chapter

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

Action	<u>Amendment to restriction on advertising dental specialties</u>
Stage	NOIRA
Comment Period	Ends 9/5/2018

All good comments for this forum [Show Only Flagged](#)[Back to List of Comments](#)

Commenter: Douglas H. Mahn, DDS

8/6/18 11:41 am

Opposing Removal of Restrictions on Dental Specialty Advertising in Virginia

Date: August 06, 2018

To: Virginia Department of Health Professions

Re: Opposing Removal of Restrictions on Dental Specialty Advertising in Virginia

Dear Board Members,

I was recently informed that the Virginia Board of Dentistry proposed removing restrictions on specialty advertising. I was informed that this proposal was in response to lobbying from dental groups that are not affiliated with the American Dental Association (ADA). Removing restrictions on dental specialty advertising places the public health at risk. Let me briefly explain why.

There are currently 9 ADA recognized specialties. To achieve recognition as a ADA recognized specialist, dentists must complete years of training under strict guidelines of their parent specialty organization. This includes intensive specialty literature review, supervision of the treatment aspects of their specialty and examinations. It has been my experience that the general public is not well informed about some of the dental specialties and the intensive training they receive.

An example of this problem is seen with the dramatic rise in the number of dentists placing dental implants with limited training. This limited training would allow them, however, to advertise as having specialty training if restrictions to advertising were removed. Removing restrictions, therefore, would place patients at increased risk for an invasive surgical procedures that could have irreversible consequences. A study published in the Journal of the American Dental Association in 2014, Outcomes of implants and restorations placed in general dental practices, concluded that "Implant success rates in general practices may be lower than those reported in studies conducted in academic or specialist settings". It would seem prudent to make sure that the public is not confused by advertising that appears to place the limited training of some dentists on the same level as an ADA recognized specialty program.

As a periodontist, I can tell you that the American Academy of Periodontology is very concerned about the considerable rise in cases of implant disease and other complications in the past few years. I have found many of the implant problems that I see are due to poor management of the implant site by dentists with limited training and were avoidable.

The problem of dentists advertising as having specialty training without having attended an ADA recognized specialty program affects all of the dental specialties and the public health. In the best interests of the public, I strongly urge you to oppose removing restrictions on specialty advertising. Failure to do so, will lead to unnecessary harm to our patients.

Respectfully,

Douglas H. Mahn, D.D.S.

Periodontist, Manassas, VA

Commenter: Rod Rogge, DDS

8/6/18 5:28 pm

Dental Specialty Designation

I would like to voice my strong opinion against allowing non-residency trained dentists to advertise and indicate to the public that they have specialty training and certification.

The American board of dental specialties is a unofficial organization that claims to have certification in specialty credentials. The "requirements" that this so-called board pretends to be valid are laughable in comparison to the requirements by the ADA Commission on Dental Accreditation. Legitimate, state-authorized licensure and credentialing and accreditation developed in the 18th century to protect the public from frauds and charlatans. Our system of state boards and licensing and accreditation of true training programs are a continuation of that process, which has resulted in a very high standard of dental and medical care in this country. Allowing dentists to claim specialty designation when they have only a fraction of the clinical and didactic training demanded of fully trained specialists is a terrific abuse of public trust. It is your responsibility in the Department of Health to ensure that our citizens receive the best possible care by the best trained practitioners. Bowing to the pressure of threatened lawsuits and other assaults on dental professionalism helps no one. If anything, as technology continues to advance at a rapid rate, the requirements of training accreditation will need to increase, not decrease. Please shut the door on this outrageous proposal to make specialty designation meaningless. Better yet, shine a light on this non-transparent organization that aims to destroy the quality of the dental profession from within, and let the public know how reckless and irresponsible and financially unprincipled their movement has become.

Commenter: Elizabeth A. Alcorn, DDS

8/8/18 9:04 am

Advertising of Dental Specialties

I do not support changing the current regulation for advertising of dental specialties. There is too much financial pressure on dentists that is leading too many to push the limits of their training to perform treatments that should be performed by a specialist.

Patients have no way of knowing the skills of the dentist they see and by keeping the current regulation as it is allow a small but important protection to the patient.

Commenter: Joshua Fein, DDS, MS

Strongly opposed

8/8/18 9:51 am

I would like to add my opposition to the excellent posts already listed.

Dental specialty training is a rigorous multi-year undertaking that leads to clear improvements in outcomes and most importantly, improved safety for our patients. The public cannot be expected to know the difference between a properly trained specialist and one advertising as such with no formal training. This regulation change would lead to widespread confusion and misinformation that would end in harm to patients and would discourage graduating specialists from coming to Virginia for fear that their hard earned specialty certificate would be undervalued.

This proposal is outrageous, irresponsible, and harmful to the people of Virginia.

Commenter: Natalie Powell

8/8/18 10:10 am

Strongly Opposed

I also am strongly opposed to this proposed change. All specialists go through years of advanced training and there is a difference in the quality of care and management of complications provided by the education learned over years of advanced training versus a few weekend courses.

Commenter: Robert LeNoir, Brown Reynolds Snow LeNoir Dentistry

8/8/18 10:15 am

Strongly opposed

This opens up the ability for the public to misled and to create a distrust among the public for the profession.

Commenter: Nicholas Iichyshyn, DDS

8/8/18 10:44 am

Oppose Amendment

Having practiced nine years as a generalist and over 34 years as a periodontist, the proposed amendment would not serve the public well. The rigorous standards of the ADA Commission on Dental Education cannot be supplanted by other competing entities aimed at confiating the definition of a specialist.

Commenter: Mark R Zemanovich, DDS

8/8/18 12:05 pm

Strongly Oppose!

The fact that this proposed change is even up for consideration is disheartening and down right scary. The practice of dentistry is complicated (and has become much more complicated over the years) and current 4 year dental education does an overall fair job at best for preparing dentists to be competent at even the most basic skills and treatment planning. Allowing undertrained practitioners to claim specialty status will, without a doubt, lead to patient harm and continue to degrade the profession into the future. I strongly oppose this change!

Commenter: Frank Grogan DDS

8/8/18 12:17 pm

Strongly Oppose Amendment to Advertising Dental Specialties

As a general dentist for 38 years, I have been impressed with the consistent quality of care provided by those dentists practicing in the recognized dental specialties. The term 'Specialty' implies care that is more focused in a specific area, provided by a dentist that has received more education and clinical experience in order to meet a prescribed and tested level of patient care. The dentist has been recognized by peer review for excellence in a specific area of dentistry. If the proposed Amendment is put in place, most of the general public will continue to assume that the professional definition of a dental specialist has not changed; but it will have completely changed. This will take the dental profession more into the area of becoming an occupation and less of a profession that exhibits self control. Passing this Amendment is not consistent with the Board's duty to protect the public from inferior dental care. Thanks for consideration of my position.

Frank Grogan DDS

Commenter: Mayer G. Levy, DDS

8/8/18 1:49 pm

Deleting from section 80 requirement to be appropriately recognized: definite opposition. It is not

Type over The Board was established to enhance the professionalism of Dentistry, not to demean it. I strongly oppose this change. text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Matthew Stephens, DDS, Dental Associates

8/8/18 3:53 pm

Opposed

The specific prohibition should remain. 18VAC60-21-80 G is well written to keep both our patients and practitioners safe. A true specialist has earned the right to advertise as such and as a profession we should hold that right in high regard.

Commenter: Chris R. Richardson, DMD, MS

8/8/18 9:44 pm

Oppose this potential change

It is truly disheartening to see that this regulatory action is being considered. The American Board of Dental Specialties has hired an exceptional attorney to make every effort to move this through each state. The threat of legal action has made this even more distasteful. To be honest, the legal threat is the only thing moving this forward. If you review the CODA requirements for specialty training for the existing dental specialties, they far outweigh the tremendously minimal requirements of the ABDS recognized specialties. In fact, their requirements are roughly equivalent to one month of a 3-5 year specialty program. Imagine going to see a dentist thinking that they are specialty trained and you find out it is a very watered down version, if that.

You should take the time to read the dissent opinion by Judge James Graves of the 5th Circuit Court of Appeals. This legislation was approved from a fear of First Amendment Rights regarding Freedom of Speech. This is ridiculous and Judge Graves states in his opposing opinion that "Misleading Speech" is not covered under the Rights of The First Amendment. Those that would claim specialty status based on a weekend continuing education course are in fact misleading the public regarding their abilities. Sadly, the public will not know the difference. The Virginia Board of

Dentistry is charged with protecting the Commonwealth's public from an oral health perspective. This legislation does not live up to that charge. Please don't misunderstand, the current regulations in place are very well done. A dentist may claim that his/her practice is limited to a certain arena, however, they must also state that they are providing this limited scope of care as a general dentist.

The ADA recently established The ADA Commission on Specialty Recognition. The first meeting of this commission was in May this year. Interestingly, The commission is made up of ONE specialist representative from the nine ADA recognized specialties and NINE general dentist. A very fair representation. These general dentist see the value in recognizing specialist for what they bring to patient care with regards to skills, predictability, long term prognosis, patient management, and ability to treat difficult problems. My advice to the Virginia Board of Dentistry is to wait and see what this commission decides and how they will, without conflict of interest, position the recognition of specialties in dentistry.

Finally, this legislation will be a heavy burden for the young clinicians who seek to become the most well-educated specialists in the field of Dentistry. These young people have invested 4 years of college, 4 years of dental school training, and 3-6 years in an ADA recognized and CODA accredited Specialty Training Program. Imagine spending 11-14 years of your life to become the very best and at the end of the day, anyone else who took a weekend course can claim specialty status. Not to mention the Time, Energy, and Stress related to that training, but also the financial commitment. Student debt is astounding and for a specialty trained student, the current graduate debt-load is anywhere from \$350,000.00-1,000,00.00 dollars. YES, you read that correctly. Please make the correct ETHICAL and MORAL decision regarding this proposed legislation. PLEASE DO NOT make this change to Specialty Advertising in Virginia. If it helps you to know, tremendous strides in defeating this have occurred in IOWA, NEW JERSEY, and NORTH CAROLINA. I appreciate your attention.

Commenter: Adam Ta, DDS

8/8/18 10:52 pm

Strongly Opposed to removing restrictions on specialist advertising

It is pretty absurd to think that there is any justification for misleading the public and allowing a general practitioner (or even for a specialist advertising outside of their specialty) to falsely advertise expertise in a specialty field without graduating from an accredited residency training program. Patients, their families (parents), and even their insurance carriers are paying specialist fees, investing their time, money, and trust into that dental practitioner, with a certain expectation for level of care and competence. It's practically fraudulent to market and advertise for patients to come receive dental care at an orthodontic practice and not be seen by an orthodontist, or go to a pediatric dentist and not see a pediatric dentist. If a general practitioner wants to offer those services outside the scope of their typical training, I think that's up to them and their comfort level, but they certainly should not be able to mislead the public and advertise as a specialist. Would you be upset if your brought your child with heart disease to a cardiology practice to be evaluated by a non-cardiologist? Or would you trust the care of your loved one undergoing chemotherapy at an oncology practice to treatment by a non-oncologist? Seems obvious to me, but if we allow this type of deceit and misinformation to become commonplace, the already skeptical public will lose even more trust in their healthcare practitioners.

Commenter: Shravan Renapurkar

8/9/18 11:20 am

Strongly oppose removal of restrictions

Recognition of a specialty should be under the guidelines and authority of a state/federal agency and not a subjective matter. I strongly oppose removal of restrictions on advertising as a specialist of any sort.

Commenter: Jonathan L Wong, Coastal Pediatric Dental & Anesthesia

8/9/18 8:53 pm

A Mislead Up roar - How to make specialties and specialists less biased and actually carry weight

While I support the ADA and the VDA, there have been some egregious behaviors that have occurred in specialty recognition that few seem to have a complete understanding of. In 2012, dentist anesthesiologists applied for specialty recognition with the ADA. This was not the first attempt at specialty recognition. However, during this attempt, the ADA, CODA, and the Board of Trustees agreed that all specialty requirements were indeed met. Nevertheless, the final phase in approval was a vote by the ADA House of Delegates. At that time, emotion and politics outweighed logic. A campaign was launched stating that anesthesia and sedation would no longer be allowed by anyone other than dentist anesthesiologist, insurance would not pay for sedation and anesthesia unless it was provided by a separate anesthesiologist, and that dentist anesthesiologist were unsafe in their practice of itinerant anesthesia. Websites were launched saying anesthesia was a right for all dentists, such as www.anesthesiaforall.org. AAOMS and its oral surgeons were single handedly able to prevent specialty recognition. In addition, standard meeting protocols for the House were allowed to be breached so that the oral surgeons could "have the floor" to express why the specialty should be denied.

As you are aware, there have been successful Federal lawsuits surrounding the protectionist and political nature of the above described proceeding. Even the ADA has openly recognized the flaws of this process, even before the first lawsuit in Texas was decided. More and more State Dental Boards are changing their position or are being met with legal action. Furthermore, the American Board of Dental Specialties has emerged as an alternative to the ADA, a trade organization, being the official and sole determinant of dental specialties.

The American Board of Dental Specialties mirrors the events that created American Board of Medical Specialties. It was born out of a determination that a trade group, in their case the American Medical Association, could not and would not determine medical specialties without bias. Therefore a 3rd party was created as the certifying organization.

The ADA, in an attempt to rectify their self-acknowledged bias and systematic flaws, unanimously approve House Resolution # 65 and created a new Council for Specialty Recognition. House Resolution # 65 states, "A dentist may ethically announce as a specialist to the public in any of the dental specialties recognized by the American Dental Association including dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics, and in any other areas of dentistry for which specialty recognition has been granted under the standards required or recognized in the practitioner's jurisdiction, provided the dentist meets the educational requirements required for recognition as a specialist adopted by the American Dental Association or accepted in the jurisdiction in which they practice. Dentists who choose to announce specialization should use "specialist in" and shall devote a sufficient portion of their practice to the announced specialty or specialties to maintain expertise in that specialty or those specialties. Dentists whose practice is devoted exclusively to an announced specialty or specialties may announce that their practice "is limited to" that specialty or those specialties. Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are

qualified to announce themselves as specialists."

Although the petition brought by Dr. Mayberry is being described by others as an attempt to circumvent the ADA and force the Virginia Dental Board to accept the American Board of Dental Specialties (ABDS), this was not what was proposed in the regulatory change. Instead § 54.1-2718 would have remained unchanged and the regulations changed such that the "specialist" must not advertise an "unsubstantiated claim." I had proposed that the regulation be changed to reflect the House Resolution # 65 and get rid of the reference to the antiquated Ethical Code that the regulation was based on. The Dental Board did not haphazardly adopt Dr. Mayberry's petition or ADA House Resolution # 65. Instead, it was well considered and thoroughly evaluated by Virginia legal counsel and announced in this fashion. Perhaps it is more prudent to recognize both the ADA and ABDS as authorities, as there are inherent flaws that have yet to be proven rectified in the ADA's Specialty Recognition.

Having said all of the above, I also understand the voiced concerns of patient safety and the risk of dentists misleading their patients. However, it appears that many dentists are advertising as cosmetic dentists, sleep dentists, sedation dentists without much concerns. However, when someone whom the State has recognized as having true advanced training required to obtain a general anesthesia permit attempts to promote their services, it is "unethical and illegal." In addition, barring the public from knowing what advanced training someone has, can actually be detrimental to patient safety. Why should patients not know that they have access to dentist anesthesiologists? Why should patients have to settle for a dentist that went to a weekend sedation or anesthesia course? Why does the public not know about anesthesia providers in dentistry? Basically, it is because of these antiquated regulations. A great example of how this protectionist mindset can backfire is the recent media storm involving Dr. Goyal in AZ, whom was able to falsify anesthesia credentials. One of the reasons this was able to occur was because there is not official recognition by the ADA and their state components of the CODA accredited anesthesia training programs as anything more than general dental training – much like a CE course a dentist may purchase and attend.

I hope that this letter may help elucidate the complexities that surround this issue. In full disclosure of the above, I am a dentist anesthesiologist by training. I have 5 years of post-graduate training in hospitals at CODA accredited and GME accredited residencies. However, I am a general dentist with the requisite training for a State recognized anesthesia permit. My own society's parameters of care restrict us from practicing dentistry while providing deep sedation or general anesthesia, therefore I must limit my practice to anesthesia, yet I am required to say I am a general dentist and not an anesthesiologist.

Thank you,

Jonathan Wong, DMD

Diplomate, American Dental Board of Anesthesiology *

Diplomate, National Dental Board of Anesthesiology *

Fellow, American Dental Society of Anesthesiology *

*Anesthesia services provided by a general dentist

Commenter: Jonathan L Wong, Coastal Pediatric Dental & Anesthesia

8/9/18 9:49 pm

A common theme among dissenters

After thoroughly reading the dissenters' opinions, there seems to be a theme. All of them seem to

suggest that advanced CODA accredited training should give specialty recognition.

Why is it then that graduates of CODA accredited residencies in Orofacial Pain, Oral Medicine, and Anesthesia are forced off the ADA list of 9 exclusive specialties? These graduates face the exact burden that was discussed by Dr Richardson as being unfair.

The problem with the proposed text is the legal argument of what would constitute an unsubstantiated claim? Does this need to be defined further? This is part of what the American Board of Dental Specialties (ABDS) has done, mostly because CODA accredited graduates were being excluded from what is being argued as the definition of a specialist.

The one exception to this might be Implant Dentistry, which from my understanding has fellowship programs, however they are not CODA accredited. However, the ABDS states, "Certifying boards seeking Dental Specialty must require a minimum of two (2) full-time, formal, advanced educational programs that are a minimum of two (2) years in duration and are presented by recognized educational institutions: Any alternate pathway must demonstrate it is equivalent with didactic, clinical and completed cases to their two-year post-graduate training program."

Commenter: Lillie Pitman, DMD

8/10/18 9:19 am

Strongly Opposed

It is truly disheartening to see that this regulatory action is being considered. The American Board of Dental Specialties has hired an exceptional attorney to make every effort to move this through each state. The threat of legal action has made this even more distasteful. To be honest, the legal threat is the only thing moving this forward. If you review the CODA requirements for specialty training for the existing dental specialties, they far outweigh the tremendously minimal requirements of the ABDS recognized specialties. In fact, their requirements are roughly equivalent to one month of a 3-5 year specialty program. Imagine going to see a dentist thinking that they are specialty trained and you find out it is a very watered down version, if that. This does not protect the public, which is the goal, isn't it?

You should take the time to read the dissent opinion by Judge James Graves of the 5th Circuit Court of Appeals. This legislation was approved from a fear of First Amendment Rights regarding Freedom of Speech. This is ridiculous and Judge Graves states in his opposing opinion that "Misleading Speech" is not covered under the Rights of The First Amendment. Those that would claim specialty status based on a weekend continuing education course are in fact misleading the public regarding their abilities. Sadly, the public will not know the difference. The Virginia Board of Dentistry is charged with protecting the Commonwealth's public from an oral health perspective. This legislation does not live up to that charge. Please don't misunderstand, the current regulations in place are very well done. A dentist may claim that his/her practice is limited to a certain arena, however, they must also state that they are providing this limited scope of care as a general dentist.

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Finally, this legislation will be a heavy burden for the young clinicians who seek to become the most well-educated specialists in the field of Dentistry. These young people have invested 4 years of college, 4 years of dental school training, and 3-6 years in an ADA recognized and CODA accredited Specialty Training Program. Imagine spending 11-14 years of your life to become the

very best and at the end of the day, anyone else who took a weekend course can claim specialty status. Not to mention the Time, Energy, and Stress related to that training, but also the financial commitment. Student debt is astounding and for a specialty trained student, the current graduate debt-load is anywhere from \$350,000.00-1,000,00.00 dollars. YES, you read that correctly. Please make the correct ETHICAL and MORAL decision regarding this proposed legislation. PLEASE DO NOT make this change to Specialty Advertising in Virginia. If it helps you to know, tremendous strides in defeating this have occurred in IOWA, NEW JERSEY, and NORTH CAROLINA. I appreciate your attention.

Commenter: Thanos Ntounis DDS,MS

8/11/18 1:58 pm

Strongly opposed to the proposed Specialty Advertising proposal.

It is truly disheartening to see such proposed action being discussed. In the interest of the patient population of Virginia, I oppose the proposed change. It is misleading and dangerous to the public for a practitioner to advertise as specialist in any area without the necessary formal training. Residency programs that are CODA- accredited provide the necessary Knowledge, Skills AND attitudes that constitute a specialist!

In case that this proposed change goes through, I am concerned that the Virginia Dental Board will face significant increase in patient complaints and possible malpractice lawsuits that will undermine the public's trust to Doctors of our state.

As a young father, I am considering a scenario where my child would need specialty care. It is my right to truly know if the Doctor has gone through rigorous accredit training prior to claiming he is a specialist! I am sure you feel the same. I urge you to oppose the proposed change on Specialty advertising.

Commenter: Dr. Robert A. Strauss

8/13/18 4:50 pm

Opposed

I stand opposed to this amendment. Specialty recognition requires that the specialty be UNIQUE and taught at a higher level. This amendment would allow self-appointed "specialties" which are neither unique (dental implants, currently performed well by multiple different groups and therefore, by definition, not unique) nor regulated (based on the ABDS rules one could be a specialist just based on CE only with no formal training). This loose set of definitions would lead to every practitioner self-describing themselves as specialists. It would seem to me that this would not be in the interest of protecting the public, the primary purpose of the Board.

As to CODA recognition for non-specialties (such as anesthesia and oral medicine) it should be recognized that ANY group can request CODA recognition, they do not have to be a specialty. Just because a group has requested and paid CODA for recognition, that does not indicate that that group is a specialty (ie it has not met the criteria of uniqueness and advanced level of training). ADA specialties are so designated because they have proven that their area of practice is NOT performed by other practitioners (eg maxillofacial surgery, advanced perio, public health, etc) and is taught in a structured advanced training program.

Thanks for your attention and all you do for our profession.

Commenter: Sorin Uram-Tuculescu, DDS, MS, PhD, VCU School of Dentistry

8/13/18 8:18 pm

Opposed

Thank you for the opportunity to voice my opinion.

It appears to me that the **Amendment to Restriction on Advertising Dental Specialties** would introduce the risk to de-quantify the effort spent in order to become a specialist. It is likely that the amount of sacrifice - including time, effort, expenses, declined opportunities - currently paid by a resident in one of the recognized specialties is in danger to dissipate as soon as one can call themselves a specialist after attending a less regulated program. The gain in knowledge and skills over a number of years, that currently characterizes a formal specialty training program cannot be matched by expedited training, regardless of the granting agency. For the best interest of the public, please reject the **Amendment to Restriction on Advertising Dental Specialties**.

Commenter: Lloyd Vakay

8/14/18 7:29 am

Dental Specialists

I believe it is wrong to mislead the public on the professional credentials of non certified dentists by allowing them to hold themselves out as specialists.

Commenter: Christabel Sweeney DDS

8/14/18 9:23 am

Oppose this change

Commenter: Pandora Wojnarwsky

8/14/18 6:14 pm

Strongly oppose

I strongly oppose this change.

Commenter: Jason Margolls

8/14/18 10:12 pm

Strongly opposed

Strongly opposed to this amendment. To pass this amendment will allow non-specialists to pose as an individual which would be misconstrued for someone with advanced formal training. WE as healthcare providers took an oath to "do no harm". This amendment allows those individuals seeking to advertise themselves as something they are not, which in turn would undoubtedly lead to doing harm to the public.

This amendment will only allow less regulation, devalue our credibility as a healthcare profession and increase the risk to the general public. As a whole, our profession is upstanding and work together to maintain the highest standard of care toward our patients as a team approach, working side-by-side with the general dentists and their respective specialists.

The few individuals whom want to mislead the general public by advertising a specific skill by which they are not formally trained is deceitful, immoral and unethical. I challenge those individuals to consider re-entering the formal educational process of an ADA CODA-accredited specialty to

obtain the rigorous formal training and better their knowledge and skill to provide the highest standard of care as opposed to modifying this amendment to a play on words.

Thank you for your consideration in maintaining the integrity of our dental healthcare standards for the general public's safety.

Commenter: Mariano Polack

8/14/18 10:14 pm

Strongly opposed

It is a disservice to the public and the profession to allow dentists that have not attended an ADA accredited specialty program to advertise as specialists. Would anyone choose to have their kidney removed by a physician who is not a surgeon, but advertises as a specialist in surgery? How is this protecting the public?

All dentists should be allowed to perform all procedures they are legally allowed and trained to do, but not to advertise as something they are not. Depending on the specialty program, 400 hours of training at an accredited institution are covered in just the first couple of months. Equating 400 hours of training to 3, 4 or more years of full time residency training diminishes the profession and confuses the public.

Commenter: Gavin Aaron DDS, MS

8/15/18 8:48 am

Strongly opposed

As a lifelong Virginian who lives and practices in Roanoke, I am surprised and taken aback by this outlandish amendment. I can't believe the proposed amendment has made it this far. What ever happened to common sense? If a law/rule change makes things less safe for the public, common sense would tell you that's bad, right?

So now Virginia is willing to change the law to make dental care potentially more dangerous to the public because a lobbying group paid enough money? Is that what this is really about? Because I don't see how any argument to allow non-ADA trained dental specialists to promote themselves as such would stand on its merits alone. Is that what this is really about? By allowing this amendment to pass, the Virginia legislature is basically saying to the dentists that relatively new fringe organizations have as much clout as the ADA, as long as the price is right. The ADA, the American Dental Association, has guided the educational standards for dentists and dental specialists since the beginning.

What's next? A mall security organization getting the laws changed so security guards can patrol our neighborhoods in cop cars?

The higher-ups may think these changes in dentistry may not make an impact, but dental specialists - as well as general dentists - see the aftermath of inadequately trained dentists performing advanced dental procedures all the time. And while not life-threatening, the poor outcomes can literally change an individual's appearance, oral function, and self-esteem for the rest of his/her life. Not to mention the physical pain and financial impact.

What gives me pride as a resident of this state is the conservative governing principles and resistance to potentially dangerous changes in state law. I realize that my comments may come across as unprofessional, but I don't know how else to convey my passion against this completely unacceptable amendment.

Commenter: John Unger, VCU School of Dentistry

8/15/18 1:09 pm

Strongly Opposed

I am strongly opposed to the proposed amendment as I believe it would mislead and confuse patients. The current guidelines provide patients with the assurance that the specialist they would see is educated and trained in the speciality and has completed a rigorous course of study that is subject to periodic reviewed by the Council on Dental Accreditation. We owe our patients nothing less.

Commenter: Herb Hughes DDS

8/16/18 6:55 am

Protect the public and oppose the amendment

I strongly oppose the amendment to restriction on advertising dental specialties for the simple reason is that it puts the general public at risk. It is our duty to create and maintain rules and regulations that have the philosophy of "Do No Harm". Throughout my 32 year career, I've seen numerous cases where non-specialists have attempted to treat patients with clear aligners only to find out after the fact that it was Improperly diagnosed and treated. I recently had an orthodontic transfer case from Houston where a general dentist spent over 3 years and 13 refinements in an attempt to correct an anterior crossbite only to find out that she had failed to make the proper diagnosis and as a result, the patient is in the process of having orthognathic surgery in order to establish a normal bite relationship. Protect the public and oppose the amendment.

Commenter: Scott Berman

8/16/18 7:31 am

R u kidding me?? Why would u want to mislead the citizens more than current advertising does? WTHeck

Commenter: Nitika Mittal DDS MSD

8/16/18 7:32 am

Opposed

This eliminates the need for specialists across the state. It would destroy the careers of thousands of individuals, causing them to become bankrupt, leave the state of Virginia, and thus would reduce access to care. Specialists are there for a reason. They have gone through extra training. Have paid for it. Have taken board exams to qualify to call themselves specialists. It's not a title which is self appointed. youre reducing the specialty practice to a dog and pony show.

Commenter: Elizabeth Jones

8/16/18 7:41 am

Strongly opposed

Strongly opposed. This will lead to patient/consumer misunderstanding and confusion in making informed decisions and consent.

Commenter: Jeffrey Rothman DDS

8/16/18 8:18 am

Strongly Oppose, Please protect our patients!

False and misleading advertsing leads to mistreatment and mistrust of our patient population. Lets keep honesty and professionalism in our field of dentistry. Dentist are trusted members of our community, please don't change this standing by passing such a flawed amendment!

Commenter: Dr. Justin Hughes DDS, Hughes Orthodontics

8/16/18 8:22 am

Strongly Opposed. Protect the Public

This ammendment allows for the deception of the public into thinking they are in the hands of a specialist when in reality they may be seeing someone who took a weekend class at a Holiday Inn. The standard and quality of care delivered to the public will be lowered by this ammendment as anyone and everyone can claim a "specialty" designation without proper credentialing and training. Please vote NO to this ammendment.

Commenter: Swathi Reddy

8/16/18 9:15 am

Strongly Oppose

Commenter: Robert A Miller DMD

8/16/18 9:42 am

Strongly oppose to reduce confusion

In this era of DIY, big budget TV advertising, we must protect our public, not just as dental specialists but also general dentists. We should be clear in advertising our practice types (if specialists, state what we do.) If a general dentist does a specialty without attending a formal residency, it confuses the public when they read an ad and conclude "my dentist does both" (pick any specialty!)

Commenter: Elvi Barcoma DDS

8/16/18 9:50 am

Strongly opposed

Commenter: Kevin Brewer, Alexandria Oral Surgery

8/16/18 9:53 am

Strongly opposed

I am strongly opposed to the proposed ammendment. There is already a great deal of confusion among the public regarding the organization of dentistry in the US. This ammendment would only further muddy the waters. General practitioners who seek to limit their practice to a given area of dentistry should be required to prominently disclose that they are a general dentist with a limited practice.

Commenter: Syed Kalim Hussaini, DDS

8/16/18 10:12 am

Strongly Opposed

I strongly oppose this ammendment. I believe this will create a lot of confusion for the general public when it comes time for them to decide what their healthcare options are. They are confused already with everything that is out on the internet and this will only make it worse.

Commenter: Dr. Gerardo Guajardo

8/16/18 10:38 am

Strongly opposed

Commenter: Luis Gutierrez

8/16/18 10:40 am

Oppose this change

This change will mislead patients and hurt the dental profession. Allowing general dentists to call themselves "specialists" will not provide any benefit to the public.

Commenter: Hyue K. Kwon, DDS, PC

8/16/18 10:44 am

Strongly oppose. The public need to know who are real specialists for their dental care

Commenter: Elijah Wang DDS MS

8/16/18 10:47 am

Opposed

Strongly opposed.

Commenter: Brandon Johnson DMS MS

8/16/18 10:51 am

Strongly Oppose

It's in the public's best interest to create honest, transparent demarcation between dental health professionals regarding training/certification. The public has no other easily accessible resource to differentiate between providers and it could cause confusion and mistrust between patient and provider.

Commenter: Thomas Waldrop, Professor, Director Graduate Periodontcs, VCU

8/16/18 11:03 am

Amendment to restriction on advertising dental specialties

I strongly oppose this action as it is miss leading to the public and and Insult to those that have trained in those specialties recognized by the ADA and specialty boards and to patients that seek out the expertise of specialist for a specified treatment. In medicine and dentistry physicians and

dentist seek out specialty training to become experts in a specific field and patients seek out those specialties knowing they are getting highly trained experts in a specific modality. I would ask those who are in favor of this amendment "would you go to a physician who took a weekend course on heart surgery do your by pass procedure?" I would think not. If we as dentist go down this road to dilute the word specialist as it was meant to mean in dentistry and medicine we are doing a great disservice to the public. As health care provides our primary mission is to serve the public and provide the highest level of care. Having been in education for over 35 years and trained over a hundred residents and given multiple surgical CE to general dentist I can ensure you that the level of training differs. Hence, the care provided to the public differs. I would not be opposed to someone doing a specific procedure if they have had good CE but I do oppose someone calling themselves a specialist unless they have had advanced training in an ADA accredited program. The ADA has established the The ADA Commission on Specialty Recognition and I would suggest Virginia consider the results from this governing body to see what it decides. I would hope Virginia has the ethical and moral fortitude to make the right decision on this proposed legislation and not make the change to Specialty Advertising in Virginia. Thank you for the opportunity to comment on this proposal.

Commenter: David Lee DDS MS

8/16/18 11:04 am

Strongly opposed

Strongly opposed

Commenter: Jordan Katyal, DMD

8/16/18 11:10 am

Strongly Opposed

I am strongly opposed to this proposition, which would grossly misinform the public about the difference between a true specialist and one who has not undergone formal additional training in order to obtain specialist credentials.

Commenter: Sarah Summers, OMFS

8/16/18 11:14 am

Strongly Opposed!

Commenter: Dr. Scott Frey

8/16/18 11:39 am

Avoid inviting fraud

While there is a need to reform the current law to recognize focused training in areas outside the 9 already established dental specialties, the board must enact the reforms in a way that avoids inviting fraudulent behavior and undermining informed patient consent. Where recognized specialties already exist, it is important to the public interest whether or not their doctor is a recognized or board certified specialist in those areas. Removing that requirement would be very unwise. In areas of dentistry that do not overlap or conflict with the currently recognized specialties where dentists might seem focused training the board must outline standards for required training in these new areas in order to continue to promote a high level of patient care. It is important that "specialization" mean something to the public both for the existing specialties and

for new areas that VA may decide to allow in the future.

Commenter: John Jewett, Tri-Cities Orthodontics

8/16/18 11:41 am

Strongly Oppose, Protect the Public

Commenter: Carlos Ibanez

8/16/18 11:43 am

Strongly opposed

A specialist undergoes additional years of education and is limited to practice in that area of expertise. A general dentist does not undergo that additional education and is not limited in that area. Advertising as such would be considered misleading the public and can actually cause harm to the population.

Commenter: Sheamus Hart, Hart Orthodontics

8/16/18 12:18 pm

Strongly Oppose

The American Dental Association has recognized the current specialties in dentistry and set guidelines for one to achieve the title of specialist. As dentists, it's false advertising to label yourself as a specialist when you know the governing body of dentistry does not recognize you as such. This attempted ammendment goes in direct violation of the standards set by the ADA.

Commenter: Taylor Vamer DDS

8/16/18 12:30 pm

Strongly oppose

Strongly oppose. Disservice (and harmful) to the public and to the integrity our profession. Thank you

Commenter: Ashley Larson

8/16/18 1:05 pm

Opposed to malpractice"

Commenter: Ann-Colter Cheron, DMD, MS

8/16/18 1:06 pm

STRONGLY oppose

Please protect the citizens of Virginia by not allowing general dentists to advertise as specialists. Would you let a primary care physician advertize as a cardiologist? I think not. As specialists we study for several years after dental school to limit our scope of practice to a single area. Allowing general dentists to claim the same level of training/standard of care would endanger the public.

Do not pass this ammendment.

Ann-Colter Cheron, DMD, MS

Commenter: Matt McCoy

8/16/18 1:41 pm

Strongly Opposed

Protect the public consumer!

Commenter: Greg Ohanlan

8/16/18 2:09 pm

Strongly oppose

Commenter: Barton D. Weis, DDS

8/16/18 3:05 pm

Very opposed

Commenter: Dr Stephan Tisseront

8/16/18 3:57 pm

Strongly opposed. Dangerous to the public

The public is already misled by unethical dentists that give our profession a bad name. By allowing these dentists to claim they are specialists we endanger the public. Today's specialists have a thorough 2-3 year full time post graduate training, which trains them to be the experts in their fields. Dentists that are trained in weekend courses or short duration courses will never achieve the same expertise and knowledge that true specialists have. In this logic of removing specialities why not let your general physician proceed with your heart surgery - understood that you are less likely to die from a truth but doesn't the public deserve the best care that they can receive?

Stephan Tisseront, DDS, MS

Commenter: Michael Huband DDS

8/16/18 4:03 pm

Strongly oppose changes

I strongly oppose changes. We cannot let anyone self-proclaim to be a specialist. This would be bad for the profession and for the public.

Commenter: Michael J. O'Shea

8/16/18 4:06 pm

Criminal behavior GPs misrepresent themselves as Specialists all the time to the unsuspecting public

General Dentists have misrepresent themselves as Specialists, or as Cosmetic Dentists in the State of Virginia - this has gone on without punishment for decades. The residents of VA are victims of the Dental profession- have been, and unfortunately, always will be unsuspecting victims of false advertising by General Dentists.

Commenter: Carlos Ibanez, DDS OMFS

8/16/18 4:08 pm

Strongly opposed

A specialist undergoes additional years of education and is limited to practice in that area of expertise. A general dentist does not undergo that additional education and is not limited in that area. Advertising as such would be considered misguiding the public and can actually cause harm to the population.

Commenter: Candice Coleman, DDS

8/16/18 4:22 pm

STRONGLY APOSED- Protect the patients!

Commenter: David M Franks

8/16/18 5:13 pm

Strongly against

Limiting and restricting the use of the word specialty protects the public because it is easy to understand.

Commenter: Quynh Tan

8/16/18 7:14 pm

STRONGLY OPPOSE, YOUR ROLE IS TO PROTECT UNSUSPECTING PUBLIC

This is a representation of the skills of the provider, or false advertising. The public doesn't understand that these dentists do not have adequate training. Many times, the paying patients are their first guinea pigs. I have attended CE courses where the instructors have said "if you want to start doing these procedures, try asking around your relatives and friends for volunteers". Proper licensing and credentials is the only way the public can discern the difference. In my specialty, I have seen a lot of messed up cases to where I can't even help them now because too much irreversible damage has been done. We need better regulations.

Commenter: Joseph Herbst, D.D.S.

8/16/18 7:31 pm

Opposed to recognition of dental specialties other than those standardized and recognized by the ADA

Strongly Oppose

The American Dental Association has recognized the current specialties in dentistry and set guidelines for one to achieve the title of specialist. Each recognized specialty sets the standards to achieve Board Certification in that recognized specialty. As dentists, it's false advertising to label

yourself as a specialist when you know the governing body of dentistry does not recognize you as such. This attempted ammendment goes in direct violation of the standards set by the ADA.

Commenter: Diana Almy Fredericksburg Orthodontics

8/16/18 7:33 pm

STRONGLY OPPOSED

Allowing this will endanger the public because they will not understand the level of education their provider has. They will not be allowed to make an informed decision because they will not understand the misinformation unless digging deeper. Dentistry unfortunately has providers whose ethics are suspect and this only opens the door to more of that. As someone who has spent years and thousands of dollars learning a specialty this devalues our work. Please do not change the law.

Commenter: Grant G. Coleman, DMD, MS VCU Graduate

8/16/18 7:53 pm

STRONGLY OPPOSE

This is absolutely ridiculous. You should absolutely not allow general dentists to identify themselves a specialists. Your job is to protect the public, not allow them to be misled.

Commenter: Kelly Morgan DMD,MS Morgan Orthodontics

8/16/18 8:24 pm

Strongly oppose! Please protect the public from confusion.

The public expects accurate and factual advertising claims. The general public is very confused about who are specialist and generalist now and if generalist are allowed to advertise and say that they are specialists then this will lead to only more confusion.

Commenter: Cameron Lamb, DDS

8/16/18 8:39 pm

OPPOSE!!!!

Strongly oppose. The purpose of the government is to protect the people. Only those you are true specialists with appropriate training should be allowed to called specialist. Protect the people

Commenter: Lauren Wegrzyniak, DMD, MBA

8/16/18 8:45 pm

Strongly oppose.

Commenter: Leeann Evans, DDS, MS

8/16/18 8:50 pm

strongly opposed

The public needs to have accurate information in order to give informed consent. Relaxing these

regulations allows the public to be easily misled.

Commenter: Renee Pompei

8/16/18 9:58 pm

Vehemently oppose!

This is NOT in the best interest of the safety and well are of the public. Specialists have highly regulated certification requirements and the line between specialists and generalists should not be blurred.

Commenter: Craig E. Vigilante M.D., D.M.D.

8/16/18 10:18 pm

What are we doing???

Forgive me but I really do not see the logic in this at all. I can't even believe this is even coming to a vote. I am genuinely not opposed to general dentists performing procedures that they are adequately trained to do. There are many well trained dentists placing implants, performing invisalign, taking out teeth, performing root canal therapy, etc. However, they are not held to the same standards as Specialists or Board Certified Specialists. That's why we have specialists. Specialists hone their craft day in and day out consistently achieving the highest standards of care for their patients. This is why patients seek out specialists. It is also the reason why general dentists seek out specialists. This amendment would be a complete disservice to the all of the specialists in Dentistry and the patients they serve. There is a reason specialists go on for further training of 2 - 6 years after dental school. Dentistry is not easy. Being a specialist is not easy. In fact, practicing Dentistry and Medicine today is more costly and more difficult on many fronts than it was many years ago. Today we have technology on our side in our offices, but look at how the internet and the regulations can make things very costly and very complicated. Those who seek a specialist in a specific field do so to receive a consistently high standard of care. Stripping the public of this knowledge is wrong. Medicine has specialists for a reason and so do we. I hope we all can use some common sense here....

Commenter: Albert Parulis, DMD

8/16/18 10:31 pm

Strongly opposed

The unethical practice of advertising specialty level care as a non-board certified/eligible specialist is a true disservice to the patient population that deserves the board's responsibility as their number one priority, which is to protect the patient. Fortunately, the vast majority of dental professionals practice safely, and defer care to those better suited for their patients' care to experienced, educated specialists when appropriate. As a board certified OMFS, there are numerous occasions when I refer patients to ENT, Plastic and Reconstructive Surgery, other dental specialists, etc., if it is in the patient's best interest. I implore you to not weaken the dental profession by encouraging unethical advertising, it will only hurt the profession. Thank you.

Commenter: Lily Padilla, DDS

8/16/18 11:20 pm

STRONGLY OPPOSED

I am strongly opposed to this proposed change. All specialists go through years of advanced training and there is a difference in the quality of care provided by advanced training versus a few weekend courses.

Commenter: Lindsay Rambo

8/16/18 11:27 pm

Strongly oppose the amendment to section 80. The current legislation should remain as is.

Commenter: Erick Carlucci

8/16/18 11:47 pm

Oppose

I strongly oppose this proposition. While it important to acknowledge when one has received additional and supplementary training within the different disciplines of dentistry, the specific term specialist or specialized should strictly connote and distinguish those with credentials from accredited residency programs. This is an important term for the patients/public to best understand the level of training, expertise, and practice focus of the provider.

Commenter: Nanda orthodontist

8/17/18 3:47 am

Oppose

oppose.

Commenter: Matt Joesse

8/17/18 8:41 am

Strongly Oppose

I am writing in opposition of the proposed change to advertising as a dental specialist.

I practiced general dentistry for 5 years, including AEGD training, and I loved general dentistry. As a general dentist, I knew the limits of my abilities when it came to different specialty areas and I referred accordingly. After my specialty training, I realized how little I actually knew about my specialty (orthodontics) when I was a practicing general dentist (I had some training in orthodontics and practiced limited orthodontics). Any specialist will tell you that specialty training enhanced their knowledge and performance of that specialty (that they are better at whatever it is because of their specialty training). This isn't to say that all specialist work is always superior to those of generalists, but there needs to be a clear distinction, for the public, between who is specialty trained and who is not.

You would be very disappointed to learn that your primary care doctor is about to perform open heart surgery on your family member...similarly, the public should be clear on who has the knowledge, skill set, and ability to perform work at the highest quality of dental professions.

Thank you for your consideration,

Matt Joesse, DMD, MEd, MSD

Commenter: Quoc Lu

8/17/18 9:26 am

Strongly Opposed

Are we going to ignore that this is likely to result in very poor and irresponsible (not to mention in some cases, unethical) patient care? The Board is supposed to help protect patients and also protect healthcare providers *from ourselves* (and financial temptation). There's already enough compromised/poor care happening already and you're advocating even more. Patients don't know any better. We should.

Commenter: Erika Sachno

8/17/18 10:36 am

Strongly Oppose

Strongly Opposed to this change.

Commenter: Dawn Crandall, DDS

8/17/18 10:41 am

Strongly Oppose Advertising Changes

As a pediatric dentist I strongly oppose any changes to the current advertising legislation in the VA Board of Dentistry. I do not feel the General public is not educated enough to understand the difference of a general dentist saying they do specialty dentistry services. I feel that it would be detrimental to the health and well-being of many children if this change in amendments occurred.

Commenter: David Burns

8/17/18 11:10 am

Inaccurate promotion of specialty status is deceiving and harmful to the public

Allowing dentists to promote themselves as having specialty training when they have not completed rigorous, multiyear, full-time didactic and clinical training in that specialty area will deceive the public and could prove harmful to public safety. The Board must protect the public and a decision to allow dentists to promote specialty recognition without adequate specialty training will jeopardize public safety.

Commenter: Zach Casagrande

8/17/18 6:45 pm

Oppose this action for obvious reasons

2 questions:

1. Would you want a family physician surgically removing your appendix? Or would you want a surgeon?
2. Would you unknowingly want a family physician removing your appendix whom you thought was a surgeon?

I say surgeon to #1 and known surgeon to #2

Commenter: Jonathan Wong, DMD; Coastal Pediatric Dental & Anesthesia

8/17/18 7:50 pm

Interesting Perspectives

As one can see this is quite possibly the most participation we have seen from Virginia Dentists in a Town Hall. This is a very unpopular proposal, and organized dentistry has been very powerful in encouraging participation.

Here are two additional facts:

1) There is only one CODA residency that must be completed in nearly all states in order to legally practice deep sedation and general anesthesia (again aside from the OMFS exemption). You simply cannot legally deliver this type of care without completing this specialized training, which consists of 3 years of anesthesia training. This training does not include any "dental surgery procedures" but instead focuses on anesthesia and sedation for both medical and dental procedures. It met all standards for specialty recognition except for a vote by the House of Delegates. This process has always been biased, and receives a response much like this Notice has. Those that are trying to make comparisons to medicine need only Google the differing opinions of the American Medical Association and the American Board of Medical Specialties to see the flaws in their argument and the conflict of interest that would be present if the AMA was the sole determinant of medical specialty education and specialty recognition. There is a reason the AMA and ABMS are co-members in an Independent Accreditation Council of Graduate Medical Education, because it helps separate the conflict of interest and lays out the standards for education and specialty (and subspecialty) recognition.

https://www.boardcertifieddocs.com/pdf/Resources_BCDInformation.pdf &
https://www.abms.org/media/120037/wed_2_brigham_addressingevolving.pdf

2) There have been many arguments discussing medical specialists voiced by others in the Town Hall. Let me also present this fact: Arguments regarding misleading advertising as cardiologists or other subspecialties does not carry weight. For example the cardiologist. Cardiologists are not specialists, they are subspecialists under the specialty of internal medicine. Now no one would say that a cardiologist should not advertise his advanced training to the public as a cardiologist. But the current regulation if applied to cardiology, would state that the cardiologist would have to disclose to everyone that they are a cardiologist by training, but that their actual specialty is internal medicine. How many people would have much faith in that cardiologist then? For more details about these designations in medicine please see:

<https://www.abms.org/media/176512/abms-guide-to-medical-specialties-2018.pdf>

The political nature of these processes and decisions have caused us to be in this current dilemma. I only ask that the Board recognize the flaws in the current system and the fact that most of the concerns being voiced are not based on facts. My position is obviously not popular, but the need for change is, in my opinion, based on facts.

I completely agree that specialists deserve specialty recognition. I agree that general dentists should not be allowed to advertise as specialists by merely taking a CE course. However, the current regulations don't seem to be stopping this anyway, but it is preventing those that have completed said "residency training" from ethically advertising what they do because the ADA House of Delegates chose not to vote to approve other CODA accredited residency programs as specialists.

Commenter: Meghan O'Connell, DDS, MS

8/17/18 9:19 pm

Strongly oppose

Strongly oppose. Protect the patient.

Commenter: Terry White. White Orthodontics

8/18/18 8:55 am

Strongly oppose. Misleading the public invites injury to patients and our profession!

Type over this text and enter your comments here. You are limited to approximately 3000 Strongly oppose. Misleading the public invites injury to patients and our profession!

Commenter: Akbar Dawood DMD

8/18/18 6:11 pm

Oppose

The general public is already unclear about the roles of the existing dental specialists. Passage of such a regulation will worsen the situation and negate the value of board certified specialists who have spent several years training and practicing to hone their skills.

Commenter: Ross Wlodawsky, DDS

8/18/18 10:15 pm

Is this a serious consideration? If it passes then I'm declaring myself an astronaut/surgeon.

Commenter: Andrew G. Gilfillan DDS

8/19/18 10:44 am

Strongly opposed

As a general dentist, I am strongly opposed to this amendment. As a profession, we have a responsibility to not harm or mislead the public by false advertising or innuendo.

Commenter: Harshit Aggarwal

8/19/18 12:08 pm

Strongly Oppose

Hello, According to CODA guidelines there are dental specialties that have been established. They go through strict accreditation criteria which involves a certain number of faculty, didactic time, clinical time and a robust curriculum which takes an individual 24-36 months of full time commitment. This is 4000-6000 hrs of supervised education by multiple faculty. This is what makes them a specialist. Any other 'course' that does not meet these standards cannot be a 'specialist' course. Would you like your baby delivered by a doctor who went for a 100 hr weekend course? Would you like your angiography done by a doctor who has attended remote learning courses? It is ludicrous to consider taking the definition of specialist out.

Commenter: John L. McDonald, DMD, Cert Ortho, McDonald Orthodontics

8/19/18 3:34 pm

Must think about the least ethical in our profession.

As you know, there are a wide range of ethics in our profession. It is the least ethical members (and corporations) that will take advantage of any confusion about who is actually a specialist and who has never actually completed an orthodontic case. Parents want the best for their children and the expense of orthodontics will probably be the single largest individual expense they will incur while raising that child. Make sure that they have some way to make an informed decision about who is best qualified to treat their child. The profession of dentistry feels that it is important that becoming an orthodontic specialist requires at least 2 years of intensive additional training AFTER dental school. Don't you think that the public should be aware that this is the feeling of the vast majority of dental professionals across the country? Make sure that holding a Virginia dental license does not become a license to mislead parents about who is qualified to care for the most valuable thing in their life. Give them some way to differentiate between a ADA approved specialist and a dentist who has decided to start doing orthodontics with possibly little or no training. Protect the public against the least ethical among our profession.

Commenter: Natalie La Rochelle DDS MSD

8/19/18 5:27 pm

STRONGLY OPPOSED

Strongly opposed, this is harmful to the public and misleading.

Commenter: Dr. Thomas Padgett, D.M.D. Oral and Facial Surgeon.

8/19/18 8:44 pm

Strongly Opposed

I realize the BOD is in a difficult position and doesn't want a lawsuit for restricting trade which has been threatened in other states. It is difficult for me to allow someone with less education to be able to advertise as a specialist in a particular area when he or she does not have the training or at least equivalent training. This is deceptive to the public and dishonest. We have worked hard to achieve this education and it should not be circumvented by General Dentists or other Dentists seeking to inflate their status. If the BOD cannot reject this proposal as some states already have, then at least mandate that a General Dentist or even another specialist who seeks to label themselves as a specialist in a certain field first make it known to the public that they are a General Dentist or another type of trained Dentist now listing themselves as a specialist or expert in this particular field. Can you imagine if the Medical field did this. What are we doing. Please take a stand the safety of the public.

Commenter: Premier Smiles of Merrifield

8/20/18 9:10 am

STRONGLY OPPOSE!!

This is an irresponsible amendment.

Commenter: Marni Voorhees Husson

8/20/18 2:19 pm

Oppose

Commenter: Lou Filippone DDS

8/20/18 6:02 pm

STRONGLY OPPOSED. This is absolutely crazy.

The worst possible idea for the following reasons:

1. Confuses the already confused public.
2. Falls to protect them from malpractice and actually encourages it.
3. Takes the incentive out of pursuing University and Hospital based specialty training. We can be whatever specialty we feel like being that day and just advertise it.
4. Makes our profession look both reckless and foolish.

Commenter: Garret Djeu, DMD, PC

8/20/18 8:38 pm

STRONGLY OPPOSE Inaccurate promotion of specialty status is deceiving and harmful to the public

STRONGLY OPPOSE!!! Inaccurate promotion of specialty status is deceiving and harmful to the public

Commenter: S Grace Djeu, DMD

8/20/18 8:39 pm

STRONGLY OPPOSE

STRONGLY OPPOSE

Commenter: Sarah Pavon Groy DMD MS

8/20/18 9:50 pm

Oppose

I strongly oppose this action which may be misleading to the public and in essence, may remove incentive for true further training in the specialties recognized by the ADA.

Commenter: Tu-Son Ngo

8/21/18 8:39 am

Strongly Oppose

Allowing this does not make sense and will mislead the patients

Commenter: Fairfax Oral and Maxillofacial Surgery

8/21/18 10:28 am

General Dentistry and Specialization

Strongly oppose....this will open up many doors for litigation. Not to mention the obvious misrepresentation to the public.

Commenter: Jason Hsieh

8/21/18 11:38 am

STRONGLY OPPOSE

Commenter: Patrick Holmes, DDS, MSD

8/21/18 11:45 am

Strongly Opposed

Informed consent is one of the most important steps in initiating treatment with a patient. It involves an honest, clear, and documented discussion between clinician and patient. It is both an ethical and a legal matter that can protect the patient from making a decision on a matter in which they are unfamiliar or uneducated. What message are we sending the public when we allow dentists to advertise as a specialist without disclosing that they are not a specialist, but instead a general dentist that has limited their practice to a specialty? This is at its best misleading, and at its worst dangerous to the public. If we are required to inform the patients about their procedures to protect them, then shouldn't we also be ensuring that they are not misled in advertising?

Commenter: Andrew Glassick

8/21/18 11:51 am

Strongly oppose

I strongly oppose this proposed regulatory action as I share the sentiments of most of the previous responders. One of the main roles of the Dental Board is to help protect the citizens of Virginia and this proposal will obviously not aid in the protection of our patients.

Commenter: Steven J Lindauer, VCU School of Dentistry

8/21/18 11:53 am

Strongly Opposed

Given that the ADA has recently appointed a commission to decide how to designate new specialties in dentistry, I believe it would be appropriate for the Virginia Board of Dentistry to hold off on making changes to its policies regarding advertising for dental specialists until the ADA finishes its study. The current Virginia regulation requires that those who advertise as "specialists" must have successfully completed a post-doctoral advanced dental educational program of at least two full-time years in a program accredited by the Commission on Dental Accreditation (CODA). This is a logical way to define a specialist and facilitates effective communication with the public. The public is best protected when they know more about a practitioner's qualifications than when they are intentionally not informed.

Commenter: VCU School of Dentistry-Department of Orthodontics

8/21/18 12:14 pm

Strongly Opposed

Commenter: Bhavna Shroff, Department of Orthodontics, VCU

8/21/18 12:17 pm

Strongly Opposed

Commenter: Eser Tufekci, VCU School of Dentistry

8/21/18 12:21 pm

Strongly opposed to the proposed specialty advertisement regulation

Dear Board Members:

I am writing to voice my strong opinion against the proposed regulation [18 VAC 60-21] that will remove restrictions on specialty advertising. The current Virginia regulation requires that those who advertise as "specialists" must have successfully completed a post-doctoral advanced dental education program of at least two full-time years in a program accredited by the Commission on Dental Accreditation (CODA). A CODA accreditation standard assures Virginia citizens that an individual who truthfully holds himself or herself out as a specialist has met high standards for education and training. The public is best protected when they know their practitioner's qualifications. With the removal of the specialty advertising, Virginia citizens will not be able to make the best decision about their health care as it will obscure important distinctions between dental professionals as far as their respective educational and training backgrounds. The mission of the Virginia Dental Board is to protect the public, and therefore, I am strongly opposed to the removal of the specialty advertising rule.

Commenter: Madueke E Ekoh

8/21/18 12:35 pm

The death of truth in dentistry

THE DEATH OF ORTHODONTIC TRUTH AND THE GUARDIAN DISCOMBOBULATION.

I once challenged a colleague of a different specialty of his intentions regarding an advertisement soliciting people to come to his office to learn how to practice his specialty. My criticism was on the fact that societal greed has clouded his professional etiquette as there are many qualified people already practicing the art and many more in the pipeline in so many schools.

The concept is not new and has being the bane of human existence, at our core we have cherished values and on our periphery, we have reserved emotions. The posterity of any society both in micro and macro forms lies on how these two are balanced. The problem sometimes is what I call the intellectual quagmire, this is where a few abandon the truth of the core values in order to embrace the emotions of the periphery. We can change our emotions with different stimuli, but we cannot change our core values without first changing who we are.

The specialty of orthodontics is at such a time where a few intellectuals are determined to affirm the emotional periphery to the detriment of the truth in our specialty. Truth by definition is exclusive and absolute, and such must be logically consistent, empirically adequate and have experiential relevance. It must correspond and cohere to reality.

When applied to our specialty as was intended one can easily see how perfect a fit it is but when applied to the sporadic sprouting of different treatment quackery like monthly smiles, weekly seminars, fast treatment, plastics for all, at home treatment, colleagues teaching in-office courses and many more it breaks down and dies the death of a thousand qualifications. While all these may have value in themselves at best they constitute the emotional periphery and cannot replace

the truth of our profession.

It is quite embarrassing that the "praetorian guards" acted like the rider of a lion who was chasing her prey without regard and upon finally having consumed all the preys the lion turned his gaze on the rider. All of our intellect never led us to protect the truth as we all have killed it, are we not now moving forward and backward and in all directions. Are we not now waking up from a self-inflicted demise? Are we not straying to infinite nothing as we ride the lion that is killing all of our own?

Can we now smell of the stench from the mess that we have caused? Orthodontic truth is dead and we all are guilty? Are we not in a professional quandary?

How shall we now comfort ourselves and the generation after us? The light which our fathers placed in our palms has fallen, who will wipe away the tears? Which association and board certification do we need to create to deliver us? Is this not too great for us to cope with as we jostle for relevance in the cacophony of our mental gymnastics. There has never been a greater effect in our profession; and whoever is coming after us for the sake of this effect will look back in disdain. He will question his knowledge, wisdom and himself. The institution that created him, now sepulchers of the truth in the past. Orthodontic truth is dead and we are all guilty.

Dr. Madueke Ekoh
TEEM Orthodontics

Commenter: William Horbaly

8/21/18 12:57 pm

Very Strongly Oppose!

This proposed change will simply embolden those who already push the envelope as to what is considered ethical advertising, etc. Unless the Board would like to take on many more complaints and cases to work on they should not make this amendment. This is not rational by any consideration.

Commenter: William Dabney

8/21/18 1:24 pm

strongly against this change

what are you thinking? we need to protect the public from inaccurate statements

Commenter: Paul White, White Orthodontics

8/21/18 1:24 pm

Strongly Opposed

In order to preserve the health and safety of the public, I am strongly opposed to the current Notice of Intended Regulatory Action" (NOIRA) to amend Virginia's specialty advertising regulations.

Commenter: Frank luomo

8/21/18 2:06 pm

Vehemently Opposed

Unfortunately, fear of litigation is driving the Board's decision to quickly change this law, and when fear acts as an impetus for change, the results are rarely positive. In light of this, the ADA is taking steps to re-evaluate it's specialty recognition and credentialing processes inclusive of the American Board of Dental Specialists. Please allow the ADA along with the ABDS to come up with guidelines that protect of all patients and include all those specialties worthy of this recognition. A knee jerk reaction to the threat of litigation will endanger the public, increase patient complication rates and result in more work for this Board in the future.

Commenter: Dr. Chen

8/21/18 2:57 pm

Strongly oppose

The proposed change will hugely harm public's health. I agree with the comments sent by ammerican association of orthodontics

Commenter: Alyssa G. Ricci

8/21/18 3:59 pm

STRONGLY OPPOSED

As a current second year resident at VCU Orthodontics, I can tell you that we put in countless hours of work to become specialists in our field. I've known I wanted to be an orthodontist since I was a middle school teenager; therefore I did research in the field of orthodontics during my undergraduate education and worked to learn as much as I could about orthodontics throughout my four years of dental school as well. However, I would never have felt ready to practice Orthodontics without attending a post-graduate Orthodontic residency program. I've been exposed to hundreds of patient cases, starting ~130 of my own cases and treating ~100 transfer cases. I've been taught by orthodontists who are experts in the field and have been practicing for many decades. There is a reason we are called specialist. We have worked tirelessly to become the best in our field so that we can serve our patients the way they deserve to be served. It would be a disservice to our community to go through with this regulation. It would be completely misleading and could lead to harm of patients who are putting their trust in their doctor.

Commenter: Carolyn Bradford

8/21/18 9:21 pm

STRONGLY opposed

As a 2nd year resident in the VCU orthodontics graduate program, I can honestly say that this proposed legislation frightens me. I went to a very highly regarded dental school prior to residency, yet I received very limited orthodontic training over the course of my 4 years in dental school. I believe I put o-ties on a patient once, and I had only a few, sparse lectures. Prior to deciding that I wanted to persue orthodontics as a career, I naively thought that I could take some weekend CE courses and maybe dabble in ortho as a general dentist. 14 months into my residency program, I can accutely appreciate how dangerous such dabbling can be. There is no possible way that a weekend or online course could prepare anybody to thoroughly diagnose, treatment plan, and treat patients to the same high degree as somebody who completed a multi-year training program.

My opposition is not so much a "protection of the specialty" as it is an impassioned plea for protection of the patients & patients' right to make informed decisions. We cannot possibly expect the general public to undertand or appreciate the nuances of a dental education

that is then followed by additional training in a specialty field. Thus, it is the duty of the state dental boards to translate these facts into information and terminology that patients can understand. Preventing a specialist's ability to use clear & accurate language to convey their qualifications directly violates the pledge that we all take as doctors – *the pledge to do no harm*

Commenter: Eric R. Shell, DDS, MS - Southside Orthodontics

8/21/18 11:40 pm

Strongly opposed

I am strongly opposed to this change. It is not logical, and does not further the purpose of protecting the public. I agree with all the comments submitted in opposition to this change by my fellow colleagues, many of whom are specialists and respected educators in specialty programs. I also agree with formal statements submitted by specialty organizations such as the American Association of Orthodontists. It makes sense that specialists would be the most likely to comment on this change, but is my hope that members of the general public comment as well, or are solicited for input beyond this comment section if few respond. I doubt that many members of the public would think it appropriate that the dental organization designed to protect them supports the ability to advertise as a dental specialist without being a dental specialist. Go survey 100 on the streets of downtown Richmond, and ask them this question: "If you picked an oral surgeon for an emergency, how would you feel if you later found out that the doctor was not actually an oral surgeon as they advertised?" See what answers you are given, and make your decision based upon those answers.

Commenter: Jeremy Davidson

8/22/18 10:49 am

Strongly Opposed

Dear Virginia Citizens and Lawmakers,

First, as a currently recognized dental specialist, I realize that am speaking with some bias in my opinions. Initially, I read this proposed change to be a threat to the public's ability to distinguish my dental practice from others in that I have attended a recognized Commission on Dental Accreditation approved dental residency program in orthodontics, and would like the public to be able to distinguish this clearly and easily. However, after reading the intent behind this proposed change, in the "Alternatives" section of the NOIRA, I now understand this to be a desire for dentists with significant training in currently "un-recognized" areas of specialization, such as implantology, to be able to have the same recognition and ability to advertise, as those of us in the recognized specialties. The American Dental Association has recently responded to this concern with the formation of a commission to oversee the decision making process for recognizing dental specialties. This will no-doubt become a political debate involving turf wars over which procedures belong to which specialties, fueled no-doubt by economic as well as academic motivations. As, I am sure several currently recognized dental specialties will lay claim to the implant placement procedures as part of their residency training. Therefore, in the interest of making the best decision for the general public in the long-run, I strongly oppose this "fast-tracked" legislation in order to allow the process to be properly vetted through the ADA's newly formed commission, as this is NOT a legislation change that will substantively improve the Virginia public's ability to access dental health.

Commenter: Paul H. Patterson, DDS,MS

8/22/18 1:50 pm

Opposition

It is obvious that the preponderance of responses in opposition to the proposed change in

specialty advertising is rooted in members of the orthodontic community. So it would not be much of a stretch to infer that they are self-serving in this vociferous opposition. On the contrary, this proposed change is one of the most absurd proposals that the Board has had the opportunity to consider in recent memory. One step forward...ten steps back....back to the days of tooth drawers, snake oil and absolute deregulation. If approved, it would be a irreversible blot on the profession of dentistry and its attendant ethical standards.

Commenter: Giridhara Chittivelu

8/22/18 3:21 pm

I strongly disagree, and appose.

Commenter: Dr. Ralph H.B. Anderson

8/23/18 10:36 am

Specialist are.....?

I strongly disagree with the proposed advertising changes which would allow any doctor to indicate that they were a specialist without having the comencerate traing and education that would pertain to that degree or certificate. It would definitely confuse the public who could be duped by wording or ommision of facts! Specialists as you know undergo years of additional training and education. A weekend course or merely completing a dental program does not make one a "specialist." Under this logic a physician would be able to perform heart surgery without any additional training or education! Absurd! Would a general dentist be allowed to do a Lefort Orthoganthic Surgical procedure? Why would our state board allow such? It makes no logical sense and discounts or eliminates the need for proper training under certified institutions. Please vote down this ridiculous proposal!

Commenter: Nikolay Mollov, DDS, MS

8/23/18 2:05 pm

Strongly Opposed

There are several important traits that distinguish a specialist - namely, the ability to properly diagnose and treat any sort of cases as well as deal with complications and be able to inform the patients of what is a reasonable/ realistic outcomes. Allowing anyone to promote him/herself as a specialist would put the general population at risk for treatment that is simply not presented or done as throughly or accurately as a specialist can. Sure some cases would turn out ok, but there will be many that won't and only a specialist be able to determine why and how to correct the unexpected outcomes. Specialties are there for a reason and it's to provide the highest possible care for the general public. This is our job as doctors and we need to protect that privilige.

Commenter: Dan W. Lee DDS

8/23/18 2:37 pm

Strongly Oppose!!!

The previous rules on advertising has kept many deceptive dentists from flooding the public with

misinformation and thinly veiled bait-and-switch tactics. If you remove this existing protection, you are opening a Pandora's box that will strongly erode the public's already weakened trust in dental professionals. Please consider the motive of whoever is suggesting such nonsense. Does it come from a place of improving the quality of care for the public? Or is it another way to thicken their pocket books? If the board sincerely considers the well being of the public, I believe you all will quickly shoot this down.

Commenter: Azita Abbasi, Top Nova Orthodontics

8/23/18 9:48 pm

Strongly Opposed

I hope that all the general dentists also oppose this matter, not only the specialists. We are healthcare providers in business. We are not business men/women who can make money out of people's illnesses. Ethics should come first not numbers.

Commenter: Elena Black, Appalachian Orthodontics of Lynchburg

8/24/18 4:52 am

Very strongly opposed

This change in regulation is tremendously damaging to the health of our nation. Are you going to allow next any MD who graduated from medical school and just WATCHED one or two heart surgeries to perform one such surgery on your mother? Or will you look for the most specialized and experienced heart surgeon you can find in the world for your dear one needing such surgery? And how are you to find him or her if there would be no difference between how the specialist and non specialist can advertise? Basically this change would allow lying to the public- plain and simple. Legalizing a lie is not the direction our country should go. It's doesn't help anyone. The health of our mouth mirrors the health of our entire bodies. There is tremendous evidence of the relationship between the health of our mouth and general diseases such as diabetes, cardiovascular disease, etc. Why would we then allow non-specialists to hurt the most precious gift we have - our general health?

Commenter: David Jones

8/24/18 8:57 am

Obviously Oppose

This is the most hilarious and idiotic proposal I've ever heard. What's the point in having specialty residencies if this passes?! This would not only hurt the professionals who have spent endless amounts of time and money becoming experts in their specialty, but this will also hurt the general public with false advertising and misleading information. If this passes, I look forward to the onslaught of lawsuits and complaints the board will have to deal with.

Commenter: Danielle Robb, DDS

8/24/18 9:49 am

Very Strongly Oppose

I am in disbelief that there are people who believe that the changes that have been suggested to specialty advertising feel that this in any way furthers or improves the quality or standard of care for Virginia patients. People we see on a daily basis are already misled and confused by the division and meaning of dental specialties. Further dilution of the term "specialty" in our advertising is harmful, and if passed there WILL be cases where the public's lack of knowledge about our educational processes and experience will be taken advantage of, risking injury as a result.

Commenter: Karen S McAndrew

8/24/18 11:01 am

Strongly oppose

The proposal to amend specialty recognition in the dental profession strongly concerns me. As a Prosthodontist, I can attest to the countless hours of specialty training, extensive review of the literature, and daily interaction with complex patient needs. As a specialist, prosthodontists are trained to treat extensive trauma and syndromic patients, treat those prosthetically who have undergone cancer treatment, and prosthetically rehabilitate oral conditions. Allowing those to advertise as a specialist, without sanctioned specialty training, to rehabilitate complex oral conditions and without certified training in these areas, is not only misleading to the public but a serious danger to the well being of patient care.

A CODA approved and sanctioned specialty program has undergone rigorous criteria to meet and uphold the training and standards within each of the specialty programs. This certification upholds the necessary training and certification of care received by the public. Patients deserve and expect care to be provided by specifically trained individuals having gone through specialty training programs for their unique challenging oral needs - especially if they advertise as such. They rely on dentistry and Virginia regulations to uphold these standards for their safety and care and not to be misled as to the training and certification each practitioner holds. Virginia has a wonderful array of dental practitioners who provide much needed services to the general patient population. Unique oral care situations present with challenges treated by those specifically trained through CODA approved specialty programs. It is a supplement to oral health care, not a competition of services.

The ADA established The ADA Commission on Specialty Recognition to specifically address these issues of oral health care delivery. Let's allow this commission to complete their job regarding Specialty Training Programs and evaluate their position, without conflict of interest, on the position of recognition of specialties in dentistry. The care of the public depends on us to provide them this information on specialty care.

Commenter: Dr. Tierney Winberg

8/24/18 1:37 pm

VERY STRONGLY OPPOSED

As an endodontist, I completed three years of post graduate training after dental school in order to refer to myself as "specialist" in doing root canal treatment. Endodontists have significantly more training, experience, and ability to handle and prevent complications than any weekend course or unsupervised clinical experience can provide.

Commenter: Dr. Mark Vagnetti

8/24/18 1:40 pm

STRONGLY OPPOSE

I understand that primarily this extends to General Dentists wanting to advertise that they are somehow specialized in placing implants. While I concur with the other comments that this skill should require a full residency type education in order to be proficient, my worry also extends to other dental specialty training. As an Endodontist, I see mostly very difficult root canal cases and surgeries that a General Dentist would not and should not attempt. Giving any leeway in advertising to patients that although they are "experts" in a certain specialties without residency training is fraud at best.

Would this even be considered with medical doctors? Do you go to your family physician for a

colonoscopy? What if he / she took a weekend course a month ago and now advertised that they offered this procedure...would that instill trust or ensure proficiency?

Commenter: R.S. Mayberry DDS, DABOI

8/24/18 3:30 pm

Why Dentistry Needs an Implant Specialty

Why a new Dental Implant Specialty Is Needed.

Despite all the opposition expressed to this new specialty, there is nothing more needed in dentistry than this change. Much of this opposition is based on misinformation and deceit, and it is my intention to clarify as much of this as possible.

I have been licensed to practice dentistry in the Commonwealth since 1977. I graduated from MCV under the guidance of dean John DiBiaggio, one of the greatest educators in the world. Dean DiBiaggio was the individual who inspired me to want to become the best dentist I could be. I placed my first implant in 1983. Today, 35 years later, my practice is dedicated completely to dental implant treatment. As a result of recent Federal Court decisions, if my practice was located in Texas, Florida, California, New Jersey, or Massachusetts, I would be permitted to market myself as a dental implant specialist. It was for this reason and because too many patients in Virginia have been mistreated and harmed, that the Virginia Board of Dentistry was petitioned to make a change to allow qualified doctors to call themselves dental implant specialists. All the comments that have been made in opposition to this measure were the same ones made in the other states where it is now legal for Diplomates of the American Board of Oral Implantology/Implant Dentistry to advertise themselves and specialists, and in the end the impartial courts agreed that we are Implant Specialists, despite all the opposing rhetoric.

American Academy of Implant Dentistry

The AAID is the oldest dental implant organization in the United States, it was founded in 1951, it was organized to promote dental implant treatment and education, and is composed of Oral Surgeons, Periodontists, Prosthodontists, and General Dentists. The Academy is the sponsor of the ABOI and all the efforts to develop this new specialty and one of the founding organizations that established the American Board of Dental Specialties. This organization was founded to remove the bias and collusion of the ADA which has prevented any new dental specialties unless they were not in competition with the existing surgical specialties. The Academy has been the leader in comprehensive dental implant education and has made this education available to any doctor with a desire to learn. Its certifications are based on valid and verifiable testing criterion, not a system of pay the money and get a certificate with no verifiable measure of the candidate's knowledge and understanding. There are many other organizations promoting excellent implant education and provide certificates of participation that appear impressive, but lack any valid testing criterion of the doctor's knowledge and understanding. I joined the AAID and have been a member since 1983. Over the many years of my involvement with the Academy there has been one unchanging goal, that has been seeing that dental implant treatment becomes a recognized dental specialty.

Over the last 30 years the Academy petitioned the American Dental Association, a biased trade organization, on two separate occasions, years apart, to accept and allow development of a dental implant specialty. These petitions were accepted and studied at the ADA, and the ADA's own council on education recommended acceptance of the measures to the House of Delegates citing the public need for this specialty. Each time the petitions came up for a vote they were turned down by the members of the House of Delegates. Because the House of Delegates was

composed of a majority of surgeon specialists it was believed that these voting members did not believe a new competing surgical specialty was in their best interest and that was why the measure was not accepted.

The Court Decisions

It was this very real and ongoing problem at the ADA, common within similar commercial trade groups, that led Diplomates of the American Board of Oral Implantology/Implant dentistry (www.aboi.org/) to sue the Boards of Dentistry in California, Florida, and Texas, in the Federal Courts. The dental boards of the states mentioned had threatened to revoke the licenses of the doctors in those states because they were accused of advertising themselves as dental Implant specialists. In each of these states the same reasons for opposing this specialty were made and in all three decisions, the courts, found for the plaintiffs saying they were truthful in their declarations and that their certifications were based upon valid and Bona Fide testing criteria. They determined that the ADA's, restrictions and opposition to any new specialty applications was an unfair restriction of trade, and against the law. They ruled that that the doctors certified as Diplomates of the ABOI should not be restricted from declaring themselves as specialists just because the ADA, a biased trade organization, had not recognized Implant Dentistry as a specialty. This led to the formation of the American Board of Dental Specialties, an organization similar to those in medicine, where the bias of the AMA, another trade organization would not have influence. The American Board of Dental Specialties is composed of the American Board of Oral Implantology, the American Board of Oral Medicine, The American Board of Orofacial Pain, and The American Dental Board of Anesthesiology. See www.dentalspecialties.org/. The ABOI examination process is open to any qualified doctor desiring to take the examination. Diplomates of the ABOI include oral surgeons, periodontists, prosthodontists, and general dentists.

Winning in the Federal Courts was the only way to effect a change in ADA opposition policy. After the court decisions came down the Federal Trade Commission approached the ADA's surgeon leadership. These individuals were taken to task for their collusion to prevent a competing surgical specialty in Implant Dentistry. They were told if they continued to oppose this new specialty they could be personally held accountable. A new specialty in Implant Dentistry has been sorely needed to better serve the public for many years. The leadership in the ADA house of Delegates had previously turned down two petitions by the American Academy of Implant Dentistry, (AAID) over the past 30 years to allow Implant dentistry, the most complex and demanding practice in dentistry, to become a specialty. The specialty applications were turned back in the House of Delegates despite the ADA's own councils recommending approval because there was clearly a need and benefit for the public. All three of the Federal Court cases found in favor of allowing Certified, Diplomates of the American Board of Oral Implantology/Implant Dentistry to advertise themselves as specialists. This was only possible after the courts determined that the candidates receiving certification from the Board's testing procedures were indeed valid and Bona Fide, and similar to the Board's testing candidates in other specialties. Court cases in California, Florida, Texas, resulted with damages that awarded to the American Academy of Implant Dentistry in the amount of \$15,000,000. Since then, other states have already adopted regulations similar to the one now prepared to be enacted in the Commonwealth. New Jersey, Massachusetts, Indiana, and Ohio have changed their regulations to allow or not interfere with Diplomates advertising as Implant Specialists, or they are currently in the process of change now.

An Implant Specialty Would Establish a Standard of Care

A new specialty is not to say implants should not be placed by anyone except specialist, but without a specialty there is no Standard of Care, no rules.

I have seen existing ADA recognized specialists say they are surgical Implant specialists, but before the recent changes in the ADA's definition of ethical behavior, they were restricted to the surgical phase only. Today, as a result of the ABOI court decisions and FTC interventions at the ADA, recognized ADA surgical specialists are no longer considered unethical when they perform prosthetic procedures, even with little prosthetic training and experience. Likewise, ADA recognized prosthodontic specialists are not considered unethical when they perform Implant or other surgical procedures. Implant dentistry is a prosthetic discipline with a surgical component,

the prosthetics determine the surgical component. Modern specialist training in the ADA recognized surgical residencies have only a small portion of their training devoted to dental implants and then only the surgical components, yet is that to be considered sufficient to be an implant specialist when implant dentistry is primarily a prosthetic discipline? Who is more qualified as the implant specialist, an ADA recognized specialist with limited experience in prosthetics or a GP with thousands of implant specific CE hours and 35 years of clinical experience in all aspects of implant dentistry? Proper treatment planning, providing patients with all options of implant care, based upon the patient's prognosis is sorely missing in the majority of implant treatment provided today. Today the vast majority of dental implant treatment plans are based upon what the patient thinks they want or what the doctor's knowledge and ability can offer. In both of these situations the treatment plans offered are typically lacking needed decision-making information, patient education and understanding of what the future holds for them.

An Implant Specialty Would Improve Treatment Plans and Patient Prognosis

Personally, I have treated thousands of patients using all types of dental implant techniques, and materials. I have placed blade implants, subperiosteal implants, root form implants, buried implants and immediately loaded implants. I have performed sinus augmentation procedures, and treated the complications associated with those procedures when needed. I've performed mandibular nerve transpositions, to allow implant placement when required. I have recognized soft tissue complications associated with implant treatment and provided soft tissue grafting procedures to obtain the tissue required to maintain long term implant stability. I have recognized and treated occlusal load complications that left unrecognized and without preventive treatment would have led to eventual painless implant failure. For the last few years my practice has been devoted to implant treatment focusing on full mouth implant restorations, "All on 4" or more implant cases, and the long-term management of these cases. I have provided years of post-treatment maintenance of implant cases recognizing potential problems before they led to case failure and treated them accordingly to prevent failure. Many failing implant cases result because of prosthetic problems not surgical problems. I have a 35-year perspective looking back at implant patients and what happened after their implant treatment was completed. My perspective is very different today from what it was ten or fifteen years ago, this is only because I have seen what happens with patients after the implants and prosthetics have been placed and paid for. A specialty in implant dentistry would go a long way in helping inexperienced dentists placing implants avoid many of the problems they will face in the future. Without an understanding of what the future will bring to the patient and the treating doctor, a set of problems that will not benefit the doctor or patient. Not understanding the prognosis and explaining to the patient what will most likely be encountered, can set the doctor and patient up for costly future problems that could have been avoided with proper initial treatment planning and patient education. This is something that for the most part is not being considered by many doctors today placing dental implants. Understanding proper treatment planning and prognosis is the single most important factor with any dental implant treatment plan, it is something that would be elucidated with a dental implant specialty, and something missing in most of the treatment being provided today.

An Implant Specialty Will Better Serve Dentistry and The Public.

Suffice it to say I do not treat patients today the same way I did 35 years ago, I have made all the mistakes possible because I did not know what I did not understand then. I see patients today asking for second opinions or corrective treatment that are shocked when they learn what is required and the associated cost. Such problems are the result of little or no understanding of implant treatment and lack of patient education. Because of the problems associated with such treatment errors I have explained to patients that the doctors providing their previous treatment were doing the best they could at the time, but for many patients harmed by implant treatment gone wrong and determined to sue there is little anyone can do. These cases are not limited to general practitioners but from more often than not, ADA recognized specialists providing less than ideal treatment. Today I see patients come in for 2nd opinions who were treated by GP's and specialists, who only have a rudimentary knowledge of implant dentistry. They have been taught by manufactures reps and bone salesmen, who want to sell them products. Today bone grafting techniques are so overdone and promoted to inexperienced doctors "as required" by bone

salesmen when all these grafts do is add unnecessary cost to patients and slow down treatment time. I've seen cases where nothing but greed, was the motivating factor behind the treatment plan. A patient was treated by a surgeon who attempted to put as many implants in place as humanly possible, placed them so close together that failure was the only possible outcome. It was obvious that the surgeon's fee was based on the maximum number of implants that could be placed, implants that were placed in the pterygoid plate that were so far out of position to make them unrestorable, but which still generated a surgeon's fee. Once the implants were placed the restorative doctor was told that he had a wonderful foundation to build anything the patient wanted as a prosthesis which was far from the truth.

I have another patient who was told by his general dentist that he needed a sinus graft for implant placement when in fact the proposed treatment could have been accomplished with no graft at all. His general dentist referred him to another general dentist who was supposed to be a dentist experienced with sinus augmentations. The patient went as recommended to this general dentist sinus expert, but who had no credentials at all, and had the procedure. The procedure failed, and the sinus opened up as it failed. The patient went back to the doctor who told him he would need a rescue procedure and the patient agreed, and paid again, only to have the mismanaged rescue procedure fail too. By the time I saw the patient most of the damage had been done. The lateral wall of the maxillary sinus was gone, leaving a huge defect with a patent opening into the patient's nose. Every time he drank something it went into his nose. I spoke with the doctor who performed these surgeries. He claimed to have done many of these surgeries without a problem and would take no responsibility for what went wrong with this patient. I tried to get him to settle with the patient out of court, but he refused, and now the case is going to the courts. All this because these doctors were unskilled in their treatment plans and diagnostic abilities.

I could go on with many more examples, but the fact of the matter is that recognized specialists and GP's are at fault equally. This problem is a result of no separate recognized dental implant specialty where standards of care could be developed that would give all doctors involved in implant treatment some guidelines. Today there are no guidelines, no standard of care that would be in the patient's and the profession's best interest. Today, implant dentistry is being damaged in the eyes of the public because of the internecine turf battles and the ADA's previous focus on what has been good for surgeons and damn the public welfare. Treatment planning is the most important aspect of any implant case, but often it turns out to be an afterthought. I've seen one implant placed into an arch of periodontally involved teeth destined for failure, where no prognosis for the patient's overall need in the future was even considered. Too often the public sees this lack of honesty as a stain on the profession, sometimes from a doctor's ignorance but more often out of greed. This affects all of us and our standing in the community and would be discussed and dealt with properly if there was an implant specialty established that could be depended upon for guidance.

Opposition to an Implant Specialty

I have read the comments of those opposing an implant specialty and most have a common thread, the lack of education, not CODA approved, a threat to the public, real specialists have years of residency training, lack of experience, and on and on. Adding a specialty will do nothing to limit the numbers of patients seeking care, or the opportunity for practitioners to provide it. But it will improve the nature of the treatment and magnify the benefits of implant treatment in the eyes of the public and profession. Today that's not the case, today implant treatment in general is developing a negative connotation, primarily because there is no specialty. Any new developing specialty needs growth and development, but it needs to be declared a specialty before that can happen. The problems with implant treatment as practiced in general today are hurting the public and the profession. I and many others have devoted their dental careers to fostering implant dentistry, I am confident that I have more complete dental implant experience than anyone commenting on this forum. Today my practice is devoted to implant treatment, and associate care based around dental implants. I consider myself a specialist in implant dentistry despite what anybody else thinks or believes. I provide all aspects of dental implant treatment, from diagnosis and treatment planning to long term follow up maintenance. I have 35 years of implant specific experience and a Credential from the ABOI that has been thoroughly examined, tested, and

upheld in the Federal Courts, against opposing state dental boards across the country. Doctors like myself had to turn to the courts when biased factions within organized dentistry determined they would not support such a move. They had their own reasons for their opposition, and the public interest and welfare was not one of them. The Virginia Board of Dentistry has the obligation to protect the public from harm and by permitting Certified doctors to advertise themselves accordingly will do exactly that.

Rodney S. Mayberry DDS

Diplomate, American Board of Oral Implantology/Implant Dentistry

Commenter: E Richard HUGHES

8/24/18 6:59 pm

Amendment to specialty advertising

I agree with the amendment. Those that have been educated and trained to the standards and successfully challenge the examinations of the American Board of Dental Specialties certainly have proved their knowledge and skill. The ADA is a trade organization period

Commenter: Dr. Matthew Cline

8/25/18 8:45 am

Strongly Oppose

This ultimately comes down to patient safety and public perception of the profession of dentistry. As a practitioner who spent several years as a general dentist who then completed a specialty program, I have been on both sides of this argument and strongly oppose this idea. General dentists should be able to perform procedures that they feel comfortable doing and for which they have received adequate training and can deliver excellent results, but in no way should they be able to call themselves specialists. Completion of a few weekend courses is no substitute for a multi-year specialty training program. A specialist is someone who limits their practice to one specific field and that is all they do all day. They have devoted all of their time to one field. A general dentist who dabbles in a particular specialty does not have the volume and experience to deliver excellent results every day. Allowing them to call themselves specialists will only confuse the general public who already doesn't understand the difference between a general dentist and a true specialist. As a profession, we need to work together to educate the public on who is properly trained to perform excellent results; not mislead them. Otherwise, the profession will be opening itself up to more botched results, which will lead to distrust from the public, more

complaints to the board, and potential lawsuits. Ultimately this is harmful to the public and to the profession.

Commenter: Ursula Klostermyer, Prosthodontist

8/26/18 3:39 pm

Strongly oppose inaccurate dental specialty advertisement

As a dental specialist in the field of prosthodontics we we have invested three years of rigorous training in an accredited dental school residency program. This involved performing increasingly complex prosthetic procedures always under direct supervision of qualified dental specialists. The successful completion of this program qualifies us to independently perform complex prosthetic procedures. Our patients would be misled if someone without this specialty training would advertise and work complex cases without this accredited qualification. A weekend course or learning on patients without supervision is not equivalent with the structured and formal training of a residency. The quality of care for our patients would diminish significantly.

With the indiscriminate use of specialty designations how can patients determine if a dentist has the appropriate skillset to treat their specific condition?

It would be inaccurate to promote a specialty status, if someone did not undergo a formal residency program and this would be harmful for the public and the entire field of dentistry.

Commenter: Dr. A B Hammond

8/26/18 7:21 pm

STRONGLY OPPOSE

I vehemently oppose "the amendment to restriction on advertising dental specialties."

All of us in Dentistry have seen cases treated by underqualified dentists that have caused series harm to the health of patients. If this amendment is passed by the VA Board of Dentistry, patients will have no way to differentiate between those dentists who practice have 2-5 years of approved specialty training and practice their specialty every day versus those dentists who have limited or no specialty training and experience. This is clearly not in the best interest of the citizens of Virginia whom you are charged with protecting.

I urge you to do the right thing for public health and safety and vote against this amendment.

Thank you for your consideration and for your service to citizens of the Commonwealth of Virginia.

A B Hammond III DDS MA

Commenter: Josh Hanson

8/26/18 8:22 pm

Must be approved to protect the public from harm

As you are aware, there have been multiple successful Federal lawsuits surrounding the protective and political nature of dental specialty recognition. Even the ADA has openly recognized the flaws of this process, even before the first lawsuit in Texas was decided. More and more State Dental

Boards are changing their position or are being met with legal action. Furthermore, the American Board of Dental Specialties has emerged as an alternative to the ADA, a trade organization, being the official and sole determinant of dental specialties. The American Board of Dental Specialties mirrors the events that created American Board of Medical Specialties. It was born out of a determination that a trade group, in their case the American Medical Association, could not and would not determine medical specialties without bias. Therefore a 3rd party was created as the certifying organization.

Implant dentistry is a prosthetic discipline with a surgical component, and as such you can only be a specialist if you perform both procedures. The AAID (American academy of Implant dentistry) has oral surgeons, prosthodontics, periodontist and general dentist as members and ensures the appropriate skills and knowledge is present through the ABOI (American Board of Oral Implantology)

It is false advertising when an oral surgeon or periodontist advertises they are specialist in implants. They only do the surgical part. Without doing and knowing the prosthetic part you cant be a specialist in implants. Is it simply not possible.

Of course all the specialist here are opposing it. They have their own reasons for their opposition, and the public interest and welfare is not one of them. Having a recognized implant specialty through the ABOI would mean they finally would not be able to advertise as implant specialist without taking the credentialing exam and presenting cases from start to finish. Again implants is a prosthetic discipline with a surgical component.

In my daily practice I see implants placed poorly by both general dentist and specialist alike. Many residency programs have oral surgeons or periodontist place less than 50 implants. Does that make you a specialist just because you did a residency, never restored anything prosthetically and managed to put 50 implant or less in bone. That is the easy part. And what about dentist that graduated specialty programs before implants even came around. Do you automatically become an implant specialist just because you did a residency but never was taught implants.

The same applies to the American Board of General Dentistry (ABGD) so I strongly suggest they should be included as well. They have not been mentioned yet. They already have federal approval since they are recognized by all the armed forces. If you become a diplomate of the American Board of General Dentistry in the armed forces you automatically get a pay increase because you are considered a specialist in your field – general dentistry just like internal medicine. They get a pay increase just like the other already ADA approved specialties. This has been a standard for over 30 years despite what the ADA says. A legal no mans land as they already are federally recognized for 30+ years as a specialty certification, yet the ADA does not endorse the ABGD. By not including them would create a legal problem with federal vs state law.

The changes does not suggest getting rid of a certifying body. It just allow us to mirror medicine. You would have a general dentistry specialist like in internal medicine. You would have a specialist in implants, anesthesiology etc. The resolution does not allow dentist to advertise being a prosthodontist, endodontist, oral surgeon, orthodontist etc. without proper training.

The Virginia Board of Dentistry has the obligation to protect the public from harm and by permitting Certified doctors to advertise themselves accordingly will do exactly that. Allowing specialists to shut this rule change down will do just the opposite.

Commenter: William S Dodson Jr DMD

8/27/18 7:23 am

Expect my complete state association withdrawal.

If you deregulate restrictions on speciality advertising expect quite a few of us to withdraw from the state association. I expect that the state association will have to fold.

Commenter: Russell Mullen, DDS MS

8/27/18 9:30 am

Oppose

I strongly oppose the proposed amendment to restriction on advertising dental specialties.

I write today as a dentist, but also as a husband, a father, a brother, and a citizen of the state of Virginia. When I welcome a new patient into my office, I do a thorough clinical exam, then collect necessary radiographs, etc in order to come up with a treatment plan to address the problems I see with a patient's teeth. When doing this, there is almost never only one single, best plan for addressing the patient's problems. I make sure to sit with the patient and present all viable treatment options to them, discussing the risks, benefits, and alternatives for each. This informed consent is an essential part of the decision making process for a patient, and withholding information from someone would violate their personal autonomy, and would be a violation of professional ethics. I feel that allowing a practitioner who has not had adequate training to advertise to the public as being a 'specialist' is a violation of the patient's personal autonomy - It is misleading and doesn't allow a layperson to be fully informed about the doctor who is treating him.

Giving patients less information is seldom in their best interest, and I hope that the Board of Dentistry will continue to do an outstanding job of protecting the health and well-being of the citizens of Virginia by not eliminating the regulations about who can advertise as a specialist.

Commenter: Southside Endodontics PC

8/27/18 10:30 am

Oppose

1) State Boards of Dentistry have a responsibility to protect the public from misleading advertising of specialty expertise by dentists who are not adequately trained and experienced in the advertised specialty.

2) Endodontists have completed two or more years of training beyond dental school. This training distinguishes endodontists from general dentists in the following ways:

- Endodontists are experts in diagnosis, treatment and relief of oral and facial pain;
- Endodontists have specialized training in administering anesthesia;
- Endodontists are trained in and used advanced technology, such as operating microscopes, rotary instrumentation, digital radiography, cone beam computed tomography; and
- Endodontists use microsurgical techniques to improve patient comfort and save natural teeth.

3) Completion of weekend courses or even a few hundred hours of specialty training does not equate with the long term comprehensive education and training received by specialists. Deregulation of specialty advertising poses a danger to the public in that it would allow for specialty claims by dentists based on inadequate training.

4) The Virginia State Dental Board should define what it regards as the minimum training and experience that dentists should have in order to claim themselves as specialists, rather than removing itself from this issue.

Commenter: Dr. Adam Hogan DDS

8/27/18 11:00 am

Strongly In favor

Dear Sir or Ma'am,

Those opposed to this amendment are either unaware of the education and certification process of the AAID/ABOI and/or they reap financial benefit from the current "standards" of specialty care. Those standards are adopted by the trade organization known as the ADA. While I support the ADA and some good regulations and recommendations to standardize dentistry and protect the public. We also recognize the ADA as a top-heavy organization run by current "specialties" with financial incentive to continue the old system. A supreme court has recently ruled that the ADA does not have the authority to regulate and define specialties in dentistry, that the ADA is hindering the first amendment and that the leadership of the ADA is overwhelmingly specialists with financial incentive to continue their old system.

When I was a general dentist coming out of the Navy, I researched specialty programs. With strong affinity and skill for surgery and desire to learn more, I called several programs and spoke with many residents in periodontics and oral surgery. I heard a unanimous, cohesive and synonomous cry from residents whose programs touted the placement of 25, 50 or even 75 implants over 2-3 years. But in reality, they barely placed half that number and got credit for other implant placement simply by watching their fellow residents place them while they took credit. In contrast, I found a mentor who placed 50 implants per month. I studied under him. I took the AAID Maxi course. I studied, submitted cases for review and passed my Associate Fellow exam. I studied, took written exams, submitted more cases and sat for oral boards to pass my Fellow exam and Diplomate of the ABOI. Now I teach dental implants to colleagues and am a board examiner for the AAID. My training and experience justifies my ability to be called a "dental implant specialist" far more than a resident who just placed (and did not restore) 20 or 40 implants over 3 years.

One has to consider that there are non-traditional and sometimes better ways that dentists seek specialty status. Our legislative branch should recognize the hard work and achievements of our general membership.

If the Virginia Board of Dentistry is not already aware, the AAID, ABOI and ABDS have already won supreme court cases in several states. This is a first amendment right issue. Unless the VA Board wishes to spend a substantial amount of money and time fighting a hopeless Constitutional fight that California, Florida and Texas have already lost, then I would recommend that they adopt an amendment and allow specialty advertising by those with the proper education and credentials.

Commenter: George Sabol DDS

8/27/18 1:16 pm

opposed to changes to specialty advertising regulations

I am writing to express my strong disapproval of the proposed changes to Virginia's specialty advertising regulations. The proposed changes would only serve to confuse the public about the differences between a dentist who has at best taken some CE and a dentist who has spent 2-5 years studying in a rigorous CODA accredited advanced specialty program. Can you imagine thinking that you scheduled an appointment with a cardiologist only to find out that the treating doctor is a family physician that took some CE and now is advertising that they specialize in Cardiology? I know that you, members of the BOD, would demand the services of a cardiologist that attended an accredited specialty residency.

The current Virginia regulations clearly state who can advertise as a dental specialist and insure that a dental specialist has indeed had 2 plus years of continuous advanced education at a CODA accredited program. The primary purpose of the BOD is protect the health and safety of the public

and the acceptance of the proposed changes would be a direct abandonment of your duty to the citizens of the Commonwealth of Virginia.

The BOD should not be involved in determining what level of education and training qualifies one to practice as a specialist. The National Commission on Recognition of Dental Specialties and Certifying Boards was recently created by the ADA House of Delegates in October 2017 to do so and it would be prudent for the BOD to postpone decisions on this matter until the Commission has had adequate time to study this issue and report their recommendations.

Lastly, I fully support the comments and suggestions that the American Association of Orthodontist recently submitted to the Virginia Board of Dentistry. I trust you will make these comments available for the public and hope that the BOD will postpone any decisions until the National Commission on Recognition of Dental Specialties and Certifying Boards has a chance to report their recommendations.

Commenter: Adam Foleck

8/27/18 1:22 pm

Strongly In Favor

I agree with those opposed that a weekend warrior course should not enable a dentist to be listed as someone with board certified credentials. Luckily, the AAID and ABOI do not allow these hours to be counted as the only type of continuing education towards their credentials. Both organizations require that the C.E. hours come from a continuum and the amount of hours for the ABOI are considerably more. The MaxiCourse sponsored by the AAID has been recognized by several Universities and used as an adjunct for training their specialists, including Dental Schools in Georgia, Florida, New Jersey and California and are being looked at by other states as well. Oral Surgeons, Periodontists, and Prosthodontists have recognized these two organizations and have become Diplomates, Assoc. Fellows and Fellows. Many of whom are leading implant educators around the world. The FCC and Federal Courts have recognized that advertising these credentials are actually in the patients best interest when looking for a qualified implantologist. Neither of these organizations "give" out credentials, and general dentists and specialists do not understand the qualifications or psychometric testing done with these organizations. The ABOI allows for board certified specialists to forgo the written test and only participate in the oral examination. Finally the ABDS is an independent Specialty Board that allows all specialties in dentistry the opportunity to apply. The Specialty Board in Medicine (the ABMS) is not associated with the AMA as it is a conflict of interest and not serving the publics best interest; by applying those same rules for dentistry, the Specialty Board in Dentistry should have no affiliation with the ADA. With an understanding of the ABOI, AAID and ABDS it only makes sense for Virginia to allow advertising so that patients are allowed to do their due diligence and research the credentials of their implantologist.

Commenter: Dr. Lillana Calkins

8/27/18 3:00 pm

STRONGLY OPPOSE

Dear Virginia Board of Dentistry,

The attempt to deregulate the specialty of orthodontics, allowing general dentists to implement orthodontic procedures in our patients is poorly thought.

As specialists we take years of education, clinical practice and seminars to understand the implications of our treatment. I have seen the damage done when our treatment outcomes are not well understood or executed.

Please respect our education and the imperative need to keep providing exceptional care to our patients.

Thank you,

Dr. Calkins.

Commenter: DrSuzanne m dennis

8/27/18 3:23 pm

Very strongly oppose

Specialists undergo years of advanced training and specialty practice to offer the public the best choices for their specialty dental care. The public has so little information to make informed choices now, loosening the restriction on advertising allows anyone to infer that they have specialty training and it allows third parties to capitalize on this also. Dental insurance companies and businesses that would profit from reduced fee for services will continue to try to reduce the quality of specialty services to the public and make it harder for the public to discern the difference.

Commenter: Owais Naeem DDS, VCU Orthodontics

8/27/18 3:24 pm

Strongly Oppose

"Do no harm" is a core tenant of dental ethics. As a recent graduate, I cannot express how many times this was stressed to us throughout dental school. This proposed legislation is terrifying. Throughout dental school, the most I ever did on a patient orthodontically in a clinical setting was to untie their braces so that they could brush. I had a passion for orthodontics from early on, and sought out orthodontic experiences, but I know for a fact that my colleagues who were focused on graduating had little to no experience over their 4 years of dental school. A simple weekend course is not nearly enough to be able to claim that you are competent at treatment planning, treating, and educating patients in regards to their orthodontic treatment.

A patient is not aware of the amount of time and effort that goes into learning these topics throughout dental school. The board of dentistry's job is to provide patients with information in a way that they can understand. In order to protect the patient from being misinformed, there must be a way to differentiate doctors who are qualified and those who just claim they are. This is the only way to ensure we are not harming our patients.

Commenter: Alfred C Griffin, Jr. DDS, Harvard School of Dental Medicine

8/27/18 3:30 pm

Opposed| Protect the Public|

sincerely yours,

Dear Virginia Board of Dentistry,

I have practiced dentistry in Virginia for over 30 years as an Orthodontic specialist. My father practiced as a general dentist for 30 years in Virginia before me, as has my brother, wife and now soon my son. We all have witnessed the deterioration of trust our profession has experienced because of the eroding public confidence. Allowing dentists who have not completed recognized specialty training to advertise as specialists will only further confuse the public. In the last year, I have had patients seek second opinions in concert with legal action against a general dentist performing comprehensive orthodontic treatment with disastrous results. All three of them did not know that the dentist was not a specialist. Please do not legalize this fraud on the public!

Sincerely yours,
Alfred C Griffin, Jr DDS
Warrenton, Virginia

Commenter: Dr. Ignacio Biasi

8/27/18 3:42 pm

Strongly Oppose

I agree with the comments sent by the AAO to the Board of Dentistry.

Commenter: Edward Snyder / Dr. Edward P. Snyder

8/27/18 4:00 pm

Strongly Oppose

8/27/2018

RE: NOIRA concerning Amendment to restriction on advertising dental specialties

Dear Virginia Board of Dentistry Members,

My name is Edward P. Snyder. I previously served on the Board of Dentistry and I truly appreciate your time and efforts spent as you continue to monitor the practice of dentistry in the Commonwealth of Virginia.

I strongly oppose the proposed language in the NOIRA removing an essential public protection. Removing a definition of specialist would allow individual dentists to advertise as a 'specialist' when they have not completed at least 2 years of full time 'approved' education and training in the specialty.

The citizens of Virginia deserve the ability to easily distinguish dentists who have completed 2+ years of full time specialty education/training in their field from those dentists who have not. The regulation, 54.1-2718 and 54.1-2720, G., 3 and 4, recognize that specialties exist and this recognition should be maintained to protect the citizens of Virginia by providing appropriate information about the advertising dentist's educational background, or lack thereof.

I understand that questions have been raised concerning how the current specialties are designated by CODA. However, work is currently in progress to create a board independent of the ADA to certify what a specialty is and what a dentist must do, in terms of education, to achieve a specialty designation.

If the Virginia Board of Dentistry eliminates section 3 and 4 and relies only on sections 1 and 2 to govern advertising, then how will the Board determine what qualifies as appropriate education/training for a specialist. I do not believe the Board would want to spend the time necessary to determine each individual case of an individual dentist who claims 'specialty' status.

I fully support the comments and suggestions that the American Association of Orthodontist recently submitted to the Virginia Board of Dentistry.

Finally, the state of Louisiana has adopted language that I believe the State of Virginia should consider. The state of Louisiana has developed language essentially defining a specialist as one who has completed 2+ years of full time post-doctorial education and is accredited by an accreditation agency that is recognized by the United States Department of Education.

Sincerely,

Edward P. Snyder, DDS

Commenter: Sean Murphy, Attorney for the American Association of Orthodontists (AAO)

8/27/18 6:33 pm

Comments in opposition to changes being proposed to 18VAC60-21

Dear Ms. Reen and Members of the Virginia Board of Dentistry,

These comments are sent on behalf of the American Association of Orthodontists ("AAO") and its Virginia members to provide comments regarding the substantive changes being proposed to 18VAC60-21 (hereinafter referred to as "specialty laws"). We appreciate this opportunity.

Revising Virginia's Specialty Laws At This Time May Be Unnecessary

The AAO presumes the parties requesting revisions to Virginia's specialty laws take issue with the current laws recognizing only the ADA specialties, and the fact that the ADA's House of Delegates has had a say on what specialties are recognized. As you likely know, however, the National Commission on Recognition of Dental Specialties and Certifying Boards ("Commission") has recently been created. Our understanding is that the Commission alone will be deciding whether a new specialty should be recognized or not, without requiring final approval from the ADA's House of Delegates. This new Commission may very well address the issues identified by those requesting revisions to Virginia's current laws. As such, the AAO requests that the Virginia Board of Dentistry ("Board") delay any revisions to Virginia's specialty laws until the Commission is able to get fully up and running.

The AAO Supports Specialty Laws That Require CODA Accreditation

To the extent the Board does not want to delay this issue, the AAO supports Virginia's regulations that require those who are advertising as "specialists" to have successfully completed a post-doctoral advanced dental educational program of at least two full-time years and which program is accredited by the Commission on Dental Accreditation (CODA).

A CODA accreditation standard assures Virginia citizens that an individual who truthfully holds himself or herself out as a specialist has met high standards for education and training. If a dentist was able to advertise as a "specialist" without completing a multi-year CODA accredited program, it would dilute Virginia's "specialty" laws and allow providers, who do not have years of supervised clinical and didactic training and/or who have not satisfied extensive criterion, to advertise on par with those providers who have long-term, comprehensive education and training through CODA accredited programs. Such dilution could threaten the health and safety of Virginia patients by obscuring important distinctions between dental professionals as far as their respective educational and training backgrounds. It is important to remember that out of the 13 groups most involved with this issue (the 9 ADA recognized specialties and 4 from the American Board of Dental Specialties ("ABDS")), 12 have CODA accredited programs and would have members able to satisfy a CODA accreditation requirement. The only group whose members cannot currently satisfy a CODA accreditation standard are the Implantologists. Removing a provision solely to accommodate the Implantologists, and allow dentists who have graduated from non-CODA accredited programs to advertise on par with those who have graduated from CODA accredited programs, does not seem in the best interests of Virginia patients.

Given the foregoing, the AAO is opposed to the suggested removal of the provision prohibiting "(I) advertising a claim of a dental specialty unless it is approved by the National Certifying Boards for Dental Specialists of the American Dental Association," to the extent it would no longer require those advertising as specialists to have successfully completed a post-doctoral advanced dental educational program of at least two full-time years and which is accredited by CODA.

AAO's Response To The Proposed Removal of the Dental Disclaimer

The AAO is also opposed to the removal of the provision prohibiting "(II) representation by a dentist who does not hold specialty certification that his practice is limited to providing services in such specialty area without disclosing that he is a general dentist." Virginia law currently requires 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)." 18VAC 60-21-80. If the proposed removal took place, the "general dentist" disclosure under 18VAC 60-21-80 would no longer be required.

Given the current language, a general dentist advertising that his or her practices is limited to orthodontic services has to state something along the lines of "John Doe, general dentist, practice limited to orthodontics." Given that requirement, Virginia patients now know exactly what education and degree the advertising dentist has – i.e. whether they are a general dentist or an orthodontic specialist. On the other hand, the proposed removal would have the unintended consequence of no longer requiring that general dentist disclosure, so the same advertisement could read "John Doe, practice limited to orthodontics." If that is all the advertisement said, it is easy to foresee how Virginia consumers might conclude (albeit incorrectly) that John Doe is a specialist in orthodontics or even an orthodontist, rather than a general dentist practicing orthodontics. And as you can imagine, Virginia consumers who relied on such advertisements to choose dental services, would not be pleased if they were injured and found out after the fact that the dental provider they thought was a specialist or orthodontist, was rather a general dentist. The cause for concern is also not just limited to Virginia patients seeking orthodontic care, but any patient seeking care from a dental specialist (e.g. pediatric dentists, endodontists, periodontists, oral surgeons, etc.).

Conclusion

In closing, if Virginia adopts regulatory revisions that dilute the meaning of a specialist, it would seem to allow the situation in which a graduate from a non-CODA accredited, specialty program could advertise as a "specialist" or not use a general dentist disclaimer, a patient could rely upon that advertisement when choosing that provider, the patient might suffer an injury, and then the patient might claim he was not protected under Virginia's laws because they allowed his doctor to advertise in the same manner as a doctor who completed a multi-year, CODA accredited program. That regrettable scenario should not be given the opportunity to play out, especially if it comes at a cost to Virginia patients. The AAO strongly believes that those dentists who identify and advertise as "specialists" or advertise that their practice is limited to specialty treatment, should have an advanced level of training and education, and any changes to Virginia's specialty laws should clearly recognize that. With that in mind, Virginia may wish to follow the lead of Louisiana, which made changes to its specialty laws that can be found at 46 LA ADC Pt XXXIII, § 122.

The AAO respectfully requests that the Virginia Board of Dentistry consider these comments during its review. If the Board needs any further information or has questions for the AAO, please feel free to contact me.

Thank you for your time and attention to this matter.

Sincerely,

Sean Murphy

Attorney for the American Association

Commenter: Deldre Maul

8/27/18 8:47 pm

Strongly Oppose

Allowing nonspecialists to advertise as specialists is misleading to the public, undermines their trust in the dental profession, and puts their health at risk. I am dumbfounded and greatly disappointed that this ammendment is even being serlouly considered.

Commenter: Steve Haverkos

8/27/18 9:40 pm

Strongly Oppose

I strongly oppose this change because I believe it puts the public health at risk of fraud and increases the potential risk to harm a patient. In my limited experience of a little more than a year, I have already seen and discussed many patient cases where they were defrauded. The patients were made to believe they were receiving quality care from someone who had undergone the appropriate amount of training. Many of the patients were ultimately harmed by a practitioner that was providing care beyond their training and skill level. It disheartens me to think that this can happen when we all took an oath to do no harm. I am afraid that changing such a regulation will only make it that much easier to confuse and defraud a patient and potentially cause irreparable harm. For this reason, I hope this regulation change does not take place.

Commenter: Juan Loza

8/28/18 11:16 am

Strongly oppose

This ammendment is sending the wrong message to the general public and to the dentists in our state. The practice of the different dental specialties is getting more sophisticated than ever. We need to maintain the highest standards of service in our profession. By passing this ammendment, we will lower the qualifications of the dental practitioners, and thus, we will bring the quality of service down.

If this ammendment goes through, I would not want to be associated with the Virginia Dental Association. Many specilalists might not find any use for the Association.

Don't lower the standards that assure best practices in our profession. Juan Loza

Commenter: Tegwyn Brickhouse DDS PhD, VCU School of Dentistry

8/28/18 4:34 pm

Oppose

As a Pediatric Dentist who strives to provide optimal oral health care to all children. To do this, I have received additional training to treat young children and adolescents with special needs. Caregivers may receive misleading or ambiguous advertising by providers who claim they are "Kids", "children" dentists yet they do not have the adequate training necessary to successfully treat these patients who have complex dental or behavioral/medical needs. I believe this is an

ethical obligation to ensure the safest and best care for this vulnerable population and a valid regulation by the VBD that protects the public. I ask that VBD reconsider this proposal, as it is clearly not in the best interest of our patients.

Commenter: Sooyeon Ahn

8/28/18 7:50 pm

Strongly oppose

A specialist's extensive training and education should be respected.

The public should not be misled and should be protected from potential injury.

Commenter: David Hughes

8/29/18 12:11 pm

Opposed. Patients come first.

For Virginians today, the distinction between orthodontic specialists and general practice orthodontic service providers is already somewhat confusing. Our patients and our profession share a mutual interest in dispelling this misunderstanding, not erasing the distinction altogether. Already in my office, an increasingly steady stream of in-town patient transfer consultations have revealed the failings of seemingly straightforward orthodontic treatment unsupported by comprehensive diagnosis and treatment planning by non-specialists. Yes, we orthodontists take great pride in our work and in our credentials, but we also know that we require the trust and cooperation of our patients as well as our education and experience to achieve the best clinical outcomes.

Please consider the public in choosing to clarify the distinction between an orthodontist and a general practice dentist by preserving advertising standards that clearly acknowledge the special skillset that results from completing a multi-year specialty residency program in orthodontics. To neglect this duty toward transparency seems to me to be clearly unethical.

Respectfully,

David R. Hughes, DDS

Commenter: Erica Brecher DMD, MS, VCU School of Dentistry

8/29/18 2:12 pm

Strongly Oppose

As a board-certified pediatric dental specialist, I am strongly opposed to this change. This will evoke significant confusion for our patients as they seek the most appropriate care for their children. Patients should understand the level of credentials of the provider they are seeking care from so they can make an informed decision. A dentist who limits their practice to children but lacks adequate training will be unable to care for children with more complex issues that are outside the scope of a general dentist. We risk the oral health of our patients and their overall health in terms of advanced behavior guidance techniques such as sedation and general anesthesia that may be used inappropriately by those without proper training.

Commenter: Mary Foley, Piedmont Regional Dental Clinic

8/29/18 2:48 pm

Strongly Oppose

PRDC works with predominantly underserved, low income patients. Our patients don't have the knowledge and sophistication to understand the difference between a general dentist that treats children and the care that can be provided by a board certified pediatric dentist. The existing regulations protect our patient base by prohibiting advertising that seeks to blur the distinction and fool patients into thinking it is 'all the same'.

If we have specialists in dental practice we need to be able to communicate the benefits of being treated by those specialists. This proposal confuses the message and, by extension, the patient. Strongly oppose.

Commenter: Barrett W. R. Peters, DDS, MSD - Virginia Society Pediatric Dentistry

8/29/18 5:32 pm

Title 18. Professional and Occupational Licensing

August 29, 2018

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233
E-mail: sandra.reen@dhp.virginia.gov

Subject: Title 18. Professional and Occupational Licensing

Dear Ms. Reen:

The Virginia Society of Pediatric Dentistry (VSPD) and the American Academy of Pediatric Dentistry (AAPD) are writing to express our concern that the Virginia Board of Dentistry (VBD) is considering amending the regulations governing the practice of dentistry by replacing the regulatory provisions specific to advertising.

?
As organizations supporting optimal children's oral health whose members have received additional training to treat young children and adolescents, including those with special healthcare needs, we feel it is important to retain and update the current provision to prohibit advertising a claim of dental specialty status without having approval by the National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSCB). Otherwise families who may already have some confusion over the various dental specialties could receive additional misleading or ambiguous advertising by providers who claim they are dental specialists yet do not have the adequate training necessary to successfully treat patients who have complex dental or behavioral/medical needs. The VSPD and the AAPD believes this is an ethical obligation to ensure the best care for this vulnerable population and is a valid regulation by the VBD that protects the public.

The VSPD and AAPD respectfully ask that VBD reconsider this proposal, as it is clearly not in the best interest of the patients we serve.

Sincerely yours,

Joseph B. Castellano, DDS
President, American Academy of Pediatric Dentistry

Barrett W. R. Peters, DDS, MSD (Charlottesville, VA)
President, Virginia Society of Pediatric Dentistry
Affiliate Professor, VCU Department of Pediatric Dentistry
Owner-Operator, Piedmont Pediatric Dentistry

Patrice B. Wunsch, DDS, MS (Richmond, VA)
Secretary/Treasurer, Virginia Society of Pediatric Dentistry
Public Policy Advocate, Virginia Society of Pediatric Dentistry
Professor, VCU Department of Pediatric Dentistry

Note: The American Academy of Pediatric Dentistry (AAPD) is the recognized authority on children's oral health. As advocates for children's oral health, the AAPD promotes evidence-based policies and clinical guidelines; educates and informs policymakers, parents and guardians, and other health care professionals; fosters research; and provides continuing professional education for pediatric dentists and general dentists who treat children. Founded in 1947, the AAPD is a not-for-profit professional membership association representing the specialty of pediatric dentistry. Its 10,000 members provide primary care and comprehensive dental specialty treatments for infants, children, adolescents and individuals with special health care needs

Commenter: Joy Phelps

8/30/18 7:14 am

Strongly Oppose

I strongly oppose this!

Commenter: Larry Scarborough

8/30/18 7:40 am

Oppose. How is this debatable? You either are a specialist or you are not.

Commenter: Daniel R Pennella DMD INC

8/30/18 7:52 am

Strongly oppose.

Commenter: Jennifer Woodside, DDS

8/30/18 8:00 am

strongly oppose

Commenter: Scott Sachs, LWSS Family Dentistry and Dentistry for Children

8/30/18 8:18 am

Very Strongly Oppose

If Virginia adopts revisions that dilute the meaning of a specialist, patients (children) may receive

improper treatment from general dentists who treat children, including but not limited to the following: poor diagnosis; poor treatment planning; failure to assess growth and development anomalies; poor patient interaction. Pediatric dentistry requires a residency with advanced training after dental school to learn to manage, diagnose, treat, and interact with the developing child. I strongly believe that providers who market themselves as "children's dentists" or "kid's dentists" should all have the same advanced level of training, that is, a pediatric dental residency from an accredited CODA institution. I have personally seen numerous clinical cases of children who received improper treatment from general dental providers

Commenter: Dan Stewart DMD MSD

8/30/18 8:24 am

Strongly oppose

I see absolutely no advantage to the general public to allow this verbal slight of hand to work its way into law. It is unfortunate that this is even up for consideration.

Commenter: Riley Hunsaker DDS, VCU Orthodontics

8/30/18 8:42 am

Strongly Oppose

I strongly oppose these changes being considered and I am very disheartened to see that this topic has somehow found its way into the category of "debatable." These unwanted changes put the general population at risk, leaving them ill-informed about the educational background of their potential dental provider. That's not fair to anyone involved. These proposed changes are trying to solve a specific problem in a very generalized way, which will easily lead to disastrous consequences for dentistry and the population as a whole.

Commenter: Michael Payne DMD, VAO

8/30/18 9:15 am

Stringly oppose. Misleading

This action serves no purpose but to allow deceptive dentists to lie to the public. How can anything positive for the public come out of this? The board of dentistry has a mandate to protect the people, not help dentists. If you vote for this you are a classic government beauracrat who is looking out for the interested of the governors instead of the governed. I am ashamed that this is even being discussed.

Commenter: Ernest E. Wooden, III

8/30/18 9:39 am

DISAGREE STRONGLY/MISLEADING

Although a dentist may be capable of doing any specialty procedure well, it is extremely misleading to the public to allow that dentist to advertise as a specialist. The ADA has always had requirements for specialists in order to protect the public and changing that would be wrong.

Commenter: Steve J Lan

8/30/18 9:42 am

Oppose in the strongest possible terms

If this proposal is passed it will only open doors for potential unethical advertisement and treatment. We have pledged to provide the highest standard of care to our patients, and this will be counter productive. I do not see any logical reasons as to why we would allow providers who have not received standardized training as a specialist to proclaim as such. No other health care professions would permit such action, and dentistry should not be the first. This will only degrade our profession, and cause public confusion and mistrust. At the end of the day, we will only do a disservice to the public we are trying to serve.

Commenter: Elizabeth C. Miller DDS, MS, Atkins, Maestrello, Miller Pediatric Dent

8/30/18 10:57 am

Strongly Opposed

Dear Ms. Reen and Members of the Virginia Board of Dentistry,

I appreciate the opportunity to comment on the proposed changes to the "specialty laws." I fully support Virginia's regulations that require those who are advertising as "specialists" to have successfully completed a post-doctoral advanced dental education program of at least two full-time years and which program is accredited by the Commission on Dental Accreditation (CODA).

Allowing providers who have not completed these extra years of training to advertise to the public as "specialists" would threaten the safety of our patients and most-likely create more work for the Virginia Board of Dentistry. If there are no distinctions between a dentist who has completed their post-doctoral training and a dentist who has not, but advertises as such, the unfortunate scenerio will be the patients who suffer and who then make their voice known publicly about their misunderstanding. For example, as a Board Certified Pediatric Dentist who is in a large group practice with four other Board Certified Pediatric Dentists and two Board Certified Dental Anesthesiologists, we see many children whose parents have been mis-led by the advertisements of large group practices of general dentists who claim to specialize in pediatric dentistry. These children are referred to us frequently after an attempt is made by the general dentist to complete a difficult procedure on a young child, but is unsuccessful. The child is then sent to our office with a very serious dental issue which potentially could have been avoided. The most difficult aspect is that the child is usually emotionally scarred from the previous dental experience, to the point that our practice has to place many of them under general anesthesia to complete the procedure that the general dentist attempted. These instances could be avolded if the public understood the extra training of a pediatric dentist prior to having a difficult procedure completed on their child.

I respectfully request that the Virginia Board of Dentistry consider these concerns during its review. If you have any questions or concerns, please feel free to contact me or our practice. Thank you for your time and attention to this matter.

Sincerely,

Elizabeth C. Miller DDS, MS

Board Certified Pediatric Dentist

Atkins, Maestrello, Miller and Associates Pediatric Dentistry, P.C.

Commenter: Chase T. Prettyman, DDS, MSD

8/30/18 11:02 am

STRONGLY OPPOSE! Can't believe this would even be considered!

General dentists can't be allowed to promote to public as specialists because THEY ARE NOT! They don't have the training and knowledge and often get themselves in over their head when trying to do orthodontics. This can be detrimental to the health of patients and their teeth and patients should know this risk and that they are choosing a non-specialist to move their teeth.

Commenter: Roger A. Hennigh, D.M.D.

8/30/18 12:05 pm

Strongly Oppose

The Board should be very circumspect in altering / loosening the advertising rules for dentistry and dental specialties as it is the Board's RESPONSIBILITY to ensure the public health with regards to dental medicine. To loosen well established protocols and rules pertaining to dentists who may or may not be certified specialists in an effort to placate one unrecognized group ("implantologists") so that they can legally proclaim themselves as specialists in their field is very unwise. Any open-eyed individual should recognize that loosening the advertising rules which presently prevent General Dentists from publicly presenting themselves as a "specialist", in whatever facet of dentistry they choose, would invite a certain percentage to then proclaim that they are a "specialist" when in actuality they are not. Human beings are noteworthy for not always doing the right thing, and changing the presently well-constructed regulations on this matter will invite chaos to dentistry in Virginia, not clarity, and the public would not be well served.

Thank you for your consideration.

Kind Regards,

Roger A. Hennigh, D.M.D.

Commenter: Kevin E. Kelleher DMD MSD

8/30/18 12:52 pm

VCU Alumni - Strongly Oppose

I strongly oppose any changes to Virginia's current "specialty laws". How can allowing a dentist to advertise as a "specialist" who has not received post-doctoral education in that area be in the best interest of the public? This proposed change in law would only benefit the few who look to misrepresent themselves and potentially harm many. In addition this proposed change will undoubtedly lead to confusion in the general public as to who is a "true specialist" with certified training and those who are just advertising themselves as "specialist".

Commenter: David Keeton D.M.D.

8/30/18 12:53 pm

Strongly Oppose

I cannot see how this would benefit patients or the population of the Commonwealth in any tangible way. I can see where it would add to confusion and lead to doubt about the dental training and fraud.

Commenter: Michael A. Weiler, DMD

8/30/18 5:20 pm

Strongly oppose

Hello,

The fact that this action is even being considered underscores the importance of transparency about who is qualified to provide specialized care. There is a profound difference between a general dentist who is exposed to specialized training in a CE, weekend-course-type format (even for hundreds of hours) and a specialist who completes a two-three year treatment-based intensive curriculum. If this isn't obvious on its face, then the results (at least orthodontically—as I am an orthodontist) clearly speak for themselves. It is dangerous enough that general dentists are embarking on inappropriate orthodontic odysseys with their patients as it is. This action would encourage something being done on the fringes with unsatisfactory results. In the interests of public health, we need to be acting to discourage this behavior not encourage it!

Commenter: John Unkel DDS, MD, MPA

8/30/18 5:28 pm

advertisement- strongly oppose change

Strongly oppose change in advertisement regulations

The ADA is in the process for developing new dental specialties and their accreditation requirements. Therefore I fail to see the need for urgency to change regulations/statutes. More importantly, the question should be asked "who does this benefit?" The answer is obvious – the dentist who does not desire to commit the time or effort to become appropriately trained to treat the patient population at risk who requires the expertise of a specialist. Therefore it is self-serving and ignores the risks and benefits (if any) to the patient.

Dental specialists have a much higher degree of clinical training – a larger fund of medical and clinical knowledge, experience with specific populations and how to manage their risks with treatment or no treatment, better understanding of the health care system to link the dental and medical homes, etc.

Hence, let us continue to do what is in the patient's best interest i.e. continue to clearly state via advertisement a choice of provider types based on formal credentials.

Commenter: Claire Kaugars, DDS

8/30/18 11:00 pm

STRONGLY OPPOSE

Dear Virginia Board of Dentistry,

I am strongly opposed to this amendment. As a dentist, I have always understood and appreciated the role of the American Dental Association in taking charge of accreditation of dental schools to ensure a standard of education throughout the country. In so doing the ADA sought to protect the public by ensuring a continually high standard of newly graduating dentists across the US over many decades. In fact on the website of the Commission of Dental Accreditation, an ADA commission, is the statement, "Accreditation is the ultimate source of consumer protection..." Included in this accreditation oversight has been the 9 ADA recognized specialties all of which require 2-4 years of post dental school education. As a dental specialist in periodontics, I did 2 years of additional training after dental school with extensive didactic education and daily hands-on treatment of multiple patient cases under direct supervision of periodontists and under review by faculty and resident peers continually in those 2 years. I am not aware of a more complete education that would give the same experience and surgical mastery.

The ADA now appears to be shifting toward a newly formed ADA National Commission on

Recognition of Dental Specialties and Certifying Boards independent of the ADA on which are 9 general dentists and 9 specialists from the 9 ADA recognized specialties. Cases won by the ABDS (American Board of Dental Specialities) in Florida (2009) and in California (2010) allowed advertising by groups other than the ADA recognized specialties by citing restraint of trade and classifying the ADA as a trade organization. Has there ever been a restraint of trade since all dentists are licensed to perform all dental procedures? In Texas (2015) the ABDS stated that there was a required credentialing process to achieve their board certification and the Texas court granted the ability of these groups to advertise as specialists under the First Amendment (freedom of speech). Dr. Richardson's comment in support of the dissenting opinion of Judge James Graves of the 5th Circuit Court of Appeals is correct. Judge Graves asserted that "Misleading Speech" is not covered under the right of the First Amendment. Those dentists who do not have an equivalent educational foundation as the 9 ADA recognized specialties but call themselves specialists are misleading the public regarding their education and clinical experience. The public will never know and the Virginia Board of Dentistry will have failed to protect the public.

My hope is that the National Commission on Recognition of Dental Specialties and Certifying Boards will consider the depth and weight of education and hands-on experience that is done by the ADA recognized specialty candidate and done by the ABDS candidate. The US courts do not seem to be evaluating that distinction. And that distinction is what is so critical to the care and safety of the public. I support the current regulations specifying that a dentist may claim that his practice is limited to a specialty but that he must note that he is providing this care as a general dentist. I would oppose any amendment change until we have heard from this joint commission.

Thank you for the opportunity to respond.

Claire C. Kaugars, D.D.S.

Diplomate, American Board of Periodontology

Drs. Kaugars and Miller, PC

Commenter: Allison Williams

8/31/18 8:49 am

STRONGLY OPPOSE

If we think back to the beginning of our careers, whether specialist or not, we all chose to enter the dental field to help patients, educate them on proper treatment decisions and oral hygiene, and increase their dental health and possibly even self-esteem. In order for us to maintain these goals, it is important that we represent ourselves and our skills appropriately. Our first priority will ALWAYS be the patient. We cannot stray from this simple fact. From my limited time in orthodontics, I have realized the intense complexities inherent to every case. Our patients are unaware of the time it takes to study a certain specialty, and to be able to deliver appropriate care in every situation. When we represent ourselves as specialists in the dental field, we are providing a service of transparency which gives our patients the confidence and trust required to complete their care. I cannot imagine treating a patient without thorough training and mentorship from experts in the field. I agree with the comments sent by the AAO to the Board of Dentistry. Above all else, we must protect our patients, and we cannot lose sight of this.

Commenter: Allison S. Purcell, DDS

8/31/18 9:19 am

STRONGLY OPPOSE CHANGE

Members of the Board,

Please take the time to read the letter prepared by the AAO general counsel Sean Murphy in opposition of any change to the current regulations on speciality advertising. I stongly oppose the changes for all reasons listed in the letter. I believe the debate on speciality recognition and the accreditation process should be addressed on the national level. Please vote to keep the advertising regulation that is currently in place to protect the health and safety of our fellow citizens.

Sincerely,

Allison S. Purcell DDS - VCU Alumni

Commenter: Denver Lyons, DDS, VCU Department of Periodontics

8/31/18 10:59 am

Strongly Opposed

As a second year resident in the VCU Department of Graduate Periodontics working to earn a specialty degree I have been absolutely astounded at the depth of literature in the field of periodontics. We spend countless hours each week reading journal articles and reviewing these articles with faculty. The residency is three years and the volume of information regarding periodontics, medicine, sedation, and implant dentistry that we review is incredible. We gain an understanding of the history of our specialty through classic literature as well as where the field is headed by going through multiple current journals each week. This is all in addition to completing a research project to fulfill the requirements for a Master's degree while managing a full schedule of patients.

The elimination of specialty recognition would allow many who have not been through the training, literature review, and research of residency to allude to the public that they have had similar experience. I do not think that this is fair to the patients who would not have the understanding to know the difference. I am strongly opposed to this change in legislation!

Commenter: Kevin Bibona, DDS, MSD

8/31/18 11:19 am

Strongly Opposed

Thank you for the opportunity to comment on the proposed changes to the "specialty laws." I fully support the American Association of Orthodontists letter to the Board of Dentistry, in which the AAO expressed its strong opposition to the changes. Allowing those who have not gone on to pursue speciality training to advertise as specialists is reckless and short sided.

This is not about protecting our territory as specialists, but instead it is about public safety. I have read through the comments about those in favor of the changes, but I still cannot grasp how the removal of or changes to the speciality law and subsequent lowering of standards would help the general public.

Thank you for your time.

Commenter: Neal Kravitz, Kravitz Orthodontics

8/31/18 11:30 am

OPPOSE-this intended only to deceive

The only purpose for a general dentist with no specialty training in an accredited university program to advertise as a 'specialist' is to distort the limit of their dental education and provide dental treatment beyond their expertise for financial benefit. Should a family practice physician advertise as a thoracic surgeon? Should a middle school science teacher advertise as university professor in chemistry? Dentistry is lacking ethics and integrity, and falsification and prevarication of dental education and specialty training will further the spread of overtreatment by unqualified practitioners. Protection of the people is your civic duty. Protection happens when the truth is not blurred. A dentist who takes a weekend course is not a specialist. They have a certificate and not a specialty license. They gained CE credit, not a specialty degree.

Commenter: Amy Reichert, DDS, VCU Department of Graduate Periodontics

8/31/18 11:31 am

STRONGLY OPPOSED

As a third year resident in the VCU Department of Graduate Periodontics I can attest to the countless hours I have spent so far, and will continue to spend indefinitely, in reading the literature, treatment planning complex cases, putting together case presentations, preparing for literature and mock board exams, attending educational meetings, and transferring my knowledge to dental students in clinic and the classroom. All of these hours are spent under the careful direction of many full-time and part-time faculty who are well known experts in the field. The residency is three years and the volume of information we take in on the subjects of periodontics, medicine, sedation, and implant dentistry is incredible. Not only do we learn about current research and treatment modalities that give us an understanding of treatment planning and clinical therapy that is unmatched by any providers that have not undergone this type of training. This is all in addition to completing a research project to fulfill the requirements for a Master's degree to further progress our field and gain an even greater understanding of future treatment modalities to improve patient outcomes.

The elimination of specialty recognition would allow many who have not been through the training, literature review, and research of residency to allude to the public that they have had similar experience. This would be a direct violation of our ethical requirement to "do no harm." I am strongly opposed to this legislation; our patients will suffer!

Commenter: Carl O. Atkins, Jr., D.D.S., Atkins, Maestrello, Miller and Assoc.

8/31/18 11:49 am

Strongly Opposed

Members of the Board,

I am a Board Certified Pediatric Dentist with over 33 years in the profession practicing with four other Board Certified Pediatric Dentists. Each of us spent two or more years in specialty training plus passing the American Board of Pediatric Dentistry's multi-part examinations. We did this to provide the very best care for our patients.

Allowing dentists who have not met the educational requirements of the Commission of Dental Accreditation to call themselves specialists deceives the public and could lead to patient harm by unscrupulous practitioners.

Thanks you for your time.

Commenter: Meng Huan Lee, VCU Graduate Periodontics Resident

8/31/18 12:11 pm

Strongly oppose

Strongly Opposed

As a second year resident in the VCU Department of Graduate Periodontics working to earn a specialty degree I have been absolutely astounded at the depth of literature in the field of periodontics. We spend countless hours each week reading journal articles and reviewing these articles with faculty. The residency is three years and the volume of information regarding periodontics, medicine, sedation, and Implant dentistry that we review is incredible. We gain an understanding of the history of our specialty through classic literature as well as where the field is headed by going through multiple current journals each week. This is all in addition to completing a research project to fulfill the requirements for a Master's degree while managing a full schedule of patients.

The elimination of specialty recognition would allow many who have not been through the training, literature review, and research of residency to allude to the public that they have had similar experience. I do not think that this is fair to the patients who would not have the understanding to know the difference. I am strongly opposed to this change in legislation

Commenter: Graham Wilson

8/31/18 1:47 pm

Strongly oppose—unbelievable

Commenter: Gregory A Conner

8/31/18 2:01 pm

NOIRA

Unfathomable that the board would even consider this amendment. This is NOT in th public's best interest!

Commenter: Stephanie C. Smith DDS

8/31/18 2:08 pm

Strongly oppose

Commenter: Melanie W. Spears, DDS, MS

8/31/18 2:20 pm

Strongly oppose

I am strongly opposed to this change.

Commenter: Geoffrey Schrelber, DDS

8/31/18 2:35 pm

Strongly Opposed

Lying to the public will only sow seeds of distrust for our profession. If this amendment were to pass, I as a citizen would question the ability of the dental board to govern the profession. Going to a residency where you practice day in and day out for years with masters within your profession and the intense didactic studies within that program prepares you adequately for treating patient's within a specialty of dentistry. If you attend a day, weekend, or even month long CE class; this will not prepare you to handle all aspects of providing care within a specialty. If a general dentist would like to be an endodontist, periodontist, oral and maxillofacial surgeon, pediatric dentist, orthodontist, oral & maxillofacial pathologist, or oral and maxillofacial radiologist; then they should attend the appropriate, accredited residency program.

Commenter: M.Magid

8/31/18 2:36 pm

Oppose

It is important that as a profession we are able to self regulate ourselves. General dentists should not be able to advertise that they have the same skill sets as a person who has spent additional time obtaining specialty certification. If this is not the case then why have advanced educational programs at all. In medicine doctors receive an unrestricted license. However; do you want your family practitioner doing your brain surgery? I think the public already has a hard time understanding the differences amongst what a general dentist does and what our specialty trained doctors offer. It would be irresponsible for the board to propogate these issues any further.

Commenter: Steven J Lindauer, Chair, VCU SOD, Orthodontics

8/31/18 2:57 pm

Additional info on recent changes in definitions by the NC Board of Dentistry

In response to recent ADA actions regarding dental specialties and specialists, the North Carolina Board of Dentistry revised their advertising regulations. There does not appear to be a mechanism to attach those changes here but they are very detailed and do appear to be designed to inform the public more completely about the educational qualifications of providers related to the services

they purport to be experts in or to which services they have limited their practice. I recommend that the Virginia BOD evaluate actions by the NC board and see how something like that might fit for Virginia.

Commenter: Aura Center For Aesthetic Dentistry, Negar S Tehrani

8/31/18 3:00 pm

Strongly Opposed

Strongly opposed

Commenter: Paul David, DDD

8/31/18 3:35 pm

Strongly Appose

I strongly believe it is unethical for general dentist to advertise him/herself as a ADA recognized specialty provider unless they have completed postgraduate course of study leading to certificate level recognition. There is absolutely no mechanism other than an ADA Specialty residency to assure minimal educational requirements to provide competence in one's area of specialty. I don't have a problem with a general dentist "limiting" themselves to a specific area of practice as long as they clearly disclose themselves as a general dentist.

Commenter: Ashley A. Harman, DDS, Children's Dentistry of Virginia

8/31/18 3:58 pm

Strongly Oppose

It would be misleading to the public to allow general dentists to advertise as a specialist, without having successfully completed an ADA CODA approved specialty training program. Specialists earn their certification and develop their expertise from YEARS of clinical and didactic training, most of which is barely even taught in dental school. Most specialists also complete an additional, rigorous certification process in order to attain board certification. We do all that we can, to be the best that we can be in our area of expertise for our patients. I truly believe this can only harm our patients and create distrust, in the eyes of the public, of dentistry as a whole. Thank you for your consideration.

Commenter: Dr. Damon Omar Watson

8/31/18 4:11 pm

strongly opposed!

It seems like common sense. A professional who has NOT had a certified education in a recognized specialty should NOT be able to advertise as such. It is deceiving and down right dishonest in most cases. This is already occurring to some level; and from my experience, patients have been adamantly appalled when they realize. Protect the patient and allow the truth to be advertised, not a "version" of it. I STRONGLY OPPOSE THIS.

Commenter: Erin Block, DDS, VCU Department of Graduate Periodontics

8/31/18 4:51 pm

STRONGLY OPPOSE

As a first year resident in the VCU Department of Graduate Periodontics working to earn a

specialty degree, I have been absolutely astounded at the depth of literature in the field of periodontics. We spend countless hours each week reading journal articles and reviewing these articles with faculty. The residency is three years and the volume of information regarding periodontics, medicine, sedation, and implant dentistry that we review is incredible. We gain an understanding of the history of our specialty through classic literature as well as where the field is headed by going through multiple current journals each week. This is all in addition to completing a research project to fulfill the requirements for a Master's degree while managing a full schedule of patients.

The elimination of specialty recognition would allow many who have not been through the training, literature review, and research of residency to allude to the public that they have had similar experience. I do not think that this is fair to the patients who would not have the understanding to know the difference. I am strongly opposed to this change in legislation.

Commenter: Scott Flood, DDS

8/31/18 4:51 pm

Strongly opposed

We must all work to place the patient first and elevate dentistry. This proposal does not serve the public.

Commenter: Katie Doswell

8/31/18 4:52 pm

Strongly opposed

Commenter: Sandy Chang

8/31/18 7:03 pm

stringly oppose amendment

The public need to be informed properly of what specialist is. Allowing general dentists to market themselves as a specialist is allowing the general public to be misinformed

Commenter: Darrell a Meeks DMD (omfs)

8/31/18 7:25 pm

specialty recognition

Extremelymisleading to the public. Patients come into my office not knowing the difference between a general dentist who calls himself an oral surgeon and someone who spent five more years to actually become one. I have had many patients who have told them that they are just as good and we will just charge them a lot more. Insurance pays us all the same! E-Mail me if you want to some of the horror stories I hasve heard.

Commenter: Paul K. Hartmann, DDS

8/31/18 7:41 pm

Srongly opposed

Advertising and marketing are cheapening our profession as currently allowed. We all recognize how well it works. Allowing non-residency trained individuals to profess non-accredited specialty status is the beginning of the slippery slope that will end with a public distrust of all dentists at an

unprecedented level. Please don't make these changes. You are charged with protecting the public, and this leads us all in the oposite direction.

Commenter: D. Eric Redmon, DDS

9/1/18 3:25 am

Strongly Oppose

I find it odd, when the public is already so naive concerning both the qualifications of their Dentist/Specialist or what they do, that the Board of Dentistry would seemingly go out of their way to blur those distinctions further. Instead of virtually erasing major ADA approved specialties of their unique status in regards to caliber of education, it is my opinion that advertising that implies expertise of a non certified person should be required to post a disclaimer, ie public warning: *** Doctor/Practice is not affiliated or certified by any specialty recognized by the American Dental Association.

Commenter: Gustav Horsey, DDS, MS

9/1/18 8:18 am

Strongly Oppose

I strongly oppose this!

Commenter: S Patel

9/1/18 9:00 am

Strongly Opposed

Advanced Education is a choice dentists pursue to provide the best care possible to our patients and community as a whole. We are depriving the public of being educated in knowing what a speciality means and therefore being able to make their choices appropriately on their needs. I have referred patients to other doctors in my own speciality just to provide the best care possible. Specialists are not even recognized appropriately by insurance companies yet we choose to work with them for the higher purpose of providing care to those in need. I strongly oppose not defining specialists as I foresee less dentists not choosing to specialize in the future and therefore a great loss for not only our patients but also for our profession.

Commenter: Andrew Zima DDS, MSD

9/1/18 9:13 am

Strongly Opposed

Commenter: Morris L. Poole DDS, MSD

9/1/18 9:36 am

Strongly Opposed

Strongly Opposed

Commenter: April Bridges-Poquils, DDS

9/1/18 8:29 pm

Strongly Oppose

I strongly oppose this change. I am an orthodontist practicing in Richmond and have unfortunately seen first-hand the irreversible damage done by non-specialists. Proper treatment must first start with a proper treatment plan. A proper treatment plan must be developed around a comprehensive understanding of the patient's cephalometric analysis as well as their dental and facial concerns. I've seen cases where teeth were not extracted when they should have been and vice-versa because a generalist failed to take into account the cephalometric analysis or facial analysis when attempting a treatment plan. The public needs to be educated and informed that specialists have invested in additional years of training and committed to practicing only their specialty so that they can provide the very best service for them. We must protect the public.

April Bridges-Poquis, DDS, VCU Alumni

Commenter: N Ray Lee DDS

9/2/18 10:28 am

Amendment to restriction on specialty advertising

STRONGLY OPPOSED

Commenter: N Ray Lee DDS

9/2/18 10:30 am

STRONGLY OPPOSED

Commenter: Mark Gardner DDS VCU Dept of Oral and Maxillofacial Surgery

9/2/18 12:59 pm

Strongly Oppose

Commenter: Chris Abernathy, DMD

9/2/18 1:09 pm

Strongly oppose

Commenter: VCU Health

9/2/18 1:21 pm

Strongly opposed

Strongly opposed

Commenter: Chris Ray, DDS

9/2/18 1:23 pm

Strongly opposed

Strongly opposed

Commenter: Dr Michael Holbert

9/2/18 1:37 pm

Strongly Opposed

I am strongly opposed to this action and believe it significantly weakens our ability as a profession to protect our patients, which requires maintaining the highest standards of care. These standards are set by the dental specialist who has received 2 to 4 years of additional training and limits their daily practice to a specific field.

Commenter: Sean Eccles DDS

9/2/18 2:03 pm

Strongly Opposed

Strongly opposed.

Commenter: Amber Johnson, DO, DMD

9/2/18 2:36 pm

STRONGLY OPPOSED

I oppose this regulatory action because I believe it will be harmful to patients and cause confusion about who has completed specific and approved advanced education in dental specialties.

Commenter: Aaron Stump DDS Charlottesville Pediatric Dentistry

9/2/18 3:33 pm

Strongly oppose

I strongly oppose this amendment for a variety of reasons:

- 1) Misleads unknowing public into believing they are receiving specialist care when they are not
- 2) Degrades specialist training and dental/medical practice

I feel that dentistry, being a subset of medicine, should hold itself to a high standard. Gone are the days of the barber-surgeon where one could get a haircut and an amputation in the same place at the same time. There should be a higher standard of advertising when there are clearly higher standards in practice, specialty training, and board certification. Although medical doctor in title, my children's pediatrician does not advertise as a gynecologist or endocrinologist, even though they may be able to handle some basic gynecological or endocrine issues.

Above all, this is a general public safety issue. The general public is not knowledgeable about technicalities of specialty dentistry as a practice. It needs to be clearly stated to allow them to objectively elect care from a general dentist or specialist, just as I have the choice to seek care from my PMD for my allergy issues or seek care at Board Certified Allergist.

The ADA Ethical Advertising Code states: Section 5.H. ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE, of the Code sets forth the General Standards for determining the education, experience and other appropriate requirements for announcing specialization and limitation of practice. These are: 1. THE SPECIAL AREA(S) OF DENTAL PRACTICE AND AN APPROPRIATE CERTIFYING BOARD MUST BE APPROVED BY THE AMERICAN DENTAL ASSOCIATION. 2. DENTISTS WHO ANNOUNCE AS SPECIALISTS MUST HAVE SUCCESSFULLY COMPLETED AN EDUCATIONAL PROGRAM ACCREDITED BY THE COMMISSION ON DENTAL ACCREDITATION, TWO OR MORE YEARS IN LENGTH, AS SPECIFIED BY THE COUNCIL ON DENTAL EDUCATION [AND LICENSURE], OR BE DIPLOMATES OF AN AMERICAN DENTAL ASSOCIATION RECOGNIZED CERTIFYING

BOARD. THE SCOPE OF THE INDIVIDUAL SPECIALIST'S PRACTICE SHALL BE GOVERNED BY THE EDUCATIONAL STANDARDS FOR THE SPECIALTY IN WHICH THE SPECIALIST IS ANNOUNCING. 3. THE PRACTICE CARRIED ON BY DENTISTS WHO ANNOUNCE AS SPECIALISTS SHALL BE LIMITED EXCLUSIVELY TO THE SPECIAL AREA(S) OF DENTAL PRACTICE ANNOUNCED BY THE DENTIST .

We should follow this guideline.

Commenter: Soheli Rostami DDS

9/2/18 5:48 pm

Strongly Oppose

Commenter: Madelyn morris

9/2/18 6:44 pm

STRONGLY OPPOSED

As an endodontist, I spent two years in advanced specialty training learning how to treat complicated cases and manage emergencies, and studying the research to back my clinical decisions. This bill will allow anyone to claim they specialize in 'root canals' which is a true disservice to our patients who won't know the difference in the quality of care they are receiving. This is deceitful to the public and seems criminal...especially to those of us who put the time in training for 2-3 years beyond dental school.

Commenter: Wm. Graham Gardner D.D.S.

9/3/18 7:19 am

STRONGLY OPPOSED TO 18VAC60-21

Dear Ms. Reen and the Virginia Board of Dentistry,

Comments in opposition to changes being proposed to 18VAC60-21

I urge you to vote against "the amendment to restriction on advertising dental specialties." This is an extremely dangerous proposal that WILL be damaging to the public and to dentists. Your decision will affect people in the Commonwealth of Virginia and will also set a precedent throughout the country. I have listed my main concerns as follows:

Important Concern: If the specialty distinction is eliminated, there is no reason for dentists to go through 3-5 years of extra education to call themselves a specialist. **The quality of care for patients will obviously drop significantly.** There will be no orthodontists straightening teeth, dentists will do that. There will no oral surgeons doing jaw surgery, dentists will do that. General dentists are not trained to do these things in dental school. Patients will receive poor treatment.

Important Concern: **Patients will be deceived.** The patients will have no idea which dentist has had adequate training and which do not. Patients will have no way to differentiate between which dentists practice specialty training consistently every day and those dentists that have done it once before. Would you want your family members to have an implant (a surgical procedure) placed by someone that has only seen it once during an afternoon course?

Important Concern: The ADA just created a National commission on dental specialty recognition

which proves that they are in favor of specialists in the dental profession. Restricting the advertising of dental specialties is a slap in the face to the American Dental Association, which represents all dentists and not just the specialists. It is even more of a detrimental insult to the American Association of Oral and Maxillofacial Surgeons, the American Academy of Periodontology, the American Association of Endodontists, the American College of Prosthodontists, the American Academy of Pediatric Dentistry, the American Association of Oral and Maxillofacial Pathology, the American Association of Public Health Dentistry, the American Academy of Oral and Maxillofacial Radiology and the American Association of Orthodontics.

Important Concern: Who does this possibly benefit? A group called the American Board of Dental Specialties which represents a very small sample of the dental community. This proposal certainly does not benefit the majority of dentists and it **MOST CERTAINLY DOES NOT BENEFIT THE PATIENT**. This is a national group trying to move their agenda throughout the country. This is not a Virginia issue.

Important Concern: This puts Virginia at risk. When the Commonwealth allows dentists to advertise that they are at the level of a specialist when they are not, and a person gets hurt by poor treatment by this dentist, then the commonwealth is to blame for allowing this unqualified dentist to treat patients at this lower level.

Why is this even being considered?

Why would health care ever be allowed to move to a sub-standard level where we are downgrading our treatment standards and deceiving patients?

I URGE you to do the right thing for the public. Do not let patients be deceived. Do not let the practice of dentistry sink to a sub-professional level. Do not let underqualified providers treat patients poorly.

Thank you for your consideration and your excellent service to our great Commonwealth.

Sincerely,

Wm. Graham Gardner D.D.S.

Commenter: Scott Eberle - VCU ALUM

9/3/18 3:07 pm

STRONGLY OPPOSED

Strongly opposed to this proposal.

Commenter: Angel K. Ray, DDS, MS

9/3/18 3:26 pm

Strongly opposed

I am writing to voice my opposition to the regulation allowing dentists without specialty post-doctoral training to advertise as a specialist. I believe that this change will result in much confusion for the layperson and ultimately create a public safety crisis. To essentially allow anyone to state that they are a specialist without benefit of proper training is unimaginable and I cannot think why the Board would even consider such a thing when its primary job is to establish regulations to ensure the safe practice of Dentistry. This regulation must not pass and I strongly object to it and appreciate the opportunity to go on record as being opposed.

Commenter: Amy Adair, DMD, MSD, Pediatric Dentist

9/3/18 3:44 pm

Strongly Oppose

The unintended consequence (or perhaps intentional consequence, depending on where one stands on the issue) of this ammendment would open the door to false advertising and is misleading the general public.

Dentistry as a whole would take a hit because of the confusion this will create to the general public.

I understand that there are several dental specialties that have been unsuccessful in becoming recognized by the ADA, but this is not the way to go about gaining recognition. This ammendment creates a slippery slope that will get abused.

Commenter: Albert Konikoff

9/3/18 3:54 pm

Strongly Oppose

Allowing non credentialed practitioners to advertise as specialists would put the public at great risk. The elimination of the current regulations on advertising as a dental specialist would seem to fall under the prohibition on deceptive advertising. The public up until this time has assumed that anyone with the designation of a specialist is in fact a dental specialist having undergone rigorous postdoctoral education in an accredited institution. There is no way that the public would now think otherwise and thus would be deceived. In this present regulation there is nothing to protect the public. It only promotes the ability of anyone to say that they are speciallist without any regard to training, competency, or ability. Who will be the benefactors of this regulation change? Certainly not the public. I strongly oppose this change as it is not in the best interest of the people of the Commonwealth of Virginia.

Commenter: Laurie Birsch, DDS

9/3/18 5:22 pm

Strongly oppose this amendment

I strongly oppose this proposal. Generalists simply are not Specialists. Clearly, you should not be able to advertise credentials and certifications that you do not possess.

Fiat-out, this amendment condones lying and deceiptfulness and does not put public interest and well-being at its core. Shame on the Board for letting the argument get this far!

Commenter: Beth Faber, DDS, MS

9/3/18 7:20 pm

STRONGLY OPPOSE

I strongly oppose the proposed change in the NOIRA to remove the definition of a specialist. Virginia's public depends on you to oversee dentistry in our state. It would be a disservice to them and a reduction in our standards of care to not recognize our dental specialties. Years of post-doctoral education in a field of specialty is essential to the ongoing dental care of our patients.

Commenter: Steven G. Forte D.D.S., Endodontist

9/3/18 8:00 pm

Strongly Opposed

I agree with much that has been said. This is not in the best interest of the public in Virginia and will only make it confusing for them. Please do not consider this change in the regulation.

Commenter: Benjamin T Overstreet

9/3/18 11:04 pm

Strongly Oppose

As a dental specialist, it truly upsets me that the American Board of Dental Specialist is trying to make it easier for the general dentist to obtain the title of a dental specialist. The requirements for the general dentist are far less than the recognized CODA requirements. As a periodontist it took 3 years of hard work, a lot of sacrifice from my family, and a lot of increased debt in order to be able to become a periodontist. 3 years is necessary for a person to be competent in a specialty and not the significantly reduced requirements of ABDS. This will be very misleading to the general public and in fact will be a great disservice to them. I hope that you will recognize the importance of this matter and will look to back the current CODA requirements.

Sincerely

Ben Overstreet DDS, MS

Board certified Periodontist

Commenter: Michael E. Miller, DDS

9/4/18 7:59 am

Strongly Opposed

This would do nothing to "protect" the public, but instead would create more confusion and likely misrepresentation.

Commenter: Sheldon A. Bates, DMD

9/4/18 8:10 am

Strongly Oppose

While the intent of this regulation appears to relate to the recognition of Implantologists as specialists, the action suggested in this NOIRA could have some far-reaching unintended consequences. The request made at the 3/10/17 board meeting constituted a request for a narrow expansion of the specialist recognition. The proposed regulation change constitutes a sweeping modification and an extensive expansion of freedoms in advertising that could serve to blur the lines between general practitioners and specialists. This could open the public to be misled in the qualifications of practitioners providing services and could result in poor dentistry being performed. Obviously, this would not be protecting the population that we serve.

Rather than eliminating all specialty advertising restrictions, I would suggest that one solution could be an additive approach by attempting to have other specialties recognized when they meet the requirements and guidelines set forth by the ADA. Whether or not additional specialties should be

recognized is beyond the scope of my comment, and I offer no opinion on the matter.

If there were no protocol in place for specific areas of dentistry to become recognized as additional specialties, the 3/10/17 petition would be a reasonable action. As it stands, the ADA presently maintains a protocol for an organization to pursue specialty recognition. Therefore, petitioning the board for recognition locally, appears to be an effort to circumvent the established systems. Although that approach appears to have been successful in Texas regulations, I believe their conclusion is flawed due to its circumvention of the current guidelines. Therefore, their action should not be considered precedent for changing our regulations.

I understand that the board has had extensive communication with attorneys from the American Board of Dental Specialties—the organization that represents four as-yet-unrecognized specialties by the ADA. Rather than expending energy and resources to change local acceptance, those energies would be better spent by the ABDS to pursue recognition on a national level for its constituent organizations.

By eliminating the specialty advertising restrictions, it would be reasonable predict that general practitioners could brand themselves as specialists in various areas of dentistry, thus implying that there is a greater degree of education and practice that does not exist. This, I believe, would be a significant unintended consequence of the proposed action. If poor dentistry is performed after these changes are made, the board could be opened to litigation for failure to appropriately protect the public.

In summary, striking the proposed language from the Virginia Code would serve to satisfy the petitioner's request, but could have far-reaching detrimental consequences—the fullest extent of which we cannot foresee. There presently exists a protocol on the national level through the ADA for a specialty to be recognized. If those petitioning the board were to go through the proper channels to become an ADA-recognized specialty, the language already exists in the Virginia Code that would afford them the same rights as the currently-recognized nine specialties.

In light of these facts, I strongly oppose the proposed action in its present form.

Commenter: Stanley F Kayes DDS

9/4/18 8:36 am

dental advertising

I am strongly opposed to changing the regulation.

Commenter: Scott A. Synnott - Prosthodontist

9/4/18 8:44 am

Most strongly oppose

It is inconceivable, in a society and profession that values transparency and honesty, that the Board would repudiate those core values and expose our patients to misleading marketing and potentially, substandard care. The definition of the term "specialist" is: *a person who concentrates primarily on a particular subject or activity; a person highly skilled in a specific and restricted field.*

It takes more than the application of a marketing label professing the ability to provide specialty level care, it requires rigorous academic and clinical experience and training in accredited programs. A weekend, or even years of OJT do not provide the foundation of knowledge necessary. Please do not put our patients at risk and ask that they alone have to sort out reality from fantasy when it comes to their care.

Commenter: RL Howell DDS & Associates, PC

9/4/18 8:53 am

Oppose

I am a general dentist and I oppose changes to this regulation.

Ralph L Howell, DDS

Commenter: Sherif N. Elhady DDS MS

9/4/18 8:57 am

Strongly Oppose

I strongly oppose this measure and am dumbfounded more by the motivations that prompted such a suggestion than by the suggestion of changing the law itself. The board needs to be transparent in how such a regulation would lead to a better outcome for the dental health of the general public.

By removing any specialty designation, the public, which is already very confused when it comes to who delivers their dental care, will have even less available truthful information on their practitioners skill level in delivering a given procedure.

As I know not one board member who understands dentistry would send their child to a general dentist to do their orthodontics or to a general dentist to do a grafting procedure, it does not seem ethically responsible that you would allow the general public to proceed with these decisions with clear misguidance through advertising.

Commenter: Ashburn Children's Dentistry

9/4/18 8:58 am

STRONGLY OPPOSE

Commenter: Reid D. Sowder Dr. Richard L. Byrd and Associates

9/4/18 9:13 am

Strongly Oppose

I voice strong opposition to the amendment that would allow practitioners to advertise as specialists even though they have not gained expertise through education, accreditation or experience. In addition to possibly allowing deceptive advertising there is a real risk that patients may be adversely affected by having a docore that is not truly an expert ion his/her field. Practioners who have spent considerable time and expense to become experts in their speciality should not be penalized by what amounts to false advertising. The public should feel confident that the practloner who has gained accreditation in a dental speciality is truly the practioner of choice when a specialist is needed.. If an non-credentialed practioner is able to advertise that they are an expert/specialist, It would lessen the impact that a post doctoral degree and years of practice in a dental speciality have on the public. It is through years of practice and education that the practioner is set apart. There is no way that the patient would know the dfference between a highly educated and practiced specialist and a new doctor just out of college. There should be some definite parameters in advertising to protect the patient. Truth is an important concept and one that the patient is entitled to.

Commenter: Wyatt Orthodontics

9/4/18 9:19 am

Strongly Opposed. Very misleading to the public.

Strongly opposed to this change. Very misleading to the public.

Commenter: Ryan C Anderson DDS, Periodontal Health Associates

9/4/18 9:30 am

Opposed

I am strongly opposed to the proposed change in legislation. I believe that this will allow underqualified individuals to mislead the public through advertising to bring them into their practice and then not be able to provide the same level of care as a true board certified specialist who has graduated from an accredited program. Over time, moves such as this will undermine the relevancy of the graduate level programs and will ultimately result in fewer applicants and attendees. I believe that this will have ramifications many years in the future with the general public not being able to find many qualified specialists due to lack of desire to attend multi-year programs with no tangible rewards for doing so.

Commenter: Rodney J Klima DDS PC

9/4/18 9:38 am

Amendment to remove advertising restrictions for dental specialists

I would like to comment that I AM STRONGLY OPPOSED to the removal of advertising restrictions for dental specialists as proposed by the Board of Dentistry. In my opinion this action would amount to an abdication of responsibility of the Board to be in existence to protect the public from false, misleading representations of clinical training and background. With the creation of the new Independent Commission on Dental Specialties created by the ADA the Board should feel reassured that legal challenges to these current restrictions would be frivolous. I believe the public and in turn the politicians would be greatly disturbed to learn that the members of the Board were led to erase a century of progress in raising the clinical standards of the practice of dentistry for fear of a lawsuit challenge.

Commenter: Dr. Lindsey North— Dr. Richard Byrd & Associates Ortho & Pediatric Dentist

9/4/18 9:39 am

Strongly Opposed- Misleading to general public

I am constantly educating friends and family about the differences between general dentists and dental specialists such as pediatric dentists and orthodontists. The general public does not understand that specialists have 2-5 years beyond dental school graduation at much personal and financial sacrifice to gain expertise in the fields of orthodontics or pediatric dentistry in order to work specifically within those fields to deliver the highest quality results for everyone including young children and individuals with special needs that embraces emotional, intellectual, behavioral and physical disabilities using expensive technology to provide the best results. My concern is for the patients and parents who trust general dentists with their specialized care are being misled to believe their doctor has obtained specific training with advanced techniques and restorative options. Pediatric dentists are specifically trained in child psychology, behavior management, and the most up-to-date restorative techniques through residency, board-certification/re-certification, and continuing education yearly. Pediatric dentists are able to offer advanced techniques to help with positive behavior and positive outcomes, we have had extensive experience with sedation and general anesthesia not just a weekend course. General dentists are important for cleaning and restoration but advanced treatment options should always be under the care of a dedicated specialist. Just as I shouldn't trust my family doctor to treat a specialized medical condition,

general dentists should not be allowed to confuse the general public by advertising as the specialists they are not. We see many DIY treatments on the internet that entice or confuse consumers about who they can trust to deliver the outcome they desire. While many general dentists do successfully treat pediatric patients, I talk to many parents of pediatric patients who came to us after having had very bad experiences with a general dentist who was unable to manage a particular behavior, disability or other challenge. Sometimes this results in a patient not returning for dental care. Sometimes this results in dental restorations that have to be replaced. We run the risk of preventing individuals to seek treatment for certain conditions when it becomes commonly believed the success and satisfaction rate has been compromised by providers who basically have not received the training to deliver the desired results. The general public does not understand the difference in a general dentist and specialist.

Commenter: Julie Stagers Orthodontics

9/4/18 9:46 am

The proposed advertising changes is dangerous to the public

The advertising laws regarding dental specialist should be strengthened, not eliminated. The public does not always understand what it means to be a dental specialist. In the absence of knowledge, marketing is king. Allowing general dentists to advertise orthodontics service is deceiving to the average patient. I see general dentists doing this all the time. They underdiagnose or overdiagnose frequently, sometimes knowingly and sometimes unknowingly. When something goes wrong, they expect the real specialist to fix it at the patient's expense. Terms like Invisalign Certified confuse patients into thinking that any one that is Invisalign Certified is an Orthodontist. The Board of Dentistry should be addressing this. Allowing general dentistry to advertise as orthodontist is putting profits above patient care and the patient's best interest. Too many general dentists think that they can attend a few weekend courses and then be equivalent to a university trained orthodontist. They don't realize what they don't know, and patients are paying the price. Please change your focus to strengthen the advertising laws, not eliminate them. Thank you! Julie Stagers

Commenter: Stephanie Voth

9/4/18 10:03 am

Strongly Opposed

To the members of the board, As a board certified periodontist, I am strongly opposed to the proposed changes in speciality recognition.

Commenter: Mala Britto DDS,MS

9/4/18 10:14 am

Strongly OPPOSE

I strongly oppose this change. The board has a commitment to the public and the profession and this step will set you back in this goal

The public are guided in thier selection of a dentist by the advertisement by the dentist and this should be accurate and based on education and skills and Not based on the dentists self assessment of his/her abilities. This would be a gross misrepresentation of the facts and therefore a risk to patient care

Specialty training is intense resulting in dentists with advanced knowledge and skills which is NOT equal to a weekend course

Please be the strength and the beacon that the dental profession has placed in you the board and

fight the dilution of our esteemed profession

Commenter: Dr. Kanyon Keeney-VOFS

9/4/18 10:30 am

Strongly Oppose - Why confuse and mislead the public?

Commenter: Jill Beitz DDS, VCU Periodontics

9/4/18 10:36 am

STRONGLY OPPOSE!

After four years of college, four years of dental school, one year in a general practice residency, and one year working in New Jersey as a general dentist, I discovered I **STILL** did not know enough and there was so much more to learn if I wanted to be a good dentist- let alone a specialist. As a second year resident in the VCU Department of Graduate Periodontics I can attest to the countless hours I have spent so far, and will continue to spend indefinitely, in reading the literature, treatment planning complex cases, putting together case presentations, preparing for literature and mock board exams, attending educational meetings, and transferring my knowledge to dental students in clinic and the classroom. All of these hours are spent under the careful direction of many full-time and part-time faculty who are well known experts in the field.

The residency is three years long and the volume of information we take in on the subjects of periodontics, medicine, sedation, and implant dentistry is insurmountable. Not only do we learn about current research and treatment techniques, but we also spend a considerable amount of time learning the classic treatment modalities that give us an understanding of treatment planning and clinical therapy that is unmatched by any providers that have not undergone this type of training. This is all in addition to completing a research project to fulfill the requirements for a Master's degree to further progress our field and gain an even greater understanding of future treatment modalities to improve patient outcomes... not to mention the more than \$500,000 I have amassed in student loans.

The elimination of specialty recognition would allow many who have not been through the training, literature review, and research of residency to allude to the public that they have had similar experience. This would be a direct violation of our ethical requirement to "do no harm." Allowing undertrained practitioners to claim specialty status will, without a doubt, lead to patient harm and continue to degrade the profession into the future. **I strongly oppose this legislation!**

Commenter: Richard F. Roadcap DDS

9/4/18 11:05 am

Opposed

As a practicing general dentist, both and I my patients would like to know if a doctor claiming to be a specialist has completed an accredited (and ADA recognized) residency program. This proposal would establish fear of litigation as the only deterrent to fraudulent claims.

Commenter: Thomas Eschenroeder DDS

9/4/18 12:10 pm

Amendment to Restriction on Advertising Dental Specialties:

Strongly Opposed.

Commenter: Thomas Eschenroeder DDS

9/4/18 12:10 pm

oppose the Amendment to Restriction on Advertising Dental Specialties

Strongly Opposed.

Commenter: John White

9/4/18 12:13 pm

Strongly Oppose

I strongly oppose this amendment. As a recent graduate of VCU's Graduate Periodontics Program I'd like to provide some comparative data on the qualifications and time commitment of a CODA certified periodontist and implant specialist as compared to an implant specialist certified by the American Board of Dental Specialists (ABDS).

Over the last three years I spent roughly 8,000 hours (including nights and weekends) learning, studying, and teaching periodontology and implant dentistry as well as treating patients. I would argue that roughly 50% of this time was dedicated specifically to implant dentistry in all its facets. The easiest route of admissions into the ABDS implantology specialty requires 670 continuing education hours to apply for specialty. That's a 7,330 hour total difference and a 3,330 hour implant difference.

I completed 174 implant cases during my residency. The ABDS requires 75. That's a 99 case difference. Please keep in mind many of my cases require knowledge and understanding outside of basic implant dentistry (i.e. sinus augmentation, ridge augmentation, soft tissue grafting, management of implant disease, management of implant complications, wound healing, sedation, etc.).

Of the 174 implant cases I completed in residency, ALL (100%), were completed with on-site, personal supervision from established periodontists and prosthodontists prior to, during, and after surgical and restorative therapy. The ABDS requires 7 years of clinical practice experience in implant dentistry, but it does not specify the amount of supervision and/or expert advice provided to the active practitioner. Furthermore, it does not specify the number of cases that must be completed during those 7 years of experience. Therefore, a dentist who completes 1 case a year for 7 years could apply. Likewise, a dentist that completes 75 cases over 10 years (or only 7.5 cases/year) could also apply. Again, this is in stark comparison to the number of cases (in my case 174) and direct instructional supervision provided to one who completes a CODA certified residency in either Periodontics, Oral Surgery, or prosthodontics. Sadly, this comment focuses on implant dentistry but similar arguments can be made for endodontics and orthodontics.

Again, I'd like to voice my opposition to this amendment. I urge the governing body to review the above comparative data. With this in mind, please ask yourself two things: (1) who is most qualified to place and manage dental implants? (2) What is in the best interest of the general public, most of whom are unfamiliar with qualitative and quantitative metrics mentioned above? I appreciate your time and attention.

Commenter: Michael Dunegan, DDS, MS

9/4/18 12:45 pm

Strongly oppose this change

For years the dental profession has had a wonderful system of certifying that specialists go

through rigorous post-doctoral training and testing. The public for the most part knows and trust this, just as they know when their orthopedic surgeon is a specialist in this medical field, the surgeon has gone through a certified training and testing process. To allow anyone to say they are a "specialist" will do nothing but confuse the public. It is misleading and not helpful to patients as they research their best options. So we are now going to have specialists with special ADA certified training, testing and continuing education and specialists who can just say they are a specialist because they feel like they have lots experience and courses. There is nothing good that is going to come out of diluting the definition of a true dental specialist. **STRONGLY OPPOSE**

Commenter: Jessica Clark DDS

9/4/18 12:55 pm

STRONGLY OPPOSE

I strongly oppose this proposal.

Commenter: Josephina Lac, DDS., MS. Pediatric Dentist.

9/4/18 1:12 pm

Opposed Strongly, please consider the Innocent children's healthy care.

Dear Ms. Reen and all members of Virginia Board of Dentistry:

I have been working in pediatric field since my residency, in Boston, Maryland and Virginia. I have heard and seen lots of poor dental work done by certain general dentists in children's mouth, and have been repairing for them all these years.

Parents do not know about the quality of dental work, or how important it is to maintain healthy primary teeth, because we (the pediatric dentists) could not tell them who did what, and who did not know how to treat pre-matured or special-needed children. Most of the cases, the children who came to a Pediatric dentist were pretty traumatized for their dental works, or suffered from infectious diseases without even being noticed by their parents until they were treated by us.

Some parents did not know their children needed to be seen by a special dentist if they themselves have not been to a dentist for any reason. Some parents did not even know how to find a pediatric dentist, let alone how to identify a dentist who advertised "pediatric dentist" from the one who were truly / genuinely trained by the accredited Pediatric Academy, who went through all the hospital training for all kinds of potential emergency and who would properly maintaining all PALS, CPR, and proper licenses for sedation, prescription, and special continuing educations which focus on children.

Please be the advocates for all children and not allowing additional misleading and ambiguous advertisement used by dentists who claimed they are specialties but were not. Thank you for your consideration and may God bless the children.

Sincerely yours,

Josephina Lac, DDS., MS.

Commenter: Christine Stang

9/4/18 1:24 pm

opposed

We vow to do no harm. Please consider this oath that we all take as dentists and think of how this change could adversely affect your own family and loved ones when they are seeking out care.

It is our duty as a profession to ensure that patients are as informed as possible when it comes to their care. Making it more difficult for a patient to understand the qualifications of their provider is not something that should even be up for discussion.

Commenter: Frederick Canby DDS, MS

9/4/18 2:16 pm

Opposed

This should not even be opened up for consideration. Quality of care needs to be tightened up. If anything a reverse logic is needed.

Removing the limits as proposed in this amendment allows non specialists (regardless of practice setting) to push the envelope to levels for which they are unqualified. Why? What are you hoping to achieve? Screw the public? Water down CODA based dental education? Is there some corporate ulterior motive here?

I most strongly oppose this amendment and it is my hope that the VDA will screw its head back on correctly.

Commenter: Kevin Toms, DDS

9/4/18 2:30 pm

Strongly Oppose

Ms. Reen and the Board of Dentistry,

The current regulations are in place to protect the people of Virginia from false and misleading advertising.

The ADA has established a separate committee to evaluate the addition of other accredited specialties. I think it would be in the boards best interest to NOT change or delay any decision until this committee has been allowed to fulfill its purpose. Reference comments by Sean Murphy for the AAO.

I would hate to see the board litigated for failing to protect the people of Virginia when an injured patient learns the board changed advertising regulations. The patient went to a dentist they thought was a CODA accredited residency trained specialist. Their advertisement said "specialist". Only to find out this dentist had taken a couple of company sponsored weekend courses and advertised as a specialist in said discipline.

In summary I am strongly opposed to any change in the current regulations. Thanks

Commenter: Rodney J Kilma DDS

9/4/18 3:15 pm

Advertising regulatory change in conflict with Virginia Dental Statutes?

Under Virginia Statute 54-1-2700 an Oral and Maxillofacial surgeon is defined as a person who has successfully completed an Oral and Maxillofacial residency program approved by the Commission on Dental Accreditation of the American Dental Association. Who an oral surgeon is is clearly defined in the statute. The regulatory change submitted by the Board of Dentistry on removing advertising restrictions for dental specialists I believe is in conflict with (and may violate) the statute since it would allow dentists who are not oral surgeons to advertise as oral surgeons.

Virginia Statute 54-1-2706 Revocation or suspension and other sanctions, states that "Practicing outside the scope of the dentists or dental hygienist's education, training, and experience" is

grounds for revocation of the dental or dental hygiene license. The regulatory change submitted by the Board of Dentistry on removing advertising restrictions for dental specialists I believe is in conflict with this statute in that it now allows a dentist to advertise that he or she is a specialist in an area where they may not have the education and training.

Commenter: Golden Pediatric Dentistry/Herschel L Jones DDS

9/4/18 4:05 pm

EXTREMELY OPPOSED!

EXTREMELY OPPOSED!!! Can't believe this is even under consideration!

Commenter: gregg l. kassan, dds

9/4/18 5:20 pm

strongly oppose advertising/ proclaiming a specialty lacking our profession's recognition!

Commenter: Bryan P. Wheeler, DMD

9/4/18 5:45 pm

Strongly opposed

It's hard to believe this is being considered. This would be misleading to the public, potentially harmful to patients, and erode trust of professionals.

Commenter: Farzaneh Rostami DDS

9/4/18 5:57 pm

Oppose

Commenter: Patel Oral Surgery

9/4/18 5:57 pm

Opposed

The dental boards sole duty is protection of the public. I do not believe it serves the public to be unaware of the training of the person doing invasive medical procedures to their own body. It is a sacred trust we hold and we must not do anything to diminish that trust. Disclosing the type of provider you are is critically important as someone informed can then make a better choice. We do informed consent for a reason.

Commenter: Dr. Evan Chalk

9/4/18 6:10 pm

Strongly opposed

I strongly oppose this amendment as this misleads the public. It also devalues the hard work and countless hours that all specialists devoted to becoming a leader in their respective field, and the right to call themselves a specialist.

Commenter: Scott H Leaf DDS

Strongly Opposed to this Amendment

9/4/18 8:56 pm

How does this protect the patient population or enhance our professional standing ? Can you see this happening in the medical community ? If this passes, I am appalled at the incompetence of the Virginia Board of Dentistry !

Commenter: Jeff Bailey, DDS, MS

9/4/18 9:21 pm

Strongly OPPOSED to this regulation

All that is needed in the state of Virginia is one large court award for failure to refer to an ADA accredited specialist...and this discussion would be mute.Would you send your mother to a cardiology specialist or a cardiologist who was trained with standards? If you sanction having a free-for-all specialty designation, you might as well put dentistry back in the barbershop!

Commenter: Thomas F. Glazier, DDS, MSD; Richardson-Overstreet-Glazier

9/4/18 9:24 pm

Strongly Oppose - Inherently Misleading Speech Should not be protected under 1st amendment

The dictionary defines the word "specialist" as a person who concentrates primarily on a particular subject or activity; a person highly skilled in a specific and restricted field.

I would imagine that if someone advertised themselves as a "specialist" in a particular medical or dental field, they should be trained in COMPLICATION MANAGEMENT.

The American Board of Oral Implantology, a constituent group of the American Board of Dental Specialties, seeks to certify their members as "specialists" in implantology through a process that bears no mention of complication management other than two lines on a multiple choice test. The 2019 ABOI/ID standards can be found here:

http://www.aboi.org/content/documents/2019_aboi_candidate_handbook.pdf

Please contrast this with the standards put forth by CODA:

PERIODONTICS

https://www.ada.org/~media/CODA/Files/2018_perio.pdf?la=en

PROSTHODONTICS

https://www.ada.org/~media/CODA/Files/2018_prostho.pdf?la=en

ORAL & MAXILLOFACIAL SURGERY

<http://www.ada.org/~media/CODA/Files/oms.pdf?la=en>

The simple fact that individuals with can inherently misleadingly advertise as a "specialist" via credentials from a board certification process that does not examine or test the candidate's ability to ACTIVELY MANAGE COMPLICATIONS should not be protected under the first amendment right to free speech.

Furthermore, I believe this puts not only the oral health, but the general health and safety, of Virginia's citizens at risk.

As the soles tasked with the responsibility of protecting the public of Virginia, I humbly ask that you

think of your relatives and loved ones in other places of Virginia that may fall prey to such advertising. How the board plans to deal with patients that were injured by individuals that were inherently misleadingly advertising as "specialists" is beyond me.

I believe this issue of inherently misleading speech not being protected under first amendment rights is best explained by the dissenting opinion of James E. Graves, Jr, Circuit Judge, 5th Circuit Court of Appeals in American Academy of Implant Dentistry v. Parker, No. 16-50157 (5th Cir. 2017) when he authored the following:

"I disagree with the majority that Rule 108.541 of the Texas Administrative Code is unconstitutional as applied to the plaintiffs (hereinafter collectively referred to as "Academy"). The advertising proposed by Academy is inherently misleading. Misleading commercial speech is not entitled to First Amendment protection. Because I would reverse the district court's grant of summary judgment on Academy's First Amendment claim and its enjoinder of the provision as applied to Academy, I respectfully dissent. Academy wants to advertise as specialists in certain subsets of dentistry that are not recognized as specialties by the American Dental Association ("ADA") and are prohibited from doing so by the rules of the Texas State Dental Board of Dental Examiners (the "Board"). Academy brought a facial and as-applied constitutional challenge against the Board arguing that Rule 108.54, which regulates specialty advertising for dentists, unconstitutionally infringes on commercial speech protected by the First Amendment. The district court partially granted both parties' cross-motions for summary judgment. Academy was granted summary judgment on its First Amendment claim, invalidating the ordinance as applied to Academy. The Board was granted summary judgment on Academy's equal protection and due process claims. The Board appeals the First Amendment claim. Academy failed to file a cross-appeal, but then attempts to revive a Fourteenth Amendment due process claim in the appellees' brief. As the majority correctly states, we apply the four-part test from *Central Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of New York*, 447 U.S. 557 (1980), as follows: At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come within that provision, it at least must concern lawful activity and not be misleading. Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine whether the regulation directly advances the governmental interest asserted, and whether it is not more extensive than is necessary to serve that interest.

As a threshold determination, for commercial speech to be protected under the First Amendment, "it at least must concern lawful activity and not be misleading." *Central Hudson*, 447 U.S. at 566. Advertising that is inherently misleading receives no protection, while advertising that is potentially misleading may receive some if it may be presented in a way that is not deceptive. In *re R.M.J.*, 455 U.S. 191, 203 (1982). This case is analogous to *American Board of Pain Management v. Joseph*, 353 F.3d 1099 (9th Cir. 2004), which involved a California statute that limits a physician from advertising as board certified in a medical specialty without meeting certain requirements. There, the Ninth Circuit said: The State of California has by statute given the term "board certified" a special and particular meaning. The use of that term in advertising by a board or individual physicians who do not meet the statutory requirements for doing so, is misleading. The advertisement represents to the physicians, hospitals, health care providers and the general public that the statutory standards have been met, when, in fact, they have not.

Because the Plaintiffs' use of "board certified" is inherently misleading, it is not protected speech. But even if the Plaintiffs' use of "board certified" were merely potentially misleading, it would not change the result in this case, as consideration of the remaining three *Hudson* factors confirms that the State may restrict the use of the term "board certified" in advertising. Such is the case here. Texas has by statute given the term specialist a particular meaning. See 22 Tex. Admin. Code § 108.54; see also 22 Tex. Admin. Code §§ 119.1-119.9 (setting out special areas of dental practice). Additionally, it is only "in the context of unregulated dental advertising" that the Board contends the term "specialist" is devoid of intrinsic meaning and is inherently misleading. But with regard to the regulated dental advertising and the recognized specialty areas, the term has a special meaning and special requirements. Further, the areas that Academy seeks to have designated as specialties are actually more like subsets, which are already encompassed within general dentistry and multiple of the existing recognized specialties. See 22 Tex. Admin. Code §§

119.1-119.9; see also Tex. Occ. Code § 251.003 (setting out the provisions of the practice of dentistry). The majority opinion allows that, instead of a general dentist having to comply with the academic, educational or certification necessary to become, for example, a prosthodontist, a general dentist can simply get "certified" in one small aspect of the branch of prosthodontics, i.e., implants, and advertise at the same level as someone who actually completed an advanced degree in an accredited specialty.² The majority relies on *Peel v. Attorney Registration and Disciplinary Commission of Illinois*, 496 U.S. 91 (1990), to conclude that "specialist" is not devoid of intrinsic meaning. In *Peel*, the issue involved letterhead and a statement that the attorney was a "certified civil trial specialist by the National Board of Trial Advocacy." The Court concluded that this was not inherently misleading, saying that "it seems unlikely that petitioner's statement about his certification as a 'specialist' by an identified national organization necessarily would be confused with formal state recognition." *Id.* at 104-05. The Court further reiterated that a "State may not, however, completely ban statements that are not actually or inherently misleading, such as certification as a specialist by bona fide organizations such as NBTA" and pointed out that "[t] here is no dispute about the bona fides and the relevance of NBTA certification." *Id.* at 110. However, that is not the case here where, as the Board correctly asserts, the term "specialist" may be used without reference to any identified certifying organization and there is a dispute about the bona fides and relevance of the certifications. Thus, despite what the majority says, the problem is not merely that "the organization responsible for conferring specialist credentials on a particular dentist is not identified in the advertisement." Nevertheless, *Ibanez v. Florida Dep't of Bus. & Prof'l Regulation, Bd. of Accountancy*, 512 U.S. 136, 145, n.9 (1994), is also distinguishable. *Ibanez* involved an attorney who advertised her credentials as CPA (Certified Public Accountant) and CFP (Certified Financial Planner). Again, there were no questions about the certifications. Further, footnote 9, which addressed only a point raised in a separate opinion, says that a consumer could easily verify *Ibanez*' credentials – as she was indeed a licensed CPA through the Florida Board of Accountancy and also a CFP. More importantly, *Ibanez* was not practicing accounting. Further, under 22 Tex. Admin. Code §§ 108.56 additional credentials or certifications are clearly allowed to be advertised in Texas.³ In *Joe Conte Toyota, Inc. v. Louisiana Motor Vehicle Commission*, 24 F.3d 754 (5th Cir. 1994), this court relied on evidence in the record to support the district court's finding that the use of the term "invoice" in the automobile industry in its entirety was inherently misleading. That evidence included testimony of various car dealers that "invoice" means different things. *Id.* at 757. Here, we have testimony that "specialist" in unregulated dental advertising means different things. The majority's statement that "[h]ere, the individual plaintiffs intend to use 'specialist' in the same manner as dentists practicing in ADA-recognized specialties" is erroneous. In fact, the plaintiffs intend to use "specialist" to encompass subsets of existing specialties that do not necessarily require the same academic, educational or certification required of the specialties recognized by both the ADA and Texas. For these reasons, I would conclude that the term "specialist" in the context of unregulated dental advertising is inherently misleading and, thus, not protected by the First Amendment. Moreover, even if *Academy's* proposed speech was only potentially misleading, the Board would still be able to regulate it under the remaining elements of the *Central Hudson* test quoted previously herein. As the Board asserts, the evidence provided, at the very least, creates a question of fact sufficient to survive summary judgment. The Supreme Court said in *Ibanez*: Commercial speech that is not false, deceptive, or misleading can be restricted, but only if the State shows that the restriction directly and materially advances a substantial state interest in a manner no more extensive than necessary to serve that interest. *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y.*, 447 U.S. 557, 566, 100 S.Ct. 2343, 2351, 65 L.Ed.2d 341 (1980); see also *id.*, at 564, 100 S.Ct., at 2350 (regulation will not be sustained if it "provides only ineffective or remote support for the government's purpose"); *Edenfield v. Fane*, 507 U.S. 761, 767, 113 S.Ct. 1792, 1798, 123 L.Ed.2d 543 (1993) (regulation must advance substantial state interest in a "direct and material way" and be in "reasonable proportion to the interests served"); *In re R.M.J.*, 455 U.S., at 203, 102 S.Ct., at 937 (State can regulate commercial speech if it shows that it has "a substantial interest" and that the interference with speech is "in proportion to the interest served").

Ibanez, 512 U.S. at 142-43. The majority acknowledges that the Board has a substantial interest. But, the majority then concludes that the Board has not demonstrated that Rule 108.54 directly advances the asserted interests. I disagree. The Board presented evidence demonstrating how

Rule 108.54 would directly and materially advance the asserted interests. That evidence included "empirical data, studies, and anecdotal evidence" or "history, consensus, and simple common sense." See *Pub. Citizen Inc. v. La. Attorney Disciplinary Bd.*, 632 F.3d 212 (5th Cir. 2011). The majority dismisses the empirical data and studies referenced in *Borgner v. Brooks*, 284 F.3d 1204, 1211-13 (11th Cir. 2002), because the actual studies are not in the record. The absence of those studies in the record does not undermine the reliability or persuasiveness of the Eleventh Circuit's analysis and conclusions about those same studies including, but not limited to, the following: These two surveys, taken together, support two contentions: (1) that a substantial portion of the public is misled by AAID and Implant dentistry advertisements that do not explain that AAID approval does not mean ADA or Board approval; and (2) that ADA certification is an important factor in choosing a dentist/specialist in a particular practice area for a large portion of the public.

Id. at 1213. Additionally, the majority dismisses deposition testimony and evidence of complications saying, in part, that the harms would not be remedied by Rule 108.54 because it merely regulates how a dentist may advertise. I disagree. Rule 108.54 regulates what a dentist may hold himself out as being to the public, i.e., a general dentist with or without certain credentials or a specialist.

The majority further dismisses witness testimony because it does not necessarily pertain to general dentists who violated the existing rule by holding themselves out as specialists in advertisements. The point of the testimony was to offer support for the fact that an ADA-recognized specialist has a higher success rate and fewer complications than a general dentist who may perform a subset of those recognized specialties. Also, what the Board does clearly establish is that the harms Rule 108.54 seeks to prevent are very real. This was established by way of both anecdotal evidence and simple common sense. With regard to consensus, the Board introduced evidence that numerous other states limit dental-specialty advertising. Rules 108.55-56 allow any pertinent information about individual plaintiffs' qualifications to be advertised to consumers. See 22 Tex. Admin. Code §§ 108.55-56.4 Rules 108.55-56 also clearly establish that Rule 108.54 is not more extensive than necessary. Dentists are able to advertise any and all dental credentials and certifications so long as they do not hold themselves out as specialists in areas where they have not complied with the statutory requirements. Thus, even if the speech was only potentially misleading, I would conclude that the Board can still regulate it under the Central Hudson test. For these reasons, I would reverse the district court's grant of summary judgment on Academy's First Amendment claim and its enjoinder of the provision as applied to Academy. Therefore, I respectfully dissent."

Thank you for your time and consideration in this highly important matter.

Best Regards,

Thomas F. Glazier, DDS, MSD

Commenter: Aaron Quitmeyer D.D.S.

9/4/18 9:47 pm

Wrong for Virginia, Wrong for Dentistry

The proposed change in advertising specialty status is far too broad to be considered. I am strongly opposed to this change as it creates more confusion for the public who relies on the Virginia Board of Dentistry to ensure safety. The risks of this proposal far outweigh the benefits and I agree with all the reasons stated by other members in this forum. It is my opinion that our rules on advertising are not strong enough and there has been little enforcement of the current statute. Those in favor of the proposed changes have a great responsibility to ensure their wishes for recognition do not undermine the ethics of dentistry and do not place the public at greater risk. The current proposal does not effectively meet those goals. Raising the advertising restrictions

would be negligent.

Commenter: Heather Moylan

9/4/18 10:04 pm

Support for Comment Prepared by AAO

I am an orthodontist who completed my specialty training at Virginia Commonwealth University in June 2018. I strongly support the AAO's stance on this proposed change. It is not in the best interest of patients to allow healthcare providers to advertise their qualifications or lack thereof in a manner that is misleading.

Commenter: Heather Moylan

9/4/18 10:05 pm

Strongly Opposed

I am an orthodontist who completed my specialty training at Virginia Commonwealth University in June 2018. I strongly support the AAO's stance on this proposed change. It is not in the best interest of patients to allow healthcare providers to advertise their qualifications or lack thereof in a manner that is misleading.

Commenter: Michael J Mayerchak, DMD

9/4/18 11:10 pm

Strongly opposed

I agree with others that voiced their disappointment that the board would even consider this proposal. It seems to open the door for misleading claims and advertising. I think the public has placed their trust in the board to make sure that someone who claims to be a specialist actually has the training and expertise to merit that designation.

Commenter: Harold J. Martinez, Commonwealth Endodontics

9/5/18 1:02 am

Deceiving the public by deregulation of dental specialty advertising. Strongly opposed.

The Virginia State Board of Dentistry should be able to protect the public from harm by not allowing a dentist to mislead their patients into believing that they can perform dental procedures with the same education, skills and qualifications as a specialist who has had the proper advanced dental education training accredited by CODA. I strongly support the American Association of Endodontists' firm stance of opposing deregulation of dental specialty advertising.

Commenter: Jeffrey Thorpe

9/5/18 7:13 am

Specialty ad regulation a must!

We must protect the patients. Advertising as a specialist without the credentials is poor protection for the public that knows no difference. The ADA is clear concerning specialty training and the board should be made sure that the dentist who call themselves specialists are trained in that specialty.

Commenter: Corey Sheppard

9/5/18 8:17 am

Opposed

I am writing to show that I oppose this change. I support protecting the public from false and misleading information. Only dentists who have completed appropriate specialty training should be allowed to advertise to the public the specialty in which they were trained.

Commenter: Ronald M. Rosenberg DDS, MS,LTD

9/5/18 9:13 am

Strongly Oppose the Advertising Dental Specialties Amendment

The Virginia Dental Board's primary focus should be the quality of care that is provided by Virginia dentists. There is no way that this amendment enhances the quality of care or the health of Virginia citizens. If anything it does the opposite. If passed, this amendment would only cloud the issue of who is the most qualified practitioner to treat a specific problem. Some highly educated people will see through the cloud but many less knowledgeable individuals will be treated by non-specialists and not be aware of it. The outcome could obviously be less than ideal. The only individuals that gain from this amendment are general dentists who did not want to take the additional time, effort or expense for their training or were academically unqualified to get into a certified post graduate training program. As an aside, there will be no reduction in costs to patients as I have seen fees from general dentists' offices that are higher than those from specialists, Virginia has always had a great reputation with regard to the quality of care that is offered to our patients. Lets keep it that way and reject this amendment.

Commenter: Carmen A. Cote, DDS

9/5/18 9:57 am

Strongly Oposed

What we will do as a General Dentist if we have to refer all the treatments to the designated especialistas????

We are fighting a battle with the Insurance companies already!. I do not think we will be able to keep our offices open. Maybe a better idea should be to require specific "days" , no hours, of training per year on the "services" that we want to advertise.

Carmen A. Cote, DDS

Azalea Family Dentistry a Division of Atlantic Dental Care, PLC

Commenter: William Goodwin DDS

9/5/18 11:51 am

Strongly opposed

This proposed amendment is not in the best interest of the people of Virginia. Strongly opposed.

Commenter: Christopher E. Bonacci DDS MD PC

9/5/18 11:57 am

Strongly oppose

It is the responsibility of The Board of Dentistry to protect the citizens of Virginia. Their mandate is clear. In no way does this action protect but actually endangers the public with false and misleading advertising. I hold an MD license in VA as well as a DDS. Are you advocating that I can now perform hernia, hemorrhoid, appendix or brain surgery? I spent months on these surgical services. I could pull it off, I bet, under most circumstances. But what is the point when we have specialists performing these services every day at a high level, having met graduation, specialization, Board and hospital certifications? The benefit of a few aggressive generalists who did not sacrifice time, tuition, graduate level acceptance and ongoing performance evaluations should not supercede the benefit of the public at large. The ADA has made a grave mistake. Virginia should not follow in their footsteps.

Commenter: Michelle Toms

9/5/18 1:05 pm

Strongly Opposed

I oppose this action. When it comes to certification and licensing there has to be a separation between residency trained specialists, and dentists that learned advanced techniques in continuing education courses. Advertising has to reflect that difference.

Commenter: Khin Mimi San, Virginia Commonwealth University

9/5/18 1:27 pm

Strongy Oppose

Strongly oppose this as it makes the point of specializing futile. We have gone through extensive training to specialize with understanding evidence based literature to enhance clinical application. Oppose this strongly!

Commenter: Marcel Lambrechts, Jr. DDS

9/5/18 2:27 pm

Strongly opposed to changes

I totally understand the fear of the Board of being sued by the lawyers of the made-up specialties, but to totally delete the requirement and protection of the citizens of Virginia is too much to allow. The so-called specialties wouldn't even want this. That would mean anybody could claim to be a specialist for anything and there's not any protection of the citizens of Virginia from an incompetent other than suing after something goes bad. That would leave this Board in question as well since you are to protect them from the very action you are now going to allow.

Commenter: Michael Gazori

9/5/18 2:40 pm

Strongly opposed

I was troubled to hear that the Board is considering amending the provisions for the advertising of dental specialties, creating the ability for non-specialists who limit their practice to providing specialized care to advertise as specialists and to not require them to disclose that they are, in fact, general dentists. As a pediatric dentist this troubles me because I know firsthand the differences between the two. I was a general dentist for 14 years. Nearly half of my patient base was pediatric because I just loved taking care of kids. In 2003 I decided to specialize in pediatric

dentistry. After attending a residency program for two years and practicing as a pediatric dentist for 13 years I know now what I did not know as a general dentist. My care is much more thorough, comprehensive, and thoughtful due to my education and experience. The difference between what I knew as a general dentist and what I know now is vast.

The way that the public views the differences between general dentists and specialists needs to be protected. Our industry is increasingly being viewed as a commodity. I venture that most of the general public does not understand the vast differences in knowledge and ability that can exist between general dentists and specialists. Blurring the lines between the two has the potential to greatly harm our patients by creating the perception of a level playing field. It would also create the illusion that the additional education that specialists receive is unnecessary and meaningless.

Unscrupulous practitioners already exist in our industry. False advertising and claims abound as practitioners scramble to grab their piece of the pie. This proposed change has the potential to open the floodgates to not only unscrupulous practitioners but also to well-meaning practitioners who just don't have the knowledge base and experience to call themselves specialists.

As a practicing dentist my only concern is for the patients we serve. I implore the Board to fully appreciate the potential harm this change may inflict on the unknowing public.

Commenter: Sang Y. Kim DMD, MD, P.C.

9/5/18 2:51 pm

STRONGLY OPPOSED

Misleading public is no different than lying. I work with many dentists who provide services which overlap with ADA recognized specialists but they do not advertise as a specialist.

Only dental licence holders who are already misleading the public by advertising as a specialist will be given more freedom to further mislead the public at the highest level.

I am not sure why we are even wasting time discussing this.

Commenter: Gregory Engel, Beach Endodontics

9/5/18 3:54 pm

Strongly opposed!

While I may agree with some of the "in favor" comments held in this comment section regarding specialties not recognized by the ADA/CODA, the board does have a responsibility to protect the welfare of our patients. And, while there have been successful litigations against other state boards (duly recognized by other "in favor" comments), that does not mean that our state board should not have to address this problem. After reading this legal brief (<https://www.aae.org/specialty/wp-content/uploads/sites/2/2018/09/bierigspecialtyadvpaper0818-002.pdf>) outlining what could be constructed, it seems obvious that our state board can still protect the welfare of its patients while still acknowledging dentist's First Amendment rights in constructing a blended regulation that would use the existing ADA/CODA specialty requirements and also allow for an alternative pathway to specialty designation by establishing (and requiring proof) of a similar accepted didactic / clinical equivalent or more stringent (not less) standard. Please read the legal brief. It clearly articulates the course that needs to be taken.

Commenter: A. Scott Anderson, III, DDS

9/5/18 4:25 pm

Strongly oppose

This comment is written concerning the "Amendment to restriction on advertising dental specialties". I strongly oppose making a change which would put the public at a severe disadvantage when they are seeking a competent level of specialty dental care for themselves or their family.

I support the Virginia Board of Dentistry in its efforts to ensure that the dental care provided in Virginia is safe and effective for the public. A significant part of that effort is to ensure that the information to which the public is exposed is not misleading and cannot be easily misconstrued.

I am writing to share my observations of a few circumstances which often develop when families believe they are presenting for healthcare services with a provider who they mistakenly believe is a pediatric dental specialist. All too often, I have observed the consequences facing families who have sought pediatric dental care from a general dental provider who the family believed was a pediatric dental specialist, a pediatric dentist, or a children's dentist. Not only have the families often depleted much of their insurance benefits, but the families may also have spent significant "out of pocket" funds. At times, their children have reportedly been "worn out" physically and mentally. Not uncommonly, the treatment has been not only incomplete, but often the treatment may have also been inappropriate for their child at his or her present stage of development. In many situations, the child's previous experiences with the general dental provider (s) may have led to the formation of an unfortunate lasting first impression and may also have resulted in the positive reinforcement of inappropriate behavior and/or responses which may not be conducive to safe and effective dental care for the child outside of a surgical care center.

Therefore, the families may be exposed to additional costs for correcting the dental care which has been inappropriately provided, and the children may require additional hospital and/or medical services associated with management of their response to the dental care setting. Had many of these families been aware preoperatively of the fact that they were not in a specialty care practice, untold headaches could have been avoided.

I understand that some individuals believe that dentists should have the First Amendment right to express their feelings and present themselves as they see themselves: as specialists. I won't say that some dentists may not be supremely qualified to provide a whole array of dental services. The concern in this particular situation is to ensure that the public is protected from potentially unscrupulous providers who are aware that the public may be unable to professionally evaluate the skills of a particular dentist. Therefore, the Virginia Board of Dentistry must be able to depend on an organization, such as the American Dental Association, that is beyond reproach in order to provide for the public's safety.

I strongly believe that only those dentists with recognized and appropriate advanced specialty education and training should be allowed to present themselves as specialists in their recognized specialties. I also strongly support that all specialty advertising be explicit, open, and honest in order to protect the public in the healthcare setting. Misleading advertising of a specialty level of care, either intentional or unintentional, is not likely to lead to the safe and effective dental care that should be expected by the citizens of Virginia.

Sincerely,

A. Scott Anderson, III, D.D.S.

Pediatric Dentist

Diplomate of the American Board of Pediatric Dentistry, Life Status

Fellow of the American Academy of Pediatric Dentistry

Commenter: Garry L. Myers, DDS, VCU Endo Grad Director, AAE Immediate Past President

9/5/18 5:00 pm

Strongly oppose this amendment proposal.

From time to time, general dentists who are not adequately trained in a dental specialty are holding themselves out to potential patients as specialists in a particular area of dentistry. This sort of promotional practice is misleading and does a disservice to patients who are seeking the most qualified dentist to treat their conditions. Accordingly, I will respectfully submit that it is the obligation of the State Boards of Dentistry that are charged with protecting the interests of dental patients to regulate and prevent this practice. While the prospect of litigation under the First Amendment may tempt some Boards to rely on general prohibitions against deceptive practices rather than promulgate regulations that specifically address the issue, I again submit that specific regulation is the preferable course. Such regulation will provide guidance to practitioners, give the Board explicit criteria to apply in evaluating dental specialty claims, and help to assure that the Board's regulation will prevail against First Amendment challenges. I strongly encourage that this board NOT make this amendment to the current regulatory policy on specialty advertising. Thank-you.

Commenter: Hisham Barakat, DDS

9/5/18 6:42 pm

Strongly In Favor

I tried my best to read most of the comments of those who opposed and I totally agree with them that a weekend course or attending an overseas class shouldn't enable a dentist to be listed as a specialist in any given field in Dentistry.

What we are trying to clarify here is that the American Academy of Implant Dentistry and the American Board of Oral Implantology have been there for decades (since 1969) and has both Specialists and General Dentists who have done extensive training in Implant Dentistry and have equally gone through the same rigorous written and oral examinations to pass the Board Certification of the ABOI/ID.

As some of my colleagues have explained in details the very strict criteria to qualify for the ABOI exam to become Board Certified should not be taken lightly and are set to the highest standards.

The ABOI/ID Diplomate designation symbolizes the highest level of competence in implant dentistry. Certification by the ABOI/ID attests to the fact that a dentist has demonstrated knowledge, ability, and proficiency in Implant dentistry through a rigorous examination process.

The certification examination is psychometrically valid and reliable, and is administered under secure, fair, and unbiased conditions. Candidates must demonstrate in-depth knowledge, and proficient skills and abilities in both the surgical and restorative aspects of implant dentistry as well as in critical aftercare even if they perform only the surgical or restorative phase.

In summary, the point I'm trying to make is that the ABOI/ID has been certified as a Specialty by the ABDS, it has been recognized after legal battles in states like California, Texas and Florida and no misleading advertisement has been done to the public and patients have been served to the highest standard by these Board Certified implantologists.

I hope my colleagues would recognize the difference between a highly respected organization like the AAID and the ABOI and a weekend course given by an Implant company or a unrecognized lecturer and again I would like to confirm that we are in agreement that specialty recognition should be given only to those who are qualified and recognized by their respective specialty organization.

Commenter: Dr. Kevin D Kiely

9/5/18 8:12 pm

Opposed

The public do not attend to details of certification. They rely on the state to monitor and enforce safe and effective Medical and Dental practices. The State must fulfill that role and enforce the restrictions that prevent the misrepresentation of "training" in those who are demonstratively undertrained from duping the general public. That is the definition of a State Regulatory Body. Protecting the rights of the general consumer from predatory practices. Please honor that commitment to the people of the State of Virginia.

Commenter: Lisa Bailey, Patient & Consumer

9/5/18 9:18 pm

Opposed - protect the patient!

As a patient, I am at the mercy of my treatment provider and his/her level of expertise. If I have specialist needs then I want a specialist with the training and education in his/her field. If dentistry has no standards with which to hold specialists to then I can have any dentist misrepresent themselves to me about their skill. Today many consumers take nutritional supplements or vitamins that are not FDA approved...the supplements have not been tested as to safety and as to effectiveness. Advertising for the supplements can include any unproven claim that the manufacturer desires to help sell their product. Consumer beware! If any dentist can claim a speciality training without standards and regulation then how can a consumer make an informed choice of provider? Consumer beware!

Commenter: William L. Davenport, DDS

9/5/18 9:50 pm

Strongly Opposed

It is heartening to see the strong opposition to this action by so many of Virginia's dentists with concern for public safety and avoiding confusion. Unfortunately, the power of advertising opens the door to misrepresentation and questionable ethical action.

Commenter: Pedram Yaghmal DDS, MD

9/5/18 10:24 pm

Strongly opposed

Commenter: Little Pearls Dentistry

9/5/18 10:26 pm

Petition against proposed change

Please see the link below to a petition indicating individuals against the proposed change to dentists advertising as specialists in Virginia.

<https://www.ipetitions.com/petition/virginia-dental-specialties>

Commenter: Dr. Greg Bath

9/5/18 11:22 pm

Strongly Opposed

This will lead to more confusion by the public with more misleading advertising and signage. It is

not in their best interest. Please do not consider this change in regulation.

Commenter: Dan Lill, DDS MS

9/5/18 11:34 pm

Strongly Opposed

I encourage the close attention to all the great comments here in opposition to this measure. Increasingly I, along with many of my colleagues, have witnessed the changing landscape in the dental profession. A steady decline in the level of care has been diluted by those already claiming to be specialists after a weekend course or equivalent. This has led to a growing level of confusion amongst the public that we specialists encounter daily whether in advertising or in the substandard care passing through in the form of a second opinion or botched treatment from non-specialty trained dentists. Patients deserve the best from all of us in the dental community and we have a duty to protect the patient from harm. *Under this principle according to the ADA, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate. Why would we move in a direction that reverses this, leads to substandard care and increases the likelihood of harm at the unknowing/uninformed patient's expense?*

I'd challenge those considering this to have the courage to see this from those that our profession serves and vote NO. Instead focus efforts towards taking care of patients by strengthening the standards that define specialist care based on true training. Set the bar to a higher level, not to a lower one and keep specialty designation a distinction that patients can understand as being more than deceptive words.



American Association of Oral and Maxillofacial Surgeons
Oral and maxillofacial surgeons
The experts in face, mouth and jaw surgery®

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Brett L. Ferguson, DDS, FACS
President

Scott Farrell, MBA, CPA
Executive Director

August 9, 2018

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, VA 23233

RE: 18 VAC 60-21-80. Advertising.

Dear Ms. Reen:

On behalf of the 209 members of the American Association of Oral and Maxillofacial Surgeons (AAOMS) practicing in Virginia, we appreciate the opportunity to provide this commentary as the Virginia Board of Dentistry ("Board") considers possible rule making on 18 VAC 60-21-80.

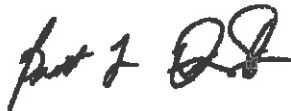
After earning a dental degree from an accredited four-year dental school, oral and maxillofacial surgeons (OMSs) complete a minimum of four years of hospital-based oral and maxillofacial surgery residency training, which includes rotations in such areas as general surgery, anesthesia and clinical research. These programs are accredited by the Commission on Dental Accreditation (CODA) and undergo meticulous review. As one of the nine ADA-recognized dental specialties, patients who visit an OMS can be assured their practitioner has been trained to the highest training standards due to the requirements for specialty recognition.

The question of dental specialty recognition is a complex issue and one that has been debated in-depth over the past several years. The ruling in *American Academy of Implant Dentistry v. Parker* caused many state Dental Boards to review their dental specialty recognition processes. Rather than completely upending the current specialty recognition process, we ask Dental Boards to remember that the basis of the *AAID v. Parker* case was founded on the fact that the state delegated all authority to determine dental specialties to the ADA, a non-governmental entity.

When considering the recognition of new dental specialties and the ability to advertise as a dental specialist, we urge the Board to consider proposed specialties on their merits individually rather than approving *en masse* through the approval of a single credentialing board, such as the American Board of Dental Specialties, as suggested in previous petitions received by the Board. We also urge the Board to require members of any new dental specialty to complete a CODA-accredited post-doctoral residency. CODA is the only dental group recognized by the U.S. Department of Education to accredit advanced dental education programs and any recognition of dental specialties should be based on advanced educational standards and training. To use any other standard would be detrimental to patient care and safety.

We thank you for the opportunity to comment on this proposal. Please contact Ms. Sandy Guenther of the AAOMS Governmental Affairs Department at 847-678-6200 or sguenther@aaoms.org with questions or for additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Brett L. Ferguson".

**Brett L. Ferguson, DDS, FACS
President**

**CC: Neel Agnihotri, DMD, MD, FACS, President, Virginia Society of OMS
Laura Givens, Executive Director, Virginia Society of OMS
Robert S. Clark, DMD, District III Trustee, AAOMS
Scott C. Farrell, MBA, CPA, Executive Director, AAOMS
Karin K. Wittich, CAE, Associate Executive Director, Practice Management and
Governmental Affairs, AAOMS**



American Academy of Periodontology

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September 4, 2018

Sandra Reen
Virginia Board of Dentistry
9960 Maryland Drive
Suite 300
Richmond, VA 23233

VIA EMAIL: Sandra.reen@dhp.virginia.gov

Dear Ms. Reen:

The American Academy of Periodontology (AAP) is the organization for the ADA-recognized specialty of periodontics. Periodontists are specialists in the prevention, diagnosis, and treatment of diseases affecting the gums and supporting structures of the teeth, and in the placement of dental implants. Periodontists are also dentistry's experts in the treatment of oral inflammation and receive three additional years of specialized training following dental school.

In response to the Virginia Board of Dentistry's request for comments regarding the proposal to amend 18 VAC 60 - 21, the AAP offers the following statement:

The AAP supports the rigorous educational standards administered by the Commission on Dental Accreditation (CODA). CODA is the sole agency responsible for accrediting all dental and specialty education programs, as charged by the US Department of Education. The AAP urges state dental boards and any organized entity authorized to recognize specialty dental practices in the state to require similar rigorous educational and practice standards. The Academy strongly believes that patient safety and proper informed consent should be the focal points for any decisions made regarding the announcement of specialties.

The educational standards for periodontics and the eight other recognized specialties can be found on the CODA website at: <http://www.ada.org/en/coda/current-accreditation-standards>.

March 28, 2018
Page 2

The AAP urges the Virginia Board of Dentistry to consider these standards and to recognize that it is in the best interest of public safety to provide clear rules about advertising for dental specialties. Such rules will allow the public to distinguish advertisements for recognized dental specialists from advertisements for services provided by general dentists who have not been trained to competency in specific procedures. It is critical for the Virginia Board of Dentistry to continue to protect the public from any misinformation and confusing advertising.

In addition, the AAP urges the Virginia Board of Dentistry to consider the case of *American Academy of Implant Dentistry v. Parker*¹ in context. That decision upheld a district court decision that found a state board could not restrict advertising as a dental specialist to only ADA-recognized specialties. The decision focused on whether the state board had sufficiently demonstrated the harm it was trying to prevent with the advertising restrictions.

Specifically, the court states, "[w]e do not suggest that the Board may not impose restrictions in the area of dental specialist advertising. The plaintiffs agree that advertising as a specialist is potentially misleading and that reasonable regulation is appropriate. We hold only that the Board has not met its burden on the record before us to demonstrate that Section 108.54 as applied to these plaintiffs, satisfies Central Hudson's test for regulation of commercial speech...Our holding neither forbids nor approves the enactment of a similar regulation supported by better evidence."²

The AAP urges the Virginia Board of Dentistry to maintain reasonable specialty advertising regulations for patient safety and proper informed consent of consumers.

Thank you for the opportunity to comment.

Sincerely,



Steven R. Daniel, DDS
President

cc: Erin O'Donnell Dotzler, Executive Director
Eileen G. Loranger, Director of Governance and Advocacy

¹ No. 169-50157 (5th Cir. 2017), U.S. Court of Appeals for the Fifth Circuit decision of June 19, 2017.

² *Id.* at 16-17.



Ms. Sandra Reen
Executive Director, Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, VA 23233
RE: 18 VAC 60-21-80. Advertising.

September 4, 2018

Dear Ms. Reen,

We hope this letter finds you well. I, along with the Executive Council of the Virginia Society of Oral & Maxillofacial Surgeons, wish to express concern regarding possible rule making on 18 VAC 60-21-80. We represent over 200 practicing members in the Commonwealth of Virginia.

Our opinion is that, while free speech is a protected right by the First Amendment, the public also has the right to be protected and the onus lies in the responsibility of boards such as the VA Board of Dentistry to protect the public. The citizens of the Commonwealth are fortunate that the Board of Dentistry and you, as its executive director, continue to take this great responsibility seriously.

We hope that when considering the recognition of new dental specialties and the ability to advertise as a dental specialist, the Board will consider proposed specialties on their merits individually rather than approving *en masse* through the approval of a single credentialing board, such as the American Board of Dental Specialties, as suggested in previous petitions received by the Board.

Further, we also hope that the Board will require members of any new dental specialty to complete a CODA-accredited postdoctoral residency. CODA is the only dental group recognized by the U.S. Department of Education to accredit advanced dental education programs and any recognition of dental specialties should be based on advanced educational standards and training. To use any other standard would be detrimental to patient care and safety.

Sincerely,

Neil Agnihotri, DMD, MD, FACS
President, VSOMS

little PEARLS

DEPARTMENT OF HEALTH SERVICES

SEP 05 2018
DHP

August 30, 2018

Dear Ms. Reen,

I was troubled to hear that the Board is considering amending the provisions for the advertising of dental specialties, creating the ability for non-specialists who limit their practice to providing specialized care to advertise as specialists and to not require them to disclose that they are, in fact, general dentists. As a pediatric dentist this troubles me because I know firsthand the differences between the two. I was a general dentist for 14 years. Nearly half of my patient base was pediatric because I just loved taking care of kids. In 2003, I decided to specialize in pediatric dentistry. After attending a residency program for two years and practicing as a pediatric dentist for 13 years I know now what I did not know as a general dentist. My care is much more thorough, comprehensive, and thoughtful due to my education and experience. The difference between what I knew as a general dentist and what I know now is vast.

The way that the public views the differences between general dentists and specialists needs to be protected. Our industry is increasingly being viewed as a commodity. I venture that most of the general public does not understand the vast differences in knowledge and ability that can exist between general dentists and specialists. Blurring the lines between the two has the potential to greatly harm our patients by creating the perception of a level playing field. It would also create the illusion that the additional education that specialists receive is unnecessary and meaningless.

Unscrupulous practitioners already exist in our industry. False advertising and claims abound as practitioners scramble to grab their piece of the pie. This proposed change has the potential to open the floodgates to not only unscrupulous practitioners but also to well-meaning practitioners who just don't have the knowledge base and experience to call themselves specialists.

As a practicing dentist my only concern is for the patients we serve. I implore the Board to fully appreciate the potential harm this change may inflict on the unknowing public.

Sincerely,



Michael Gazoni, DDS

19465 Deerfield Ave, Suite 302
Lansdowne, VA 20176



littlepearlsdentistry.com

RECEIVED
SEP 05 2018
Board of Dentistry
SEP 05 2018 SKR

Agenda Item: Board Action on Change in Renewal Schedule

Included in your agenda package are:

NOIRA for change of renewal schedule from expiration on March 31 to renewal by birth month beginning in 2020

Comments on NOIRA

DRAFT proposed regulation

Board action:

- Adopt proposed regulation to change renewal schedule to birth month as recommended by the Regulation Committee

Notices of Intended Regulatory Action

Statutory Authority: §§ 54.1-2400 and 54.1-2709.5 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

V.A.R. Doc. No. R18-5512; Filed July 5, 2018, 5:12 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-21, Regulations Governing the Practice of Dentistry; 18VAC60-25, Regulations Governing the Practice of Dental Hygiene; and 18VAC60-30, Regulations Governing the Practice of Dental Assistants. The purpose of the proposed action is to change the license renewal schedule from the set date of March 31 to renewal in the licensee's birth month. The change will occur in the calendar year after the effective date of the regulation. The intent is to distribute the workload associated with renewal across a calendar year and to make the renewal deadline easier for licensees to remember.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

V.A.R. Doc. No. R18-5362; Filed July 5, 2018, 5:11 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-30, Regulations Governing the Practice of Dental Assistants. The purpose of the proposed action is to modify the educational qualifications for registration of a dental assistant II by moving to a competency-based program in which basic didactic course work is followed by clinical training under the direction and supervision of a dentist who has successfully completed a calibration exercise on evaluating the clinical skills of a student. The intent of the proposed regulatory action is to make entry into the profession more accessible to students and ensure greater consistency in their training and assurance of competency.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

V.A.R. Doc. No. R18-5267; Filed July 17, 2018, 3:59 p.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Funeral Directors and Embalmers intends to consider amending 18VAC65-40, Regulations for the Funeral Service Internship Program. The purpose of the proposed action is to provide clear, enforceable regulations for the supervision and practice of interns so that interns and funeral homes are not misleading the public about their status and are being appropriately supervised to protect public health and safety in the handling of human remains. The proposed action will amend 18VAC65-40-130 to (i) indicate that training should be completed within a timeframe of 18 months through 60 months and provide that the board will only consider extensions for extenuating circumstances; (ii) reduce the initial intern supervisor application fee to \$25 but institute a yearly renewal fee of \$25 to allow the board to track active supervisors and make sure supervisors are in good standing; and (iii) add a requirement that interns be identified as interns in titles, correspondence, and communications with the public.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 54.1-2400 and 54.1-2817 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Corie Tillman-Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4424, FAX (804) 527-4637, or email corie.wolf@dhp.virginia.gov.

V.A.R. Doc. No. R18-5392; Filed July 17, 2018, 4:00 p.m.

BOARD OF OPTOMETRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Optometry intends to consider amending 18VAC105-20, Regulations Governing the Practice of Optometry. The purpose of the proposed action is to issue inactive licenses. The intent is to allow licensees who are no longer practicing, either because they

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Logged in as

Elaine J. Yeatts

Agency Department of Health Professions

Board Board of Dentistry

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

Action	Change In renewal schedule
Stage	NOIRA
Comment Period	Ends 9/5/2018

All good comments for this forum [Show Only Flagged](#)

[Back to List of Comments](#)

Commenter: E.A. Bernhard DMD

8/8/18 9:42 am

Date of renewal

I feel the current fixed date makes it easier to remember. Not in favor of change.

Commenter: Robert F. Morrison D.M.D.; Morrison Dental Group

8/8/18 9:50 am

2 Year renewal.

To further distribute workload for both the regulatory agency and the dental practices and to facilitate less credentialing burden with insurance companies and maspractice carriers, a 2 year renewal period, with appropriate fee is indicated. Much like the 3 year renewal period for a DEA license this eases the administrative burden on practitioners and their staff. As there are regulatory pathways for disciplinary actions on a license irregardless of the length of renewal period this seems to be the most efficient pathway. Our Board should be run as a business as our practices.
Dr. Morrison

Commenter: Matthew Stephens, DDS, Dental Associates

8/8/18 3:21 pm

Birth Month Renewal-Against

From the user end, I am a member of a group practice and the single date renewal is easiest for our dentists and hygienists. Therefore, I am against a change to month of birth license renewal.

However, if this proceeds, what is the plan for the valid dates of the license that is given for the year prior to this regulation's implementation? For example, if the changed regulation goes into effect Dec 2019 and a practitioner's birthday is the following May ,the previous year's license, that

was issued in March, would have expired before their new personal renewal date.

Commenter: Karen Dunegan, DMD

8/8/18 6:28 pm

Renewal by birth month

I'd like to keep the March 31 date because the year end month December is very busy as it is with holidays and school activities and patients who need to schedule before the end of the year. My birth month is December. Thank you.

Commenter: Bridgett Davis R.D.H.

8/16/18 7:15 pm

Against

This is not a hard date to remember. This will just make it more difficult for offices to keep track of who is currently registered.

Commenter: Eileen Tarulis, RDH BBA

8/16/18 7:30 pm

Against Birth Month

Against Birth Month Renewal

Commenter: Christine Rodgers RDH Randazzo Dentistry

8/16/18 7:47 pm

Renewal

Renewal by birth sounds ok . If you already renewed for a year how are you compensated for the year paid. Do we renew for a half a year? Or do we get a prorated deal for the months we already paid????

Commenter: Mariana Bruce RDH

8/16/18 7:51 pm

Against Birth Month

I believe it should stay March 31 for everyone. Much easier to keep track since it has been done this way for a long time.

Commenter: Christine Rodgers

8/16/18 7:51 pm

Renewal

Two year renewal is a great idea!!

Commenter: H. Chegini DDS

8/16/18 8:14 pm

2 Year Renewal

Please consider 2 year renewal on birth month.

Commenter: April M. Snyder

8/16/18 9:44 pm

Support a birth-month biennial renewal schedule

I support birth-month biennial renewal. Licensees renew every two years by the end of their birth month. Individuals born in even numbered years, renew no later than the end of their birth month in even numbered years. Individuals born in odd-numbered years, renew by the end of their birth month in odd-numbered years. This spreads out the workload of renewals across a longer time-frame, as well as makes it easier for licensees to remember when to renew.

Commenter: Debra Dycus

8/16/18 9:53 pm

Against

I'm against changing the current renewal date to birth date.

Commenter: Noreen Leyden. RDH

8/17/18 6:54 am

Against birth month.

Birth month throws ce completion/ deadline into a much different, more hectic part of the year for me. Do NOT like the idea at all.

Commenter: Becky C.

8/17/18 7:04 am

against

I am against changing the renewal date to birth months. Some offices take CE course together and this may effect timing. If the renewal date is the same for everyone, it will encourage more team involvement which is important in an office.

Commenter: Dr. Z

8/17/18 7:55 am

Against

I am licensed in a few states, and it's great that each has a set date. Birthdates for Virginia means people will be all over the place with Ce coursework and remembering to renew. I am against this, as communicating with others and taking courses together is what builds our community and makes us all better practitioners.

Commenter: Arlene G. USN

8/17/18 8:14 am

against

Some CE courses in my area are scheduled for all RDHs to have the requirements in time for the

renewal. I don't have a problem remembering when my license is due for renewal.

Commenter: Dr. T

8/17/18 10:35 am

Against

Birth months would not be in sync with CE requirements, or compatible with other state licenses.

Commenter: Kim Mulvey

8/17/18 11:19 am

License renewal by birth month

Against

Commenter: Jernice Giles, DDS

8/18/18 7:24 pm

Against

Please keep the March 31st renewal date. Managing staff with various renewal dates would present unnecessary challenges.

Commenter: M Nazareth

8/25/18 2:17 pm

Support

Renewal at the end of the birth month would be easier for me to remember. I am concerned that it might create an administrative burden, though. Initially, there would be inequities in time periods between renewals. It seems as though this might cause increased renewal rates.

Commenter: Richard F Roadcap DDS

9/4/18 10:57 am

Change in renewal date

Against the change; it's better that the current system, but why not renew January 1 and track all CE beginning in January? Every other organization operates on a calendar year.

Commenter: Ursula Klostermyer

9/4/18 5:09 pm

Why not a 2 year renewal?

I would suggest a 2 year renewal as this would reduce the workload for both sides - the regulatory agency and the dental practices.

Commenter: Walter Saxon, Jr.

9/5/18 9:56 am

Against Renewal Change

Having all the licenses renew in an office the same month makes it much easier to be sure that everyone is up to date. Also nursing homes, hospitals, dental school, etc. are setup to check licenses and know that March 31st is the date for renewal. Multiple renewal dates will probably impact these entities. With today's automation, I don't understand the reasoning behind this proposal.

Commenter: Carmen A. Cote, DDS

9/5/18 10:02 am

Two Years Renewal/ Same date

Why to make things more complicated for the Board?. Keep the same date we have or move it but make it the same for everybody. I really will like to have Two Years Renewal or more if possible.

Carmen A. Cote, DDS

Azalea Family Dentistry a Division of Atlantic Dental Care, PLC

Dentistry Renewal Proposal

In 2020, renewal per current regulation in March. Beginning in January of 2021, renewal by birth month.

Dentists

March 2020 = renew with current fee of \$285 (\$23.75/month); expiration date is set based on birth month for 2021

In 2021:

Fee reduction to \$15 per month X number of months since last renewal:

January 2021: \$15 X 10 months = \$150
February 2021: \$15 X 11 months = \$165
March 2021: \$15 X 12 months = \$180
April 2021: \$15 X 13 months = \$195
May 2021: \$15 X 14 months = \$210
June 2021: \$15 X 15 months = \$225
July 2021: \$15 X 16 months = \$240
August 2021: \$15 X 17 months = \$255
September 2021: \$15 X 18 months = \$270
October 2021: \$15 X 19 months = \$285
November 2021: \$15 X 20 months = \$300
December 2021: \$15 X 21 months = \$315

January 2022 = renew in birth month with current fee of \$285

Dental Hygienists

March 2020 = renew with current fee of \$75 (\$6.25/month); expiration date is set based on birth month for 2021

In 2021:

Fee reduction to \$4 per month X number of months since last renewal:

January 2021: \$4 X 10 months = \$40
February 2021: \$4 X 11 months = \$44
March 2021: \$4 X 12 months = \$48
April 2021: \$4 X 13 months = \$52
May 2021: \$4 X 14 months = \$56
June 2021: \$4 X 15 months = \$60
July 2021: \$4 X 16 months = \$64
August 2021: \$4 X 17 months = \$68
September 2021: \$4 X 18 months = \$72
October 2021: \$4 X 19 months = \$76
November 2021: \$4 X 20 months = \$80
December 2021: \$4 X 21 months = \$84

January 2022 = renew in birth month with current fee of \$75; expiration date is set based on birth month for 2021

Dental Assistants II

March 2020 = renew with current fee of \$50 (\$4.16/month); expiration date is set based on birth month for 2021

In 2021:

Fee reduction to \$3 per month X number of months since last renewal:

January 2021: \$3 X 10 months = \$30

February 2021: \$3 X 11 months = \$33

March 2021: \$3 X 12 months = \$36

April 2021: \$3 X 13 months = \$39

May 2021: \$3 X 14 months = \$42

June 2021: \$3 X 15 months = \$45

July 2021: \$3 X 16 months = \$48

August 2021: \$3 X 17 months = \$51

September 2021: \$3 X 18 months = \$54

October 2021: \$3 X 19 months = \$57

November 2021: \$3 X 20 months = \$60

December 2021: \$3 X 21 months = \$63

January 2022 = renew in birth month with current fee of \$50

Agenda Item: Education & training of DAII

Included in your agenda package are:

Minutes from Regulatory Advisory Panel – January 5, 2017

NOIRA – Agency background document (substance of action on pages 3-5)

NOIRA notice in Register

Comments on NOIRA

Draft of proposed amendments

Staff Note:

The substance of the proposed regulation has already been approved by the Panel, but there was a need to review and finalize recommendations on language. A Regulatory Advisory Panel (RAP) for that purpose convened on 11/27/18; there was no quorum for a meeting but draft regulations were drafted in consultation with the program director of the DAII educational program in Virginia.

Board action:

Adopt the recommendations for proposed regulations from the RAP or other action.

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, 6960 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. Parrie-Wildna, D.D.S.
Tammy C. Ridout, R.D.H

COMMITTEE MEMBERS ABSENT: Augustus A. Petticoles, 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. Palmstier, 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 Talliaferro, 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 (DAAsII). He then asked each member of the panel to state their recommendations for revising the requirements.

**Virginia Board of Dentistry
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. Talliferro 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

**Virginia Board of Dentistry
Regulatory-Legislative Committee-RAP Meeting
January 8, 2017**

programs.

Dr. Wyman questioned if there is a need for DAAs 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 DAAs 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 DAAs 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 DAAs was noted.
- Requirements for clinical experience settings DAAs 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 DAI 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 DAI 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



townhall.virginia.gov

Notice (NOIRA)

Agency name	Board of Dentistry, Department of Health Professions
Virginia Administrative Code (VAC) citation(s)	18VAC80-30
Regulation title(s)	Regulations Governing the Practice of Dental Assistants
Action title	Requirements for educational programs and registration of DAI
Date this document prepared	9/15/17

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 68 (1999), and the Virginia Registrar Form, Style, and Procedure Manual.

Please describe briefly the subject matter, intent, and goals of the planned regulatory action.

At its meeting on September 15, 2017, the Board voted to initiate rulemaking to modify the educational qualifications for registration of a dental assistant II by moving to a competency-based program in which basic didactic course work is followed by clinical training under the direction and supervision of a dentist who has successfully completed a calibration exercise on evaluating the clinical skills of a student. The intent is to make entry into the profession more accessible to students and ensure greater consistency in their training and assurance of competency.

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400, which provides the Board of Dentistry the authority to promulgate regulations to administer the regulatory system:

§ 54.1-2400 -General powers and duties of health regulatory boards
The general powers and duties of health regulatory boards shall be:

- 1. To establish the qualifications for registration, certification or licensure in accordance with the applicable law which are necessary to ensure competence and integrity to engage in the regulated professions.*
- 2. To examine or cause to be examined applicants for certification or licensure. Unless otherwise required by law, examinations shall be administered in writing or shall be a demonstration of manual skills.*
- 3. To register, certify or license qualified applicants as practitioners of the particular profession or professions regulated by such board.*
- ...*
- 6. To promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title. ...*

Specific authority for regulation of the profession of dental assisting is found in Chapter 27 of Title 54.1:

§ 54.1-2729.01. Practice of dental assistants.

- A. A person who is employed to assist a licensed dentist or dental hygienist by performing duties not otherwise restricted to the practice of a dentist, dental hygienist, or dental assistant II, as prescribed in regulations promulgated by the Board may practice as a dental assistant I.*
- B. A person who (i) has met the educational and training requirements prescribed by the Board; (ii) holds a certification from a credentialing organization recognized by the American Dental Association; and (iii) has met any other qualifications for registration as prescribed in regulations promulgated by the Board may practice as a dental assistant II. A dental assistant II may perform duties not otherwise restricted to the practice of a dentist or dental hygienist under the direction of a licensed dentist that are reversible, intraoral procedures specified in regulations promulgated by the Board.*

Please describe the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, please explain any potential issues that may need to be addressed as the regulation is developed.

The proposed regulatory action is to amend the educational requirements to become a dental assistant II from a program based on completion of required hours to a competency-based program based on satisfactory completion of didactic course work and clinical experiences. The expanded duties permitted for practice by a DAI in Virginia are outside the scope of practice for dental assistants in most other states. However, the current qualifications for a DAI appear to be more burdensome and costly than most dental assistants can afford. Therefore, the Board is proposing to modify the qualifications to a competency-based model that would allow a well-trained assistant to complete the coursework and clinical training in fewer hours. To ensure some standardization in the determination of competency by supervising dentists, they will be required to undergo a calibration of the procedures in which they are training. The combination of didactic hours, competency determination in specific procedures, and both written and clinical examination should provide evidence of competency to protect the public health and safety.

Please briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.

Following recommendations from the Regulatory Advisory Panel, the Board intends to amend the educational requirements to become a dental assistant II from a program based on completion of required hours to a competency-based program based on satisfactory completion of didactic course work and clinical experiences.

There will be a new section (18VAC60-30-116) to specify the requirements for educational programs training persons for registration as dental assistants II, which will likely include the following:

1. The program shall be provided by an educational institution which maintains a program accredited by the Commission on Dental Accreditation of the American Dental Association.
2. The program shall have a program coordinator who is registered in Virginia as a dental assistant II or licensed in Virginia as a dental hygienist or dentist. The program coordinator shall have administrative responsibility and accountability for operation of the program.
3. The program shall have a clinical practice advisor who must be a licensed dentist in Virginia. The clinical practice advisor shall assist in the laboratory training component of the program and conduct the calibration exercise for dentists who supervise the student clinical experience.

4. A dental hygienist who assists in teaching the laboratory training component of the program must have a minimum of two years' experience in performing clinical dental assisting.
5. The program shall enter into a participation agreement with any dentist who agrees to supervise clinical experience. The dentist shall successfully complete a calibration exercise on evaluating the clinical skills of a student. The dentist supervisor may be the employer of the student.
6. Each program shall enroll practice sites for clinical experience which may be a dental office, non-profit dental clinic or at an educational institution clinic.
7. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.

The Board intends to amend Section 120 by making the following changes from completion of a certain number of hours to a competency-based program:

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete ~~the following requirements a competency-based program~~ from an educational institution that ~~maintains a program in dental assisting, dental hygiene or dentistry accredited by CODA~~ meets the requirements of 18VAC60-30-116 and includes all of the following:

1. ~~At least 50 hours of didactic~~ Didactic course work in dental anatomy and operative dentistry that may be completed online that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation, occlusion and function, muscles of mastication and any other item related to the restorative dental process.

2. ~~Didactic course work in operative dentistry to include materials used in direct and indirect restorative techniques, economy of motion, fulcrum techniques, tooth preparations, etch and bonding techniques and systems, and luting agents.~~

~~2-3. Laboratory training that may to be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:~~

a. ~~At least 40~~ No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations and pulp capping procedures ~~and no less than 6 class I and 6 class II restorations completed on a manikin simulator to competency;~~

b. ~~At least 60~~ No less than 40 hours of placing and shaping composite resin restorations and pulp capping procedures ~~and no less than 12 class I, 12 class II, 5 class III, 5 class IV, and 5 class V restorations completed on a manikin simulator to competency;~~

c. ~~At least 20~~ 10 hours of ~~taking~~ making final impressions ~~and use~~ placement of a non-epinephrine retraction cord ~~and~~ and final cementation of crowns and bridges after preparation, adjustment and fitting by the dentist and no less than 4 crown impressions, 2 placements of retraction cord, 5 crown cementations, and 2 bridge cementations on a manikin simulator to competency.

~~d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

~~3.4. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office, in the following modules:~~

~~a. At least 80 30 hours of placing, packing, carving, and polishing of amalgam restorations and no less than 6 class I and 6 class II restorations completed on a live patient to competency;~~

~~b. At least 120 60 hours of placing and shaping composite resin restorations and no less than 6 class I, 6 class II, 5 class III, 3 class IV and 5 class V restorations completed on a live patient to competency;~~

~~c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and At least 30 hours of making final impressions, placement of non-epinephrine retraction cord, and final cementation of crowns and bridges after preparation, adjustment and fitting by the dentist and no less than 4 crown impressions, 2 placements of retraction cord, 5 crown cementations, and 2 bridge cementations on a live patient to competency.~~

~~d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

~~4.5. Successful completion of the following competency examinations given by the accredited educational programs:~~

~~a. A written examination at the conclusion of the 50 hours of didactic coursework; and~~

~~b. A practical examination at the conclusion of each module of laboratory training; and~~

~~c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules. A clinical competency exam.~~

~~G. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.~~

In adoption of proposed regulations, the Board will determine whether the didactic course work required as a prerequisite for the clinical experiences may be completed on-line or in a classroom setting.

The Board also intends Section 140 on Registration by endorsement as a dental assistant II to specify that an applicant must hold a registration or credential in another U. S. jurisdiction with qualification substantially equivalent to those set out in Section 120.

Finally, the Board will consider any editorial changes necessary for clarity.



Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

The Board has been concerned that only 18 persons are currently registered as dental assistants II and has discussed the need to re-examine the requirements to determine whether they could be

made less burdensome and costly. Public comment was received at the October, 2016 meeting of the Regulatory-Legislative Committee recommending that the DAI eligibility requirements be changed to a competency-based program which addresses the classification levels of procedures. It was further recommended that dentists should be calibrated in teaching the procedures to ensure a better understanding of competency.

Accordingly, a Regulatory Advisory Panel (RAP) was convened in January of 2017. It consisted of dentists and a dental hygienist who are board members; instructors from VCU School of Dentistry, Fortis College, J. Sargeant Reynolds Community College, Germanna Community College, and ECPI University; a Past-President of the Virginia Dental Association; President of the Virginia Dental Hygiene Association; and a representative of the Virginia Department of Education. The RAP agreed upon recommendations for a competency-based program that could reduce the time and cost associated with qualifying as a DAI but would include better standardization of the clinical training by calibration of supervising dentists in teaching of procedures and making the determination of competency.

Please indicate whether the agency is seeking comments on the intended regulatory action, including ideas to assist the agency in the development of the proposal and the costs and benefits of the alternatives stated in this notice or other alternatives. Also, indicate whether a public hearing is to be held to receive comments. Please include one of the following choices: 1) a panel will be appointed and the agency's contact if you're interested in serving on the panel is _____; 2) a panel will not be used; or 3) public comment is invited as to whether to use a panel to assist in the development of this regulatory proposal.

The agency is seeking comments on this regulatory action, including but not limited to: ideas to be considered in the development of this proposal, the costs and benefits of the alternatives stated in this background document or other alternatives, and the potential impacts of the regulation.

The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: projected reporting, recordkeeping, and other administrative costs; the probable effect of the regulation on affected small businesses; and the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Townhall website , www.townhall.virginia.gov, or by mail, email or fax to Elaine Yeatts, Agency Regulatory Coordinator, 9960 Mayland Drive, Henrico, VA 23233 or elaine.yeatts@dhp.virginia.gov or by fax to (804) 527-4434. Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last day of the public comment period.

A public hearing will be held following the publication of the proposed stage of this regulatory action and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (<http://www.townhall.virginia.gov>) and on the Commonwealth Calendar website

(<https://www.virginia.gov/connect/commonwealth-calendar>). Both oral and written comments may be submitted at that time.

A regulatory advisory panel (RAP) was used to develop the substance of the NOIRA. Unless there are substantial comments on the NOIRA, the proposed regulations will follow the substance in the NOIRA document.

Notices of Intended Regulatory Action

Statutory Authority: §§ 54.1-2400 and 54.1-2709.5 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

V.A.R. Doc. No. R18-5113; Filed July 5, 2018, 5:12 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-21, Regulations Governing the Practice of Dentistry; 18VAC60-25, Regulations Governing the Practice of Dental Hygiene; and 18VAC60-30, Regulations Governing the Practice of Dental Assistants. The purpose of the proposed action is to change the license renewal schedule from the set date of March 31 to renewal in the licensee's birth month. The change will occur in the calendar year after the effective date of the regulation. The intent is to distribute the workload associated with renewal across a calendar year and to make the renewal deadline easier for licensees to remember.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

V.A.R. Doc. No. R18-5102; Filed July 5, 2018, 5:11 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending 18VAC60-30, Regulations Governing the Practice of Dental Assistants. The purpose of the proposed action is to modify the educational qualifications for registration of a dental assistant II by moving to a competency-based program in which basic didactic course work is followed by clinical training under the direction and supervision of a dentist who has successfully completed a calibration exercise on evaluating the clinical skills of a student. The intent of the proposed regulatory action is to make entry into the profession more accessible to students and ensure greater consistency in their training and assurance of competency.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Volume 34, Issue 26

Virginia Register of Regulations

August 6, 2018

Public Comment Deadline: September 5, 2018.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

V.A.R. Doc. No. R18-5287; Filed July 17, 2018, 3:59 p.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Funeral Directors and Embalmers intends to consider amending 18VAC65-40, Regulations for the Funeral Service Internship Program. The purpose of the proposed action is to provide clear, enforceable regulations for the supervision and practice of interns so that interns and funeral homes are not misleading the public about their status and are being appropriately supervised to protect public health and safety in the handling of human remains. The proposed action will amend 18VAC65-40-130 to (i) indicate that training should be completed within a timeframe of 18 months through 60 months and provide that the board will only consider extensions for extenuating circumstances; (ii) reduce the initial intern supervisor application fee to \$25 but institute a yearly renewal fee of \$25 to allow the board to track active supervisors and make sure supervisors are in good standing; and (iii) add a requirement that interns be identified as interns in titles, correspondence, and communications with the public.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 54.1-2400 and 54.1-2817 of the Code of Virginia.

Public Comment Deadline: September 5, 2018.

Agency Contact: Carle Tillman-Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4424, FAX (804) 527-4637, or email carle.wolf@dhp.virginia.gov.

V.A.R. Doc. No. R18-5399; Filed July 17, 2018, 4:00 p.m.

BOARD OF OPTOMETRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Optometry intends to consider amending 18VAC105-20, Regulations Governing the Practice of Optometry. The purpose of the proposed action is to issue inactive licenses. The intent is to allow licensees who are no longer practicing, either because they



Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

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September 4, 2018

Virginia Board of Dentistry
Attention: Sandra Reen, Executive Director
9960 Mayland Drive, Suite 300
Richmond, VA 23233
sandra.reen@dhp.virginia.gov

Dear Distinguished Members of the Virginia Board of Dentistry:

I am writing on behalf of the Dental Assisting National Board, Inc. (DANB) in connection with the Notice of Intended Regulatory Action related to 18VAC80-30, Regulations Governing the Practice of Dental Assistants, that is currently the subject of a public comment period ending September 5, 2018.

As you may know, DANB is recognized by the American Dental Association as the national certification board for dental assistants, administering the national Certified Dental Assistant™ (CDA®) certification program and four other certification programs for dental assistants. Current DANB CDA certification is required to qualify for Dental Assistant II registration in Virginia. DANB exams and certifications are recognized or required to qualify to perform specified dental assisting duties in 38 states, the District of Columbia, the Department of Veterans Affairs, and the U.S. Air Force. DANB's exams meet nationally accepted test development standards, and DANB's CDA and Certified Orthodontic Assistant certification programs are nationally accredited by the National Commission on Certifying Agencies (NCCA) and internationally accredited by the International Accreditation Service to the ISO 17024 standard for organizations that certify personnel.

The Notice describes a series of proposed changes to the educational requirements to earn status as a Dental Assistant II (DA II) in Virginia, and I note that the proposal would require those seeking registration as a DA II to complete a written examination at the conclusion of didactic coursework.

Although the proposal seems to suggest that the required written examination would be an end-of-course exam developed and administered by each individual course provider, DANB would like to encourage the Board to consider the merits of requiring a standardized written exam upon conclusion of didactic coursework.

While DANB supports the use of end-of-course exams to assess a student's mastery of material presented in a particular course, instructor-developed end-of-course exams generally do not have the same level of reliability and validity as those of standardized tests that have been independently developed using accepted psychometric methods.

Reliability (whether the exam consistently assesses all candidates) and validity (whether the exam measures the required knowledge for performing the intended task) are two key underlying factors that should be considered when creating or approving an exam to be used for high-stakes purposes, such as granting regulatory authorization to perform certain functions—especially those that may impact public safety. Objective and independently developed standardized tests meeting national psychometric standards tend to be more reliable and valid and, consequently, more likely to provide consistent and accurate results across multiple courses/instructors than tests developed by a course instructor and administered by that instructor at the end of the course. In addition, requiring one uniform knowledge-based competence assessment developed by a qualified independent third-party testing organization will

- provide assurance to regulators that all who have completed a defined course of study have understood the important concepts at the same required level
- allow regulators to compare the quality of preparation provided by all state dental board-approved courses
- help employer dentists to feel confident that dental assistants who have completed the state's requirements have met one uniform standard of knowledge-based competence

One group of standardized assessments that might be considered by the Virginia Board of Dentistry to measure competence of DA II candidates is a combination of exams that make up DANB's Certified Restorative Functions Dental Assistant (CRFDA®) certification program.

DANB's CRFDA certification program consists of the following six component exams:

- Anatomy, Morphology and Physiology (AMP)
- Impressions (IM)
- Isolation (IS)
- Sealants (SE)
- Temporaries (TMP)
- Restorative Functions (RF)

Based on a review of the functions that the DA II is authorized to perform, we believe a combination of AMP, IM, IS and RF will address much of the knowledge that a Dental Assistant II must hold to perform expanded functions safely and effectively. For your reference, I am including a brief overview of the CRFDA certification program as Attachment 1, and the exam blueprints for the CRFDA exams, which outline the content for each exam, as Attachment 2. I am also including an overview of the services that DANB provides to state dental boards in connection with competence measurement programs for dental assistants as Attachment 3.

DANB national exams are administered at more than 250 proctored, secure computerized testing sites nationwide (through Pearson VUE), including eight in Virginia. Pearson VUE testing centers use standardized, rigorous security and proctoring procedures, ensuring that each candidate has a reasonably similar testing experience and protecting the integrity of exam results by minimizing opportunities for dishonest test-taking behavior.

Virginia Board of Dentistry
September 4, 2018
Page 3

If the Virginia Board of Dentistry is considering standardized written examinations for DA II candidates and would like additional information about DANB exams or how to work with DANB to implement a new examination program for dental assistants, please don't hesitate to contact me at klandsberg@danb.org or 1-800-367-3262, ext. 431. I will be happy to provide any information you might need or to set up a phone call or meeting with our in-house credentialing and psychometric experts for further discussion.

Thank you for your consideration.

Sincerely,


Katherine Landsberg
Director, Government Relations

Attachments

Cc: Cynthia C. Durley, M.Ed., MBA, DANB Executive Director
Johnna Gueorguleva, Ph.D., DANB Chief Credentialing and Research Officer



Logged in as

Elaine J. Yeatts

Agency Department of Health Professions

Board Board of Dentistry

Chapter Regulations Governing the Practice of Dental Assistants [18 VAC 80 - 30]

Action	Education and training for dental assistants II
Stage	NOIRA
Comment Period	Ends 9/5/2018

All good comments for this forum [Show Only Flagged](#)

[Back to List of Comments](#)

Commenter: Nicholas Iichyshyn, DDS 8/8/18 11:00 am
 In favor of proposal
 Higher standards of competency are achieved by definite calibration and consistency.

Commenter: Josh Hanson 8/28/18 7:58 pm
 Make a dental assistant 2 and 3
 I suggest making a level 2 or 3 or a level 2a and 2b. For instance Iowa has different levels of expanded functions and different requirements. Their level 1 expanded functions can do among other place gingival retraction, make temporaries, take final impressions, preliminary charting etc. Only their level 2 expanded functions can place fillings.
 See link here:
<https://dentalboard.iowa.gov/practitioners/expanded-functions/dental-assistants-expanded-functions>
 I think if you made a level that allowed dental assistants to be expanded functions to what most dentist utilize them for, like final impressions, temporaries, cord packing etc and make this a smaller course.
 Most dentist do not want their assistants placing fillings. So having this as a separate options like Iowa means a lot more assistants would be able to get certified in what dentist wants them to do. Making the training requirements so hard because they need to know how to place fillings still keeps it too hard to get them certified and does not solve the underlying problem. You need to divide it up into basic and advanced expanded functions to make it functional.

Commenter: Lori Yvonne Stanley 9/3/18 6:02 pm

Education and Training for DA II

As a CDA and educator of a high school level DA 1 program, I am happy there is room for advancement for Virginia dental assistants. There is value in quality education; it should result in quality patient care.

Specific didactic course work and clinical training should absolutely be required in a DA II program. The combination of didactic work, practice on manikin simulators, and on consenting patients with a 'calibrated' dentist in the treatment room makes good sense. At a glance, the proposed changes seem specific enough to encourage a solid, competency-based program.

However, I am not in favor of shortening the hours of the documented training just to get a higher quantity of DA II's. Lessening requirements doesn't seem to be an ideal solution to the burden of cost. In fact, a less expensive education could ultimately cost the patient. This, in turn, would cost the profession.

With over 35 years of experience as a dental assistant, I have learned that there is no substitute for quality. The dental profession is not the only profession that struggles to maintain a good balance of quality and quantity. But, our patients depend on us to do the very best we can. It is the responsibility of us, as professionals, to ensure they get just that!

Commenter: RICHARD COTTRELL DDS

9/4/18 8:49 am

In favor

How does Dentist become calibrated

Commenter: Jennifer S Tyres, RDH, Dental Assisting Educator

9/4/18 8:50 am

DAII expanded function is under utilized

The DAII role is not utilized in most of South Central Virginia. I am an educator of a high school DA program and have been for 5 years. I have also practiced hygiene in various areas all over Virginia. The students that graduate from the high school program does not have a problem getting hired here due to not being Certified or DAII, in fact, most DDS in this area do not pay for Certified or expanded DA's in this area.

I feel like a DAII may be considered for largely populated areas of Virginia like Northern VA or maybe the Tidewater area (although I know several DA's there that are neither Certified or DAII and have no intention of becoming so because it will not be reflected in pay for them).

I think DAII should be competency based because people work at different paces and levels and their competency of needed requirements may be achieved at different levels.

I also feel like this is a moot point for most of Virginia until Certification is more recognized all over the state, then having another level attainable would be worth the effort for a Dental Assistant in this state.

Commenter: Patricia B. Gobble

9/4/18 9:13 am

Regulatory Action/Stage

As an RDH and instructor of a high school entry level DA program, I absolutely agree with the regulation proposed for the competency based instruction for DA II's. Most of the dental healthcare team have all had competency based instruction throughout their educational experiences. I do think this is the best way to show that you are competent to do the procedures you are allowed to do in your profession. I have seen a lot of students who do well on the didactic portion of their training, but not so well on the clinical aspect.

I do not agree with shortening the hours in order to get more DA II's faster. I think patients deserve the best quality care they can get, and cutting corners by shortening the hours in my opinion would not be in the best interest of the patient.

With over 40 years in the dental field, holding jobs as receptionist, dental assistant, office manager, and registered dental hygienist, I have never thought compromising quality for quantity has ever paid off in the long term. We are living in a society that a lot of people are interested in taking the short cuts to complete the task sooner. Is this in the best interest of our profession? Is this in the best interest of our patients? I say no.

Project 5287 - NOIRA

BOARD OF DENTISTRY

Education and training for dental assistants II

18VAC60-30-10. Definitions. (NO CHANGE IN THIS SECTION)

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

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

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

"Code" means the Code of Virginia.

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

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-30-60 and 18VAC60-30-70.

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

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

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

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

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

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

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

18VAC60-30-60. Delegation to dental assistants II.

~~The following duties~~ Duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-30-120:

- ~~1. Performing pulp capping procedures;~~
- ~~2. Packing and carving of amalgam restorations;~~
- ~~3. Placing and shaping composite resin restorations with a slow speed handpiece;~~
- ~~4. Taking final impressions;~~
- ~~5. Use of a non-epinephrine retraction cord; and~~
- ~~6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

18VAC60-30-116. Requirements for educational programs.

In order to train persons for registration as a dental assistant II, an educational program shall meet the following requirements:

1. The program shall be provided by an educational institution that maintains a program accredited by the Commission on Dental Accreditation of the American Dental Association.

2. The program shall have a program coordinator who is registered in Virginia as a dental assistant II or is licensed in Virginia as a dental hygienist or dentist. The program coordinator shall have administrative responsibility and accountability for operation of the program.

3. The program shall have a clinical practice advisor who is a licensed dentist in Virginia and who may also serve as the program coordinator. The clinical practice advisor shall assist in the laboratory training component of the program and conduct the program's calibration exercise for dentists who supervise the student clinical experience.

4. A dental assistant II, registered in Virginia, who assists in teaching the laboratory training component of the program shall have a minimum of two years of clinical experience in performing duties delegable to a dental assistant II.

5. The program shall enter into a participation agreement with any dentist who agrees to supervise clinical experience. The dentist shall successfully complete the program's calibration exercise on evaluating the clinical skills of a student. The dentist supervisor may be the employer of the student.

6. Each program shall enroll practice sites for clinical experience which may be a dental office, non-profit dental clinic or at an educational institution clinic.

7. All treatment of patients shall be under the immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.

18VAC60-30-120. Educational requirements for dental assistants II.

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete the following requirements a competency-based program from an educational institution that maintains a program in dental assisting, dental hygiene or dentistry accredited by CODA meets the requirements of 18VAC60-30-116 and includes all of the following:

1. ~~At least 50 hours of didactic~~ Didactic course work in dental anatomy and operative dentistry ~~that may be completed online~~ that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation, occlusion and function, muscles of mastication and any other item related to the restorative dental process.

2. Didactic course work in operative dentistry to include materials used in direct and indirect restorative techniques, economy of motion, fulcrum techniques, tooth preparations, etch and bonding techniques and systems, and luting agents.

~~2.3. Laboratory training that may to be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:~~

a. ~~At least 40~~ No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than six class I and six class II restorations completed on a manikin simulator to competency;

b. ~~At least 60~~ No less than 40 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than 12 class I, 12 class II, five class III, five class IV, and five class V restorations completed on a manikin simulator to competency;

c. ~~At least 20~~ 10 hours of ~~taking~~ making final impressions ~~and use,~~ placement of a non-epinephrine retraction cord; ~~and,~~ and final cementation of crowns and bridges

after preparation, adjustment and fitting by the dentist and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a manikin simulator to competency.

~~d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

3.4. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office, in the following modules:

a. At least 80 30 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and no less than six class I and six class II restorations completed on a live patient to competency;

b. At least 120 60 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and no less than six class I, six class II, five class III, three class IV and five class V restorations completed on a live patient to competency;

c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and At least 30 hours of making final impressions, placement of non-epinephrine retraction cord, and final cementation of crowns and bridges after preparation, adjustment and fitting by the dentist and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a live patient to competency.

d. ~~At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.~~

4.5. Successful completion of the following competency examinations given by the accredited educational programs:

a. A written examination at the conclusion of the 50 hours of didactic coursework; and

- ~~b. A practical examination at the conclusion of each module of laboratory training; and~~
- ~~e. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules clinical competency exam.~~

~~C. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences. An applicant may be registered as a dental assistant II with specified competencies set forth in a, b, or c of subdivisions B 3 and B 4.~~

Agenda Item: Board Action on Content of Examination

Included in your agenda package are:

Minutes of August Examination Committee

Copy of current Guidance document 60-25

DRAFT of proposed regulation

Board action:

- Adopt recommendation of Regulatory Committee for proposed regulation to include specific content for examinations acceptable to the board.

UNAPPROVED
MINUTES

BOARD OF DENTISTRY
EXAMINATION COMMITTEE
August 10, 2018

- TIME AND PLACE:** The Examination Committee convened on August 10, 2018, at 1:06 p.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:** Jamiah Dawson, D.D.S.
Patricia B. Bonwell, R.D.H., PhD
Tonya A. Parris-Wilkins, D.D.S.
- MEMBER ABSENT:** Nathaniel C. Bryant, D.D.S.
Carol R. Russek, J.D.
- STAFF PRESENT:** Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Sheila Beard, Executive Assistant
- BOARD COUNSEL PRESENT:** James E. Rutkowski, Assistant Attorney General
- ESTABLISHMENT OF A QUORUM:** With three members of the Committee present, a quorum was established.
- PUBLIC COMMENT:** There were no public comments.
- APPROVAL OF MINUTES:** Dr. Watkins asked if the Committee members had reviewed the February 2, 2018 minutes and asked if there were any corrections needed. Dr. Bonwell moved to accept the minutes presented. The motion was seconded and passed.
- DISCUSSION:** **Letter from JCNDE** - The letter included in the agenda package from JCNDE was accepted for informational purposes.

Acceptance of Clinical Examinations

ADHA - Dr. Bonwell acknowledged the letter included in the agenda package and shared the information presented at the recent SRTA meeting. Extensive conversation went forth surrounding ADHA's support to eliminate clinical exams.

ADEA - Ms. Reen informed the Committee that this matter continues to come before the Board and should be addressed by the Committee. Ms. Reen stated when licensing by credentials the Board must be aware what will be good for Virginia. The information for ADHA and ADEA will be added to the September Board Meeting package.

Acceptance of Regional Exams - Ms. Reen informed the Committee that it must review the examinations of all the regional testing agencies and recommend to the Board which examinations are acceptable. Ms. Reen stated there are inconsistencies between regional exams and how results are reported, which seem to change year to year. Currently, the prosthodontics section of the WREB exam is optional and is a required section of all other regional exams. There is a concern that many applicants are applying with no intention to practice in Virginia.

Dr. Watkins asked if it would be beneficial for a Board representative to be part of each exam agency in order to keep up with the changes that take place.

Ms. Reen informed the Committee that Guidance Document 60-25, as currently written, cannot be enforced. Ms. Reen suggested that consideration should be given to possibly accepting ADEX exams only and that the Board put a new policy in place. The Board can make changes to this Guidance Document in September. Mr. Rutkowski reminded the Committee that guidance documents are not enforceable as law and recommended a regulatory change. Ms. Reen stated the Board can choose to adopt a fast-track regulatory action at the September Board meeting.

Dr. Dawson made a motion to change Guidance Document 60-25 to read "All examinations taken after January 1, 2019 must include, at a minimum, sections on Endodontics; Prosthodontics; operative dentistry consisting of a Posterior Class II and Anterior Class III restorations; and Periodontal" for dental licensure applicants by examination or credentials. This motion was seconded by Dr. Bonwell and passed.

Dr. Bonwell made a motion to adopt a regulatory action to change the policy for exam acceptance under the section of licensure by examinations and credentials.

The next Exam Committee meeting is being considered for September 13, 2018.

ADJOURNMENT:

With all business concluded, the meeting adjourned at 2:54pm

**Virginia Board of Dentistry
Examination Committee
August 10, 2018**

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

Sandra K. Keen, Executive Director

Date _____

Date _____

Virginia Board of Dentistry

Policy on Clinical Examinations Acceptable to the Board

Excerpts of Applicable Law, Regulation and Guidance

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

Applications for dental licensure by Examination

- If applying by examination, the examination results accepted are: SRTA from any year; CRDTS, WREB (request a detailed report) or NERB/CDCA if taken after January 1, 2005; CITA if taken after September 1, 2007; and ADEX if taken after January 1, 2012. *All examinations taken after December 7, 2012¹ must include, at a minimum, sections on Endodontics; Prosthodontics; and operative dentistry consisting of a Posterior Class II and Anterior Class III restorations.*

Applications for dental licensure by Credentials

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

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

BOARD OF DENTISTRY

Content of dental examination

18VAC60-21-210. Qualifications for an unrestricted license.

A. Dental licensure by examination.

1. All applicants for licensure by examination shall have:

a. Successfully completed all parts of the National Board Dental Examination given by the Joint Commission on National Dental Examinations; and

b. Passed a dental clinical competency examination that is accepted by the board.

2. If a candidate has failed any section of a clinical competency examination three times, the candidate shall complete a minimum of 14 hours of additional clinical training in each section of the examination to be retested in order to be approved by the board to sit for the examination a fourth time.

3. Applicants who successfully completed a clinical competency examination five or more years prior to the date of receipt of their applications for licensure by this board may be required to retake an examination or take continuing education that meets the requirements of 18VAC60-21-250 unless they demonstrate that they have maintained clinical, ethical, and legal practice in another jurisdiction of the United States or in federal civil or military service for 48 of the past 60 months immediately prior to submission of an application for licensure.

4. After (the effective date of this regulation), all applicants shall have passed a clinical competency examination that included sections on endodontics, prosthodontics,

periodontics, and operative dentistry consisting of a posterior class II and anterior class II restoration.

B. Dental licensure by credentials. All applicants for licensure by credentials shall:

1. Have passed all parts of the National Board Dental Examination given by the Joint Commission on National Dental Examinations;
2. Have successfully completed a clinical competency examination acceptable to the board that shall, after (the effective date of this regulation), include sections on endodontics, prosthodontics, periodontics, and operative dentistry consisting of a posterior class II and anterior class II restoration;
3. Hold a current, unrestricted license to practice dentistry in another jurisdiction of the United States and be certified to be in good standing by each jurisdiction in which a license is currently held or has been held; and
4. Have been in continuous clinical practice in another jurisdiction of the United States or in federal civil or military service for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in another jurisdiction of the United States (i) as a volunteer in a public health clinic, (ii) as an intern, or (iii) in a residency program may be accepted by the board to satisfy this requirement. One year of clinical practice shall consist of a minimum of 600 hours of practice in a calendar year as attested by the applicant.

Agenda Item: Petition for rulemaking

Included in your agenda package are:

Copy of petition from Dr. Ilchyshyn

Copy of comments on petition

Copy of applicable regulations – Dentistry & Medicine

Board action:

To deny the petition as recommended by the Regulatory Committee or to decide to initiate rulemaking



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 (5 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.)
 NICHOLAS ILCHYSHYN, DDS

Street Address
 2391 Mariners Mark Way, #303

Area Code and Telephone Number
 757-481-1471

City
 Virginia Beach

State
 VA

Zip Code
 23461-1371

Email Address (optional)
 nichyshyn@verizon.net

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. Regulations Governing the Practice of Dentistry 18VAC60-21-250. Requirements for continuing education. Item # A 5

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

I am writing to petition the Board regarding consideration of granting Continued Education credits for volunteer dentists who serve as preceptors to senior VCU dental students at community/ free clinics.

Medical providers do get CE credit for their preceptorship / mentoring of medical and pharmacy students, as has been the actuality at the Chesapeake Care Clinic. This is above and beyond the credit that they receive for delivery of medical services. This benefit or acknowledgement is not afforded the dental preceptors based on Dental Board Regulations.

In essence, the educator, volunteer preceptor interaction that the students receive at these community clinics is as relevant and valuable as the didactic and practical education that they receive at their dental school. The medical profession recognizes this preceptorship / mentoring service by their volunteer colleagues and affords them CE credit for such.

See attached PDF cover 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.

§ 54.1-2400. 6 of General powers and duties of health regulatory boards.

Signature: *Nicholas Kalythymos, D.O.*

Date: *6-15-18*



FROM THE DESK OF
Nicholas Ilchyshyn, DDS

June 15, 2018

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

Dear Board Members,

I am writing to petition the Board regarding consideration of granting Continued Education credits for volunteer dentists who serve as preceptors to senior VCU dental students at community/ free clinics.

I have been serving as a volunteer at the Chesapeake Care Dental Clinic (CCDC) since the summer of 2017, upon retirement from private practice in Northern Virginia. Approximately two days a week are devoted to either actual dental treatment of the disadvantaged population or as a preceptor to the senior VCU dental students.

As a member of the executive committee of the Chesapeake Care clinic, which encompasses medical and dental components, it was revealed that the medical providers do get CE credit for their preceptorship/ mentoring of medical and pharmacy students from Liberty University College of Medicine and Hampton U. School of pharmacy, respectively. This is above and beyond the credit that they receive for delivery of medical services. This benefit or acknowledgement is not afforded the dental preceptors based on Dental Board Regulations. This was confirmed by Ms. Sandra Reen the Board of Dentistry executive director.

Volunteer preceptors have to qualify for the opportunity to mentor the next generation of dental practitioners. Our curriculum vitae, licenses, credentials, specialty board memberships, etc. have to be submitted and vetted. Our duties as preceptors entail interacting with students on patient care: from reviews of medical and dental histories, proper examination, documentation as well as treatment planning, education of patients, patient and practice management and execution of treatment. At times instructors intervene in treatment if challenges occur for the novice practitioners. In many instances mini seminars are presented during our

lunch breaks in order to further expand the students' horizons as to long term actual cases, multidisciplinary dentistry and unique, unusual cases.

In essence, the educator interaction that the students receive at these free clinics is as relevant and valuable as the didactic and practical education that they receive at their dental school. I would surmise that forty to fifty percent of their dental exposure in their senior year is at these free clinics?

So, some acknowledgment of the preceptors' contribution to dental education would be apropos. The non-for-profit clinics do not get any financial support from VCU for the altruistic service we provide to the communities as well as for the students.

As such, I respectfully request that the Board consider affording CE credits to the volunteer dental preceptors for their service, which would be comparable to what our medical colleagues are afforded. It would represent an equitable acknowledgement.

With Best Regards,



Nicholas Ilchyshyn, D.D.S.

Diplomat, American Board of Periodontology (Ret.)

SEP AUG 14 2018

Eric Forsbergh DDS, 18498 Lanier Island Square, Leesburg, VA, 20176

August 9, 2018

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

Dear Board Members,

I am writing to support Dr. Iichyshyn's proposal that Continuing Education hours be granted to volunteer dentists who serve as preceptors to senior dental students at community / free clinics.

I have done many hours of volunteering in dentistry for underserved populations, and since there are not enough dentists who are willing to perform this work, it would be advantageous to provide any cost-free incentives you are willing to grant. This should increase participation.

I have enclosed paperwork needed to help this initiative.

Sincerely,



Eric Forsbergh DDS

Received
AUG 14 2018 SKR
Board of Dentistry



Logged in as

Elaine J. Yeatts

Agency

Department of Health Professions

Board

Board of Dentistry

Chapter

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

All good comments for this forum [Show Only Flagged](#)[Back to List of Comments](#)

Commenter: Pedro L Casingal Jr., DDS

8/1/18 9:28 am

CE credit for volunteering at free dental clinics

This would be a great incentive for Dentists to volunteer. There is a need for Dental Volunteers especially Dentist.

I am one of the preceptors at Chesapeake Care Free Dental Clinic. I find it rewarding to pay it forward.

Thanks

Pedro Casingal Jr

Commenter: Zaneta T. Hamlin, DDS

8/14/18 9:21 pm

Petition for volunteer CEUs

I am currently a preceptor for the VCU senior dental students and a clinical volunteer at the Chesapeake Care Clinic. Providing CEUs for volunteers would be a great incentive and opportunity for other clinicians to volunteer. We could definitely use the help!

Commenter: Walter Melvin DMD

8/15/18 3:06 pm

Public Petition for Rulemaking: CE credit for volunteer dentists serving as preceptors

I believe that dentists who provide preceptor ships especially at Free or Low cost clinics for Dental School students (example VCU) should be allowed to take more CE credit than is currently allowed (2 CEUs). Mentoring students is rewarding but demanding particularly if there are 3-4 students present at the same time (as is the case at Chesapeake Care Clinic) By offering more CE credits this will encourage dentist to do more mentoring at low cost or Free clinics and provide more dental care for patients in need. I support Dr Ilchyshyn's petition to increase CE credits for volunteer dentists who serve as preceptors.

18VAC60-21-250. Requirements for Continuing Education.

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

- 1. All renewal applicants shall attest that they have read and understand and will remain current with the laws and regulations governing the practice of dentistry and dental hygiene in Virginia.**
- 2. A dentist shall maintain current training certification in basic cardiopulmonary resuscitation with hands-on airway training for health care providers or basic life support unless he is required by 18VAC60-21-290 or 18VAC60-21-300 to hold current certification in advanced life support with hands-on simulated airway and megacode training for health care providers.**
- 3. A dentist who administers or monitors patients under general anesthesia, deep sedation, or conscious/moderate sedation shall complete four hours every two years of approved continuing education directly related to administration and monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.**
- 4. Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.**
- 5. Up to two hours of the 15 hours required for annual renewal may be satisfied through delivery of dental services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.**

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

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

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

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

2. The American Dental Hygienists' Association and the National Dental Hygienists Association, and their constituent and component/branch associations;
 3. The American Dental Assisting Association and its constituent and component/branch associations;
 4. The American Dental Association specialty organizations and their constituent and component/branch associations;
 5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;
 6. The Academy of General Dentistry, its constituent and component/branch associations, and approved continuing education providers;
 7. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Healthcare Organizations;
 8. The American Heart Association, the American Red Cross, the American Safety and Health Institute, and the American Cancer Society;
 9. A medical school accredited by the American Medical Association's Liaison Committee for Medical Education;
 10. A dental, dental hygiene, or dental assisting program or advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association;
 11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);
 12. The Commonwealth Dental Hygienists' Society;
 13. The MCV Orthodontic Education and Research Foundation;
 14. The Dental Assisting National Board and its affiliate, the Dental Auxiliary Learning and Education Foundation; or
 15. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, Council of Interstate Testing Agencies, or Western Regional Examining Board) when serving as an examiner.
- D. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted prior to renewal of the license.
- E. The board may grant an extension for up to one year for completion of continuing education upon written request with an explanation to the board prior to the renewal date.

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

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

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

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

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

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 32, Issue 05, eff. December 2, 2015; amended, Virginia Register Volume 33, Issue 09, eff. February 10, 2017.

18VAC85-20-235. Continued Competency Requirements for Renewal of an Active License.

A. In order to renew an active license biennially, a practitioner shall attest to completion of at least 60 hours of continuing learning activities within the two years immediately preceding renewal as follows:

1. A minimum of 30 of the 60 hours shall be in Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession.

a. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board.

b. Type 1 hours in podiatry shall be accredited by the American Podiatric Medical Association, the American Council of Certified Podiatric Physicians and Surgeons or any other organization approved by the board.

2. No more than 30 of the 60 hours may be Type 2 activities or courses, which may or may not be approved by an accredited sponsor or organization but which shall be chosen by the licensee to address such areas as ethics, standards of care, patient safety, new medical technology, and patient communication. Up to 15 of the Type 2 continuing education hours may be satisfied through delivery of services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for one hour of providing such volunteer services. For the purpose of continuing education credit for voluntary service, documentation by the health department or free clinic shall be acceptable.

B. A practitioner shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure in Virginia.

C. The practitioner shall retain in his records all supporting documentation for a period of six years following the renewal of an active license.

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

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

H. The board may grant an exemption for all or part of the requirements for a licensee who:

1. Is practicing solely in an uncompensated position, provided his practice is under the direction of a physician fully licensed by the board; or
2. Is practicing solely as a medical examiner, provided the licensee obtains six hours of medical examiner training per year provided by the Office of the Chief Medical Examiner.

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 16, Issue 04, eff. December 8, 1999; amended, Virginia Register Volume 20, Issue 10, eff. February 25, 2004; Volume 23, Issue 11, eff. April 21, 2007; Volume 23, Issue 25, eff. September 20, 2007; Volume 29, Issue 04, eff. November 21, 2012; Volume 33, Issue 11, eff. March 9, 2017.

Practice of a Dental Hygienist under Remote Supervision

References from § 54.1-2722 and §54.1-3408 of the Code of Virginia

1. What is meant by “remote supervision”?

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

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

A dentist who holds an active, license issued by the Virginia Board of Dentistry and who has a dental office physically located in the Commonwealth, including dental offices maintained by a federally qualified health center, charitable safety net facility, free clinic, long-term care facility, elementary or secondary school, Head Start program, or women, infants, and children (WIC) program, including a mobile dental clinic or portable dental operation that is operated by one of these settings.

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

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

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

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

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

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

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

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

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

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

Under the provisions of § 54.1-3408 V as referenced above, a dental hygienist is authorized to possess and administer topical fluoride varnish under a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine. Such administration is limited to children aged six months to three years who receive home visits from the Health Department or who are enrolled in Head Start programs or who are clients of safety-net healthcare facilities (e.g. rural health, community health centers, mobile dental clinics, and Health Department programs). The standing protocol must conform to the standards adopted by the Department of Health.

8. Is the dental hygienist allowed to administer local anesthetic or nitrous oxide ~~or other~~ Schedule VI drugs?

No, a dental hygienist practicing under remote supervision is not allowed to administer local anesthetic parenterally or to administer nitrous oxide. A dental hygienist practicing under remote supervision is not permitted to possess and administer topical oral fluorides outside the scope of the provisions of §54.1-3408 as addressed in question and answer number 7 above. Further, while practicing under remote supervision, a dental hygienist may not possess and administer topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions or any other Schedule VI topical drug. Also see question and answer number 12.

9. What disclosures and permissions are required?

Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not

a substitute for the need for regular dental examinations by a dentist and (2) verbal confirmation from the patient that he does not have a dentist of record whom he is seeing regularly.

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

- a) After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision may provide further dental hygiene services following a written practice protocol developed and provided by the supervising dentist. Such written practice protocol shall consider, at a minimum, the medical complexity of the patient and the presenting signs and symptoms of oral disease.
- b) A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a diagnosis and treatment plan for the patient and either the supervising dentist and/or the dental hygienist shall provide the treatment plan to the patient.
- c) The supervising dentist shall review a patient's records at least once every 10 months.

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

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

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

Yes, the requirements of § 54.1-2722.F do not prevent practice under general supervision. specifically states that "nothing in this subsection shall prevent a dental hygienist from practicing dental hygiene under general supervision whether as an employee or as a volunteer."

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

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

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

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

DRAFT

Standards for Professional Conduct In The Practice of Dentistry

Preamble

The Standards for Professional Conduct for licensees of the Virginia Board of Dentistry establishes a set of principles to govern the conduct of licensees in the profession of dentistry. Licensees must respect that the practice of dentistry is a privilege which requires a high position of trust within society. The Board maintains that adherence to these standards will safeguard patients, uphold the laws and regulations governing practice and maintain the public trust. The standards are an expression of types of conduct that are either required or encouraged and that are either prohibited or discouraged to provide further guidance on the requirements for practice set out in the Code of Virginia and the Regulations Governing the Practice of Dentistry and Dental Hygiene.

Scope of Practice

- Keep knowledge and skills current. The privilege, professional status, and a license to practice derive from the knowledge, skill, and experience needed to safely serve the public and patients.
- Seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing the knowledge and skills of those who have special skills, knowledge and experience, or advanced training.
- Do not prescribe treatment or use diagnostic techniques or diagnose, cure, or alleviate diseases, infections or other conditions that are not within the scope of the practice of dentistry or that are not based upon accepted scientific knowledge or research.
- Do not treat or prescribe for yourself.

Treating or Prescribing for Family

- Only treat and prescribe based on a bona-fide practitioner-patient relationship, and prescribe by criteria set forth in §54.1-3303 of the Code of Virginia.
- Do not prescribe to a family member a controlled substance or a medicine outside the scope of dentistry.
- When treating a family member or a patient maintain a patient record documenting a bona-fide practitioner-patient relationship.

Staff Supervision

- Protect the health of patients by only assigning to qualified auxiliaries those duties which can be legally delegated.
- Prescribe and supervise the patient care provided by all auxiliary personnel in accordance with the correct type of supervision.
- Maintain documentation that staff has current licenses, certificates for radiology, up-to-date vaccinations, CPR training, HIPPA training, and OSHA training in personnel files.

- Display documents that are required to be posted in the patient receiving area so that all patients might see and read them.
- Be responsible for the professional behavior of staff towards patients and the public at all times.
- Avoid unprofessional behavior with staff
- Provide staff with a safe environment at all times.
- Provide staff with opportunities for continuing education that will keep treatment and services up-to-date and allow staff to meet continuing education requirements
- Supervise staff in dispensing, mixing and following the instruction for materials to be used during treatment.
- Instruct the staff to inform the dentist of any event in the office concerning the welfare of the patient regarding exposures or blood borne pathogens

Practitioner-Patient Communications

- Before performing any dental procedure, accurately inform the patient or the guardian of a minor patient of the diagnoses, prognosis and the benefits, risks, and treatment alternatives to include the consequences of doing nothing.
- Inform the patient of proposed treatment and any reasonable alternatives in understandable terms to allow the patient to become involved in treatment decisions.
- Acquire informed consent of a patient prior to performing any treatment.
- Refrain from harming the patient and from recommending and performing unnecessary dental services or procedures.
- Specialists must inform the patient that there is a need for continuing care when they complete their specialized care and refer patients to a general dentist or another specialist to continue their care.
- Immediately inform any patient who may have been exposed to blood or other infectious material in the dental office or during a procedure about the need for post exposure evaluation and follow up and to immediately refer the patient to a qualified health care professional
- Do not represent the care being provided in a false or misleading manner
- Inform the patient orally and note in the record any deviation in a procedure due to the dentist's discretion or a situation that arises during treatment that could delay completion of treatment or affect the prognosis for the condition being treated.
- Inform the patient about the materials used for any restoration or procedure such as crowns, bridges, restorative materials, ingestibles, and topicals as to risks, alternatives, benefits, and costs, as well as describing the materials, procedures, or special circumstances in the patient's notes.
- Refrain from removing amalgam restorations from a non-allergic patient for the alleged purpose of removing toxic substances from the body. The same applies to removing any other dental materials.

Patient of Record

- A patient becomes a patient of record when the patient is seated in the dental chair and examination and diagnosis of the oral cavity is initiated.

- In §54.1-2405(B) of the Code of Virginia, “current patient” means a patient who has had a patient encounter with the provider or his professional practice during the two-year period immediately preceding the date of the record transfer.

Patient Records

- Maintain treatment records that are timely, accurate, legible and complete.
- Note all procedures performed as well as substances and materials used.
- Note all drugs with strength and quantity administered and dispensed.
- Safeguard the confidentiality of patient records.
- Upon request of a patient or an authorized dental practitioner, provide any information that will be beneficial for the welfare and future treatment of that patient.
- On request of the patient or the patient’s new dentist, timely furnish gratuitously or at a reasonable cost, legible copies of all dental and financial records and readable copies of x-rays. This obligation exists whether or not the patient’s account is paid in full.
- Comply with §32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.
- Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.
- Maintain records for not less than six years from the last date of treatment as required by the Board of Dentistry and maintain records for longer periods of time to meet contractual obligations or requirements of federal law.
- When closing, selling or relocating a practice, meet the requirements of §54.1-2405 of the Code of Virginia for giving notice and providing records.

Financial Transactions

- Do not accept or tender “rebates” or split fees with other health professionals.
- Maintain a listing of customary fees and represent all fees being charged clearly and accurately.
- Do not use a different fee without providing the patient or third party payers a reasonable explanation which is recorded in the record.
- Return fees to the patient or third party payers in a timely manner if a procedure is not completed or the method of treatment is changed.
- Do not accept a third party payment in full without disclosing to the third party that the patient’s payment portion will not be collected.
- Do not increase fees charged to a patient who is covered by a dental benefit plan.
- Do not incorrectly describe a dental procedure in order to receive a greater payment or reimbursement or incorrectly make a non-covered procedure appear to be a covered procedure on a claim form.
- Do not certify in a patient’s record or on a third party claim that a procedure is completed when it is not completed.
- Do not use inaccurate dates that are to benefit the patient; false or misleading codes; change the procedure code to justify a false procedure; falsify a claim not having done the procedure, or expand the claim.
- Avoid exploiting the trust a patient has in the professional relationship when promoting or selling a product by: advising the patient or buyer if there is a financial incentive for

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 care 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. Even if fees have not been paid, emergency care must be provided during the 30-day 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. See <https://www.cdc.gov/oralhealth/infectioncontrol/index.html>
- 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.

- ~~Do not claim to be a specialist or claim to be superior in any dental specialty or procedure unless you have attained proper credentials from an advanced postgraduate education program accredited by the Commission on Dental Accreditation of the American Dental Association.~~

Reports and Investigations

- Cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board and timely provide information and records as requested.
- Allow staff to cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board.
- Report the adverse reaction of a drug or dental device to the appropriate medical and dental community and in the case of a serious event to the Food and Drug Administration or Board of Dentistry.
- Provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.
- Become familiar with the special signs of child abuse and report suspected cases to the proper authorities.
- Report to the Board of Dentistry instances of gross or continually faulty treatment by other dentists.

Notice

This guidance document ~~does not address every law and regulation~~ which governs the practice of dentistry. To fully understand your legal responsibilities you should periodically review the laws, regulations, notices and guidance documents provided on the Board of Dentistry webpage, www.dhp.virginia.gov/dentistry.

Adopted: December 4, 2009

Revised: March 13, 2015, September 16, 2016

Virginia Board of Dentistry

Policy on Recovery of Disciplinary Costs

Applicable Law and Regulations

- §54.1-2708.2 of the Code of Virginia.
The Board of Dentistry (the Board) may recover from any licensee against whom disciplinary action has been imposed reasonable administrative costs associated with investigating and monitoring such licensee and confirming compliance with any terms and conditions imposed upon the licensee as set forth in the order imposing disciplinary action. Such recovery shall not exceed a total of \$5,000. All administrative costs recovered pursuant to this section shall be paid by the licensee to the Board. Such administrative costs shall be deposited into the account of the Board and shall not constitute a fine or penalty.
- 18VAC60-15-10 of the *Regulations Governing the Disciplinary Process*. The Board may assess:
 - the hourly costs to investigate the case,
 - the costs for hiring an expert witness, and
 - the costs of monitoring a licensee's compliance with the specific terms and conditions imposed up to \$5,000, consistent with the Board's published guidance document on costs. The costs being imposed on a licensee shall be included in the order agreed to by the parties or issued by the Board.

Policy

1. Disciplinary costs will not be assessed for licensees receiving their first Board Order in which violations were found and sanctions were imposed.
2. The maximum cost assessment for a dentist is \$5,000.
3. The maximum cost assessment for a dental hygienist is \$1,250.
4. In a second and any subsequent Order against a licensee, in addition to the sanctions to be imposed entered which might include a monetary penalty, the Board will specify the administrative costs to be recovered from a licensee in each pre-hearing consent order offered and in each order entered following an administrative proceeding. These administrative costs are in addition to the sanctions imposed which might include a monetary penalty.
5. The amount of administrative costs to be recovered will be calculated using the assessment of costs specified below and will be recorded on a Disciplinary Cost Recovery Worksheet (the worksheet). All applicable costs will be assessed as set forth in this guidance document. Board staff shall complete the worksheet and assure that the cost to be assessed is included in Board orders. The completed worksheets shall be maintained in the case file. Assessed costs shall be paid within 45 days of the effective date of the Order, unless a payment plan has been requested and approved.

Assessment of Costs

Based on the expenditures incurred in the state's fiscal year which ended on June 30, 2018, the following costs will be used to calculate the amount of funds to be specified in a board order for recovery from a licensee being disciplined by the Board:

- ~~\$114~~ **114** per hour for an investigation multiplied by the number of hours the DHP Enforcement Division reports having expended to investigate and report case findings to the Board.
- ~~\$150~~ **150** per hour for an inspection conducted during the course of an investigation, multiplied by the number of hours the DHP Enforcement Division reports having expended to inspect the dental practice and report case findings to the Board.
- If applicable, the amount billed by an expert upon acceptance by the Board of his expert report.
- The applicable administrative costs for monitoring compliance with an order as follows:
 - \$ ~~130.25~~ **130.25** Base cost to open, review and close a compliance case
 - ~~73.25~~ **73.25** For each continuing education course ordered
 - ~~19.00~~ **19.00** For each monetary penalty and cost assessment payment
 - ~~19.00~~ **19.00** For each practice inspection ordered
 - ~~38.00~~ **38.00** For each records audit ordered
 - ~~114.00~~ **114.00** For passing a clinical examination
 - ~~108.50~~ **108.50** For each practice restriction ordered
 - ~~89.50~~ **89.50** For each report required.

Inspection Fee

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

~~Effective: November 21, 2017~~

~~Revised: September 16, 2016~~

Virginia Board of Dentistry

Policy on Dental Clinical Examinations Acceptable to the Board

Excerpts of Applicable Law, Regulation and Guidance

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

Applications for dental licensure by Examination

- If applying by examination, the examination results accepted are: SRTA from any year; CRDTS, WREB (request a detailed report) or NERB/CDCA if taken after January 1, 2005; and CITA if taken after September 1, 2007; ~~and ADEX if taken after January 1, 2012.~~
- ~~All examinations taken after December 7, 2012¹~~ **Clinical examinations taken after January 1, 2019 must include, at a minimum, passage of all the following sections on : Endodontics; Prosthodontics; and operative dentistry consisting of a Posterior Class II and Anterior Class III restorations; and Periodontal.**

Applications for dental licensure by Credentials

- If applying by credentials, the examinations results accepted are CRDTS, WREB, NERB/CDCA, CITA and ADEX and the results of state administered examinations are accepted when the scorecard or report shows that testing included live patients. ~~All examinations taken after December 7, 2012~~ **Clinical examinations taken after January 1, 2019 must include, at a minimum, passage of all the following sections on; Endodontics, Prosthodontics, and operative dentistry consisting of a Posterior Class II and Anterior Class III restorations; and Periodontal.**

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

Board of Dentistry

Formal Hearings

March 14, June 20, September 12, December 12

Board Business Meetings

March 15, June 21, September 13, December 13

Committee Meetings

February 8, May 17, October 18

\ - Holidays (Agency Closed)



SCC-A

February 11, March 25, May 10, June 17,

July 29, September 6, October 21, November 25

SCC-B

January 11, February 22, April 5, May 24,

June 7, August 9, September 20, November 1

SCC-C

January 25, March 8, April 19, May 31, July 12,

August 23, October 11, December 6

Meeting Calendar

2019

SEPTEMBER

S	M	T	W	T	F	S
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JUNE

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JULY

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MARCH

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DECEMBER

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AUGUST

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APRIL

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Disciplinary Board Report for December 14, 2018

Today's report reviews the 2018 calendar year case activity then addresses the Board's disciplinary case actions for the last quarter of fiscal year 2018 (April 1, 2018-June 30, 2018) and first quarter of fiscal year 2019 (July 1, 2018 through September 30, 2018).

Calendar Year 2018

The table below includes all cases that have received Board action since January 1, 2018 through November 16, 2018.

Calendar 2018	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
January	35	24	6	30
February	28	19	9	28
March	30	35	6	41
April	41	26	3	29
May	44	48	3	51
June	39	52	3	55
July	40	28	8	36
August	72	38	4	42
September	159	147	3	150
October	113	92	2	94
November 16th	35	41	2	43
Totals	636	550	49	599

Q4 FY 2018

For the fourth quarter of 2018, the Board received a total of 90 patient care cases. The Board closed a total of 98 patient care cases for a 109% clearance rate, which is down from 115% in Q3 of 2018. The current pending caseload older than 250 days is 29%, which is up from 25% in Q3 of 2018. The Board's goal is 20%. In Q4 of 2018, 96% of the patient care cases were closed within 250 days, whereas 89 % of the patient care cases were closed within 250 days in Q3 of 2018. The Board's goal is 90% of patient care cases closed within 250 days.

Q1 FY 2019

For the first quarter of 2019, the Board received a total of 91 patient care cases. The Board closed a total of 80 patient care cases for an 88% clearance rate, which is down from 109% in Q4 of 2018. The current pending caseload older than 250 days is 23%, which is down from 29% in Q4 of 2018. The Board's goal is 20%. In Q1 of 2019, 87% of the patient care cases were closed within 250 days, whereas 96% of the patient care cases were closed within 250 days in Q4 of 2018. The Board's goal is 90% of patient care cases closed within 250 days.

Other Health Professions Board Case Processing Times

When reviewing the time to close a case at the board level, overall it continues to slow for the Agency. Q4 of 2018 is the 5th consecutive quarter that the percent of cases disposed within 120 days has decreased. The Board of Nursing, which carries the majority of discipline cases in the agency, and therefore contributes heavily to agency-wide fluctuations, again saw a decline. However, the other "large" boards – Medicine, Dentistry and Pharmacy all showed improvement. Again, Dentistry's percent of cases closed within 120 days (96) in Q4 2018 is at 96% versus overall of 79%.

License Suspensions

There were two mandatory suspensions of dental licenses between May 26, 2018 and November 16, 2018.

Late License Renewals

The Board began the investigation of late license renewals for dentists and dental hygienists in September 2018. Between April 1, 2018 and September 12, 2018 there were a total of 152 late dental hygiene renewals. In September, 115 advisory letters were sent to dental hygienists that renewed fewer than 30 days after March 31, 2018. Between April 1, 2018 and September 12, 2018 there were a total of 154 late dental renewals. In October, 56 advisory letters were sent to dentists that renewed fewer than 30 days after March 31, 2018.

OMS Audits

The triennial OMS Cosmetic Procedures Audit has begun. Inspectors began conducting audits August 1, 2018. There are 38 Oral and Maxillofacial Surgeons who have a cosmetic procedure certification with the Board and of those only 28 performed cosmetic procedures during the audit period. In October, 11 advisory letters were sent to dentists that did not update their OMS profiles during the audit period.

Student Observations

As you all have noticed at our informal conferences and formal hearings, we have many student observers from both dental and dental hygiene programs. For your review and contemplation are attached copies of summaries that were submitted to their professors about Special Conference Committee performance.

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?