VIRGINIA BOARD OF DENTISTRY
Regulatory-Legislative Committee
AGENDA
May 17, 2019

Department of Health Professions
Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center
Henrico, Virginia 23233

TIME

9:00 a.m. **Call to Order – Augustus A. Petticolas, Jr., DDS, Chair**

Evacuation Announcement – Ms. Reen

Public Comment **PG.1**

Approval of Minutes
- **October 26, 2018** **PG.2**

Status Report on Legislation and Regulatory Actions – Ms. Reen **PG.6**

Committee Discussion

- **Reinstatement/Reactivation fees** **PG.8**
- **Definition of Dentistry and A1C testing** **PG.15**
  - **Alabama** **PG.19**
  - **Mississippi** **PG.29**
  - **West Virginia** **PG.32**
- **National Reports on Licensing** **PG.59**

- **Dental Licensure Compact Update**

Next meeting

Adjourn

Virginia Board of Dentistry
Regulatory- Legislative Committee Meeting
May 17, 2019

ANNOUCEMENT REGARDING PUBLIC COMMENT

The **NOIRA*** public comment period for each of the following regulatory actions is closed:

- Administration of sedation and anesthesia
- Use of dental specialties,
- Change in renewal schedule, and
- Education and training of dental assistants II

The Committee cannot accept comments on these actions at this meeting.

There will be another public comment period during the **Proposed**** stage on each of these regulatory actions. The comment period will be posted on the Regulatory TownHall and sent to the Board's Public Participation list.

Standard Three Stage Process

1. Notice of Intended Regulatory Action (NOIRA): The public receives notification that a regulatory change is being considered, along with a description of the changes being considered. Once this stage is published in *The Virginia Register of Regulations* and appears on the Town Hall, there is at least a 30-day period during which the agency receives comments from the public. The agency reviews these comments as it develops the proposed regulation.

2. Proposed: The public is provided with the full text of the regulation, a statement explaining the substance of the regulatory action, and an Economic Impact Analysis (EIA) prepared by the Department of Planning and Budget. Once the proposed stage is published in *The Virginia Register of Regulations* and appears on the Town Hall, there is at least a 60-day public comment period. Based on the comments received, the agency may modify the proposed text of the regulation. The agency also provides a summary of comments that have been received during the NOIRA period, and the agency's response.

3. Final: The public is provided with the full text of the regulation, this time with an explanation of any changes made to the text of the regulation since the proposed stage. Once the final stage is published in *The Virginia Register of Regulations* and appears on the Town Hall, there is a 30-day final adoption period.

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

Agenda Item: Regulatory Actions - Chart of Regulatory Actions
As of May 1, 2019

Chapter		Action / Stage Information
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Change in renewal schedule [Action 4975] Proposed - *At Secretary's Office for 20 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Amendment to restriction on advertising dental specialties [Action 4920] Proposed - *At Secretary's Office for 20 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Administration of sedation and anesthesia [Action 5056] Proposed - *At Secretary's Office for 20 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	(E) Technical correction [Action 5198] Final - *AT Attorney General's Office for 40 days*
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	Education and training for dental assistants II [Action 4916] Proposed - *DPB Review in progress for 43 days*

Board of Dentistry
Regulatory/Policy Actions – 2019 General Assembly

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
HB1849	Remote supervision for hygienists at DBHDS	Dentistry	6/21/19 (signed 2/21)	**11/24/19**
HB2559	Waiver for electronic prescribing	Medicine Nursing Dentistry Optometry	6/13/19 or 8/2/19 7/16/19 6/21/19 6/28/19 (signed 3/21)	**12/24/19**

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB2184	Restricted volunteer practice	Dentistry	6/21/19	8/7/19
HB2493	DH – administration of drugs; remote supervision	Dentistry	6/21/19	8/7/19

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB2184	Dentistry	Revision of volunteer registration form	7/1/19
HB2556	Department – Enforcement	Revision of procedures & policy for disclosure of investigative information to state and federal law enforcement Revision of designation form for Boards	7/1/19
HB2557	Department – PMP	Change in reporting requirements; publication on websites Gabapentin in Schedule III	7/1/19

Future Policy Actions:

HB2559 (2019) - requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by **November 1, 2022.**

Agenda Item: Board Action on Reinstatement/Reactivation fees

Included in agenda package:

Draft amendments to fee section to include reinstatement fees for sedation/anesthesia permits and mobile clinics/dental operations

Draft amendments to reduce the fee for reactivation of an inactive license/registration

Excerpts from regulations for Medicine & Nursing with language on reactivation

Staff note:

Reinstatement fees for two categories of permits issued by the Board were inadvertently omitted and need to be added

The reactivation fee (equal to the current renewal fee) is more burdensome than other boards that only require payment of the difference between the inactive fee and the current renewal fee. The draft proposal would mirror Medicine and Nursing regulation.

Committee action:

Recommendation to full Board for adoption of proposed changes by a fast-track action.

Project 5967 - none

BOARD OF DENTISTRY

Reinstatement and reactivation fees

18VAC60-21-40. Required fees.

A. Application/registration fees.

1. Dental license by examination	$400
2. Dental license by credentials	$500
3. Dental restricted teaching license	$285
4. Dental faculty license	$400
5. Dental temporary resident's license	$60
6. Restricted volunteer license	$25
7. Volunteer exemption registration	$10
8. Oral maxillofacial surgeon registration	$175
9. Cosmetic procedures certification	$225
10. Mobile clinic/portable operation	$250
11. Moderate sedation permit	$100
12. Deep sedation/general anesthesia permit	$100

B. Renewal fees.

1. Dental license - active	$285
2. Dental license - inactive	$145
3. Dental temporary resident's license	$35
4. Restricted volunteer license	$15
5. Oral maxillofacial surgeon registration	$175
6. Cosmetic procedures certification	$100
7. Moderate sedation permit	$100
8. Deep sedation/general anesthesia permit	$100

C. Late fees.

1. Dental license - active	$100
2. Dental license - inactive	$50
3. Dental temporary resident's license	$15
4. Oral maxillofacial surgeon registration	$55
5. Cosmetic procedures certification	$35
6. Moderate sedation permit	$35
7. Deep sedation/general anesthesia permit	$35

D. Reinstatement fees.

1. Dental license - expired	$500
2. Dental license - suspended	$750
3. Dental license - revoked	$1000
4. Oral maxillofacial surgeon registration	$350
5. Cosmetic procedures certification	$225
6. Sedation or anesthesia permit	$170
7.Mobile clinic/portable operation	$250

E. Document fees.

1. Duplicate wall certificate	$60
2. Duplicate license	$20
3. License certification	$35

F. Other fees.

1. Returned check fee	$35
2. Practice inspection fee	$350

G. No fee will be refunded or applied for any purpose other than the purpose for which the fee is submitted.

H. For the renewal of licenses, registrations, certifications, and permits in 2018, the following fees shall be in effect:

1. Dentist - active	$142
2. Dentist - inactive	$72
3. Dental full-time faculty	$142

4. Temporary resident	$17
5. Dental restricted volunteer	$7
6. Oral/maxillofacial surgeon registration	$87
7. Cosmetic procedure certification	$50
8. Moderate sedation certification	$50
9. Deep sedation/general anesthesia	$50
10. Mobile clinic/portable operation	$75

18VAC60-21-220. Inactive license.

A. Any dentist who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of the required fee, be issued an inactive license. With the exception of practice with a current restricted volunteer license as provided in § 54.1-2712.1 of the Code, the holder of an inactive license shall not be entitled to perform any act requiring a license to practice dentistry in Virginia.

B. An inactive license may be reactivated upon submission of the required application, which includes evidence of continuing competence and payment of the difference between the inactive fee and the current renewal fee. To evaluate continuing competence the board shall consider (i) hours of continuing education that meet the requirements of 18VAC60-21-250; (ii) evidence of active practice in another state or in federal service; (iii) current specialty board certification; (iv) recent passage of a clinical competency examination that is accepted by the board; or (v) a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association.

1. Continuing education hours equal to the requirement for the number of years in which the license has been inactive, not to exceed a total of 45 hours, must be included with the application. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months immediately preceding the application for activation.

2. The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-2706 of the Code or who is unable to demonstrate continuing competence.

18VAC60-25-210. Reinstatement or reactivation of a license.

A. Reinstatement of an expired license.

1. Any person whose license has expired for more than one year and who wishes to reinstate such license shall submit to the board a reinstatement application and the reinstatement fee.

2. An applicant for reinstatement shall submit evidence of completion of continuing education that meets the requirements of 18VAC60-25-190 and is equal to the requirement for the number of years in which his license has not been active in Virginia, 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.

3. An applicant for reinstatement shall also provide evidence of continuing competence that may also include (i) documentation of active practice in another state or in federal service, (ii) recent passage of a clinical competency examination accepted by the board, or (iii) completion of a refresher program offered by a CODA accredited program.

4. The executive director may reinstate a license provided that the applicant can demonstrate continuing competence, that no grounds exist pursuant to § 54.1-2706 of the Code and 18VAC60-25-120 to deny said reinstatement, and that the applicant has paid the reinstatement fee and any fines or assessments.

B. Reactivation of an inactive license.

1. An inactive license may be reactivated upon submission of the required application, payment of the difference between the inactive fee and the current renewal fee, and documentation of having completed continuing education that meets the requirements of 18VAC60-25-190 and is equal to the requirement for the number of years in which the license has been inactive, 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 immediately preceding the application for activation.

2. An applicant for reactivation shall also provide evidence of continuing competence that may also include (i) documentation of active practice in another state or in federal service, (ii) recent passage of a clinical competency examination accepted by the board, or (iii) completion of a refresher program offered by a CODA accredited program.

3. The executive director may reactivate a license provided that the applicant can demonstrate continuing competence and that no grounds exist pursuant to § 54.1-2706 of the Code and 18VAC60-25-120 to deny said reactivation.

18VAC60-30-160. Inactive registration.

A. Any dental assistant II who holds a current, unrestricted registration in Virginia may upon a request on the renewal application and submission of the required fee be issued an inactive registration. The holder of an inactive registration shall not be entitled to perform any act requiring registration to practice as a dental assistant II in Virginia.

B. An inactive registration may be reactivated upon submission of the required application, payment of the difference between the inactive fee and the current renewal fee, and evidence of current certification from the Dental Assisting National Board or a national credentialing organization recognized by the American Dental Association. An applicant for reactivation shall also provide evidence of continuing clinical competence, which may include (i) documentation of

active practice in another state or in federal service or (ii) a refresher course offered by a CODA accredited educational program.

C. The board reserves the right to deny a request for reactivation to any registrant who has been determined to have committed an act in violation of § 54.1-2706 of the Code.

Virginia Board of Dentistry
Regulatory/Legislative Committee – May 17, 2019

Definition of Dentistry and A1C Testing

Background:
Following discussion at its December 2018 meeting, The Board assigned discussion of the current definition of dentistry and A1C testing to the Committee.

Code of Virginia § 54.1-2700. Definitions.
As used in this chapter, unless the context requires a different meaning:

"Dental hygiene" means duties related to patient assessment and the rendering of educational, preventive, and therapeutic dental services specified in regulations of the Board and not otherwise restricted to the practice of dentistry.

"Dentistry" means the evaluation, diagnosis, prevention, and treatment, through surgical, nonsurgical or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent and associated structures and their impact on the human body.

Provided for review are:

- A clipping from the **endocrineweb** on A1c testing
- Questions sent to other Boards of Dentistry
- Overview of Responses
- Information provided by Alabama, Mississippi and West Virginia

endocrineweb

FOLLOW US | EMAIL PRINT DISCUSS

Diabetes News and Research

As a patient, it's so important to understand your condition. This is especially true for people with diabetes. Though diabetes has no known cure right now, you should be aware of the recent medical advances and discoveries as researchers work on finding a cure and improving treatments.

Having access to up-to-date news about diabetes research is one of the best ways to become an educated patient. That's why we'll update you with weekly research and treatment information, so that you can take the best care of your diabetes, whether it's type 1, type 2, or gestational.

The goal is to make you an informed person who can talk with ease about diabetes, not just with relatives and friends but also with your doctor. The more you know, the more involved you can be in your healthcare decisions.

Hemoglobin A1c Not Reliable in Diagnosing Type 2 Diabetes (/news/diabetes/61790-hemoglobin-a1c-not-reliable-diagnosing-type-2-diabetes)

03/27/2019 - New data confirm that the hemoglobin A1c test is unreliable in assessing diabetes risk. The A1c misses 3 in 4 people who have prediabetes or type 2 diabetes, especially anyone of non-White ethnicity or race. Going forward, doctors are advised to use one of the more reliable tests to screen for diabetes.

What is the Best Diabetes Medication? One that Can Protect Your Heart Health (/news/diabetes/61707-what-best-diabetes-medication-one-protects-your-heart-health)

03/12/2019 - The new diabetes medications also protect heart health, which is a common complication of type 2 diabetes. If your doctor suggests adding a second drug to your care plan, do it. You'll lower your risk of heart attack and stroke almost in half.

Sheila Beard

Subject: FW: Virginia Board of Dentistry - Inquiry on Glucose Testing

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Good Morning,

Virginia Board of Dentistry is contacting various state dental boards inquiring about the following:

Are dentists and/or dental hygienists in [redacted] allowed to administer blood glucose testing for diabetes, aka A1C testing? If yes, what is the definition of dentistry in your state? In addition to your response, please provide a copy of your statute or regulation that addresses testing for diabetes.

We kindly request a response by Monday, April 29, 2019. If there are any questions, you may contact Virginia Board of Dentistry at 804-367-4538 and ask to speak with Sheila Beard. Your time and cooperation is greatly appreciated. Thank you.

Sheila Beard

Subject: FW: Board Responses

Below I have listed the responses we have received from the state boards as of April 29, 2019.

Alabama – "We allow testing for dental treatment purposes, but not for diagnosing diabetes. I have searched all Alabama statutes myself, and spoken with someone in the legal department at the Medical Board, and there appears not to be a statute governing diabetes testing. We could be wrong, but I didn't find anything. I also checked the Medical Board's regulations.
Our definition of the practice of dentistry is provided at Ala. Code (1975), section 34-9-6."
Florida – "If it is within their scope of practice for treating their patient. Florida law does not outline those specific tests."
Georgia – No response
Kentucky – No response
Maryland – No response
Minnesota – No response
Mississippi – "I hope the attached items answer your questions. Our Board did determine, if any blood is drawn in a dental office, the administer must have some type of license or certification to do so. If you have any questions, feel free to ask." (attachments included)
New Jersey – No response
New York – "Good Morning, The below tests are not allowed in New York State for either dentists or hygienists."
North Carolina – No response
Ohio – No response
Pennsylvania – No response
South Carolina – No response
Tennessee – "This is not addressed in the statute and rules of the Tennessee Board of Dentistry."
West Virginia – "Glucose testing is not specifically set out in our laws and rules. However, our rules for dental anesthesia refers to proper equipment. Emergency drug requirements and equipment list is available on our website. The emergency equipment list for Class 3A, 3B and 4 anesthesia permit holders (oral sedation, parenteral sedation and general anesthesia respectively) requires a glucometer.
http://www.wvdentalboard.org/
This list is under Licensee Information on our homepage. "

(13) SEDATION. A depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command, produced by a pharmacologic method.

§34-9-2. Legislative findings.

(a) The Legislature hereby declares that the practice of dentistry and the practice of dental hygiene affect the public health, safety, and welfare and should be subject to regulation. It is further declared to be a matter of public interest and concern that the dental profession merit and receive the confidence of the public and that only qualified dentists be permitted to practice dentistry and only qualified dental hygienists be permitted to practice dental hygiene in the State of Alabama. All provisions of this chapter relating to the practice of dentistry and dental hygiene shall be liberally construed to carry out these objects and purposes.

(b) The Legislature also finds and declares that, because of technological advances and changing practice patterns, the practice of dentistry and the practice of dental hygiene is occurring with increasing frequency across state lines and that the technological advances in the practice of dentistry and in the practice of dental hygiene are in the public interest.

(c) The Legislature further finds and declares that the practice of dentistry and the practice of dental hygiene are each a privilege. The licensure by this state of nonresident dentists who engage in dental practice and persons who engage in the practice of dental hygiene within this state are within the public interest. The ability to discipline the nonresident dentists and dental hygienists who engage in dental practice in this state is necessary for the protection of the citizens of this state and for the public interest, health, welfare, and safety.

§34-9-3. License or permit required to practice dentistry.

It shall be unlawful for any person to practice dentistry in the State of Alabama except the following:

(1) Those who are now duly licensed or permitted dentists, pursuant to law.

(2) Those who may be hereafter duly licensed or permitted and who are currently registered as dentists, pursuant to this chapter.

(3) Those nonresident dentists who have been issued a special purpose license to practice dentistry across state lines in accordance with Section 34-9- 10. This subdivision shall not apply to those dentists who hold a full, unrestricted, and current license or permit issued pursuant to Section 34-9- 8 or Section 34-9-10.

§34-9-4. License required to practice dental hygiene or expanded duty dental assisting.

It shall be unlawful for any person to practice dental hygiene or expanded duty dental assisting in the State of Alabama, except:

(1) Those who are now licensed dental hygienists or expanded duty dental assistants pursuant to law; and

(2) Those who may hereafter be duly licensed and who are currently registered as dental hygienists or expanded duty dental assistants pursuant to the provisions of this chapter.

§34-9-5. Penalties.

Any person who shall engage in the practice of dentistry across state lines or practice dentistry or dental hygiene in this state within the meaning of this chapter without having first obtained from the board a license and an annual registration certificate, when the certificate is required by this chapter, or who violates this chapter, or who willfully violates any published rule or regulation of the board, or who does any act described in this chapter as unlawful, the penalty for which is not herein specifically provided, shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than five thousand dollars ($5,000) for each offense, to be fixed by the court trying the case, and in addition thereto may be, in the discretion of the court, sentenced to hard labor for the county for a period not to exceed 12 months.

§34-9-6. What constitutes practice of dentistry.

Any person shall be deemed to be practicing dentistry who does any of the following:

(1) Performs, or attempts or professes to perform, any dental operation or dental service of any kind, gratuitously or for a salary, fee, money or other remuneration paid, or to be paid, directly or indirectly, to himself or herself, or to any person in his or her behalf, or to any agency which is a proprietor of a place where dental operations or dental services are performed.

(2) Directly or indirectly, by any means or method, makes impression of the human tooth, teeth, jaws or adjacent tissue, or performs any phase of any operation incident to the replacement of a tooth or any part thereof.

(3) Supplies artificial substitutes for the natural teeth, and who furnishes, supplies, constructs, reproduces, or repairs any prosthesis (fixed or removable), appliance, or any other structure to be worn in the human mouth.

(4) Places such appliance or structure in the human mouth, or adjusts, attempts, or professes to adjust the same, or delivers the same to any person other than the dentist upon whose prescription the work was performed.

(5) Professes to the public by any method to furnish, supply, construct, reproduce, or repair any prosthesis (fixed or removable), appliance, or other structure to be worn in the human mouth, or who diagnoses, or professes to diagnose, prescribe for, professes to prescribe for, treats or professes to treat disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure, or who extracts or attempts to extract human teeth, or remove tumors, abnormal growths, or other lesions from the human gums, jaws, and adjacent structures, or who operates for cleft lip or palate, or both; or who treats surgically or mechanically fractures of the human jaw; or who administers local or general anesthetics in the treatment of any dental lesion.

(6) Repairs or fills cavities in the human teeth.

(7) Uses a roentgen, radiograph, or digital imaging machine for the purpose of making dental roentgenograms, radiographs, or digital images, or who gives, or professes to give, interpretations or readings of dental roentgenograms, radiographs, or digital images, or radiographic or roentgen therapy.

(8) Administers an anesthetic of any nature in connection with a dental procedure.

(9) Uses the words "dentist," "dental surgeon," "oral surgeon," or the letters "D.D.S.," "D.M.D." or any other words, letters, title, or descriptive matter which in any way represents him or her as being able to diagnose, treat, prescribe, or operate for any disease, pain, deformity, deficiency, injury, or physical condition of the teeth or jaws, or adjacent structures.

(10) States, or professes, or permits to be stated or professed by any means or method whatsoever that he or she can perform or will attempt to perform dental procedures, or render a diagnosis connected therewith.

(11) Performs any clinical operation included in the curricula of recognized dental colleges; provided, that members of the faculty, teachers, instructors, fellows, interns, residents, dental students, student dental hygienists, and student expanded duty dental assistants who are employed by or who are taking courses or instructions at the University of Alabama School of Dentistry or such other dental colleges, hospitals, or institutions in Alabama, as may be approved by the board; and provided, that the work of fellows, interns, residents, dental students, and student dental hygienists is performed within the facilities of such dental colleges, hospitals, and institutions under the supervision of an instructor and as an adjunct to his or her course of study or training, shall not be required to take examination or obtain a license certificate and renewal license certificate when all of such work, dental procedures, and activities are confined to his or her work in the college, hospital, or other institution and the work is done without remuneration other than the regular salary or compensation paid by such colleges, hospitals, or other institutions.

(12) Professes to the public by any method to bleach human teeth, performs bleaching of the human teeth alone or within his or her business, or instructs the public within his or her business, or through any agent or employee of his or her business, in the use of any tooth bleaching product.

§34-9-6.1 Mobile dental facilities or portable dental operations.

ARTICLE 1.
GENERAL PROVISIONS.

§34-9-1. Definitions.

For the purposes of this chapter, the following terms shall have the respective meanings ascribed by this section:

(1) ANNUAL REGISTRATION. The documentary evidence that the board has renewed the authority of the licensee to practice dentistry or dental hygiene in this state.

(2) BOARD. The Board of Dental Examiners of Alabama.

(3) COMMERCIAL DENTAL LABORATORY. A technician or group of technicians available to any or all licensed dentists for construction or repair of dental appliances.

(4) EXPANDED DUTY DENTAL ASSISTANT. A dental assistant who holds a current expanded license certificate from the board.

(5) GENERAL ANESTHESIA. A controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic method.

(6) LICENSE. The grant of authority by the board to a person to engage in the practice of dentistry or dental hygiene.

(7) LICENSE CERTIFICATE. The documentary evidence under seal of the board that the board has granted authority to the licensee to practice dentistry or dental hygiene in this state.

(8) LICENSED DENTIST. A dentist who holds a current license certificate from the board.

(9) LICENSED HYGIENIST. A hygienist who holds a current license certificate from the board.

(10) LOCAL ANESTHESIA. The elimination of sensations, especially pain in one part of the body by topical application or regional injection of a drug.

(11) PRACTICE OF DENTISTRY ACROSS STATE LINES.

a. The practice of dentistry as defined in Section 34-9-6 as it applies to the following:

1. The rendering of a written or otherwise documented professional opinion concerning the diagnosis or treatment of a patient located within this state by a dentist located outside this state as a result of transmission of individual patient data by electronic or other means from within this state to the dentist or his or her agent.

2. The rendering of treatment to a patient located within this state by a dentist located outside this state as a result of transmission of individual patient data by electronic or other means from this state to the dentist or his or her agent.

3. The holding of himself or herself out as qualified to practice dentistry, or use any title, word, or abbreviation to indicate or induce others to believe that he or she is licensed to practice dentistry across state lines.

b. This definition is not intended to include an informal consultation between a licensed dentist located in this state and a dentist located outside this state provided that the consultation is conducted without compensation or the expectation of compensation to either dentist, and does not result in the formal rendering of a written or otherwise documented professional opinion concerning the diagnosis or treatment of a patient by the dentist located outside the state.

(12) PRIVATE TECHNICIANS. A technician employed by a dentist or group of dentists for a specified salary.

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Code of Alabama/Alabama Dental Practice Act

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Alabama State Code & Rules of the Board of Dental Examiners of Alabama

Published by
BOARD OF DENTAL EXAMINERS OF ALABAMA

INTRODUCTION

Code of Alabama (1975), §34-9-43(11) requires the Board to annually publish the provisions of the Alabama Dental Practice Act and Board Rules. The purpose and intent of this requirement is to ensure that all licensees have knowledge and are informed of the statutes and rules which govern their professional activities and license. The Board implores you to take the time to review and understand both the Act and Rules and to call the Board office if you have any questions. Many problems can be avoided if you ask first rather than act first. Remember, you are charged with knowledge of these requirements, and ignorance of or not reading them is no excuse.

You are also encouraged to carefully read Board newsletters, its website www.dentalboard.org, Alabama Dental Association News or other publications for any changes or proposed changes to the Act or Rules which may occur during the year. The Board has express statutory rule making authority and must follow the provisions of the Alabama Administrative Procedure Act whenever a rule is adopted, amended or rescinded. Before any of these actions can be taken, there must be publication of the Board's intended action in the Alabama Administrative News Monthly and a public hearing before the Board.

YOUR LICENSE IS VALUABLE. With the benefits of licensure, there are also responsibilities and obligations. One of those is adhering to the requirements of the Alabama Dental Practice Act and Board Rules. The Board believes that disciplinary actions can be reduced if you seek guidance before acting. Relying upon forgiveness rather than permission is an unwise course of action when it involves your license.

You are encouraged to contact the Board if you have questions about any requirement. Your questions will be answered as promptly as possible.

Please remember that annual renewal of licenses or any required permits must be timely and presently there are penalties and disciplinary consequences for your failure to do so. Please also remember to timely renew your Federal Drug Enforcement Administration (DEA) registration. The expiration date is on the permit. The DEA also requires YOU to notify them of any address change.

It is YOUR responsibility to notify the Board of any address change. Please make sure individuals in your office who require licensure have timely renewed. Requesting to see a copy and posting of the current annual registration certificate is the fail safe method of verification.

Please remember to comply with the mandatory continuing education requirements and to retain documentation evidencing your attendance so that if you are randomly audited, there will be no adverse consequences.

Alabama Dental Professionals Wellness Committee

The Alabama Legislature has mandated that it is the "duty and obligation of the Board to promote the early identification, intervention, treatment and rehabilitation of individuals licensed by the Board of Dental Examiners (BDEA) who may be impaired. Impairment may include inebriation, excessive use of drugs, controlled substances, alcohol, chemicals or other dependent forming substances which results in a physical or mental condition rendering such person unable to meet the standards of their profession." Code of Alabama (1975), §34-38-2. Impaired is defined as the inability to practice with reasonable skill and safety to patients due to the conditions or diseases described above.

To fulfill its statutory "duty and obligation" the BDEA created what is now known as the Alabama Dental Professionals Wellness Committee (Committee). The Committee is led by a dedicated group of recovering professionals who discharge or assist in the important functions of identification, intervention, treatment and rehabilitation of impaired professionals. The BDEA commends the Committee on its success due to the procedures, policies and compliance monitoring they have adopted. The cooperation between the Committee and the BDEA has produced one of the lowest relapse rates in the nation and excellent relationships with treatment facilities and providers have been established. The Committee currently monitors a number of individuals who have successfully returned to practice.

As a part of the mandate of the Committee, the Board has adopted a non disciplinary procedure for those licensees who SELF REPORT their abuse of or addiction to alcohol or drugs and voluntarily participates in rehabilitation. If the licensee on his or her own contacts the Committee and agrees to recommended treatment, completes treatment and is acknowledged by the treatment facility as able to resume practice with reasonable skill and safety to patients, a Deferral Agreement will be offered. The essential terms of this Agreement require complete compliance with a five year chemical dependency monitoring contract, payment of costs, annual monitoring fee and strict compliance with any recommendations imposed by the treatment facility or the Committee. This agreement also provides that if its terms are violated the licensee agrees to the entry of a Consent Order which sanctions the license, imposes penalties and is reportable as discipline.

If a licensee qualifies for the above described Agreement he or she is not required to appear before the Board. The Agreement will not be reported as discipline either in the BDEA newsletter or to the Federal Data Banks as long as there is compliance throughout the term of the Agreement. The Committee has a hotline, 1-800-818-3880, which you are encouraged to call should the need arise or you have any information regarding the impairment of any individual. More information on the history of the Committee, how the Committee functions, contact information and links to treatment facilities can be found on the BDEA's website, www.dentalboard.org.

THE ALABAMA BOARD OF DENTAL EXAMINERS
THE EARLY YEARS
Dr. Mike Mahan

According to the Code of Alabama, the practice of dentistry was deemed to "affect the public health, safety, and welfare." To protect this public interest, the Alabama Board of Dental Examiners was created by the Alabama Dental Association in 1881, the first such regulatory body for dentists in the nation.

The inaugural meeting of the Board of Examiners took place at Lotus Hall in Selma on July 19, 1881. Elected to the first Board were the following: Drs. E.S. Chisholm (Chair), W.R. McWilliams, F.M. Allen (secretary), and W.D. Dunlap, and J.G. McAuley. Also at the initial meeting, the Board chose the seal still used today - the coat of arms of Alabama, with "Board of Dental Examiners of Alabama, organized July the 19th 1881" engraved on it. But more importantly, they began reviewing applications for license, approving some and rejecting others.

The 1882 meeting took place in Montgomery on April 9-11. Secretary Allen reported the Board that his "labors [had] not been light" during the previous year and that he had worked with an insufficient budget. He made up some of the deficit out of his own pocket, but, at the year's end, he was able to report a balance of fifty-two cents.

By the end of the second meeting of the Board of Dental Examiners, rules and regulations governing the Board had been adopted. New applicants for license had been approved, and those rejected were sent off to study more before receiving the imprimatur of the Board. In subsequent years during the nineteenth century, the Board met annually to approve licenses. It never acted as a rubber stamp, always turning down some of the applicants.

The year of 1889 is a signal year for the board in that it adopted for the first time a standard for grading the examinations of the candidates. The applicant had to score seventy-five points out of one hundred. In the following years, the Board found that the dental colleges were becoming better and better, and in 1896, eighty percent, rather than seventy-five, was required for successfully passing the exam. In his message to the Alabama Dental Association that year, Chairman W.D. Boyd, Jr., lamented, "We regret to state that we have parties coming before us who claim to have diplomas who are totally incapacitated to pass a theoretical examination."

In 1897, 1898, and 1899, the work continued as usual, and the numbers of applicants examined were growing. In 1888, under the leadership of Chairman E.S. Chisholm and Secretary G.M. Rousseau, the organization seemed to take stock of itself and get new bearings. Dr. Chisolm reported to the Alabama Dental Association that "it affords the Board gratification to state that the gentlemen who have been examined by us stood a closer and more thorough examination that has ever been given by the board." In addition, the board tightened the requirements for temporary licenses and issued a new directory of Alabama dentists.

As the century turned, The Alabama Board of Dental Examiners was well established, continuing to accomplish the task it was charged with when it was organized in 1881: to protect the public's interest and insure quality dental care in Alabama.

CODE OF ALABAMA

The portion of the Code of Alabama (1975) that deals specifically with the practice of dentistry and the licensing of dentists and dental hygienists in the state of Alabama may be found in §34. If you would like to view the entire Code of Alabama please visit http://alisondb.legislature.state.al.us/acas/ACASLogin.asp. The Board has provided you with §34 for you to review should you have any questions about the practice of dentistry and the licensing of dentists and dental hygienists in Alabama. Should you have any questions after reviewing the Code of Alabama please contact the Board office.

Chapter 9
Dentists and Dental Hygienists

Article 1.
General Provisions

Section:

Article 2.
Board of Dental Examiners

Article 3.
Use of Anesthesia by Dentists.

Chapter 38
Impaired Professionals Committee
(Alabama Dental Professionals Wellness Committee)

§ 73-9-3–"DENTISTRY" DEFINED

"Dentistry" is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his or her education, training and experience, in accordance with the ethics of the profession and applicable law, provided that nothing in this section shall be so construed as to prevent:

(a) The practice of his or her profession by a regularly licensed and registered physician under the laws of this state unless he or she practices dentistry as a specialty; or

(b) The performance of mechanical work upon inanimate objects by persons working in dental offices under their supervision; or

(c) The operation of a dental laboratory and taking work by written work authorization from regularly licensed and registered dentists as provided for elsewhere in this chapter; or

(d) Dentists from outside the state from giving educational clinics or demonstrations before a dental society, convention or association; or

(e) Licensed dentists from outside the state from being called into Mississippi by licensed dentists of this state for consultative or operative purposes when the consultative or operative purposes have been authorized or approved by the Board of Dental Examiners for specified periods of time or as provided for by rules and regulations set forth by the board; or

(f) Applicants for a license to practice dentistry or dental hygiene in this state from working during an examination by and under the supervision and direction of the Board of Dental Examiners; or

(g) The practice of dentistry or of dental hygiene by students under the supervision of faculty in any dental school, college, or dental department of any school, college or university, or school of dental hygiene recognized by the board; or

(h) Dental or dental hygiene students enrolled in accredited dental or dental hygiene schools from participating in off-site training recognized and approved by the board, but those activities shall not be carried on for profit; or

(i) A regularly licensed and registered dentist from the delegation of procedures to a regularly licensed and registered dental hygienist or other competent dental auxiliary personnel while acting under the direct supervision and full responsibility of the dentist except as follows: Those procedures that require the professional judgment and skill of a dentist such as diagnosis, treatment planning, surgical procedures involving hard or soft tissues, or any intra-oral

procedure of an irreversible nature that could result in injury to the patient. However, the dentist may delegate the removal of calcareous deposits only to a regularly licensed and registered dental hygienist as regulated by the State Board of Dental Examiners.

All dentists and dental hygienists serving as faculty, as provided for in paragraphs (g) and (h) of this section, shall be required to be licensed by the Mississippi State Board of Dental Examiners.

s a dentist allowed to draw blood in the dental office?

t its 11/05/2010 meeting, the Board considered a question regarding who is allowed to draw blood in a dentist's office. Several questions were addressed regarding platelet rich plasma, e.g., due to the fact that this blood must be drawn and processed within an hour, can blood be drawn in the dental office; can the dentist draw blood; can a dental auxiliary draw blood; can a registered nurse draw blood in a dental office; and is there anyone who can draw blood in a dental office. The Board determined that documentation must be maintained regarding the licensure or certification of any individual performing Venipuncture in the dental office.

TITLE 5
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF DENTISTRY

SERIES 1
RULE FOR THE WEST VIRGINIA BOARD OF DENTISTRY

§5-1-1. General.

1.1. Scope. This rule regulates the W. Va. Board of Dentistry's proceedings and carries out the purposes and enforces the provisions of W. Va. Code§§30-1-1 et seq and 30-4-1 et seq which are applicable to the W. Va. Board of Dentistry.

1.2. Authority. – W. Va. Code §30-4- 5 & 6 and W. Va. Code §30-1D-1(d).

1.3. Filing Date. – May 18, 2017

1.4. Effective Date. – June 1, 2017

1.5. Sunset Provision. -- This rule shall terminate and have no further force or effect on June 1, 2027.

1.6. Amend. – This rule amends W. Va. Board of Dentistry Rule 5CSR1, W. Va. Administrative rules, W. Va. Board of Dentistry which became effective on June 1, 2015.

§5-1-2. Definitions.

2.1. "Dental public health"means the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. For the purposes of this rule the term "community" is used in a restricted sense and relates to the people of a particular region having common organization or interests and living in the same place under the same laws. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with research, and the application of the findings of research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.

2.2. "Endodontics" means that area of dentistry dealing with the morphology physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

2.3. "Oral and maxillofacial surgery" means the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries, and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions.

2.4. "Oral and maxillofacial pathology" means the specialty of dentistry and discipline of pathology that

deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.

2.5. "Orthodontics and dentofacial orthopedics" means the dental specialty that includes the diagnosis, prevention, interception, and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

2.6. "Pediatric dentistry" means an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, also including persons with special health care needs.

2.7. "Periodontics" means that specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.

2.8. "Prosthodontics" means that dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes.

2.9. "Oral and maxillofacial radiology" means the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.

2.10. "Trade name" means a fictitious name, firm name or doing business as name under which you do business other than the current official name on your business registration.

§5-1-3. Specialties.

3.1. Specialist General Qualifications. A licensee may apply to the Board for a certificate of qualification in a specialty of dentistry if the licensee can satisfactorily prove to the State Board of Dentistry that he or she possesses the following general qualifications, in excess of those required for the completion of a general course of study as given in a dental school or college recognized by the State Board:

3.1. a. Membership in the American Dental Association or the National Dental Association;

3.1. b. An exemplary record of professional ethics; and

3.1. c. Requisite training. All training requirements for qualifications of each specialty shall be approved by the Commission on Dental Accreditation.

3.2. Specialist General Limitations. A person certified by the W. Va. State Board of Dentistry as a specialist has the following limitations:

3.2 a. The licensee shall limit his or her practice of dentistry only to the specialty in which he or she is licensed and in which he or she holds himself out to the general public as a specialist; and

3.2 b. The licensee shall limit his or her listing in the telephone directory to the specialties in which he or she has an office or offices.

3.3. Specialty Fields Licensed by the W. Va. Board of Dentistry. The Board may issue certificates of qualification in the following specialties:

3.3. a. Dental public health. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of one full-time academic year of at least eight calendar months each of graduate or post-graduate education, internship or residency.

3.3. b. Endodontics. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

3.3. c. Oral and maxillofacial surgery. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of three full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

3.3. d. Oral and maxillofacial pathology. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

3.3. e. Orthodontics and dentofacial orthopedics. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency. In addition, any applicant for an orthodontic and dentofacial orthopedic specialty certificate commencing on July 1, 2014, shall submit verification of successful completion of the American Board of Orthodontics written examination.

3.3. f. Pediatric dentistry. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

3.3. g. Periodontics. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

3.3. h. Prosthodontics. -- In order to qualify for certification in this specialty, the licensee shall have a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

3.3. i. Oral and maxillofacial radiology -- In order to qualify for certification in this specialty, the licensee shall have a minimum of two full-time years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

TITLE 5
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF DENTISTRY

SERIES 12
ADMINISTRATION OF ANESTHESIA BY DENTISTS

§5-12-1. General.

1.1. Scope. This legislative rule regulates the administration of anesthesia by dentists.

1.2. Authority. -- W. Va. Code §30-4-6.

1.3. Effective Date. -- June 1, 2014

1.4. Filing Date. -- April 1, 2014

§5-12-2. Definitions.

As used in this rule and unless the context clearly requires a different meaning, the following terms shall have the meanings ascribed in this section.

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

2.2. "AAPD" means the American Academy of Pediatric Dentistry.

2.3. "ACLS" means Advanced Cardiac Life Support.

2.4. "ADA" means the American Dental Association.

2.5. "AMA" means the American Medical Association.

2.6. "Anxiolysis/minimal sedation" or premedication for anxiety - means removing, eliminating or decreasing anxiety by the use of a single anxiolytic or analgesia medication that is administered in an amount consistent with the manufacturer's current recommended dosage for the unsupervised treatment of anxiety, insomnia or pain, in conjunction with nitrous oxide and oxygen. This does not include multiple dosing or exceeding current normal dosage limits set by the manufacturer for unsupervised use by the patient (at home), for the treatment of anxiety.

2.7. "ASA" means American Society of Anesthesiologists.

2.8. "BLS" means Basic Life Support.

2.9. "Board" means West Virginia Board of Dentistry.

2.10. "Central Nervous System Anesthesia" means an induced controlled state of unconsciousness or depressed consciousness produced by a pharmacologic method.

2.11. Class 2 Permit means a licensed dentist is authorized to induce anxiolysis/minimal sedation.

2.12. Class 3 Permit means a licensed dentist is authorized to induce conscious sedation/moderate sedation as limited enteral (3a) and/or comprehensive parenteral (3b), and anxiolysis/minimal sedation.

2.13. Class 4 Permit means a licensed dentist is authorized to induce general anesthesia/deep conscious sedation, conscious sedation/moderate sedation, and anxiolysis/minimal sedation.

2.14. "Conscious sedation/moderate sedation" means an induced controlled state of depressed consciousness, produced through the administration of nitrous oxide and oxygen and/or the administration of other agents whether enteral or parenteral, in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

2.15. "CPR" means Cardiopulmonary Resuscitation.

2.16. "CRNA" means Certified Registered Nurse Anesthetist.

2.17. "Dentist Anesthesiologist" means a dentist who is trained in the practice of anesthesiology and has completed an additional approved anesthesia education course;

2.18 "Dental Assistant"means a personal qualified by education, training or experience who aids or assists a dentist in the delivery of patient care.

2.19. "Facility Permit" means a permit for a facility where sedation procedures are used that correspond with the level of anesthesia provided.

2.20. "General anesthesia/deep conscious sedation" means an induced controlled state of unconsciousness in which the patient experiences complete loss of protective reflexes, as evidenced by the inability to independently maintain an airway, the inability to respond purposefully to physical stimulation, or the inability to respond purposefully to verbal command. "Deep conscious sedation/general anesthesia" includes partial loss of protective reflexes and the patient retains the ability to independently and continuously maintain an airway.

2.21. "Health Care Provider BLS/CPR" means Health Care Provider Basic Life Support/Cardiopulmonary Resuscitation.

2.22. "Operating Team" means the dentists, physicians, certified registered nurse anesthetists, qualified monitors or dental assistants participating in a dental procedure wherein levels of sedation are being administered.

2.23. "PALS" means Pediatric Advanced Life Support.

2.24. "Pediatric Patient" means infants and children.

2.25. "Physician Anesthesiologist" means a physician, MD or DO, who is specialized in the practice of anesthesiology;

2.26. "Qualified Monitor" means an individual who by virtue of credentialing and/or training checks closely and documents the status of a patient undergoing anesthesia and observes utilized equipment;

2.27. "Qualified Monitor Certificate" certifies an individual is authorized to act as a qualified monitor during sedation procedures.

2.28. "Relative analgesia/minimal sedation" means an induced controlled state of minimally depressed consciousness, produced solely by the inhalation of a combination of nitrous oxide and oxygen, or single oral pre-medication without the addition of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command. Dosage of oral pre-medication is not to exceed the recommended dosage limits set by the manufacturer for the treatment of anxiety, insomnia or pain.

2.29. "Subcommittee" means West Virginia Board of Dentistry Subcommittee on Anesthesia.

§5-12-3. General Rules for Administering Dentist.

3.1. Each dentist who wishes to administer anesthesia to patients must be licensed to practice in the State of W. Va.

3.2. The licensed dentist shall apply to the Board for an anesthesia permit, on a form provided by the Board, and consent to an office inspection. The application shall be accompanied by the appropriate permit fee, inspection fee, and/or renewal fee, no part of which is refundable.

3.3. The licensed dentist shall maintain a facility in compliance with the applicable provisions of the level of anesthesia being administered.

§5-12-4. Education.

4.1. Licensed dentists may apply to the Board for an anesthesia permit if the licensed dentist can satisfactorily prove to the Board of Dentistry that the dentist possesses a valid and current Health Care Provider BLS/CPR certification; and

(a). To administer relative analgesia/minimal sedation, the dentist must also have completed a training course of instruction in the administration of relative analgesia either in dental school, continuing education or as a postgraduate. No permit is required for this level of sedation.

(b). To induce anxiolysis/minimal sedation, the dentist must have completed a board approved course of at least six (6) hours didactic and clinical in either pre-doctoral dental school or postgraduate instruction.

(c). To induce conscious sedation/moderate sedation, the dentist must hold a valid and current documentation showing successful completion of ACLS and/or PALS course if treating pediatric patients; as well as one of the following:

(1). Certificate of completion of a comprehensive training program in conscious sedation/moderate sedation beyond the undergraduate dental curriculum that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students and the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists at the time training was commenced;

(2). Certificate of completion of an ADA accredited postdoctoral training program which affords comprehensive and appropriate training necessary to administer and manage conscious sedation/moderate sedation, commensurate with these guidelines; or

(3). In lieu of these requirements the board may accept evidence of equivalent training or experience in conscious sedation/moderate sedation anesthesia for Limited Enteral Permit as Class 3a or comprehensive Parenteral Permit as Class 3b.

(d). To induce general anesthesia/deep conscious sedation, the dentist must hold valid and current documentation showing successful completion of ACLS and/or PALS course if treating pediatric patients; as well as one of the following:

(1). Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students and the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists at the time training was commenced;

(2). Completion of an ADA or AMA accredited postdoctoral training program which affords comprehensive and appropriate training necessary to administer and manage general anesthesia/deep conscious sedation, commensurate with these guidelines;

(3). In lieu of these requirements, the board may accept documented evidence of equivalent training or experience in general anesthesia/deep conscious sedation.

§5-12-5. Equipment and Emergency Drugs.

5.1. Equipment used for the purposes stated in this rule shall be inspected, calibrated and certified as safe to use according to the manufacturer's specifications and in compliance with applicable law.

5.2. The dentist's facilities shall contain the following during all levels of sedation procedures and during recovery.

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow the operating team to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a power failure.

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities;

(e) An oxygen delivery system that will insure appropriate continuous oxygen delivery;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system, if nitrous oxide is used;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Appropriate blood pressure monitoring and pulse oximeter;

(i) An emergency drug kit as developed, updated and published by the Board; and

(j) An external defibrillator device for class 2, 3 and 4 levels of sedation.

(k) All equipment and medication dosages must be in accordance with the age, height and weight of the patient being treated.

(l) Monitoring of breathing, respiration and airway management as described by the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists, ASA Standards, Guidelines and Statements for the practice of Anesthesiology, the AAOMS Office Anesthesia Evaluation Manual, or the AAPD Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

§5-12-6. Qualified Monitors

6.1. All individuals acting as a qualified monitor during sedation procedures shall apply to the Board for a qualified monitor certificate, on a form provided by the Board. The application shall be accompanied by the appropriate application fees and/or renewal fees, no part of which are refundable. The certification shall be renewed annually. Qualified monitor certificates are to be posted in the facility and supporting documentation be available for inspection.

6.2. Qualified monitors shall complete the following educational or certification requirements:

(a) Relative analgesia/minimal sedation - the qualified monitor shall possess a current health care provider BLS/CPR certification, qualified monitor certification is not required for this level of sedation.

(b) Anxiolysis/minimal sedation - the qualified monitor shall possess a current health care provider BLS/CPR certification.

(c) Conscious sedation/moderate sedation as limited enteral (3a) or comprehensive parenteral (3b) - the qualified monitor shall possess a current health care provider BLS/CPR certification and successful completion of an AAOMS or AAPD anesthesia assistants certification program or an equivalent.

(d) General anesthesia/deep conscious sedation - the qualified monitor shall possess a current health care provider BLS/CPR certification and successful completion of an AAOMS or AAPD anesthesia assistants certification program or an equivalent.

(e) In addition to the above requirements for a qualified monitor, for all levels of sedation, including relative analgesia/minimal sedation, when monitoring a nitrous oxide unit, a certificate to monitor nitrous oxide must be obtained from the Board, on a form provided by the Board. The application shall be accompanied by the appropriate application fees, no part of which are refundable. Qualified monitors shall have received training and be competent in the recognition and treatment of medical emergencies, monitoring vital signs, the operation of nitrous oxide delivery systems and the use of the sphygmomanometer and stethoscope.

(f) Registered Nurses, Licensed Practical Nurses, Paramedics, and Emergency Medical Technicians and those individuals qualified by ACLS or PALS must maintain current certification, registration or licensure.

6.3. A licensed dentist acting as a dentist anesthesiologist with a permit to induce any level of anesthesia, who is only administering anesthesia during a dental procedure, may act as the qualified monitor without a qualified monitor certificate.

6.4. A licensed physician anesthesiologist or certified registered nurse anesthetist, who is only administering anesthesia during a dental procedure, may act as the qualified monitor without a qualified monitor certificate.

6.5. A licensed dentist inducing relative analgesia/minimal sedation, may act as the qualified

monitor without a qualified monitor certificate.

§5-12-7. Continuous Monitoring

7.1. A patient undergoing any level of sedation must be continually monitored until discharge criteria have been met.

§5-12-8. Change of Employment or Address; Change of or additional facilities

8.1. Every qualified monitor certified by the Board shall report a change of employment to the Board office within twenty-four hours. A change of residence shall be reported within thirty days.

8.2. Every class 2 anesthesia permit holder who desires to change or add a facility where anesthesia services are to be rendered shall report the same to the Board office, complete any necessary requirements, and receive authorization from the Board before administering anesthesia services in the new or additional facility.

8.3. Every class 3 or 4 anesthesia permit holder who desires to change or add a facility where anesthesia services are to be rendered shall report to the Board office in writing sixty days prior to the anticipated start date to allow the Board to schedule a facility inspection and upon successful inspection shall receive authorization from the Board before administering anesthesia services in the new or additional facility.

Anesthesia Emergency Drug Requirements & Equipment List

DISCLAIMER

The following lists of emergency drugs for different levels of sedation is a guideline for the practitioner to follow. Alternative medications that are appropriate substitutes are authorized by the WV Board of Dentistry.

All Dental Offices

Oxygen Portable tank with appropriate masks or nasal prongs
Aspirin 325mgs (Chewable
Diphenhydramine 50mg/ml vial
Albuteral inhaler
Ammonia Capsules
Epi pen (Auto injectors) adult and child
Nitroglycerine tablets/or spray
Insta-glucose
Diazepam 5mg/ml vial (Recommended)
CPR Breathing mask
Blood Pressure cuff
Stethoscope
Thermometer
AED - Automated External Defibrillator (Highly Recommended)
Nasal Naloxone (Recommended)

Class 2 Anesthesia Permit

Oxygen
Aspirin 325mgs chewable
Diphenhydramine 50mg/ml
Albuterol Inhaler
Ammonia Capsule
Epi-pen(Auto-injector) Adult and child
Nitroglycerine tablets /spray
Insta-glucose
Diazepam 5mg/ml vial
Flumazenil
Naloxone **Note patients who take narcotics are subject to a deeper level of sedation.
AED
CPR Breathing Mask
Blood Pressure Cuff
Stethoscope
Thermometer
Pulse Oximeter

Class 3A and B and Class 4

Oxygen portable
Aspirin 325mg chewable
Diphehydramine 50mgs/ml vial
Albuterol inhaler
Ammonia Capsule
Epi-pen auto injector (adult and child)
Morphine
Nitroglycerine tablets or spray
Insta-glucose
Flumazenil
Naloxone
Epi ampoules 1:10,000 and 1:1,000
Atropine
D50
Midazolam
Diazepam
Adenosine
Amiodarone
Succinylcholine
Ephedrine
Labatelol
Solu-cortef
Odensatron(Zofran)

Class 4 with Sevofluorane

Danrolene 6 Vials in office
Temperature Monitors mandatory

Class 3A and B and Class 4

AED
Blood Pressure Monitor
Pulse Oximeter
EKG Monitor
Pre-Cordial Stethoscope
CO2 Monitor (Capnography/end-tidal C02)
Thermometer
Glucometer

ARTICLE 4A. ADMINISTRATION OF ANESTHESIA BY DENTISTS.

§30-4A-1. Requirement for anesthesia permit; qualifications and requirements for qualified monitors.

(a) No dentist may induce central nervous system anesthesia without first having obtained an anesthesia permit for the level of anesthesia being induced.

(b) The applicant for an anesthesia permit shall pay the appropriate permit fees and renewal fees, submit a completed board-approved application and consent to an office evaluation.

(c) Permits shall be issued to coincide with the annual renewal dates for licensure.

(d) Permit holders shall report the names and qualifications of each qualified monitor providing services to that permit holder. A qualified monitor may not perform the functions and responsibilities specified in this article for any level of anesthesia, other than relative analgesia/minimal sedation, without certification by the board. Qualified monitors shall apply for certification and pay the appropriate application fees and renewal fees. Qualified monitors are required to renew annually by the 30th day of June. To be certified as a qualified monitor, the applicant must meet the following minimum qualifications:

(1) Possess a current health care provider BLS/CPR certification;

(2) For monitoring, conscious sedation/moderate sedation or general anesthesia/deep conscious sedation procedures, successful completion of an AAOMS or AAPD anesthesia assistants certification program; and

(3) For monitoring a nitrous oxide unit, successful completion of a board-approved course in nitrous oxide monitoring.

(e) A dentist shall hold a class permit equivalent to or exceeding the anesthesia level being provided unless the provider of anesthesia is a physician anesthesiologist or another licensed dentist who holds a current anesthesia permit issued by the board.

§30-4A-2. Presumption of Degree of Central Nervous System Depression.

(a) In any hearing where a question exists as to the level of central nervous system depression a licensee has induced, as outlined in this article, the board may base its findings on, among other things, the types, dosages and routes of administration of drugs administered to the patient and what result can reasonably be expected from those drugs in those dosages and routes administered in a patient of that physical and psychological status.

(b) No permit holder may have more than one person under conscious sedation/moderate sedation and/or general anesthesia/deep conscious sedation at the same time, exclusive of recovery.

§30-4A-3. Classes of anesthesia permits.

(a) The board shall issue the following permits:

(1) Class 2 Permit: A Class 2 Permit authorizes a dentist to induce anxiolysis/minimal sedation.

(2) Class 3 Permit: A Class 3 Permit authorizes a dentist to induce conscious sedation/moderate sedation as limited enteral (3a) and/or comprehensive parenteral (3b) and anxiolysis/minimal sedation.

(3) Class 4 Permit: A Class 4 Permit authorizes a dentist to induce general anesthesia/deep conscious sedation, conscious sedation/moderate sedation and anxiolysis/minimal sedation.

(b) When anesthesia services are provided in dental facilities by a medical doctor or doctor of osteopathy physician anesthesiologist or dentist anesthesiologist, the dental facility shall be inspected and approved for a Class 4 permit and the dentist shall have a minimum of a Class 2 permit. If anesthesia services are provided by a CRNA, the dental facility shall be inspected and approved for a Class 4 permit and the supervising dentist shall have the same level of permit for the level of anesthesia provided by the CRNA.

§30-4A-4. Qualifications, standards and continuing education requirements for relative analgesia/minimal sedation use.

(a) The board shall allow administration of relative analgesia/minimal sedation if the practitioner:

(1) Is a licensed dentist in the state;

(2) Holds valid and current documentation showing successful completion of a Health Care Provider BLS/CPR course; and

(3) Has completed a training course of instruction in dental school, continuing education or as a postgraduate in the administration of relative analgesia/minimal sedation.

(b) A practitioner who administers relative analgesia/minimal sedation shall have the following facilities, equipment and drugs available during the procedure and during recovery:

(1) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow delivery of age appropriate care in an emergency situation;

(2) An operating table or chair which permits the patient to be positioned so that the patient's airway can be maintained, quickly alter the patient's position in an emergency and provide a firm platform for the administration of basic life support;

(3) A lighting system which permits evaluation of the patient's skin and mucosa color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(4) Suction equipment which permits aspiration of the oral and pharyngeal cavities;

(5) An oxygen delivery system with adequate age appropriate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(6) A nitrous oxide delivery system with a fail-safe mechanism that will ensure appropriate continuous oxygen delivery and a scavenger system; and

(7) A defibrillator device: Provided, That this requirement is only for Class 2, 3 and 4 permitees.

(c) All equipment used shall be appropriate for the height and weight and age of the patient.

(d) Before inducing relative analgesia/minimal sedation by means of nitrous oxide or a single premedication agent, a practitioner shall:

(1) Evaluate the patient;

(2) Give instruction to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(3) Certify that the patient is an appropriate candidate for relative analgesia/minimal sedation.

(e) A practitioner who administers relative analgesia/minimal sedation shall see that the patient's condition is visually monitored. At all times, the patient shall be observed by a qualified monitor until discharge criteria have been met.

(f) A qualified monitor's record shall include documentation of all medications administered with dosages, time intervals and route of administration including local anesthesia.

(g) A discharge entry shall be made in the patient's record indicating the patient's condition upon discharge.

(h) A qualified monitor shall hold valid and current documentation:

(1) Showing successful completion of a Health Care Provider BLS/CPR course; and

(2) Have received training and be competent in the recognition and treatment of medical emergencies, monitoring vital signs, the operation of nitrous oxide delivery systems and the use of the sphygmomanometer and stethoscope.

(i) The practitioner shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(1) The patient is alert and oriented to person, place and time as appropriate to age and preoperative neurological status;

(2) The patient can talk and respond coherently to verbal questioning or to preoperative neurological status;

(3) The patient can sit up unaided or without assistance or to preoperative neurological status;

(4) The patient can ambulate with minimal assistance or to preoperative neurological status; and

(5) The patient does not have uncontrollable nausea, vomiting or dizziness.

§30-4A-5. Qualifications, standards, and continuing education requirements for a Class 2 Permit.

(a) The board shall issue a Class 2 Permit to an applicant who:

(1) Is a licensed dentist in West Virginia;

(2) Holds valid and current documentation showing successful completion of a Health Care Provider BLS/CPR; and

(3) Has completed a board approved course of at least six hours didactic and clinical of either predoctoral dental school or postgraduate instruction.

(b) A dentist who induces relative analgesia/minimal sedation and anxiolysis/minimal sedation shall have the following facilities, properly maintained equipment and appropriate drugs available during the procedures and during recovery:

(1) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency and provide a firm platform for the administration of basic life support;

(3) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(4) Suction equipment which permits aspiration of the oral and pharyngeal cavities;

(5) An oxygen delivery system with adequate age appropriate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(6) A nitrous oxide delivery system with a fail-safe mechanism that will ensure appropriate continuous oxygen delivery and a scavenger system;

(7) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(8) Sphygmomanometer, stethoscope and pulse oximeter;

(9) Emergency drugs as specified by rule;

(10) A defibrillator device; and

(11) All equipment and medication dosages shall be in accordance with the height and weight and age of the patient being treated.

(c) Before inducing anxiolysis/minimal sedation, a dentist shall:

(1) Evaluate the patient by using the ASA Patient Physical Status Classification of the ASA that the patient is an appropriate candidate for anxiolysis/minimal sedation; and

(2) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(d) The dentist shall monitor and record the patient's condition or shall use a qualified monitor to monitor and record the patient's condition. The documented requirements of a qualified monitor monitoring anxiolysis/minimal sedation cases are as specified by rule. A Class 2 Permit holder may have no more than one person under anxiolysis/minimal sedation at the same time.

(e) The patient shall be monitored as follows:

(1) Patients shall have continuous monitoring using pulse oximetry. The patient's blood pressure, heart rate and respiration shall be recorded at least once before, during and after the procedure and these recordings shall be documented in the patient record. At all times, the patient shall be observed by a qualified monitor until discharge criteria have been met. If the dentist is unable to obtain this information, the reasons shall be documented in the patient's record. The record shall also include documentation of all medications administered with dosages, time intervals and route of administration including local anesthesia.

(2) A discharge entry shall be made by the dentist in the patient's record indicating the patient's condition upon discharge.

(f) A permit holder who uses anxiolysis/minimal sedation shall see that the patient's condition is visually monitored. The patient shall be monitored as to response to verbal stimulation, oral mucosal color and preoperative and postoperative vital signs.

(g) The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(1) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(2) The patient is alert and oriented to person, place and time as appropriate to age and preoperative neurological status;

(3) The patient can talk and respond coherently to verbal questioning or to preoperative neurological status;

(4) The patient can sit up unaided or to preoperative neurological status;

(5) The patient can ambulate with minimal assistance or to preoperative neurological status; and

(6) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(h) A dentist may not release a patient who has undergone anxiolysis/minimal sedation except to the care of a responsible adult third party.

§30-4A-6. Qualifications, standards, and continuing education requirements for Class 3 Anesthesia Permit.

(a) The board shall issue or renew a Class 3 Permit to an applicant who:

(1) Is a licensed dentist in West Virginia;

(2) Holds valid and current documentation showing successful completion of a Health Care Provider BLS/CPR course, ACLS and/or a PALS course if treating pediatric patients; and

(3) Satisfies one of the following criteria:

(A) Certificate of completion of a comprehensive training program in conscious sedation that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students and the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists at the time training was commenced.

(B) Certificate of completion of an ADA-accredited postdoctoral training program which affords comprehensive and appropriate training necessary to administer and manage conscious sedation commensurate with these guidelines.

(C) In lieu of these requirements, the board may accept documented evidence of equivalent training or experience in conscious sedation anesthesia for Limited Enteral Permit as Class 3a or comprehensive Parenteral Permit as Class 3b as specified by rule.

(b) A dentist who induces conscious sedation shall have the following facilities, properly maintained age appropriate equipment and age appropriate medications available during the procedures and during recovery:

(1) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(3) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(4) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(5) An oxygen delivery system with adequate age appropriate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(6) A nitrous oxide delivery system with a fail-safe mechanism that will ensure appropriate continuous oxygen delivery and a scavenger system;

(7) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(8) Sphygmomanometer, pulse oximeter, oral and nasopharyngeal airways, intravenous fluid administration equipment and/or equipment required for the standard of care or as specified by rule;

(9) Emergency drugs as specified by rule; and

(10) A defibrillator device.

(c) Before inducing conscious sedation, a dentist shall:

(1) Evaluate the patient and document, using the ASA Patient Physical Status Classifications, that the patient is an appropriate candidate for conscious sedation;

(2) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or neurological status of the patient, the patient's guardian; and

(3) Obtain written informed consent from the patient or patient's guardian for the anesthesia.

(d) The dentist shall ensure that the patient's condition is monitored and recorded on a contemporaneous record. The dentist shall use a qualified monitor to monitor and record the patient's condition in addition to the chair side dental assistant. A qualified monitor shall be present to

monitor the patient at all times.

(e) The patient shall be monitored as follows:

(1) Patients shall have continuous monitoring using pulse oximetry and/or equipment required for the standard of care or as specified by rule by a qualified monitor until discharge criteria have been met. The documented requirements of a qualified monitor monitoring limited enteral or comprehensive parenteral sedations cases are as specified by rule. The patient's blood pressure, heart rate and respiration shall be recorded every five minutes and these recordings shall be documented in the patient record. The record shall also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration including local anesthesia. If the dentist is unable to obtain this information, the reasons shall be documented in the patient's record.

(2) During the recovery phase, the patient shall be monitored by a qualified monitor.

(3) A discharge entry shall be made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(f) A dentist may not release a patient who has undergone conscious sedation/moderate sedation except to the care of a responsible adult third party.

(g) When discharging a pediatric patient the dentist shall follow the current edition of AAPD Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(h) The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(1) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(2) The patient is alert and oriented to person, place and time as appropriate to age and preoperative neurological status;

(3) The patient can talk and respond coherently to verbal questioning or to preoperative neurological status;

(4) The patient can sit up unaided or to preoperative neurological status;

(5) The patient can ambulate with minimal assistance or to preoperative neurological status; and

(6) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(i) A dentist who induces conscious sedation shall employ the services of a qualified monitor and a chair side dental assistant at all times who each shall hold a valid BLS/CPR certification and maintains certification as specified by rule.

§30-4A-7. Qualifications, standards, and continuing education requirements for Class 4 Anesthesia Permit.

(a) A Class 4 Permit permits the use of general anesthesia/deep conscious sedation, conscious sedation/moderate sedation and anxiolysis/minimal sedation.

(b) The board shall issue or renew a Class 4 Permit to an applicant who:

(1) Is a licensed dentist in West Virginia;

(2) Holds a valid and current documentation showing successful completion of a Healthcare Provider BLS/CPR course, Advanced Cardiac Life Support (ACLS) and/or Pediatric Advanced Life Support (PALS) course if treating pediatric patients;

(3) Satisfies one of the following criteria:

(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students and the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists at the time training was commenced;

(B) Completion of an ADA- or AMA-accredited postdoctoral training program which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these guidelines;

(C) In lieu of these requirements, the board may accept documented evidence of equivalent training or experience in general anesthesia/deep conscious sedation.

(c) A dentist who induces general anesthesia/deep conscious sedation shall have the following facilities, properly maintained age appropriate equipment and age appropriate drugs available during the procedure and during recovery:

(1) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least three individuals to freely move about the patient;

(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency and provide a firm platform for the administration of basic life support;

(3) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(4) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup

suction device which will function in the event of a general power failure;

(5) An oxygen delivery system with adequate age appropriate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(6) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(7) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(8) Equipment as specified by rule;

(9) Emergency drugs as specified by rule

(10) A defibrillator device.

(d) Before inducing general anesthesia/deep conscious sedation the dentist shall:

(1) Evaluate the patient and document, using the ASA Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or deep conscious sedation;

(2) Shall give written preoperative and postoperative instructions to the patient or, when appropriate due to age or neurological status of the patient, the patient's guardian; and

(3) Shall obtain written informed consent from the patient or patient's guardian for the anesthesia.

(e) A dentist who induces general anesthesia/deep conscious sedation shall ensure that the patient's condition is monitored and recorded on a contemporaneous record. The dentist shall use a qualified monitor to monitor and record the patient's condition on a contemporaneous record and a chair side dental assistant. The documented requirements of a qualified monitor monitoring general anesthesia/deep conscious sedation cases are as specified by rule. No permit holder may have more than one patient under general anesthesia at the same time.

(f) The patient shall be monitored as follows:

(1) Patients shall have continuous monitoring using pulse oximetry and/or equipment required for the standard of care or as specified by rule by a qualified monitor until discharge criteria have been met. The patient's blood pressure, heart rate and oxygen saturation shall be assessed every five minutes and shall be contemporaneously documented in the patient record. The record shall also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration including local anesthesia. The person administering the anesthesia may not leave the patient while the patient is under general anesthesia;

(2) During the recovery phase, the patient shall be monitored, including the use of pulse oximetry, by a qualified monitor; and

(3) A dentist may not release a patient who has undergone general anesthesia/deep conscious sedation except to the care of a responsible adult third party.

(4) When discharging a pediatric patient the dentist shall follow the current edition of AAPD Guidelines for the Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(g) The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(1) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(2) The patient is alert and oriented to person, place and time as appropriate to age and preoperative neurological status;

(3) The patient can talk and respond coherently to verbal questioning or to preoperative neurological status;

(4) The patient can sit up unaided or to preoperative neurological status;

(5) The patient can ambulate with minimal assistance or to preoperative neurological status; and

(6) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(7) A discharge entry shall be made in the patient's record by the dentist indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(h) A dentist who induces general anesthesia shall employ the services of a qualified monitor and a chair side dental assistant at all times, who each shall hold a valid BLS/CPR certification and maintains certification as specified by rule.

§30-4A-8. Board to review, inspect and reinspect dentists for issuance of permits.

(a) By making application to the board for an anesthesia permit, a dentist consents and authorizes the board to review his or her credentials, inspect or reinspect his or her facilities and investigate any alleged anesthesia mortalities, misadventure or other adverse occurrences. The board shall conduct an in-office review or on-site inspection of any dentist applying for or holding a permit to administer anesthesia.

Prior to issuing a permit, the board shall conduct an on-site inspection of facility, equipment and auxiliary personnel of the applicant to determine if, in fact, all the requirements for the permit have been met. This inspection or evaluation, if required, shall be carried out by at least two members of the subcommittee. This evaluation is to be carried out in a manner following the principles, but not

necessarily the procedures, set forth by the current edition of the AAOMS Office Anesthesia Evaluation Manual. On-site inspections are required and shall be performed for all Class 3a, 3b and 4 permitees. The board may reinspect annually, at its discretion, but shall perform an on-site inspection for all permit holders at least once every five years except Class 2 permit holders. The board reserves the right to conduct an on-site inspection whenever it deems necessary for all permit holders. All on-site inspections shall be held during regular business hours.

(b) Cancellation or failure to appear or be present for a scheduled evaluation by a permit holder, for an unexplained or unexcusable reason, shall be assessed a penalty fee two times the permit holders normal annual renewal fee. The penalty fee shall be separate from the annual renewal fees.

§30-4A-9. Office evaluations.

(a) The in-office evaluation shall include:

(1) Observation of one or more cases of anesthesia to determine the appropriateness of technique and adequacy of patient evaluation and care;

(2) Inspection of facilities, which shall include but not be limited to, the inspection of equipment, drugs and patient records and qualified monitor's certifications and documentation; and

(3) The evaluation shall be performed by a team appointed by the board and shall include a member of the subcommittee who holds a current anesthesia permit in the same class or in a higher class than that held by the permit holder being evaluated.

(4) Class 2 permit holders may be audited periodically as determined by the committee; and

(5) Class 3 and 4 permit holders shall be evaluated once every five years.

(b) A dentist utilizing a licensed dentist who holds a current anesthesia permit issued by the board shall have his or her office inspected to the level of a Class 4 permit as specified by section twelve of this article. The office is only approved at that level when the anesthesia permit holder is present and shall have the number of qualified monitors present as required by this article.

(c) In addition to the requirements of this article, a treating dentist who applies for a certificate to allow a CRNA to administer anesthesia and sedation to a patient shall maintain a permit as follows:

(1) A treating dentist who allows a CRNA to administer limited enteral sedation to a patient shall maintain a Class 3a permit for themselves and the administration site shall be inspected to a Class 4 permit level;

(2) A treating dentist who allows a CRNA to administer comprehensive parenteral sedation to a patient shall maintain a Class 3b permit for themselves and the administration site shall be inspected to a Class 4 permit level; and

(3) A treating dentist who allows a CRNA to administer general anesthesia/deep conscious sedation to a patient shall maintain a Class 4 permit for themselves and the administration site shall be inspected to a Class 4 permit level.

§30-4A-10. Reporting of Death, Serious Complications or Injury.

If a death, any serious complication or any injury occurs which may have resulted from the administration of general anesthesia/deep conscious sedation, conscious sedation/moderate sedation, anxiolysis/minimal sedation, or relative analgesia/minimal sedation, the licensee performing the dental procedure shall submit a written detailed report to the board within seventy-two hours of the incident along with copies of the patient's original complete dental records. If the anesthetic agent was administered by a person other than the person performing the dental procedure, that person shall also submit a detailed written report. The detailed report(s) shall include:

(1) Name, age and address of patient;

(2) Name of the licensee and other persons present during the incident along with their names and addresses;

(3) Address where the incident took place;

(4) Type of anesthesia and dosages of drugs administered to the patient including local anesthesia;

(5) A narrative description of the incident including approximate times and evolution of symptoms; and

(6) The anesthesia record and the signed informed consent form for the anesthesia.

§30-4A-11. Immunity from liability.

(a) Notwithstanding any other provision of law, no person providing information to the board or to the subcommittee may be held, by reason of having provided the information, to be civilly liable under any law unless the information was false and the person providing information knew or had reason to believe the such information was false.

(b) No member or employee of the board or the subcommittee may be held by reason of the performance by him or her of any duty, function or activity authorized or required of the board or the subcommittee to be civilly liable. The foregoing provisions of this subsection do not apply with respect to any action taken by any individual if the individual, in taking the action, was motivated by malice toward any person affected by the action.

§30-4A-12. Facility Inspections.

(a) The board shall perform an onsite evaluation of Class 3 and 4 applicants dental facilities, equipment, techniques and personnel prior to issuing a permit. The board may conduct further on-site

evaluations.

(b) The board may inspect Class 2 applicants facilities.

§30-4A-13. Issuance of regular annual permits.

Upon the recommendation of the subcommittee, the board shall issue permits to applicable dentists. An anesthesia permit shall be renewed annually: Provided, That the permittee meets the requirements of this article and has not been subject to disciplinary action prohibiting issuance of the permit.

§30-4A-14. Waiting period for reapplication or reinspection of facilities.

A dentist whose application has been denied for failure to satisfy the requirements in the application procedure or the on-site evaluation shall wait thirty days from the date of the denial prior to reapplying and shall submit to another on-site evaluation prior to receiving a permit. The board and the subcommittee shall promptly reinspect the applicant dentist's facilities, techniques, equipment and personnel within ninety days after the applicant has made reapplication.

§30-4A-15. Application and annual renewal of regular permits; fees.

The board shall require an initial application fee and an annual renewal fee for Class 2, Class 3 and 4 Permits. Permits expire annually. The board shall renew permits for the use of anesthesia after the permittee satisfies the application for renewal.

§30-4A-16. Violations of article; penalties for practicing anesthesia without a permit.

Violations of any of the provisions of this article, whether intentional or unintentional, may result in the revocation or suspension of the dentist's permit to administer anesthesia; multiple or repeated violations or gross infractions, such as practicing anesthesia without a valid permit may result in suspension of the dentist's license to practice dentistry for up to one year as well as other disciplinary measures as deemed appropriate by the board.

§30-4A-17. Appointment of Subcommittee; credentials review; and on-site inspections.

(a) The board shall appoint a subcommittee to carry out the review and on-site inspection of any dentist applying for or renewing a permit under this article.

(b) The subcommittee shall make a recommendation for issuing or revoking a permit under this article.

(c) This subcommittee shall be known as the West Virginia Board of Dentistry Subcommittee on Anesthesia. The subcommittee shall, at a minimum, consist of one member of the board who shall act as chairman of the subcommittee and two members holding a Class 4 permit and two members holding a Class 3 permit.

(d) The subcommittee shall adopt policies and procedures related to the regulation of general anesthesia/deep conscious sedation, conscious sedation/moderate sedation, anxiolysis/minimal sedation, and relative analgesia/minimal sedation with the same being approved by the board. The subcommittee members shall be paid and reimbursed expenses pursuant to article one of this chapter.

Virginia Board of Dentistry
Regulatory/Legislative Committee – May 17, 2019

National Reports on Licensing

Provided for review and possible discussion are:

- Report: Restrictions on licensing people with records burdening millions
- Report of the Task Force on Assessment of Readiness to Practice

PLR | PROFESSIONAL LICENSING REPORT
Licensing, testing, and discipline in the professions

Report: Restrictions on licensing of people with records burdening millions

Posted on April 24, 2019 in Licensing Reforms, Licensing Requirements, News, Sample Articles

Bipartisan momentum is building in support of "fair chance licensing" reforms that lift restrictions on granting licensure to people with records, according to a November 2018 report from the National Employment Law Project (NELP), a research organization that advocates broadly for wage, unemployment, and regulatory policies that benefit workers.

About one in four jobs in the U.S now require a license and, commonly, a background check, to practice, NELP notes. This is at a time when mass incarceration has been at its peak and there are now 70 million people in the U.S. who have an arrest or conviction record.

But the report, Fair Chance Licensing Reform: Opening Pathways for People with Records to Join Licensed Professions, points to a recent trend: a surge in new laws that restrict licensing agencies to only consider convictions that are "substantially related" to the occupation and occurred within seven years of the application trend started with Illinois and Georgia in 2016. It expanded to Arizona, Kentucky, and Louisiana in 2017, and to seven other states in 2018: California, Delaware, Indiana, Kansas, Maryland, Massachusetts, and Tennessee.

More jobs in the economy require a license or "permission to work," as both NELP and the Heritage Foundation term it, than ever before—an estimated 25% of workers, steeply higher than about 5% in the 1950s. About two thirds of the growth is from significant expansion of licensing into new sectors, the report notes.

About 27,000 state occupational licensing restrictions are on the books for people with records, according to the American Bar Association. "Of those, 6,000 can be based on misdemeanors, 19,000 are permanent disqualifications, and 11,000 are mandatory disqualifications."

The stigma of a prison record falls harder on Hispanic women and blacks, who are much less likely than whites with prison records to be interviewed for or offered a job.

Even misdemeanor convictions can scotch a licensure application. The NELP report relates the story of a child care provider who lost her day-care-owner certification and license to work in caregiving facilities. The offense: a 30-year-old overpayment of public assistance imposed for mistakenly failing to report gifts from a boyfriend. That led to a misdemeanor conviction and, three decades later, permanent revocation of her licenses.

Fair chance licensing would help workers, employers, and the economy, NELP argues. The report quotes Pennsylvania Governor Tom Wolf 's call, in June 2016, for repeal of the automatic 10-year ban on licensing for those convicted of a drug felony: "Pennsylvania must be a place where people can put their skills, experience, and education to work. Requiring a government license to work in certain jobs helps to make all of us safe, but those requirements should be fair."

NELP's report includes a table listing, for each state and the District of Columbia, estimated numbers of people with arrest or conviction records, percent of adult population with arrest or conviction records, number of people with felony convictions, number of people with prison records, percent of the workforce licensed by the state, percent of occupations with lower incomes requiring a license, and the number of disqualifications for a record in state occupational licensing laws.

State policy reforms to reduce disqualifications for people with records

Ten state policy reforms would promote greater transparency and accountability and help achieve fairer, more consistently applied licensing laws, the NELP report concludes.

1. Eliminate blanket bans that automatically disqualify workers with certain records through "mandatory" or "permanent" licensing disqualifications.
2. Limit the types of record information requested in a background check, including less relevant information such as offenses that are old, minor, or unrelated to the occupation can cloud opinions of licensing boards even when they intend to consider only recent, occupation-related offenses.
3. Require licensing boards to assess candidates case by case, examining both whether a conviction is occupation-related and how much time has passed since the offense.
4. Mandate consideration of applicants' rehabilitation and any mitigating circumstances, which may provide context that reveals the insignificance of a serious-sounding record.
5. Provide applicants with notice of potential disqualification and an opportunity to respond before the application is rejected, since background reports may be inaccurate and the applicant should be allowed to point out errors.
6. "Ban the box" by removing questions about conviction records from the application, and stop asking applicants to self-report their records at any time during the application process.
7. Remove "good moral character" requirements, restrictions against "moral turpitude" offenses, and other vague legal standards. "When the law lacks clear limits on licensing board discretion, opaque statutory language affords cover to automatically reject applicants with virtually any record," NELP points out.
8. Evaluate state occupational licensing restrictions and mandate ongoing data collection by licensing boards so that lawmakers can better understand current barriers and ensure that any attempted reforms make headway toward addressing them.
9. Promote transparency by providing clear guidance to applicants regarding potential disqualifications for the occupation.
10. Create more uniform standards by incorporating these recommendations into a broadly applicable state licensing law that expressly supersedes any conviction record restrictions contained in other laws governing specific professions.

Report of the Task Force on Assessment of Readiness for Practice

Issued September 2018

A Joint Task Force of:
American Dental Association, American Dental Education Association
and American Student Dental Association

Overview: A Call for Change

Each year nearly 6,000 students graduate from dental schools across the United States. To practice dentistry, they must first obtain a dental license, the purpose of which is to ensure public safety by showing that new dentists can provide safe and quality dental care on day one of their careers. Similarly, out of over 196,000 active licensed dentists in the United States, more than 10,000 moved across state lines from 2011 to 2016.[1] To continue practicing dentistry, each must obtain a new state license.

Ensuring patient safety and that each dentist meets professional standards for practice are the critical underpinnings of the dental licensure process. It is the responsibility of state boards of dentistry to establish the qualifications for licensure and subsequently issue licenses to qualified individuals.

The Task Force on Assessment of Readiness for Practice ["Task Force"] observes two challenges and priority concerns with the existing licensure process in place in most states:

- The use of single encounter, procedure-based examinations on patients[2] as part of the licensure examination.
- Mobility challenges that are unduly burdensome and unnecessary for ensuring patient safety.

First, the Task Force opposes single encounter, procedure-based examinations on patients, which virtually all states currently use to fulfill the clinical examination requirement. This approach has been demonstrated to be subject to random error; does not have strong validity evidence; is not reflective of the broad set of skills and knowledge expected of a dentist; and poses ethical challenges for test-takers, dental schools and the dental profession.

While not by design, the single encounter, procedure-based examination may not be in the best interest of the patients who participate in the examination process. In particular, these exams are administered in such a way that the focus is on a single quadrant, lesion and tooth that both best meets the exam criteria for acceptance (and will not be rejected resulting in failure of the exam) and is perceived by the candidate (test-taker) to provide the highest likelihood of success. This single focus is typically in lieu of the patient's comprehensive and most severe or urgent needs, resulting in a standard of care that may well be below today's acceptable level. Patients in the exam are often not patients of record or they have been solicited and registered at the school solely for the purpose of sitting for the exam. These patients may experience great difficulty in follow-up care, along with potentially significant liability issues regarding who is responsible for the patient's treatment, if the outcome is below the standard of care. The search for the "minimally acceptable cavity" as a path to exam success has led to the rise in patient brokering services, further compromising ethical treatment of patients. Identical challenges exist for clinical exams taken by senior dental students away from their school sites, and also for experienced dentists who must take second or third clinical exams to apply for licensure in a new state. The American Dental Association's Council on Ethics, Bylaws, and Judicial Affairs (CEBJA) published a white paper examining these ethical issues[3] and concluded that certain safeguards are necessary to protect the patient during the exam process. The patient protection protocols outlined by CEBJA mirror those used by research and academic institutions that utilize patients in medical clinical studies, serving as a nationally recognized standard by which patient rights are protected in the examination process. Unfortunately, the majority of clinical exams proceed without these recommended safeguards.

After careful study, the Task Force calls upon state dental boards to eliminate the single encounter, procedure-based patient exams, replacing these with clinical assessments that have stronger validity and reliability evidence.

Second, licensure portability also presents a significant issue for the dental profession in both expected and unexpected ways. The majority of students at over half of the country's dental schools do not practice in the same state where they were educated. For students in states with restrictive licensure policies, the cost of licensure in another state is often extremely expensive and unnecessarily burdensome. A similar burden exists for the over 10,000 active licensed dentists who moved across state lines between 2011 and 2016.

Restrictions on portability of dental licensure also have some unexpected impacts on society:

- Although dentists serving in the military and federal services are afforded a level of professional mobility, their spouses are not. When following a spouse or partner to a new military posting, the civilian spouses who are practicing dentists may be forced to spend significant financial resources and time submitting extensive documentation required for licensure by credentials; some are also required

to re-take a procedure-based patient clinical exam. Others simply stop practicing, which impacts their professional identities and their family's economic stability and further reduces access to care.

- Academia is a highly mobile profession. Dental school faculty who move across state lines for employment must go through a similar process as described above. While it may be possible for faculty members to get a "restricted license" to teach in the dental school clinic, they are typically not allowed to participate in either faculty practice or private practice. Most clinical faculty members see patients in the school's faculty practice or private practice one or more days per week in order to remain current and supplement their income. As a result, this type of limited license, which diminishes the individual's earning power and practice opportunities, creates a challenge for schools when recruiting new faculty members.
- Restrictions on mobility also impact dentists' ability to participate in volunteer outreach efforts to increase access to care, such as Missions of Mercy, Remote Area Medical or emergency response such as the response to Hurricanes Harvey, Irma and Maria in 2017. While some states allow for volunteer licensure, particularly for the provision of free dental care, most do not.

Barriers to licensure can have adverse impact on state and local economies. The federal government and the Federal Trade Commission (FTC) are also interested in the requirements for obtaining occupational licensure at the state level. This interest includes licensure of the health professions, with dentistry featured predominantly in several papers. According to Kleiner in *Reforming Occupational Licensure Policies*:

> "...by making it more difficult to enter an occupation, licensing can affect employment in licensed occupations, wages of licensed workers, the prices for their services, and worker economic opportunity more broadly. Indeed, economic studies have demonstrated far more cases where occupational licensing has reduced employment and increased prices and wages of licensed workers than where it has improved the quality and safety of services."[4]

Johnson and Kleiner pointed out in 2017[5] that occupational licensure, one of the most significant labor market regulations in the United States, may restrict the interstate movement of workers. They analyzed the interstate migration of 22 licensed occupations. Of note, the paper stated:

> "...three occupations stand out as showing substantially limited interstate migration, at a level comparable to lawyers: social workers, dental hygienists, and dentists."

As our nation becomes more mobile, these challenges will only grow worse over time. The Task Force calls upon state dental boards to enact changes that allow for increased licensure portability and to critically evaluate their licensure-by-credentials regulations and statutes, with the goal of accepting a common core of credentials that can serve as a basis for licensure compacts.

In summary, the Task Force calls upon state dental boards to amend their licensure requirements to (1) eliminate single encounter, procedure-based examinations on patients; (2) allow for increased initial licensure portability; and (3) work on the national level to establish a common core of dentist credentials for licensure that can serve as a basis for licensure compacts between states. This paper provides a summary of the existing licensure process and proposes new approaches to licensure.

Overview of Existing Licensure Processes

State boards of dentistry are entrusted with establishing the qualifications for licensure and for issuing licenses to qualified individuals as part of their responsibility to protect the public. This includes establishing rules of practice and conduct and taking disciplinary action against licensees who engage in misconduct. Though requirements vary by state, all dental licensure applicants must meet three basic requirements: an education requirement, a written examination requirement and a demonstration of clinical competence.[6]

1. The **educational requirement** in all states is a D.D.S. (doctor of dental surgery) or D.M.D. (doctor of dental medicine) degree from a university-based dental education program accredited by the Commission on Dental Accreditation (CODA). CODA is nationally recognized by the U.S. Department of Education as the sole agency to accredit dental, advanced dental and allied dental education programs conducted at the post-secondary level. CODA accreditation is evidence that the dental school meets predetermined quality assurance standards including requirements for documentation

of student competency (i.e., readiness for practice) throughout the D.D.S./D.M.D. curriculum.

2. All U.S. licensing jurisdictions require evidence that a candidate for licensure has passed a comprehensive **written examination**, called the National Board Dental Examination (NBDE). Currently this is a two-part exam. Part I covers biomedical sciences, dental anatomy and ethics. Part II covers clinical dentistry and case-based components, including diagnosis, ethics, critical thinking and patient management. In 2020, Parts I and II will be phased out and replaced by a single exam, the Integrated National Board Dental Examination (INBDE), which will combine and integrate the content areas of Parts I and II. The Joint Commission on National Dental Examinations (JCNDE), an independent agency, administers the NBDE and will administer the INBDE.
3. Currently, candidates for dental licensure in virtually all U.S. licensing jurisdictions must pass a single encounter, procedure-based **clinical examination** demonstrating a limited set of psychomotor skills (hand skills). Each state board of dentistry establishes its clinical examination requirement(s). Five regional testing agencies administer the four procedure-based clinical examinations; not all states accept all exam results even though the examinations are comparable. The result is limited licensure portability for dentists. Meanwhile, a growing number of states have adopted, or are in the process of adopting, pathways to licensure that do not include the single encounter performance of procedures on a patient.

The Task Force recognizes and supports the critical role that state dental boards perform in protecting the public through the licensure process. The Task Force remains committed to ensuring the highest levels of professionalism, ethical behavior and clinical competence through the licensure process and believes that third-party review, at key moments in the licensure process, is essential for ensuring trust and credibility in the process.

In light of the rationale presented, the Task Force members are all on record in opposition to single encounter, procedure-based examinations on patients currently utilized by all states (with the exception of the state of New York, which requires completion of a PGY1 in lieu of a single encounter clinical exam) to fulfill the clinical examination requirement. As stated earlier, the single encounter, procedure-based clinical examination is subject to random error; does not have strong validity evidence; is not reflective of the broad set of skills and knowledge expected of the new dentist; and poses ethical challenges for the test-takers, the dental schools and the dental profession. For all these reasons, the random error inherent in the current clinical examinations that require single encounter, procedure-based examinations on patients cannot assure that the public is being protected at the highest levels from unsafe beginning dentists.

Federal Government Interest in Occupational Licensure

"States' legal authority to license professions is well-established. In 1889, the Supreme Court in *Dent v. West Virginia* established the rights of States to license professions. Under a line of cases starting with *Parker v. Brown*, State licensing boards have been assumed to be shielded from Federal antitrust liability, in the same manner as State courts and legislatures. However, in a recent decision, *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, the Supreme Court held that state licensing boards are not automatically exempted from antitrust scrutiny. Under the standard articulated by the Court, if a controlling number of board members are themselves 'active market participants,' then the licensing board's conduct is only immune from antitrust scrutiny if it is (1) clearly articulated State policy, and (2) actively supervised by the State. The extent to which the Court's decision will in practice increase State licensing boards' exposure to antitrust actions and constrain occupational regulation is unclear" (from *Occupational Licensing: A Framework for Policymakers*[7]).

Two white papers released in 2015 on occupational licensure contain references to dental licensure: *Reforming Occupational Licensing Policies*,[4] which was prepared by the Hamilton Project and The Brookings Institution, and *Occupational Licensing: A Framework for Policymakers*,[7] a White House report prepared by the Department of the Treasury Office of Economic Policy, the Council of Economic Advisers and the Department of Labor. Both papers come to essentially the same conclusion:

> "When designed and implemented appropriately, licensing can benefit practitioners and consumers through improving quality and protecting public health and safety. This can be especially important in situations where it is costly or difficult for consumers to obtain information on service quality, or where low-quality practitioners can potentially inflict serious harm on consumers

> or the public at large.... Yet while licensing can bring benefits, current systems of licensure can also place burdens on workers, employers, and consumers, and too often are inconsistent, inefficient, and arbitrary. The evidence in this report suggests that licensing restricts mobility across States, increases the cost of goods and services to consumers, and reduces access to jobs in licensed occupations. The employment barriers created by licensing may raise wages for those who are successful in gaining entry to a licensed occupation, but they also raise prices for consumers and limit opportunity for other workers in terms of both wages and employment."

In the White House report, restrictive dental licensure is specifically referenced:

> "While older research suggests that more stringent entry requirements are associated with lower rates of untreated dental disease, more recent studies that control for potentially confounding factors find no evidence that tighter dentistry licensing requirements lead to better dental health, though they do lead to higher prices."

The FTC's Economic Liberty Task Force followed up on these papers with two webinars: one on July 27, 2017, examined ways to mitigate the effects of state-based occupational licensing requirements that make it difficult for license holders to obtain licenses in other states, and the other on November 7, 2017, examined empirical evidence on the effects of occupational licensure.

Finally, the National Conference of State Legislatures has selected 11 states for a public policy consortium that will familiarize participants with occupational licensing policy in their own states and occupational licensing best practices in other states. Each state will begin implementing actions to remove barriers to labor market entry and improve portability and reciprocity.

These initiatives highlight the need for the profession to become involved early in the process; otherwise, federal entities may impose solutions on dental boards and state legislatures.

A Contemporary Approach to Initial Dental Licensure

In the past, state dental boards understandably relied on the single encounter, procedure-based clinical examination, as there were few proven alternatives and varying points of view regarding the rigor of the CODA accreditation process and both the scope and rigor of school-based assessment processes. However, thanks to the adoption and evolution of competency-based education in accredited dental schools over the past 25 years, along with new effective pathways for dental clinical assessment, state dental boards no longer need to rely on this dated approach for the clinical assessment of candidates for licensure.

There is a critical need to modernize the dental licensure process that reflects current practices in pedagogy, assessment and licensure and that includes opportunities for third-party review and assurance throughout the process.

The Task Force proposes a modernized process for initial licensure that includes the following three components:

1. Completion of a D.D.S. or D.M.D. degree from a university-based dental education program accredited by the Commission on Dental Accreditation, which requires documentation of clinical competence and the assessment of psychomotor skills ("hand-skills");
2. Passage of the National Board Dental Examination, a valid and reliable written test of applied knowledge; and
3. Successful passage of a valid and reliable clinical assessment that does not require single encounter, procedure-based examinations on patients. Examples include: an Objective Structured Clinical Examination (OSCE); or graduation from CODA-accredited PGY-1 program; or completion of a standardized compilation of clinical competency assessments designed to demonstrate psychomotor skills and practice relevant patient care knowledge, skills and abilities (e.g., California Hybrid Portfolio or Compendium of [Clinical] Competency Assessments).

Overview of the Proposed Licensure Process

The table below describes a proposed licensure process and demonstration of skills as well as the role of third-party review.

Component 1 of the Licensure Process

Completion of a D.D.S. or D.M.D. degree from a university-based dental education program accredited by the Commission on Dental Accreditation (CODA), which includes documentation of clinical competence and the assessment of psychomotor skills ("hand-skills").

What This Demonstrates

The awarding of a D.D.S. or D.M.D. degree demonstrates that the student has fulfilled all the requirements of the educational program leading to that degree, including a comprehensive assessment of the graduate's ability to be a safe, beginning practitioner.

CODA accreditation ensures that the dental schools' processes meet the quality standards in six areas established for dental education programs, including the requirement that graduates demonstrate specified competencies.

Throughout the dental school experience, students must demonstrate competence by challenging hundreds of school-based competency examinations. Over time, students and their institutions develop a compendium of competency assessments that demonstrates the acquisition of relevant knowledge and ability across all competencies that meets pre-specified criteria for success.[8]

School-based competency examinations go far beyond the current single encounter clinical examination and include multiple measures of competencies across a wide range of clinical and non-clinical competencies.

Third-Party Review

The dental schools are accredited by the Commission on Dental Accreditation (CODA). CODA has the authority to make independent accreditation decisions.

Reaccreditation for dental programs occurs every seven years, and CODA monitors dental programs for continued compliance with all quality standards between the formal accreditation reviews.

The CODA Board of Commissioners has a fiduciary responsibility to the Commission, not to the agency that appoints them.

CODA is recognized by the U.S. Department of Education as the sole agency for accrediting dental education programs. This recognition assures the public that the CODA meets quality standards for accreditation of educational programs. CODA must renew its recognition every five years.

The Commission must demonstrate to the U.S. Department of Education that conflicts of interest are appropriately handled and cannot affect accreditation decisions.

To build trust and credibility in the independence and objectivity of school-based competency exams, the Task Force recommends that state dental boards work in partnership with the dental schools in their state to develop methods for the calibration, quality assurance and third-party auditing of these exams. Potential examples include engagement of state dental board members on key dental school committees; "auditing" of data, images and other documentation from the competency exams; utilizing faculty as examiners; and creating opportunities for observation by state board members of these challenge exams.

Component 2 of the Licensure Process

Passage of the National Board Dental Examination, a valid and reliable written test of didactic knowledge.

What This Demonstrates	Third-Party Review
The National Board Dental Examination is a standardized, comprehensive set of examinations covering the basic biomedical sciences, dental anatomy, ethics and clinical dental subjects, including patient management. Note: Currently, the exam is divided into Part I and Part II, but as the dental school curriculum has moved to a more integrated format, the Joint Commission on National Dental Examinations (JCNDE) will transition to the integrated National Board Dental Examination in 2020.	The National Board Dental Examination is administered by the Joint Commission on National Dental Examinations (JCNDE). The Joint Commission has authority to make independent decisions regarding exam content and administration. Members of the JCNDE Board of Commissioners have a fiduciary responsibility to the Joint Commission, not to the agency that appoints them. The Joint Commission's examination program meets the quality standards for high stakes testing as outlined in the *Standards for Educational and Psychological Testing*. Accordingly, the JCNDE publishes and makes publicly available its annual *Technical Report* documenting the reliability and validity evidence for each examination.

Component 3 of the Licensure Process

Successful passage of a valid and reliable clinical assessment that does not require single encounter, procedure-based examinations on patients. Three examples are provided:

What This Demonstrates	Third-Party Review
EXAMPLE 1. Objective Structured Clinical Examination (OSCE). An OSCE is a high-stakes examination consisting of multiple, standardized stations, each of which require candidates to use their clinical knowledge and skills to successfully complete one or more dental problem-solving tasks. The OSCE provides information to dental boards about whether a candidate for dental licensure possesses the necessary level of clinical knowledge and skills to safely practice entry-level dentistry thought the use of a valid and reliable examination. The OSCE can protect public health more effectively than current clinical licensure exams. Traditionally, an OSCE format used in health professions training and testing may include physical materials, such as radiographs, photographs, models and order/ prescription writing. Advances in computer-based testing, simulated patient and haptic technologies suggest that these modalities may be incorporated into the OSCE format in the future. OSCEs are widely used across the health sciences, including the United States Medical Licensing Examinations, and are used by the National Dental Examining Board of Canada for dental licensure in that country.[9] Note: The Dental Licensure Objective Structured Clinical Examination (DLOSCE) is currently being developed by the ADA's Department of Testing Services, which is staffed by testing professionals with advanced degrees in psychological measurement and related fields. The Department of Testing Services has significant experience in the development of standardized tests for the dental and dental hygiene communities.	The OSCE is utilized by state dental boards — in conjunction with the school-based competency assessments — to fulfill the clinical examination requirement. The OSCE is administered by an independent, third-party testing agency, similar to the process used for the National Dental Board Examination.

Component 3 of the Licensure Process (continued)	
What This Demonstrates	**Third-Party Review**
EXAMPLE 2. Graduation from CODA-accredited PGY-1 program. PGY-1 is completion of a residency program at least one year in length at a CODA-accredited clinically based advanced general dentistry and/or specialty residency program. PGY-1 programs are designed to provide education beyond the level of D.D.S./ D.M.D. programs in oral health care, using applied basic and behavioral sciences. The programs are designed to expand the scope and depth of the graduates' knowledge and skills to enable them to provide comprehensive oral health care to a wide range of populations.	PGY-1 programs are CODA-accredited and competency-based.
EXAMPLE 3. Completion of a standardized compilation of clinical competency assessments designed to demonstrate psychomotor skills and practice relevant patient care knowledge, skills and abilities that is accepted by licensing jurisdictions (e.g., California Hybrid Portfolio or Compendium of [Clinical] Competency Assessments). The compilation of clinical competency assessments is a standardized approach to assessing psychomotor skills and practice relevant patient care knowledge, skills and abilities for licensure that is accepted by licensing jurisdictions. The compilation of clinical assessments uses the evaluation mechanisms currently applied by the dental schools to assess student competence. The compilation of clinical assessments can evaluate candidate performance in a broader range and complexity of common dental procedures, in addition to newer clinical procedures and technologies, than single encounter, procedure-based examinations on patients. An approved compilation will consist of competencies assembled using selected measures of assessment, will be collected over the course of time and will support provision of comprehensive patient care. Examples include the California Hybrid Portfolio and Compendium of (Clinical) Competency Assessments. Note: The Compendium of (Clinical) Competency Assessments, a standardized set of clinical competency assessment, is currently being developed by a working group of members of the American Dental Education Association. The working group contains representation of dental and allied dental educators and experts in competency assessment.	Performance is assessed by calibrated examiners who are members of the dental school faculty. The dental board routinely audits the examinations to ensure reliability and objectively.

Increasing Dental Licensure Portability

The more contemporary approach to the clinical licensure process outlined in the preceding section is focused on the *initial* licensure process. Initial licensure is the process through which a first-time candidate, who does not hold a dental license in another jurisdiction at the time of application, applies for and receives a dental license.

While pursuing the goal of a modernized process for dental licensure that does not contain single encounter, procedure-based examinations on patients, in the near term, the Task Force is seeking to enhance the professional mobility and success of the nearly 200,000 active licensed dentists in the United States by two primary means:

1. Through increased portability of licensure, and
2. By enabling new graduates to use any of the available examination modalities to obtain a license.

To this end, while acknowledging that there are subtle differences among the traditional single encounter, procedure-based examinations on patients administered by the five clinical testing agencies, an analysis conducted by the ADA found that these clinical examinations "adhere to a common set of core design and content requirements that renders them *conceptually comparable*."

What makes these clinical examinations conceptually comparable?

- All reported additional reliance on subject matter experts to inform test specifications (for exams with information available).
- All include both patient-based and manikin-based test sections.
- All require candidates to pass each examination section in order to pass the examination.
- All rely on subject matter expert ratings of candidate performance (typically three subject matter experts).
- All have procedures for selecting, training and evaluating subject matter experts (for exams with information available).
- All use established scoring rubrics that share many common characteristics, but also present some differences.
- All employ criterion-referenced performance standards (cut scores) to facilitate use of examination results by state boards.
- Most examinations use compensatory scoring within test sections, as well as the concept of "critical errors." Some examinations also include penalty points in scoring.
- The five clinical testing agencies differ significantly with respect to the amount of validity and reliability evidence made publicly available.

Currently more than half of the states accept passing results from all five regional testing agencies, while 10 states accept two or three of the available exams and four states accept only one of the available exams. Recognizing that the transition to a more contemporary approach for dental licensure that eliminates the use of single encounter, procedure-based examinations on patients will take time to implement across the 53 licensing jurisdictions and in light of the fact that more than half of the states currently accept results from all five testing agencies, the Task Force calls upon state dental boards to accept all clinical examinations and pathways to licensure until this transition is complete.

Once a dentist passes a clinical examination, receives a license and has been actively practicing for several years, a process exists for obtaining licensure by credentials in the majority of states (exceptions are Delaware, Florida, Hawaii, Nevada and the Virgin Islands). However, licensed dentists who relocate to another state (or whose practice crosses state lines) in many cases are forced to expend significant financial resources and time submitting extensive documentation required for licensure by credentials; some are required to re-take a procedure-based patient clinical exam.

No consensus exists among state dental boards of what constitutes a credential for licensure; therefore, licensure by credentials varies significantly among the states. A credential is defined as "diplomas, degrees, certificates, and certifications, in order to attest to the completion of specific training or education programs by students, to attest to their successful completion of tests and exams, and to provide independent validation of an individual's possession of the knowledge, skills, and ability necessary to practice a particular occupation competently."[10] Based on this definition, many of the most common requirements for "licensure by credentials" are, in fact, not credentials and do not provide dental boards with a reliable or valid measurement of whether an individual already licensed in one or more states will provide competent dental care in another state:

Credential
Dental school diploma from accredited program
Specialty certificate/master's degree from accredited program
Specialty Board certification
GPR/AEGD certificate from accredited program
Current license in good standing
Criminal background check
Passing grade on an initial clinical licensure exam
Documentation of completion of continuing education

Not a Credential
Interview
Oral examination
Hours/years of practice
Affidavits from colleagues/letters of recommendation
Physician statement of good health
Case presentation
Retake of a clinical licensure exam, or a portion thereof
Dental school transcripts

The Task Force calls for state dental boards across the country to allow for increased mobility for new and practicing dentists by (1) accepting all clinical examinations and pathways to licensure for the purpose of licensure portability in the short-term, (2) accepting a common core of requirements for licensure by credentials in the mid-term, and (3) investigating the establishment of licensure compacts among states in the longer-term.

An Environment of Trust: A Necessary Precursor to Change

There is a common attribute among a handful of states in which new and additional pathways to licensure have been adopted. That is, a high degree of trust exists among the state dental board, the state dental association and the dental schools located within the state.

For this contemporary approach to licensure to be successful, there must be a strong partnership among these entities based on transparency, communication, collaboration and mutual understanding. State dental boards should have trust and confidence that a combination of a graduate's D.D.S./D.M.D. degree from a university-based CODA-accredited program including the assessment of psychomotor skills (hand skills), passage of the NBDE and successful completion of a reliable and valid OSCE examination or a PGY1 program or a standardized compilation of clinical competency assessments assures the public of a competent practitioner.

The Task Force believes that for this to occur, there needs to be increased understanding of the:

- CODA accreditation process and confidence that CODA accreditation is a credible marker of the quality standards for dental schools and advanced dental education programs; and
- Rigor of the competency-based challenge examinations performed in dental schools and advanced dental education programs, the independence and objectivity of the assessment process, and the development of appropriate methods of third-party oversight of this process to ensure credibility; and
- Purpose and methodology of the OSCE, including the Dental Licensure Objective Structured Clinical Examination being developed by the ADA's Department of Testing Services, and the validity and reliability of this clinical exam that does not utilize performance of procedures on patients for licensure decisions; and
- Challenges to professional mobility and access to care created by current licensure portability restrictions.

The members of the Task Force believe that collectively, we can achieve our long-term goals of creating a valid and reliable process for dental licensure that does not include single encounter, procedure-based examinations on patients and increasing the portability of dental licensure among all states for the benefit of both the public and the profession.

Endnotes

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2 Single encounter, procedure-based examinations on patients are administered by five dental clinical testing agencies in the United States. The candidate is required to preselect usually up to three patients who have met predetermined criteria and to ensure the patients are present on the day of the test. The test takes place on one day. During this single encounter the candidate must perform the following treatment on the patient(s): periodontal scaling/root planing, an anterior restoration, and a posterior restoration. Patients receive only these specific, limited procedures.

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