Virginia Department of Health Professions

AGENDA
FEBRUARY 28, 2020
BOARD ROOM 4

MEETING OF THE VIRGINIA BOARD OF DENTISTRY

REGULATORY – LEGISLATIVE COMMITTEE

Perimeter Center, 9960 Mayland Drive, Second Floor Conference Center, Henrico, VA 23233

TIME		PAGE
9:00 AM	**Call to Order – Tammy C. Ridout, RDH, Chair**	
	Evacuation Announcement - Ms. Sandra K. Reen	**1**
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	Approval of Minutes	**3**
	• **November 15, 2019**	
	Status Report on Legislation and Regulatory Actions –Ms. Elaine Yeatts	**9**
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	Sedation	
	• **Overview of Regulatory Advisory Panel regarding Sedation Regulations**	**59**
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PERIMETER CENTER CONFERENCE CENTER EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS

(Script to be read at the beginning of each meeting)

PLEASE LISTEN TO THE FOLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by security staff

BOARD ROOM 1

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, tum **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

BOARD ROOM 2

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, tum **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

You may also exit the room using the side door **(Point),** tum **RIGHT** out of the door and make an immediate **LEFT.** Follow the corridor to the emergency exit at the end of the ball.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

BOARD ROOMS 3 AND 4

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, turn RIGHT. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

TRAINING ROOMS 1 AND 2

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, turn **LEFT**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

SCRIPT FOR PUBLIC COMMENT

Before opening the floor for public comment, I want the audience to know that this is an opportunity to make the committee aware of your interests or concerns related to dentistry. It is not an opportunity to:

- engage the committee in a discussion;
- comment on regulatory actions for which the public comment period is closed; or
- address an investigation, a disciplinary proceeding, or a closed case.

Topics Identified through public comment will be reviewed by the committee later on the agenda. The committee might decide to:

- receive the comment as information and take no action
- direct the executive director to respond, or
- assign the matter to the Board for review.

In order to allow ample time for the committee to conduct its business, we ask that you limit your comment to 3 - 5 minutes.

TIME AND PLACE The meeting of the Regulatory – Legislative Committee ("Committee") was called to order at 9:03 a.m., on November 15, 2019, at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

PRESIDING Tammy C. Ridout, RDH, Chair

MEMBERS PRESENT Sandra J. Catchings, D.D.S., Vice-President
Mike Nguyen, D.D.S.
James D. Watkins, D.D.S.

OTHER BOARD MEMBERS PRESENT Augustus A. Petticolas, Jr., D.D.S., President
Perry E. Jones, D.D.S.

STAFF PRESENT Sandra K. Reen, Executive Director
Elaine Yeatts, DHP Senior Policy Analyst
Kathryn Brooks, Executive Assistant

COUNSEL PRESENT James E. Rutkowski, Assistant Attorney General

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

Ms. Reen read the emergency evacuation procedures.

PUBLIC COMMENT Ms. Ridout explained the parameters for public comment and opened the public comment period.

Gianna Harting (American Association of Orthodontists) stated the AAO is hopeful the Board adopts rules that support and clarify that an "impression" includes "digital scans" and that dental and orthodontic treatment should not occur before a physical, in-person examination of the patient has occurred by a licensed dentist to establish the doctor/patient relationship.

Susan Pharr, RDH (VDH Dental Health Program - Retired) asked that proposed Guidance Document 60-13 on remote

supervision be amended to be consistent with the provisions of the statute addressing practice settings and submitted her proposed language for consideration. She said her proposal clarifies the qualifications of the dentist, explaining that the term 'dental office' does not apply to any of the non-dental practice settings such as schools, Head Start programs, WIC clinics, and long-term care facilities.

Elisabeth Reynolds (VDA President) spoke in favor of dentists and dental hygienists being able to perform A1C screening in the dental office. She stated oral health is a major component of overall health and the dental community should be doing everything possible to work hand in hand with their medical colleagues to protect the public. She said it is the responsibility of dental professionals to screen for this disease as many already screen for hypertension by routinely taking blood pressure readings on patients before any invasive procedure.

Tracey Martin (VDHA President-Elect) spoke in support of allowing dentists and dental hygienists to perform screening tests to identify those at risk of diabetes. She noted that screening procedures are not diagnostic. They determine the likelihood of already high-risk patients having a certain disease. She also provided handouts listing states that support testing/screening conducted by dental professionals.

APPROVAL OF MINUTES

Ms. Ridout asked if there were corrections to the posted minutes. Hearing none, Dr. Petticolas moved to accept the minutes for May 17, 2019 as presented. The motion was seconded and passed.

LEGISLATION AND REGULATORY ACTIONS

Ms. Yeatts reported that the Governor only approved one DHP bill for introduction in the upcoming legislative session.
She also indicated that the comment period on the regulatory proposal for changing the renewal schedule closed on 11/15/19 and the other regulatory actions are pending review by the Secretary of Health and Human Resources or the Governor.

BLANCHARD PETITION

FOR RULEMAKING	Ms. Yeatts addressed the Petition for Rulemaking, received from Deborah Blanchard, DDS, to eliminate the regulatory requirement for a dentist to be present in the facility and to examine a patient when a dental hygienist treats a patient. Ms. Yeatts said that taking the proposed action would require amending the Dentistry and Dental Hygiene regulations. Dr. Catchings moved to recommend that the Board keep the current regulatory provisions for indirect supervision and deny the petition. The motion was seconded and passed.
A1C TESTING/ DEFINITION OF DENTISTRY	Ms. Ridout opened discussion by asking if the current definition of the term “”dentistry” in the Code is broad enough to include A1C testing. Following discussion of relying on the current definition, Mr. Rutkowski explained that A1C testing does not fall within the current definition because screening for diabetes is not related to treatment of the oral cavity and its adjacent and associated structures. Ms. Reen advised that the Board had accepted this advice previously given to it by Counsel and charged the Committee with proposing an amendment. Ms. Yeatts explained that the Board would need to act on amending the definition no later than at its June 2020 meeting to propose legislation for the 2021 Session of the General Assembly.
	Ms. Ridout read the current Code definition of dentistry and stated the goal should be an amendment to include A1C testing without establishing a “laundry list” of amendments. In response to further questions about the current definition asked by Dr. Jones and Dr. Watkins, Dr. Catchings read the definition in a different order to explain that a dentist seeing a patient with a sinus condition cannot treat the sinus condition because that condition is not associated with the oral cavity. Mr. Rutkowski stated again that the definition as written does not include A1C testing. Ms. Yeatts said a simple sentence that is concise, not all inclusive of the practice of medicine and presents clear boundaries could be added. Dr. Catchings commented that dentists need parameters to “know where to stop” in addressing medical procedures such as flu shots and HIV testing. Ms. Ridout asked who would serve on a sub-committee to develop a proposal. Dr. Catchings and Dr. Watkins volunteered

and Mr. Rutkowski, Ms. Yeatts and Ms. Reen agreed to assist. Ms. Ridout charged the sub-committee with bringing its proposal to the next Committee meeting, which was scheduled for February 28, 2020.

REVIEW GUIDANCE DOCUMENTS:

Ms. Reen said she has reviewed the Board's Guidance Documents in response to statutory changes addressing the definition and publication of agencies' guidance addressing the conduct of public business. As a result of her review, Ms. Reen recommended that:

GD 60-1 on CCAs be amended as highlighted to delete references to GD 60-6, which was withdrawn by the Board at a previous meeting.

GD 60-3 on Periodic Office Inspections be amended to address concerns about the management of inspections raised by the Enforcement Division and by permit holders. Ms. Reen explained the sections highlighted in yellow are editorial in nature and the sections highlighted in blue are policy changes. Ms. Yeatts advised that regulatory action would be needed to require an inspection before issuing a permit. Ms. Reen explained that dentists are changing locations more often than previously assumed and that they are obtaining permits without being prepared to administer moderate sedation. She said changes are needed to be more efficient in utilizing the inspectors and to eliminate the dilemma of what level of sedation is being practiced and what equipment is required. She asked for guidance on how to proceed in light of these issues. The options are to withdraw the document pending edits, or to adopt with edits.

Ms. Yeatts advised that the yellow highlighted areas did not require discussion, only the blue highlighted portions. Ms. Reen suggested that the blue highlighted sections be referred to a sub-committee. Dr. Catchings recommended that a sub-committee discuss the entire process. Dr. Petticolas moved to adopt the yellow highlighted portions. The motion was seconded and passed.

Ms. Ridout asked for discussion of the blue highlighted sections. Ms. Reen said the DHP director of inspections might want to address the Board directly on announcing inspections. Dr.

Petticolas expressed his support for announced inspections. Dr. Catchings agreed and she supported using a two-step permit application process before a permit is given. The first step to review the education credentials and the second step to inspect for readiness. Ms. Yeatts advised that specifics would need to be worked out, as DHP's policy is to conduct unannounced inspections. Ms. Reen requested this matter be tabled to the February 28, 2020 meeting so a subcommittee could gather more information. Dr. Catchings, Dr. Watkins and Ms. Yeatts agreed to serve on the subcommittee with Ms. Reen. Ms. Ridout tabled the discussion until the next meeting.

GD 60-4 Q & A on Sedation be revised to be consistent with current regulations. Dr. Catchings moved approval. The motion was seconded and passed.

GD 60-9 Code of Conduct can be withdrawn because it does not fall within the definition of a guidance document. Dr. Watkins moved to remove the document. The motion was seconded and passed.

GD 60-13 Remote Supervision be revised to be consistent with Code and regulatory changes. In response to public comment, the proposed language addressing who can supervise the practice of remote supervision was discussed. The consensus was that a revision was needed. After reviewing the language recommended in public comment, Ms. Yeatts proposed adding the word "would" in front of the word "qualify" as a solution. Dr. Watkins moved to add the word "would" as suggested by Ms. Yeatts. Ms. Yeatts then suggested also changing the word "office" to "practice" as requested by the commenter. Dr. Watkins amended his motion to include changing the word" office" to "practice" in the response. The motion was seconded and passed.

Ms. Reen asked for consideration of the other proposed changes highlighted in yellow, which are directly related to changes in the law. Ms. Ridout asked for a motion on the entire document as amended. Dr. Petticolas moved adoption of the changes as revised. The motion was seconded and passed.

GD 60-17 Recovery of Costs needs updating to show the actual FY2019 hourly costs for staff to be used to calculate the

	administrative costs to be assessed in disciplinary orders. Dr. Catchings moved to accept the updated costs. The motion was seconded and passed.
TELEHEALTH PRACTICE	Ms. Reen advised there are no proposed changes to this guidance document and noted it is however a hot topic so it is available for discussion. Dr. Petticolas asked if there is a policy for review of guidance documents. Ms. Yeatts responded that the documents are reviewed on a four-year cycle and can be revised as needed. She also identified one typo to be corrected. Dr. Petticolas moved to reaffirm the document. The motion was seconded and passed.
CLEAR ALIGNER THERAPY, INTRAORAL DIGITAL SCANNING, OUTSOURCING CBCT SCANS	Ms. Reen stated the Board referred these topics to the Committee for discussion. She explained that the Board does not typically regulate specific types of equipment used in dentistry and noted that the Department of Health regulates x-ray machines. She added that action should be considered if needed to protect patients or the public. Dr. Jones spoke against addressing clear aligner therapy, CBCT and digital scanning in regulations. Dr. Catchings questioned if untrained individuals are reading CBCT scans and if scans are being misread. Mr. Rutkowski advised that the concerns surrounding these subjects seems to be more about billing and not necessarily public health. Mr. Rutkowski was asked to research the feasibility of requiring an in person, physical examination by a dentist before orthodontic treatment is initiated.
NEXT MEETING	February 28, 2020
ADJOURNMENT	With all business concluded, the meeting was adjourned at 11:16 a.m.

______________________________	______________________________
Tammy C. Ridout, RDH, Chair	Sandra K. Reen, Executive Director
______________________	______________________
Date	Date

Agenda Item: Regulatory Actions - Chart of Regulatory Actions As of February 20, 2020

		Action / Stage Information
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Waiver for e-prescribing [Action 5382] Emergency/NOIRA - *Register Date: 12/23/19* *NOIRA comment closed: 1/22/20* *Board to adopt proposed regulations: 3/13/20*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Amendment to restriction on advertising dental specialties [Action 4920] Proposed - *At Governor's Office for 158 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Administration of sedation and anesthesia [Action 5056] Proposed - *At Governor's Office for 151 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Technical correction [Action 5198] Fast-Track - *At Governor's Office for 95 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Handling fee/returned check [Action 5451] Fast-Track - *At Secretary's Office for 37 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Change in renewal schedule [Action 4975] Final - *At Secretary's Office for 48 days*
[18 VAC 60 - 25]	Regulations Governing the Practice of Dental Hygiene	Protocols for remote supervision of VDH and DBHDS dental hygienists [Action 5323] Proposed - *At Secretary's Office for 3 days*
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	Education and training for dental assistants II [Action 4916] Proposed - *Register Date: 1/20/20* *Comment period closes: 3/20/20*

HB 115 Health care providers, certain; programs to address career fatigue and wellness, civil immunity.

Chief patron: Hope

Summary as introduced:

Programs to address career fatigue and wellness in certain health care providers; civil immunity. Expands civil immunity for health care professionals serving as members of or consultants to entities that function primarily to review, evaluate, or make recommendations related to health care services to include health care professionals serving as members of or consultants to entities that function primarily to address issues related to career fatigue and wellness in health care professionals licensed to practice medicine or osteopathic medicine or licensed as a physician assistant. The bill also clarifies that, absent evidence indicating a reasonable probability that a health care professional who is a participant in a professional program to address issues related to career fatigue or wellness is not competent to continue in practice or is a danger to himself, his patients, or the public, participation in such a professional program does not trigger the requirement that the health care professional be reported to the Department of Health Professions. The bill contains an emergency clause.

EMERGENCY

HB 165 Teledentistry; definition, establishes requirements for the practice of teledentistry, etc.

Chief patron: Hope

Summary as passed House:

Teledentistry. Defines "teledentistry," establishes requirements for the practice of teledentistry and the taking of dental scans for use in teledentistry by dental scan technicians, and clarifies requirements related to the use of digital work orders for dental appliances in the practice of teledentistry.

HB 299 Fluoride varnish; possession and administration by medical assistants, etc.

Chief patron: Sickles

Summary as passed House:

Medical assistants; administration of fluoride varnish. Allows an authorized agent of a doctor of medicine, osteopathic medicine, or dentistry to possess and administer topical fluoride varnish pursuant to an oral or written order or a standing protocol issued by a doctor of medicine, osteopathic medicine, or dentistry.

HB 347 Commonwealth's medical cannabis program; SHHR to convene work group to review & make recommendation.

Chief patron: Davis

Summary as passed House:

Tetrahydrocannabinol products; permits to process and dispense cannabidiol oil and THC-A oil. Directs the Secretary of Health and Human Resources to convene a work group to review the Commonwealth's medical cannabis program and issues of critical importance to the medical cannabis industry and patients, including expansion of the medical cannabis program and the medical use of cannabis flowers, and to report its findings and recommendations, including any legislative recommendations, to the Governor, the Attorney General, and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health no later than October 1, 2020.

HB 471 Health professionals; unprofessional conduct, reporting.

Chief patron: Collins

Summary as passed House:

Health professionals; unprofessional conduct; reporting. Requires the chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth, the director of every licensed home health or hospice organization, the director of every accredited home health organization exempt from licensure, the administrator of every licensed assisted living facility, and the administrator of every provider licensed by the Department of Behavioral Health and Developmental Services in the Commonwealth to report to the Department of Health Professions any information of which he may become aware in his professional capacity that indicates a reasonable belief that a health care provider is in need of treatment or has been admitted as a patient for treatment of substance abuse or psychiatric illness that may render the health professional a danger to himself, the public or his patients, or that he determines,

following review and any necessary investigation or consultation with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, indicates that there is a reasonable probability that such health professional may have engaged in unethical, fraudulent, or unprofessional conduct. Current law requires information to be reported if the information indicates, after reasonable investigation and consultation with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, a reasonable probability that such health professional may have engaged in unethical, fraudulent, or unprofessional conduct.

HB 648 Prescription Monitoring Program; information disclosed to Emergency Department Information.

Chief patron: Hurst

Summary as introduced:

Prescription Monitoring Program; information disclosed to the Emergency Department Information Exchange; redisclosure. Provides for the mutual exchange of information between the Prescription Monitoring Program and the Emergency Department Information Exchange and clarifies that nothing shall prohibit the redisclosure of confidential information from the Prescription Monitoring Program or any data or reports produced by the Prescription Monitoring Program disclosed to the Emergency Department Information Exchange to a prescriber in an electronic report generated by the Emergency Department Information Exchange so long as the electronic report complies with relevant federal law and regulations governing privacy of health information.

HB 967 Military service members and veterans; expediting the issuance of credentials to spouses.

Chief patron: Willett

Summary as passed House:

Professions and occupations; expediting the issuance of credentials to spouses of military service members. Provides for the expedited issuance of credentials to the spouses of military service members who are (i) ordered to federal active duty under Title 10 of the United States Code or (ii) veterans who have left active-duty service within one year of the submission of an application to a board if the spouse accompanies the service member to the Commonwealth or an adjoining state or the District of Columbia. Under current law, the expedited review is provided more generally for active-duty members of the military who are the subject of a military transfer

to the Commonwealth. The bill also authorizes a regulatory board within the Department of Professional and Occupational Regulation or the Department of Health Professions or any other board in Title 54.1 (Professions and Occupations) to waive any requirement relating to experience if the board determines that the documentation provided by the applicant supports such waiver. The bill incorporates HB 930.

HB 1059 Certified registered nurse anesthetists; prescriptive authority.

Chief patron: Adams, D.M.

Summary as passed House:

Certified registered nurse anesthetists; prescriptive authority. Authorizes certified registered nurse anesthetists to prescribe Schedule II through Schedule VI controlled substances and devices to a patient requiring anesthesia, as part of the periprocedural care of the patient, provided that such prescribing is in accordance with requirements for practice by certified registered nurse anesthetists and is done under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry.

HB 1328 Offender medical and mental health information and records; exchange of information to facility.

Chief patron: Watts

Summary as passed House:

Exchange of offender medical and mental health information and records. Provides that a health care provider who has been notified that a person to whom he has provided services within the last two years is committed to a local or regional correctional facility shall, upon request by the local or regional correctional facility, disclose to the local or regional correctional facility where the person is committed any information necessary to ensure the continuity of care of the person committed. The bill also provides protection from civil liability for such health care provider, absent bad faith or malicious intent.

HB 1506 Pharmacists; initiating of treatment with and dispensing and administering of controlled substances.

Chief patron: Sickles

Summary as passed House:

Pharmacists; prescribing, dispensing, and administration of controlled substances. Allows a pharmacist to initiate treatment with and dispense and administer certain drugs and devices to persons 18 years of age or older in accordance with a statewide protocol developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health. The bill directs the Board of Pharmacy to establish such protocols by November 1, 2020, and to convene a workgroup to provide recommendations regarding the development of protocols for the initiating of treatment with and dispensing and administering of additional drugs and devices for persons 18 years of age and older. The bill also clarifies that an accident and sickness insurance policy that provides reimbursement for a service that may be legally performed by a licensed pharmacist shall provide reimbursement for the initiating of treatment with and dispensing and administration of controlled substances by a pharmacist when such initiating of treatment with or dispensing or administration is in accordance with regulations of the Board of Pharmacy.

SB 122 Teledentistry; definition, establishes requirements for the practice of teledentistry, etc.

Chief patron: Barker

Summary as passed Senate:

Teledentistry. Defines "teledentistry," establishes requirements for the practice of teledentistry and the taking of dental scans for use in teledentistry by dental scan technicians, and clarifies requirements related to the use of digital work orders for dental appliances in the practice of teledentistry. The bill incorporates SB 210 and SB 884.

Agenda Item: Petition for rulemaking

Included in your agenda package are:

A copy of a petition from Misty Mesimer on behalf of the Va. Dental Hygiene Program Directors' Consortium

Copy of comments on the petition

Copies of applicable sections of regulation

Staff note:

The Regulatory/Legislative Committee should review the petition, the comments, and applicable sections of law and regulation and make a recommendation to the Board.

Committee action:

1) Accept the petitioner's request and initiate rulemaking, or
2) Deny the petitioner's request for stated reasons

COMMONWEALTH OF VIRGINIA
Board of Dentistry

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

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

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

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

Petitioner's full name (Last, First, Middle initial, Suffix,)		
Mesimer, Misty, L on behalf of the Virginia Dental Hygiene Program Directors' Consortium		
Street Address 2130 Germanna Hwy, P.O. Box 1430	**Area Code and Telephone Number** 540-423-9823	
City Locust Grove	**State** Virginia	**Zip Code** 22508
Email Address (optional) mmesimer@germanna.edu	**Fax (optional)** 540-423-9827	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.
2.

18 VAC 60-30-10. Definitions.

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

March 2019

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

The Virginia Dental Hygiene Program Directors' Consortium who also includes program directors for American Dental Association Commission on Dental Accreditation approved dental assisting programs recommends the amending 18 VAC 60-30-10. Definitions. Dental

"Dental assistant I" means any ~~unlicensed~~ person certified in infection control procedures and radiation health and safety recognized by the Dental Assisting National Board (DANB) or the National Entry Level Dental Assistant (NELDA) under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.

The primary purpose of the Virginia Board of Dentistry is to protect the public. Dental practices must have strict infection control practices in order to protect patients and employees. Breaches in infection control techniques jeopardize the safety of patients and the community. In Oklahoma, an aseptic breach by an oral surgeons office resulted in exposure to more than 7000 patients. In New Jersey, there is documentation of a patient death. In both California and Georgia, there are cases of pediatric patients developing infections in the bone as a result of pulpotomy procedures where instruments were not correctly processed. All dental professionals have a responsibility to societal trust, nonmaleficence, and beneficence.

Historically, dental assistants have received on the job training, putting the responsibility of infection control training on the dentist. Establishing a requirement for calibrated training and certification would ensure that all assistants have received the same information. In reality, dental practitioners are not the people in the office responsible for infection control processes and procedures. The CDC reports that majority of dental offices have no written protocol, exposure control plans, or a designated infection control coordinator.

Frequent breaches in asepsis is a result from not following transportation requirements, not wearing correct personal protective equipment, incorrect instrument packaging and reprocessing practices, inadequate sterilization testing procedures, and incorrect waterline maintenance.

We urge the Board to require minimum credentials for the safety of the citizens in the Commonwealth. The recommended credentials are successful completion of the Infection Control Examination and Radiation Health and Safety portions of the Dental Assisting National Board Examination or the National Entry Level Dental Assistant examination. This will not only benefit patients by improving safety. It will improve the quality of oral health care delivered in Virginia. Dentists will be able to focus on the art and science of dentistry, treating their patients, and growing their practices. They will be able to delegate with confidence the most important task related to patient care – SAFETY. There is absolutely no reason why Virginia should wait for one case of morbidity or mortality to occur before taking action. We urge you be proactive, not reactive.

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

§ 54.1-2400. General powers and duties of health regulatory boards.

The general powers and duties of health regulatory boards shall be:

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

2. To examine or cause to be examined applicants for certification, licensure, or registration. Unless otherwise required by law, examinations shall be administered in writing or shall be a demonstration of manual skills.

3. To register, certify, license, or issue a multistate licensure privilege to qualified applicants as practitioners of the particular profession or professions regulated by such board.

Signature: Misty L. Mesimer, RDH, CDA

Date: 11/5/19

Christian Waterman, RDH, BSDH, BS
7702 Merrick Road
Richmond, VA 23294

12/23/19

Virginia Board of Dentistry
9960 Mayland Drive, Ste 300
Richmond, VA 23233-1463

Dear Honorable Board Members,

My name is Christian Waterman, RDH. I graduated from Virginia Tech with a BA in Psychology in 2014. I graduated from Virginia Commonwealth University School of Dentistry Dental Hygiene program in 2018. I have been working as a full-time clinical dental hygienist at Virginia Family Dentistry for the past 1.5 years. I held the position of Virginia Dental Hygiene Association (VDHA) Component 2-Greater Richmond Chair last year. I currently hold the position of VDHA Vice President. This testimony is in regards to 18 VAC 60-30-10 Definitions. I write in support of regulation of Dental Assistant I and II's to have educational requirements to comply standards of Infection Control as defined by the Centers for Disease Control and Prevention guidelines for preventing the transmission of infectious disease. I have attached current VDHA policies that provide support for change in regulation of dental assistants to the end of this document.

On-the-job training alone does not ensure there is an understanding of current standards and practices within infection control prior to the potential dental assistant starting to practice or be involved with live patients. I believe it is a high risk to allow a potential dental assistant to be involved or practice on patients prior to having a form of infection control education. A potential dental assistant may learn a given infection control standard at some point during on-the-job training, but the dental assistant has a higher likelihood of violating this standard if he or she is assisting prior to learning or demonstrating an understanding of the standard. This places patients at a higher risk of exposure to an infectious disease. Dentists and dental hygienists are typically using all allotted time for treating patients without having to teach at the same time. Of course dentists and dental hygienists can easily teach and provide rational for the clinical actions they are preforming at a given time, but I do not believe all the standards can be taught through one given action or over a reasonable amount of time while treating patients. On-the- job training requires more dentist-dental assistant interaction and takes away from potential dentist/dental hygienist-patient interaction. Dentists and dental hygienists are also placed at a higher risk. If a potential dental assistant, while participating in on-the-job training, does not have educational requirements to comply standards of Infection Control as defined by the Centers for Disease Control and Prevention guidelines for preventing the transmission of infectious disease and violates an infection control standard, exposing a patient, who is responsible? My thought is the dentist or dental hygienist will be held responsible for not ensuring the potential dental assistant had knowledge or understanding of the infection control standard prior to actively assisting. If the potential dental assistant claims the dentist or dental hygienist never informed him or her of the infection control standard that was violated, how would the dentist or dental hygienist prove otherwise?

Again, I support regulation of Dental Assistant I and II's to have educational requirements to comply with standards of Infection Control as defined by the Centers for Disease Control and Prevention guidelines for preventing the transmission of infectious disease. I appreciate the Board of Dentistry's past and current dedication and efforts to ensure patient and professional safety in the field of dentistry. If the Board of Dentistry has any questions or concerns, please feel free to contact me through email at watermanrdh@gmail.com.

Respectfully,

Christian Waterman, RDH, BSDH, BS
VDHA Vice President

R 4-05
STANDARD PRECAUTIONS
The Virginia Dental Hygienists' Association advocates the utilization of universal infection and exposure control precau- tions, and maximum work site safety and training to protect the health and safety of both practitioner and patient.

R 4-97
INFECTIOUS DISEASE TRANSMISSION GUIDELINES
The Virginia Dental Hygienists Association supports the Centers for Disease Control and Prevention's (CDC) guidelines for preventing the transmission of infectious disease.

Heather Fonda, CDA
14279 Deertrack Trail
Culpeper, VA. 22701

December 22, 2019

Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, VA. 23233-1463

Dear Honorable Board Members,

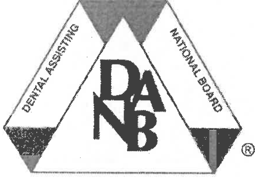
My name is Heather Fonda and I am writing in support of the proposed regulation change (petition 313) requiring dental assistants to be infection control and radiology certified through DANB or NELDA before they are allowed to practice in the Commonwealth of Virginia. Having graduated from an accredited dental assisting program as a CDA in December of 2018, I am well aware that dentistry, like other medical fields, has its potential for health altering hazards. My education and subsequent DANB certifications have provided me with the knowledge I need to protect my patients, myself, my team, and my community from injury and communicable disease. An on-the-job trained dental assistant without certifications, however, will likely have no idea what air borne or blood borne pathogens are, what standard precautions are, or even that there is a difference between disinfection and sterilization; all of which are paramount knowledge in the avoidance of maleficence. Patients and people, in general, have immense societal trust in their healthcare providers; dentists and their team members included. Let's not ever let anyone down! Allowing substandard practice is unacceptable. I ask you to please see the validity and criticality in this proposed change. The patients and dentists in the Commonwealth of Virginia deserve competent certified dental assistants.

Thank you for reading my testimony and for your consideration of this very important issue.

Should you need to contact me for further comment I can be reached via the following means:
(Cell) 703-966-2977
(Email) heatherfonda@yahoo.com

Very respectfully,

Heather Fonda



Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

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Executive Director
Cynthia C. Durley, M.Ed., MBA

December 25, 2019

Virginia Board of Dentistry
Attention: Sandra Reen, Executive Director
9960 Mayland Drive, Suite 300
Richmond, 23233
sandra.reen@dhp.virginia.gov

Dear Distinguished Members of the Virginia Board of Dentistry:

I am writing on behalf of the Dental Assisting National Board, Inc. (DANB) in connection with the petition filed on Virginia's Regulatory Town Hall Website on November 5, 2019, titled "Certification for dental assistants."

The petition asks the Virginia Board of Dentistry to amend its rules to require that dental assistants be "certified in infection control procedures and radiation health and safety recognized by the Dental Assisting National Board or the National Entry Level Dental Assistant."

It is our understanding that the petitioner is referring to DANB's Infection Control (ICE®) Exam and Radiation Health and Safety (RHS®) Exam, along with DANB's NELDA® certification.

As you may know, DANB is recognized by the American Dental Association (ADA) as the national certification board for dental assistants. DANB administers the nationally recognized Certified Dental Assistant™ (CDA®) certification program and four other certification programs for dental assistants, including the National Entry Level Dental Assistant (NELDA®) certification. DANB exams are recognized or required to qualify to perform dental assisting duties in 38 states, the District of Columbia, the Department of Veterans Affairs and the U.S. Air Force. Successful performance on DANB's RHS exam is currently recognized in Virginia as meeting the exam requirements for one pathway to qualify to perform radiography procedures.

DANB is a nonprofit organization whose mission is *to promote the public good by providing credentialing services to the dental community.* In accordance with that mission, DANB is fully supportive of all efforts to ensure that those who provide dental assisting services to the public are competent and qualified to do so. As such, DANB supports the current petition and encourages the Virginia Board of Dentistry to reduce the risk of infection or injury to dental patients and dental team members by requiring that dental assistants demonstrate competence in areas of knowledge that are critical to patient safety through successful performance on high-quality standardized assessments, developed in accordance with best practices, such as DANB's RHS and ICE exams.

To assist the Virginia Board of Dentistry in considering this petition, DANB is providing the following information about the exams and certification that are referenced in the petition:

444 N. Michigan Ave., Suite 900, Chicago, IL 60611-3985 • 1-800-367-3262 • Fax: 312-642-8507 • danbmail@danb.org • www.danb.org

About DANB Exams

DANB exams are developed in accordance with nationally accepted test development standards. DANB's CDA and Certified Orthodontic Assistant (COA®) certification programs are nationally accredited by the National Commission for Certifying Agencies (NCCA) and internationally accredited by the International Accreditation Service (IAS) to the ISO 17024 standard for organizations that certify personnel. These national and international accreditations encompass evaluation of DANB's CDA certification component exams, which include the RHS and ICE exams.

DANB exams are administered at more than 250 proctored, secure computerized testing sites nationwide (through Pearson VUE), including eight in Virginia. Pearson VUE testing centers use standardized, rigorous security and proctoring procedures, ensuring that each candidate has a reasonably similar testing experience and protecting the integrity of exam results by minimizing opportunities for dishonest test-taking behavior.

DANB's Infection Control (ICE) Exam

DANB's ICE exam assesses a dental assistant's knowledge-based competence in dental infection control practices and is a component of the National Entry Level Dental Assistant (NELDA®), Certified Dental Assistant™ (CDA®) and Certified Orthodontic Assistant (COA®) certification programs. There are no eligibility requirements to take the ICE exam, when it is taken as a standalone exam. The ICE exam is a 75-minute, 100-question multiple choice test addressing the following content areas:

I. Standard Precautions and the Prevention of Disease Transmission (20%)

II. Prevention of Cross-contamination during Procedures (34%)

III. Instrument/Device Processing (26%)

IV. Occupational Safety/Administrative Protocols (20%)

A more detailed content outline for the ICE exam and suggested references for study are provided as Attachment 1.

DANB's Radiation Health and Safety (RHS) Exam

DANB's RHS exam assesses a dental assistant's knowledge-based competence in radiographic safety and technique and is a component of the National Entry Level Dental Assistant (NELDA®) and Certified Dental Assistant™ (CDA®) certification programs. There are no eligibility requirements to take the RHS exam, when it is taken as a standalone exam. The RHS Exam is a 75-minute, 100-question multiple choice test addressing the following content areas:

I. Expose and Evaluate (26%)

II. Quality Assurance and Radiology Regulations (21%)

III. Radiation Safety for Patients and Operators (31%)

IV. Infection Control (22%)

A more detailed content outline for the RHS exam and suggested references for study are provided as Attachment 2.

National Entry Level Dental Assistant (NELDA) Certification

DANB's NELDA certification provides entry-level dental assistants—those not yet qualified for DANB's Certified Dental Assistant (CDA) certification—with the opportunity to demonstrate mastery of foundational concepts and of knowledge critical to patient health and safety. NELDA certification consists of three component exams: DANB's ICE and RHS Exams, detailed on the preceding page, and the Anatomy, Morphology and Physiology (AMP) Exam.

There are no requirements to take each of the NELDA component exams, but to earn NELDA certification, candidates must meet the requirements of one of four eligibility pathways. All NELDA certifications require the applicant to hold a DANB-accepted hands-on CPR, BLS or ACLS card.

Education Pathways

Pathway I: Graduate of a DANB-accepted dental assisting program for NELDA certification (located within a post-secondary institution that is accredited by an organization recognized by the U.S. Department of Education) AND high school graduation or equivalent

Pathway II: Graduate of a U.S. Department of Labor Job Corps dental assisting program

Pathway III: Graduate of a DANB-accepted dental assisting program for NELDA certification offered within a high school that is recognized in the U.S. education system; this dental assisting program must encompass at least one semester of dental assisting curriculum (not a survey of all health occupations) AND high school graduation or equivalent

Work Experience Pathway

Pathway IV: A minimum of 300 hours and up to 3,000 hours of work experience as a dental assistant accrued over a period of at least two months and no more than three years AND high school graduation or equivalent

DANB's NELDA certification can be held for up to four years, after which NELDA certificants are encouraged to earn CDA certification. Additional information about the NELDA, certification, including renewal requirements, can be found in Attachment 3.

An Additional Note of Clarification About the Term "Certification"

"Certification" is a voluntary process by which a non-governmental entity grants a time-limited recognition and use of a credential to an individual after verifying that he or she has met predetermined and standardized criteria. *Typically, certification programs include education and/or experience requirements and passing a certification exam* built from a weighted exam outline based on the results of a formal job analysis. Only those who meet all certification requirements (including periodic renewal requirements) are authorized to use a specific certification mark, such as CDA or NELDA. For example, a person named Sue Smith who has earned DANB's NELDA certification is authorized to hold herself out as "Sue Smith, NELDA."

Although, like certification exams, DANB's ICE and RHS exam blueprints are developed based on the results of a formal job analysis, they are not certifications. Rather, they are two of three component exams that make up DANB's CDA certification and DANB's NELDA certification. A

person who passes the ICE or RHS exam as a standalone exam earns a certificate of knowledge-based competence but is not “certified.”

One feature that distinguishes an exam leading to a certificate of knowledge-based competence, like the standalone ICE and RHS exams, from a certification is that the ICE and RHS exams do not have eligibility prerequisites. In addition, passing either or both of these exams does not result in the individual being awarded a certification mark (that is, a person may not call herself "Sue Smith, RHS") as one would receive upon earning a professional certification like DANB's CDA or NELDA certifications (e.g., "Sue Smith, CDA" or "Sue Smith, NELDA"). Furthermore, unlike certifications, the certificates earned by passing the individual RHS or ICE exams do not expire and are not subject to renewal.

Though the petition under consideration uses the word “certification” to refer to DANB’s ICE and RHS exams, it would be more accurate to avoid referring to these exams as “certifications” in any future rulemaking proposal that might mention these exams. If there are any questions about using these terms accurately, I will be happy to provide more information.

If the Virginia Board of Dentistry would like any additional information about DANB’s ICE and RHS component exams or NELDA certification program, please don’t hesitate to contact me at klandsberg@danb.org or 1-800-367-3262, ext. 431. I will be happy to provide any information that may be useful for the Board’s discussion in advance of the Board’s March 13, 2020 meeting.

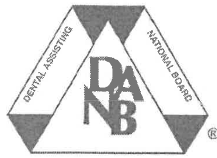
Thank you for your consideration.

Sincerely,

Katherine Landsberg
Director, Government Relations

Cc: Cynthia C. Durley, M.Ed., MBA, DANB Executive Director
Johnna Gueorguieva, Ph.D., DANB Chief Credentialing and Research Officer

Attachment 1
DANB Comments, 12/25/2019



Dental Assisting National Board, Inc.
Measuring Dental Assisting Excellence®

Infection Control (ICE®)

Exam Blueprint and Suggested References

The ICE® exam is a component of the National Entry Level Dental Assistant (NELDA®), Certified Dental Assistant™ (CDA®) and Certified Orthodontic Assistant (COA®) certification programs.

NELDA component exams

Anatomy, Morphology and Physiology (AMP)

Radiation Health and Safety (RHS®)

Infection Control (ICE)

CDA component exams

General Chairside Assisting (GC)

Radiation Health and Safety (RHS)

Infection Control (ICE)

COA component exams

Orthodontic Assisting (OA)

Infection Control (ICE)

Effective 01/01/2018

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Attachment 1

ICE

Exam Blueprint Overview

ICE Exam Weighting by Sub-Content Area

I. Standard Precautions and the Prevention of Disease Transmission (20%)

II. Prevention of Cross-contamination during Procedures (34%)

III. Instrument/Device Processing (26%)

IV. Occupational Safety/Administrative Protocols (20%)

ICE Exam Administration

- Number of Questions: 100
- Time for Exam: 75 minutes
- Tutorial Time: 5 minutes
- Comment Time: 5 minutes

DANB uses computer adaptive testing (CAT) to present questions to candidates. Each candidate starts with a question at or around the pass point. If the candidate gets a question correct, the next question will be slightly harder. If the question is incorrectly answered, the next question will be slightly easier. Question selection takes into account the content of the question, as each candidate is presented with the same percentage of questions from each domain on the exam outline. Using this method of testing, DANB can more accurately pinpoint a candidate's ability level. The average candidate will get around 50% of the questions correct and around 50% of the questions incorrect. The candidate's score is based on the difficulty of the questions that were answered correctly.

ICE Exam Blueprint

DANB exams are created using the exam blueprint, which is annually reviewed by subject matter experts. The blueprint is developed through a rigorous content validation study (CVS) and validated by DANB certificants using a job analysis survey. A CVS is conducted every five to seven years to ensure the blueprint is consistent with current clinical practices. DANB's Board of Directors approves all updates to DANB exam blueprints.

This exam references the following (see p. 6 for full citations for these references):

- Centers for Disease Control and Prevention. Guidelines for Infection Control in Dental Health-Care Settings-2003
- Centers for Disease Control and Prevention. Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care
- Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens (BBP) standard
- OSHA Hazard Communication standard

Sub-Content Area I: Standard Precautions and the Prevention of Disease Transmission (20%)

A. **Recognize infection diseases and their relationship to patient and occupational risk.**
   1. Modes of disease transmission.
   2. Needs for immunization against infectious diseases (e.g., hepatitis, B, influenza).

B. **Demonstrate understanding of how to review a medical history to prevent adverse reactions during dental care (e.g., adverse reactions to latex or vinyl).**

C. **Demonstrate understanding of proper hand hygiene as performed before, during and after oral surgery and intraoral procedures, including but not limited:**
   1. Products (e.g., anti-microbial, anti-bacterial, alcohol rub).
   2. Skin/nail care.
   3. Techniques (e.g., length of time, sequencing).
   4. Select appropriate hand hygiene protocol.

D. **Describe how to protect the patient and operator by using personal protective equipment (PPE)**
   1. Selection and sequence of placing, removing and disposal of PPE according to the procedures(s) and areas, including but not limited to:
      a. Instruments/device processing.
      b. Laboratory.
      c. Oral surgery.

   d. Radiology.
   e. Treatment room.
2. Dispose of or launder contaminated clothing according to the OSHA Bloodborne Pathogens standard.

E. Demonstrate understanding of how to protect the patient and operator through the reduction or aerosol, droplets and spatter, including but not limited to:

1. Barrier techniques.
2. Dental dams.
3. Evacuation techniques.
4. Patient eyewear.
5. Pre-procedural mouth rinses.

Sub-Content Area II: Prevent Cross-contamination during Procedures (34%)

A. Identify modes of disease transmission.

B. Demonstrate understanding of how to maintain aseptic conditions to prevent cross-contamination for procedures and services.

1. Clean and disinfect for breakdown and setup of clinical treatment areas, the laboratory, and equipment.
   a. Prepare and use chemical disinfection for breakdown and setup.
   b. Protect the patient and operator using barrier techniques.
   c. Prepare tray setups (e.g., single-use devices [SUD], single unite dosing, aseptic retrieval).
   d. Maintain and monitor dental unit water lines.
   e. Clean and maintain evacuation lines and traps.
2. Clean and disinfect radiological areas and equipment to protect the patient and operator.
3. Use aseptic techniques for acquiring and processing conventional and digital radiographic images.
4. Select proper methods of disinfection for impressions and dental appliances.
5. Dispose of biohazardous and other waste according to federal regulations.

Sub-Content Area III: Instrument/Device Processing (26%)

A. Demonstrate understanding of processing reusable dental instruments and devices.

1. Transport contaminated instruments/devices to prevent cross-contamination.
2. Use work flow patterns to avoid cross-contamination of instruments/devices and supplies.
3. Clean and maintain dental instruments/devices and supplies prior to sterilization
4. Prepare and sue chemical agents for cleaning instruments/devices instructions.
5. Prepare dental instruments/devices and supplies for sterilization.
6. Select the system for sterilization.
7. Select the system for sterilization monitoring (e.g., biological monitoring, chemical integrators).
8. Package and label instruments/devices for sterilization.
9. Load and unload the sterilizer.
10. Store and maintain integrity of sterile instruments/devices and supplies.

B. Demonstrate understanding of how to monitor and maintain processing equipment and sterilizers (e.g., ultrasonic cleaner, autoclave).

1. Interpret sterilization monitoring devices, errors and results.
2. Respond to equipment malfunctions.

Sub-Content Area IV: Occupational Safety/Administrative Protocols (20%)

A. Demonstrate understanding of occupational safety standards and guideline for personnel.

1. OSHA Bloodborne Pathogens standard as it applies to, but not limited to:
   a. Engineering and work practice controls.
   b. Needle and sharps safety.
   c. Record keeping and training.
   d. Sharps exposure and post-exposure protocol (e.g., first aid procedures).

2. OSHA Hazard Communication standard as it applies to, but not limited to:
   a. Chemical exposure/hazard (e.g., amalgam, nitrous oxide, laser) and first aid.
   b. Engineering and work practice controls.
   c. Safety data sheets (SDS).
   d. Secondary containers.
3. CDC Guidelines for Infection Control in Dental Health-Care Settings – 2003.
4. CDC Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care, 2016.
5. Federal regulations (e.g., EPDA, FDA).

B. Demonstrate understanding of how to maintain and document programs/policies for infection control and safety, including but not limited to:

1. Exposure control plan.
2. Infection control breaches.
3. Quality assurance (quality improvement).
4. Sterilization logs/records.
5. Training records.

ICE Exam Suggested References

DANB exam committees use the following textbooks and reference materials to develop this exam. This list does not include all the available textbooks and materials for studying for this exam; these are simply the resources that exam committee subject matter experts determined as providing the most up-to-date information needed to meet or surpass a determined level of competency for this exam. Any one reference will likely not include all the material required to study to take the exam.

This list is intended to help prepare for this exam. It is not intended to be an endorsement of any of the publications listed. You should prepare for DANB certification and component exams using as many different study materials as possible.

Textbook References

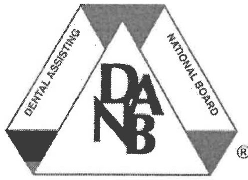
1. Bird, Doni L., and Debbie S. Robinson. *Essentials of Dental Assisting*. 5th ed. St. Louis, MO: Elsevier/Saunders, 2013.
2. Bird, Doni L., and Debbie S. Robinson. *Modern Dental Assisting*. 10th and 11th ed. St. Louis, MO: Elsevier/Saunders, 2012 and 2015.
3. Miller, Chris and Charles J. Palenik. Infection Control and Management of Hazardous Materials for the Dental Team. 5th ed. Mosby, 2013.
4. Molinari, John and Jennifer Harte. *Cottone's Practical Infection Control in Dentistry.* 3rd ed. Lippincott, 2010
5. Phinney, Donna J., and Judy H. Halstead. *Dental Assisting: A Comprehensive Approach*. 3rd and 4th ed. Clifton Park, NY: Delmar, 2008 and 2013.

Organizational References

1. The Organization for Safety and Asepsis (OSAP). www.osap.org.
   - *From Policy to Practice: OSAP's Guide to the Guidelines*
   - *OSAP's OSHA & CDC Guidelines: Interact Training System*
2. The American Dental Assistants Association (ADAA). www.dentalassistant.org
   - *Infection Control in the Dental Office: A Review for a National Infection Control Exam* (Course #0906)
   - *Guidelines for Infection Control in Dental Health Care Settings* (Course #1305)
3. The DALE Foundation. www.dalefoundation.org.
   - *DANB ICE Review*
   - *DANB ICE Practice Test*
   - *Glossary of Dental Terms*
   - *CDEA module: Understanding CDC's Summary of Infection Prevention Practice in Dental Settings: Basic Expectations for Safe Care*

(list continues next page)

4. Centers for Disease Control and Prevention (CDC). www.cdc.gov
    - *Guidelines for Infection Control in Dental Health-Care Settings — 2003* (MMWR, Vol. 52, RR 17)
    - *Centers for Disease Control and Prevention. Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health; 2016*
    - *Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis* (MMWR, Vol. 50, RR 11)
5. U.S. Department of Labor, Occupational Safety and Health Administration (OSHA). www.osha.gov.
    - *Hazard Communication Guidelines for Compliance* (Publication 3111)
    - *Hazard Communication Standard* (Code of Federal Regulations #29, Part 1910)
    - *Bloodborne Pathogens Standard* (1910.1030)



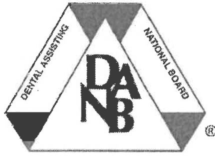
Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

State Regulations

Each state's dental board implements regulations and establishes rules for delegating legally allowable duties to dental assistants. Passing one or more of the DANB component exams or earning DANB certification only conveys authority to perform these duties in those states that recognize these exams or this certification as meeting state dental assisting requirements. This information is at www.danb.org.

Attachment 2
DANB Comments, 12/25/2019



Dental Assisting National Board, Inc.
Measuring Dental Assisting Excellence®

Radiation Health and Safety (RHS®)

Exam Outline and Suggested References

The RHS® exam is a component of the National Entry Level Dental Assistant (NELDA®) and Certified Dental Assistant™ (CDA®) certification programs.

NELDA component exams

Anatomy, Morphology and Physiology (AMP)
Radiation Health and Safety (RHS)
Infection Control (ICE®)

CDA component exams

Radiation Health and Safety (RHS)
Infection Control (ICE)
General Chairside Assisting (GC)

Effective 01/01/2018

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Attachment 2

RHS

Exam Outline Overview

RHS Exam Weighting by Domain

I. Expose and Evaluate (26%)

II. Quality Assurance and Radiology Regulations (21%)

III. Radiation Safety for Patients and Operators (31%)

IV. Infection Control (22%)

RHS Exam Administration

- Number of Questions: 100
- Time for Exam: 75 minutes
- Tutorial Time: 5 minutes
- Comment Time: 5 minutes

DANB uses computer adaptive testing (CAT) to present questions to candidates. Each candidate starts with a question at or around the pass point. If the candidate gets a question correct, the next question will be slightly harder. If the question is incorrectly answered, the next question will be slightly easier. Question selection takes into account the content of the question, as each candidate is presented with the same percentage of questions from each domain on the exam outline. Using this method of testing, DANB can more accurately pinpoint a candidate's ability level. The average candidate will get around 50% of the questions correct and around 50% of the questions incorrect. The candidate's score is based on the difficulty of the questions that were answered correctly.

RHS Exam Outline

DANB exams are created using the exam outline, which is annually reviewed by subject matter experts (e.g., Certified Dental Assistant™ [CDA®] certificants and dentists). The outline is developed using a Content Validation Study (CVS), which includes a job analysis survey where practicing CDA certificants are surveyed about how often tasks are performed and how important competent performance of tasks is to the health and safety of the public. This study is conducted every five to seven years to ensure the outline is consistent with current clinical practices. DANB's Board of Directors approves all updates to DANB exam outlines. The RHS exam measures a candidate's knowledge of national radiographic imaging practices.

NOTE: DANB uses "image receptor" to refer to conventional film or sensors used for digital imaging.

Domain I: Expose and Evaluate (26%)

A. Assessment and Preparation

1. Describe patient preparation for radiographic exposures (e.g., inspect the patient's head and neck for removable appliances and foreign objects).
2. Select radiographic technique.
   a. Describe use and purpose of intraoral and extraoral radiographic images, including but not limited to:
      i. periapical.
      ii. bitewing.
      iii. occlusal.
      iv. panoramic.
      v. cephalometric and other extraoral views.
   b. Select radiographic survey to examine or view conditions, teeth or landmarks.
   c. Describe technique modifications based on anatomical variations.
3. Select equipment for radiographic technique.
   a. Describe purpose or advantage of accessories.
   b. Select image receptor size.
   c. Describe purpose and advantage of double (dual) film packets.

B. Acquire

1. Describe how to acquire radiographic images using various techniques.
   a. Define radiographic exposure concepts.
   b. Intraoral
      i. Define factors that influence quality of the radiographic image.
      ii. Compare paralleling and bisecting angle techniques (e.g., advantages, disadvantages).
      iii. Describe the parts and functions of radiographic film packets and digital image receptors.
   c. Extraoral
      i. Identify function and maintenance of film cassettes and intensifying screens.
      ii. Describe exposure technique (i.e., patient positioning).
         a) Panoramic radiography.
         b) Cephalometric radiography.
      iii. Demonstrate basic understanding of CBCT (cone-beam computed tomography).
2. Demonstrate basic knowledge of digital radiography.
   a. Advantages/disadvantages.
   b. Handling errors.
   c. Image receptors.
3. Demonstrate basic knowledge of conventional film processing.
   a. Functions of processing solutions.
   b. Process exposed intra- and extraoral films using automatic processors.
   c. Procedures for processing films.

C. Evaluate

1. Evaluate radiographic images for diagnostic value.
   a. Describe features of a diagnostically acceptable radiographic image.
   b. Identify and describe how to correct errors related to acquiring intraoral radiographic images.
   c. Identify and correct radiographic processing errors.
   d. Identify and describe how to correct improper film handling errors.
   e. Identify and describe how to correct errors related to acquiring panoramic radiographic images.
2. Mount and label radiographic images.
   a. Describe how to mount radiographic images using facial (buccal and labial) view.
      i. Identify anatomical landmarks that aid in mounting.

ii. Match tooth views to tooth mount windows.

iii. Demonstrate understanding of radiographic image viewing techniques.

b. Identify anatomical structures, dental materials and patient information observed on radiographic images (e.g., differentiating between radiolucent and radiopaque areas).

D. Patient Management

1. Describe techniques for patient management before, during and after radiographic exposure (e.g., patients with special needs).
2. Describe techniques for patients with a severe gag reflex.

Domain II: Quality Assurance and Radiology Regulations (21%)

A. Quality Assurance

1. Evaluate film storage areas.
2. Identify and describe how to correct errors related to improperly storing radiographic film.
3. Describe how to prepare, maintain and replenish automatic processor solutions.
4. Identify conditions required for film processing.
5. Describe how to implement quality assurance procedures.

B. Radiology Regulations

1. Describe how to prepare radiographic images for legal requirements, viewing, duplication and transfer.
2. Describe how to store chemical agents used in dental radiography procedures according to regulatory agencies, in compliance with the Occupational Safety and Health Administration (OSHA) Hazard Communication Standard.
3. Describe how to dispose of chemical agents and other materials used in dental radiography procedures.

Domain III: Radiation Safety for Patients and Operators (31%)

A. Identify current American Dental Association (ADA) guidelines for patient selection and limiting radiation exposure.

B. Apply the principles of radiation protection and hazards in the operation of radiographic equipment.

1. Factors affecting x-ray production (e.g., kVp, mA, exposure time).
2. X-radiation characteristics.
3. X-ray machine factors that influence radiation safety (e.g., filtration, shielding, collimation, PID [cone] length).
4. X-radiation physics.
   a. Primary radiation.
   b. Scatter (secondary) radiation.
5. Protocol for suspected x-ray machine malfunctions.

C. Demonstrate knowledge of patient safety measures to provide protection from x-radiation.

1. Major causes of unnecessary x-radiation exposure.
2. X-radiation biology:
   a. short- and long-term effects of x-radiation on cells and tissues.
   b. concepts of x-radiation dose and effective dose.
3. Reduce x-radiation exposure to patients (ALARA).

D. Address patient radiation concerns (e.g., informed consent, patient refusal).

E. Identify operator safety measures to provide protection from x-radiation.

1. Sources of x-radiation to operators/other staff while exposing image receptors.
2. Safety measures to reduce operator x-radiation exposure.
3. X-radiation physics and biology pertaining to operator exposure.

F. Describe techniques for monitoring individual x-radiation exposure.

1. ALARA principle as related to operator safety.
2. Function of a personal monitoring device.

Domain IV: Infection Control (22%)

A. Standard Precautions for Equipment

1. Demonstrate understanding of infection control techniques used to minimize cross-contamination during radiographic procedures according to ADA, Centers for Disease Control and Prevention (CDC) and OSHA guidelines for conventional and digital radiography.
2. Demonstrate understanding of barriers used to minimize cross-contamination during radiographic procedures according to ADA, CDC and OSHA guidelines for conventional and digital radiography.

B. Standard Precautions for Patients and Operators

1. Demonstrate understanding of infection control for radiographic procedures according to ADA, CDC and OSHA guidelines for conventional and digital radiography.
2. Describe infection control techniques used during radiographic processing, following ADA, CDC and OSHA guidelines.

RHS Exam Suggested References

DANB exam committees use the following textbooks and reference materials to develop this exam. This list does not include all the available textbooks and materials for studying for this exam; these are simply the resources that exam committee subject matter experts have determined provide the most up-to-date information needed to meet or surpass a determined level of competency for this exam. Any one reference will likely not include all the material required to study to take and pass the exam.

This list is intended to help prepare for this exam. It is not intended to be an endorsement of any of the publications listed. You should prepare for DANB certification and component exams using as many different study materials as possible.

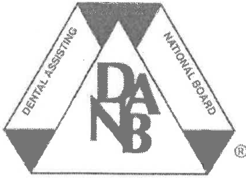
Textbook References

1. Bird, Doni L., and Debbie S. Robinson. *Essentials of Dental Assisting*. 5th ed. St. Louis, MO: Elsevier/Saunders, 2013.
2. Bird, Doni L., and Debbie S. Robinson. *Modern Dental Assisting*. 11th and 12th ed. St. Louis, MO: Elsevier/Saunders, 2015 and 2017.
3. Ianucci, Joen M., and Laura J. Howerton. *Dental Radiography Principles and Techniques* (with CD-ROM). 5th ed. St. Louis, MO: Elsevier/Saunders, 2017.
4. Johnson, Orlen N., and Evelyn M. Thomson. *Essentials of Dental Radiography for Dental Assistants and Hygienists*. 9th ed. Upper Saddle River, NJ: Pearson Education, 2012.
5. Miller, Chris H. *Infection Control and Management of Hazardous Materials for the Dental Team*. 5th and 6th ed. St. Louis, MO: Elsevier/Mosby, 2014 and 2018.
6. Phinney, Donna J., and Judy H. Halstead. *Dental Assisting: A Comprehensive Approach*. 5th ed. Clifton Park, NY: Delmar Cengage Learning, 2013.

Organizational References

1. Centers for Disease Control and Prevention (CDC). www.cdc.gov.
   - *Guidelines for Infection Control in Dental Health-Care Settings — 2003* (MMWR, Vol. 52, RR 17)
   - *Centers for Disease Control and Prevention. Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health; 2016*
2. U.S. Department of Labor, Occupational Safety and Health Administration (OSHA). www.osha.gov.
   - *Hazard Communication Standard* (Code of Federal Regulations #29, Part 1910)
   - *Bloodborne Pathogens Standard* (1910.1030)
3. American Dental Assistants Association (ADAA). www.dentalassistant.org.
   - *An Introduction to Basic Concepts in Dental Radiography* (Course #715)

4. The DALE Foundation. www.dalefoundation.org.
    - *DANB RHS Review*
    - *Conventional Dental Radiography Review*
    - *DANB RHS Practice Test*
    - *Glossary of Dental Terms*



Dental Assisting National Board, Inc.

Measuring Dental Assisting Excellence®

State Regulations

Each state's dental board implements regulations and establishes rules for delegating legally allowable duties to dental assistants. Passing one or more of the DANB component exams or earning DANB certification only conveys authority to perform these duties in those states that recognize these exams or this certification as meeting state dental assisting requirements. This information is available at www.danb.org.

Dental Assisting National Board, Inc.
Measuring Dental Assisting Excellence®

NELDA®
National Entry Level Dental Assistant Certification Program Overview

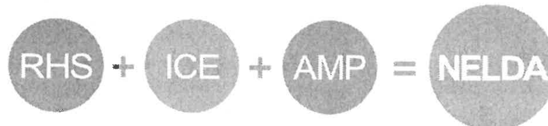
DANB has developed a certification program for entry-level dental assistants — the National Entry Level Dental Assistant (NELDA) certification program. The NELDA certification program is an additional rung on the dental assisting career ladder, with eligibility pathways for individuals who do not yet qualify to earn DANB's Certified Dental Assistant™ (CDA®) certification.

NELDA Component Exams

A candidate must pass the three NELDA component exams within a three-year period to be eligible for NELDA certification. Exam questions are multiple-choice.

- Radiation Health and Safety (RHS®) — 100 questions
- Infection Control (ICE®) — 100 questions
- Anatomy, Morphology and Physiology (AMP) — 105 questions

Candidates may take the three component exams in one administration (the NELDA exam) or may take each exam separately, in any order. Candidates also have the option of taking the RHS and ICE exams together in a combined administration.



Eligibility Requirements

There are no eligibility requirements to take the RHS, ICE and AMP exams. However, a candidate must meet eligibility requirements to earn NELDA certification after passing the three exams.

All eligibility pathways to earn certification require candidates to hold a current DANB-accepted, hands-on CPR, BLS or ACLS card.

Education Pathways

Pathway I: Graduate of a DANB-accepted dental assisting program for NELDA certification (located within a post-secondary institution that is accredited by an organization recognized by the U.S. Department of Education) AND high school graduation or equivalent

Pathway II: Graduate of a U.S. Department of Labor Job Corps dental assisting program

Pathway III: Graduate of a DANB-accepted dental assisting program for NELDA certification offered within a high school that is recognized in the U.S. education system; this dental assisting program must encompass at least one semester of dental assisting curriculum (not a survey of all health occupations) AND high school graduation or equivalent

Work Experience Pathway

Pathway IV: A minimum of 300 hours and up to 3,000 hours of work experience as a dental assistant accrued over a period of at least two months and no more than three years AND high school graduation or equivalent

Renewal Requirements

- NELDA certificants may annually renew the certification for up to four years
- To renew, certificants must
  - Earn 6 continuing dental education credits annually, in clinical topics, of which one must be in the OSHA Bloodborne Pathogens standard and two must be in infection control
  - Hold current a DANB-accepted, hands-on CPR, BLS or ACLS card
  - Answer Background Information Questions
  - Submit the annual NELDA renewal fee (currently $50)

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- After four years, to maintain DANB certification, an individual who holds NELDA certification must earn one of DANB's other national certifications— CDA, Certified Orthodontic Assistant (COA®), Certified Preventive Functions Dental Assistant (CPFDA®), or Certified Restorative Functions Dental Assistant (CRFDA®)

NELDA certificants may use the "NELDA" certification mark on a résumé, on a business card, on a website, in a book or publication, and in other print and electronic media. A certificant may also display the mark on a nametag or uniform worn during the rendering or promoting of services and on a wall plaque present at the place where he or she renders or promotes the services. Former NELDA certificants who do not renew their certification are no longer authorized to represent that they hold NELDA certification and may not use the certification mark "NELDA" following their names or represent themselves to the public as being a NELDA certificant, in any manner. Emeritus status is not available for NELDA certificants.

Background, Program Development and Launch

DANB's initiation of a certification program for entry-level dental assistants was influenced by several factors:

- Each state defines its own regulations and requirements for dental assistants, and in most states, there are no eligibility requirements to work as an entry-level dental assistant; however, entry-level assistants may be entrusted with tasks that affect patient health and safety, such as radiography and instrument sterilization
- In a 2011 DANB survey, state dental boards and state dental associations expressed a need for a valid and reliable way to measure knowledge-based competence of dental assistants who have completed some type of dental assisting education but who do not yet meet the eligibility requirements to qualify for competence testing through DANB's CDA certification program

In considering the structure and content of a competence measurement solution for entry-level dental assistants, DANB reviewed:

- The lists of duties that each state allows entry-level dental assistants to perform
- Oral healthcare concepts that the Commission on Dental Accreditation (CODA) considers to be "foundational" in dental assisting education

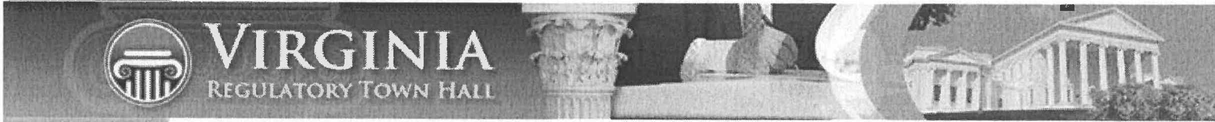
DANB's NELDA certification program includes component exams in the fundamental areas of dental radiation health and safety; infection control; and anatomy, morphology and physiology. The first two areas are critical to patient safety, and the third assesses knowledge of basic concepts that serve as a strong foundation required to perform most other dental assisting duties. States differ greatly in which chairside functions are allowed to be performed by entry-level dental assistants; consequently, DANB's Board of Directors has determined that specific knowledge-based competencies associated with chairside functions will continue to be tested by DANB's higher-level certification programs: CDA, COA, CPFDA, and CRFDA.

In June 2013, DANB invited representatives from select communities of interest to a forum about the proposed NELDA certification program. In August 2013, DANB solicited additional feedback from relevant stakeholder groups. DANB's Board reviewed the stakeholder feedback at its January 2014 meeting, and DANB launched the NELDA certification program in April 2015.

About DANB

DANB is recognized by the American Dental Association as the national certification board for dental assistants. DANB's mission is to promote the public good by providing credentialing services to the dental community. For those dental assistants who meet the eligibility and exam requirements, DANB certifications include the National Entry Level Dental Assistant (NELDA®), Certified Dental Assistant™ (CDA®), Certified Orthodontic Assistant (COA®), Certified Preventive Functions Dental Assistant (CPFDA®) and Certified Restorative Functions Dental Assistant (CRFDA®). In addition to these national certifications, DANB offers certificates of knowledge-based competency in Radiation Health and Safety (RHS®); Infection Control (ICE®); Coronal Polish (CP); Sealants (SE); Topical Anesthetic (TA); Topical Fluoride (TF); Anatomy, Morphology and Physiology (AMP); Impressions (IM); Temporaries (TMP); and Isolation (IS).

DANB's CDA and COA certification programs are accredited by the National Commission for Certifying Agencies and are also accredited by the International Accreditation Service (IAS) to the ISO 17024 Standard for personnel certification. Currently, there are more than 37,000 DANB certificants nationwide, and DANB certifications and certificates of knowledge-based competence are recognized or required in 38 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs. Passing DANB's exams demonstrates a dental assistant's competence in areas that are important to the health and safety of oral healthcare workers and patients alike.



Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter **Regulations Governing the Practice of Dental Assistants [18 VAC 60 - 30]**

29 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Hannah Tatum 12/4/19 2:13 pm

I agree with this petition

I believe it is important for all dental assistants to have their radiation and health safety and their infection control. That way the dental assistants are aware of their surroundings and know how to protect themselves and others.

CommentID: **77034**

Commenter: Ashanty Ogborn, Dental Assisting Student 12/4/19 2:14 pm

I agree

Infection control is important enough to require certification. It's not just enough to know to wash your hands between patients and to wear a mask. We need to know how infection is transmitted and what needs to be done to prevent it. It's also important to know the effects of radiation and how to minimize it's exposure. Knowing that the staff at any dental (or medical) office is certified in infection control and radiation health and safety would give any patient peace of mind.

CommentID: **77035**

Commenter: Monique Redcross 12/4/19 2:20 pm

I Agree!!!

Me knowing what I know now from taking the Dental Assisting course being if I were a patient I would want any assistant working on me to be certified or to at least have the knowledge of both Infectious Control and Radiation Health Safety. I want to be able to walk into a office and now that I am safe because I am putting my life in someone else hands. So by me feeling this way I know my patients feel the same as well. They deserve the fairness and respect that I would want as a patient. So I agree.

CommentID: **77036**

Commenter: Kimberly Little ,ECPI University 12/10/19 3:44 pm

All Dental Assistants should be certified in Infection Control ,this law should be pass.

CommentID: **77744**

Commenter: Kim Richardson, ECPI University 12/10/19 6:33 pm

Infection Control and Radiation Health Safety

It is a disservice to dental assistants and more importantly to the public, to have uneducated assistants that are ignorant to the dangers they are a part of each and every day as they provide care to the patient. The Infection Control certification and Radiation Health Safety certification through DANB is a very logical approach to a solution. I believe that if the public were truly aware of the critical nature of this issue, they would have grave concern when seeking dental treatment. The organisms we deal with in today's world of healthcare in general are far more infectious and life threatening than those of the "good old days". I believe that our approach to this should no longer be one that was appropriate for the "good old days".

CommentID: **77803**

Commenter: Delia Phelps 12/10/19 8:52 pm

Certification for dental assistant infection control.

I agree with this petition

CommentID: **77831**

Commenter: Rebekah Marrero Ortiz 12/10/19 9:23 pm

I agree

I agree

CommentID: **77840**

Commenter: Melanie Laronda, RDH, BS 12/11/19 3:26 pm

Certification for Dental Assistants

As a former clinical dental hygiene instructor, I agree that the importance of both radiation safety and infection control protocol needs to be part of the entire dental team's education.

CommentID: **78203**

Commenter: Kimberly A Arny 12/11/19 9:52 pm

AGREE

If Virginia required credentialled assistants, this would not be necessary,as they would be tested in radiology, infection control, emergency procedures, and other areas. Be proactive!!

CommentID: **78380**

Commenter: Kristin Page, RDH 12/12/19 1:21 pm

DAs should be certified in infection control

Many DAs don't understand the weight of good infection control. This helps protect the public from there dangers that exist withbpoor infection control. The patient is our number one priority and this is a major component to his/her safety.

CommentID: **78470**

Commenter: Patricia A. MacDougall 12/12/19 1:56 pm

DA Infection Control and Radiation Safety

I agree with the petitioner's amendment.

CommentID: **78472**

Commenter: Sheila B. Sheats, RDH, NVDHC Chair 12/12/19 2:48 pm

DA Certification

A agree, however, instituting this for all the many assistants that have OJT would have to be advised to this. How would this be implemented? The schools (DA assisting, proprietary, and community college) would need to offer these certifications. The DDS would need to ensure that their staff was properly certified. I feel that hygienists have had many, many courses and yearly OSHA (BBP) updates yearly. Thank you

CommentID: **78473**

Commenter: Tammy Swecker 12/12/19 2:57 pm

Dental Assistant Certificate

Dental assistants need formal education to protect themselves and patients. Dental assistants need more than just on the job training. Infection control and Radiation Safety are just some of the courses all dental assistants should be required to take. They should also have to take a test on the laws that govern the practice of dentistry so they know what is a delegable and nondelegable duty.

CommentID: **78474**

Commenter: Joan Pellegrini, RDH, BSDH, MSDH, PhD 12/12/19 3:13 pm

Certification for dental assistants

As a long-time care provider and educator, I support regulation for dental assistants being certified in OSHA, infection control and radiation health/safety. Additionally, the dental assistants should be current in their certification in Basic Life Support (BLS/CPR). These areas of certification are a protection for the patient, as well as other members of the dental team.

CommentID: **78475**

Commenter: Angela Smith, BS, CDA 12/12/19 3:38 pm

DA Certification

At a minimum, dental assistants need formal education on Radiation Safety and Infection Control as well as CPR certification. Breaches of infection control are happening all over the country in all sorts of healthcare situations, and we need to gain control of this problem by making sure those people who perform these procedures most often in dental offices, the dental assistants, have the proper training. As for radiation health and safety, this training needs to be more than a few hours on radiation. Most often, it's the dental assistant in a practice taking the radiographs. Knowing proper sensor placement and tube head placement is as important as knowing how X-rays are generated to keeping the patient exposure level at the absolute minimum. The proper technique not only means reduced exposure but also proper diagnosis and treatment for the patient. This law should pass without hesitation.

CommentID: **78476**

Commenter: Cynthia Saxton Flowers RDH, CDA 12/12/19 6:24 pm

I agree with Petition

As a former Dental Assistant, I am in favor to have all Dental Assistants be certified in Infection Control and Radiation Safety. The CDC has recognized that one of the main duties as a DA is infection control. It is the utmost importance to protect our public and staff from the spread of disease.

CommentID: **78478**

Commenter: Gloria Langmeyer CDA CDPMA PAST PRESIDENT VDAA 12/12/19 7:28 pm

Certification for DA I totally agree

CommentID: **78479**

Commenter: Jeannie Lipscomb, CDA 12/12/19 7:31 pm

Certification for Dental Assistants

Agreed that knowledge in both areas is important. The Dental Assisting National Board (DANB) has offered certification for both Radiation Health and Safety and Infection Control for many years. Additionally, both of these exams are part of the CDA examination.

CommentID: **78480**

Commenter: Virginia T Dugge CDA Retired 12/13/19 10:11 am

Certification for Dental Assistants

All Dental Assistants need to be certified for the protection of their patients as well as for their own protection and knowledge.

As a former president of the VDAA back in the 80's I had been fighting for this for over 25 years before retiring.

I highly recommend that the BOD finally makes this happens!

Thank you.

Virginia T Dugge

CommentID: **78488**

Commenter: Deborah Vernon, CDA

12/13/19 11:04 pm

Support of formal testing and credentialing of Dental Assistants

As a Certified Dental Assistant with 30+ years in dentistry, it is my sincere belief that having dental assistants properly trained and tested in radiation and infection control is vital to the health and safety of not only the patients and staff, but the community in general. *This is a public health issue*. Even a cursory search would reveal dozens of infection control breaches, affecting thousands, including deaths. These are not isolated "once in a blue moon" incidents. They can happen, and have happened, anywhere - dental schools, public health clinics, corporate and private practices, and more. Dental staff who know the how, what and why of pathogens and how to stop them are an absolute necessity in ALL dental practices. Please pass this regulation. Thank you!

CommentID: **78504**

Commenter: Shannon Pace Brinker, CDA

12/15/19 12:16 am

I agree with this Certification

Appropriate infection control procedures must be performed to ensure patient and staff safety. Following the CDC and OSHA guidelines for infection control can prevent or reduce the risk of disease transmission to patients and DHCP. With only 35k dental assistants who are certified in the US, this is a must to required dental assistants be certified in Infection Control in order to work in a dental practice. I have taught over 60k dental assistants in the US and this is the widest area of concern and clinical misunderstanding. We must protect our patients. Requirements for education should be the standard for every dental professional. I support this change

CommentID: **78510**

Commenter: Julie Martin BSDH, RDH

12/15/19 7:25 am

DA infection control certification and radiation safety

As a former DA and current RDH in VA, I strongly feel that DA's in VA should be certified in infection control with no grandfathering. I continuously witness many incidents of cross-contamination in the dental offices by DA's, due to a lack of knowledge and training.

I feel that not only should DA's be certified in radiation health and safety, but the certification should include proper placement of film to prevent repeated exposure.

I recommend that the VA BOD votes in favor of this petition to keep the public safe.

Julie A. Martin, BSDH, RDH

CommentID: **78511**

Commenter: Heidi Hessler-Allen, CDA

12/16/19 6:23 am

Support certification requirements for all dental assistants

CommentID: **78517**

Commenter: Summer Barnett, CDA 12/16/19 10:20 am

Absolutely!

CommentID: 78519

Commenter: Rebecca Coelho CDA, RDH 12/16/19 11:17 am

RHS and ICE are important!

I teach radiology and infection control classes to dental assisting students. Students have NO concept of infection control at the start of class, they touch their face and other surfaces with gloves on and then try to perform procedures on patients! This poses a huge concern for cross contamination. Radiology is also very important. Radiation causes permanent damage to tissues. If a student doesn't understand how radiation works they will not take seriously why it is so important to take images correctly the first time to minimize exposure to the patient. Dental assistants also need to have an understanding of radiology to help educate patients about why xrays are necessary and important....... patients try to refuse xrays all the time!

CommentID: 78520

Commenter: RHONDA LUCAS RDH, BSDH, CDA 12/18/19 2:46 pm

I AGREE

Infection Control is the main duty of ALL dental professionals. First and upmost, we must protect ourselves and our patients form contamination and diseases.

CommentID: 78539

Commenter: Smithfield Dental 12/19/19 6:57 pm

I agree

CommentID: 78542

Commenter: Heather Fonda, CDA 12/22/19 10:25 pm

I Agree! DA's need ICE & RHS Certifications!

I am writing in support of the proposed regulation change (petition 313) requiring dental assistants to be infection control and radiology certified through DANB or NELDA before they are allowed to practice in the Commonwealth of Virginia. Having graduated from an accredited dental assisting program as a CDA in December of 2018, I am well aware that dentistry, like other medical fields, has its potential for health altering hazards. My education and subsequent DANB certifications have provided me with the knowledge I need to protect my patients, myself, my team, and my community from injury and communicable disease. An on-the-job trained dental assistant without certifications, however, will likely have no idea what airborne or bloodborne pathogens are, what standard precautions are, or even that there is a difference between disinfection and sterilization. All of which are paramount knowledge in the avoidance of maleficence. Patients and people, in general, have immense societal trust in their healthcare providers; dentists and their team members included. Let's not ever let anyone down! Allowing substandard practice is unacceptable. I

ask you to please see the validity and criticality of this proposed change. The patients and dentists in the Commonwealth of Virginia deserve competent certified dental assistants.
CommentID: 78563

Commenter: Vicki Brett, CDA, RDH, BSDH 12/24/19 3:47 pm

Safety for All

I am writing in support of the rulemaking petition proposing to require dental assistants in Virginia to pass the Infection Control (ICE) and Radiation Health and Safety (RHS) exams administered by the Dental Assisting National Board, Inc. (DANB) or to earn DANB's NELDA certification.

The risk of transmission of infection in a dental office is a serious concern, and these concerns have been heightened by a series of high-profile breaches of infection control protocols reported in the media, including the following:

- In 2014, New Jersey public health officials discovered 15 cases of endocarditis linked to improper infection prevention procedures at one oral surgery office; of the 15 confirmed endocarditis patients, 12 underwent cardiac surgery and one died from complications of endocarditis and subsequent cardiac surgery.[i]

- In a highly publicized incident in Oklahoma in 2013, more than 4,200 dental patients required testing for infectious diseases after receiving treatment in the office of an oral surgeon whose staff was found to be using improper sterilization practices. Of those tested, 89 were positive for hepatitis C, with at least one of these cases confirmed through genetic testing as a patient-to-patient transmission of the disease.[ii] Though it is unclear whether this oral surgeon's assistants had any formal training or education, it is known that they did not hold DANB's Certified Dental Assistant certification and had not taken DANB's Infection Control exam, which is a component of the CDA certification.

At the time of the incident, Oklahoma did not have any laws or regulations requiring dental assistants to receive any specific education or training in infection control or to hold independent professional certification in dental assisting from DANB or any other entity. The supervising dentist, in a statement to investigators, indicated that he delegated all sterilization responsibilities to his dental assisting staff, yet the errors made by these assistants demonstrated that they lacked even a basic knowledge of infection control principles, including those on which they would have been comprehensively tested had they taken DANB's Infection Control exam and/or been holders of DANB's CDA certification.

- The Oklahoma incident described above followed a series of significant but less well publicized infection control breaches, including one in which more than 500 veterans were notified that they might have been exposed to hepatitis B, hepatitis C, and HIV after having procedures performed in a VA dental clinic where proper infection control protocols were not followed.[iii]

In Virginia, there have been at least two allegations of breaches in the past two years, including one incident in which a dentist in a Richmond pediatric dental office informed patients that the practice's one high-speed handpiece was not being heat sterilized between patients, but only wiped with an intermediate disinfectant. The practice is also accused of improperly maintaining water lines.[iv] In another case, a lawsuit filed in May 2019 alleges that employees/agents of a dental clinic owned by a company based in Roanoke used improperly sterilized instruments on at least 50 patients.[v]

The DALE Foundation, the official affiliate of the Dental Assisting National Board, Inc. (DANB), conducted a research study in 2016 focused on the value of dental assistants to dental practices. The cornerstone of the study was a survey that researchers circulated to dentists, dental assistants and dental hygienists in general dental practices; the survey included questions about delegation of duties to dental assistants.

The survey responses revealed the following related to delegation of infection control-related tasks to dental assistants:

- 69% of responding dentist and dental assistants indicated that "perform sterilization and infection control procedures" is one of the top five functions most frequently delegated to dental assistants

- 99% of responding dentists and dental assistants indicated that "perform sterilization and infection control procedures" is a function delegated to dental assistants; 28% indicated that this function was performed by qualified dental assistants, and 71% indicated that this function is performed by all dental assistants, including those who have not met any specific requirements[vi]

The consequences to the public of improper performance of infection prevention and control procedures can be very serious. Survey data indicate that dental assistants are performing sterilization and infection control procedures in 99% of general dental practices. However, because Virginia does not regulate first-level dental assistants (Dental Assistants I), we don't know how many dental assistants in Virginia do not have adequate training in infection control.

According to occupational employment statistics available from the U.S. Bureau of Labor Statistics, there were approximately 8,520 dental assistants employed in Virginia in May 2018. In January of that year, there were 2,400 dental assistants with Virginia addresses who had passed DANB's Infection Control (ICE) exam since 1997, which is less than one third of all employed dental assistants. While it is possible that the approximately two thirds of dental assistants in Virginia who have not passed DANB's ICE exam have received some type of formal education or training in infection prevention and control, there is simply no way to know. The good news is that, if Virginia adopts a requirement that all dental assistants must pass the ICE exam, approximately one third of assistants will have already met this requirement.

I am in full agreement with dental assistants being required to take DANB's Infection Control Exam. I have worked in dentistry in Virginia for 37 years as a clinician, a dental sales consultant, and an educator and administrator. From my own experiences, I can say that the need for all dental assistants to be educated in infection control is crucial for the safety of dental professionals and our patients.

I worked for 27 years in the same dental office. In my first few years as a dental assistant, I also thought infection control was not an issue, because the dental office where I worked employed highly educated dental assistants (including me) that believed in continuing education and maintaining current knowledge of the latest technology. When I started temping as a dental hygienist on my days off, I realized that not every office maintained the same standards. On several occasions, a dental assistant in the office where I was temping would give me an orientation to the office's sterilization process and procedures, and I was frequently shocked at the deviations in best practices that I saw.

As a dental sales representative, I visited hundreds of dental offices in Virginia and had the opportunity to learn quite a bit about the way different offices operate. I wish I had kept a record of how many offices didn't know the OSHA guidelines and the mandated rule to have office training in the bloodborne pathogens standard each year. I am not aware of anyone checking to see if dental offices comply with this mandate.

Ten years ago, I became an educator and director of a dental assisting program that has four campuses located throughout Virginia. This role has ignited a passion in me for the profession of dental assisting and reinforced my belief that there is a critical need for dental assistants who are properly trained and educated and who are certified.

My students all take and pass DANB's Infection Control Exam before going on externship/internship and have demonstrated mastery of proper infection control concepts and procedures. They regularly bring stories back to class of appalling deviations from the best practices they have learned. While I recognize these are second-hand anecdotal accounts, they cause me to be deeply concerned about the health and safety of dental patients in Virginia.

In 2015, I served on the Regulatory Advisory Committee on the Education and Practice of Dental Assistants I and II. The committee recommended that the Virginia Board of Dentistry adopt infection control requirements for dental assistants. In the Board's discussion, it was stated that there are no issues with infection control in Virginia. I am certain that the Board members expressing this view were indeed following best practices in their own offices. But I am not aware of anyone checking or inspecting offices for proper infection control, and so I am not sure where the belief that there is "no issue" comes from.

To fully protect the public, I ask the Board to address the incorrect infection control protocols or disinfecting and sterilization issues that are happening all over Virginia by adopting a requirement that all dental assistants be required to pass DANB's Infection Control exam.

Regarding radiography requirements:
As of March 2019, 3,698 individuals had passed DANB's Radiation Health and Safety (RHS) exam since 1997, representing less than half of all dental assistants in Virginia. This means that more than half of Virginia dental assistants have qualified to perform radiography procedures by passing the ARRT certification exam, which is not specific to dentistry and contains very little, if any, content on dental radiography, or by taking a course from a CODA-accredited program. Because many of the radiography courses offered in Virginia are themselves not accredited (though they may be offered by an accredited program), they do not follow a standard curriculum and there is significant variability in content, duration of hands-on instruction and assessment in these courses.

DANB's RHS exam is a standardized exam, the content of which is based on a formal study to determine the tasks that are actually performed by dental assistants on the job and the knowledge that is needed to perform those tasks safely and competently. Dental assistants who pass DANB's RHS exam demonstrate mastery of a standardized body of knowledge. Requiring DANB's RHS exam for all dental assistants who perform radiography procedures will provide the Virginia Board of Dentistry with the means of verifying that dental assistants who perform radiography have the required knowledge to do their jobs safely.

I agree with the petition.

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[iii] Sutherly, Ben. "At least 9 Dayton VA dental patients test positive for hepatitis." DaytonDailyNews.com. Dayton Daily News, 3 Mar. 2011. Web. Accessed 26 May 2016. http://www.daytondailynews.com/news/news/local/at-least-9-dayton-va-dental-patients-test-positive/nMpfc/.

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[v] Garrity, Mackenzie." Virginia dental practice used unsterile equipment, class-action suit alleges." BeckersDental.com. Becker's Dental + DSO Review. 10 May 2019. https://www.beckersdental.com/dentists/34693-6-dentists-making-headlines-3.html

[vi] Correspondence with DALE Foundation staff. 19 Dec 2019.

CommentID: **78681**

Code of Virginia

Article 4. Practice of Dental Assistants.

§ 54.1-2729.01. Practice of dental assistants.

A. A person who is employed to assist a licensed dentist or dental hygienist by performing duties not otherwise restricted to the practice of a dentist, dental hygienist, or dental assistant II, as prescribed in regulations promulgated by the Board may practice as a dental assistant I.

B. A person who (i) has met the educational and training requirements prescribed by the Board; (ii) holds a certification from a credentialing organization recognized by the American Dental Association; and (iii) has met any other qualifications for registration as prescribed in regulations promulgated by the Board may practice as a dental assistant II. A dental assistant II may perform duties not otherwise restricted to the practice of a dentist or dental hygienist under the direction of a licensed dentist that are reversible, intraoral procedures specified in regulations promulgated by the Board.

Regulations of the Board

18VAC60-30-10. Definitions.

Part I

General Provisions

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

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

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

"Code" means the Code of Virginia.

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

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-30-60 and 18VAC60-30-70.

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

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

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

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

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

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

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

18VAC60-30-80. Radiation Certification.

A dental assistant I or II shall not place or expose dental x-ray film unless he has one of the following: (i) satisfactory completion of a radiation safety course and examination given by an institution that maintains a program in dental assisting, dental hygiene, or dentistry accredited by CODA; (ii) certification by the American Registry of Radiologic Technologists; or (iii) satisfactory completion of the Radiation Health and Safety Review Course provided by the Dental Assisting National Board or its affiliate and passage of the Radiation Health and Safety Exam given by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

Virginia Department of
Health Professions

VIRGINIA BOARD OF DENTISTRY

Overview of Regulatory Advisory Panel regarding Sedation Regulations

- **Sedation Inspections and Locations**

Recommendations

  - The Committee recommended that each location for sedation should be registered with the Board.
  - The Committee recommended that dentist holding a permit should notify the BOD within 30 days of a change of address.
  - The Committee recommended that the change in location be reflected in the MLO database.
  - The Committee recommended that the each location and each dentist should have a permit for sedation.
  - The Committee recommended that dentists will receive a copy of their inspection report with listed deficiencies at the time of inspection. It is recommended that dentist will be asked to correct those deficiencies within a period (15 to 30 days) and provide proof of correction.
  - The Committee recommended that inspections be announced, when possible, but that there is an option of inspections being unannounced due to inspectors' schedules. The Committee recommended that if an inspection could be announced, that it is within a short period of time (1 week prior to inspection).

Not Recommended

  - The Committee did not recommend that a re-inspection be required prior to renewal. The Committee stated this was unnecessary, because actions would be taken if there were violations of the regulations during the last inspection, limited workforce in how the current inspection process operates, and if a facility had significant violations there would be more frequent visits to ensure compliance.

Other Discussion

  - The Committee considered that the permit could be a longer length of time depending on compliance at inspection; however, the committee took into consideration that this could cause confusion, since currently sedation permits are renewed at the same time as licenses.

VIRGINIA BOARD OF DENTISTRY

More Information Needed

- Having a rating score or a pass/fail score was discussed but the Committee would need more information to consider. BOD would need to define "pass" and "fail".

- **Inspection prior to permit being issued**

Recommendations

- The Committee recommended that there should be announced initial pre-permit inspections.

Other Discussion

- The Committee proposed a possible "conditional" permit to be issued at the pre-permit inspection that stated compliance with equipment, appropriate training of staff, physical plant requirements, and drug control act requirements. Then a permanent permit be issued when the dentist has performed sedation in relation to the permit issued and after the dentist is in compliance per record review from a follow up inspection. However, it was also discussed that during the pre-permit inspection the inspector will ensure that the dentist has all the necessary equipment and training required and therefore, a "conditional permit" would not be necessary.
- It was discussed that on the pre-inspection application that the dentists have been attesting that they have all the required equipment but during subsequent inspections they do not have all the necessary equipment.

- **Types of Permits**

Recommendations

- The Committee did recommend additional regulations for pediatric sedation and possibly a pediatric sedation permit. The Committee recommended the BOD review the National Pediatric Guidelines.

Not Recommended

- The Committee did not recommend an oral sedation permit.

- **Recordkeeping**

  Recommendations

  - The Committee recommended that regulations should address that the patient record should reflect the intended level of sedation for each patient and procedure.

- **OMS Requirements for Inspections**

  Recommendations

  - The Committee recommended that an OMS be required to submit AAMOS office examination reports when they occur. The Committee also recommended scanning this report into MLO.
  - The Committee recommended that if an OMS is waiting to be certified by AAMOS and in the meantime, obtained a sedation permit, that the OMS be required to notify the BOD when they become AAMOS certified. This will require the OMS to have their sedation permit removed, to prevent further inspection and require the OMS to send the AAMOS office examination report.

- **Guidance Document 60-3**

  Recommendations

  - The Committee recommended that the term "announced" and "unannounced" be defined or more specific within the guidance document.
  - The Committee recommended that the guidance document be updated to state that the dentist is required to notify the BOD when there are facility changes.
  - The Committee recommended that the guidance document be updated to require, in the patient record, that the intended level of sedation be documented.

- **Other Concerns from the Committee**

  Recommendations

  - The Committee recommended adding regulations regarding when dentist cancels an announced inspection.
  - The Committee stated concerns about dentists utilizing a laryngoscope stating that, as a dentist, they have limited training and practice and there was a concern that if utilized the dentist would cause more damage. They stated it was more reasonable for a dentist to utilize CPR and call 911 and let an EMT who has

more experience and practice to utilize a laryngoscope. Therefore, it was recommended to review this requirement within the regulations.

- The Committee recommended that within regulations, there be the same emergency procedures for minimal sedation as there is in moderate sedation.
- The Committee recommended a requirement in regulations for emergency lighting.
- The Committee recommended addressing, in a future newsletter, from the BOD to licensee on what is involved in a sedation inspection.

Virginia Board of Dentistry

Periodic Office Inspections for Administration of Sedation and Anesthesia

- **Enforcement has requested that inspection be required before a permit is issued indicating they could do this timely.**
- **Need to require notice of practice location changes.**
- **Need to clarify if all permit holders are subject to inspection whether or not they report not currently administering moderate sedation or deep sedation and general anesthesia.**
- **Consider allowing advance scheduling of periodic inspections.**
- **Should the Board request OMSs to provide AMOS office examination reports every five years?**

Purpose
The purpose of instituting periodic unannounced office inspections is to foster and verify compliance with regulatory requirements by dentists who hold a permit to administer sedation or general anesthesia (hereinafter referred to as permit holders). Verifying compliance with the requirements will assure that appropriate protections are in place for the health and safety of patients who undergo ~~conscious/~~moderate sedation, deep sedation, or general anesthesia for dental treatment.

Applicable Laws and Regulation
- Employees of the Department of Health Professions, when properly identified, shall be authorized, during ordinary business hours, to enter and inspect any dental office or dental laboratory for the purpose of enforcing the provisions of this chapter as provided by §54.1-2703 of the Code of Virginia.
- The Board shall establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of sedation and anesthesia to patients in a dental office as provided by §54.1-2709.5 of the Code.
- Part ~~VI~~ VII of the Regulations Governing the Practice of Dentistry addresses the requirements for administration of anesthesia, sedation and analgesia beginning at 18VAC60-21-260.*

Scope of Periodic Inspections
- Dentists who do not provide any level of sedation and those that only provide minimal sedation do not require a permit and are not subject to periodic inspections related to sedation and anesthesia.
- Oral and maxillofacial surgeons (hereinafter referred to as OMSs) who maintain membership in AAOMS and who provide the Board with the reports which result from the periodic office examinations required by AAOMS do not require a permit and are not subject to periodic inspections. ~~by the Board so long as~~ ~~e~~Each ~~Virginia office an~~ OMSs ~~practices in~~ ~~has~~ must have undergone an AAMOS periodic office examination within the

five preceding years and the reports of the examinations are to be provided to the Board upon request.

- Every OMS who does not maintain AAOMS membership or who does not ~~provide an~~ have a current AAOMS report ~~to the Board~~ is required to hold a permit to administer sedation or general anesthesia and is subject to periodic inspections by the Board.
- Every dentist who administers ~~conscious/~~moderate sedation, ~~enteral conscious/moderate sedation~~, deep sedation or general anesthesia is required to hold a permit. Permit holders are subject to periodic unannounced office inspections with the following two exceptions. Permit holders are not subject to periodic office inspections if they administer any of these levels of sedation to patients:
    - only as a faculty member within educational facilities owned or operated by or affiliated with an accredited dental school or program, or
    - only in a hospital or an ambulatory surgery center accredited by a national accrediting organization, such as the Joint Commission, which is granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation pursuant to § 1865 of Title XVIII of the Social Security Act (42 U.S.C. § 1395bb).
- Permit holders who practice in multiple offices shall identify each location for inspection. Each office will be inspected at least once in an inspection cycle. If a permit holder is the sole practitioner in each of the locations, inspections of each office will be coordinated to address findings in a comprehensive inspection report.
- Practices with multiple permit holders will be inspected for general compliance at least once in an inspection cycle. These inspections will address the compliance of each permit holder at the practice so that a complete inspection report is issued for each permit holder as necessary to have each permit holder's practices inspected once every three years.
- Permit holders practicing on an itinerant basis shall identify a primary practice location for a periodic inspection and shall report and provide information about the arrangements in place with employing dentists to facilitate inspection of those practice settings.
- The practice locations of permit holders who use the services of another qualified health professional to administer ~~conscious/~~moderate sedation, deep sedation or general anesthesia as permitted in sections 18VAC60-21-291.A and 18VAC60-21-301.B of the Regulations Governing the Practice of Dentistry shall be inspected.

Inspection Cycle

The standard inspection cycle is to conduct an unannounced inspection of each permit holder's practice(s) once every three to five years. This cycle will be followed when an inspection finds that all requirements have been met or that only a few minor violations have been identified for correction. ~~which~~ Such findings might be resolved through an advisory letter or a confidential consent agreement. Significant findings of violations may result in administrative proceedings, disciplinary action and more frequent inspections.

Initiation of Inspections

The Board will conduct a pre-inspection survey of all permit holders. The purpose of this survey will be to collect information about the level of sedation practiced, practice locations and

staffing. This information will facilitate planning for inspections. Permit holders will receive a copy of this guidance document and the inspection form with the survey.

Following review of the survey results, the Enforcement Division of the Department of Health Professions will initiate unannounced inspections of the offices of permit holders.

Following initiation of the periodic inspections, the Board will send an e-mail request to each OMS for submission of the most recent reports which resulted from the periodic office examinations required by AAOMS. This request will include a form to be completed and returned to the Board with the name of the primary contact person and the name, address, and phone number of each office where the OMS practices.

Costs Related to Inspections

Permit holders will not be charged an inspection fee for a periodic inspection. A $350 fee will be charged for any additional inspections that result from a disciplinary order issued to address findings of non-compliance in periodic inspections.

Inspection Reports and AAOMS Office Examination Results

Inspection reports and AAOMS results will be submitted to the Board for review. ~~The~~ Board staff will review the information received to determine if the results indicate that a probable cause review of a permit holder's or AAOMS member's inspection findings ~~is~~ are in compliance with the regulatory requirements addressed in the inspection form. The inspection reports and AAOMS results are confidential documents pursuant to §54.1-2400.2 of the Code of Virginia.

~~* Previously such administration was addressed in Part IV of the Expired May 7, 2014 Regulations Governing Dental Practice beginning at 18VAC60-20-107.~~

Sedation Inspections by State

State	Each Location Must be Registered	Dentist and Location Must be Registered	Must receive on-site inspection prior to permit being issued	Minimal Sedation Permit	Oral Sedation Permit	Moderate Sedation Permit	Deep/ General Permit	Pediatric Sedation Regulations/ Permit	Re-inspection required prior to renewal	Length of time permit is good for	Location cannot be registered without equipment	Record Keeping must indicate intended level of sedation	Onsite inspections have a pass/ fail or rating score	Discharge Regulations; Sedation related
Arizona	X	X	X		X	X	X		X	1 year	X		X	
Arkansas	X	X	X			X	X	X	X	5 years	X		X	
California	X	X	X			X	X		X	2 years	X		X	
Colorado			X	X		X	X	X	X	5 years				
Connecticut	X	X	X			X	X			3 years	X		X	
Delaware	X	X	X	X		X	X			2 years	X		X	
Florida	X	X	X			X	X	X		2 years	X		X	
Georgia	X	X	X			X	X		Depending	2 years	X			
Idaho	X	X				X				5 years	X			
Kansas						X	X	X		2 years				X
Maine	X					X	X	X		?	X			X
Maryland	X	X	X			X	X		X	5 years	X		X	
Massachusetts	X	X	X	X		X	X	X		2 year	X			
Mississippi	X	X	X			X	X	X	X	5 years	X			
Missouri	X	X	X			X	X		X*see notes	5 years	X			
Montana	X	X	X			X	X		X	5 years	X			
Nebraska	X	X	X	X		X	X		Discretion	?	X			
Nevada	X	X	X			X	X		X	2 Years	X			
New Hampshire	X	X	X			X	X		X	5 years	X	X	X	
New Jersey	X	X	X	X		X	X		X	2 years	X			
New Mexico	X	X	X	X		X	X	X		6 years	X			
North Carolina	X	X	X	X		X	X	X	Depending	?	X		X	
North Dakota	X	X	X			X	X		X	5 years	X			
Ohio	X	X	X			X	X		X*see notes	2 Years	X		X	
Oklahoma	X	X	X			X	X	X	X*see notes	1 year	X		X	
Pennsylvania	X	X	X	X		X	X	X	X	6 years	X			
West Virginia	X	X	X			X	X				X			

G. All licensees are required to maintain original documents verifying the date and subject of the program or activity, the sponsor, and the amount of time earned. Documentation shall be maintained for a period of four years following renewal.

H. A licensee who has allowed his license to lapse, or who has had his license suspended or revoked, shall submit evidence of completion of continuing education equal to the requirements for the number of years in which his license has not been active, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months preceding an application for reinstatement.

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

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

Part VII. Controlled Substances, Sedation, and Anesthesia.

18VAC60-21-260. General provisions.

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

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

C. Patient evaluation required.

1. The decision to administer controlled drugs for dental treatment must be based on a documented evaluation of the health history and current medical condition of the patient in accordance with the Class I through V risk category classifications of the American Society of Anesthesiologists (ASA) in effect at the time of treatment. The findings of the evaluation, the ASA risk assessment class assigned, and any special considerations must be recorded in the patient's record.

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

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

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

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

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

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

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

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

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

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

1. Notation of the patient's American Society of Anesthesiologists classification;

2. Review of medical history and current conditions, including the patient's weight and height or, if appropriate, the body mass index;

3. Written informed consent for administration of sedation and anesthesia and for the dental procedure to be performed;

4. Preoperative vital signs;

5. A record of the name, dose, and strength of drugs and route of administration including the administration of local anesthetics with notations of the time sedation and anesthesia were administered;

6. Monitoring records of all required vital signs and physiological measures recorded every five minutes; and

7. A list of staff participating in the administration, treatment, and monitoring including name, position, and assigned duties.

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

F. Informed written consent. Prior to administration of any level of sedation or general anesthesia, the dentist shall discuss the nature and objectives of the planned level of sedation or general anesthesia along with the risks, benefits, and alternatives and shall obtain informed, written consent from the patient or other responsible party for the administration and for the treatment to be provided. The written consent must be maintained in the patient record.

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

H. Emergency management.

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

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

1. Training and hold current certification in basic resuscitation techniques with hands-on airway training for health care providers, such as Basic Cardiac Life Support for Health Professionals or a

clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18VAC60-21-250 C; or

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

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

K. Patient monitoring.

2. The person monitoring the patient shall:

a. Have the patient's entire body in sight;

b. Be in close proximity so as to speak with the patient;

c. Converse with the patient to assess the patient's ability to respond in order to determine the patient's level of sedation;

d. Closely observe the patient for coloring, breathing, level of physical activity, facial expressions, eye movement, and bodily gestures in order to immediately recognize and bring any changes in the patient's condition to the attention of the treating dentist; and

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

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

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

2. The person administering the anesthesia or sedation is appropriately licensed and the staff monitoring the patient is qualified.

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

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

1. A dentist;

2. An anesthesiologist;

3. A certified registered nurse anesthetist under his medical direction and indirect supervision;

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

5. A dental hygienist to administer Schedule VI topical oral anesthetics under indirect supervision or under his order for such treatment under general supervision; or

6. A dental assistant or a registered or licensed practical nurse to administer Schedule VI topical oral anesthetics under indirect supervision.

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

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

1. The appropriate use and physiological effects of nitrous oxide, the potential complications of administration, the indicators for complications, and the interventions to address the complications.

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

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

C. Delegation of administration.

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

a. A dentist;

b. An anesthesiologist;

c. A certified registered nurse anesthetist under his medical direction and indirect supervision;

d. A dental hygienist with the training required by 18VAC60-25-100 B and under indirect supervision; or

e. A registered nurse upon his direct instruction and under immediate supervision.

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

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

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

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

1. Blood pressure monitoring equipment;

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

3. Mechanical (hand) respiratory bag; and

4. Suction apparatus.

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

F. Monitoring requirements.

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

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

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

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

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

G. Discharge requirements.

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

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

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

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

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

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

2. The physiological effects of minimal sedation, the potential complications of administration, the indicators for complications, and the interventions to address the complications.

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

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

C. Delegation of administration.

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

a. A dentist;

b. An anesthesiologist;

c. A certified registered nurse anesthetist under his medical direction and indirect supervision;

d. A dental hygienist with the training required by 18VAC60-25-100 C only for administration of nitrous oxide/oxygen with the dentist present in the operatory; or

e. A registered nurse upon his direct instruction and under immediate supervision.

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

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

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

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

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

1. Blood pressure monitoring equipment;

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

3. Mechanical (hand) respiratory bag;

4. Suction apparatus; and

5. Pulse oximeter.

E. Required staffing. The treatment team for minimal sedation shall consist of the dentist and a second person in the operatory with the patient to assist the dentist and monitor the patient. The second person shall be a licensed health care professional or a person qualified in accordance with 18VAC60-21-260 I.

F. Monitoring requirements.

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

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

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

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

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

G. Discharge requirements.

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

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

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

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

A. No dentist may employ or use moderate sedation in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the board with reports that result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.
B. Automatic qualification. Dentists who hold a current permit to administer deep sedation and general anesthesia may administer moderate sedation.
C. To determine eligibility for a moderate sedation permit, a dentist shall submit the following:

1. A completed application form;

2. The application fee as specified in 18VAC60-21-40;

3. A copy of a transcript, certification, or other documentation of training content that meets the educational and training qualifications as specified in subsection D of this section; and

4. A copy of current certification in advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) as required in subsection E of this section.

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

1. Completion of training for this treatment modality according to the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students in effect at the time the training occurred, while enrolled in an accredited dental program or while enrolled in a post-doctoral university or teaching hospital program; or

2. Completion of a continuing education course that meets the requirements of 18VAC60-21-250 and consists of (i) 60 hours of didactic instruction plus the management of at least 20 patients per participant, (ii) demonstration of competency and clinical experience in moderate sedation, and (iii) management of a compromised airway. The course content shall be consistent with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students in effect at the time the training occurred.

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

2. Have current training in the use and maintenance of the equipment required in 18VAC60-21-291.

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

A. Delegation of administration.

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

sedation shall use either a qualified dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer such sedation.

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

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

b. An anesthesiologist;

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

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

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

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

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

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

a. All equipment required in subsection B of this section is present, in good working order, and immediately available to the areas where patients will be sedated and treated and will recover; and

b. Qualified staff is on site to monitor patients in accordance with requirements of subsection D of this section.

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

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

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

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

5. Pulse oximetry;

6. Blood pressure monitoring equipment;

7. Pharmacologic antagonist agents;

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

9. Mechanical (hand) respiratory bag;

10. Appropriate emergency drugs for patient resuscitation;

11. Electrocardiographic monitor if a patient is receiving parenteral administration of sedation or if the dentist is using titration;

12. Defibrillator;

13. Suction apparatus;

14. Temperature measuring device;

15. Throat pack; and

16. Precordial or pretracheal stethoscope.

17. An end-tidal carbon dioxide monitor (capnograph).

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

D. Monitoring requirements.

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

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

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

E. Discharge requirements.

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

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

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

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

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

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

AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.

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

1. A completed application form;

2. The application fee as specified in 18VAC60-21-40;

3. A copy of the certificate of completion of a CODA accredited program or other documentation of training content which meets the educational and training qualifications specified in subsection C of this section; and

4. A copy of current certification in Advanced Cardiac Life Support for Health Professionals (ACLS) or Pediatric Advanced Life Support for Health Professionals (PALS) as required in subsection C of this section.

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

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

2. Completion of an CODA accredited residency in any dental specialty that incorporates into its curriculum a minimum of one calendar year of full-time training in clinical anesthesia and related clinical medical subjects (i.e., medical evaluation and management of patients) comparable to those set forth in the ADA's Guidelines for Graduate and Postgraduate Training in Anesthesia in effect at the time the training occurred; and

3. Current certification in advanced resuscitative techniques with hands-on simulated airway and megacode training for health care providers, including basic electrocardiographic interpretations, such as courses in ACLS or PALS; and

4. Current training in the use and maintenance of the equipment required in 18VAC60-21-301.

18VAC60-21-301. Requirements for administration of deep sedation or general anesthesia.

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

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

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

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

B. Delegation of administration.

2. A dentist who meets the requirements of 18VAC60-21-300 may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

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

b. An anesthesiologist; or

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

3. Preceding the administration of deep sedation or general anesthesia, a dentist who meets the requirements of 18VAC60-21-300 may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

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

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

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

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

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

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

6. Mechanical (hand) respiratory bag;

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

8. Appropriate emergency drugs for patient resuscitation;

9. EKG monitoring equipment;

10. Temperature measuring devices;

11. Pharmacologic antagonist agents;

12. External defibrillator (manual or automatic);

13. An end-tidal carbon dioxide monitor (capnograph);

14. Suction apparatus;

15. Throat pack; and

16. Precordial or pretracheal stethoscope.

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

E. Monitoring requirements.

1. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility to include: temperature, blood pressure, pulse, oxygen saturation, and respiration.

2. The patient's vital signs, end-tidal carbon dioxide, and EKG readings shall be monitored, recorded every five minutes, and reported to the treating dentist throughout the administration of controlled drugs. When depolarizing medications are administered, temperature shall be monitored constantly.

3. Monitoring of the patient undergoing deep sedation or general anesthesia is to begin prior to the administration of any drugs and shall take place continuously during administration, the dental procedure, and recovery from anesthesia. The person who administers the anesthesia or another licensed practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

F. Emergency management.

1. A secured intravenous line must be established and maintained throughout the procedure.

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

G. Discharge requirements.

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

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

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

Part VIII. Oral and Maxillofacial Surgeons.

18VAC60-21-310. Registration of oral and maxillofacial surgeons.

Every licensed dentist who practices as an oral and maxillofacial surgeon, as defined in § 54.1-2700 of the Code, shall register his practice with the board.

1. After initial registration, an oral and maxillofacial surgeon shall renew his registration annually on or before December 31.

3. Within one year of the expiration of a registration, an oral and maxillofacial surgeon may renew by payment of the renewal fee and a late fee.

4. After one year from the expiration date, an oral and maxillofacial surgeon who wishes to reinstate his registration shall update his profile and pay the reinstatement fee.

18VAC60-21-320. Profile of information for oral and maxillofacial surgeons.

A. In compliance with requirements of § 54.1-2709.2 of the Code, an oral and maxillofacial surgeon registered with the board shall provide, upon initial request, the following information within 30 days:

1. The address of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;

Sandra Reen

Subject:	FW: FW: Response from AAOMS in JOMS
Attachments:	dairs_user_guide_2019.pdf; DAIRSUsersGuide03012018.pdf

From: Sandy Guenther <SGuenther@aaoms.org>
Sent: Friday, October 4, 2019 2:32 PM
To: Sandy Guenther <SGuenther@aaoms.org>
Cc: Karin Wittich <KarinW@aaoms.org>
Subject: Response from AAOMS in JOMS

Dear Colleagues:

We wanted to ensure you were aware of the attached document – AAOMS Response to Recent Challenges to OMS Office-Based Anesthesia for Pediatric Patients – published in the Journal of Oral and Maxillofacial Surgery (JOMS). AAOMS stands firmly in support of its fellows and members' ability to deliver sedation and anesthesia services in their office-based practices.

One way dental boards can work to promote our joint goal of patient safety is to provide information regarding adverse events related to dental anesthesia delivery to a centralized, deidentified database where these incidents can be catalogued, quantified and studied. We previously reached out to you regarding the establishment of such a database, the Dental Anesthesia Incident Reporting System (DAIRS), which is offered free of charge to submitters and dental board officials. We would encourage you to consider participating in this system. For more information or any questions, please contact DAIRS@AAOMS.org.

We welcome further discussions on how the dental community can work together to improve the safe delivery of care by all dental practitioners to all patients. Please do not hesitate to reach out with any questions.

Sandy Guenther

Manager, State Government Affairs

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Dental Anesthesia Incident Reporting System (DAIRS)

Quick Start Guide

Version 1.1

1. Background

The Dental Anesthesia Incident Reporting System (DAIRS) is an anonymous, self-reporting tool created to facilitate reporting, collection and analysis of anesthesia-related incidents that occur during oral and maxillofacial surgery (OMS) procedures.

This document outlines the process a provider needs to follow to access DAIRS and report anesthesia incidents to AAOMS.

The target audience for DAIRS and this Quick Start Guide is the OMS clinician and support staff.

2. Log in to DAIRS

Step	Action	Notes
Step 1	DAIRS link on AAOMS website: https://omsqor.aaoms.org/DAIRS/IncidentReportModule.aspx **OR** DAIRS link within OMSQOR®: https://omsqor.aaoms.org/Dashboard/Login.aspx	Only OMSQOR® participants may access DAIRS within OMSQOR®; however, the DAIRS application is the same regardless of which link is used to access it.
Step 2	DAIRS welcome screen displays with introductory language and **I Agree** button	For technical support, contact aaoms.support@bot.figmd.com
Step 3	Click **I Agree** to proceed to complete an incident report.	

3. Overview of DAIRS

The DAIRS collection form consists of nine tabs listed in steps 4-12 below. As you answer questions, additional questions based on specific responses to questions may appear. You can navigate throughout the tabs but cannot submit the report until all required information is completed.

Step	Action	Notes
Step 4	**Provider Information** This tab captures demographic information about the provider and the support staff present during the incident that you are reporting. 1. Always select **Real** when submitting an actual incident. You will be able to review all information prior to submission. 2. Complete all information as accurately and completely as possible.	You can navigate to the next tab ONLY after completing the mandatory fields within this tab.

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Step	Action	Notes
Step 5	**Patient Pre-Op Assessment** This tab requests key patient demographics and clinical details captured before the procedure was performed. 1. Click **Add Procedures** field to view procedures listed in the table. 2. Select the applicable **planned or performed procedures**.	For planned operative procedures, you may select the category first to limit the number of codes shown in the table. You may also search by code or description.
Step 6	**Anesthesia Procedure** This tab captures the billing codes applicable to anesthesia used during the procedure. 1. Click **Add Procedures** field to view procedures listed in the table. 2. Select all applicable anesthesia codes for the anesthesia administered during the procedure in which the incident occurred. 3. Enter the number of units of anesthesia billed.	Here again, you may select the category first to limit the number of codes shown in the table. When entering Billed Units, keep in mind that one unit is equal to 15 minutes.
Step 7	**Monitors** This tab captures information about the patient vital signs that were monitored and documented during anesthesia.	Select all monitors used during sedation.
Step 8	**Medication Administered** This tab captures information about the medication given to the patient during the procedure/visit. 1. Click to **Add Medications** field. 2. Begin typing the name of the medication in the **Search Medications** box. 3. Select the administered medications by clicking the checkbox to the left of the medication name. 4. Enter dosage, units, number of doses and administration timing.	Click **Add Medication** button to add medication that is not listed. The newly added medication and its corresponding information is added to the previously selected medication list. If you select **Other** for units, enter the units into the text field that is provided.
Step 9	**Complications/Incidents** This tab captures information about the complications/incidents that occurred during the visit. 1. The boxes in this section allow you to select more than one complication/incident. 2. Make your first selection, then return your mouse to the box to choose your next selection.	The default is set to **YES** for the first question. Click **X** next to your selection to delete it, if needed.
Step 10	**Narrative** This tab captures detailed information related to anesthesia administered to the patient during the visit and the complication/incident.	

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Step 11	**<u>Additional Information</u>** This tab captures additional details regarding the complication/incident and how your team responded.	AAOMS is capturing this information to share best practices with AAOMS members and OMSQOR® participants.
Step 12	**<u>Submit</u>** This tab allows you to share the information corresponding to the incident with AAOMS. Before you submit the report, you may review all information entered. 1. Click **Preview** to view the DAIRS report before submitting. 2. Click **Submit** to send the report to AAOMS.	You cannot submit the report until you resolve any existing errors. Once you submit the report, it is final and you cannot make any additional changes. Once you click submit, a PDF of the report may be downloaded to your computer for your records.

4. Errors and Warnings

The **Errors and Warnings** box is displayed to the top right of the screen.

It expands automatically when the system encounters an error and lists the questions that require your attention before you can submit the incident report.

- The issues listed in the **Errors and Warnings** box are hyperlinked to the question that needs attention.
- Once the error is addressed, the item is removed from the Errors and Warnings box.

Errors and Warnings
(Click the error to locate the question)

Provider Information

1. Please select a real case or a test
2. Please select State/Province
3. Anesthesia Provider Responsibility
4. Please select Number of support staff present

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BOARD OF DENTISTRY
REGULATORY-LEGISLATIVE COMMITTEE

SUBCOMMITTEE ON AMENDING THE DEFINITION OF DENTISTRY

A1C TESTING/DEFINITION OF DENTISTRY

Ms. Ridout opened discussion by asking if the current definition of the term "'"dentistry" in the Code is broad enough to include A1C testing. Following discussion of relying on the current definition, Mr. Rutkowski explained that A1C testing does not fall within the current definition because screening for diabetes is not related to treatment of the oral cavity and its adjacent and associated structures. Ms. Reen advised that the Board had accepted this advice previously given to it by Counsel and charged the Committee with proposing an amendment. Ms. Yeatts explained that the Board would need to act on amending the definition no later than at its June 2020 meeting to propose legislation for the 2021 Session of the General Assembly.

Ms. Ridout read the current Code definition of dentistry and stated the goal should be an amendment to include A1C testing without establishing a "laundry list" of amendments.

In response to further questions about the current definition asked by Dr. Jones and Dr. Watkins, Dr. Catchings read the definition in a different order to explain that a dentist seeing a patient with a sinus condition cannot treat the sinus condition because that condition is not associated with the oral cavity. Mr. Rutkowski stated again that the definition as written does not include A1C testing. Ms. Yeatts said a simple sentence that is concise, not all inclusive of the practice of medicine and presents clear boundaries could be added. Dr. Catchings commented that dentists need parameters to "know where to stop" in addressing medical procedures such as flu shots and HIV testing.

Ms. Ridout asked who would serve on a sub-committee to develop a proposal. Dr. Catchings and Dr. Watkins volunteered and Mr. Rutkowski, Ms. Yeatts and Ms. Reen agreed to assist. Ms. Ridout charged the sub-committee with bringing its proposal to the next Committee meeting, which was scheduled for February 28, 2020. *Excerpt from Regulatory-Legislative Committee November 15, 2019 DRAFT Minutes*

AMENDMENT PROPOSED BY SUBCOMMITTEE

DEFINITION OF "DENTISTRY" IN THE CODE OF VIRGINIA:

"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.

PROPOSED DEFINITION OF "DENTISTRY" FROM SUBCOMMITTEE:

"Dentistry" includes the monitoring of patient blood glucose levels through HbA1c screening, prior to comprehensive, complex, or long term treatment. HbA1c screening is not presumed to be a standard of care.

TIME & PLACE: The meeting of the Regulatory-Legislative Subcommittee was convened at 10:00 a.m. on February 7, 2020 at the Perimeter Center Conferencing Center, 9960 Mayland Drive, in Training Room 1, Henrico, Virginia 23233.

MEMBERS PRESENT: Sandra J. Catchings, D.D.S., Vice President
James D. Watkins, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kathryn E. Brooks, Executive Assistant

DEFINITION OF DENTISTRY: Ms. Reen said the purpose of this meeting is to propose an amendment to the definition of "Dentistry" to include HbA1c testing for discussion by the Regulatory - Legislative Committee at its February 28, 2020 meeting. She reviewed the following materials in the agenda package:

- Notes from the November 15, 2019 Committee meeting
- Current definition in Virginia, and
- Definitions used by other states.

She also reviewed information on HbA1c testing in the American Dental Association's publications, CDT 2020 Dental Procedure Codes and CDT 2020 Coding Companion.

Discussion followed on appropriate terminology and on establishing when HbA1c screening may be warranted within the scope of the practice of dentistry. After discussing several proposals, the Subcommittee agreed by consensus to propose adding the following sentences to the current definition for discussion on February 28th.

> "Dentistry" includes the monitoring of patient blood glucose levels through HbA1c screening, prior to comprehensive, complex, or long term treatment. HbA1c screening is not presumed to be a standard of care.

A1C TESTING INFORMATION

TAKEN FROM THE REGULATORY-LEGISLATIVE COMMITTEE 11/15/19 AGENDA PACKAGE

A1c Testing

The A1C test is a common blood test used to diagnose type 1 and type 2 diabetes and to monitor how well you're managing your diabetes. The A1C test goes by many other names, including glycated hemoglobin, glycosylated hemoglobin, hemoglobin A1C and HbA1c.

The A1C test result reflects your average blood sugar level for the past two to three months. Specifically, the A1C test measures what percentage of your hemoglobin — a protein in red blood cells that carries oxygen — is coated with sugar (glycated). The higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications. (Mayo Clinic, 2018)

Current CDT Codes

Code D0411 was added to the CDT Code effective January 1, 2018 and the full published entry is:

> D0411 HbA1c in-office point of service testing Code (American Dental Association, 2019)

D0412 was added to the CDT Code effective January 1, 2019 and the full published entry is:

> D0412 blood glucose level test – in-office using a glucose meter This procedure provides an immediate finding of a patient's blood glucose level at the time of sample collection for the point of service analysis. (American Dental Association, 2019)

Why would dentist administer the A1c?

Dentists are not expected to diagnose diabetes but in-office monitoring of patient blood glucose levels on an ongoing basis or immediately prior to treatment are appropriate activities. Findings from monitoring the patient's glycemic control may prompt a dentist to amend the patient's oral care treatment planning. (American Dental Association, 2019)

There are several factors associated with increased risk of diabetes, some of which may already be in their dental records, such as:

- Obesity or being overweight
- Ethnic background (diabetes happens more often in Hispanic/Latino Americans, African Americans, Native Americans, Asian-Americans, Pacific Islanders, and Alaska natives)
- Sedentary lifestyle (exercise less than three times a week)
- Family history (parent or sibling who has diabetes) (American Dental Association, 2019)

If a person with diabetes or at risk for the condition is about to undergo a long complex dental procedure, it is important to know their current blood glucose level – and the D0412 procedure determines the patient's blood glucose level at the time of sample collection. HbA1c measures the proportion of hemoglobin that is glycosylated (to which glucose is bound) and provides a summary measure of a patient's average circulating blood glucose level over the previous 2 to 3-month period. (American Dental Association, 2019)

Even though the patient's HbA1c percentage may indicate good glycemic control, glucose levels vary during the course of a day. Therefore, the patient's actual blood glucose level at the time of procedure delivery could be very low, or very high. (American Dental Association, 2019)

A dentist can determine, using the D0412 procedure, how the patient's blood glucose level, may affect treatment scheduled for the day's appointment.

- A glucose level below 70mg/dl is the clinical definition of hypoglycemia alert level, which means the patient is at risk of a hypoglycemic event during the procedure. Therefore, the procedure ought not be initiated until the patient's blood sugar level is in the acceptable range.

- A glucose level over 300 mg/dl could lead to delayed healing of the surgical site and severe infection. This suggests that elective surgical procedures be rescheduled and delivered when the patient's circulating glucose level is in the acceptable range. (American Dental Association, 2019)

Dentistry by State regarding A1c testing

New Jersey: In 2018, New Jersey Dentist were able to get paid for performing chairside diabetes screenings for at-risk patients (Stainton, 2017). In 2014, the New Jersey State Board of Dentistry ruled that dentists in New Jersey could screen at-risk patients for diabetes, and although such in-office screening is within the scope of licensure in the state, this testing is not to be presumed to be the standard of care (Richard H. Nagelberg, 2017). The New Jersey State Board of Dentistry has explicitly state that HbA1c screening is not presumed to be a standard of care (American Dental Association, 2019).

Definition of Dentistry: 45:6-19. "Practicing dentistry" defined Any person shall be regarded as practicing dentistry within the meaning of this chapter who (1) Uses a dental degree, or the terms "mechanical dentist" or the use of the word "dentist" in English or any foreign language, or designation, or card, device, directory, poster, sign, or other media whereby he represents himself as being able to diagnose, treat, prescribe or operate for any disease, pain, deformity, deficiency, injury, or physical condition of the human tooth, teeth, alveolar process, gums, cheek, or jaws, or oral cavity and associated tissues; or (2) Is a manager, proprietor, operator, or conductor of a place where dental operations are performed; or (3) Performs dental operations of any kind gratuitously, or for a fee, gift, compensation or reward, paid or to be paid, either to himself or to another person or agency; or (4) Uses himself or by any employee, uses a Roentgen or X-ray machine for dental treatment, dental radiograms, or for dental diagnostic purposes; or (5) Extracts a human tooth or teeth, or corrects or attempts to correct malpositions of the human teeth or jaws; or (6) Offers and undertakes, by any means or method, to diagnose, treat or remove stains or concretions from human teeth or jaws; or (7) Uses or administers local or general anesthetics in the treatment of dental or oral diseases or in any preparation incident to a dental operation of any kind or character; or (8) Takes impressions of the human tooth, teeth, jaws, or performs any phase of any operation incident to the replacement of a part of a tooth, teeth, or associated tissues; or (9) Performs any clinical operation included in the curricula of recognized dental schools or colleges.

New York: As part of their scope of professional practice, dentists licensed in New York State can perform "physical examinations" necessary to provide dental treatment safely and effectively. It is permissible for dentists to do blood glucose testing on their own patients as part of a complete physical examination when necessary. Dentists ***cannot*** diagnose diabetes and need to refer any patient with questionable test results to their physician. (New York State Dental Association, 2019)

Definition of Dentistry: § 6601. Definition of practice of dentistry.

The practice of the profession of dentistry is defined as diagnosing, treating, operating, or prescribing for any disease, pain, injury, deformity, or physical condition of the oral and maxillofacial area related to restoring and maintaining dental health. The practice of dentistry includes the prescribing and fabrication of dental prostheses and appliances. The practice of dentistry may include performing physical evaluations in conjunction with the provision of dental treatment.

Oregon: At its Board Meeting on December 14, 2018, the Board of Dentistry recognized that it is within the scope of practice for a licensee to perform in-office A1C diabetes screening test for at-risk patients. The Board noted that: a) such testing is not presumed to be the standard of care; and b) for A1C screenings beyond the normal range, licensees should refer patients to a physician for a formal evaluation, diagnosis, and treatment (Oregon Dental Association, 2018).

Definition of Dentistry: (7)(a) "Dentistry" means the healing art concerned with:

(A) The examination, diagnosis, treatment planning, treatment, care and prevention of conditions within the human oral cavity and maxillofacial region, and of conditions of adjacent or related tissues and structures; and

(B) The prescribing, dispensing and administering of prescription drugs for purposes related to the activities described in subparagraph (A) of this paragraph.

(b) "Dentistry" includes, but is not limited to, the cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the Oregon Board of Dentistry and included in the curricula of:

(A) Dental schools accredited by the Commission on Dental Accreditation of the American Dental Association;

(B) Post-graduate training programs; or

(C) Continuing education courses.

North Carolina: The new American Dental Association CDT Code D0411 became effective on January 1, 2018. The code concerns a finger stick capillary HbA1c glucose test procedure. The test is a measure of the amount of glucose attached to red blood cells and directly relates to the average blood glucose levels over a certain time frame. The test can be utilized by physicians as part of a potential diagnosis of diabetes. Because only a physician can diagnose diabetes, dentists should not administer an HbA1c test to diagnose or pre-screen for diabetes. Consequently, ADA CDT Code D0411 cannot be billed in North Carolina for an HbA1c test administered to pre-screen or diagnose diabetes.

It is within the proper scope of the practice of dentistry, however, for a dentist with appropriate training, knowledge, and experience to administer the HbA1c test and use the test results to make decisions about potential dental treatment. As noted in the ADA guide on CDT Code D0411, a dentist also would need to comply with all applicable federal and state regulatory requirements to offer such tests, including the federal regulation

-- Clinical Laboratory Improvement Amendments of 1988 (CLIA). ADA CDT Code D0411 may be billed if a dentist properly administers the HbA1c test to determine appropriate dental treatment. If a dentist receives the results of an HbA1c test properly administered to determine dental treatment, which results along with other known risk factors also raise concerns about potential diabetes or pre-diabetes, it is appropriate for the dentist to make a referral to a physician for a potential diagnosis and treatment (North Carolina State Board of Dental Examiners, 2018).

Definition of Dentistry: b) A person shall be deemed to be practicing dentistry in this State who does, undertakes or attempts to do, or claims the ability to do any one or more of the following acts or things which, for the purposes of this Article, constitute the practice of dentistry:

(1) Diagnoses, treats, operates, or prescribes for any disease, disorder, pain, deformity, injury, deficiency, defect, or other physical condition of the human teeth, gums, alveolar process, jaws, maxilla, mandible, or adjacent tissues or structures of the oral cavity;

(2) Removes stains, accretions or deposits from the human teeth;

(3) Extracts a human tooth or teeth;

(4) Performs any phase of any operation relative or incident to the replacement or restoration of all or a part of a human tooth or teeth with any artificial substance, material or device;

(5) Corrects the malposition or malformation of the human teeth;

(6) Administers an anesthetic of any kind in the treatment of dental or oral diseases or physical conditions, or in preparation for or incident to any operation within the oral cavity; provided, however, that this subsection shall not apply to a lawfully qualified nurse anesthetist who administers such anesthetic under the supervision and direction of a licensed dentist or physician;

(6a) Expired pursuant to Session Laws 1991, c. 678, s. 2.

(7) Takes or makes an impression of the human teeth, gums or jaws;

(8) Makes, builds, constructs, furnishes, processes, reproduces, repairs, adjusts, supplies or professionally places in the human mouth any prosthetic denture, bridge, appliance, corrective device, or other structure designed or constructed as a substitute for a natural human tooth or teeth or as an aid in the treatment of the malposition or malformation of a tooth or teeth, except to the extent the same may lawfully be performed in accordance with the provisions of G.S. 90-29.1 and 90-29.2;

(9) Uses a Roentgen or X-ray machine or device for dental treatment or diagnostic purposes, or gives interpretations or readings of dental Roentgenograms or X rays;

(10) Performs or engages in any of the clinical practices included in the curricula of recognized dental schools or colleges;

(11) Owns, manages, supervises, controls or conducts, either himself or by and through another person or other persons, any enterprise wherein any one or more of the acts or practices set forth in subdivisions (1) through (10) above are done, attempted to be done, or represented to be done;

(12) Uses, in connection with his name, any title or designation, such as "dentist," "dental surgeon," "doctor of dental surgery," "D.D.S.," "D.M.D.," or any other letters, words or descriptive matter which, in any manner,

represents him as being a dentist able or qualified to do or perform any one or more of the acts or practices set forth in subdivisions (1) through (10) above;

(13) Represents to the public, by any advertisement or announcement, by or through any media, the ability or qualification to do or perform any of the acts or practices set forth in subdivisions (1) through (10) above.

Factors to consider

- Scope of Practice/knowledge
- Referral considerations: closing the referral loop, what to do with the results if pt. doesn't have a PCP.
- Equipment needed
- Ethical obligations
- Documentation

References

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