VIRGINIA BOARD OF DENTISTRY
Regulatory-Legislative Committee
AGENDA
October 16, 2015

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

TIME		PAGE
9:00 a.m.	**Call to Order – Melanie C. Swain, RDH, Chair**	
	Evacuation Announcement – Ms. Reen	
	Public Comment	
	Approval of Minutes October 24, 2014 minutes	**P1**
	Status Report on Regulatory Actions – Ms. Yeatts	
	ASSIGNMENTS	
	➢ Address who may own a dental practice. 12/7/2012	**P6**
	➢ Consider establishing a policy on the role of a dentist in treating sleep apnea. 10/24/2014	**P18**
	➢ Work on a proposal to expand the use of remote supervision to free clinics and settings serving children and the elderly and review the education requirements for dental assistants II. 6/12/2015	**P28**
	➢ Consider policy action on the subject of teledentistry. 9/18/2015	**P94**
	➢ Consider requiring a clinical examination similar to Ohio's for dental assistants II. 9/18/2015	**P119**
	Next meetings	
Adjourn		

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY-LEGISLATIVE COMMITTEE
October 24, 2014

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order at 1:00 p.m., on October 24, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.

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

MEMBERS PRESENT: Charles E. Gaskins, III, D.D.S.
Melanie C. Swain, R.D.H.

MEMBERS ABSENT: Evelyn M. Rolon, D.M.D.

OTHER BOARD MEMBERS: Al Rizkalla, D.D.S.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager

OTHERS PRESENT: David E. Brown, D.C., Director, Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
James E. Rutkowski, Assistant Attorney General

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

PUBLIC COMMENT: Christopher Nolen, Senior Vice-President of McGuireWoods Consulting introduced himself as representing the Association of Dental Support Organizations (ADSO). He stated that ADSO is interested in the discussion of practice ownership and would like to participate in any Regulatory Advisory Panel formed to address practice ownership.

Martin Guy Rohling of Albers & Company introduced himself as representing Kool Smiles which operates 14 dental clinics in Virginia. He said he would like to participate in any Regulatory Advisory Panel (RAP) addressing practice ownership.

Trudy Levitin, R.D.H., stated that she recalled the Board's decision to not address charging for examinations performed by dental hygienists when practice under general supervision was permitted. She noted her experience and said billing using the CDT Code D0120 is appropriate. She questioned why the Board would choose to address this billing practice now.

David C. Sarrett, D.D.S., Dean of VCU School of Dentistry, stated that the General Practice Residency and the Advanced Education in General Dentistry

residency program are designed to provide training beyond the level of a pre-doctoral dental education program and are not remedial education programs. He provided a handout which listed the goals of these programs. He added that successful completion of an accredited post-doctoral general dentistry program, demonstrates the candidate has met, and surpassed, the entry level for licensure.

APPROVAL OF MINUTES:

Dr. Wyman asked if Committee members had reviewed the May 2, 2014 minutes. Dr. Gaskins moved to accept the minutes. The motion was seconded and passed.

STATUS REPORT ON REGULATORY ACTIONS:

Ms. Yeatts reported that the Periodic Review of proposed regulations to establish four chapters is pending administrative review at the office of the Secretary of Health and Human Resources.

BILLING FOR A PERIODIC EXAM PERORMED BY RDH:

Ms. Reen stated that the Board assigned this topic to the Committee. She added that the Committee is to consider proposing a position on the practice of billing for periodic exams performed by dental hygienists and possibly developing a guidance document on the subject.

Dr. Watkins stated that he brought this matter to the Board's attention because in a case he reviewed, the dentist billed the insurance company CDT Code D0120 for the exam performed by the hygienist under general supervision. He said clarification is needed because he cited it as a violation but was told by staff that it is permissible.

Information on current billing practices in Virginia and on the provisions in the CDT Code was discussed. Following discussion, Dr. Gaskins moved to take this as information and to take no action at this time. The motion was seconded and passed.

CHANGING THE EDUCATION REQUIREMETN FOR DENTAL LICENSURE:

Dr. Wyman stated that there is no uniform standard for foreign trained dentists to become licensed in the United States. He noted his concern is that the 12-month post-doctoral advanced general dentistry program is not sufficient training to prove competency for licensure in Virginia.

Dr. Sarrett stated that foreign trained dentists without competitive skills are not accepted into the advanced programs. Those dentists must complete DDS or DMD programs from a CODA accredited program before being accepted in an advanced program. He added that the VCU School of Dentistry does not offer non-CODA accredited dental training programs.

Dr. Wyman moved to recommend amending the regulations to require foreign trained dentists to complete at least a 24-month post-doctoral advanced general dentistry program. The motion was seconded and failed.

PRACTICE OWNERSHIP:

Ms. Reen reported that she discussed forming a Regulatory Advisory Panel (RAP) with Dr. Brown who recommended having focused conversations with the other state agencies that may have a role or interest in practice ownership before establishing a RAP. She added that Dr. Brown was facilitating these meetings and that a meeting with the Department of Medical Assistance Services' (DMAS) has taken place. Ms. Reen noted that DMAS has agreed to facilitate earlier communication about action taken against providers and DHP agreed to explore conducting joint investigations.

She said Committee discussion of the materials in the agenda package would help her explain the Board's interests and goals. The Committee took no action.

DAII REGISTRATION OPTIONS FOR QUALIFYING:

Ms. Reen stated that very few people qualified for Dental Assistant II (DAII) registration either by education or by endorsement. She explained that many of the duties classified as "expanded" in other states are duties any dental assistant can perform in Virginia. She said that she has included the Minnesota Board of Dentistry provisions for restorative functions to facilitate discussion. She added that the Minnesota Board is working with be CODA to establish standards for dental therapy programs.

Ms. Yeatts noted that the Board has not reviewed this regulation since its implementation. She suggested bringing back dental assistant educators for discussion and feedback on the requirements for registration.

Discussion followed about dental hygienists being allowed to take coursework that is similar to the coursework required by the DAII regulations and about the requirements being too strict that no one will be able to qualify for a DAII registration.

Dr. Gaskin moved to recommend to the full Board that a task force be created to look at the DAII requirements. The motion was seconded and passed.

ADVANCED DENTAL HYGIENE PRACTICE:

Ms. Reen stated that the Committee was asked to consider the Joint Commission on Health Care's (JCHC) request to allow licensed dental hygienists to take continuing education classes to qualify to perform the duties delegable to DAIIs.

She added that the JCHC is also interested in expanding the Remote Supervision model in use in the Virginia Department of Health (VDH) to

include community clinics. She noted that this model allows dental hygienists who are employed by the VDH to see patients who have been seen by a dentist.

It was agreed by consensus that the task force established to address the DAII requirements should also address the Joint Commission recommendations.

ELECTRONIC DENTAL RECORDS:

Dr. Wyman asked Dr. Rizkalla to address his concern. Dr. Rizkalla stated that, through an informal conference, he learned that licensees can modify electronic treatment records after their initial entry.

Dr. Brown stated that this issue transcends the Board of Dentistry and is an agency issue. He asked whether electronic record alteration is a significant enough issue to have separate policy for electronic records. He suggested looking at other states' regulations.

No action was taken following discussion.

TELEDENTISTRY:

Dr. Wyman asked Dr. Brown for guidance. Dr. Brown stated that it is an area of interest of Secretary Hazel for addressing unmet need for services. He added that the Board of Medicine convened an ad hoc committee on this and a guidance document is being drafted. He suggested the need for a broad based workgroup which includes the private sector and educational institutions to study this matter.

Dr. Wyman moved to ask the Board President to appoint an ad hoc committee to address this matter. The motion was seconded and passed.

DENTAL ROLE IN TREATING SLEEP APNEA:

Ms. Reen stated the Board requested consideration of having a policy addressing sleep apnea because it is not currently addressed in the law or regulations. She added that the position of the Board in disciplinary cases is that sleep apnea must first be diagnosed by a physician who can then make a referral to a dentist to provide treatment or a dentist may observe symptoms of sleep apnea and refer to a physician for an evaluation. She referred the Committee to the October 23, 2014 letter from the Virginia Academy of Dental Sleep Medicine (VADSM) and the American Academy of Dental Sleep Medicine (AADSM) Treatment Protocol: Oral Appliance Therapy for Sleep Disordered Breathing for review and discussion.

Discussion followed about when and how sleep apnea is taught dental programs. A member of the audience stated that doctoral level dental students at the VCU School of Dentistry are taught the basics of recognizing sleep apnea and the screening process. He added that once the diagnosis is done by a physician, it is an airway issue that can be treated by a dentist. A member of the Virginia Society of Oral & Maxillofacial Surgeons (VSOMS), suggested that the Committee review VASOMS's position paper before recommending a guidance document.

By consensus, the Committee decided it wanted to review additional information at its next meeting.

ADJOURNMENT: With all business concluded, Dr. Wyman adjourned the meeting at 2:55 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

Virginia Board of Dentistry

REGULATORY /LEGISLATIVE COMMITTEE
10/16/2015

Assignment: Address who may own and operate a dental practice

Background
On December 7, 2012, the Board assigned this task to the Committee and voted to establish a Regulatory Advisory Panel (RAP) to assist in evaluating regulatory action. The Committee was asked to address (1) how long a non-dentist relative such as a widow can operate a dental practice, and (2) to identify options for holding practice management companies and other such business entities accountable for policies and practices that contribute to unsafe dental treatment.

Applicable Law
Presently there is no comprehensive provision in the Code of Virginia (Code) which addresses dental practice ownership and operation. A list of the current Code provisions addressing permissible and impermissible employment sites for dentists is provided. It includes state agencies, charitable corporations, partnerships, professional corporations, professional limited liability companies, health care institutions, and schools with CODA accredited programs. There is a provision which prohibits a dentist from practicing in a commercial or mercantile establishment.

Prior to 1988, the Code section §54-146 addressed "what constitutes the practice of dentistry" and expressly stated that any person who is a manager, proprietor, operator, or a conductor of a place for performing dental operations shall be deemed to be practicing dentistry. In 1988, the Code's numbering system was changed and section §54-146 became §54.1-2711 which addressed the "practice of dentistry." During this recodification the substance of the section was also changed significantly. The provision about any person "...who is a manager, proprietor, operator or a conductor ...." was replaced with this sentence, "No dentist shall be supervised within the scope of the practice of dentistry by any person who is not a licensed dentist." This section has not been amended since 1988. A page with these two provisions is provided.

Model for Discussion
After looking at a number of states' statutes and regulations, the Committee decided to use the Texas laws to facilitate discussion. The Texas statutes and regulations are attached.

Other Agencies
At the request of the Committee, staff contacted several state agencies to get information on the authority they have to hold practice management companies and other such businesses accountable for policies and practices that contribute to unsafe dental treatment.

- The State Corporation Commission indicated it is simply the filing office under corporate law and does not handle complaints against businesses unless they fall under one of their bureaus (insurance company, financial institution, utility company, etc)

- Dr. Brown facilitated a meeting with the director of the Department of Medical Assistance Services (DMAS) and her staff to discuss information sharing during investigations of dentists and practice management companies. Two additional meetings followed to address when and how information might be shared and points of contact for the DHP Enforcement Division and DMAS were established.
- The Consumer Protection Section of the Office of the Attorney General (CPS) indicated it refers complaints about health care to DHP and sometimes it will work with another agency when there is a concurrent issue with fraudulent acts or practices in connection with a consumer transaction.

While working relationships have been established with DMAS and CPS, it is unclear what outcomes can be expected.

Establishing a Regulatory Advisory Panel

As indicated in the name, a RAP may be appointed to address a specific regulatory issue. This action has been delayed because it is not evident that the Board has the statutory authority to regulate practice ownership. A copy of the Board's regulation for formation of a RAP is provided.

Decide Next Steps

Current Statutes on Dental Practice Ownership and Dental Practice Settings

There are several provisions in the Code of Virginia which address practice ownership and practice settings as follows:

- §§54.1-2711.1 and 54.1-2713 provide for restricted licenses for practice at CODA accredited programs

- §54.1-2712.1 provides for a restricted license to volunteer for public health or community free clinics

- §54.1-2717 addresses the practice of dentistry by professional corporations and professional limited liability companies

- §54.1-2715 lists permissible work sites for certain dentists to qualify for temporary permits. The qualifying locations listed are:
  (a) the Virginia Department of Corrections,
  (b) the Virginia Department of Health,
  (c) the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, or
  (d) a Virginia charitable corporation granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code and operating as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services: (i) as a federal qualified health center designated by the Centers for Medicare and Medicaid Services or (ii) at a reduced or sliding fee scale or without charge.

- §54.1-2716 prohibits a dentist from practicing in a commercial or mercantile establishment.

- §54.1-2718 permits the practice of dentistry by a partnership under a firm name, a licensed dentist practicing as the employee of a licensed dentist, practicing under his own name or under a firm name, or as the employee of a professional corporation, or as a member, manager, employee, or agent of a professional limited liability company or as the employee of a dental clinic operated as specified in subsection A of § 54.1-2715.

- §54.1-2709.4 lists the entities responsible for reporting any type of disciplinary action taken against an oral and maxillofacial surgeon. This list includes health care institutions licensed by the Commonwealth as required reporters.

Virginia Law on What Constitutes the Practice of Dentistry

1987

§54-146. What constitutes practice of dentistry. – Any person shall be deemed to be practicing dentistry, who uses the words dentist, or dental surgeon, the letters D.D.S., D.M.S., or any letters or title in connection with his mane, which in any way, represents him as engaged in the practice of dentistry, or any branch thereof; or who holds himself out, advertises or permits to be advertised by sign, card, circular, handbill, newspaper or otherwise that he can or will attempt to perform dental operations of any kind; or who shall diagnose, profess to diagnose, or treat or profess to treat any of the diseases or lesions of the oral cavity, its contents or contiguous structures, or shall extract teeth, or shall correct malpositions of the teeth or jaws, or shall take impressions, or shall supply or repair artificial teeth as substitutes for natural teeth, or shall place in the mouth and adjust such substitutes, or do any practice included in the curricula of recognized dental colleges, or administer or prescribe such remedies, medicinal or otherwise, as shall be needed in the treatment of dental or oral diseases or shall use a X-ray or administer local or general anesthetic agents for dental treatment or dental diagnostic purposes.

And any person shall be deemed to be practicing dentistry who is a manager, proprietor, operator, or conductor of a place for performing dental operations of any kind, or who for a fee, salary, or other reward paid or to be paid either to himself or to another person, performs or advertises to perform dental operations of any kind, diagnoses or treats diseases or lesions of human teeth or jaws, mechanically, medicinally, or by means of radiograms, or attempts to correct malpositions thereof.

1988

§54.1-2711. Practice of dentistry. – Any person shall be deemed to be practicing dentistry who (i) uses the words dentists, or dental surgeon, the letter D.D.S., D.M.D., or any letter or title in connection with his name, which in any way represents him as engaged in the practice of dentistry; (ii) holds himself out, advertises or permits to be advertised that he can or will perform dental operations of any kind; (iii) diagnoses, treats, or professes to diagnose or treat any of the diseases or lesions of the oral cavity, its contents or contiguous structures, or (iv) extracts teeth or jaws, take impressions for the fabrication of appliances or dental prosthesis, supplies or repairs artificial teeth as substitutes for natural teeth, or places in the mouth and adjusts such substitutes.

No dentist shall be supervised within the scope of the practice of dentistry by any person who is not a licensed dentist.

Texas Statutes

OCCUPATIONS CODE

TITLE 3. HEALTH PROFESSIONS

SUBTITLE D. DENTISTRY

CHAPTER 254. BOARD POWERS AND DUTIES

Sec. 254.001. GENERAL RULEMAKING AUTHORITY. (a) The board may adopt and enforce rules necessary to:

(1) perform its duties; and

(2) ensure compliance with state laws relating to the practice of dentistry to protect the public health and safety.

(b) The board may adopt rules governing:

(1) the board's proceedings; and

(2) the examination of applicants for a license to practice dentistry.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

Sec. 254.0011. RULES RELATING TO CONTROL OF DENTAL PRACTICE. (a) The board may adopt rules relating to the practice of dentistry as described by Section 251.003(a)(9) to prohibit a dentist from engaging in contracts that allow a person who is not a dentist to influence or interfere with the exercise of the dentist's independent professional judgment.

(b) Rules adopted by the board under this subtitle may not preclude a dentist's right to contract with a management service organization. Rules affecting contracts for provision of management services apply the same to dentists contracting with management service organizations and to dentists otherwise contracting for management services.

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 14.074(a), eff. Sept. 1, 2001.

~~Sec. 254.002. RULES REGARDING ADVERTISING AND COMPETITIVE BIDDING. (a) Except as provided by Section 259.005, the board may not adopt rules restricting advertising or competitive bidding except~~

Sec. 254.019. DEFINITIONS. (a) In this section:

(1) "Dental service agreement" means an agreement between a dental service organization and a dentist under which the dental service organization will:

(A) provide services related to the nonclinical business aspects of a dental practice, including arranging or providing financing, performing billing or payroll tasks, processing patient insurance claims, scheduling or otherwise interacting with patients, and performing other administrative tasks;

(B) supervise or manage the employees or contractors of the dentist; or

(C) employ or otherwise contract with a dentist in the dentist's capacity as a dentist.

(2) "Dental service organization" means an entity that:

(A) is owned wholly or partly by a person who is or is not a dentist; and

(B) under a dental service agreement, provides or offers to provide services to a dentist or employs or otherwise contracts with a dentist in the dentist's capacity as a dentist.

(b) The board shall collect the following information from dentists licensed by the board in conjunction with the issuance and renewal of each dental license:

(1) the number and type of dentists employed by the license holder, if any;

(2) the name under which the license holder provides dental services and each location at which those services are provided by that license holder;

(3) whether the license holder is a participating provider under the Medicaid program operated under Chapter 32, Human Resources Code, or the child health plan program operated under Chapter 62, Health and Safety Code;

(4) whether the license holder is employed by or contracts with a dental service organization and, if so, the name and address of the dental service organization;

(5) whether the license holder owns all or part of a dental service organization and, if so, the name and address of the dental service organization and of each dental office at which the dental service organization provides services to patients;

(6) whether the license holder is a party to a dental service agreement and, if so, the name and address of the dental service organization that provides services under the agreement; and

(7) if the license holder owns all or part of a dental service organization, whether that practice is a party to a dental service agreement and, if so, the name and address of the dental service organization that provides services under the agreement.

(c) If requested by the board, a dental service organization shall provide to the board the address of the locations where the organization provides dental services in this state and the name of each dentist providing dental services at each location.

(d) The board shall provide an option for the electronic submission of the information required under this section.

(e) Not later than November 1 of each even-numbered year, the board shall provide a report to the legislature on the information collected under this section and on the board's use of the information in the exercise of the board's statutory authority to regulate the practice of dentistry.

Added by Acts 2013, 83rd Leg., R.S., Ch. 709 (H.B. 3201), Sec. 4, eff. September 1, 2013.

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TITLE 22	EXAMINING BOARDS
PART 5	STATE BOARD OF DENTAL EXAMINERS
CHAPTER 108	PROFESSIONAL CONDUCT
SUBCHAPTER F	CONTRACTUAL AGREEMENTS
RULE §108.70	**Improper Influence on Professional Judgment**

(a) For the purposes of this rule, the term dentist shall include the following:

(1) a dentist licensed by the State Board of Dental Examiners;

(2) a professional corporation wholly owned by one or more dentists;

(3) other entities that provide dental services and are owned by one or more dentists.

(b) Any dentist entering into any contract, partnership or other agreement or arrangement which allows any person other than a dentist any one or more of the following rights, powers or authorities shall be presumed to have violated the provisions of the Dental Practice Act, Section 251.003 regarding controlling, attempting to control, influencing, attempting to influence or otherwise interfering with the exercise of a dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition:

(1) Controlling, owning or setting any conditions for access to or the specific contents of dental records of patients of a dentist.

(2) Setting a maximum or other standardized time for the performance of specific dental procedures.

(3) Placing any limitations or requirements on treatments, referrals, or consultations except those based on the professional judgment of the dentist.

(4) Limiting or imposing requirements concerning the type or scope of dental treatment, procedures or services which may be recommended, prescribed, directed or performed, except that a dentist may limit the dentist's practice or the practice of a dentist employed by or contracting with the dentist to certain procedures or the treatment of certain dental diseases.

(5) Limiting or imposing requirements concerning the supplies, instruments or equipment deemed reasonably necessary by a dentist to provide diagnoses and treatment of the patients of the dentist.

(6) Limiting or imposing requirements for the professional training deemed necessary by the dentist to property serve the patients of the dentist.

(7) Directing or influencing the selection of specific diagnostic examinations and treatment or practices regarding patients without due regard to the recommended diagnostic examinations and treatment agreed upon by the dentist and the patient, except that a dentist having the responsibility for training or supervising another dentist may reasonably limit treatment or practices as a part of the training or supervision of a dentist based upon the training and competency of a dentist to perform certain treatment or practices

(8) Limiting or determining the duties of professional, clinical or other personnel employed to assist a dentist in the practice of dentistry.

(9) Establishing professional standards, protocols or practice guidelines which in the professional judgment of the dentist providing dental service to the dentist's patient, conflict with generally accepted standards within the dental profession.

(10) Entering into any agreement or arrangement for management services that:

(A) interferes with a dentist's exercise of his/her independent professional judgment;

(B) encourages improper overtreatment or undertreatment by dentists; or

(C) encourages impermissible referrals from unlicensed persons in consideration of a fee.

(11) Placing limitations or conditions upon communications that are clinical in nature with the dentist's patients.

(12) Precluding or restricting a dentist's ability to exercise independent professional judgment over all qualitative and quantitative aspects of the delivery of dental care.

(13) Scheduling patients of the dentist in a manner that may have the effect of discouraging new patients from coming into the dentist's practice, or postponing future appointments or that give scheduling preference to an individual, class or group.

(14) Penalizing a dentist for reporting violations of a law regulating the practice of dentistry.

(15) Conditioning the payment of fees to a dentist or the amount of management fees a dentist must pay, on the referral of patients to other health care providers specified by a non-dentist.

(c) The entry into one or more of the following agreements by a dentist shall not be presumed to have violated the Texas Dental Practice Act, Section 251.003.

(1) Leases, mortgages, ownership agreements or other arrangements regarding use of space for dental offices, based on a set, non percentage fee reasonably related to the fair market value of the office space provided at the time the lease or other arrangement is entered into.

(2) Agreements regarding the purchase, sale, financing or lease of dental equipment, instruments and supplies so long as the dentist maintains the complete care, custody, and control of the dental instruments and supplies and the lease does not provide for a payment or fee based upon a percentage of the revenue received by the dentist, or the dental practice.

(3) Agreements providing for accounting, bookkeeping, investment or similar financial services.

(4) The financing, lease, use or ownership of non-dentist business equipment such as telephones, computers, software, and general office equipment at reasonable, market related fees.

(5) Services regarding the pledge, collection or sale of accounts receivable from patients.

(6) Agreements regarding billing and collection services.

(7) Advertising and marketing services so long as the dentist remains solely responsible for the content of any advertising or marketing services and for ensuring that such conform to all applicable legal requirements.

(8) Agreements regarding consulting, professional development, business practices and other advisory agreements which do not limit the dentist's ability to use the dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition.

(9) Employment agreements which specify that the dentist shall continue to have the right to use the dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition, provided that in practice the dentist is allowed to use the dentist's professional judgment.

(d) The provisions of subsection (c) of this section herein may be rebutted and the entry into these agreements or other undertakings may be found to be in violation of the Dental Practice Act if it can be shown that the agreements or other undertakings result in the control, attempt to control, influence, attempt to influence or otherwise interfere with the exercise of a dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition.

(e) This rule shall not be applicable to dentists or others covered by the Dental Practice Act, Section 251.004, entitled Exceptions, Section 260.001, regarding administration of an estate and continuation of practice nor Sections 260.002 through 260.004, regarding employment of dentists.

Source Note: The provisions of this §108.70 adopted to be effective February 20, 2001, 26 TexReg 1494

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TITLE 22	EXAMINING BOARDS
PART 5	STATE BOARD OF DENTAL EXAMINERS
CHAPTER 108	PROFESSIONAL CONDUCT
SUBCHAPTER F	CONTRACTUAL AGREEMENTS
RULE §108.73	**Dental Service Organizations**

Upon written request by the Board, a dental service organization, as defined by §254.019(c) of the Dental Practice Act, shall provide to the Board the address of the locations where the organization provides dental services in this state and the name of each dentist providing dental services at each location.

Source Note: The provisions of this §108.73 adopted to be effective August 25, 2013, 38 TexReg 5262

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E. Nothing in this chapter shall prohibit the agency from receiving information or from proceeding on its own motion for rulemaking.

18VAC60-11-70. Appointment of regulatory advisory panel.

A. The agency may appoint a regulatory advisory panel (RAP) to provide professional specialization or technical assistance when the agency determines that such expertise is necessary to address a specific regulatory issue or action or when individuals indicate an interest in working with the agency on a specific regulatory issue or action.

B. Any person may request the appointment of a RAP and request to participate in its activities. The agency shall determine when a RAP shall be appointed and the composition of the RAP.

C. A RAP may be dissolved by the agency if:

1. The proposed text of the regulation is posted on the Town Hall, published in the Virginia Register, or such other time as the agency determines is appropriate; or

2. The agency determines that the regulatory action is either exempt or excluded from the requirements of the Administrative Process Act.

18VAC60-11-80. Appointment of negotiated rulemaking panel.

A. The agency may appoint a negotiated rulemaking panel (NRP) if a regulatory action is expected to be controversial.

B. A NRP that has been appointed by the agency may be dissolved by the agency when:

1. There is no longer controversy associated with the development of the regulation;

2. The agency determines that the regulatory action is either exempt or excluded from the requirements of the Administrative Process Act; or

3. The agency determines that resolution of a controversy is unlikely.

18VAC60-11-90. Meetings.

Notice of any open meeting, including meetings of a RAP or NRP, shall be posted on the Virginia Regulatory Town Hall and Commonwealth Calendar at least seven working days prior to the date of the meeting. The exception to this requirement is any meeting held in accordance with §2.2-3707 D of the Code of Virginia allowing for contemporaneous notice to be provided to participants and the public.

18VAC60-11-100. Public hearings on regulations.

Virginia Board of Dentistry

REGULATORY /LEGISLATIVE COMMITTEE
10/16/2015

Assignment: Consider establishing a policy on the role of a dentist in treating sleep apnea.

Background:
On October 24, 2014, the Committee t See page 4 of the minutes.

In addition to the letter considered on October 24, 2014, two NIH articles are provided. The are:
How is Sleep Apnea Diagnosed?
and
How is Sleep Apnea Treated?

Vu, Huong (DHP)

From: Reen, Sandra (DHP)
Sent: Thursday, October 23, 2014 2:29 PM
To: Vu, Huong (DHP)
Subject: FW: BOARD OF DENTISTRY MEETING - SLEEP APNEA
Attachments: Letter_to_Va_State_Board_of_Dentistry_Oct2014.pdf; American_Academy_of_Dental_Sleep_Medicine_Protocol_Update2013.pdf

Huong:
Please copy the attachments for tomorrow.
Thank you!

From: Jim Schroeder [mailto:drjimschroeder@gmail.com]
Sent: Thursday, October 23, 2014 1:52 PM
To: melanie17rdh@gmail.com; Reen, Sandra (DHP)
Subject: BOARD OF DENTISTRY MEETING - SLEEP APNEA

Good Afternoon, Ms. Reen and Ms. Swain,

It was brought to my attention that sleep apnea will be on the agenda for the BOD meeting on Friday, October 24, 2014. As an organization that supports the guidelines of the American Academy of Dental Sleep Medicine, we welcome the opportunity to serve as a resource for your board as you discuss the growing collaborative care that's involved in achieving best patient outcomes regarding obstructive sleep apnea. I am attaching a letter on behalf of the Virginia Academy of Dental Sleep Medicine. Please feel free to share this letter and the AADSM guidelines at your meeting.

I look forward to hearing from you and future conversations -

Regards,

James R. Schroeder, DDS, MS, FACD
Virginia Academy of Dental Sleep Medicine
President
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VADSM Virginia Academy of Dental Sleep Medicine
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October 23, 2014

Virginia Board of Dentistry
Ms. Sandra Reen, *Executive Director*
Ms. Melanie Swain, *President*
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dear Members of the Virginia Board of Dentistry:

On behalf of the Virginia Academy of Dental Sleep Medicine (VADSM), I want to thank you for your interest in dental sleep medicine.

Obstructive sleep apnea has gained tremendous national attention in the past 10 years. As an organization that supports the guidelines of the American Academy of Dental Sleep Medicine, VADSM is committed to supporting the highest standards of care for patients suffering from obstructive sleep apnea (OSA).

It is our policy that patients presenting with symptoms of OSA require a face-to-face evaluation conducted by a qualified physician trained in sleep medicine. The American Academy of Sleep Medicine (AASM) defines such a physician as one who is licensed by a state to practice medicine and who maintains certification through one of the sponsoring sleep medicine boards of the American Board of Medical Specialties or who is licensed by a state to practice medicine and has been certified by the American Board of Sleep Medicine. VADSM encourages dental practices, including those involved in the education of dental students, to understand the importance of oral screening for OSA, just as they recognize the need to screen for oral cancer and high blood pressure. Furthermore, as an expert of the oral cavity, the dentists can play an important role, when properly trained in OSA, to provide collaborative patient care. This collaborative approach to patient care has the potential to save lives and improve the quality of life for millions of people.

Therapies for OSA, such as continuous positive airway pressure (CPAP), oral appliances and surgery must be prescribed by a qualified physician. The elevated awareness of the role dentists can play in regards to early detection and screening, as well as the proper fitting of oral appliances, has not yet fully taken place.

It is the opinion of the VADSM that oral appliances should be fit by a qualified dentist with training and experience in the temporomandibular joint, dental occlusion, and associated oral structures. Dentists who provide OAT as a treatment for OSA must function within their scope of practice according to the dental practice law in the state in which they are licensed.

As the board moves forward in its understanding of this disease, and the importance of having a collaborative team for the benefit and safety of the patient, we welcome the opportunity to be part of the process and to help develop the necessary guidelines.

Sincerely,

Dr James R Schroeder

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American Academy of Dental Sleep Medicine (AADSM) Treatment Protocol: Oral Appliance Therapy for Sleep Disordered Breathing: An Update for 2013

Conditions presented by a patient may require the dentist to deviate from this protocol while collaborating with the patient's physician to maximize treatment efficacy.

1. Medical assessment must be made by a physician before oral appliance therapy (OAT) is initiated. (1-4)

   a. In order for the dentist to practice within the limits of his or her license as designated and required by the state in which the dentist practices, and in compliance with all applicable state and federal regulations, the dentist shall refer the patient to the physician for a complete medical evaluation and diagnosis to determine the absence or presence, and severity, of sleep-disordered breathing (SDB), which may include snoring, upper airway resistance syndrome (UARS) or obstructive sleep apnea (OSA). Following diagnosis, the dentist may provide OAT as appropriate with a prescription provided by a physician that has had a face-to-face evaluation. The treatment of primary snoring does not require a physician's prescription; or

   b. The physician refers the patient directly to the dentist for OAT as appropriate.

2. The diagnostic sleep study is interpreted by a medical sleep specialist, who provides a copy of the interpretation to the dentist for review. The reviewed copy of the interpretation shall be maintained in the patient record.

3. The dentist assesses the patient through a complete clinical examination, including a determination of the current health and prognosis of oral tissues that might be affected by OAT. Evaluation of a recent radiographic survey is important to a complete examination. The dentist recommends the choice of appliance (1, 2, 5, 6, 7, 8), discloses and discusses relevant fees with the patient, and explains the rationale for OAT to the patient while recording all appropriate documentation. A dentist who owns or has any partial ownership of the device, or patent for the device, that is being recommended for treatment must disclose this information to the patient as a potential conflict of interest (COI) prior to the delivery of the device to the patient.

4. The dentist communicates the proposed plan for OAT to the patient's physician, and appropriate health care providers, and the dentist regularly provides the patient's physician and other health care providers with progress and follow-up notes, as well as other pertinent information. (1,2)

5. Dentist shall provide the patient with a copy of the consent form prior to appliance delivery. (9)

6. In accordance with protocol established between the treating dentist and referring physician, the dentist fabricates a custom-made oral appliance and meets with the patient for an initial calibration and adjustment. After this initial calibration, the dentist may obtain objective data during an initial trial period to verify that the oral appliance effectively improves upper airway patency during sleep by enlarging the upper airway and/or decreasing upper airway collapsibility. If necessary, the dentist makes further adjustments to the device during a final calibration to ensure that optimal fit and positioning have been attained. (10-13)

7. Following the final calibration, the dentist refers the patient back to the physician for a medical evaluation and assessment of OAT outcomes. To ensure satisfactory therapeutic benefit, an order

may be written for the patient to undergo an overnight sleep test with the oral appliance in place. If the treatment is sub-therapeutic, the physician and dentist collaborate to discuss: the possibility of further calibration, validated alternative treatments, or combining positive airway pressure (PAP) therapy with OAT. (11-13)

8. Patients diagnosed with primary snoring may be treated without objective, follow-up data; however, the patients should be reevaluated at least annually.

9. Follow-up protocol after the final calibration should include a patient evaluation every six (6) months for the first year and at least annually thereafter. The annual recall exam should: verify appliance efficacy and occlusion stability; check the structural integrity of the device; ensure that there is a resolution of symptoms such as snoring and daytime sleepiness; inquire about patient comfort and adherence to therapy; and screen for possible side effects. If the patient's annual assessment reveals symptoms of worsening OSA or the potential need for additional adjustments to the device, then the dentist shall communicate this information to the patient's physician. (1, 2, 5, 14-16)

10. Knowledge of various appliances is strongly recommended, as no single appliance is effective for treatment of all patients. Dentists who treat SDB are encouraged and have a responsibility to routinely pursue additional education in the field and to comply with all applicable state and federal regulations. (6, 7, 8, 17, 18)

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National Heart, Lung, and Blood Institute

How Is Sleep Apnea Diagnosed?

Doctors diagnose sleep apnea based on medical and family histories, a physical exam, and sleep study results. Your primary care doctor may evaluate your symptoms first. He or she will then decide whether you need to see a sleep specialist.

Sleep specialists are doctors who diagnose and treat people who have sleep problems. Examples of such doctors include lung and nerve specialists and ear, nose, and throat specialists. Other types of doctors also can be sleep specialists.

Medical and Family Histories

If you think you have a sleep problem, consider keeping a sleep diary for 1 to 2 weeks. Bring the diary with you to your next medical appointment.

Write down when you go to sleep, wake up, and take naps. Also write down how much you sleep each night, how alert and rested you feel in the morning, and how sleepy you feel at various times during the day. This information can help your doctor figure out whether you have a sleep disorder.

You can find a sample sleep diary in the National Heart, Lung, and Blood Institute's "Your Guide to Healthy Sleep."

At your appointment, your doctor will ask you questions about how you sleep and how you function during the day.

Your doctor also will want to know how loudly and often you snore or make gasping or choking sounds during sleep. Often you're not aware of such symptoms and must ask a family member or bed partner to report them.

Let your doctor know if anyone in your family has been diagnosed with sleep apnea or has had symptoms of the disorder.

Many people aren't aware of their symptoms and aren't diagnosed.

If you're a parent of a child who may have sleep apnea, tell your child's doctor about your child's signs and symptoms.

Physical Exam

Your doctor will check your mouth, nose, and throat for extra or large tissues. Children who have sleep apnea might have enlarged tonsils. Doctors may need only a physical exam and medical history to diagnose sleep apnea in children.

Adults who have sleep apnea may have an enlarged uvula (U-vu-luh) or soft palate. The uvula is the tissue that hangs from the middle of the back of your mouth. The soft palate is the roof of your mouth in the back of your throat.

Sleep Studies

Sleep studies are tests that measure how well you sleep and how your body responds to sleep problems. These tests can help your doctor find out whether you have a sleep disorder and how severe it is. Sleep studies are the most accurate tests for diagnosing sleep apnea.

There are different kinds of sleep studies. If your doctor thinks you have sleep apnea, he or she may recommend a polysomnogram (poly-SOM-no-gram; also called a PSG) or a home-based portable monitor.

Polysomnogram

A PSG is the most common sleep study for diagnosing sleep apnea. This study records brain activity, eye movements, heart rate, and blood pressure.

A PSG also records the amount of oxygen in your blood, air movement through your nose while you breathe, snoring, and chest movements. The chest movements show whether you're making an effort to breathe.

PSGs often are done at sleep centers or sleep labs. The test is painless. You'll go to sleep as usual, except you'll have sensors attached to your scalp, face, chest, limbs, and a finger. The staff at the sleep center will use the sensors to check on you throughout the night.

A sleep specialist will review the results of your PSG to see whether you have sleep apnea and how severe it is. He or she will use the results to plan your treatment.

Your doctor also may use a PSG to find the best setting for you on a CPAP (continuous positive airway pressure) machine. CPAP is the most common treatment for sleep apnea. A CPAP machine uses mild air pressure to keep your airway open while you sleep.

If your doctor thinks that you have sleep apnea, he or she may schedule a split-night sleep study. During the first half of the night, your sleep will be checked without a CPAP machine. This will show whether you have sleep apnea and how severe it is.

If the PSG shows that you have sleep apnea, you'll use a CPAP machine during the second half of the split-night study. The staff at the sleep center will adjust the flow of air from the CPAP machine to find the setting that works best for you.

Home-Based Portable Monitor

Your doctor may recommend a home-based sleep test with a portable monitor. The portable monitor will record some of the same information as a PSG. For example, it may record:

- The amount of oxygen in your blood
- Air movement through your nose while you breathe
- Your heart rate
- Chest movements that show whether you're making an effort to breathe

A sleep specialist may use the results from a home-based sleep test to help diagnose sleep apnea. He or she also may use the results to decide whether you need a full PSG study in a sleep center.

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Last Updated: July 10, 2012

National Heart, Lung, and Blood Institute

How Is Sleep Apnea Treated?

Sleep apnea is treated with lifestyle changes, mouthpieces, breathing devices, and surgery. Medicines typically aren't used to treat the condition.

The goals of treating sleep apnea are to:

- Restore regular breathing during sleep
- Relieve symptoms such as loud snoring and daytime sleepiness

Treatment may improve other medical problems linked to sleep apnea, such as high blood pressure. Treatment also can reduce your risk for heart disease, stroke, and diabetes.

If you have sleep apnea, talk with your doctor or sleep specialist about the treatment options that will work best for you.

Lifestyle changes and/or mouthpieces may relieve mild sleep apnea. People who have moderate or severe sleep apnea may need breathing devices or surgery.

If you continue to have daytime sleepiness despite treatment, your doctor may ask whether you're getting enough sleep. (Adults should get at least 7 to 8 hours of sleep; children and teens need more. For more information, go to the Health Topics Sleep Deprivation and Deficiency article.)

If treatment and enough sleep don't relieve your daytime sleepiness, your doctor will consider other treatment options.

Lifestyle Changes

If you have mild sleep apnea, some changes in daily activities or habits might be all the treatment you need.

- Avoid alcohol and medicines that make you sleepy. They make it harder for your throat to stay open while you sleep.
- Lose weight if you're overweight or obese. Even a little weight loss can improve your symptoms.
- Sleep on your side instead of your back to help keep your throat open. You can sleep with special pillows or shirts that prevent you from sleeping on your back.
- Keep your nasal passages open at night with nasal sprays or allergy medicines, if needed. Talk with your doctor about whether these treatments might help you.
- If you smoke, quit. Talk with your doctor about programs and products that can help you quit smoking.

Mouthpieces

A mouthpiece, sometimes called an oral appliance, may help some people who have mild sleep apnea. Your doctor also may recommend a mouthpiece if you snore loudly but don't have sleep apnea.

A dentist or orthodontist can make a custom-fit plastic mouthpiece for treating sleep apnea. (An orthodontist specializes in correcting teeth or jaw problems.) The mouthpiece will adjust your lower jaw and your tongue to help keep your airways open while you sleep.

If you use a mouthpiece, tell your doctor if you have discomfort or pain while using the device. You may need periodic office visits so your doctor can adjust your mouthpiece to fit better.

Breathing Devices

CPAP (continuous positive airway pressure) is the most common treatment for moderate to severe sleep apnea in adults. A CPAP machine uses a mask that fits over your mouth and nose, or just over your nose.

The machine gently blows air into your throat. The pressure from the air helps keep your airway open while you sleep.

Treating sleep apnea may help you stop snoring. But not snoring doesn't mean that you no longer have sleep apnea or can stop using CPAP. Your sleep apnea will return if you stop using your CPAP machine or don't use it correctly.

Usually, a technician will come to your home to bring the CPAP equipment. The technician will set up the CPAP machine and adjust it based on your doctor's prescription. After the initial setup, you may need to have the CPAP adjusted from time to time for the best results.

CPAP treatment may cause side effects in some people. These side effects include a dry or stuffy nose, irritated skin on your face, dry mouth, and headaches. If your CPAP isn't adjusted properly, you may get stomach bloating and discomfort while wearing the mask.

If you're having trouble with CPAP side effects, work with your sleep specialist, his or her nursing staff, and the CPAP technician. Together, you can take steps to reduce the side effects.

For example, the CPAP settings or size/fit of the mask might need to be adjusted. Adding moisture to the air as it flows through the mask or using nasal spray can help relieve a dry, stuffy, or runny nose.

There are many types of CPAP machines and masks. Tell your doctor if you're not happy with the type you're using. He or she may suggest switching to a different type that might work better for you.

People who have severe sleep apnea symptoms generally feel much better once they begin treatment with CPAP.

Surgery

Some people who have sleep apnea might benefit from surgery. The type of surgery and how well it works depend on the cause of the sleep apnea.

Surgery is done to widen breathing passages. It usually involves shrinking, stiffening, or removing excess tissue in the mouth and throat or resetting the lower jaw.

Surgery to shrink or stiffen excess tissue is done in a doctor's office or a hospital. Shrinking tissue may involve small shots or other treatments to the tissue. You may need a series of treatments to shrink the excess tissue. To stiffen excess tissue, the doctor makes a small cut in the tissue and inserts a piece of stiff plastic.

Surgery to remove excess tissue is done in a hospital. You're given medicine to help you sleep during the surgery. After surgery, you may have throat pain that lasts for 1 to 2 weeks.

Surgery to remove the tonsils, if they're blocking the airway, might be helpful for some children. Your child's doctor may suggest waiting some time to see whether these tissues shrink on their own. This is common as small children grow.

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Last Updated: July 10, 2012

Virginia Board of Dentistry

REGULATORY /LEGISLATIVE COMMITTEE
10/16/2015

Assignment: Consider expanding remote supervision to free clinics and settings serving children and the elderly

Background:
Expanding the use of remote supervision is a strategy recommended by multiple speakers at the Board's Forum on Policy Strategies to Increase Access to Dental Treatment. The Department of Health's Protocol for Dental Hygienists to Practice in an Expanded Capacity Under Remote Supervision is provided.

Also provided are:

- A discussion of the topic prepared by Ms. Swecker.
- Information on an accredited dental hygiene program's coursework.
- Descriptions of Minnesota's Dental Therapist and Advanced Dental Therapists Scope of Practice
- An ADHA report on States with Oral Health Workforce Models

Title of document: Protocol adopted by Virginia Department of Health (VDH) for Dental Hygienists to Practice in an Expanded Capacity under Remote Supervision by Public Health Dentists

Reference to 18VAC60-20-220: Regulations Governing Dental Practice – Dental Hygienists

Filed by: Virginia Board of Dentistry

Date filed: September 7, 2012

Document available from:

Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233

Definitions:

- *"Expanded capacity"* means that a VDH dental hygienist provides education, assessment, prevention and clinical services as authorized in this protocol under the remote supervision of a VDH dentist.
- *"Remote supervision"* means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but who has not done an initial examination of the patients who are to be seen and treated by the dental hygienist, and who is not necessarily onsite with the dental hygienist when dental hygiene services are delivered.

Management:

- Program guidance and quality assurance shall be provided by the Dental Program in the Division of Child and Family Health at VDH for the public health dentists providing supervision under this protocol. Guidance for all VDH dental hygienists providing services through remote supervision is outlined below:
    - VDH compliance includes a review of the remote supervision protocol with the dental hygienist. The hygienist will sign an agreement consenting to remote supervision according to the protocol. The hygienist will update the remote agreement annually attaching a copy of their current dental hygiene license, and maintain a copy of the agreement on-site while providing services under this protocol.
    - VDH training by the public health dentist will include didactic and on-site components utilizing evidence based protocols, procedures and standards from the American Dental Association, the American Dental Hygienists' Association, the Centers for Disease Control and Prevention, Association of State and Territorial Dental Directors, as well as VDH OSHA, Hazard Communication and Blood Borne Pathogen Control Plan.
    - VDH monitoring during remote supervision activities by the public health dentist shall include tracking the locations of planned service delivery and review of

daily reports of the services provided. Phone or personal communication between the public health dentist and the dental hygienist working under remote supervision will occur at a minimum of every 14 days.

- VDH on-site review to include a sampling of the patients seen by the dental hygienist under remote supervision will be completed annually by the supervising public health dentist. During the on-site review, areas of program and clinical oversight will include appropriate patient documentation for preventive services (consent completed, assessment of conditions, forms completed accurately), clinical quality of preventive services (technique and sealant retention), patient management and referral, compliance with evidence-based program guidance, adherence to general emergency guidelines, and OSHA and Infection Control compliance.

- No limit shall be placed on the number of full or part time VDH dental hygienists that may practice under the *remote supervision* of a public health dentist(s)
- The dental hygienist may use and supervise assistants under this protocol but shall not permit assistants to provide direct clinical services to patients.
- The patient or responsible adult should be advised that services provided under the remote supervision protocol do not replace a complete dental examination and that he/she should take his/her child to a dentist for regular dental appointments.

Remote Supervision Practice Requirements:

- The dental hygienist shall have graduated from an accredited dental hygiene school, be licensed in Virginia, and employed by VDH in a full or part time position and have a minimum of two years of dental hygiene practice experience.
- The dental hygienist shall annually consent in writing to providing services under remote supervision.
- The patient or a responsible adult shall be informed prior to the appointment that no dentist will be present, that no anesthesia can be administered, and that only limited described services will be provided.
- Written basic emergency procedures shall be established and in place, and the hygienist shall be capable of implementing those procedures.

Expanded Capacity Scope of Services:

Public health dental hygienists may perform the following duties under *remote supervision:*

- Performing an initial examination or assessment of teeth and surrounding tissues, including charting existing conditions including carious lesions, periodontal pockets or other abnormal conditions for further evaluation by a dentist, as required.
- Prophylaxis of natural and restored teeth.
- Scaling of natural and restored teeth using hand instruments, and ultrasonic devices.
- Assessing patients to determine the appropriateness of sealant placement according to VDH Dental Program guidelines and applying sealants as indicated. Providing dental sealant, assessment, maintenance and repair.
- Application of topical fluorides.
- Providing educational services, assessment, screening or data collection for the preparation of preliminary written records for evaluation by a licensed dentist.

Required Referrals:

- Public health dental hygienists will refer patients without a dental provider to a public or private dentist with the goal to establish a dental home.
- When the dental hygienist determines at a subsequent appointment that there are conditions present which require evaluation for treatment, and the patient has not seen a dentist as referred, the dental hygienist will make every practical or reasonable effort to schedule the patient with a VDH dentist or local private dentist volunteer for an examination, treatment plan and follow up care.

Virginia Department of Health Professions
Board of Dentistry

Pursuant to a request from the Secretary of Health and Human Resources to facilitate implementation of the Affordable Care Act, the Virginia Department of Health Professions advised a review of the scope of practice of a dental hygienist. The Board of Dentistry has three concepts outlined during the October, 2014 Regulatory/Legislative meeting investigate to improve access to dental care to all Virginians.

Concept 1: Adjust the education and endorsement requirements for dental assistant II registration.

Justification: Currently, there are ten dental assistants II licensed in the Commonwealth. Reduction of education and endorsement requirements may increase the applicant pool and thereby increase access to care. Fortis College offers an expanded function dental assisting program with a maximum of ten students per enrolment and Germanna Community College offers a continuing education program for expanded function dental assistants (EFDA).

Challenges:

- The DAII must work under the direct supervision of a dentist, limiting access to care to those unable to afford care in a dental office.
- There are no CODA standards for expanded function dental assistants, thus no accredited programs however the programs can be housed in an accredited school.
- DA II skills are technical in nature, potentially lacks the foundational education to work independently.
- DAII are not required to take a national written board or take a regional clinical board per Virginia regulation thus there is no standardization of the educational process.
- DAII are not required to take a jurisprudence examination upon application for licensure.
- Dental assistants or dental hygienists interested in performing DAII functions can select the duties they want to perform in a dental office as Virginia does not require them to perform all duties.
- All DAII by regulation should be required to have the same skill set in order to regulate the duties performed by a DAII. By allowing a DAII to choose the components they wish to perform, further regulation of continuing education by the Board of Dentistry is required.
- There is no regional clinical exam to prove competency.

Strengths:

- Utilization of a DAII will increase patients treated by a dentist.
- Dental assistants or dental hygienists interested in performing DAII functions can select the duties they want to perform in a dental office as Virginia does not require them to perform all duties.

- Implementation for decreasing hours for preclinical and clinical as it pertains the functions the DAII selects to perform.

Next Steps:

- Develop number of didactic hours needed for a DAII to perform certain duties.
- Develop number of clinical procedures to complete to prove competence as clinical hours do not prove competence.
- The DANB does offer a Certified Restorative Functions Dental Assistant Examination (105 multiple choice questions) that encompasses the following:
    - Head and neck anatomy
    - Oral Cavity
    - Tooth anatomy, morphology and related characteristics
    - Tooth numbering systems
    - Occlusion
    - Oral Pathology
    - Purpose of impressions
    - Taking impressions
    - Patient management techniques
    - Bite/occlusal registration
    - Infection control/OSHA protocol
- There is a significant fee to take the Certified Restorative Functions Dental Assistant Exam. ($350)
- The Board of Dentistry will need to determine need for regional clinical exam to prove competency.

Concept 2: Create a pathway for dental hygienists to perform the reversible intraoral procedures which are delegable to a dental assistant II (EFDA)

Justification: Dental hygiene education provides a foundation in occlusion, dental anatomy, and dental materials with associated laboratory experience. Creation of continuing education programs for dental hygienists to complete DAII skills is appropriate since DAII programs are not accredited programs and simulate a continuing education program.

Challenges:

- Current regulations require a dental hygienist to take the DANB and receive CDA status to enter a DAII program.
- CDA examination offered by DANB is repetitive education for dental hygienists as the core of the exam focuses on the following:
    - General Chair side Assisting
    - Radiation Health and Safety
    - Infection Control
- There is a significant fee to take the DANB CDA examination. ($375)
- Differentiation between a registered dental hygienist and a DAII
- Differentiation between a dental hygienist and a dental hygienist with expanded functions.

Strengths:

- The DAII program is not accredited, continuing education for a RDH to obtain these skills is justified.
- Programs could be offered on weekends or evenings so dental hygienists would not reduce care to current population of patients in order to attend.
- A dental hygienist is qualified to take the Certified Restorative Function Dental Assisting (CRFDA) examination as a dental hygienist has graduated from a CODA-accredited dental hygiene program.
- In order to take the national certification for Expanded Functions Dental Assisting the restorative course/program is required to be offered by an institution with a CODA-accredited dental assisting, dental hygiene or dental program. Each function does not have to be listed separately, but the documentation must indicate that expanded functions/duties or restorative functions/duties were included in the course curriculum. This requirement eliminates continuing education programs offered by non-accredited programs.

Concept 3: Expand options for dental hygienists to practice under the remote supervision model.

Background: In 2009, the General Assembly enacted legislation that reduces dentist oversight requirements for dental hygienists employed by the Virginia Department of Health (VDH) in selected dentally underserved areas. The results of the Remote Supervision Pilot Project favors phasing out VDH funded dental clinics in favor of the preventive services model. Due to recruitment challenges, dental hygienists employed by VDH would work in designated regions across the Commonwealth and report to one supervising public health dentist. The VDH has documented improved oral health care outcomes using the remote supervision model for dental hygienists.

Challenges:
- Virginia is currently one of eight most restrictive states in the country in regards to supervision and scope of practice for a dental hygienist.
- Developing collaborative agreements with a dentist willing to have a dental hygienist work under remote supervision.
- Communicating to the dental community that a dentist would still have oversight and supervision of the dental hygienist working in a collaborative agreement with a remotely supervised dental hygienist.
- Developing agreements with safety net facilities, nursing homes, community health clinics and other non-traditional settings.
- VDH has demonstrated success in remote supervision however limited state funding to VDH prohibits a sufficient workforce to meet the dental needs of the Commonwealth. Allowing expansion of remote supervision of dental hygienists to private practice dentists will increase the volume of patients with access to dental care.
- Ability of dental hygienists to utilize dental auxiliaries under remote supervision.

Strengths:
- Documented improved oral health care outcomes demonstrated by the VDH Remote Supervision Model.
- Using models of collaborative agreement between dentists and dental hygienists would allow hygienists to work to their full capacity and address access to care issues.

- Due to a shortage of dentists in the underserved communities, dental hygienists working under remote supervision in collaborative agreements will reach those in need.
- Expanding supervision of dental hygienist to included physicians, nurse practitioners and physician assistants.
- Sufficient dental hygiene workforce exists with proposed education and practice requirements to be immediately employed.
- Licensed dental hygienists have the education to assess medical status and determine referrals to appropriate providers.
- A dental hygienist is educated to perform an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for assisting the dentist in a diagnosis.
- The ability to assess patient needs both oral and systemic differentiates the educational level of dental hygienists as opposed to other dental auxiliaries.
- Numerous states allow some collaborative model or advanced dental hygiene practice.
- The potential for reducing unnecessary emergency department visits for non-injury dental conditions as the ADA estimates 80% of these visits are preventable through fluoridation, hygiene and preventive routine care.
- Initiation of preventive care/examination by the dental hygienist and referral to a dentist for treatment of dental disease.

Next Steps:

- Development of protocol for experience and educational requirements as follows:
    - Require a Baccalaureate degree in dental hygiene and two years clinical experience for practice in remote supervision settings.
    - Justification of a baccalaureate degree as these programs emphasize the following:
        - Curriculum fosters interprofessional and team based delivery of healthcare
        - Community dental health
        - Cultural competency and diversity
        - Education on healthcare systems and reimbursement procedures
        - Education on request for funding proposals, process of internal review boards, and funding allocation
    - Old Dominion University and many other universities offer an online degree completion program in dental hygiene.
- Remote supervised dental hygienists must take the jurisprudence exam every three years.
- Board of Dentistry determines need for baccalaureate degree specifically in dental hygiene as 41% of dental hygienists currently have a baccalaureate degree to meet the needs of remote supervision workforce demands.
- Develop procedures a dental hygienist can perform under remote supervision without the initial examination of dentist to include the following:
    - Initial examination and charting of oral conditions
    - Prophylaxis
    - Fluoride treatment
    - Making radiographs
    - Pulp vitality testing

- Fabrication and delivery of athletic guards
- Fabrication and delivery of soft occlusal guards
- Oral health education, disease prevention to include tobacco cessation and nutritional counseling
- Blood glucose testing
- Blood pressure measurement
- Suture removal
- Fabrication and delivery of fluoride trays
- Fabrication and delivery of bleaching trays

Prepared by: Tammy K. Swecker, RDH

NOVA | Northern Virginia Community College

COLLEGE CATALOG 2014-2015

General Information and Admissions Requirements
DENTAL HYGIENE

Associate of Applied Science Degree
Offered through MEC

- Advising Sheets

Purpose: The program is designed to prepare students to serve in a dynamic and growing health profession as members of the dental health team. After successful completion of the program, the student will be eligible to take the National Board Dental Hygiene Examination and professional licensure examinations. Upon successful completion of the licensing process, the title "Registered Dental Hygienist" (R.D.H.) is awarded.

Transfer Information: Transfer is *not* the primary purpose of an A.A.S. program, but NOVA has articulation agreements that facilitate the transfer of this and other career-oriented programs to selected senior institutions. Students interested in transfer should contact a counselor or their academic advisor early in their program.

Admission Requirements:

Applicants must do the following:
- Comply with all General Admission Requirements for Allied Health Programs.
- Be eligible to sit for the licensure exam, which will require the student to present documentation of legal status in the US.
- Pass NAS 161-162 Health Science I-II with a grade of "B" or higher prior to being admitted to the program.
- Pass ENG 111 College Composition I and SDV 101 Orientation to Health Care with a "C" or higher prior to being admitted to the program. (For admission in Fall 2009 or later)
- Be willing to repeat courses or to complete evaluative testing for credits earned more than ten years ago.
- Look for the competitive admission and deadlines for applications on the Dental Hygiene web site at www.nvcc.edu/campuses-and-centers/medical/academic-divisions/allied-health/dental-hygiene/index.html.

Special Program Requirements: The The Virginia Board of Dentistry reserves the right to deny licensure to any candidate who has been convicted of a crime involving moral turpitude or the use of drugs or alcohol to the extent that such use renders him/her unsafe to practice dental hygiene. Any applicant who has been found guilty of a misdemeanor or felony must consult with the Dental Hygiene assistant dean prior to admission.

Special Accreditation Status: The Dental Hygiene Program is accredited by the American Dental Association's Commission on Dental Accreditation and has been granted the accreditation status of approval without reporting requirements. The Commission is a specialized accrediting body recognized by the United States Department of Education. The Commission on Dental Accreditation can be contacted at (312) 440-4653 or at 211 East Chicago Avenue, Chicago, IL 60611-2678. The Commission's web address is www.ada.org/100.aspx.

Bloodborne Pathogens and Infectious Diseases Statement: By nature of the profession, students accepted into the Dental Hygiene Program may be exposed to blood and body fluids while practicing dental hygiene skills or providing services during clinical, preclinical, and laboratory sessions. Policies and procedures have been established to ensure the working environment is safe in order to minimize disease transmission. Prospective students may request a copy of the policy on bloodborne infectious diseases by calling 703-822-6627.

			Credits
Prerequisites			
ENG	111	College Composition I	3
[1]NAS	161	Health Science I	4
[1]NAS	162	Health Science II	4
SDV	101	Orientation to HealthCare	1
Total			12
Two Years			**Credits**
1st Semester			
DNH	111	Oral Anatomy	2
DNH	115	Histology/Head and Neck Anatomy	3
DNH	130	Oral Radiography for the Dental Hygienist	3
DNH	141	Dental Hygiene I	5
Total			13
2nd Semester			

DNH	120	Management of Emergencies	2
DNH	142	Dental Hygiene II	5
DNH	145	General and Oral Pathology	2
DNH	146	Periodontics for the Dental Hygienist	2
DNH	216	Pharmacology	2
Total			**13**
3rd Semester			
DNH	143	Dental Hygiene III	4
DNH	214	Practical Materials for Dental Hygiene	2
Total			**6**
4th Semester			
DNH	150	Nutrition	2
DNH	226	Public Health Dental Hygiene I	2
DNH	235	Mgmt of Pain and Anxiety in the Dental Office	2
DNH	244	Dental Hygiene IV	5
PED	116	Lifetime Fitness and Wellness	1
PSY	201	Intro to Psychology I	3
Total			**15**
5th Semester			
CST	229	Intercultural Communication	3
DNH	227	Public Health Dental Hygiene II	1
DNH	230	Office Practice and Ethics	1
DNH	245	Dental Hygiene V	5
[2]___		Humanities/Fine Arts Elective	3
Total			**13**
Total credits for the Dental Hygiene A.A.S.=72 (includes 12 prerequisite credits)			

[1] Although students who have graduated with a transfer-oriented A.A., A.S., or A.A. & S. degree or any baccalaureate or higher degree from a regionally accredited United States institution of higher education will have most of their general education considered as fulfilled, they must meet the math and science requirements specified for this program. Exceptions must be approved by the division dean responsible for the student's curriculum.

[2] See humanities/fine arts courses listed under General Education Electives.

MINNESOTA BOARD OF DENTISTRY

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DENTAL THERAPIST SCOPE OF PRACTICE

*According to Minnesota 2009 Session Laws, Chapter 95, Article 3, Subd. 4, the **scope of practice** for a Dental Therapist includes the following:*

(a) A licensed dental therapist may perform dental services as authorized under this section within the parameters of the collaborative management agreement.

(b) The services authorized to be performed by a licensed dental therapist include the oral health services, as specified in paragraphs (c) and (d), and within the parameters of the collaborative management agreement.

(c) A licensed dental therapist may perform the following services under general supervision, unless restricted or prohibited in the collaborative management agreement:

(1) oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;
(2) preliminary charting of the oral cavity;
(3) making radiographs;
(4) mechanical polishing;
(5) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
(6) pulp vitality testing;
(7) application of desensitizing medication or resin;
(8) fabrication of athletic mouthguards;
(9) placement of temporary restorations;
(10) fabrication of soft occlusal guards;
(11) tissue conditioning and soft reline;
(12) atraumatic restorative therapy;
(13) dressing changes;
(14) tooth reimplantation;
(15) administration of local anesthetic; and
(16) administration of nitrous oxide.

(d) A licensed dental therapist may perform the following services under indirect supervision:

(1) emergency palliative treatment of dental pain;
(2) the placement and removal of space maintainers;
(3) cavity preparation;
(4) restoration of primary and permanent teeth;
(5) placement of temporary crowns;
(6) preparation and placement of preformed crowns; and
(7) pulpotomies on primary teeth;
(8) indirect and direct pulp capping on primary and permanent teeth;
(9) stabilization of reimplanted teeth;
(10) extractions of primary teeth;
(11) suture removal;
(12) brush biopsies;
(13) repair of defective prosthetic devices; and
(14) recementing of permanent crowns.

(e) For purposes of this section and section 150A.106, "general supervision" and "indirect supervision" have the meanings given in Minnesota Rules, part 3100.0100, subpart 21.

Subd. 5. **Dispensing authority.** (a) A licensed dental therapist may dispense and administer the following drugs within the parameters of the collaborative management agreement and within the scope of practice of the dental therapist: analgesics, anti-inflammatories, and antibiotics.

(b) The authority to dispense and administer shall extend only to the categories of drugs identified in this subdivision, and may be further limited by the collaborative management agreement.

(c) The authority to dispense includes the authority to dispense sample drugs within the categories identified in this subdivision if dispensing is permitted by the collaborative management agreement.

(d) A licensed dental therapist is prohibited from dispensing or administering a narcotic drug as defined in section 152.01, subdivision 10.

Subd. 6. **Application of other laws.** A licensed dental therapist authorized to practice under this chapter is not in violation of section 150A.05 as it relates to the unauthorized practice of dentistry if the practice is authorized under this chapter and is within the parameters of the collaborative management agreement.

Subd. 7. **Use of dental assistants.** (a) A licensed dental therapist may supervise dental assistants to the extent permitted in the collaborative management agreement and according to section 150A.10, subdivision 2.

(b) Notwithstanding paragraph (a), a licensed dental therapist is limited to supervising no more than four registered dental assistants or nonregistered dental assistants at any one practice setting.

MINNESOTA BOARD OF DENTISTRY

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ADVANCED DENTAL THERAPIST SCOPE OF PRACTICE

*According to Minnesota 2009 Session Laws, Chapter 95, Article 3, Section 25, the **scope of practice** for an Advanced Dental Therapist includes the following:*

Subd. 2. **Scope of practice.**

(a) An advanced dental therapist certified by the board under this section may perform the following services and procedures pursuant to the written collaborative management agreement:

(1) an oral evaluation and assessment of dental disease and the formulation of an individualized treatment plan authorized by the collaborating dentist;

(2) the services and procedures described under [the Dental Therapist scope of practice] section 150A.105, subdivision 4, paragraphs (c) and (d); and

(3) nonsurgical extractions of permanent teeth as limited in subdivision 3, paragraph (b).

(b) The services and procedures described under this subdivision may be performed under general supervision.

Subd. 3. **Practice limitation.**

(a) An advanced practice dental therapist shall not perform any service or procedure described in subdivision 2 except as authorized by the collaborating dentist.

(b) An advanced dental therapist may perform nonsurgical extractions of periodontally diseased permanent teeth with tooth mobility of +3 to +4 under general supervision if authorized in advance by the collaborating dentist. The advanced dental therapist shall not extract a tooth for any patient if the tooth is unerupted, impacted, fractured, or needs to be sectioned for removal.

(c) The collaborating dentist is responsible for directly providing or arranging for another dentist or specialist to provide any necessary advanced services needed by the patient.

(d) An advanced dental therapist in accordance with the collaborative management agreement must refer patients to another qualified dental or health care professional to receive any needed services that exceed the scope of practice of the advanced dental therapist.

(e) In addition to the collaborative management agreement requirements described in section 150A.105, a collaborative management agreement entered into with an advanced dental therapist must include specific written protocols to govern situations in which the advanced dental therapist encounters a patient who requires treatment that exceeds the authorized scope of practice of the advanced dental therapist. The collaborating dentist must ensure that a dentist is available to the advanced dental therapist for timely consultation during treatment if needed and must either provide or arrange with another dentist or specialist to provide the necessary treatment to any patient who requires more treatment than the advanced dental therapist is authorized to provide.

Subd. 4. **Medications.**

(a) An advanced dental therapist may provide, dispense, and administer the following drugs within the parameters of the collaborative management agreement, within the scope of practice of the advanced dental therapist practitioner, and with the authorization of the collaborating dentist: analgesics, anti-inflammatories, and antibiotics.

(b) The authority to provide, dispense, and administer shall extend only to the categories of drugs identified in this subdivision, and may be further limited by the collaborative management agreement.

(c) The authority to dispense includes the authority to dispense sample drugs within the categories identified in this subdivision if dispensing is permitted by the collaborative management agreement.

(d) Notwithstanding paragraph (a), an advanced dental therapist is prohibited from providing, dispensing, or administering a narcotic drug as defined in section 152.01, subdivision 10.

Minnesota Administrative Rules

Authenticate

3100.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purpose of this chapter and unless the context otherwise requires, the terms in this part have the meanings given them.

Subp. 2. **Act.** "Act" means Minnesota Statutes, chapter 150A.

Subp. 2a. **Advanced cardiac life support or ACLS.** "Advanced cardiac life support" or "ACLS" refers to an advanced educational course for a health care provider that teaches a detailed medical protocol for the provision of lifesaving cardiac care in settings ranging from the prehospital environment to the hospital setting. The course must include advanced airway management skills, cardiac drug usage, defibrillation, and arrhythmia interpretation. An ACLS certificate must be obtained through the American Heart Association.

Subp. 2b. **Analgesia.** "Analgesia" means the diminution or elimination of pain as a result of the administration of an agent including, but not limited to, local anesthetic, nitrous oxide, and pharmacological and nonpharmacological methods.

Subp. 2c. [Repealed, 35 SR 459]

Subp. 3. **Applicant.** "Applicant" means a person who has submitted an application to become a licensee.

Subp. 4. **Assistant.** "Assistant" means a person who assists a dentist in carrying out the basic duties of a dental office described in part 3100.8400.

Subp. 5. **Allied dental personnel.** "Allied dental personnel" means an advanced dental therapist, dental therapist, dental hygienist, licensed dental assistant, dental assistant with a limited-license permit, assistant without a license or permit, and dental technician.

Subp. 5a. **Blood borne diseases.** "Blood borne diseases" means diseases that are spread through the exposure to, inoculation of, or injection of blood; or exposure to blood contained in body fluids, tissues, or organs. Blood borne diseases include infection caused by such agents as the human immunodeficiency virus (HIV) and hepatitis B virus (HBV).

Subp. 6. **Board.** "Board" means the Board of Dentistry.

Subp. 7. **CDE.** "CDE" means professional development and continuing dental education.

Subp. 7a. **Clinical subject.** "Clinical subject" means those subjects directly related to the provision of dental care and treatment to patients.

Subp. 8. [Repealed, 39 SR 1455]

Subp. 8a. [Repealed, 35 SR 459]

Subp. 8b. **Core subject.** "Core subject" means those areas of knowledge that relate to public safety and professionalism as determined by the board or a committee of the board.

Subp. 9. **Course.** "Course" means an educational offering, class, presentation, meeting, or other similar event.

Subp. 9a. **CPR.** "CPR" refers to a comprehensive, hands-on course for a health care provider that includes: cardiopulmonary resuscitation on an adult, child, and infant; two-person rescuer; barrier mask or bag for ventilation; foreign body airway obstruction; and automated external defibrillation. A CPR certificate shall be obtained through the American Heart Association health care provider course or the American Red Cross professional rescuer course.

Subp. 9b. **Deep sedation.** "Deep sedation" means a depressed level of consciousness produced by a pharmacological or nonpharmacological method or a combination thereof during which patients cannot be easily aroused but respond purposefully following

repeated or painful stimulation. Deep sedation is characterized by impairment of the patient's ability to independently maintain ventilatory function, spontaneous ventilation potentially being inadequate to meet a patient's needs, and the need for assistance in maintaining a patent airway. A patient's cardiovascular function does not typically require assistance during deep sedation.

Subp. 9c. **Dental assistant with a limited-license permit.** "Dental assistant with a limited-license permit" means a person holding a limited-license permit as a dental assistant under part 3100.8500, subpart 3.

Subp. 9d. **Dental health care personnel or DHCP.** "Dental health care personnel" or "DHCP" means individuals who work in a dental practice who may be exposed to body fluids such as blood or saliva.

Subp. 9e. **Dental hygienist.** "Dental hygienist" means a person holding a license as a dental hygienist issued by the board pursuant to the act.

Subp. 10. **Dental technician.** "Dental technician" means a person other than a licensed dentist who performs any of the services described in Minnesota Statutes, section 150A.10, subdivision 3.

Subp. 11. **Dentist.** "Dentist" means a person holding a license as a general dentist, specialty dentist, or full faculty dentist issued by the board pursuant to the act.

Subp. 11a. **Elective activities.** "Elective activities" refers to those activities directly related to, or supportive of, the practice of dentistry, dental therapy, dental hygiene, or dental assisting.

Subp. 11b. **Enteral.** "Enteral" means a technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa, such as with oral, rectal, or sublingual administration.

Subp. 11c. **Faculty dentist.** "Faculty dentist" has the meaning given it in Minnesota Statutes, section 150A.01, subdivision 6a.

Subp. 11d. **Fundamental activities.** "Fundamental activities" means those activities directly related to the provision of clinical dental services.

Subp. 12. [Repealed, 10 SR 1613]

Subp. 12a. **General anesthesia.** "General anesthesia" means an induced state of unconsciousness produced by a pharmacological or nonpharmacological method or a combination thereof during which patients are not arousable, even by painful stimulation. General anesthesia is characterized by the frequent impairment of the patient's ability to independently maintain ventilatory function, the patient's need for assistance in maintaining a patent airway, the need for positive pressure ventilation due to depressed spontaneous ventilation or drug-induced depression of neuromuscular function, and potential impairment of cardiovascular function.

Subp. 12b. **Hospital.** "Hospital" means an institution licensed by the state commissioner of health that:

A. is adequately and properly staffed and equipped;

B. provides services, facilities, and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and

C. regularly provides clinical laboratory services, diagnostic x-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

For the purposes of this chapter, diagnostic or treatment centers, physicians' offices or clinics, or dentists' offices or clinics are not hospitals.

Subp. 12c. **Infection control.** "Infection control" means programs, procedures, and methods to reduce the transmission of agents of infection for the purpose of preventing or decreasing the incidence of infectious diseases.

Subp. 12d. **Inhalation.** "Inhalation" means a technique of administration in which the gaseous or volatile agent is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

Subp. 12e. **Licensed dental assistant.** "Licensed dental assistant" means an assistant licensed by the board pursuant to Minnesota Statutes, section 150A.06, subdivision 2a.

Subp. 13. **Licensee.** "Licensee" means a dentist, dental therapist, dental hygienist, licensed dental assistant, or dental assistant with a limited-license permit.

Subp. 13a. **Minimal sedation.** "Minimal sedation" means a minimally depressed level of consciousness produced by a pharmacological or nonpharmacological method that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Minimal sedation is characterized by moderate impairment to the patient's cognitive function and coordination, but leaves unaffected the patient's ventilatory and cardiovascular functions.

Subp. 14. **Minnesota Professional Firms Act.** "Minnesota Professional Firms Act" means Minnesota Statutes, sections 319B.01 to 319B.40.

Subp. 14a. **Moderate sedation.** "Moderate sedation" means a depressed level of consciousness produced by a pharmacological or nonpharmacological method or a combination thereof during which patients respond purposefully to verbal commands, either alone or accompanied by light tactical stimulation. Moderate sedation is characterized by unaffected cardiovascular functions, no need for intervention to maintain a patent airway for the patient, and adequate spontaneous ventilation.

Subp. 15. **National board.** "National board" means an examination administered nationally that is acceptable to the board.

Subp. 15a. **Nitrous oxide inhalation analgesia.** "Nitrous oxide inhalation analgesia" means the administration by inhalation of a combination of nitrous oxide and oxygen, producing an altered level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

Subp. 15b. **Parenteral.** "Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract, such as with intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular administration.

Subp. 15c. **Pediatric advanced life support or PALS.** "Pediatric advanced life support" or "PALS" refers to an advanced life support educational course for the pediatric health care provider that teaches the current certification standards of the American Academy of Pediatrics or the American Heart Association. A PALS certificate must be obtained through the American Heart Association.

Subp. 16. **Person.** "Person" includes an individual, firm, partnership, association, or any other legal entity.

Subp. 16a. **Portfolio.** "Portfolio" means an accumulation of written documentation of professional development activities.

Subp. 16b. **Professional development.** "Professional development" means activities that include, but are not limited to, continuing education, community services, publications, and career accomplishments throughout a professional's life.

Subp. 17. [Repealed, 35 SR 459]

Subp. 18. [Repealed, 35 SR 459]

Subp. 18a. **Resident dentist.** "Resident dentist" has the meaning given it in Minnesota Statutes, section 150A.01, subdivision 8a.

Subp. 18b. **Self-assessment.** "Self-assessment" means an ungraded examination provided by the board intended to help determine strengths and weaknesses in specific areas of dental practice.

Subp. 19. [Repealed, 10 SR 1613]

Subp. 20. [Repealed, 29 SR 306]

Subp. 21. **Supervision.** "Supervision" means one of the following levels of supervision, in descending order of restriction.

A. "Personal supervision" means the dentist is personally operating on a patient and authorizes the allied dental personnel to aid in treatment by concurrently performing supportive procedures.

B. "Direct supervision" means the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before dismissal of the patient, evaluates the performance of the allied dental personnel.

C. "Indirect supervision" means the dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed by the allied dental personnel.

D. "General supervision" means the supervision of tasks or procedures that do not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed but require the tasks be performed with the prior knowledge and consent of the dentist.

Subp. 22. **Transdermal or transmucosal.** "Transdermal" or "transmucosal" means a technique of administration in which the drug is administered by patch or iontophoresis.

Statutory Authority: *MS s 150A.04; 150A.06; 150A.08; 150A.10; 150A.11; 214.06; 319A.18*

History: *10 SR 1613; 14 SR 1214; 16 SR 2314; 18 SR 580; 18 SR 2042; 20 SR 2623; 29 SR 306; 31 SR 1238; 35 SR 459; 36 SR 738; 39 SR 1455*

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American Dental Hygienists' Association

The Benefits of Dental Hygiene-Based Oral Health Provider Models

The American Dental Hygienists' Association (ADHA) is leading the transformation of the dental hygiene profession to improve the public's oral and overall health.

Dental hygienists are formally educated and licensed by each state and are poised to help prevent oral health diseases. ADHA is committed to working on the development and implementation of new workforce models.

A 2014 report on expanding the provision of affordable preventive services outside dentists' offices from the National Governors Association noted that states have looked into altering supervision or reimbursement rules, as well as creating professional certifications for advanced-practice dental hygienists. To date, studies of pilot programs have shown safe and effective outcomes.[1]

Currently, 37 states allow dental hygienists to initiate patient care in a setting outside of the private dental office without the presence of a dentist. These policies enable dental hygienists to practice in community settings and reach a variety of patient populations.

ADHA policies highlight the association's flexibility in considering various dental hygiene-based models as well as ADHA's commitment to the development of providers who are appropriately educated and personally committed to deliver safe, quality oral healthcare to those in need.

Most recently, Maine passed legislation allowing a dental hygienist or an independent practice dental hygienist to become a Dental Hygiene Therapist. Maine and Minnesota are the only two states that recognize these oral health workforce models, along with tribal lands in Alaska.

ADHA supports oral healthcare workforce models that culminate in:

- Graduation from an accredited institution
- Professional Licensure
- Direct access to patient care

Mid-level Oral Health Practitioner:

A licensed dental hygienist who has graduated from an accredited dental hygiene program and who provides primary oral healthcare directly to patients to promote and restore oral health through assessment, diagnosis, treatment, evaluation, and referral services. The Mid-level Oral Health Practitioner has met the educational requirements to provide services within an expanded scope of care and practices under regulations set forth by the appropriate licensing agency.

ADHA is committed to advocating in support of new dental hygiene-based models for oral health care for many reasons:

1. The dental hygiene workforce is ready and available; there are currently **185,000+ licensed dental hygienists in the United States**.
2. The **educational infrastructure is developed**; there are 335 entry-level dental hygiene programs
3. The public will benefit from providers with a **broad range of skills sets which include preventive and limited restorative services**.

[1] National Governors Association Report: The role of dental hygienists in providing access to oral health care. http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf

States with Oral Health Workforce Models

- **Minnesota:** ***Advanced Dental Therapist, ADT (Signed into Law, 2009)***
  - Hygiene-based and non-hygiene based model
  - Education – Masters degree
  - ADT services can be provided under general supervision
  - An ADT may perform all the services a dental therapist provides and the following procedures, pursuant to a written collaborative management agreement with a dentist:
    - Oral assessment and treatment planning.
    - Routine, nonsurgical extractions of certain diseased teeth.

- **Maine:** ***Dental Hygiene Therapist, DHT (Signed into Law, 2014)***
  - Hygiene-based
  - Education – RDH + post-secondary dental therapy program
  - Preventive and restorative scope
  - Licensure required
  - Direct supervision by a licensed dentist and a written practice agreement is required
  - Dually licensed as DHT and RDH
  - ADTs may be dually licensed as RDHs

- **Connecticut:** ***Advanced Dental Hygiene Practitioner***
  - Hygiene-based
  - Education – RDH + master's degree
  - Preventive and restorative scope
  - Licensure required
  - Must be dually licensed

- **Georgia:** ***Dental Hygiene Therapist***
  - Hygiene-based
  - Education – B.S. in dental hygiene + Dental Hygiene Therapist program (4 semesters min)
  - Preventive and restorative scope
  - Licensure required
  - Direct supervision is required
  - May be dually licensed

- **Hawaii:** ***Advanced Dental Therapist***
  - Hygiene-based and non-hygiene based model
  - Education – master's degree
  - Preventive and restorative scope
  - Licensure required
  - May be dually licensed

  Hawaii
  - A resolution is pending that would direct the state Auditor General to conduct a "sunrise analysis" of the profession of dental therapy in other states. If adopted, findings and recommendations would be submitted to the legislature in 2016.

- **Kansas:** ***Dental Practitioner***
  - Hygiene-based
  - Education – RDH + 18-month dental practitioner education program
  - Preventive and restorative scope
  - Licensure required
  - Must be dually licensed

- **Massachusetts:** ***Advanced Dental Hygiene Practitioner***
  - Hygiene-based
  - Education – RDH + 12-18 month registered dental practitioner education program
  - Preventive and restorative scope
  - Licensure required
  - Must be dually licensed

- **New Hampshire**
  - Workforce legislation was replaced with a bill establishing a commission to study pathways to oral health care. The commission shall report its findings prior to November 15, 2015.

- **New Mexico:** ***Dental Therapist***
  - Hygiene-based
  - Education – 3 years combined dental hygiene/dental therapy curriculum
  - Preventive and restorative scope
  - Licensure required
  - Must be dually licensed

  New Mexico
  - A Senate memorial was adopted establishing a task force to develop proposed workforce legislation by October 1, 2015.

- **North Dakota:** ***Advanced Practice Dental Hygienist***
  - Hygiene-based
  - Education – RDH + Advanced Practice Dental Hygiene education program
  - Preventive and restorative scope
  - Licensure required
  - Must be dually licensed

- **South Carolina:** ***Dental Therapist***
  - Hygiene-based
  - Education – RDH + post-baccalaureate dental hygiene therapist education program
  - Preventive and restorative scope
  - Licensure required
  - Must be dually licensed

- **Texas:** ***Dental Hygiene Practitioner***
  - Hygiene-based
  - Education: RDH + 2 year dental hygiene practitioner program. Program must culminate at minimum with a Bachelor of Science degree.
  - Preventive and restorative scope
  - Licensure required

- **Vermont:** ***Dental Practitioner***
  - Hygiene-based
  - Education – RDH + CODA-approved Dental Therapist program
  - Preventive and restorative scope
  - Licensure required
  - Must be dually licensed

- **Washington:** ***Dental Hygiene Practitioner***
  - Dual-track: hygiene based and non-hygiene based model
  - Education – RDH + post-baccalaureate certificate
  - Preventive and restorative scope
  - Licensure required
  - Dual-licensed

Direct Access States

The American Dental Hygienists' Association (ADHA) defines direct access as the ability of a dental hygienist to initiate treatment based on their assessment of a patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider-patient relationship (ADHA Policy Manual, 13-15).

** Indicates direct Medicaid reimbursement allowed*

Alaska 2008
Sec. 08.32.115
Collaborative Agreement:
Dental hygienist may provide services according to the terms of a collaborative agreement. The dentist's presence, diagnosis or treatment plan are not required unless specified by agreement. Care under the agreement can be provided in settings outside of the "usual place of practice" (i.e. private dental office).

Requirements: Dental hygienist must have minimum of 4,000 hours of clinical experience within preceding 5 years. Agreement must be approved by state board of dental examiners. Dentists are limited to 5 or fewer collaborative agreements.

Provider Services: Agreement can authorize nearly the entire dental hygiene scope of practice (patient education, prophylaxis, sealants, radiographs, etc).

Arizona 2004/2015
Sec. 32-1281, 32-1289
Affiliated Practice Agreement:
Dental hygienist with a written affiliated practice agreement may perform dental hygiene services in specified settings outside the private dental office. The written agreement must be submitted to state board of dental examiners. The affiliated practice dental hygienist shall consult with the affiliated practice dentist before initiating further treatment on patients who have not been seen by a dentist within 12 months of the initial treatment by the dental hygienist.

Requirements: Dental hygienist must have held an active license for at least 5 years and be actively engaged in dental hygiene practice for at least five hundred hours in each of the 2 years immediately preceding the affiliated practice relationship. Alternatively, dental hygienist who holds a bachelor's degree in dental hygiene, an active license for at least 3 years and is actively engaged in dental hygiene practice for at least 500 hours in each of the 2 years preceding the affiliated practice relationship, may also quality for affiliated practice. In addition, dental hygienist must successfully complete 12 hours of specified continuing education that hold a current certificate in basic cardiopulmonary resuscitation.

**Provider Services:* The agreement must outline practice settings and services provided. The full dental hygiene scope is permitted with the exception of root planing, nitrous oxide and the use of local anesthesia unless under specified circumstances. After taking an accredited course and exam the dental hygienist will also be able to: place, contour and finish restorations, cement prefabricated crowns and place interim therapeutic restorations.

Arizona 2006
Sec. 32-1289
Dental hygienist employed by or working under contract or as a volunteer for a public health agency or institution or a public or private school authority before an examination by a dentist may screen patients and apply topical fluoride without entering into an affiliated practice relationship pursuant to this section.

Arkansas 2010
Sec. 17-82-7
Collaborative Agreement:
Dental hygienist with a Collaborative Care permit I or II who has entered into a collaborative agreement may perform dental hygiene services on children, senior citizens age 65 and older, and persons with developmental disabilities in long-term care facilities, free clinics, hospitals, head start programs, residence of homebound patients, local health units, schools, community health centers, state and county correctional institutions. Dental hygienist must have written agreement with no more than one dentist.

Requirements: Must have malpractice insurance. Collaborative Care Permit I: Dental hygienist must have 1,200 hours of clinical practice experience, or have taught dental hygiene courses for 2 of the proceeding 3 years. Collaborative Care Permit II: Dental hygienist must have 1,800 hours of clinical practice experience or taught dental hygiene courses for 2 of the proceeding 3 years and has completed 6 hours of continued education courses.

Provider Services: Collaborative Care Permit I may provide prophylaxis, fluoride treatments, sealants, dental hygiene instruction, assessment and other services in scope if delegated by consulting dentist to children in public settings without supervision or prior examination.

Collaborative Care Permit II may provide prophylaxis, fluoride treatments, sealants, dental hygiene instruction, assessment, and other services in scope if delegated by the consulting dentist to children, senior citizens, and persons with developmental disabilities in public settings without supervision or prior examination.

California 1998
Sec. 1922-1931
Registered Dental Hygienist in Alternative Practice (RDHAP):
RDHAP may provide services to a patient without obtaining written verification that the patient has been examined by a dentist or physician. If the RDHAP provides services to a patient 18 months or more after the first date that he or she provides services, the RDHAP shall obtain written verification that the patient has been examined by a dentist or physician.

Once licensed, the RDHAP may practice as: an employee of a dentist; an employee of another RDHAP; as an independent contractor; as a sole proprietor of an alternative dental hygiene practice; as an employee of a primary care clinic or specialty clinic; as an employee of a clinic owned or operated by a public hospital or health system; or as an employee of a clinic owned and operated by a hospital that maintains the primary contract with a county under the California welfare code. Allowed practice settings include: residences of the homebound; schools; residential facilities and other institutions; hospitals; or dental health professional shortage areas.

Requirements: Must hold a current and active California license as a dental hygienist; have been engaged in clinical practice as a dental hygienist for a minimum of 2,000 hours during the immediately preceding 36 months (in California or another state); possess a bachelor's degree or an equivalent of 120 semester units; complete 150 hours of an approved educational RDHAP program; and pass a written examination.

**Provider Services:* All services permitted under general supervision, including prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue.

California 2002
Sec. 1911
Dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

Colorado 1987
Sec. 12-35-124
Unsupervised Practice:
There is no requirement that a dentist must authorize or supervise most dental hygiene services. Dental hygienist may also own a dental hygiene practice.

Requirements: None.

**Provider Services:* Dental hygienist can provide dental hygiene diagnosis, radiographs, remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, topical anesthetic, oral inspection and charting. Local anesthesia requires general supervision.

Connecticut 1999
Sec. 20-126l
Public Health Dental Hygienist:
Dental hygienist with 2 years experience may practice without supervision in institutions, public health facilities, group homes and schools.

Requirements: Dental hygienist must have at least 2 years of experience.

**Provider Services:* Dental hygienist can provide oral prophylaxis, remove deposits, accretions and stains, root planing, sealants, assessment, treatment planning and evaluation.

Florida 2011
Sec. 466.003, 466.024
Dental hygienist may provide services without the physical presence, prior examination, or authorization of a dentist, provided that a dentist or physician gives medical clearance prior to performance of a prophylaxis in "health access settings." A dentist must examine a patient within 13 months following a prophylaxis and an exam must take place before additional oral services may be performed.

Health access settings are: a program of the Department of Children and Family Services, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center centers, a Head Start centers, a federally-qualified health

center, a school-based prevention program or a clinic operated by an accredited dental or dental hygiene program.

Requirements: Dental hygienist must maintain liability insurance.

Provider Services: Dental charting, take vital signs, record histories, apply sealants and fluorides (including varnish) and perform prophylaxis.

The setting operating the program may bill a third party for reimbursement.

Idaho 2004
Sec. 54-903, 54-904
Extended Access Endorsement (EAE):
Dental hygienist can provide services in hospitals, long term care facilities, public health facilities, health or migrant clinics or other board-approved settings, if the dentist affiliated with authorizes services.

Requirements: Dental hygienist must be an employee of the facility or obtain extended care permit. EAE requires 1,000 hours experience in last 2 years.

Provider Services: As determined by authorizing dentist.

Iowa 2004
Rule 650-10.5 (153)
Public Health Dental Hygienist:
Dental hygienist may administer care based on standing orders and a written agreement with a dentist. Services can be administered in schools, Head Start settings, nursing facilities, federally-qualified health centers, public health vans, free clinics, community centers and public health programs.

Requirements: Dental hygienist must have 3 years of clinical experience and must submit an annual report to the state department of health noting the number of patients treated/services administered.

Provider Services: All services in the dental hygiene scope (except local anesthesia and nitrous) may be provided once to each patient. The supervising dentist must specify a period of time in which an examination by a dentist must occur prior to the dental hygienist rendering further dental hygiene services. However, this requirement does not apply to educational services, assessments, screenings and fluoride if specified in the supervision agreement.

Kansas 2003/2012
Sec. 65-1456
Extended Care Permit I, II & III (ECP):
Dental hygienist may practice without the prior authorization of a dentist if the dental hygienist has an agreement with sponsoring dentist. Examples of settings are schools, Head Start programs, state correctional institutions, local health departments, indigent care clinics, and in adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. The ECP I permit authorizes treatment on children in various limited access categories, while the EPT II permit is for seniors and persons with developmental disabilities. ECP III permit authorizes dental hygienists to

treat a wider range of patients, including underserved children, seniors and developmentally disabled adults and to provide more services than ECP I and II.

Requirements: Dental hygienist must have 1,200 clinical hours or 2 years teaching in last 3 years for ECP I; 1,600 hours or 2 years teaching in last 3 years plus 6 hour course for ECP II. Dental hygienist must also carry liability insurance and must be paid by dentist or facility. ECP III requires 2,000 hours clinical experience plus 18 clock hour board approved course. Dentist can monitor a maximum of 5 practices.

Provider Services: ECP I and II provide prophylaxis, fluoride treatments, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist, and other services if delegated by the sponsoring dentist. ECP III can additionally provide atraumatic restorative technique, adjustment and soft reline of dentures, smoothing sharp tooth with handpiece, local anesthesia in setting where medical services available, extraction of mobile teeth.

Kentucky 2010
Sec. 313.040
Volunteer Community Health Settings:
A dental hygienist may provide the services listed below without the supervision of a dentist in volunteer community health settings.

Provider Services: Dental hygienist can provide dental hygiene instruction, nutritional counseling, oral screening with subsequent referral to a dentist, fluoride application, demonstration of oral hygiene technique, and sealants.

Maine 2001
Rule 02 313 Chap. 1. Sec. 4
Public Health Dental Hygienist:
Dental hygienist may provide services in a public or private school, hospital or other nontraditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The dental hygienist may perform services rendered under general supervision. The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided.
A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

Requirements: A dental hygienist must apply to the board to practice providing such information the board deems necessary. The board must take into consideration whether the program will fulfill an unmet need, whether a supervising dentist is available and that the appropriate public health guidelines and standards of care can be met and followed.

**Provider Services:* All services that can be provided under general supervision. Dentist's diagnosis for sealants is not needed in public health or school sealant programs.

Maine 2008/2015
Sec. B-1. 32 MRSA c. 16, sub-c. 3-B
Independent Practice Dental Hygienist:
Dental hygienist licensed as an independent practice dental hygienist may practice without supervision by a dentist in all settings.

Requirements: Dental hygienist must possess a Bachelor's degree from a CODA-accredited dental hygiene program and 2,000 work hours of clinical practice during the two years preceding the application or possess an associate degree from a CODA-accredited dental hygiene program and 6,000 work hours of clinical practice during the six years preceding the application. They are also required to provide a referral plan to patients in need of additional care by a dentist.

Provider Services: Dental hygienist may interview patients and record complete medical and dental histories, take and record the vital signs of blood pressure, pulse and temperature, perform oral inspections, recording all conditions that should be called to the attention of a dentist; perform complete periodontal and dental restorative charting; perform all procedures necessary for a complete prophylaxis, including root planing; apply fluoride to control caries; apply desensitizing agents to teeth; apply topical anesthetics; apply sealants; smooth and polish amalgam restorations, limited to slow speed application only; cement pontics and facings outside the mouth; take impressions for athletic mouth guards and custom fluoride trays; place and remove rubber dams; place temporary restorations in compliance with the protocol adopted by the board; and apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. May expose and process radiographs.

Maryland 2010/2014
Sec. 10.44.21.10
General Supervision:
Dental hygienist may practice under the general supervision of a dentist in a long-term care facility. A dental hygienist practicing under the general supervision of a licensed dentist in a long-term care facility shall have a written agreement with the supervising dentist that clearly sets forth the terms and conditions under which the dental hygienist may practice.

Requirements: Dental hygienist must hold an active license, hold a current certificate evidencing Health Care Provider Level C Proficiency, or its equivalent, in cardiopulmonary resuscitation, have at least 2 years of active clinical practice in direct patient care, and ensure that the long-term care facility where the dental hygienist will practice under general supervision has:
(a) A written medical emergency plan in place;
(b) Adequate equipment, including portable equipment and appropriate armamentarium, available for the appropriate delivery of dental hygiene services; and
(c) Adequate safeguards to protect the patient's health and safety.

Provider Services: Limit dental hygiene tasks and procedures to toothbrush prophylaxis, application of fluoride, dental hygiene instruction, and other duties as may be delegated, verbally or in writing, by the supervising dentist.

Massachusetts 2009
Chap. 112, Sec. 51.
Public Health Dental Hygienist:
Dental hygienist may provide services without the supervision of a dentist in public health settings including, and not limited to, hospitals, medical facilities, schools and community clinics. Prior to providing services, a public health dental hygienist must have a written collaborative agreement with a local or state government agency or institution, or licensed dentist that states the level of communication with the dental hygienist to ensure patient health and safety. Public health dental hygienists shall provide patients with a written referral to a dentist and an assessment of further dental needs.

Requirements: Dental hygienist must have at least 3 years of full-time clinical experience practicing in a public health setting and any other training deemed appropriate by the department of health.

**Provider Services:* Dental hygienist can provide full scope of dental hygiene practice services allowed under general supervision in the private office, including prophylaxis, root planing, curettage, sealants and fluoride.

Michigan 2005
Sec. 333.16625
PA 161 Dental Hygienist:
Dental hygienist with grantee status can practice in a public or nonprofit entity, or a school or nursing home that administers a program of dental care to a dentally underserved population. Collaborating dentist need not be present for or authorize treatment, but dental hygienist must have continuous availability of direct communication with a dentist to establish emergency protocol and review patient records.

Requirements: Dental hygienist must apply to the state department of community health for designation as grantee health agency.

**Provider Services:* Dental hygienist can provide full scope of dental hygiene services allowed under general supervision, including prophylaxis, sealants, and fluoride treatments.

Minnesota 2001
Sec. 150A. 10, Subd. 1a
Collaborative Practice:
Dental hygienist must enter into a written collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist. Collaborative practice hygienist can be employed or retained by a health care facility, program or nonprofit organization.

Requirements: Dental hygienist must have at least 2,400 hours of clinical experience in the preceding 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Dental hygienist must also meet additional continuing education requirements.

**Provider Services:* Collaborative practice dental hygienist can administer prophylaxis, application of topical preventive and prophylactic agents, application of sealants, fluoride varnishes, coronal polishing, preliminary charting, radiographs and root planing.

Missouri 2001
Sec. 332.311.2
Public Health Dental Hygienist:
Dental hygienist may provide services without supervision in public health settings to Medicaid-eligible children and can be directly reimbursed.

Requirements: Dental hygienist must have 3 years of experience.

**Provider Services:* Dental hygienist can provide oral prophylaxis, sealants and fluorides.

Montana 2003
Sec. 37-4-405
Public Health Dental Hygienist/Limited Access Permit (LAP):
Dental hygienists may obtain a limited access permit to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, head start programs, migrant work facilities and local and state public health facilities. Public health supervision means the dental hygienist can provide services without the authorization of a dentist provided he or she follows protocols established by the board and refers any patients needing further dental treatment.

Requirements: Dental hygienist must have 2,400 hours experience in the last 3 years; 3,000 hours over career with 350 hours each of the last 2 years. An additional 12 hours of continuing education every 2 years and liability insurance are also required.

**Provider Services:* Dental hygienist can provide prophylaxis, fluoride, root planing, sealants polish restorations, radiographs for diagnosis by a dentists and oral cancer screening.

Nebraska 2007
Sec. 38-1130
Public Health Dental Hygienist:
The Department of Health may authorize an unsupervised dental hygienist to provide services in a public health setting or a health care or related facility.

Requirements: Dental hygienist must have 3,000 hours experience in at least 4 of last 5 years. Dental hygienist must also have professional liability insurance.

**Provider Services:* Dental hygienist can perform prophylaxis for a healthy child, pulp vitality testing and preventive measures including fluorides and sealants.

New Hampshire 1993
Rule 302.02(d), 402.01(c)
Public Health Supervision:
Dental hygienist may treat patients in a school, hospital, institution or residence of a homebound patient. Supervising dentist must authorize dental hygienist to provide services but need not be present for care.

Requirements: None.

Provider Services: Dental hygienist can provide instruction in oral hygiene, topical fluorides, prophylaxis, assess medical/dental history, periodontal probing/charting, and sealants.

New Hampshire 2012
Sec. 317-A:21-e
Certified Public Health Dental Hygienist:
Dental hygienist may practice in a school, hospital, or other institution, or for a homebound person without the dentist having to be present, provided the dentist has reviewed the records once in a 12-month period. Dental Hygienists may perform any procedure that is within the scope of practice that has been authorized under public health supervision.

Requirements: Any dental hygienist shall be considered qualified as a certified public health dental hygienist after obtaining a bachelor's degree in dental hygiene with a minimum of 6 semester hours in community dental health; obtaining a master's degree in public health; or after successfully completing specified courses and successful completion of an examination by the course provider.

Provider Services: Dental hygienist can perform radiographic imaging limited to bite wings, and occlusal and periapical radiography and provide nutritional counseling for the control of dental disease.

New Mexico 1999/2011
Sec. 16.5.17
Collaborative Practice:
Dental hygienist can practice in any setting with collaborative agreement and can own or manage a collaborative dental hygiene practice. Dental hygienist must enter into a written agreement with one or more collaborative dentist(s) which must contain protocols for care. Dental hygienist must refer patients for annual dental exam.

Requirements: Dental hygienist must have 2,400 hours of active practice in preceding 18 months or 3,000 hours in 2 of the past 3 years. Dentists may not collaborate with more than 3 dental hygienists.

**Provider Services:* Collaborative practice dental hygienist can provide a dental hygiene assessment, radiographs, prophylaxis, fluoride treatments, assessment for and application of sealants, root planing, and may prescribe and administer and dispense topically applied fluoride and antimicrobials, depending on the specific services allowed in agreement with collaborating a dentist.

New Mexico 2007
Sec. 61-5A-C
No supervision required for any dental hygienist to apply topical fluorides and remineralization agents in public and community medical facilities, schools, hospitals, long-term care facilities and such other settings as the board may determine.

New York 2005
Rules Sec. 61.9
General Supervision:
Dental hygienist can initiate patient care in any public or private setting. Dentist must authorize procedures and be available for consultation, diagnosis and evaluation.

Provider Services: Dental hygienist can provide prophylaxis, root planing, fluoride treatments, patient education, charting and radiographs without a prior dental examination, the presence of a dentist, or need to refer to a dentist.

New York 2013
Sec. 6606
Collaborative Practice:
The practice of dental hygiene may be conducted in the office of any licensed dentist or in any appropriately equipped school or public institution but must be done either under the supervision of a licensed dentist or, in the case of a registered dental hygienist working for a hospital as defined in article twenty-eight of the public health law, pursuant to a collaborative arrangement with a licensed and registered dentist who has a formal relationship with the same hospital in accordance with regulations promulgated by the department in consultation with the Department of Health.

Article twenty-eight facilities include: hospitals, public health, diagnostic and treatment centers, dental clinics, dental dispensaries, nursing homes, out-patient departments, rehab centers not solely for vocational rehab and other such facilities overseen by the state Health Department.

Requirements: Dental hygienist must instruct individuals to visit a dentist for comprehensive examination or treatment, possess and maintain certification in cardiopulmonary resuscitation and provide collaborative services only pursuant to a written agreement that is maintained in the practice setting of the dental hygienist and collaborating dentist.

Provider Services: May only provide those services that may be provided under general supervision.

Nevada 1998
Sec. 631.287
Public Health Dental Hygienist:
Dental hygienist may obtain approval to work as public health dental hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

Requirements: Special endorsement from the dental board. Submissions of protocol to describe the methods a dental hygienist will use to provide services.

**Provider Services:* May provide most hygiene services and may administer local anesthesia and nitrous oxide in a facility with certain equipment and dentist authorization.

Ohio 2010
Sec. 4715.363
Oral Health Access Supervision Permit Program:
Dental hygienist who possess an oral health access supervision permit may provide dental hygiene services through a written agreement with a dentist in public health settings including, and not limited to a health care facility, state correctional institution, residential facility, school, shelter for victims of domestic abuse or runaways, foster home, non-profit clinic, dispensary or mobile dental clinic.

Prior to providing services, a dental hygienist with an oral health access supervision permit must have a written agreement with a dentist, who possesses an oral health supervision permit, that states the dentist has evaluated the dental hygienist's skills and the dentist has reviewed and evaluated the patient's health history. The dentist need not be present or examine the patient before the dental hygienist may provide care. The collaborating dentist must perform a clinical evaluation of the patient before the dental hygienist may provide subsequent care. The evaluation may be done using electronic communication.

Requirements: Two years and a minimum of 3,000 hours of clinical experience, minimum of 24 continuing education credits during the two years prior to apply for the oral health access supervision permit including an eight hour course as required by the board.

Provider Services: Prophylactic, preventive and other procedures a dentist can delegate to a dental hygienist except definitive root planing, definitive subgingival curettage, administration of local anesthesia and other procedures specified in rules adopted by the board.

Ohio 2013
Sec. 4715.22
The requirement for a dentist to perform an examination and diagnose a patient prior to the patient receiving dental hygiene services through a program operated by a school district or other specified entity does not apply when the only services to be provided are the placement of pit and fissure sealants.

Oklahoma 2003
Sec. 328.34
General Supervision:
Dental hygienist may provide services outside of the private dental office for a patient not examined by the dentist. Dentist must authorize care in writing.

Requirements: Dental hygienist must have at least 2 years of experience.

Provider Services: Most dental hygiene services, including sealants, fluorides, and prophylaxis, to a patient one time prior to a dental exam.

Oregon 1997
Sec. 680.200, Rule 818-035-0065
Limited Access Permit (LAP):
Dental hygienists who have obtained a limited access permit (LAP) may initiate unsupervised services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, medical offices or offices operated or staffed by a nurse practitioner midwives or physicians assistants, and job training centers. Dental hygienist must refer the patient annually to a licensed dentist available to treat the patient.

Requirements: Dental hygienist must have 2,500 hours of supervised dental hygiene practice and complete 40 hours of board-approved courses in an accredited dental hygiene program or completed a course of study approved by the board that includes at least 500 hours of dental hygiene practice on limited access patients while under direct faculty supervision. Dental hygienist must also have liability insurance.

Provider Services: LAP dental hygienists can provide all dental hygiene services, except several (local anesthesia, pit and fissure sealants, denture relines, temporary restorations, radiographs and nitrous oxide) which must be supervised by a dentist. Dental hygienist may prescribe fluorides and assess the need for sealants.

Oregon 2011
Sec. 680.205
Expanded Practice Dental Hygienist (EPDH)
Replaces Limited Access Permit. Adds services to patients below federal poverty level and other settings approved by the board to EPDH practice settings. Adds limited prescriptive authority, local anesthesia, temporary restorations and dental assessments to unsupervised EPDH scope if EPDH has agreement with a dentist. Requires insurance reimbursement of EPDHs.

Pennsylvania 2007
Sec. 2 (Definitions), Sec. 11.9
Public Health Dental Hygiene Practitioner:
Dental hygienists who are certified as public health dental hygiene practitioners may provide care in a variety of public health settings without the supervision or prior authorization of a dentist.

Requirements: Dental hygienist must have 3,600 hours experience and liability insurance. Dental hygienist must also complete 5 hours of continuing education in public health during each licensure period.

Provider Services: Dental hygienist can provide educational, preventive, therapeutic, and intra-oral services, including complete prophylaxis and sealants, dental hygienists in the state are authorized to provide.

Rhode Island 2006
Sec. 5-31.1-6.1
General Supervision:
Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Requirements: None.

Provider Services: Dental hygienist can initiate dental hygiene services, including oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.

Rhode Island 2015
Sec. 5-31.1-39 (Not yet codified)
Public Health Hygienists:
Any public health dental hygienist may perform dental hygiene procedures in a public health setting, without the immediate or direct supervision or direction of a dentist. Public health settings includes, but are not limited to, residences of the homebound, schools, nursing home and long-term care facilities, clinics, hospitals, medical facilities or community health centers.

Requirements: A public health dental hygienist shall enter into a written collaborative agreement with a local or state government agency or institution or with a licensed dentist. Any public health dental hygienist shall provide to the patient or to the patient's legal guardian a consent form to be signed by the patient or legal guardian. The consent form shall also inform the patient or legal guardian that the patient should obtain a dental examination by a dentist within ninety days after undergoing a procedure.

**Provider Services:* Any procedure or service that is within the dental hygiene scope of practice that has been authorized and adopted by board as a delegable procedure for a dental hygienist under general supervision in a private practice setting.

South Carolina 2003

Sec. 40-15-110 (A) (10)
General Supervision:
Dental hygienist employed by, or contacted through, the Department of Health and Environment Control may provide services under general supervision that does not require prior examination by a dentist in settings such as schools or nursing homes.

Requirements: Dental hygienist must carry professional liability insurance.

Provider Services: Dental hygienist employed by, or contacted through, the Department of Health and Environment Control may provide prophylaxis, fluorides, and sealants.

South Dakota 2011

Rules 20:43:10
Dental hygienist may provide preventive and therapeutic services under collaborative supervision of a dentist in a school, nursing facility, Head Start program, non-profit mobile dental clinic, community health center or government program.

Requirements: Dental hygienist must possess a license to practice in the state and have 3 years of clinical practice in dental hygiene and a minimum of 4,000 practice hours. A minimum of 2,000 of those hours must have been completed within 2 of the 3 years preceding application. Dental hygienist must have a written collaborative agreement with a dentist and satisfactorily demonstrate knowledge of medical and dental emergencies and their management, infection control, pharmacology, disease transmission, management of early childhood caries and management of special needs population.

Provider Services: Any services that can be provided under general supervision.

Tennessee 2013

Sec. 63-5-109
Dental hygienist may apply dental sealants or topical fluoride to the teeth of individuals in a setting under the direction of a state or local health department, without requiring an evaluation by a dentist prior to such application, under a protocol established by the state or a metropolitan health department.

Texas 2001
Sec. 262.1515
General Supervision:
Dental hygienist may provide services for up to 6 months without dentist seeing the patient. Services may be performed in school-based health center, nursing facility or community health center. Dental hygienist must refer the patient to a dentist following

treatment and may not perform a second set of services until the patient has been examined by a dentist.

Requirements: Dental hygienist must have at least 2 years of experience.

Provider Services: No limitations. Dentist must authorize services in writing.

Vermont 2008
Rule 10.2
General Supervision Agreement:
Dental hygienist may provide services in a school or institution under the supervision of a dentist via a general supervision agreement. The agreement authorizes the dental hygienist to provide services, agreed to between the dentist and the dental hygienist. The agreement does not require physical presence of the dentist but it stipulates that the supervising dentist review all patient records.

Requirements: Dental hygienist must have 3 years licensed clinical practice experience.

Provider Services: Dental hygienist can provide sealants, fluoride varnish, prophylaxis and radiographs. Periodontal maintenance is allowable to patients with mild periodontitis.

Virginia 2009
Sec. 54.1-2722
Remote Supervision:
Dental hygienist employed by the Virginia Department of Health can enter into a remote supervision agreement with a dentist. Remote supervision means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have done an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

Requirements: Dental hygienist must have 2 years of experience and must be employed by the VDH.

Provider Services: Dental hygienist can provide initial examination of teeth and surrounding areas, prophylaxis, scaling, sealants, topical fluoride, education services, assessment and screening.

Washington 1984/2009
Sec. 18.29.056
Unsupervised and Off-Site Supervision:
Dental hygienist may be employed, retained or contracted by health care facilities to perform authorized dental hygiene services without supervision, provided the dental hygienist refers patient to a dentist for dental planning and treatment.

Health care facilities are limited to hospitals; nursing homes; home health agencies; group homes serving the elderly, individuals with disabilities and juveniles; state-operated institutions under the jurisdiction of the department of social and health services or the department of corrections; and federal, state, and local public health facilities, state or federally funded community and migrant health centers and tribal

clinics. Specifically in senior centers, dental hygienist may provide limited dental hygiene services with under the "off-site supervision" of a dentist.

Requirements: Dental hygienist must have 2 years clinical experience within the last 5 year with a dentist. Written practice plan required in certain settings.

**Provider Services:* Dental hygienist may provide prophylaxis, application of typical preventive or prophylactic agents, polishing and smoothing restorations root planing and curettage.

Washington 2001
Sec. 18.29.220
Public Health Dental Hygienist:
Dental hygienist who is school endorsed may assess for and apply sealants and fluoride varnishes and perform prophylaxis in community-based sealant programs carried out in schools.

Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health. Dental hygienist must submit data to the Department of Health concerning patient demographics, treatment, reimbursement and referrals.

West Virginia 2008
Sec. 5-1-8.5
Public Health Dental Hygienist:
Dental hygienist may provide care in hospitals, schools, correctional facilities, jails, community clinics, long-term care facilities, nursing homes, home health agencies, group homes, state institutions under the Department of Health and Human Resources, public health facilities, homebound settings and accredited dental hygiene education programs. Dentist must authorize dental hygienist to provide care but need not be present or have previously seen patient.

Requirements: Dental hygienist must have 2 years and 3,000 hours of clinical experience and take six additional continuing education hours. Dental hygienist and dentist must submit annual written report of care to state board of dental examiners.

Provider Services: Dental hygienist can provide patient education, nutritional counseling, oral screening with referral to dentist, apply fluoride, sealants, and offer a complete prophylaxis (pursuant to a collaborative agreement or written order.)

Wisconsin 2007
Sec. 447.06
The statute does not require the presence or supervision of a dentist in a public or private school, a dental or dental hygiene school or a facility owned by a local health department.

Requirements: None

**Provider Services:* Dental hygienist can provide prophylaxis, root planing, screening, treatment planning, sealants and delegable duties.

Virginia Board of Dentistry

REGULATORY /LEGISLATIVE COMMITTEE
10/16/2015

Assignment: Review the Education Requirements for Dental Assistants II

Background:
Reviewing the education requirements for DAII was supported by multiple speakers at the Board's Forum on Policy Strategies to Increase Access to Dental Treatment. The current statute is provided below and the and regulations are provided.

Also provided are the statutes and regulations of the Pennsylvania State Board of Dentistry and the North Carolina State Board of Dental Examiners which address expanded functions for 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.

(2008, cc. 84, 264.)

VIRGINIA BOARD OF DENTISTRY
Excerpts from the **Regulations Governing Dental practice on the**
Registration and Practice of Dental Assistants II

18VAC60-20-61. Educational requirements for dental assistants II.

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete the following requirements from an educational program accredited by the Commission on Dental Accreditation of the American Dental Association:
1. At least 50 hours of didactic course work in dental anatomy and operative dentistry that may be completed on-line.
2. Laboratory training that may be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:
a. At least 40 hours of placing, packing, carving, and polishing of amalgam restorations;
b. At least 60 hours of placing and shaping composite resin restorations;
c. At least 20 hours of taking final impressions and use of a non-epinephrine retraction cord; and
d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.
3. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office in the following modules:
a. At least 80 hours of placing, packing, carving, and polishing of amalgam restorations;
b. At least 120 hours of placing and shaping composite resin restorations;
c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and
d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.
4. Successful completion of the following competency examinations given by the accredited educational programs:
a. A written examination at the conclusion of the 50 hours of didactic coursework;
b. A practical examination at the conclusion of each module of laboratory training; and
c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules.

C. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.

18VAC60-20-70. Licensure examinations; registration certification.

C. Dental assistant II certification. All applicants for registration as a dental assistant II shall provide evidence of a current credential as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board, which was granted following passage of an examination on general chairside assisting, radiation health and safety, and infection control.

VIRGINIA BOARD OF DENTISTRY
Excerpts from the **Regulations Governing Dental practice on the**
Registration and Practice of Dental Assistants II

18VAC60-20-72. Registration by endorsement as a dental assistant II.

A. An applicant for registration by endorsement as a dental assistant II shall provide evidence of the following:

1. Hold current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association;
2. Be currently authorized to perform expanded duties as a dental assistant in another state, territory, District of Columbia, or possession of the United States;
3. Hold a credential, registration, or certificate with qualifications substantially equivalent in hours of instruction and course content to those set forth in 18VAC60-20-61 or if the qualifications were not substantially equivalent the dental assistant can document experience in the restorative and prosthetic expanded duties set forth in 18VAC60-20-230 for at least 24 of the past 48 months preceding application for registration in Virginia.

B. An applicant shall also:

1. Be certified to be in good standing from each state in which he is currently registered, certified, or credentialed or in which he has ever held a registration, certificate, or credential;
2. Be of good moral character;
3. Not have committed any act that would constitute a violation of § 54.1-2706 of the Code of Virginia; and
4. Attest to having read and understand and to remain current with the laws and the regulations governing dental practice in Virginia.

18VAC60-20-230. Delegation to dental assistants.

A. Duties appropriate to the training and experience of the dental assistant and the practice of the supervising dentist may be delegated to a dental assistant under the direction or under general supervision required in 18VAC60-20-210, with the exception of those listed as nondelegable in 18VAC60-20-190 and those which may only be delegated to dental hygienists as listed in 18VAC60-20-220.

B. Duties delegated to a dental assistant under general supervision shall be under the direction of the dental hygienist who supervises the implementation of the dentist's orders by examining the patient, observing the services rendered by an assistant and being available for consultation on patient care.

C. The following duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-20-61:

1. Performing pulp capping procedures;
2. Packing and carving of amalgam restorations;
3. Placing and shaping composite resin restorations;
4. Taking final impressions;
5. Use of a non-epinephrine retraction cord; and
6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

Public

Dental Staff

- Licensure and Certification Requirements
- Continuing Education Resources
- Insurance Claims
- Accredited Education Programs
- Dental Radiology Requirements & Testing
- Dental Hygienist & Assistant Professional Societies
- Material Safety Data Sheet (MSDS)

Licensure and Certification Requirements for Dental Staff

The Pennsylvania State Board of Dentistry (SBOD) sets standard requirements for individuals wishing to obtain or renew a license or certificate to practice in the dental profession. The requirements include standards for education, examination, biennial renewal and continuing education.

Education and Examination

Dental Hygienists
Candidates for licensure as a dental hygienist must:

- Submit certification of graduation from a dental hygiene school accredited by the Commission on Accreditation of the American Dental Association (ADA).
- Pass the written National Board Dental Hygiene Examination and the clinical North East Regional Board (NERB) Dental Hygiene Examination.

Please refer to the PA Code for more **education** and **examination** regulations.

Expanded Function Dental Assistants
Candidates for certification as expanded function dental assistants (EFDAs) must submit verification for one of the following:

- Graduation with an Associate Degree from an EFDA program at a two-year college or institution that is accredited by an accrediting agency approved by the U.S. Department of Education Council on Postsecondary Accreditation.
- Graduation from a dental hygiene school accredited by the ADA Commission on Accreditation, at which a minimum of 75 hours of clinical and didactic instruction in restorative functions were completed.
- Completion of an EFDA certification program, including at least 200 hours of clinical and didactic instruction, from a program accredited by the ADA Commission on Dental Accreditation or an agency approved by the U.S. Department of Education Council on Postsecondary Accreditation.

Candidates also must pass an examination containing both written and clinical components acceptable to the SBOD. Please refer to the PA Code for more **education** and **examination** regulations.

Dental Assistants
The SBOD does not set any requirements or standards regarding the education or examination of

dental assistants; however, radiological certification is necessary.

License and Certificate Renewal

Licenses and certificates are renewable biennially beginning April 1 of every odd-numbered year, for a fee charged by the SBOD. Dental hygienists and EFDAs who fail to renew their licenses and certificates are prohibited from practicing their profession in Pennsylvania. For more information on license and certificate renewal, please refer to **section 33.105 of the PA Code**.

Online Licensing
Dental professionals can apply for and renew licenses and certificates online through the **Pennsylvania Bureau of Professional and Occupational Affairs**.

Continuing Education Requirements

The following CE requirements must be met to be eligible for license or certificate renewal:

- Dental hygienists – 20 hours
- EFDAs – 10 hours
- Dental Assistants – no required CE

At least 50 percent of the required credit hours must be taken in lecture or clinical presentation, and a **maximum** of 50 percent of the required credit hours may be taken through individual study. CE subject areas must be approved by the SBOD. For a full list of subject areas please refer to **section 33.402 of the PA Code**. For specific details regarding continuing education requirements for dental hygienists and EFDAs, please refer to **section 33.401 of the PA Code**.

Related Links

Pennsylvania State Board of Dentistry
The Pennsylvania Code – Chapter 33 State Board of Dentistry
National Board Dental Hygiene Exam Information
North East Regional Board of Dental Examiners

Website questions or comments? Contact Natalie Owens
Pennsylvania Dental Association | 3501 North Front Street | P.O. Box 3341 | Harrisburg, PA | 17105
Phone: (717) 234-5941

§ 33.102. Professional education.

(a) *Dentists.*

(1) Candidates for licensure as dentists shall show compliance with section 3(c) of the act (63 P. S. § 122(c)) which requires a diploma from an ''approved institution or college,'' by submitting certification of graduation from a dental school accredited or provisionally accredited by the Commission on Accreditation of the American Dental Association.

(2) Candidates for licensure who received their professional education outside the United States in a nonaccredited school may satisfy the education requirement by submitting their credentials to an accredited or provisionally accredited school and obtaining additional preclinical and clinical training that will lead to the awarding of the D.M.D. or D.D.S. degree by that school.

(b) *Dental hygienists.*

(1) Candidates for licensure as dental hygienists shall show compliance with section 3(d) of the act by submitting certification of graduation from a dental hygiene school accredited or provisionally accredited by an approved United States Department of Education-recognized regional accrediting agency or the Commission on Dental Accreditation (CODA) of the American Dental Association, if the school's dental hygiene course of study comprises a minimum of 2 years of at least 32 weeks of at least 30 hours each week or its equivalent.

(2) Candidates for licensure who received their professional education outside the United States in a nonaccredited school may satisfy the education requirement by submitting their credentials to an accredited or provisionally accredited school and obtaining additional training that will lead to the awarding of a degree in dental hygiene by that school.

(c) *Expanded function dental assistants.*

(1) Candidates for certification as expanded function dental assistants shall show compliance with section 3(d.1) of the act by submitting verification of one of the following:

(i) Graduation from a Board-approved EFDA program at a 2-year college or other institution accredited or provisionally accredited by an accrediting agency approved by the United States Department of Education Council on Postsecondary Accreditation which offers an Associate Degree.

(ii) Graduation from a dental hygiene school which required the successful completion of at least 75 hours of clinical and didactic instruction in restorative functions accredited or provisionally accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association.

(iii) Completion of a Board-approved EFDA program, which offers a certificate or diploma, consisting of at least 200 hours of clinical and didactic instruction from a dental assisting program accredited by one of the following:

(A) The Commission on Dental Accreditation (CODA) of the American Dental Association.

(B) An accrediting agency approved by the United States Department of Education Council on Postsecondary Accreditation whose expanded function educational standards are approved by the Board.

(2) The Board will approve EFDA programs that meet the criteria in § 33.117 (relating to EFDA program approval). A list of Board-approved EFDA programs will be maintained on the Board's web site.

(3) Candidates for certification who receive their professional education outside the United States or from a nonaccredited program may satisfy the education requirement by submitting their credentials to a program listed in paragraph (1) and obtaining additional training that will lead to the awarding of a degree by that school.

(4) This subsection does not apply to persons who are not required to meet the educational requirements under section (3)(d.1)(2) of the act.

Authority

The provisions of this § 33.102 amended under sections 2—5.1, 10—11.5 and 11.7 of The Dental Law (63 P. S. § § 121—124.1, 129—129.1, 130, 130e and 130h).

Source

The provisions of this § 33.102 adopted June 23, 1995, effective June 24, 1995, 25 Pa.B. 2492; amended May 12, 2000, effective May 13, 2000, 30 Pa.B. 2359; amended December 11, 2009, effective December 12, 2009, 39 Pa.B. 6982; amended February 10, 2012, effective February 11, 2012, 42 Pa.B. 769. Immediately preceding text appears at serial pages (346645) to (346646) and (349677).

Cross References

This section cited in 49 Pa. Code § 33.117 (relating to EFDA program approval).

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§ 33.103. Examinations.

(a) *Dentists*. Candidates for licensure shall pass the National Board Dental Examination (written examination) and the dental clinical examination administered by one of the following:

(1) The North East Regional Board of Dental Examiners, Inc. (NERB).

(2) The Southern Regional Testing Agency, Inc. (SRTA).

(3) The Western Regional Examining Board (WREB).

(4) The Central Regional Dental Testing Service, Inc. (CRDTS).

(5) The Council of Interstate Testing Agencies, Inc. (CITA).

(b) *Dental hygienists*. Candidates for licensure shall pass the National Board Dental Hygiene Examination (written examination) and the dental hygiene clinical examination administered by one of the following:

(1) The North East Regional Board of Dental Examiners, Inc. (NERB).

(2) The Southern Regional Testing Agency, Inc. (SRTA).

(3) The Western Regional Examining Board (WREB).

(4) The Central Regional Dental Testing Service, Inc. (CRDTS).

(5) The Council of Interstate Testing Agencies, Inc. (CITA).

(c) *Expanded function dental assistants*. Candidates for certification shall pass a written examination acceptable to the Board.

(d) *Additional requirement*. The Board will recognize successful completion of the dental or dental hygiene clinical examinations or the expanded function dental assistant examination approved by the Board for up to 5 years from the date scores are reported to the Board. After 5 years, the Board will accept passing scores on the examinations only if the

candidate has been engaged in postgraduate training or in the practice of dentistry, as a dental hygienist or as an expanded function dental assistant in another jurisdiction.

Authority

The provisions of this § 33.103 amended under sections 2—5.1, 10—11.5 and 11.7 of the Dental Law (63 P. S. § § 121—124.1, 129—129.1, 130, 130e and 130h).

Source

The provisions of this § 33.103 adopted June 23, 1995, effective June 24, 1995, except subsection (c) effective June 24, 1996, 25 Pa.B. 2492; amended May 12, 2000, effective May 13, 2000, 30 Pa.B. 2359; amended September 3, 2004, effective September 4, 2004, 34 Pa.B. 4882; amended May 14, 2010, effective May 15, 2010, 40 Pa.B. 2532. Immediately preceding text appears at serial pages (346647) and (342139).

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§ 33.117. EFDA program approval.

(a) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

Clinical evaluation—An evaluation system based on observation of a student's performance of clinical skills in contexts that resemble those the student will be expected to encounter as an expanded function dental assistant in a dental office.

Clinical instruction—A learning experience in a clinical setting where the student performs expanded functions on patients under the supervision of an instructor.

Clinical setting—

(i) A setting in which expanded function dental assisting procedures are performed through direct patient care.

(ii) The term does not include a setting where procedures are performed on typodonts, manikins or by other simulation methods.

Competencies—Statements describing the necessary requirements to perform each procedure in § 33.205a (relating to practice as an expanded function dental assistant) to the level required to meet the acceptable and prevailing standard of care within the dental community in this Commonwealth.

Competent—Having sufficient knowledge, skill and expertise in performing expanded functions to meet and maintain the acceptable and prevailing standard of care within the dental community in this Commonwealth.

Laboratory or preclinical instruction—A learning experience in which students perform expanded functions using study models, typodonts, manikins or other simulation methods under the supervision of the instructor.

(b) *Application.* EFDA programs shall apply for Board approval on forms to be provided by the Board and pay the fee in § 33.3 (relating to fees). The application must include the following information:

(1) The EFDA program goals and objectives.

(2) The criteria for measuring competencies.

(3) Documentation of accreditation as required under section 3(d.1) of the act (63 P. S. § 122(d.1)).

(4) The curriculum vitae and job description of the EFDA program director.

(5) The curriculum vitae and job description of each faculty member assigned to the EFDA program.

(6) A description of the physical facilities and equipment used by the EFDA program for laboratory, preclinical and clinical instruction.

(7) A copy of the formal written agreement for the use of off-campus laboratory, preclinical or clinical facilities, if applicable.

(8) Course outlines, course descriptions or syllabi for the EFDA program curriculum.

(9) Other information related to the EFDA program requested by the Board.

(c) *Requirements for approval.* The Board will approve EFDA programs that meet the following requirements:

(1) *Planning and assessment.*

(i) The EFDA program shall delineate its program goals and objectives for preparing individuals in the expanded function dental assisting procedures in § 33.205a to a level consistent with the acceptable and prevailing standard of care within the dental community in this Commonwealth.

(ii) The EFDA program shall develop specific criteria for measuring levels of competency for the procedures in § 33.205a which reflect the acceptable and prevailing standards and expectations of the dental

community. Students shall be evaluated by faculty according to these predetermined criteria.

(iii) The EFDA program shall record and retain student clinical evaluations as documentation of student competency for a minimum of 5 years from the student's graduation or completion of the EFDA program.

(2) *Institutional accreditation.* The EFDA program shall comply with the accreditation requirements of section 3(d.1) of the act and § 33.102(c) (relating to professional education).

(3) *Program director.* The EFDA program shall identify a program director who is responsible for and involved in the following:

(i) Student selection.

(ii) Curriculum development and implementation.

(iii) Ongoing evaluation of program goals, objectives, content and outcomes assessment.

(iv) Annual evaluations of faculty performance including a discussion of the evaluation with each faculty member.

(v) Evaluation of student performance and maintenance of competency records for 5 years from graduation or completion of the EFDA program.

(vi) Participation in planning for and operation of facilities used in the EFDA program.

(vii) Evaluation of the clinical training and supervision provided in affiliated offices and off-campus facilities, as applicable.

(viii) Maintenance of records related to the EFDA program, including instructional objectives and course outcomes.

(ix) Instruction of licensed dentists overseeing off-campus clinical procedures performed by expanded function dental assistant students to ensure that the policies and procedures of the off-campus facility are consistent with the philosophy and objectives of the EFDA program.

(4) *Faculty.* An EFDA program faculty member shall either be a dentist who holds a current license in good standing from the Board or meets the following criteria:

(i) Holds a current expanded function dental assistant certificate issued by the Board.

(ii) Has a minimum of 2 years of practical clinical experience as an expanded function dental assistant.

(iii) Holds National certification as a certified dental assistant issued by the Dental Assisting National Board.

(iv) Has completed a course in education methodology of at least 3 credits or 45 hours offered by an accredited institution of postsecondary education or complete a course in educational methodology no later than 18 months after employment as a faculty member.

(5) *Facilities and equipment.*

(i) The EFDA program shall provide physical facilities which provide space adequate to the size of its student body and sufficient to enable it to meet its educational objectives for laboratory, preclinical and clinical instruction.

(ii) The EFDA program shall provide equipment suitable to meet the training objectives of the course or program and shall be adequate in quantity and variety to provide the training specified in the course curriculum or program content.

(iii) If the EFDA program contracts for off-campus laboratory, preclinical or clinical instruction facilities, the following conditions must be met:

(A) There must be a formal written agreement between the EFDA program and the laboratory, preclinical or clinical facility.

(B) In off-campus clinical facilities, a licensed dentist shall oversee dental procedures performed on patients by EFDA program students. The licensed dentist shall receive instruction to ensure that the policies and procedures of the off-campus facility are consistent with the philosophy and objectives of the EFDA program.

(iv) The standards in this paragraph are equally applicable to extramural dental offices or clinic sites used for clinical practice experiences, such as internships or externships.

(6) *Curriculum.* The curriculum of an EFDA program must consist of the following components:

(i) *General education.* The EFDA program shall include general education subjects as determined by the educational institution with a goal of preparing the student to work and communicate effectively with patients and other health care professionals.

(ii) *Dental sciences.* The EFDA program shall include content in general dentistry related to the expanded functions in section 11.10(a) of the act (63 P. S. § 130k(a)) and as set forth in § 33.205a, including courses covering the following topics:

(A) Dental anatomy.

(B) Occlusion.

(C) Rubber dams.

(D) Matrix and wedge.

(E) Cavity classification and preparation design.

(F) Bases and liners.

(G) Amalgam restoration.

(H) Composite restoration.

(I) Sealants.

(J) Crown and bridge provisional fabrication.

(K) Dental law and ethics.

(L) Coronal polishing.

(M) Fluoride treatments, including fluoride varnish.

(N) Taking impressions of teeth for study models, diagnostic casts and athletic appliances.

(iii) *Clinical experience component.* The EFDA program shall include a minimum of 120 hours of clinical experience performing expanded function

dental assisting procedures as an integral part of the EFDA program. The clinical experience component shall be designed to achieve a student's clinical competence in each of the expanded function dental assisting procedures in § 33.205a.

(7) *Demonstrating competency.*

(i) *General education.* Students of the EFDA program shall be required to demonstrate competency in general education subjects by attaining a passing grade on examinations.

(ii) *Laboratory and preclinical instruction.* Students in the EFDA program shall be required to demonstrate competency by attaining a score of at least 80% in laboratory and preclinical courses. Students shall be required to demonstrate the knowledge and skills required to:

(A) Carve the anatomy of all teeth.

(B) Establish proper contact areas, embrasures, marginal adaptation, as well as facial and lingual heights of contour to restore the proper tooth form and function in restorative materials commonly used for direct restorations, such as amalgam and composite resin.

(C) Apply the basic concepts and terms of occlusion and carving concepts in the restoration of proper occlusal relationships.

(D) Describe the problems associated with improper contouring of restorations.

(E) Identify and differentiate G.V. Black's cavity classifications.

(F) Select, prepare, assemble, place and remove a variety of matrices and wedges.

(G) Place and finish Class I—VI restorations with correct marginal adaptation contour, contact and occlusion.

(H) Assemble, place and remove rubber dams.

(I) Place sealants.

(J) Crown and bridge provisional fabrication.

(K) Understand the act and this chapter as they apply to an expanded function dental assistant's responsibilities.

(L) Perform coronal polishing.

(M) Perform fluoride treatments, including fluoride varnish.

(N) Take impressions of teeth for study models, diagnostic casts and athletic appliances.

(iii) *Clinical experience.* EFDA program students shall be evaluated and deemed clinically competent by at least one licensed dentist evaluator in a clinical setting. The EFDA program director shall instruct the dentist clinical evaluators regarding the required competencies to ensure consistency in evaluation. Clinical competency is achieved when the dentist evaluator confirms the student has sufficient knowledge, skill and expertise in performing expanded functions to meet and maintain the acceptable and prevailing standard of care within the dental community in this Commonwealth.

(iv) *Documenting competency.*

(A) The EFDA program faculty and program director shall document the student's general education, preclinical and laboratory competency attainment.

(B) The licensed dentist evaluator shall document the student's clinical competency attainment prior to graduation from the EFDA program.

(C) The EFDA program director shall sign a statement certifying the student's competency attainment in general education, laboratory and preclinical instruction, and clinical experience to the Board as part of the student's application for certification as an expanded function dental assistant.

(D) The EFDA program shall retain supporting documentation evidencing the student's competency attainment for a minimum of 5 years from graduation or completion of the EFDA program.

(d) *Refusal or withdrawal of approval.* The Board may refuse to approve an EFDA program or may remove an EFDA program from the approved list if it fails to meet and maintain the requirements set forth in this section, in accordance with the following:

(1) The Board will give an EFDA program notice of its provisional denial of approval or of its intent to remove the program from the approved list.

(2) The notice will set forth the requirements that are not being met or maintained by the EFDA program.

(3) A program served with a provisional denial or notice of intent to remove will be given 45 days in which to file a written answer to the notice.

(4) The EFDA program will be provided an opportunity to appear at a hearing to demonstrate why approval should not be refused or withdrawn.

(5) The Board will issue a written decision.

(6) The Board's written decision is a final decision of a governmental agency subject to review under 2 Pa.C.S. § 702 (relating to appeals).

(e) *Biennial renewal of EFDA program approval.* EFDA program approvals are renewable for a 2-year period beginning on April 1 of each odd-numbered year. An EFDA program shall apply for renewal of Board approval on forms provided by the Board and pay the fee for biennial renewal in § 33.3. Upon applying for renewal, the EFDA program shall update all of the information required under subsection (b)(1)—(9) or certify that there have not been changes to the EFDA program.

Authority

The provisions of this § 33.117 adopted under section 3(a), (b), (d.1)(1) and (o) of The Dental Law (63 P. S. § 122(a), (b), (d.1)(1) and (o)).

Source

The provisions of this § 33.117 adopted February 10, 2012, effective February 11, 2012, 42 Pa.B. 769.

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§ 33.205a. Practice as an expanded function dental assistant.

(a) *Scope of professional practice.*

(1) An expanded function dental assistant may offer to perform or perform the following services:

(i) Placing and removing rubber dams.

(ii) Placing and removing matrices.

(iii) Placing and removing wedges.

(iv) Applying cavity liners and bases.

(v) Placing and condensing amalgam restorations.

(vi) Carving and contouring amalgam restorations.

(vii) Placing and finishing composite resin restorations or sealant material, or both.

(viii) Performing coronal polishing as defined in § 33.1 (relating to definitions).

(ix) Performing fluoride treatments, including fluoride varnish.

(x) Taking impressions of teeth for study models, diagnostic casts or athletic appliances.

(2) Each of the professional services identified in paragraph (1) shall be performed under the direct supervision of a dentist.

(b) *Prohibitions.* An expanded function dental assistant may not perform the following procedures:

(1) Complete or limited examination, diagnosis and treatment planning.

(2) Surgical or cutting procedures of hard or soft tissue.

(3) Prescribing drugs, medicaments or work authorizations.

(4) Final inspection and approval of restorative and other treatment which affects occlusion and necessary occlusal adjustments.

(5) Pulp capping, pulpotomy and other endodontic procedures.

(6) Placement and intraoral adjustments of fixed and removable prosthetic appliances.

(7) Administration of local anesthesia, parenteral or inhalational sedation, nitrous oxide analgesia or general anesthesia.

(8) Take impressions other than for study models, diagnostic casts or athletic appliances.

(c) *Supervision.* Expanded function dental assistants shall perform under the direct supervision of a dentist. Direct supervision means that a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedure and remains in the dental office or treatment facility while the procedure is being performed by the expanded function dental assistant, and, before dismissal of the patient, personally evaluates the work performed by the expanded function dental assistant.

Authority

The provisions of this § 33.205a amended under sections 2—5.1, 10—11.5 and 11.7 of The Dental Law (63 P. S. § § 121—124.1, 129—129.1, 130, 130e and 130h); and section 4 of the act of April 29, 2010 (P. L. 176, No. 19).

Source

The provisions of this § 33.205a adopted May 12, 2000, effective May 13, 2000, 30 Pa.B. 2359; amended September 7, 2012, effective September 8, 2012, 42 Pa.B. 5736. Immediately preceding text appears at serial pages (348144) and (360159).

Cross References

This section cited in 49 Pa. Code § 33.117 (relating to EFDA program approval).

Rules & Laws
License & Permits
License Renewal
Fees
License Verification
Online Services
Disciplinary Action
Continuing Education
Dental Assisting
Filing Complaint
Management Arrangements
Forms
Professional Corporation
Online Examination

dental assisting

Dental Assistant I and Dental Assistant II

In North Carolina, there are two classifications for Dental Assistants (DAI and DAII.) North Carolina does NOT certify assistants. Classification is based on experience and/or training as listed below. It is up to the employer to verify an assistant's qualifications and determine if he/she is a DAI or DAII.

Education and Training Requirements

To be classified as a Dental Assistant II, an assistant shall meet one of the following criteria:

(1) completion of:
(a) an ADA-accredited dental assisting program and current certification in CPR; or
(b) one academic year or longer in an ADA-accredited dental hygiene program, and current certification in CPR; or

(2) completion of the Dental Assistant certification examination(s) administered by the Dental Assisting National Board and current certification in CPR; or

(3) completion of:
(a) a 3-hour course in sterilization and infection control;
(b) a 3-hour course in dental office emergencies; and
(c) current certification in CPR.
(d) after completing Sub-Items (3)(b), (c), and (d) of this Rule, dental assistants may be trained in any dental delivery setting and allowed to perform the functions of a Dental Assistant II under the direct control and supervision of a licensed dentist, except as listed in Sub-Item 3(e) of this Rule.
(e) dental assistants may take radiographs after completing radiology training consistent with G.S. 90-29(c)(12).
(f) full-time employment and experience as a chairside assistant for two years (3,000 hours) of the preceding five, during which period the assistant may be trained in any dental delivery setting and allowed to perform the functions of a Dental Assistant II under the direct control and supervision of a licensed dentist.

Radiography Requirements

A certified dental assistant [(one who successfully completes the DANB exam (see (3) above)] or an assistant who completes an ADA-accredited dental assisting or dental hygiene program may take radiographs without further examination. All others, including those who move to North Carolina from out-of-state, must successfully pass an equivalency exam. This exam may be challenged after completing "seven hours of instruction in the production and use of dental x-rays and an education program of not less than seven hours in clinical dental radiology." You must be able to prove that you have the minimal amount of training to be eligible to

Functions of the Board of Dental Examiners

- The administration of licensure examinations for dentists and dental hygienists
- The promulgation of rules and enforcement of laws and regulations governing the practice of dentistry and dental hygiene in this state
- The issuance and renewal of licenses to dentists and dental hygienists

take the radiology equivalency exam, or you may take a course prior to taking the exam. Any Board approved radiography course is acceptable and any approved course's final examination is recognized as the equivalency exam.

Click here to see the latest list of approved radiology courses.

Delegable Functions

For a list of delegable functions for DA I or DA II, please refer to the Dental Assisting National Board's (DANB) latest publication for North Carolina. Click here.

info@ncdentalboard.org

North Carolina

DANB Certificant Counts: North Carolina

Certified Dental Assistants (CDAs)	XXXX
Certified Orthodontic Assistants (COAs)	XX
Certified Preventive Functions Dental Assistants (CPFDAs)	XX
Certified Restorative Functions Dental Assistants (CRFDAs)	X

DANB Contact

Dental Assisting National Board, Inc. (DANB)
444 N. Michigan Ave., Suite 900
Chicago, IL 60611
1-800-367-3262 • Fax: 312-642-1475
www.danb.org • danbmail@danb.org

State Board of Dentistry Contact

Bobby D. White, Chief Operations Officer
North Carolina State Board of Dental Examiners
507 Airport Boulevard, Suite 105
Morrisville, NC 27560-8200
Phone: 919-678-8223
Fax: 919-678-8472
Website: www.ncdentalboard.org

CODA-Accredited Dental Assisting Programs

Alamance Community College
Asheville-Buncombe Technical Community College
Cape Fear Community College
Central Carolina Community College
Central Piedmont Community College
Coastal Carolina Community College
Fayetteville Technical Community College
Forsyth Technical Community College
Guilford Technical Community College
Martin Community College
Miller-Motte College
Miller-Motte College-Raleigh
Montgomery Community College
Rowan-Cabarrus Community College
University of North Carolina School of Dentistry
Wake Technical Community College
Wayne Community College
Western Piedmont Community College
Wilkes Community College

DANB Certificates of Knowledge-Based Competency & Component Exams* in This State

Radiation Health and Safety (RHS)	XXXX
Infection Control (ICE)	XXXX
Coronal Polish (CP)	XX
Sealants (SE)	XX
Topical Anesthetic (TA)	XX
Topical Fluoride (TF)	XX
Anatomy, Morphology and Physiology (AMP)	X
Impressions (IM)	X
Temporaries (TMP)	X
Isolation (IS)	X

Median Salary of DANB Certified Assistants

DANB Certified Assistant State of North Carolina+	$XX.XX per hour
DANB Certified Assistant National+	$XX.XX per hour
Non-DANB Certified Dental Assistant National++	$XX.XX per hour

DANB certificant and exam information is current as of [date].
State-specific information on the pages that follow is current as of February 16, 2015.

The pages that follow contain information about this state's requirements for dental assistants. If you have any questions about DANB-administered exams, contact DANB. For questions or further information about state requirements, contact the state board of dentistry.

DANB is a member of the Institute for Credentialing Excellence. The National Commission for Certifying Agencies (NCCA), an Institute for Credentialing Excellence commission with responsibility for accrediting certification programs, has evaluated DANB national certification programs (CDA and COA), including DANB component exams (RHS, ICE, GC and OA), and finds that DANB programs meet NCCA's highest standards, thus helping to assure validity, reliability and objectivity in the testing process.

* RHS and ICE: cumulative totals since 1997; CP, SE, TA and TF: cumulative totals since 2010; AMP, IM, TMP and IS: cumulative totals since 2012

+ Source: 2012 DANB Salary Survey (based on 28 responses from this state)

++ Source: U.S. Bureau of Labor Statistics median salary for dental assistants in 2013, with cost of living adjustment for 2014

North Carolina State Radiography Requirements

To legally operate dental x-ray equipment and perform dental radiographic procedures in the state of North Carolina, a dental assistant must: (1) Pass the national DANB Certified Dental Assistant (CDA) exam ***OR*** (2) Pass a radiological equivalency exam recognized by the North Carolina State Board of Dental Examiners (The equivalency exam may be taken by an assistant who can show evidence of seven hours of instruction in the production and use of dental x-rays and an educational program of not less than seven hours in clinical dental radiography) ***OR*** (3) Successfully complete a CODA-accredited dental assisting program ***OR*** (4) Qualify as a DA II *(see requirements below).*

State Requirements For Expanded Functions

The classifications for dental assistants in the state of North Carolina are: **Dental Assistant I (DA I), Dental Assistant II in Training (DA II In Training)** and **Dental Assistant II (DA II)**. It is up to the dentist/employer to determine an assistant's classification and the functions the assistant is allowed to perform.

To perform **expanded functions** under the direct supervision of a licensed dentist in the state of North Carolina, one must be classified as a **DA II**. To qualify as a **DA II**, one must: (1) Hold a current Cardiopulmonary Resuscitation (CPR) certification ***AND*** (2a) Successfully complete a CODA-accredited dental assisting program or one academic year or longer in a CODA-accredited dental hygiene program ***or*** (2b) Complete full-time employment and experience as a chairside assistant for two years (3,000 hours) of the preceding five, radiography training as required by law, a three-hour course in dental office emergencies, and a three-hour course in sterilization and infection control ***OR*** (3) Pass the national DANB Certified Dental Assistant (CDA) exam.

To qualify to *perform coronal polishing*, a **DA II** must successfully complete a 7-hour (three hours of didactic and four hours of clinical) coronal polishing course meeting North Carolina Board requirements.

To qualify to *monitor patients under nitrous oxide*, a **DA II** must successfully complete a North Carolina Board-approved seven-hour course in nitrous oxide-oxygen conscious sedation.

A **Dental Assistant II In Training (DA II in Training)** in the state of North Carolina is an individual who is participating in on the job training to become a DAII. During the training period, which consists of at least two years (3,000 hours) of chairside assisting, the assistant may be trained and allowed to perform most of the functions of a DAII under the direct control and supervision of a North Carolina licensed dentist. A DAII in Training may not monitor patients under nitrous oxide, take radiographs, or coronal polish until he or she successfully completes the required courses in these topics.

A Dental Assistant I (DA I) in the state of North Carolina is an individual who may perform basic supportive dental procedures under the direct control and supervision of a licensed dentist. To qualify to *monitor patients under nitrous oxide*, a DA I must successfully complete a North Carolina Board-approved seven-hour course in nitrous oxide-oxygen conscious sedation.

North Carolina State Dental Practice Act and Administrative Rules for Dental Assistants

Classification of Dental Assistants In North Carolina
Delegable Functions | Radiography Requirements

Dental Assistant I and Dental Assistant II

In North Carolina, there are two classifications for Dental Assistants (DAI and DAII). North Carolina does NOT certify assistants. Classification is based on experience and/or training as listed below. It is up to the employer to verify an assistant's qualifications and determine if he/she is a DAI or DAII.

To be classified as a Dental Assistant II, an assistant must meet one (1) of the following criteria:

(1) successful completion of:
   a) an ADA-accredited dental assisting program and current certification in CPR; or
   b) one academic year or longer in an ADA-accredited dental hygiene program, and current certification in CPR

(2) successful completion of:
   a) full-time employment and experience as a chairside assistant for two years (3,000 hours) of the preceding five, during which period the assistant may be trained in any dental delivery setting and allowed to perform the functions of a Dental Assistant II under the direct control and supervision of a licensed dentist;

b) a 3-hour course in sterilization and infection control;
c) a 3-hour course in dental office emergencies;
d) radiology training consistent with G.S. 90-29(s)(12); and
e) current certification in CPR; or

(3) successful completion of the certification examination administered by the Dental Assisting National Board (DANB), and current certification in CPR.

Radiography Requirement
A certified dental assistant [one who successfully completes the DANB CDA exam (see (3) above)] or an assistant who completes an ADA-accredited dental assisting or dental hygiene program may take radiographs without further examination. All others, including those who move to North Carolina from out-of-state, must successfully pass an equivalency exam. This equivalency exam may be challenged after completing "seven hours of instruction in the production and use of dental x-rays and an education program of not less than seven hours in clinical dental radiology." You must be able to prove that you have the minimal amount of training to be eligible to take the radiology equivalency exam, or you may take a course prior to taking the exam. Any Board approved radiography course is acceptable and any approved course's final examination is recognized as the equivalency exam.

DELEGABLE FUNCTIONS IN NORTH CAROLINA AS OF AUGUST 1, 2000

subject to change

Please note: *A DAI can perform the same functions as a DAII while he or she is in training, with the exception of coronal polishing.*

FUNCTION	DAI	DAII
Take Impressions for Study Models & Opposing Casts	X	X
Apply Sealants after DDS has Examined Patient & Prescribed Procedure	X	X
Insert Matrix Bands and Wedges	X	X
Place Cavity Bases and Liners	X	X
Place and/or remove Rubber Dams	X	X
Cement Temp. Restorations using Temp. Cement	X	X
Apply Acid Etch Materials/Rinses	X	X
Apply Bonding Agents	X	X
Remove Periodontal Dressings	X	X
Remove Sutures	X	X
Place Gingival Retraction Cord	X	X
Remove Excess Cement	X	X
Flush, Dry & Temporarily Close Root Canals	X	X
Place & Remove Temp. Restorations	X	X
Place & Tie In or Untie & Remove Ortho. Arch Wires	X	X
Insert Interdental Spacers	X	X
Fit (size) Orthodontic Bands or Brackets	X	X
Apply Dentin Desensitizing Solutions	X	X
Perform Extra-Oral Adjustments of any Temp. Restoration or Appliance	X[3]	X
Initially Form & Size Orthodontic Arch Wires & Place Arch Wires after Final Adjustment & Approval by DDS	X	X
Apply Topical Anesthetics/DentiPatch®	X	X
Apply Topical Fluoride	X	X
Expose Radiographs	X[1]	X[1]
Write Laboratory Work Orders	X[2]	X[2]

FUNCTION	DAI	DAII
Write Prescriptions (Drugs)	X[2]	X[2]
Remove Sutures	X	X
Polish Dentures	X[3]	X[3]
Take wax bites	X	X
Monitor Pt.'s under Nitrous Oxide	X[4]	X[4]
Oral Hygiene Instruction	X	X
Polish Coronal Portion of Tooth -X[6]		X[5]
Place Amalgam in Prep w/ Carrier	X	X
Take Pulse, Blood Pressure & Temperature	X	X
Place Ligature Wire or Lock Pins	X	X
Insert Spacer Wires or Springs	X	X

1 – After satisfactory completion of ONE of the following: (1) the North Carolina radiography equivalency examination, (2) dental assisting school (an ADA-accredited program), (3) the Dental Assisting National Board CDA examination (1-800-367-3262), or (4) classification as a DAII in North Carolina.
2 – Exact words must be dictated by the dentist.
3 – Extra-orally, upon instruction by the dentist and re-insertion by the dentist.
4 – After completing a 7-hour Board-approved course in nitrous oxide-oxygen conscious sedation, unless included in an ADA-accredited program (DAII).
5 – After completing a 7-hour (3 hours didactic, 4 hours clinical) course in coronal polishing.
6 – Use of a hand-held brush & appropriate polishing agents OR a combination of a slow-speed handpiece (not to exceed 10,000 rpm) with an attached rubber cup or bristle brush and appropriate polishing agents. An individual designated as a "DA II in training" cannot perform this function.

Dental Practice Act - North Carolina State Board of Dental Examiners

North Carolina General Statutes
Chapter 90: Medicine and Allied Occupations

Article 2 - Dentistry

§ 90-29. Necessity for license; dentistry defined; exemptions.

(c) The following acts, practices, or operations, however, shall not constitute the unlawful practice of dentistry:

(9) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board;

(10) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of subdivision (3) above;

(12) The use of a dental x-ray machine in the taking of dental radiographs by a dental hygienist, certified dental assistant, or a dental assistant who can show evidence of satisfactory performance on an equivalency examination, recognized by the Board of Dental Examiners, based on seven hours of instruction in the production and use of dental x rays and an educational program of not less than seven hours in clinical dental radiology.

(13) A dental assistant, or dental hygienist who shows evidence of education and training in Nitrous Oxide – Oxygen Inhalant Conscious Sedation within a formal educational program may aid and assist a licensed dentist in the administration of Nitrous Oxide – Oxygen Inhalant Conscious Sedation. Any dental assistant who can show evidence of having completed an educational program recognized by the Board of not less than seven clock hours on Nitrous Oxide – Oxygen Inhalant Conscious Sedation may also aid and assist a licensed dentist in the administration of Nitrous Oxide – Oxygen Inhalant Conscious Sedation. Any dental hygienist or dental assistant who has been employed in a dental office where Nitrous Oxide – Oxygen Inhalant Conscious Sedation was utilized, and who can show evidence of performance and instruction of not less than one year prior to July 1, 1980, qualifies to aid and assist a licensed dentist in the administration of Nitrous Oxide – Oxygen Inhalant Conscious Sedation.

Article 16 - Dental Hygiene Act

§ 90-221. Definitions.

(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts, except those acts performed under direction and in compliance with G.S. 90-233(a) or G.S. 90-233(a1), and such acts are being performed pursuant to the dentist's order, control and approval.

§ 90-233. Practice of dental hygiene.

(c) Dental hygiene may be practiced only by the holder of a license or provisional license currently in effect and duly issued by the Board. The following acts, practices, functions or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(3) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3).

Amended Rules & Regulations
SUBCHAPTER 16H – DENTAL ASSISTANTS
SECTION .0100 – CLASSIFICATION AND TRAINING

21 NCAC 16H .0101 CLASSIFICATION

Based upon education, training, and experience, a dental assistant shall be categorized as a Dental Assistant I or a Dental Assistant II. *[See note on page 345.*]*

21 NCAC 16H .0102 DENTAL ASSISTANT I

A Dental Assistant I is a dental assistant who does not qualify by training and experience for classification as a Dental Assistant II.

21 NCAC 16H .0103 DENTAL ASSISTANT II

A Dental Assistant II is an expanded duty assistant who has completed training in accordance with Rule .0104 of this Section. Under direct control and supervision, a Dental Assistant II may be delegated intra-oral procedures in accordance with 21 NCAC 16H .0203 the supervising dentist deems appropriate, with the dentist personally and professionally responsible for any and all consequences or results arising from the performance of said acts. All delegated procedures must be reversible in nature.

21 NCAC 16H .0104 APPROVED EDUCATION AND TRAINING PROGRAMS*

To be classified as a Dental Assistant II, an assistant must meet one of the following criteria:

(1) successful completion of:
  (a) a CODA-Accredited dental assisting program and current certification in CPR; or
  (b) one academic year or longer in a CODA-accredited dental hygiene program, and current certification in CPR; or

(2) successful completion of:
  (a) full-time employment and experience as a chairside assistant for two years (3,000 hours) of the preceding five, during which period the assistant may be trained in any dental delivery setting and allowed to perform the functions of a Dental Assistant II under the direct control and supervision of a licensed dentist;
  (b) a 3-hour course in sterilization and infection control;
  (c) a 3-hour course in dental office emergencies;
  (d) radiology training consistent with G.S. 90-29(c)(12); and
  (e) current certification in CPR; or

(3) successful completion of the certification examination administered by the Dental Assisting National Board, and current certification in CPR.

SECTION .0200 – PERMITTED FUNCTIONS OF DENTAL ASSISTANT

21 NCAC 16H .0201 GENERAL PERMITTED FUNCTIONS OF DENTAL ASSISTANT I

(a) A Dental Assistant I may assist a dentist as a chairside assistant as long as the acts and functions of the Dental Assistant I do not constitute the practice of dentistry or dental hygiene.

(b) A Dental Assistant I may do and perform only routine dental assisting procedures such as oral hygiene instruction; chairside assisting; application of topical fluorides or topical anesthetics; and exposure of radiographs, provided that the assistant can show evidence of compliance with radiography training consistent with G.S. 90-29(c)(12). However, functions may be delegated to a Dental Assistant I pursuant to 21 NCAC 16H .0104(2)(a).

21 NCAC 16H .0203 PERMITTED FUNCTIONS OF DENTAL ASSISTANT II

(a) A Dental Assistant II may perform any and all acts or procedures which may be performed by a Dental Assistant I. In addition, a Dental Assistant II may be delegated the following functions to be performed under the direct control and supervision of a dentist who shall be personally and professionally responsible and liable for any and all consequences or results arising from the performance of such acts and functions:
- (1) Take impressions for study models and opposing casts which will not be used for construction of dental appliances, but which may be used for the fabrication of adjustable orthodontic appliances;
- (2) Apply sealants to teeth that do not require mechanical alteration prior to the application of such sealants, provided a dentist has examined the patient and prescribed the procedure;
- (3) Insert matrix bands and wedges;
- (4) Place cavity bases and liners;
- (5) Place and/or remove rubber dams;
- (6) Cement temporary restorations using temporary cement;
- (7) Apply acid etch materials/rinses;
- (8) Apply bonding agents;
- (9) Remove periodontal dressings;
- (10) Remove sutures;
- (11) Place gingival retraction cord;
- (12) Remove excess cement;
- (13) Flush, dry and temporarily close root canals;
- (14) Place and remove temporary restorations;
- (15) Place and tie or untie and remove orthodontic arch wires;
- (16) Insert interdental spacers;
- (17) Fit (size) orthodontic bands or brackets;
- (18) Apply dentin desensitizing solutions;
- (19) Perform extra-oral adjustments which affect function, fit or occlusion of any temporary restoration or appliance;
- (20) Initially form and size orthodontic arch wires and place arch wires after final adjustment and approval by the dentist;
- (21) Polish the clinical crown using only:
  - (A) a hand-held brush and appropriate polishing agents; or
  - (B) a combination of a slow speed handpiece (not to exceed 10,000 rpm) with attached rubber cup or bristle brush, and appropriate polishing agents.

(b) A Dental Assistant II must complete a course in coronal polishing consisting of at least seven hours before using a slow speed handpiece with rubber cup or bristle brush attachment. A polishing procedure shall not be represented to the patient as a prophylaxis and no specific charge shall be made for such unless the dentist has performed an evaluation for calculus, deposits, or accretions and a dentist or dental hygienist has removed any substances detected.

21 NCAC 16H .0205 SPECIFIC PROHIBITED FUNCTIONS OF DENTAL ASSISTANTS I AND II

Those specific functions which shall not be delegated to either a Dental Assistant I or a Dental Assistant II include those procedures prohibited in 21 NCAC 16G .0103 for Dental Hygienists. In addition, neither a Dental Assistant I nor a Dental Assistant II shall perform a prophylaxis, or shall perform periodontal screening, periodontal probing, subgingival exploration for or removal of hard or soft deposits, or sulcular irrigation.

21 NCAC 16H .0206 DIRECT CONTROL AND SUPERVISION DEFINED

In any instance in which the rules adopted by the Board or any portion of the North Carolina Dental Practice Act shall require or direct that any act or function be performed by a Dental Assistant I or II under the direct control and supervision of a dentist, the term "direct control and supervision of a dentist" means that the dentist must be present in the office when the act or function is being performed and that the dentist must directly and personally supervise, examine, and evaluate the results of any and all acts and functions lawfully done or performed by any person other than the dentist.

SUBCHAPTER 16J - SANITATION

21 NCAC 16J .0103 STERILIZATION

All instruments or equipment used in the treatment of dental patients shall be sterilized according to usage. All dental health care settings shall follow the most current guidelines on infection control for the dental office and the dental laboratory adopted by the American Dental Association. Effective control techniques and precautions to prevent the cross contamination and transmission of infection to all persons is the professional responsibility of all dentists. All licensees are required to maintain and provide a safe, therapeutic environment for patients and employees and to follow a comprehensive and practical infection control program at all times.

SUBCHAPTER 16O – NITROUS-OXIDE-OXYGEN CONSCIOUS SEDATION
SECTION .0400 - QUALIFICATIONS TO PERFORM FUNCTIONS

21 NCAC 16O .0402 EDUCATIONAL REQUIREMENTS

A Dental Assistant I or a Dental Assistant II not otherwise qualified under G.S. 90-29(c)(13) may aid and assist a licensed dentist in the administration of nitrous oxide-oxygen inhalant conscious sedation after completion of a Board-approved course totalling at least seven hours and directed by an individual or individuals approved by the Board. Such course shall include:

(1) Definitions and descriptions of physiological and psychological aspects of pain and anxiety;
(2) The states of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and unconscious state;
(3) Respiratory and circulatory physiology and related anatomy;
(4) Pharmacology of agents used in the conscious sedation techniques being taught, including drug interaction and incompatibility;
(5) Patient monitoring, with particular attention to vital signs and reflexes related to consciousness;
(6) Prevention, recognition and management of complications and life threatening situations that may occur during the use of the conscious sedation techniques, including cardiopulmonary resuscitation;
(7) Description and use of ventilation sedation equipment; and
(8) Potential health hazards of trace anesthetics, and proposed techniques for elimination of these potential health hazards.

SUBCHAPTER 16Q – GENERAL ANESTHESIA AND SEDATION
SECTION .0200 - GENERAL ANESTHESIA

21 NCAC 16Q .0202 EQUIPMENT

(d) A dentist administering general anesthesia shall ensure that the facility is staffed with auxiliary personnel who shall document annual successful completion of basic life support training and be capable of assisting with procedures, problems, and emergency incidents that may occur as a result of the general anesthetic or secondary to an unexpected medical complication.

**Note: According to the Chief Operations Officer of the North Carolina State Board of Dental Examiners (personal communication, 2/19/09), North Carolina also recognizes a "DA II in training" [Sec. 21.NCAC 16H.0104 (2)(a)]. A DA II in training is a DA I with two years (3,000 hours) of work experience as a dental assistant. A DA II in training may perform all DA II functions except coronal polishing. A dental assistant must be a DA II (no longer in training) to qualify to enroll in a coronal polishing course. In addition, to expose radiographs and monitor nitrous oxide, a DA II in training must successfully complete required courses as described in Subchapter 16H Section .0200.*

Virginia Board of Dentistry

REGULATORY /LEGISLATIVE COMMITTEE
10/16/2015

Assignment: Consider the comments received to identify any policy action the Board might take regarding the use of teledentistry in Virginia to increase access to dental treatment.

Background:
Addressing the appropriate equipment and uses of teledentistry was supported by multiple speakers at the Board's Open Forum on Policy Strategies to Address Teledentistry. The minutes and transcript of the Forum and the CTEL Safe Telemedicine Principles and the Board of Medicine's Guidance Document are provided.

APPROVED MINUTES

VIRGINIA BOARD OF DENTISTRY
OPEN FORUM ON
POLICY STRATEGIES TO ADDRESS TELEDENTISTRY

Friday, August 14, 2015

Perimeter Center
9960 Mayland Drive, Suite 201
Richmond, Virginia 23233-1463
Board Room 4

CALL TO ORDER:	The Virginia Board of Dentistry convened an Open Forum at 9:00 a.m. to receive views on the need for policies on the use of teledentistry in Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	John M. Alexander, D.D.S. Charles E. Gaskins, III., D.D.S. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Director Huong Vu, Operations Manager
OTHERS PRESENT:	David E. Brown, D.C., DHP Director
COURT REPORTER:	Earlina King, Court Reporter, Crane-Snead & Associates, Inc.
QUORUM:	Not required.
FORUM COMMENTS:	**Antoinett Kahan, RDH**, Dental Assisting Program Director at Virginia Beach Technical & Career Education Center and President of the Oral Health Improvement Coalition of South Hampton Roads, stated that teledentistry is used on dental access days to give patients their x-rays. She said Emergency Departments (ED) should do this to reduce the number of subsequent ED visits and added that the equipment needed to do this is a NOMAD handheld x-ray unit, digital sensors, laptop, and intraoral camera. She suggested that x-ray technicians should be certified to take dental x-rays, ED physicians should be allowed to approve dental x-rays, and that the telemedicine protocol for the Health Insurance Portability and Accountability Act (HIPAA) should be followed. She asked the Board to amend regulation 18 VAC 60-20-195 to address her recommendations.

Susan Reid Carr, RDH, Virginia Dental Hygienists' Association (VDHA), said that VDHA supports all delivery models of oral health care services which are safe and cost-effective. She said the concepts for teledentistry which VDHA supports are:

- A dentist-patient relationship should be established through an in-person visit to a dentist to establish a dental home, and
- Use of the HIPPA approved communications equipment.

She noted that the initial investment in equipment would improve access and reduce travel costs for patients.

Linda Wilkinson, CEO of Virginia Association of Free and Charitable Clinics, Inc., stated that the clinics serve over 70 thousand people and only 15 thousand receive dental care. She said that teledentistry would allow greater flexibility in expanding access to dental care to all parts of Virginia.

David Sarrett, DDS, Dean of VCU School of Dentistry, said the School uses teledentistry for education and research purposes as well as patient treatment. He asked the Board to allow for these uses in any policy action.

Benita Miller, DDS, Virginia Dental Association (VDA), said that the VDA supports a collaborative pilot project for teledentistry with a Community Dental Health Coordinator (CDHC) as a vital part.

Nicole Pugar read written comment from Sarah Bedard Holland, Executive Director of Virginia Oral Health Coalition (VaOHC). Ms. Holland reported that VaOHC is in support of teledentistry and has convened a teledentistry workgroup which determined that "Store and Forward" teledentistry might be an effective way to increase access. She explained that "Store and Forward" may:

- Create more efficiency in the delivery of health care;
- Reduce transportation burden for families; and
- Result in cost savings to the state for Medicaid patients.

She stated that VaOHC recommends that the Board's policies mirror existing telemedicine protocols on a dentist-patient relationship, communications and equipment requirements.

Ms. Swain opened the floor for questions and discussion.

Dr. Adam Wyatt, DDS, Health Services for the Virginia Department of

Corrections (VADOC), explained that VADOC uses telemedicine for inmates. Based on his experience, he recommends policies for:

- A point of accountability in organizations using teledentistry;
- Camera and Monitor Resolution requirements to prevent misdiagnosis;
- acceptable networks for secure transmission of records;
- completing a comprehensive examination with an Intra-Oral camera;
- time-frames for physical exams and oral cancer screenings;
- procedures permitted using teledentistry guidance; and
- teledentistry guidelines for dental education programs.

Discussion followed about billing codes for teledentistry, the need to train ED doctors and nurses to evaluate dental conditions, the work of national organizations, the availability of dental hygienists and using the Board of Medicine's policies as the model for teledentistry in Virginia.

The proceedings of the open forum were recorded by a certified court reporter. The transcript is attached as part of these minutes.

Ms. Swain reminded everyone that any policy action the Board decides to take will include the standard comment opportunities required for regulatory action and for advancing a legislative proposal.

She thanked everyone for the wealth of information provided and concluded the forum at 10:21 a.m.

Melanie C. Swain, President

9/18/15
Date

Sandra K. Reen, Executive Director

September 18, 2015
Date

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH PROFESSIONS

FORUM FOR THE BOARD OF DENTISTRY

Complete transcript of the Forum in the above-styled matter, when heard on the 14th day of August, 2015.

CRANE-SNEAD & ASSOCIATES, INC.
4914 Fitzhugh Ave, Suite 203
Henrico, Virginia 23230
Tel. No. (804) 355-4335

PROCEEDING

MS. SWAIN: This is a opem forum to receive your views on policy strategies to address the use of the College of Dentistry of Virginia. Thank you for your participation. If you wish to speak, please sign up on the sheets available outside the open door to this room. Speakers will be called in the order as they appear on the sign-up sheet. Each presentation will be timed and will be limited to ten minutes. Speakers will be notified when they have reached the nine minutes so that they may conclude in the allotted time. The forum will close at noon. If time permits, following the presentation attendees will be asked to participate in a question and answer session to allow for explanation and discussion of the recommendations.

At this time, I will call on persons who have signed up to present. As I call your name, please come forward and speak into the microphone. Start by telling us your name and where you're from and if you're presenting an institutional organization.

Let's start with, it looks like Antwanette Kahan.

MS. KAHAN: Good morning, ladies and gentlemen, colleagues, distinguished members of the board. My name is Antwanette Kahan. I've been a Registered Dental Hygienist in the great Commonwealth of Virginia for over 30 years. I am the Dental Assisting Program Director for the Virginia Beach Technical Career Education Center and the Standing President of the Oral Health Improvement Coalition of South Hampton Roads. As Program Director, I'm in an extremely fortunate position. The Virginia Beach Public City Schools is more than generous when it comes to providing me with state of the art technology to insure my students leave my two-year, 180 hour curriculum with knowledge and skills required to ensure success in subsequent dental employment or continuing with their education at the community college or university level.

While working the coalition to provide access to the area's steadily underserved, we often use tele-dentistry as a tool to link patient with provider. Our dental access days that we do two times a year had filled a peri preprocessor and that took forever. The City of Virginia Beach gave me a nomad to show my students how to use a wireless x-ray unit. We took that instead, and the taking of the x-rays went faster, but once I got sensors and a dedicated laptop, it went even faster. Taking the digital x-rays and emailing them to the patient, the patient was able to keep the image on their personal device for future use at any dental health facility or another outreach. This capability lit up a spark.

How can we use this technology to serve the public at large? I'm sure you all read the cover story in the Journal of the American Dental Association regarding the Trends in Emergency Department to Fake Visits. The research is overwhelming that something must be done to curtail the costly exsurgents that jam up the emergency departments and confound the medical staff. I think down here it says it's doubled from 2014 the number of people that have gone to the emergency room have doubled in that time. A lot of our patients that we see at our dental access days -- we did a survey, and those students did a survey there; and over half of them said that they have used the emergency room as their dental care provider.

I won't use up most of the time here with redundancy so I'll get right to the point of how Tele-Dentistry can reduce the economic imperative facing emergency room departments with a positive inadvertent component. The equipment required and how it works: You'll need a nomad hand-held unit which is quite expensive but if my public education class can have one, then I can send -- for them. The digital sensors, size one and two, were recommended -- the -- sleeves, a dedicated laptop, an inter-oral camera and then a dental emergency referral service.

So here's your scenario: Dental patients'

usually after hours enter the emergency department with oral pain. Interviewer reveals that the patient has been okay for sometime and lacks access to dental care. Perhaps they've tried, unsuccessfully, home remedies. A cursory exam reveals a swollen gum rapid --. The x-ray technician takes a picture of the affected area and emails it to the dentist on call. The doctor, via cell phone, Face Time, Skype, discusses options or referrals with the patient and the emergency room doctor. By the way, should the on-call dentist's finding indicate the need for a medical evaluation due to the oral manifestation that are systemic in nature, not dental, early intervention may save someone's life in the case of leukemia, throat cancer, or osteonecrosis.

So the initial obstacles that we can foresee are three: Compliance with 18 VAC 60-20-195 Radiation Certification, the x-ray tech process certification as described in the mentioned regulations right now. There are three ways in which they can do them. They can take the Danby Course. They can take Early View, -- View, at one of the community colleges that offer these courses, or in -- radiation, health and safety is built into the X-Ray Tech curriculum as it was with anesthesia dental hygiene.

Number two, Compliance with 18 AC 60-20-210 Requirements for Directive General Supervision. The emergency room, as it stands, cannot give the okay to take a

dental x-ray, so the emergency room doctor calls a dental on call and the doctor can okay it remotely to send an inter-oral picture of the offending tooth, then receives directive for x-ray for the certified x-ray tech to take the x-ray. The second part is the dental board can amend the current regulations to allow, in limited settings such as emergency departments, that emergency room physicians can approve the dental x-ray.

Number three is the HIPPA confidentiality. That I minimized to just say see the medical ethics regarding telemedicine because that's what they're already doing.

In April, 2015, -- dentistry, Dr. Bruce Donoff, DDS MD, Dean of the Public of School of Dental Medicine writes of his vision to transform dentistry by removing the distinction between oral and systemic health. His persuasive article, The Economic Reform of Poor Health, identifies care as a goal, and states achieving that goal requires a cultural change. The caring medical personnel in the emergency departments would like to be able to offer better treatment to those who seek them out to rid them of their pain and suffering. Yet, they cannot help because so many feel that they are at sea regarding dental treatment. A recent survey found 90 percent of medical doctors think oral health should be addressed, but half of them said that

they have little or no training receiving less than two hours of oral health training. Only nine percent of them could answer oral health questions correctly.

After collaborating with a radiologist and an emergency room doctor, they both agreed that Tele-Dentistry would not keep patients from using the emergency department as their first stop in their quest for emergency dental care. However, with a proper referral system and follow-up provision in place, it would substantially decrease the number of subsequent visits to the emergency department, providing significant cost-savings to an already heavily-burdened healthcare system.

Also the consequence of the medical dental collaboration will eventually improve human health through a more patient-centered model of care. Thank you.

MS. SWAIN: Thank you. Sara Holland?

MS. DUGAR: She's not here yet. You may want to skip over her?

MS. SWAIN: Sure. We can skip over her.

MS. DUGAR: That would be great. Thank you.

MS. SWAIN: Susan B. Reid.

MS. DUGAR: Thanks.

MS. REID-CARR: Good morning, ladies and gentlemen. I'm Susan Reid-Carr. I'm the President of -- Dental Virginia Hygienist Association, and on behalf of the

Virginia Dental Hygienist Association that represents the 5,563 licensed dental hygienists in the Commonwealth, we appreciate the opportunity --

MS. SWAIN: I'm sorry. Ms. Reid, can you speak up? She can't --

MS. REID-CARR: Okay. I'm going to start over.

MS. SWAIN: You can pull the mike over.

MS. REID-CARR: Okay.

MS. SWAIN: Thank you.

MS. REID-CARR: You ready?

COURT REPORTER: Yes.

MS. REID-CARR: On behalf of the Virginia Dental Hygienist Association, that represents the 5,563 licensed dental hygienists in the Commonwealth, we appreciate the opportunity to provide comments on Tele-Dentistry in Virginia. The VDHA supports all the delivery modules of oral healthcare services that maintain a safe, cost-effective and high standard of oral healthcare. The discussion that brings us to developing concepts on tele-dentistry is the consistent proven fact that there is an access to oral healthcare issue in the Commonwealth of Virginia.

The VDHA believes that tele-dentistry is a critical component in assisting to fulfill that deficit.

Using technological methods such as tele-dentistry to provide education, treatment, consultation and necessary referrals can be a vital tool to help solve this problem. In delivering care through tele-dentistry, the VDHA promotes the following concepts that we believe can enhance the safe and effective utilization of dentistry. VDHA supports establishing a dentist-patient relationship through an in-person licensed dental hygienist. To create these opportunities, VDHA supports a collaborative agreement for licensed dental hygienists and dentists. This can create additional opportunities for access to patients and establish a dental home for these patients. HIPAA approved communications equipment seems appropriate as this can maintain the current standard of protective care for patients and providers. VDHA believes that cost may be incurred for equipment, however, the overall investment can provide for far-reaching access to more patients, establish dental homes for more populations, reduce travel cost for patients and potentially reduce costs for payers.

As new technology develop, the VDHA encourages the Commonwealth to keep an open mind on ways to adapt safe, cost-effective and quality care. The VDHA is mindful of the fact that while tele-dentistry can benefit various areas of delivery of oral health care, this is a tool that is not the comprehensive solution to the access

problem.

Thank you.

MS. SWAIN: Linda Wilkinson.

MS. WILKINSON: Good morning. My name is Linda Wilkinson and I am the CEO of the Virginia Association of Free and Charitable Clinics, and I'm here to remind the Board about the patients that could particularly benefit from these regulations.

Our 60-member clinics served 72,000 low-income, uninsured adult patients last year. Our clinics are providing medical, behavioral, health, pharmaceutical and/or oral health services. Despite the generosity of time and talent of over 700 volunteer dentists and hygienists, our clinics were only able to serve approximately 15,000 of the 72,000 patient population purely based on the availability of the providers. We're here to support any and all regulations that will expand access to all health services to our patients who are suffering from multiple -- exacerbated by their oral health conditions and vice versa. So we ask the Board to please consider again any and all regulations, including and not limited to tele-dentistry regulations that again, will enable our providers to have greater flexibility to provide much needed oral health services to all parts of the Commonwealth and to more than 72,000 uninsured low-income patients within the free health

system.

I thank you for this time, and I thank you for what you do for the Commonwealth.

MS. SWAIN: Thank you. David Sarrett.

MR. SARRETT: Good morning. Actually, I signed the list. I thought it was attendance but I -- I'm the Dean of the School -- certainly we support the use of technology and all forms of the system, patient care, as well as teaching and education and -- I think most people here are addressing, as well as the patient care. I ask that you keep in mind there are educational functions of the search functions -- clinical evaluations.

They should not fall prey to some - - - consequences of the regulation of the law. I didn't review the document that the Board of Medicine -- I guess it's a guiding document, read carefully, which I thought covered many of the issues that came to my mind quite well. I suggest that's a good starting point so just keep in mind that -- particularly the thorny issues of doctor/patient relationship, establishing the fact that the patient needs to know who the consultant dentist or physician would be in that case, so I found. Thank you.

MS. SWAIN: Thank you, Mr. Sarrett. Dr.

Bonita Miller.

DR. MILLER: I just want to thank the Board as well for considering this concept because there is certainly a great potential use for tele-dentistry and addressing access to care issues. As you know, the Virginia Dental Association has long been interested and active in programs and initiatives and projects, services and other things to try to address the issue. The Virginia Dental Association is very interested in tele-dentistry. It would be great to have ongoing conversations like this to gather the interested stakeholders. It could certainly be a wonderful collaborative effort among our dental oral stakeholders to develop a pilot project.

It is certainly something to consider within the Department of Health maybe as a pilot project, and also the Community Dental Health Coordinator could also be an entity that could be a very vital part of the success of the tele-dentistry program. So I thank you for opening the conversation and hopefully gathering an interested group of stakeholders, developing something that would really have a meaningful long-term aspect of addressing access to care. Thank you.

MS. SWAIN: Thank you. I hope I don't mess this up, Tonya Adesh.

MS. ADESHA: -- sorry.
MS. SWAIN: Oh, that's fine, and referring back to Sara Holland, I'm not sure she's here.
MS. DUGAR: She's not here. I can read her comments if you'd like?
MS. SWAIN: That would be great. Thank you.
MS. DUGAR: I'm not Sara Holland. I'm Nicole Dugar, a little obvious, for the Oral Healthcare.
COURT REPORTER: I'm sorry, repeat your name?
MS. DUGAR: Nicole Dugar, D-U-G-A-R. Let me just touch briefly on what we had submitted oral -- I'm sorry, we had commented. I can just read through some of the highlights here. First of all, thank you for the opportunity to comment on the use of tele-dentistry. The Virginia -- Hospital Coalition is the highest of several hundred organizational and individual partners trying to integrate World Healthcare and all the aspects of health and wellness. One side of this mission is to improve the process to oral health services.
Tele-medicine has proven to be an effective mechanism for improving access and to manage. Tele-dentistry appears to have similar promise in improving access to oral healthcare services. The Virginia Oral Health Plan, a state plan offered by over

200 state voters from across the Commonwealth, in 2010 recommends the goal of prevalence of dental disease as reviewed in Virginia through prevention and early diagnosis and treatment and that stakeholders explore the use of tele-dentistry and server areas of the Commonwealth analyzing -- its appropriate use, reimbursement models and reimbursement models used by other states for tele-dentistry.
To support this objective, the Oral Health Coalition needs a support group, and they included a number of different stakeholders including The Department of Health, The Department of Medical Assistance, Private Practice Dentists, Community Healthcare Center Dentists, The Mid Atlantic -- Resource Center for the DCS School of Dentistry of Virginia Dental Health, The Dental Association of Headstart and the Coalition. Sara had provided, I think, an attachment of some of the work that the work group had done.
Our group members were particularly interested in how well the tele-dentistry could increase access and decrease the transportation burden of families and -- children's program. We particularly would love to have a store-in-forward -- to tele-dentistry as an effective way to address the

access issue, a store-in-forward approach because, as you all know, by -- data, says the state of -- x-rays are captured via secured connection and reviewed by a provider at a later time.
The working members felt that this was a favorable way to explore the use of this technology as a first step. We thought that it would create more efficiency in the delivery of healthcare. It would produce transportation burden for families, and it would reduce a cost savings to the state for Medicaid patients. It would decrease reliance on the Medicaid transportation benefit.
Additionally we thought that a store-in-forward would not be a change in people's practice as it was already occurring in Virginia Medicaid and Dermatology and Radiology and other areas. We had some questions and concerns from the workgroup about duplicative services and this could drive up costs. Examples in California and other common programs demonstrate reduced costs and no duplication. If a consulting provider using tele-dentistry is also the dentist performing the procedure, regulations created by the Board can address and prevent duplicative consults. Given that tele-medicine is already established in Virginia, we recommend as the

Coalition that the issues related to the dentist/patient relationship and communication equipment requirements mirror existing tele-medicine protocol.
MS. DUGAR: I just also want to make a comment from the Dental -- Foundation and -- you all should have received this as well. Thank you.
MS. SWAIN: Thank you. We have time for discussion and a few recommendations of questions. I want to remind everyone that our policy -- I'm sorry. I'm just reading this dialogue here, but I just want to make sure that since we do have time for discussion, I'd like to open the floor for anybody who'd like to speak in regards to -- and any board members who might have questions regarding to -- Mr. Alexander?
QUESTIONS BY THE BOARD

MR. ALEXANDER: The first speaker, I appreciate that. I understand what's going on. Have you discussed this with any of the ER physicians? What is their take on it?
MS. KAHAN: Their take, again, was we started thinking about doing this. A friend of mine, her husband is an emergency room dentist, and my other friend's married to a radiologist. They both agreed that it won't stop the

first one. People that don't have insurance or for whatever reason, they don't go to the emergency room that first time, it won't stop the first time, but it would probably cut down on subsequent visits so if there's somewhere in there right now, there isn't a way to get the patient from the emergency room. They leave with pain medicine and antibiotics and that we all know will just be a very short-term fix for them. But if we can provide for them through donated dental care, whatever type of referral service that we have, yes that, but then the dentists can take a look at it, the inter oral picture or the x-ray and they could call the referral, whether it's to an endodontist, and sometimes it might be that the patient just needs a cleaning. The patient needs a filling. It could be a very simple fix. It doesn't necessarily need to be a very big thing so they can make the appropriate referral.

They can refer them to their own office. They can refer to any of the clinics that we have, and they would be provided with that information and given an appointment to go to that particular place. The Oral Health Improvement Coalition – also has dental vouchers that can be given to the patient to go to any of the clinics to receive the care that they need so that, that way will keep them from returning to the emergency room. So it won't reduce the first one, but hopefully it will reduce subsequent visits.

MR. ALEXANDER: Well I think it's a great idea.

MS. KAHAN: We're trying that as a pilot by the way. One of my students is working on her Masters.

MR. ALEXANDER: You're trying it in the emergency room?

MS. KAHAN: Yeah. That's where she's working on her Masters at Fulton A&M for Community Health. When we started talking about this, she wasn't really quite sure what she was going to do for her project, and this is her project.

MR. ALEXANDER: She's gonna have fun, I'll bet.

MS. KAHAN: We're going to have fun.

MR. ALEXANDER: Have you talked to the emergency room, the people that run it, are they willing to buy this equipment?

MS. KAHAN: That is our next step.

MR. ALEXANDER: The other thing is, you're going to have to have dentists on call that are willing to, having worked in the emergency room for years, a lot of these patients come in after hours in the middle of the night, so you know, having the dental people available is another thing that you're really going to have to work through.

MS: KAHAN: Well, I think what they're hoping to do is get -- with larger practices where they might just have some of the doctors -- some of the doctors might take a week so it won't fall on one particular – they'll be a bunch of doctors that they could call.

I don't think that it is all that much. It's not like there's ten or 15 a night. It isn't that much, but the few people that do go there really do pose a significant cost increase to emergency rooms, and then, of course, the human cost. While they're in there and they're taking care of somebody who is non-life threatening dental, it's taking the emergency room doctors time away from something that –

MR. ALEXANDER: Thank you.

MS. SWAIN: Are you okay over there?

COURT REPORTER: Just have to speak up?

MR. SARRETT: I think it's great that you're working on this. I will refer – there is a publication. I have a doctor and one of his residents, Adam -- the name will come to me. About two years ago, we had a conversion program for dental issues to the – Health System. -- to the ER for them being registered in the ER and come to dental to help solve these issues.

That was fairly successful, very successful. As a hospital, they're worse -- of probably undiagnosed is other things like cardiac events so they decided they really

needed a triage so now it's kind of snarled up in the back where you walk in the door.

Even if they say, "I think I've got a toothache," they've got to be somewhat triaged so that kind of complicates things. If I recall their publication, actually they indicated most of the visits were Monday through Thursday during the daytime. I guess, to the nature of that, -- the weekend.

MR. ALEXANDER: Which means there will be more dentists in their office during the daytime that might take a tele-medicine call and not have to be woke up in the middle of the night so that might help out too?

MS. KAHAN: One of the things that they Talked about at Harvard was doing that and to disciplinary because we do know the connection now between dental issues – now, we need to get those physicians –

MS. SWAIN: Ms. Kahan, I think, Ms. Rucker has a question.

MS. RUCKER: What type of students do you have?

MS. KAHAN: I have juniors and seniors in high school.

MS. RUCKER: Your dental assistant program that they use -- are you going to have one here in Chesterfield?

MS. ALEXANDER: Like a technical program.
MS. RUCKER: Like a technical program, and so they use it as a stepping stone for hygiene schools?
MS. KAHAN: So they're really – because again, I'm very fortunate that the Virginia T schools, whenever something comes up, the head of technical career education, his wife happens to be a dentist, and the person who funds me, her brother, is a dentist up in Boston and so whenever I say to them, I need a plug.
As a matter of fact, I have a first-edition nomad, which now, with their lypo hand gliders, this is like the big one, but it's whenever I ask them for anything, they're behind anything I want to do with the students. When I say hey, let's think about this, I make them read these journal articles which is laid out carefully, a lot of them. They do understand. They do empathize with people, some of their families.
Twenty-five percent of my school is on free lunch and Medicaid so we do see students in my clinic. Our public health dentist comes one day a week, and my assistants help her help the kids in my school so it's worked out really well so I'm really very, very fortunate.
MS. RUCKER: A number of you spoke to the – you made a comment about physicians having more – and supervising maybe assistants or possibly hygienists. I just

know we speak with remote supervision because they are in these settings. They're in nursing homes or free clinics.
They're already there and having a broader supervision of a hygienist, possibly instead of just being under direct supervision of a dentist or an assistant. Maybe you could speak to that because you're seeing that in an ER setting, if you'd like to speak on that?
MS. KAHAN: Well, I brought that up because a couple of years ago, it's probably Hampton Roads now, but it was the Chesapeake Care Clinic. They only had a dentist there, I think Tuesday and Thursday nights, but during the day, it was mainly a medical facility. Someone had called me and said I have a patient here and there's a dental assistant here, but the physician wants her to take an x-ray. Can they do it? I said I don't know, and I called Sandra Reen, and she was like absolutely, if you can remember. I called and they were like, no. I was sort of -- 18 VAC 60. I mean she knew it like that. It has to come from a dentist.
So I already knew that, that would be one of the obstacles that you would suggest to me. An x-ray tech in a hospital – when we were first initially thinking about this, we were thinking a nurse could do it, and then my friend who is an RN, she was like, no, we're too heavily burdened.

So we were going through the people, and we were like they already have x-ray techs, but there is no dental component to x-ray technology, that particular profession. So we either have to add it to their curriculum or they would have to become dental x-ray certified –. There was no other way to do it, and so that was how I knew about it.
MS. RUCKER: Then you would have to --
MS. KAHAN: They would have to either call the attending dentist, then he could give the remote thing to that person acting as a dental assistant or to x-ray; or you're going to have to change it, at least in the emergency room. In free clinics or whatever, allow the physician to say, okay, go take my x-rays.
MS. RUCKER: And that's why I wanted to say that as we have these discussions as board members, that we may need to look at in these settings to have a physician to say all right, we have a hygienist. He could clean this person's teeth or an assistant, he could take this radiograph so that we could have tele-medicine work.
MS. KAHAN: Like I said, sometimes it works the other way, sometimes you'll find out that it isn't a dental thing, that it's more of a medical thing and you write down to see a physician. You're having a heart attack.
MS: RUCKER: I work in a hospital setting,

too.
MS. SWAIN: Dr. Wyatt?
MR. WYATT: I was just interested in having a conversation. We always used to have a conversation about what are the regulatory barriers providing access to dental care? What I'm hearing is that it's only just another supervision conversation or at least in part, it's supervision.
Can a dental hygienist be in an emergency room and be performing any services without a dentist being present? I think that, to some degree, is some of the conversation. You know, I loved hearing the model of just another way of allowing access to care.
People currently -- I know it's appalling when you hear the wait list that the free clinics have simply because of manpower, a lack of workforce to be able to --. I think the more specific we can look at this and identify barriers, regulatory barriers, is what I think the point is here and what are potential solutions? What have other states done to allow -- the reality is that when people with oral pain seek help in emergency rooms on a regular basis, how do we make sure they have the most effective care possible when they go there? That's a great task for this board to see if there are any models, things we can do regulatory-wise to pass such regulation that addresses that without

compromising the patient's safety.

I think we should encourage more discussion on this so we can leave this with some clarity. What are the problems? How are we not able to use tele-dentistry currently in an effective way, and what are the potential solutions to those problems? I'd like to have that as part of a discussions about that or any comments about that, that would be great.

MS. SWAIN: Yes, sir.

DR. WYATT: Excuse me for being late. I've been traveling around in circles. I'm Dr. Wyatt. I'm representing the doctor and what we do currently for tele-medicine.

MS. SWAIN: Yeah. We need for you to speak into the mic.

DR. WYATT: In here, okay. What we do currently with tele-medicine and also the county shed some light.

MR. ALEXANDER: Just to be clear to my knowledge, you're a dentist or an assistant?

DR. WYATT: Yes, I'm a dentist. I've actually been practicing with the department for about eight years. I practiced clinically in various different situations -- I have a Masters in Health Informatics and I've been using tele-dentistry and things of that nature on and off for the past 20 years,

either to ripen myself or try to incorporate the methods into wherever I've practiced.

What I was wanting to do was give some recommendations based on that experience. I did review the materials that you all gave me. Most of the things that I saw that had been said, I guess that's going to be precedent that you all are going to be looking; I just wanted to add a few things that might be considered that I did not find in that material.

Some of those things may have been addressed. I'm not sure, in the board and in different areas, but based on what you all have provided, I just wanted to bring certain things to your attention so that you might want to debate whether they would be an issue or whether they wouldn't be. Did I have enough copies? Did everybody get one of these?

MS. SWAIN: Yes, we did.

MR. WYATT: Well, currently the Virginia Department of Corrections, if you look on the first page. I've given an example of what we're doing, and we usually communicate with VCU. This is how we get all of our referrals.

The materials that you see here on the front of the pictures, these are video conferencing devices that are used. The problem I foresee is that they have

taken administrative type of areas in offices, and they have incorporated this pretty well but they're for screening of the papers or the documentation that you provided me. You were interested in seeing how far we could go with tele-dentistry, whether we could do comprehensive examinations and things of that nature.

Currently, most of their consultations are for external general review. That's fine for screenings. That's fine for writing prescriptions, things of that nature, but for comprehensive examinations, I think that there are some parameters that should be set through the technology, the use of interval cameras.

I didn't see any of that documented as a requirement, specified requirements in the amendments that allow for the tele-dentistry in the other states. I think it's important that Virginia start out that way. The reason I'm saying this is I can see a problem with accountability and whether it's fraud, whether it's misdiagnosis based on the fact that no specifics were set with respect to resolution. Of course, high definition is pretty common, but it's not actually specified in the documentation. You don't want someone snapping a picture and then end up in a case or I end up in a case trying to defend something and the

resolution be an issue because it hasn't been -- things like that.

We, for instance, the Virginia Department of Corrections, we do everything on a secure network. It's an isolated network. Well, if you allow doctors to pursue this and you haven't defined that that needs to be a parameter, you wouldn't want things being transmitted, not that they would think about that, but being transmitted over unsecured networks because they don't have a list, because they would be doing things like they would normally do, hot-mailing procedures or pictures or images or things like that. So I tried to make a list of certain things that I would think the Board may want to define.

It doesn't have to be exhaustive, but at least it gives doctors a framework so everybody's playing on the same rulebook using the same specs, and also you all are provided with the information to where they could resource materials that they need so that everyone is pretty consistent and standardized. Did I make myself clear?

MS. SWAIN: Thank you. Does anyone have any questions to Dr. Wyatt's information?

MS. REEN: You talked a little bit about what a defined tele-dental liaison would? What is that?

DR. WYATT: At the DOC, we actually have a medical tele-medicine liaison. She is the one who is responsible for communicating with the physician and they can either request or fill in the request, communicate with VCU to actually set up the consult. Because we know who that is, if there's any issue with the transmission, if there's any issue with privacy, if there's any issue with whether or not providers were given the health history and that sort of thing, we know who to go to because she set up the appointment.

So if the Board ever had to review an issue in tele-dentistry, if you have a liaison and you have one person in the organization responsible for it, you know who to point to, who would have that material, and I just think it would be easier to regulate if you know you have one contact person.

MR. ALEXANDER: You said that you are using it? Explain how you document them.

DR. WYATT: Right now for us, it's in the dental clinic. We're not using it as far as tele-dentistry with respect to exams and things of that nature. I assume this is what you'd like to expand to. I think it's good, but for instance, if I refer a patient for oral surgery, which I do a lot. I do some surgery, and there are some cases I can't do, I refer to DMVC. Those consultations are

set up using the on-site medical liaison who's responsible for that.

All the documentation you have here on the first page, she coordinates that document. She sets it up, and then there's a direct coordination with the oral surgery department. Now, I don't have the ability in my clinic to do that, which is what I think would be a good idea, but they're set up like a medical referral. In other words, it just falls in line with the other medical consultations that are in the form at this point.

MR. ALEXANDER: So it's not a face-to-face thing?

DR. WYATT: Yeah, it's face-to-face, but it's face-to-face with the physician at this point, not with the dentist.

I write the consults when I refer to medical and medical sets up the consultation and does the communication, and I assume we want to expand to the point where the dentist can do the same thing, but right now we're set up with tele-medicine, not tele-dental, so I was just trying to see how organizations who are already practicing it, how it could be expanded and regulated?

MR. GASKIN: What do you perceive the model

MR. WYATT: Well, as with any fields in healthcare, cost is always an issue. So if you want

widespread acceptance, I think that there should be some evidence-based practice based on what the resolutions are, what type of networks and what the states are already using. If you have a predominance of equipment that's out there, we should be able to expand with that. The only major barriers, other than what is included in what I've listed here, inter-oral cameras and the areas that the actual examinations are being performed, currently the medical department is able to do there in administrative office settings.

It's just an administrative office because they're pretty much teleconferencing and that's because they're not performing exams. What they're doing is consulting and it's fine for screenings or writing prescriptions, but if you want to do actual exams, you would obviously need to either lay a patient back in the clinical chair in the same setting that he or she is comfortable with and be able to do it there. Now, I don't see that as being a huge barrier, but what you don't want is to put the regulations out there and then people reading them the way that they want. If that's not defined, then someone may start doing it in their office. Well, now you see a whole can of worms opening up for things that are not listed, the same thing for the training, the same thing for every aspect of this. I don't think it's complicated. I just think that we –

MS. SWAIN: Mr. Gaskin.

MR. GASKIN: The liaison that you're speaking of is within your facility or centrally here in Richmond?

DR. WYATT: No. It's in my facility, but the way that the correctional facility is, it's similar to a VA.

MR. GASKIN: Now, does every correctional facility in the state that has a dental facility have this capability or just you at Suffolk?

DR. WYATT: Well, I'm at Deerfield, but I'm not exactly sure. She is a tele-medicine liaison. She is located right there at that facility. Now, I'm not sure if she is a tele-medicine liaison for different facilities because it's common practice with the "now" culture. If a patient needs something and we can't provide it at the facility, we have direct communication with another facility that will. Dental is pretty much in-house. I'm not very familiar with how they're handling their patients. I just know what they're capable of doing. They could very well be shipping in medical patients that either tele-medicine comes from another facility that's close and having that consultation at their facility. I'm not sure.

I do know that video conferencing is available at all the facilities because we have medical quarterly meetings with all the providers. But as far as doing consults with VCU and –, I'm not sure what facility has the capability

but it's not an issue with us because we move our people to where we will be moving, but expanding to that is probably pretty simple, especially if they're –

MR. GASKIN: I'm just trying to sort through in my mind listening to you, how much – or are you speaking for the Department of Corrections and how they intend to manage all of their dental clinics with these technicians and then trying to overlay that in private practice or any other nursing home or other situation? As far as each one maybe having a liaison or something?

MS. SWEEKER: Dr. Wyatt, I used to work for DSA too but this was a million years ago. We had tele-dentistry in 1994 and that dentist actually talked to DCU and they didn't do it. They did it face-to-face. They talked to the oral surgeons $_{T}$ your facility did, but we did that then so I'm familiar with tele-dentistry. The dentist actually talked to the oral surgeon and talked about the wisdom teeth, and they had the radiographs and everything. That was at –

It's closed now, or it's getting ready to close, but they did that then. Anyway, now I know why dentists actually talked to the oral surgeon. So I guess each facility – and we had a coordinator so I'm very familiar with what you're talking about.

DR. WYATT: Right, right.

MS. SWEEKER: Candy was her name, and she transported everything that went along with tele-medicine, tele-dentistry so that the inmates were transported, because it's different when you're transporting an inmate than when you're transporting someone who can get themselves there on their own accord.

MR. GASKIN: So through the Chair, my question still stands, are you speaking for yourself or are you speaking for DSUV? Who are you speaking for today as I read your comments and listen? Could you define that for us?

DR. WYATT: I'm speaking for me as a clinician within DOC and I'm also speaking on behalf of DOC because if this is something that's going to be made available, we need to be able to make sure that it works. Now, for clarification, I'm not sure whether it's a contract to state issue. Most of this is administrative, so in order to get approval, there's an approval process that we have now. They don't approval every tele-medicine or every tele-dental consultation. I'm not in that loop, okay.

I do refer to oral surgery. We do refer the radiographs, but I haven't found the need to have to consult face-to-face with the surgeon. Usually, they contact me on the phone because it's separate from my dental clinic so I don't have the ability to go in right now and to use that

office space for tele-dentistry so I have been locked out.

MS. SWEEKER: You used to do it though?

DR. WYATT: Right. If that's something that was going on then, I don't see why it can't return to that.

MS. SWEEKER: Right.

DR. WYATT: Now, it's been eight years. Now, I could request a time and I'm sure that I would be given access but it's common practice in medical to be able to walk into the office and do that. That's not me. I have to go through. Did that answer your question, sir?

MS. SWAIN: Thank you. Do you have any questions?

MS. DUGAR: I do have a -- I guess in reading all this information, I am realizing that there's a crossover with medicine and dentistry and I didn't know if anybody might have any input on coding or how that's done with filing. I think -$_{T}$ indicated that there's issues with no duplication and cost. Can you speak to that?

MS. SWEEKER: I can't speak specifically to that, but what I can speak to is I know that -- had done tele-dentistry in other states. They are working on establishing codes to $_{T}$ - dentistry. I can't prove it, of course, but –

MS. DUGAR: I was just curious because obviously that's going to be something that's going to be something we'll have to look at.

MS. SWEEKER: In terms of duplication, what the workgroup preferred was making sure that the same dentist who's doing the consultation isn't providing the service so that you're not getting a patient who has a consult done by one dentist, goes back and has another procedure or has the procedure done by another dentist, so you're getting a double charge.

MS. DUGAR: Right. Because the standard is, like in private practice, you can only fee out an exam once or twice a year.

MS. SWEEKER: Right.

MS. DUGAR: Yes.

MS. SWAIN: This is an opportunity for everybody to discuss. Does the audience have any questions to ask of each other to get the forum carried over, the information presented to us. Any other comments? Really this is an informational scenario for us, and it would be great for us to have all of the input laid out because we're going out blindly and it would be nice to have as much information to help us review the policies. Ma'am?

MS. KAHAN: I don't have a question so much as

a comment. Inside dentistry, the Dean of Dental Medicine, this year I think is starting, and again, there's so much research out there. Just to put in emergency room dentistry, whatever it is, there's just so much research. In their clinic, they are now bringing in physicians, dentists, medical students, dental students and nursing.

To do this and be disciplinary, starting now, the way that our current system is, that might be a little difficult to change, but starting with medical schools, dental schools, combining and adding more dental curriculum to the medical school and administering -- we don't have a lot of medicine built into our curriculum. I used to tell everybody how over qualified I am to be -- I mean, I'm glad that I'm over qualified but just in dental hygiene, what we have to know about the human body, but then it doesn't transfer over.

We take blood pressures, but I've never ever gone -- and my husband's a dentist. I've never ever gotten from the medical practice, although I do know some of them do it, where my neighbors are OBGYN and orthopedists, and I always say to them, do you make sure that your patient has their teeth cleaned before you do the joint replacement.

It's always after, so I think maybe where we need to start is intergrating with, and I'm reaching out to our medical, our nursing program, the Virginia Health and Medical Educators Association to try to get more dentists into the nursing programs. At EVMS we had talked about that, coming in and just giving some sort of semester on dentistry because they get so little of it, and so I think once we start incorporating that, there won't be that barrier where, okay, who do we charge for the fee because we're still doing that.

We still think the mouth is here, and we have separate fees, and then we have the body here that has its separate fees and he does address that so I know that there -- so we don't have to reinvent the wheel that other -- about putting them both together. It might be a place for discussion.

MS. SWAIN: Sir, in the back?

MR. BLACK: I'm from Roanoke, and -- Virginia Tech Medical School -- young and he's five years old now. The dental clinic at the Korean Hospital decided they needed to have studies there, and so if you want to look to a model to teach medical students more about dentistry, they have a 25-hour curriculum in the medical school on dentistry. That is Dr.

I don't know if you know Dr. -- who is head of that program. So if you want to look to a model for teaching physicians more about this, you don't have to go to Harvard, you can go right here.

MS. KAHAN: Sorry to --. It's just from the article.

MS. SWAIN: Any other comments? This is really a good time. Dr. Sarrett?

DR. SARRETT: I'll just give you a piece of information that may help in the future, and when I tell you this, you're going to think how could this be fixed? There's another organization called the American Association of Medical Colleges, the AAMC, who's kind of the educational oversight for medical education. They're in Washington, DC. There's also an organization called the American Dental Education Association which is the comparable dental education association for US members and Canada.

AAMC purchased a large building in Washington DC and moved into it. The American Association is now in the same building as the American Association of Medical Colleges. They have moved from their location and have space right next to the AAMC so I predict that will be the single most important thing that's going to change this entire situation, because you've got

everything now.

You've got the Dental Education Association people running into and talking to the people at the AAMC, and finally that message will start to trickle through them. Something needs to happen in medical education in order to bring an understanding. I had a personal experience recently with this whole thing which kind of got me interested in what they're doing down there.

We frequent a restaurant on Wednesday evenings, -- because it's half price burger night on Wednesday nights, and I've gotten very familiar with a server there, and about a month and a half ago, I could tell she wasn't feeling well.

She had this mass swelling under her right here (pointing). I said, "Any of your teeth bothering you?" She said, "Well, I don't know. I haven't been to a dentist in ten years." So I said, "You have to be very careful because if that's an infection under there, that could be very dangerous and you could die from that."

So she called her husband. She said, "I think I'm going to go to the hospital when I get off work." I took a napkin and I wrote a note on the napkin and said, "A dentist has talked to you and

thinks you might have a dental infection causing that swelling under the midline of your jaw." I said give this to the -- I said to the MCV emergency department because they will have dentists there.

I didn't say -- but I knew they would have somebody with dental, give them this note. So we left. I didn't catch back up with her until the following Wednesday night until the next -- hamburger night, and I said, "What happened?" She said, "Well, I went to the hospital, and I spent the night in the hospital and they called in an ENT. They weren't sure what it was. They took me into the operating room and they drained it.

They weren't really sure what it was, thought it might be a cyst. I said, "What did they say about your teeth?" She said, "Well, they didn't think it was a⊤ they didn't really know." I said, "Where did you go?" She said she went to another hospital in the city, not MCV. I won't say the name of it. I said, "So a dentist never looked at you?" She said, "No". I'm feeling much better.

I'm going to go back and they want to do some scans and figure out what's wrong." So I said, "Okay". So a week and a half later, she texted me. My face is all swollen up on one side, and I'm really hurting and

my mouth is hurting terribly. So I got her in the next morning to the AB Williams Clinic, and it turned out she had two bad teeth. They took those teeth out.

I saw her last night, Thursday night. It's not -- burger night. I saw her last night. She's feeling fine so the assumption is she had a dental infection this whole time that had crossed the mid-line. I think the medical community needs to really start learning about this stuff because she's got this huge hospital bill. She doesn't have health insurance over at this hospital, and they totally misdiagnosed her because they didn't have the expertise to do it. You have to have provided care. Huge implications, I think, for professional liability. So I think these things are going to change relative to the understanding and a better appreciation for what's between the lips and the tonsils, once people start seeing these issues.

MS. SWAIN: Ms. Wilkinson, I believe you had your hand up?

MS. WILKINSON: Thank you. I wanted to elaborate on some of that about what Dr. Brown mentioned earlier about wait lists at clinics. Unfortunately, three of our -- in larger practices. That is in Charlottesville, here in Richmond, and the

Fredericksburg Clinic known as the Moss Free Clinic. Each of those free clinics has well over a million dollar operating budget.

Crossover here has a $3 million budget with two sites here serving over 70,000 unduplicated patients. The Charlottesville Clinic has a $1.5 million operating budget, and the Crossover Free Clinic in Fredericksburg has a $1.8 million operating budget. I mentioned their operating budget to give you an idea of the scope of these particular clinics and their practices. They are serving thousands of unduplicated, uninsured adult patients. Each of those three clinics has a dental practice. The Moss Free Clinic, if you've never visited the Moss Free Clinic in Fredericksburg, I encourage you to do so. They have a state of art dental practice. They have six dental operatories that on any given day of the week sits empty because they do not have dentists and dental hygienists who can practice during the day.

They cannot afford to hire a dentist at whatever dentists make in the Fredericksburg market. They can afford to hire some dental hygienist who could benefit from remote supervision and/or tele-dentistry. So I mentioned these three specific communities because these are three communities that are known as resource

wealthy areas of our state, and imagine the problem that's in Wise, Virginia. You've seen the news.

You've probably seen 60 Minutes and you're familiar with the RAM Place that takes place every year. They serve thousands of patients and to the generosity of the VDA and VCU and other providers, they're pulling thousands of teeth from patients every summer that could have otherwise been saved if they had the necessary oral healthcare. There's going to be another RAM Clinic down in Kilmart in November and the same thing is going to happen. They will pull thousands of teeth because we don't have the necessary providers who have the flexibility to serve these patients despite the fact that we know, because the providers tell us, they very much want to volunteer at the free clinics, but they just can't be there during the day when the patients can be there. So I mentioned all of that to follow up with Dr. Brown's comment about the wait list and unfortunately, the Charlottesville free clinic has a wait list that is two years long, and it's 500 hundred patients.

I just wanted to share that little extra tidbit and again, I remind you, I know it is a focus for you because it is a focus for us that patients need to be at the center of your conversation. I heard what

the other speakers said, and I thank you for having this conversation and for including the patients.

MS. SWAIN: Dr. Gaskin.

DR. GASKIN: While you're standing, can you tell her whatever medicine -- tele-dentistry because I know Crossover does pay, but here in Richmond. I'm very familiar with that clinic. How do you see tele-dentistry helping with what you're presenting to us as a problem?

MS. WILKINSON: Primarily because of the availability of a provider, if I don't have a dentist, I can't afford to hire that dentist, or if I don't have a volunteer dentist who's willing to be onsite during the days that my practice is open, tele-dentistry would expand my practice at all of my free clinics that have onsite dentistry. So it allows greater flexibility. We can serve more patients with more flexible hours.

DR. GASKIN: Where do you see having their dentistry done? Do you mean come back after they're screened? I'm not sure logistically what you're telling me.

MS. WILKINSON: Oh, I'm sorry. I didn't understand the question. The hygienist could be providing the services onsite.

DR. GASKIN: Isn't that the same problem,

availability of healthcare, volunteers?

MS. WILKINSON: We have 150 volunteer hygienists. Clinics can afford to hire hygienists. They can't afford to hire the dentists. We have in just the past 24 hours, we have had free clinics turn down money from -- because they can't use the money to pay for the dentists. It's not enough money to pay for a dentist. It's great that I hire another hygienist, but if I don't have the dentists to supervise him or her, the hygienists, there's no point. They have actually declined money from the association because it's not enough. It's not enough to hire a dentist, and it doesn't do any good to hire a hygienist when they can't do much without that dentist there.

MS. SWAIN: Ms. Wilkinson, do you actually have a list of hygienists who can actually be hired who are willing to volunteer their time?

MS. WILKINSON: We do have 150 of them.

MS. MILLER: No, no, no, no. I just want to make sure that you actually have hygienists who are willing to work and who are willing to --

MS. WILKINSON: We have 150, and they are available on those times that you are asking for, not just -- some of those hygienists are, but there are other hygienists that we would like to hire, but we

can't hire them without having a dentist. I believe another speaker mentioned the Chesapeake Dental Clinic. Unfortunately, that dentist that we mentioned heard her hours were just cut in half from full time.

I'm probably sure it worked out. Her hours were cut in half so it means that half of the patients who were served prior to her hours being cut, because the clinic just couldn't afford her. They just can't afford that six-digit salary that she's being paid, but she's worth every penny of it, but they can't afford it. So now, the patient population will be cut in half. Half the number of pediatric -- at that particular clinic, they serve pediatrics. Half the number of children and half the adults will be served at the Hampton Roads Dental Clinic.

MS. SWAIN: Yes, sir, Dr. Wyatt?

DR. WYATT: To further the point, I'd like to understand the dilemma of the free clinic --

COURT REPORTER: I'm sorry. I cannot hear.

DR. WYATT: I understand the dilemma of the free clinics, but it seems that we can also be opening up another can of worms. Patients would still have to have dentistry performed in addition to preventive services, but I think tele-dentistry could help in that regard. Because I am sure that there are contracts

that could be written with various businesses throughout the state that would represent tele-dentistry providers.

There would be tele-dentistry providers where some of this work could be funneled through their practice if they were willing. Do you follow me? So that you would be sharing resources, and that's what all of this is about; sharing resources, not creating problems off an issue. If you have enough patients who are not being seen, and obviously they're not being treated, then it's great we're being proactive with the preventive, because eventually that will decrease the amount of emergencies and dentistry that needs to be performed, but you also have to make sure that the backend of that is covered because what you create is a scenario where you have a lot of people who need work and then you have a dental shortage. You have to have the foresight in place to fulfill that, and there are a lot of private practitioners I am sure that would be willing to take on that burden if their staff is trained.

If that becomes common culture within our profession, then it's just a matter of working together and setting those type of logistics up. Right now, I think we've got gaps. Everybody has these issues, and

they figure, well, we can see more patients; but now you've got more procedures. Okay, now, that's not to say ignore the fact that we have these patients out here, they need to be treated. I think we need to make sure that we can address all of these needs.

I want to talk about organizations and to include the private practitioners because it would be another source of income for them. They're willing and able, and they're in their own environment so if they know that they're being trained, they might be a pool of private practitioners. That's another source of revenue and treatment. It's a win-win situation for everyone.

MS. SWAIN: Yes, sir, Mr. Black?

MR. BLACK: David Black again. I'm speaking as a model representative of the UVA party. I started my career in 1971 in Clintwood, Virginia in the Department of Public Health Dental Clinic, a very nice dental clinic that had just opened. We actually had dentist in the Division of Dental Health. I don't know the politics of this, but dentists - there weren't many dentists who worked for Department of Public Health and they could ask these people to do the dentistry of tele-dentistry.

We actually had some dentists who worked for

us. I think that's the ultimate rule, as the Department of Dental Health has been obliterated over the last years because of budget concerns because medical Medicaid took up all the money. Like I said, it's too obvious, but maybe we ought to talk to our legislators about getting some dentists to work for the Department of Dental Health.

That would be a very obvious place where we could get these people to do the tele-dentistry. I'm for tele-dentistry. I think it's very good, but who are you going to hire to do it? There's a dental clinic in Roanoke that the Department of Health owns, and I think they're trying to sell it at this point. I'm sure there's a bunch of them around the state. Like I said, we need to talk to our legislators about that. The offer was there so I thought I'd make my -

MS. KAHAN: In regards to that, again I think it's the separation of the medical. Medicaid takes up most -- again, we keep separating medicine and dentistry. It's always been, you have medical insurance. You have dental insurance. I think we're getting to that part of the discussion where you can't separate the two anymore.

The other thing is that in Virginia Beach I can't speak for anyone else, but assuming we have

Heartland Dentists who are coming to Virginia. We have a chain of dentistry and a lot of private dentists take on Medicaid now in their practice which is fabulous and great. Because they extend their hours until 9 o'clock at night, our public health in Virginia Beach, when I tried to get that person to come up into our school, we technically don't have funds for public health dental.

That had gone away a long time ago, but they found another way so they don't have to keep worrying about budget cuts. They found a way to find money to keep a dental person in public health, although technically not through that particular type of funding. We do have it. They were sort of not doing anything, and their hours were from 8:30 until 4 o'clock, exactly the same time when kids were at school. So I would say to them that you either have to go to the school, and I had a full dental health lab, and it took me eight years to get a four-page memorandum of understanding passed by all of the legal stuff. It took eight years.

I retired as a director and a dentist in our public health, until I finally got one to come on down, one day a week, and again, you would think it was like, I don't even know what they thought I was asking. She's finally going to do dentistry here. When I said

to them, why didn't you just change your hours? Why are you still 8:30 until 4 o'clock? Why don't you change it, and so Heartland – I got a thing in the mail announcing this new dentist. Guess when she is open? She is open until 9 o'clock at night, seven days a week so they're open on Saturday and Sunday, but of course, that's what I said to public health.

Why are you still open? Close on Monday and Tuesday for your weekend and open on Wednesday, Thursday, Friday and come in at 12 and open until 9 and you would make it more easier for patients so the parents would have it more accessible to them. Anyway, public health didn't do it, but Heartland did it and Heartland is getting remunerated through Medicaid for the kids that they see. So sometimes it just takes minor changes.

MR. SWAIN: We seemed to be hearing the common lack of providers and economic issues. Does anybody have anything to say about the top three questions: What should the standards for establishing a dentist/patient should be? Should there be requirements for communications equipment at remote sites which I think some of that's been covered, and what are the risks and costs associated with dentistry? Final comments on that?

MS. DUGAR: We, specifically, Dental Quest, has specifically addressed each of the questions that were posed, and we just felt like we should hear what is done in tele-medicine in terms of the patient/physician relationship. So if there's an appropriate model and the business that I'm in, when this is discussed in a broader sense in terms of medicine, Virginia has always led, for example, other states in terms of our -- of medical so we felt like it was important to keep -- location and identity of the requesting patient, disclose the validating practitioner's identity credentials to the patient, which I think you touched on, obtain consent from the patient to provide consent to use tele-medicine, that a practitioner has to be licensed in the state. I think the tele-medicine regulations do a nice job of what establishes what constitutes a dentist/patient relationship.

MS. SWAIN: Any other comments? Any other questions for the board members?

MR. GASKIN: Perhaps for the record, it might be that this is the Department of Health Professions for medicine, it's document 85-12. At this point, I think everyone cited me at this point.

MS. SWAIN: I want to remind everyone that

any policy action that the Board decides to take will include the standard comment, opportunities require regulatory action and for the legislative of this later proposal. If you would like notice of board meetings and comment opportunities, please add your name and email address on the sign-up sheet outside the door.

We appreciate your time this morning, and thank you for the wealth of information provided. This is a big issue, and we appreciate all the input, and this concludes our forum at this time.

Thank you.

(Proceeding concluded.)

CERTIFICATE OF COURT REPORTER

I, Earlina O. King, hereby certify that I was the duly sworn Court Reporter in the Board of Dentistry Forum For the City of Richmond, Virginia, on August 14, 2015 at the time of the hearing herein.

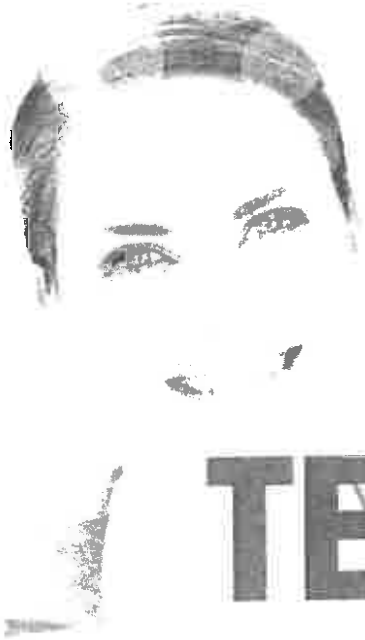
I further certify that the foregoing transcript, to the best of my ability, is a true and accurate record of the testimony and other incidents of the proceedings.

Given under my hand this 27th day of August 2015.

_____

Earlina King
Court Reporter

COMMISSION EXPIRES October 31, 2015



CTEL EXECUTIVE TELEHEALTH SPRING SUMMIT 2015:

CTEL SAFE TELEMEDICINE PRINCIPLES

Telemedicine is a mechanism to deliver safe, effective healthcare.

Telemedicine is the means by which healthcare is delivered. Telemedicine can deliver safe, effective healthcare. Or, not unlike the general practice of medicine, corners can be cut.

Legally recognize an examination through telemedicine technology that provides the practitioner with information equal to or superior to an in person examination.

States commonly require that a physician-patient relationship be established prior to diagnosing and treating a patient. Most states require that first examination to be "in-person" or "face-to-face". Once a physician-patient relationship has been established, the physician may communicate with the patient through whatever medium the physician chooses (e.g. telephone, web camera, email, etc.). Approximately 20 states allow telemedicine technology to be used to establish this first examination between physician and patient. Provided the information exchanged between the practitioner and the patient is equal to the information that would be included in an in-person exam, we believe that state laws and regulations should permit the practitioner to utilize telemedicine technology to conduct the first time examination to establish the physician-patient relationship.

A physician-patient relationship can only be established through an examination by tablet, phone app, or web camera if the examination 1) provides information equivalent to an in person exam, 2) conforms to the standard of care expected of in-person care; and 3) if necessary, incorporates peripherals and diagnostic tests sufficient to provide an accurate diagnosis. A physician-patient relationship cannot be established through an examination by telephone (audio-only) or email.

In order to practice safe telemedicine, the standard of care applied by a practitioner must be the same standard required of the practitioner for an in-person visit. There may be certain diagnosis that can be rendered by a practitioner using any of these mediums. However, we maintain the mere communication between a practitioner and patient using one of these mediums does not ensure either that the telemedicine examination is equal to an in-person encounter or that it conforms to the standard of care. This is particularly true if the diagnosis is rendered without the use of appropriate peripherals or diagnostic tests, if necessary to confirm the diagnosis.

We believe that an encounter mirroring an in-person examination and conforming to the standard of care must incorporate diagnostic tests and peripherals, such as an otoscope and stethoscope, if necessary to provide and confirm an accurate diagnosis. For example, if the standard of care for an in-person encounter requires a visual examination of the patient's tympanic membrane prior to diagnosing, the same should be applied to a telemedicine encounter. Likewise, if a diagnostic test is required for an accurate diagnosis of strep throat or a urinary tract infection, then a diagnostic test should be available to the practitioner prior to diagnosing what are described by some in the telemedicine industry as "uncomplicated" issues.

"On call" language may not be used by a physician to prescribe for a patient never seen by the physician unless there is an established agreement between the patient's personal physician and covering physician, compliant with state law governing on call relationships between practitioners.

The only time that a physician should diagnose through the "on call" language (commonly found in all states) without previously establishing a physician-patient relationship is through an established agreement between the two physicians. We recognize legally-compliant "on call" relationships, but do not believe the patient may self-designate the on-call relationship to a physician designated by the patient, and not designated by the patient's physician.

Guidance document: 85-12 Adopted: February 19, 2015

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. The Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.
These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For clarity, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303 and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Definitions.
For the purpose of these guidelines, "telemedicine services" shall be defined as it is in HB 2063,[1] which was approved by the Virginia General Assembly as an amendment to § 38.2-3418.16 of the Code of Virginia. Under that definition,

> "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.
> Va. Code § 38.2-3418.16 (as amended by HB 2063).[2]

Section Three: Establishing the Practitioner-Patient Relationship.
The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[3] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[4] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

Specifically, Virginia Code § 54.1-3303(A) provides the requirements to establish a practitioner-patient relationship. *See* Va. Code § 54.1-3303(A).[5]

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

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[1] HB 2063 amended Virginia Code §§ 38.2-3418.16 and 54.1-3303. HB2063 was passed by the Virginia General Assembly during the 2015 Legislative Session and, if signed by the governor, will become law on July 1, 2015.

[2] The Board reserves the right to revisit these Guidelines and in particular this definition should the General Assembly further alter the statutory definition of "telemedicine services" or authorize the Board to provide a definition of telemedicine or telehealth.

[3] This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

[4] The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

[5] By passing HB 2063, the General Assembly amended Virginia Code § 54.1-3303(A), which amendment specifically addresses the establishment of a patient-practitioner relationship for the purposes of prescribing Schedule VI controlled substances via telemedicine services. Once signed by the governor, this amendment will become law on July 1, 2015. All licensees are responsible for ensuring and maintaining compliance with applicable laws.

Section Four: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Prescribing:

Prescribing medications, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe medications as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A) as amended by HB 2063. Additionally, practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care

and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Virginia Board of Dentistry

REGULATORY /LEGISLATIVE COMMITTEE
10/16/2015

Assignment: Consider if the Board should require a clinical exam for DA II registration

Background:
The Board assigned the review of this recommendation to the Committee following review of the attached letter from the Commission on Dental Competency Assessments (CDCA). Also provided is the CDCA's Dental Auxiliary Exam Information and Ohio's regulations for an Expanded Function dental Auxiliary.

THE COMMISSION ON **DENTAL COMPETENCY** ASSESSMENTS
1304 CONCOURSE DRIVE, SUITE 100 | LINTHICUM, MD 21090
TEL: 301-563-3300 | FAX: 301-563-3307
cdcaexams.org

Dear Friends,

During the first 6 months since you have elected me as your Chair, it has been an honor and privilege to serve the CDCA while working in concert with my fellow Board of Director members and our committed Central Office staff to meet CDCA's mission of excellence, integrity and fairness at every exam that we deliver. I thank you all again for this opportunity.

The last 6 months have offered many new opportunities for the CDCA.

In January we welcomed the Commonwealth of Jamaica as the first international member of the CDCA. In May, we delivered Jamaica's first ADEX/CDCA examination, at the University of Technology, in Kingston,. During the examination, the Most Honorable Portia Simpson-Miller, the Prime Minister of Jamaica, visited the dental school to welcome the CDCA exam team and thank us for bringing the ADEX examination to Jamaica. I had the pleasure of representing the CDCA and it was one of the proudest moments of my life. I wish you all could have been there to share in the honor that the people of Jamaica gave to us. While we were there, we also scheduled the first exam to be given at the University of the West Indies, also in Kingston, Jamaica. Next year our goal is to schedule both schools at the same time so that one travel team can exam at both sites. We all owe Dr. Maurice Miles our thanks for all of his efforts to make this a reality.

For the last several years a dialogue has been on-going between the New York State Dental Association, the New York State Dental Board and the CDCA. Dr. John Iacono has been instrumental in helping to keep the lines of communication open. This past January at the University Of Buffalo School Of Dental Medicine a major breakthrough was reached. Dr. Michael Glick, Dean at Buffalo School of Dental Medicine, hosted a meeting including Dr. Mark Feldman, New York State Dental Association Executive Director, Dr. Guy Shampaine, myself, and other interested parties. At this meeting a pilot ADEX examination was proposed with the intention that the New York legislature would consider recognizing this new exam as a possible avenue for licensure. The pilot "Buffalo Model" examination would serve as a modification of the traditional licensure exam format which enables the focus of the exam to shift from the candidate to the patient. This new "Buffalo Model" ADEX exam was approved at the November ADEX meeting and CDCA's Buffalo pilot examinations began this past January.

The focus of this year's Steering Committee/Educator's Conference was Dr. Joe Gambacorta's presentation of the new CDCA administered ADEX "Buffalo Model" examination protocol. Dr. Gambacorta and Dean Glick were instrumental in the success of the CDCA/ADEX "Buffalo Model" pilot exams. Dr. Gambacorta's presentation was followed by a panel discussion with Dr. Gambacorta, Dean Glick, Dr. Guy Shampaine and myself. The excitement created by Dr.

Gambacorta was obvious and reflected by the wide variety of questions from the audience. In short, our presenters and panel discussed with the audience how the "Buffalo Model" represents an evolution of the CIF examination format that provides advantages for a more patient-centered approach during examinations. The CDCA plans on making this format available for all dental schools. You will hear more about this new examination process at the CDCA Annual Meeting in Orlando, January 14-15, 2016.

Also at this year's Steering Committee/Educators Conference, the dental hygiene educators were presented with an update on the success of the dental hygiene site consolidation as well as an update on the pilot of the electronic grading of the dental hygiene examination. Through the tremendous efforts of Pat Connolly-Atkins, this project has been a huge success and all hygiene exams will be graded electronically next year. The most significant benefit of this will be the quicker reporting on the results of the examination to the candidates. Additionally, grading electronically has reduced overall grading time for examiners, will help to prevent errors, since examiners cannot log out unless they have completed all grading requirements, and will enable us to gather statistical data for better calibration of examiners.

The Central Office has been integrating Florida examinations into the standard processes for all of our other CDCA dental and dental hygiene examinations. All of us owe Dr. LeeAnn Podruch a huge thank you for all of her efforts over the last five years to ensure that the examinations in Florida went off without a hitch. Florida examiners all now have individual EAS profiles and have been fully incorporated into the CDCA examiner assignment committee processes led by Dr. Dean McCleese. Other ongoing efforts involving candidates, schools and the Florida Department of Health have been assimilated within Central Office support systems. We are blessed to have a Central Office Staff that is as dedicated and committed to the CDCA mission as are all of you. Our exams require the dedication and commitment of each and every one of us. I thank you all for this commitment to excellence.

The State of Ohio through Dr. Mark Armstrong asked the CDCA late last year to consider administering the Expanded Function Dental Assistant (EFDA) examination. Dr. Armstrong provided Dr. Ellis Hall and Dr. Lisa Deem the statute for EFDA's in Ohio and the CDCA submitted our proposal to the Ohio State Dental Board for consideration. The Ohio State Board approved our proposal and the CDCA EFDA examination will be offered in Ohio this June 23rd.

The Florida Board of Dentistry has a required jurisprudence examination that was self-administered up until earlier this year. Florida inquired if the CDCA would be interested in taking over the administration of this examination. Alex Vandiver, our Executive Director, did an analysis and submitted a proposal to Florida that was accepted and the CDCA began implementing this new Florida jurisprudence examination through Prometric starting this past May. The early feedback is that Florida has been extremely pleased with the CDCA and the quicker availability of scores to the candidates.

The CDCA Board continues to reach out to new schools to offer our ADEX/CDCA examinations. We have a new school in Bradenton, Florida, and in Portland, Maine, that will be taking our exam. We have answered requests by schools outside our normal geographical area that have students that are interested in having the ADEX credential for licensure and would

have to travel with patients to be able to take it. We are ready and willing to go wherever we are asked.

Finally, some of you have expressed disappointment in not receiving as many assignments as you may have had in the past, or perhaps not receiving a site that you had enjoyed going to in the past. The Assignment Committee tries to give priority to members on their active State Boards for assignments. Therefore, there may not be as many slots for others. However, I am confident that with the implementation of the "Buffalo Model" examinations that there will be many more opportunities for assignments at multiple exam sites, especially if you have flexibility in your schedule.

While all of this has been going on, we have continued to administer hundreds of exams to our dental hygiene and dental schools throughout the USA. Our staff continues to answer every challenge. With the addition of new schools and the potential that the "Buffalo Model" presents, we will need the continued support of all of you to answer the calls for examiners. These new exams will present many different challenges and exciting opportunities for all of us. I know I can count on all of you. With your support and commitment to excellence there is no challenge that we cannot meet.

Thank you!

Dave Perkins

Dental Auxiliary Exam Information

Auxiliary Restorative Examination

The Expanded Function Dental Auxiliary competency assessment consists of a computer based written examination and a patient simulated clinical examination. The written examination is administered at PSI testing centers, and can be taken anytime for up to one year after applying for the exam. Details about the written exam can be found at www.psiexams.com after June 15, 2015 and the first written administration will be July 1, 2015.

The patient simulated clinical examination is scheduled at a clinical examination site, and consists of the restoration of three prepared teeth (anterior composite, posterior composite, posterior amalgam). A minimum score of 75 is required to pass each examination. For more extensive information please see the Expanded Function Dental Auxiliary Candidate Manual.

The overall Exam Fee is $695. For more details on fees, please click here. To Register/Apply, please click here. To view the upcoming Exam Schedule, please click here.

Ohio Application Information

In order to be eligible for the examination, one of the following criteria must apply:

1. Graduate of an accredited educational (Expanded Function Dental Auxiliary) program that complies with standards set forth in the Ohio Administrative Code, Section 4715-11, EFDA Guidelines.
2. Unlicensed dentist who has graduated from an accredited dental college and does not have a dental license under suspension or revocation by the boards;
3. Dental student who is enrolled in an accredited dental college and is considered by the dean of the dental school to be in good standing as a dental student;
4. Graduate of an unaccredited dental college located outside the United States;
5. Dental assistant who is certified by the Dental Assisting National Board, or the Ohio Commission on Dental Assistant Certification;
6. Licensed dental hygienist whose license is in good standing; or
7. Unlicensed dental hygienist who has graduated from an accredited dental hygiene program, and does not have a dental hygiene license under suspension or revocation by the board.

the educational institution in which the applicant has obtained successful completion of an approved training program.

(1) The examination shall be conducted within sixty days after the conclusion of the training program and shall be governed in format, content and subject matter by the testing agency and/or educational institution.

(2) The minimum passing score for the standardized testing is seventy-five per cent.

(3) An applicant must submit the examination fee established by the testing entity each time the applicant takes the examination.

(4) An applicant who fails to successfully complete the examination after the third attempt must retake the training program.

(5) An applicant must file a new application for each examination to be taken and submit a new examination fee as provided for in paragraph (C)(3) of this rule.

(D) The board shall issue a certificate to perform coronal polishing to currently certified dental assistants who, within one year immediately preceding the date of application, have completed the requirements set forth in paragraphs (A)(2) and (A)(3) of this rule.

(E) A certified dental assistant shall be exempt from the approved training program and standardized testing requirements provided in paragraphs (A)(2) and (A)(3) of this rule if he holds a current license, certificate, or other credential issued by another state that the board determines uses standards that are at least equal to those established by agency 4715 of the Administrative Code.

Replaces: 4715-10-01

Effective: 12/24/2010
R.C. 119.032 review dates: 12/01/2015
Promulgated Under: 119.03
Statutory Authority: 4715.39
Rule Amplifies: 4715.39
Prior Effective Dates: 06-21-04

4715-11-04 Expanded function dental auxiliaries; functions.

(A) A licensed dentist may assign to an expanded function dental auxiliary under his direct supervision and full responsibility the following tasks and/or procedures in addition to those basic remediable intra-oral and extra-oral dental tasks and/or procedures as defined in rule 4715-11-02 of the Administrative Code.

(B) "Advanced remediable intra-oral dental tasks and/or procedures" - all tasks and/or procedures involved in the art or placement of preventive or restorative materials limited to the following:

(1) Pit and fissure sealants;

(2) Amalgam restorative materials; and

(3) Non-metallic restorative materials, including direct-bonded restorative materials.

Replaces: 4715-11-03

Effective: 12/24/2010
R.C. 119.032 review dates: 12/01/2015
Promulgated Under: 119.03
Statutory Authority: 4715.03, 4715.39, 4715.66
Rule Amplifies: 4715.39, 4715.63
Prior Effective Dates: 04-09-77, 03-03-95, 06-21-04, 10-09-06

4715-11-04.1 Application for registration as expanded function dental auxiliary; requirements; renewal; exemptions.

(A) Each individual seeking to practice as an expanded function dental auxiliary shall register with the board in accordance with section 4715.62 of the Revised Code. An applicant for registration shall file with the secretary of the board a written application for registration, under oath, on a form the board shall prescribe and provide. An applicant shall include with the completed application all of the following:

(1) An application fee of twenty dollars;

(2) Proof satisfactory to the board that the applicant has successfully completed, at an educational institution accredited by the American dental association commission on dental accreditation or the higher learning commission of the north central association of colleges and schools, the education or training specified in rule 4715-11-04.2 of the Administrative Code. Proof of completion of the education or training may be evidenced by a diploma or certificate of graduation or completion that has been signed by an appropriate official of the accrediting institution that provided education or training;

(3) Proof satisfactory to the board that the applicant has passed an examination that meets the standards established in rule 4715-11-04.3 of the Administrative Code;

(4) Proof that the applicant holds current certification to perform basic life-support procedures, evidenced by documentation showing the successful completion of a basic

life-support training course certified by the American red cross, the American heart association, or the American safety and health institute.

(B) Registration as an expanded function dental auxiliary expires on the thirty-first day of December of the year following the year in which the registration occurs. An individual may renew a registration for subsequent two-year periods in accordance with the standard renewal procedures established under Chapter 4745. of the Revised Code by submitting both of the following to the secretary of the state dental board each time the individual seeks to renew a registration:

(1) A completed application for renewal, under oath, on a form the board shall prescribe and provide; and

(2) A renewal fee of twenty dollars.

(C) Paragraph (A) of this rule does not apply to any of the following:

(1) A dentist licensed under this chapter;

(2) A dental student who engages in any activities performed by expanded function dental auxiliaries as an integral part of a program of study leading to receipt of a license to practice as a dentist under this chapter;

(3) An expanded function dental auxiliary student when the student participates in an educational or training activity of an accredited education institution or a training program that does both of the following:

(a) Provides the education or training necessary to practice as an expanded function dental auxiliary; and

(b) Ensures that a dentist licensed under this chapter, or a dentist who holds a limited teaching license issued under this chapter, is physically present in the facility where the expanded function dental auxiliary performs clinical dental procedures on patients.

Replaces: 4715-11-04

Effective: 12/24/2010
R.C. 119.032 review dates: 12/01/2015
Promulgated Under: 119.03
Statutory Authority: 4715.66
Rule Amplifies: 4715.39, 4715.61, 4715.62, 4715.63
Prior Effective Dates: 10-09-06, 04-02-10

4715-11-04.2 Education or training necessary to register as an expanded function dental auxiliary.

(A) In order to register with the board as an expanded function dental auxiliary, an individual must complete an educational program that meets all of the following requirements:

(1) The program is offered by an educational institution accredited by the American dental association commission on dental accreditation or the higher learning commission of the north central association of colleges and schools.

(2) The program must include a minimum of one hundred eighty hours of coursework, of which one hundred hours are preclinical and didactic, and eighty hours are clinical, and includes training in all of the following areas:

(a) Nomenclature

(b) Caries classification

(c) Oral anatomy

(d) Dental morphology

(e) Periodontium

(f) Histology

(g) Basics of occlusion

(h) Ergonomics

(i) Instrumentation

(j) Pulp protection

(k) Dental materials

(l) Posterior amalgam and non-metallic restorations

(m) Matrix and wedge techniques

(n) Temporization

(o) Amalgam placement and carving

(p) Polishing amalgams

(q) Non-metallic restorative material placement

(r) Non-metallic restorative material finishing and polishing utilizing both low and high speed handpieces

(s) Pit and fissure sealant placement

(t) Rubber dam clamp placement and removal

(u) Rubber dam placement and removal

(3) A dentist licensed under section 4715.10 of the Revised Code or a dentist holding a limited teaching license under section 4715.16 of the Revised Code is physically present in the facility when clinical procedures associated with the education or training of expanded function dental auxiliary are performed on patients.

(B) An unlicensed dentist who does not have a dental license under suspension or revocation by the board and who seeks to register with the board as an expanded function dental auxiliary shall fulfill the requirements of paragraph (A) of this rule upon submission of proof of graduation from an accredited dental college as specified in section 4715.10 of the Revised Code.

(C) A dental student seeking to register with the board as an expanded function dental auxiliary shall fulfill the requirements of paragraph (A) of this rule upon submission to the board proof that the dental student is currently enrolled in an accredited dental college and is considered by the dean of the college to have completed sufficient clinical training as set forth in paragraph (A) of this rule, and be in good standing as a dental student.

(D) A graduate of an unaccredited dental college located outside the United States seeking to register with the board as an expanded function dental auxiliary shall fulfill the requirements of paragraph (A) of this rule upon submission of proof that the individual has completed sufficient clinical training at an accredited dental college as evidenced by a letter signed by the dean of the college to have completed sufficient clinical training as set forth in paragraph (A) of this rule.

Replaces: 4715-11- 04.1

Effective: 12/24/2010
R.C. 119.032 review dates: 12/01/2015
Promulgated Under: 119.03
Statutory Authority: 4715.66
Rule Amplifies: 4715.62
Prior Effective Dates: 10-09-06, 04-02-10

4715-11-04.3 Examination of applicants.

(A) Each individual seeking to register with the board as an expanded function dental auxiliary must successfully pass the examination administered by the commission on dental testing in Ohio or an examination accepted by the board as an examination of competency to practice as an expanded function dental auxiliary.

(B) An examination may be accepted by the board only if the entity that administers the examination requires an individual to be one of the following as a condition of admission to the examination:

(1) An unlicensed dentist who has graduated from an accredited dental college, as specified in section 4715.10 of the Revised Code, and does not have a dental license under suspension or revocation by the board;

(2) A dental student who is enrolled in an accredited dental college, as specified in section 4715.10 of the Revised Code, and is considered by the dean of the college to be in good standing as a dental student;

(3) A graduate of an unaccredited dental college located outside the United States;

(4) A dental assistant who is certified by the dental assisting national board or the Ohio commission on dental assistant certification;

(5) A dental hygienist licensed under this chapter whose license is in good standing; or

(6) An unlicensed dental hygienist who has graduated from an accredited dental hygiene program, as specified in section 4715.21 of the Revised Code, and does not have a dental hygiene license under suspension or revocation by the board.

Replaces: 4715-11- 04.2

Effective: 12/24/2010
R.C. 119.032 review dates: 12/01/2015
Promulgated Under: 119.03
Statutory Authority: 4715.03, 4715.39, 4715.66
Rule Amplifies: 4715.39, 4715.62
Prior Effective Dates: 10-09-06

4715-11-05 *[Rescinded]* Dentists may employ and supervise expanded function dental auxiliaries.

Effective: 12/24/2010
R.C. 119.032 review dates: 09/30/2010

KOOL SMILES
3824 Mechanicsville Pike, Unit #12
Richmond, Virginia 23223-1114

VIA ELECTRONINC MAIL

Ms. Sandra Reen
Executive Director Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

In Support of Dental Support Organizations

Dear Ms. Reen:

My name is Dr. Ashley Nichols and I am the Managing Dental Director for Kool Smiles with 15 offices here in Virginia. I write this letter in support of Dental Support Organizations (DSO) as I understand that on Friday October 16th DSO's may be discussed at the next Regulatory-Legislative Committee meeting.

Kool Smiles was founded and was built on the belief that every child has the right to quality dental care in a clean, safe and fun environment. Our first goal is to provide quality in a compliant manner to the traditional underserved community. Since 2005 we have treated tens of thousands of children who benefit from the Medicaid and CHIP program. We have engaged Benevis, a DSO to provide non-clinical, business services to our practices in Virginia which operate under the Kool Smiles brand. We are proud that we have been part of the expanding access for Medicaid children.

I have been a Kool Smiles dentist for over 9 years and appreciate the excellent clinical environment that the practice provides me as a dentist, a manager and a dental leader and owner. At Kool Smiles, dentists oversee clinical training and auditing of our dental team to ensure

adherence to quality and compliance standards. Our unique clinical structure and high-level of IT integration helps to ensure quality care is delivered to our patients.

I chose to affiliate with a Dental Service Organization (DSO), because of the many benefits the DSO provides me and all our dentists. The DSO provides business management and professional support to dentists so that they can focus their time on providing quality patient care. Kool Smiles is also able to leverage the business expertise of a DSO, and their purchasing power, to lower our operating costs, making it possible for our dental teams to care for patients who utilize Medicaid benefits.

This type of business arrangement also fosters an environment of professional support through peer-to-peer collaboration and helps dentists achieve better work-life balance by allowing our dentists to come to the office, practice what they love, and leave at the end of the day without having to worry about endless paperwork, dealing with various vendors or financial forms.

As a private practice dentist, I would have none of this administrative and business support without the relationship with our DSO. On top of that, I would be faced with the very difficult decision of turning away certain patients due to lack of profitability.

Having a DSO support system in place also makes it possible for the dental team to offer patients greater appointment flexibility. At Kool Smiles, we offer same-day and weekend appointments to accommodate patients who might require urgent dental care, or who cannot come to the office during the work week. This kind of flexibility is important for our unique patient population.

Kool Smiles dentists spend as much time with each patient as the average dentist, according to a recent survey conducted by the American Academy of Pediatric Dentistry (AAPD). However, we can see more patients, at a lower Medicaid reimbursement rate, because we are able to focus 100% of our time on patients, many of whom have complex care needs. We are also able to build strong relationships with our patients and their parents, so that we can stress the benefits of maintaining good oral health.

Through this model all our doctors are able to exercise their independent clinical judgment and focus on delivering quality care. It allows our doctors to help people in the way I envisioned when I decided to become a dentist.

Thank you for your attention.

Respectfully submitted,

Ashley Nichols, DDS

Dr. Ashley Nichols
Kool Smiles
Managing Dental Director

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of October 7, 2015)

Board	Board of Dentistry	
Chapter		Action / Stage Information
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Requirement for jurisprudence examination [Action 4364] NOIRA - *At Governor's Office for 139 days*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Requirement for capnography for monitoring anesthesia or sedation [Action 4411] NOIRA - *At Governor's Office for 34 days*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Recognition of Commission on Dental Accreditation of Canada [Action 4387] Fast-Track - *At Governor's Office for 24 days*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252] Final - *Register Date: 11/2/15* *Effective date: 12/2/15*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	(E) Fee reduction [Action 4436] Final - *Register Date: 11/2/15* *Effective date: 12/2/15*

Assembly Bill No. 1174

CHAPTER 662

An act to amend Sections 1684.5, 1925, and 1944 of, to add Section 1926.05 to, and to add, repeal, and add Sections 1753.55 and 1910.5 of, the Business and Professions Code, and to add and repeal Section 128196 of the Health and Safety Code, and to amend Section 14132.725 of the Welfare and Institutions Code, relating to oral health.

[Approved by Governor September 27, 2014. Filed with Secretary of State September 27, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1174, Bocanegra. Dental professionals.

(1) Under existing law, the Dental Practice Act, the Dental Board of California licenses and regulates dentists. Existing law creates, within the jurisdiction of the board, a Dental Assisting Council that is responsible for the regulation of dental assistants, registered dental assistants, and registered dental assistants in extended functions and a Dental Hygiene Committee of California, that is responsible for the regulation of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions. Existing law governs the scope of practice for those professionals, and authorizes a dentist to require or permit one of those professionals, referred to as a dental auxiliary, to perform specified duties, including exposing emergency radiographs upon the direction of the dentist, prior to the dentist examining the patient.

This bill would add to those specified duties exposing radiographs, as specified, make a dentist responsible to provide a patient or the patient's representative written notice, including specified contact information and disclosing that the care was provided at the direction of that authorizing dentist, and would prohibit a dentist from concurrently supervising more than a total of 5 dental auxiliaries, as specified. The bill would authorize specified registered dental assistants in extended functions, registered dental hygienists, and registered dental hygienists in alternative practice to determine which radiographs to perform and to place protective restorations, as specified. The bill would require the board to adopt related regulations, and would also require the committee to review proposed regulations and submit any recommended changes to the board for review to establish a consensus.

(2) Existing law requires the committee to establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, registered dental hygienist in alternative practice, and registered dental hygienist in extended functions. Existing law limits the fee for each review of courses required for licensure that are not accredited to $300. Under

existing law, those fees are further limited to the reasonable regulatory cost incurred by the committee.

This bill would instead limit the fee for each review or approval of course requirements for licensure or procedures that require additional training to $750.

(3) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including certain dental services, as specified. Existing law provides that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for "teleophthalmology and teledermatology by store and forward," as defined to mean the asynchronous transmission of medical information to be reviewed at a later time by a licensed physician or optometrist, as specified, at a distant site.

This bill would additionally provide that face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teledentistry by store and forward, as defined.

(4) Existing law authorizes the Office of Statewide Health Planning and Development to approve Health Workforce Pilot Projects (HWPP) No. 172, as defined. The office has approved operation HWPP No. 172, relating to dental workforce, through December 15, 2014.

This bill would extend the operation of HWPP through January 1, 2016. The bill would also delete redundant provisions, and would make conforming changes.

The people of the State of California do enact as follows:

SECTION 1. Section 1684.5 of the Business and Professions Code is amended to read:

1684.5. (a) In addition to other acts constituting unprofessional conduct under this chapter, it is unprofessional conduct for any dentist to perform or allow to be performed any treatment on a patient who is not a patient of record of that dentist. A dentist may, however, after conducting a preliminary oral examination, require or permit any dental auxiliary to perform procedures necessary for diagnostic purposes, provided that the procedures are permitted under the auxiliary's authorized scope of practice. Additionally, a dentist may require or permit a dental auxiliary to perform all of the following duties prior to any examination of the patient by the dentist, provided that the duties are authorized for the particular classification of dental auxiliary pursuant to Article 7 (commencing with Section 1740):

(1) Expose emergency radiographs upon direction of the dentist.

(2) If the dental auxiliary is a registered dental assistant in extended functions, a registered dental hygienist, or a registered dental hygienist in alternative practice, determine and perform radiographs for the specific purpose of aiding a dentist in completing a comprehensive diagnosis and

treatment plan for a patient using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist pursuant to Sections 1753.55, 1910.5, and 1926.05. A dentist is not required to review patient records or make a diagnosis using telehealth.

(3) Perform extra-oral duties or functions specified by the dentist.

(4) Perform mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, malocclusions, existing restorations, and missing teeth.

(b) For purposes of this section, "patient of record" refers to a patient who has been examined, has had a medical and dental history completed and evaluated, and has had oral conditions diagnosed and a written plan developed by the licensed dentist.

(c) For purposes of this section, if dental treatment is provided to a patient by a registered dental assistant in extended functions, a registered dental hygienist, or a registered dental hygienist in alternative practice pursuant to the diagnosis and treatment plan authorized by a supervising dentist, at a location other than the dentist's practice location, it is the responsibility of the authorizing dentist that the patient or the patient's representative receive written notification that the care was provided at the direction of the authorizing dentist and that the notification include the authorizing dentist's name, practice location address, and telephone number. This provision shall not require patient notification for dental hygiene preventive services provided in public health programs as specified and authorized in Section 1911, or for dental hygiene care when provided as specified and authorized in Section 1926.

(d) A dentist shall not concurrently supervise more than a total of five registered dental assistants in extended functions, registered dental hygienists, or registered dental hygienists in alternative practice providing services pursuant to Sections 1753.55, 1910.5, and 1926.05.

(e) This section shall not apply to dentists providing examinations on a temporary basis outside of a dental office in settings including, but not limited to, health fairs and school screenings.

(f) This section shall not apply to fluoride mouth rinse or supplement programs administered in a school or preschool setting.

SEC. 2. Section 1753.55 is added to the Business and Professions Code, to read:

1753.55. (a) A registered dental assistant in extended functions is authorized to perform additional duties as set forth in subdivision (b) pursuant to the order, control, and full professional responsibility of a supervising dentist if the licensee meets one the following requirements:

(1) Is licensed on or after January 1, 2010.

(2) Is licensed prior to January 1, 2010, has successfully completed a board-approved course in the additional procedures specified in paragraphs (1), (2), (5), and (7) to (11), inclusive, of subdivision (b) of Section 1753.5, and passed the examination as specified in Section 1753.4.

(b) (1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific

purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental assistant in extended functions shall follow protocols established by the supervising dentist. This paragraph only applies in the following settings:

(A) In a dental office setting.

(B) In public health settings, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics, under the general supervision of a dentist.

(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft material from the tooth using only hand instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:

(A) In either of the following settings:

(i) In a dental office setting, under the direct or general supervision of a dentist as determined by the dentist.

(ii) In public health settings, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics, under the general supervision of a dentist.

(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.

(c) The functions described in subdivision (b) may be performed by a registered dental assistant in extended functions only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the board, of having completed a board-approved course in those functions.

(1) No later than January 1, 2018, the board shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental assistant in extended functions pursuant to this section, using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Health Planning and Development. The board shall submit to the committee proposed regulatory language for the Interim Therapeutic Restoration to the committee for the purpose of promulgating regulations for registered dental hygienists and registered dental hygienists in alternative practice as described in Section 1910.5. The language submitted by the board to the committee shall mirror the curriculum requirements for the registered dental assistant in extended functions. Any subsequent amendments to the regulations that are promulgated by the board for the Interim Therapeutic Restoration curriculum shall be submitted to the committee.

(2) Until the regulations adopted by the board pursuant to paragraph (1) become effective, the board shall use the competency-based training protocols established by HWPP No. 172 through the Office of Statewide Health Planning and Development to approve courses of instruction for the procedures authorized in this section.

(3) A registered dental assistant in extended functions who has completed the prescribed training in HWPP No. 172 established by the Office of Statewide Health Planning and Development pursuant to Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 of the Health and Safety Code shall be deemed to have satisfied the requirement for completion of a course of instruction approved by the board.

(4) In addition to the instructional components described in this subdivision, a program shall contain both of the instructional components described in this paragraph:

(A) The course shall be established at the postsecondary educational level.

(B) All faculty responsible for clinical evaluation shall have completed a one-hour methodology course in clinical evaluation or have a faculty appointment at an accredited dental education program prior to conducting evaluations of students.

(d) The board may issue a permit to a registered dental assistant in extended functions who files a completed application, including the fee, to provide the duties specified in this section after the board has determined the registered dental assistant in extended functions has completed the coursework required in subdivision (c).

(e) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 3. Section 1753.55 is added to the Business and Professions Code, to read:

1753.55. (a) A registered dental assistant in extended functions is authorized to perform the additional duties as set forth in subdivision (b) pursuant to the order, control, and full professional responsibility of a supervising dentist, if the licensee meets one of the following requirements:

(1) Is licensed on or after January 1, 2010.

(2) Is licensed prior to January 1, 2010, has successfully completed a board-approved course in the additional procedures specified in paragraphs (1), (2), (5), and (7) to (11), inclusive, of subdivision (b) of Section 1753.5, and passed the examination as specified in Section 1753.4.

(b) (1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental assistant in extended functions shall follow protocols established by the supervising dentist. This paragraph only applies in the following settings:

(A) In a dental office setting.

(B) In public health settings, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics, under the general supervision of a dentist.

(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft material from the tooth using only hand instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:

(A) In either of the following settings:

(i) In a dental office setting, under the direct or general supervision of a dentist as determined by the dentist.

(ii) In public health settings, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics, under the general supervision of a dentist.

(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.

(c) The functions described in subdivision (b) may be performed by a registered dental assistant in extended functions only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the board, of having completed a board-approved course in those functions.

(d) No later than January 1, 2018, the board shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental assistant in extended functions pursuant to this section using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Health Planning and Development. The board shall submit to the committee proposed regulatory language for the curriculum for the Interim Therapeutic Restoration to the committee for the purpose of promulgating regulations for registered dental hygienists and registered dental hygienists in alternative practice as described in Section 1910.5. The language submitted by the board shall mirror the instructional curriculum for the registered dental assistant in extended functions. Any subsequent amendments to the regulations that are promulgated by the board for the Interim Therapeutic Restoration curriculum shall be submitted to the committee.

(e) The board may issue a permit to a registered dental assistant in extended functions who files a completed application, including the fee, to provide the duties specified in this section after the board has determined the registered dental assistant in extended functions has completed the coursework required in subdivision (c).

(f) This section shall become operative on January 1, 2018.

SEC. 4. Section 1910.5 is added to the Business and Professions Code, to read:

1910.5. (a) In addition to the duties specified in Section 1910, a registered dental hygienist is authorized to perform the following additional duties, as specified:

(1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental hygienist shall follow protocols established by the supervising dentist. This paragraph shall only apply in the following settings:

(A) In a dental office setting.

(B) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft material from the tooth using only hand instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:

(A) In either of the following settings:

(i) In a dental office setting.

(ii) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.

(b) The functions described in subdivision (a) may be performed by a registered dental hygienist only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the committee, of having completed a committee-approved course in those functions.

(c) (1) No later than January 1, 2018, the committee shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental hygienist and registered dental hygienist in alternative practice pursuant to Sections 1910.5 and 1926.05 using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Health Planning and Development. The committee shall use the curriculum submitted by the dental board, pursuant to Section 1753.55, to adopt

regulatory language for approval of courses of instruction for the Interim Therapeutic Restoration. Any subsequent amendments to the regulations for the Interim Therapeutic Restoration curriculum that are promulgated by the committee shall be agreed upon by the board and the committee.

(2) Prior to January 1, 2018, the committee shall use the competency-based training protocols established by HWPP No. 172 through the Office of Statewide Health Planning and Development to approve courses of instruction for the procedures authorized in this section.

(3) A registered dental hygienist who has completed the prescribed training in HWPP No. 172 established by the Office of Statewide Health Planning and Development pursuant to Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 of the Health and Safety Code shall be deemed to have satisfied the requirement for completion of a course of instruction approved by the committee.

(4) In addition to the instructional components described in this subdivision, a program shall contain both of the instructional components described in this paragraph:

(A) The course shall be established at the postsecondary educational level.

(B) All faculty responsible for clinical evaluation shall have completed a one-hour methodology course in clinical evaluation or have a faculty appointment at an accredited dental education program prior to conducting evaluations of students.

(d) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 5. Section 1910.5 is added to the Business and Professions Code, to read:

1910.5. (a) In addition to the duties specified in Section 1910, a registered dental hygienist is authorized to perform the following additional duties, as specified:

(1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental hygienist shall follow protocols established by the supervising dentist. This paragraph only applies in the following settings:

(A) In a dental office setting.

(B) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft material from the tooth using only hand

instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:

(A) In either of the following settings:

(i) In a dental office setting.

(ii) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.

(b) The functions described in subdivision (a) may be performed by a registered dental hygienist only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the committee, of having completed a committee-approved course in those functions.

(c) No later than January 1, 2018, the committee shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental hygienist and registered dental hygienist in alternative practice pursuant to Sections 1910.5 and 1926.05, using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Health Planning and Development. The committee shall use the curriculum submitted by the board pursuant to Section 1753.55 to adopt regulatory language for approval of courses of instruction for the Interim Therapeutic Restoration. Any subsequent amendments to the regulations for the Interim Therapeutic Restoration curriculum that are promulgated by the committee shall be agreed upon by the board and the committee.

(d) This section shall become operative on January 1, 2018.

SEC. 6. Section 1925 of the Business and Professions Code is amended to read:

1925. A registered dental hygienist in alternative practice may practice, pursuant to subdivision (a) of Section 1907, subdivision (a) of Section 1908, subdivisions (a) and (b) of Section 1910, Section 1910.5, and Section 1926.05 as an employee of a dentist or of another registered dental hygienist in alternative practice, as an independent contractor, as a sole proprietor of an alternative dental hygiene practice, as an employee of a primary care clinic or specialty clinic that is licensed pursuant to Section 1204 of the Health and Safety Code, as an employee of a primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code, as an employee of a clinic owned or operated by a public hospital or health system, or as an employee of a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

SEC. 7. Section 1926.05 is added to the Business and Professions Code, to read:

1926.05. (a) In addition to the duties specified in Section 1926, a registered dental hygienist in alternative practice is authorized to perform the duties pursuant to Section 1910.5, in the following settings:

(1) Residences of the homebound.

(2) Schools.

(3) Residential facilities and other institutions.

(b) A registered dental hygienist in alternative practice is authorized to perform the duties pursuant to paragraph (2) of subdivision (a) of Section 1910.5 in the settings specified in this section under the general supervision of a dentist.

SEC. 8. Section 1944 of the Business and Professions Code is amended to read:

1944. (a) The committee shall establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in effect until modified by the committee. The fees are subject to the following limitations:

(1) The application fee for an original license and the fee for issuance of an original license shall not exceed two hundred fifty dollars ($250).

(2) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(3) For third- and fourth-year dental students, the fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(4) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(5) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

(6) The biennial renewal fee shall not exceed one hundred sixty dollars ($160).

(7) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

(8) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars ($25) or one-half of the renewal fee, whichever is greater.

(9) The fee for certification of licensure shall not exceed one-half of the renewal fee.

(10) The fee for each curriculum review and site evaluation for educational programs for dental hygienists who are not accredited by a

committee-approved agency shall not exceed two thousand one hundred dollars ($2,100).

(11) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars ($750).

(12) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars ($500).

(13) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

(b) The renewal and delinquency fees shall be fixed by the committee by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars ($5).

(c) Fees fixed by the committee by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the committee and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund shall, upon appropriation by the Legislature in the annual Budget Act, be used to implement the provisions of this article.

(e) No fees or charges other than those listed in this section shall be levied by the committee in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars ($250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars ($150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars ($250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars ($250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars ($250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph (6) of subdivision (a).

(*l*) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out the provisions of this article.

SEC. 9. Section 128196 is added to the Health and Safety Code, to read:

128196. (a) Notwithstanding Section 128180, the office shall extend the duration of the health workforce project known as Health Workforce Pilot Project No. 172 until January 1, 2016, in order to maintain the competence of the clinicians trained during the course of the project, and to authorize training of additional clinicians in the duties specified in HWPP No. 172.

(b) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 10. Section 14132.725 of the Welfare and Institutions Code is amended to read:

14132.725. (a) To the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, "teleophthalmology, teledermatology, and teledentistry by store and forward" means an asynchronous transmission of medical or dental information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, or a dentist, where the physician, optometrist, or dentist at the distant site reviews the medical or dental information without the patient being present in real time. A patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist, or dentist, upon request. If requested, communication with the distant specialist physician, optometrist, or dentist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.

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§ 54.1-2708.3. Regulation of mobile dental clinics.

No person shall operate a mobile dental clinic or other portable dental operation without first registering such mobile dental clinic or other portable dental operation with the Board, except that the following shall be exempt from such registration requirement: 1) mobile dental clinics or other portable dental operations operated by federal, state, or local government agencies or other entities identified by the Board in regulations; 2) federally qualified health centers with a dental component that provides dental services via a mobile model to children within 30 miles of the center; and 3) free health clinics or health safety net clinics that have been granted tax exempt status under § 501 C (3) of the Internal Revenue Code that provides dental services via mobile model to children within 30 miles of the clinic. ~~shall be exempt from such registration requirement.~~

The Board shall promulgate regulations for mobile dental clinics and other portable dental operations to ensure that patient safety is protected, appropriate dental services are rendered, and needed follow-up care is provided. Such regulations shall include, but not be limited to, requirements for the registration of mobile dental clinics, locations where services may be provided, requirements for reporting by providers, and other requirements necessary to provide accountability for services rendered.

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