VIRGINIA BOARD OF DENTISTRY

REVISED AGENDA

June 9-10, 2016

Department of Health Professions

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

PAGE

June 9, 2016

1:00 p.m. **Formal Hearings**

June 10, 2016

Board Business

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

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- March 10, 2016 Formal Hearing **P1**
- March 11, 2016 Business Meeting **P4**
- April 27, 2016 Nitrous Subcommittee Meeting **P11**

DHP Director's Report – Dr. Brown

Liaison/Committee Reports

- BHP - Dr. Watkins
  May 5, 2016 minutes **P13**
- AADB Mid-Year Meeting in April 2016
  Dr. Parris-Wilkins' report **P19**
  Ms. Palmatier's report **P24**
- ADEX – Dr. Rizkalla & Ms. Swecker **P26**
  ADEX letter to State Board **BLUE PAPERS**
- Regulatory-Legislative Committee – Ms. Swain
  May 6, 2016 Minutes **P27**
- SRTA– Dr. Rizkalla, Dr. Watkins & Ms. Swecker
- Nitrous Subcommittee Meeting – Dr. Gaskins
  See Nitrous Subcommittee Minutes Above

Legislation and Regulation – Ms. Yeatts

- Status Report on Regulatory Actions **P31**
- Board Action on the Monitoring of Nitrous Oxide And Minimal Sedation **P32**
- Board Action on Public Participation Guidelines **P67**
- Board Action on HB319 – Volunteer Hours to Count Toward CE requirement **P71**
- Board Discussion on SB712 – Remote Supervision of Dental Hygienists **P83**

PAGE

- HB310 (Expanding the Exemptions for Registration Requirements to Mobile Dental Clinics) will be Addressed at the September 16, 2016 Meeting

Board Discussion/Action

- Review and Discussion of Public Comment Topics – Dr. Gaskins
- ADEA Letter to State Board — **P103**
- ADEA Letter to Maryland State Board of Dental Examiners — **P105**
- JCNDE Letter to State Board — **P108**
- ADEX Letter to State Board — **P124**
- Guidance Document Addressing Failure to Report to the PMP — **P135**
- ADA Sedation and Anesthesia Guidelines — **BEIGE PAPERS**

Disciplinary Activity Report/Business – Ms. Palmatier — **P136**

Executive Director's Report/Business – Ms. Reen

- 2017 Proposed Calendar — **P137**
- Guidance Document Addressing Auditing Continuing Education — **P139**
  Sample Size Calculator by Raosoft, Inc. — **PINK PAPERS**
- Review of the Alternatives Recommended by Commenters on the NOIRA to Require a Periodic Jurisprudence Examination — **P144**

- Implementation of the Four Chapters — **GRAY PAPERS**

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
March 10, 2016

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:05 a.m., on March 10, 2016 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Tammy K. Swecker, R.D.H., Secretary-Treasurer

MEMBERS PRESENT: John M. Alexander, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
Carol R. Russek, J.D., Citizen Member
Melanie C. Swain, R.D.H.
James D. Watkins, D.D.S.

MEMBERS ABSENT: Evelyn M. Rolon, D.M.D.
Bruce S. Wyman, D.M.D.

STAFF PRESENT: Sandra K. Reen, Executive Director
Huong Q. Vu, Operations Manager

COUNSEL PRESENT: Erin L. Barrett, Assistant Attorney General

OTHERS PRESENT: James E. Schliessmann, Senior Assistant Attorney General
Tiffany A. Laney, Adjudication Specialist
Andrea Pegram, Court Reporter.

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

James A. Pollard, D.D.S.
Case No.: 155229

Dr. Pollard was present without legal counsel in accordance with the Notice of the Board dated November 4, 2015.

Ms. Swecker swore in the witnesses.

Following Mr. Schliessmann's opening statement, Ms. Swecker admitted into evidence Commonwealth's Exhibits 1 through 3.

Following Dr. Pollard's opening statement, Ms. Swecker admitted into evidence Respondent's Exhibit A.

Testifying on behalf of the Commonwealth were Laura Pezzulo, DHP Senior Investigator, Brandon S. Fletcher, Pharmacist, Bethany Sawyer Pettry, Pharmacist, David Petrunyak, Pharmacist, and Jamie Pauley, Pharmacist.

Testifying on behalf of Dr. Pollard were Jane Kelly Mattox, former Office Manager and Michelle Miller, Dental Assistant. Dr. Pollard testified on his own behalf.

Closed Meeting: Dr. Watkins moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Dr. Pollard. Additionally, he moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Ms. Barrett attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

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

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

Decision: Dr. Watkins moved to accept the Findings of Facts and Conclusion of Law as presented by the Commonwealth, amended by the Board, and read by Ms. Barrett. The motion was seconded and passed.

Ms. Barrett reported that the Board decided to reprimand Dr. Pollard with the following terms and conditions:

- Monetary Penalty of $7,000.00 to be paid to the Board within 33 days from entry of Order;
- Indefinite Restriction on prescribing Schedule II medications until Dr. Pollard takes and completes the required continuing education courses;
- Completion of two continuing education courses:
  - 7 hours on the principles of pharmacology and prescription writing and
  - 4 hours in risk management for the administration of sedation.

  Both courses must be taken from a dental program

accredited by the Commission on Dental Accreditation of the American Dental Association (CODA).

Dr. Watkins moved to adopt the sanctions as read by Ms. Barrett. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 3:33 p.m.

_____ _____

Tammy K. Swecker, R.D.H., Secretary-Treasurer Sandra K. Reen, Executive Director

_____ _____

Date Date

VIRGINIA BOARD OF DENTISTRY
MINUTES
March 11, 2016

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:03 a.m. on March 11, 2016, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.

PRESIDING: Charles E. Gaskins III, D.D.S., President

BOARD MEMBERS PRESENT:
John M. Alexander, D.D.S
Tonya A. Parris-Wilkins, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
Carol R. Russek, J.D., Citizen Member
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

BOARD MEMBERS ABSENT: Bruce S. Wyman, D.M.D.

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

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

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

Ms. Palmatier read the emergency evacuation procedures.

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

PUBLIC COMMENT: **Dr. Nick Lombardozzi, DDS**, a pediatric dentist, asked the Board to adhere to the American Dental Association and the American Academy of Pediatric Dentistry's (AAPD) guidelines for monitoring pediatric patients during the administration of nitrous oxide for minimal sedation.

Dr. Carl Atkins, DDS, a pediatric dentist, said the current guidelines of the AAPD state that children who receive minimal sedation generally will not require more than observation and intermittent assessment of their level of sedation. He described how the current Board requirements for minimal sedation significantly increase the cost of treatment. He also questioned the requirement for recording vital signs prior to discharge.

Dr. Tegwyn H, Brickhouse, DDS, PhD, VCU School of Dentistry Pediatric Department Chair, said that there is no rationale for monitoring requirements for minimal sedation when the child is verbally responsive.

Dr. Robert A. Strauss, DDS, Oral and Maxillofacial Surgeon and Professor at VCU School of Dentistry, noted that a second person is not required for the administration of nitrous oxide and said when only nitrous oxide is administered taking intraoperative vital signs is not needed.

Kara Sprouse, RDH, DA II, said she is currently teaching the DA II program at Fortis College. She stated taking the CDA exam to be registered as a DA II was an unreasonable requirement for an RDH. She asked the Board to remove this requirement for dental hygienists to qualify for registration as a DA II.

APPROVAL OF MINUTES:

Dr. Gaskins asked if there were any corrections to the December 10, 2015 minutes. Dr. Watkins moved to accept the December 10, 2015. The motion was seconded and passed. The minutes for December 11, 2015 were also adopted.

DHP DIRECTOR'S REPORT:

Dr. Brown reported that DHP is working with other agencies to develop a statewide website of resources on prescribing opioids, pain management, continuing education courses, and help for addiction. He invited recommendations of sites that could be linked. He added that now dentists are required to check the Prescription Monitoring Program before prescribing opioids for more than 14 days.

WORKFORCE DATA REPORTS:

Dr. Carter, director of the Healthcare Workforce Data Center, reviewed the latest reports on Virginia's dental and dental hygiene workforce prepared from the information collected through the 2015 online renewals. She highlighted the following findings:

- half the current dental workforce expects to retire by 2035.

- 84% of dentists and 91% of dental hygienists renewing online completed the surveys.
- 76% of dentists and 82% of dental hygienists reported working in Virginia.
- the median age for dentists is 50 years and for dental hygienists it is 44 years.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Watkins said he did not attend the February 11, 2016 meeting, and the minutes of the meeting are provided. He added that the topic of electronic records is still on the agenda.

AADB. Dr. Gaskins reported that Dr. Parris-Wilkins and Ms. Palmatier will attend the April, 2016 AADB Mid-Year meeting in Chicago.

ADEX. Dr. Rizkalla reported on the ADEX Bylaws changes made following SRTA's decision to not administer the ADEX exam. He added that CITA will be giving the ADEX exams at VCU. Dr. Rizkalla moved to have Ms. Reen consult with CITA to see if it would be willing to comply with Virginia's State Travel Regulations, and with Board counsel to further explore whether interested Board members can serve as examiners for CITA. The motion was seconded and passed. Dr. Gaskins added that he will appoint a Board member to SRTA's Board of Directors and another to the ADEX House of Representatives. Ms. Swecker reported that she was appointed to represent region six on the ADEX Dental Hygiene Committee.

Regulatory-Legislative Committee. Ms. Swain stated that the Committee met on February 12, 2016, and the recommendations on DA II registrations will be addressed later on the agenda. Dr. Gaskins noted that any committee's minutes of attendance should list the committee members attending along with Board members attending ex-officio (i.e.: able to vote), those committee members absent, and any other Board members attending but non-voting, separately.

SRTA. Dr. Rizkalla announced that Dr. Watkins is one of the nominees for President of SRTA. Ms. Swecker and Dr. Watkins had no additional information to report.

SCDDE. Dr. Gaskins stated that along with Dr. Watkins and Ms. Reen, they attended the annual SCDDE meeting in January, 2016. He said the "Unconscious Bias" presentation was very engaging and would be good for all Boards in DHP. The session on an

integrative model for medical and dental professionals to work together also was informative. Dr. Watkins' report was published in the meeting's materials and agenda.

LEGISLATION AND REGULATIONS:

Report of the 2016 General Assembly. Ms. Yeatts reviewed legislation passed by the General Assembly, stating:

- HB310 expands the exemptions for registration requirements to mobile dental clinics operated by federally qualified health centers, and free health clinics or health safety net clinics.
- HB319 requires boards to amend regulations to allow volunteer hours at local health departments or free clinics to count toward continuing education requirements.
- HB586 requires boards to decide whether or not to disclose practitioners' health records in notices and orders.
- SB491 authorizes the DHP director to send unsolicited reports on prescribers and dispensers.
- SB513 requires prescribers to query the PMP when prescribing opioids for more than 14 consecutive days.
- SB712 allows dental hygienists to practice under remote supervision in free clinics and federally qualified health centers.

Ms. Yeatts noted that HB310 requires the Board to amend its regulations, which can be done as an exempt action, and added SB712 requires the Board to adopt emergency regulations at its September meeting in order to meet the 280 day enactment clause. She recommended that the Regulatory-Legislative Committee be convened soon to start work on these regulations. It was noted that HB 319 also requires regulatory action.

Ms. Swain referenced SB212 and expressed her disappointment that the provision to add another citizen member to the Board had been withdrawn since it had the full approval of the Board. Ms. Yeatts explained the Board could consider submitting another legislative proposal. Dr. Brown added it appeared to him that the VDA misunderstood the reasons the proposal was made.

Status Report on Regulatory Actions. Ms. Yeatts reported:

- The comment period for the NOIRA to add capnography to the equipment required for conscious/moderate sedation ended on December 30, 2015, with no comments received. Ms. Yeatts provided a revision of the proposed regulation to amend Chapter 21; rather than Chapter 20 which has been repealed. She noted that this amendment was adopted as a fast-track action by the Board, but was changed to the standard regulatory process in response to the Department of Planning Budgets review, and is now presented for Board

action. Dr. Watkins moved to adopt the proposed amendments. The motion was seconded and passed.

- The comment period for the NOIRA to require passage of a jurisprudence examination closed on December 16, 2015, with all commenters opposing this action. Dr. Rizkalla moved to withdraw the NOIRA. The motion was seconded and passed. Ms. Reen was asked to give the history on this proposal. She explained that previously applicants were required to take the law exam, but issues arose with the testing agency. The Board then offered an exam through another testing agency for 3 hours of CE credit to get dentists to voluntarily take the exam. She added that the testing agency didn't renew the contract because only licensees under a Board Order were taking it. Following discussion of mandating an hour of CE, Ms. Reen suggested allowing staff to review the recommendations made in the comments received, look at other states' requirements, and present information at the June meeting for further discussion. Dr. Alexander moved to accept Ms. Reen's recommendation. The motion was seconded and passed.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics. Dr. Gaskins expressed the Board's appreciation for the comments received. In response to the comments on the nitrous oxide and minimum sedation monitoring requirements, he asked the Board to move quickly to consider amendment(s) of the requirement. Ms. Yeatts said the Board could take fast-track action. Discussion followed about the need for some research to develop the proposal. Dr. Rizkalla moved to take fast track action to amend 18VAC60-21-280, and to authorize Dr. Gaskins to convene a subcommittee to develop the language to be submitted. The motion was seconded and passed. Dr. Gaskins indicated that he would ask Dr. Alexander, Dr. Robert Strauss, Dr. Tegwyn Brickhouse, Ms. Yeatts, and Ms. Reen to be on the subcommittee. All agreed. Then Dr. Gaskins referred the comment on DA II registration to the Regulatory-Legislative Committee.

Auditing Continuing Education (CE). Ms. Reen asked the Board to review the information provided on how other boards within DHP and other boards of dentistry are conducting CE audits and provide guidance on what action the Board would like to take. Ms. Yeatts suggested requesting a statistically valid sample from Dr. Carter. Dr. Rizkalla moved to collect every year a random sample for CE audit based on Dr. Carter's statistic. The motion was seconded and passed. Ms. Reen suggested developing a guidance

document (GD) on how audits would be conducted, and she noted the Board has a GD on sanctioning for missing CE. All agreed.

Recommendation on the Requirements for DA II Registration. Ms. Swain reported the Regulatory-Legislative Committee is planning to address these recommendations further in October. Ms. Reen added she has not yet contacted the VCU School of Dentistry.

Guidance Document (GD) Addressing Dental Practice. Ms. Reen stated that the Board asked for a GD which addresses who can own a dental practice and what duties are restricted to dentists. She said Board counsel advised her to compile the various Code of Virginia and regulatory provisions. The resulting draft is offered for consideration. Dr. Rolon moved to accept the GD as proposed. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported that for calendar year 2015, the Board received 552 cases and closed 680. She added that since January 1, 2016 through February 23, 2016, the Board received 52 cases and closed 35. She then reported the following for the second quarter of 2016 (October 1 – December 1, 2015):

- A total of 39 patient care cases received and 110 closed for a 282% clearance rate
- The current pending caseload older than 250 days is 33% and the goal is 20%;
- 79% of the patient care cases were closed within 250 days and the goal is 90%

She added that between November 20, 2015 and February 23, 2016, the Board has not mandatorily or summarily suspended any licenses.

She then reported the following on the fourth OMS Cosmetic Procedures Quality Assurance Review (1/1/2011 – 12/31/2013):

- 30 Oral & Maxillofacial surgeons held cosmetic procedure certifications
- 24 performed cosmetic procedures in their office
- Expert reviewer was an OMS and MD in private practice in Maryland
- Cost for the review was $18,330.75 ($104.75 hours x $175)
- Four (4) were closed with no violation
- 19 were closed with advisory letters
- Two (2) were offered Pre-Hearing Consent Orders
- Two (2) were entered into Informal Orders

- Three (3) are still pending

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Dentists Referring Patients for Sleep Studies. Ms. Reen stated that Dr. Alexander asked at the last meeting if a dentist is permitted to refer patients for sleep studies. She reported consulting with Board counsel who advised that a dentist can refer a patient for a sleep study; then the polysomnographer would perform the study under the direction of a physician and subsequently provide the report to the physician. The physician then might or might not share the results with the referring dentist.

SCDDE Annual Meeting Report. Ms. Reen stated that she also was impressed with the "Unconscious Bias" presentation at the SCDDE meeting, and she agreed with Dr. Gaskins that it would be good for board member training and also for DHP staff training.

ADA Update on Sedation and Anesthesia Guidelines. Ms. Reen said the ADA continues to work on its guidelines and is currently holding hearings for member comments. She added the Board again will be able to offer comments.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 12:21 p.m.

_____ _____

Charles E. Gaskins, III, D.D.S., President Sandra K. Reen, Executive Director

_____ _____

Date Date

Unapproved

VIRGINIA BOARD OF DENTISTRY
NITROUS OXIDE / MINIMAL SEDATION SUBCOMMITTEE
MINUTES
April 27, 2016

TIME AND PLACE:	The meeting of the Nitrous Oxide / Minimal Sedation Subcommittee of the Board of Dentistry was called to order at 2:05 p.m. on April 27, 2016 in Hearing Room 5, Department of Health Professions, 9960 Mayland Drive, Suite 201, Richmond, Virginia.
PRESIDING:	Charles E. Gaskins, III, D.D.S, President
SUBCOMMITTEE MEMBER PRESENT:	John M. Alexander, D.D.S.
ADVISORS PRESENT:	Tegwyn Brickhouse, D.D.S., Pediatric Department Chair, VCU School of Dentistry David C. Sarrett. D.M.D., Dean, VCU School of Dentistry, Anesthesia Committee Chair of the ADA Council on Dental Education and Licensure (CDEL) Robert A. Strauss, D.D.S., Oral and Maxillofacial Surgery Professor and Residency Program Director, VCU School of Dentistry
STAFF PRESENT:	Sandra K. Reen, Executive Director Elaine J. Yeatts, DHP Policy Analyst Huong Vu, Operations Manager
PUBLIC COMMENT:	**Carl Atkins, DDS,** a pediatric dentist, reported he has had to stop procedures to settle children because of blood pressure cuffs. He added there is no known issue with nitrous oxide and no national standard for monitoring nitrous oxide beyond observation.
RECOMMENDATION ON THE MONITORING REQUIREMENTS OF NITROUS OXIDE AND MINIMAL SEDATION:	Dr. Gaskins stated that at the last Board meeting, there were comments regarding the minimal sedation monitoring requirements, as well as their effect on pediatric care. He added the subcommittee is convened to suggest changes in those requirements. He asked Dr. Sarrett to share information with the Subcommittee regarding work currently underway on the ADA's "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students" document. Dr. Sarrett reported he is currently serving as Chair of the Anesthesia Committee of the ADA Council on Dental Education and Licensure (CDEL), which is reviewing the ADA's "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students". He commented that there is a proposal to require a 60 hour course for all modes of administration of moderate sedation. He stated that general dentists are the ones who use the ADA guidelines, which do not focus on children. He added that the American Academy of Pediatric Dentistry (AAPD) plans to have new guidelines in May. Dr. Gaskins asked Ms. Yeatts for the timeline if the Board decides to take legislative action. Ms. Yeatts said any proposed legislation must be at the Governor's office by August, 2016, so the Board would need to adopt a proposal at its June business meeting. Ms. Reen added that amending the

regulations could either be done through a fast-track action or, if there is a controversy, the standard regulatory process which takes about two years.

Dr. Gaskins called for discussion of the current provisions in 18VAC60-21-280. Discussion on how to amend the various provisions for monitoring minimal sedation, how to create exceptions for pediatric patients, and any clinical need for requiring blood pressure, pulse oximetry, and intraoperative monitoring of vital signs. Separating nitrous oxide inhalation analgesia into a separate section of the regulations was then discussed. There was agreement that intraoperative monitoring for all nitrous oxide only and minimal sedation patients should be limited to continuous visual observation of responsiveness, color, and respiration. Ms. Yeatts facilitated a review of the minimal sedation provisions to identify the content for the new section.

Ms. Reen asked if the subcommittee wanted to schedule another meeting to review the draft regulatory proposal, or have it circulated for individual review. The preference was to have it circulated and to have Dr. Gaskins address the comments/edits received. Ms. Yeatts noted that it is important that everyone respond individually to only Ms. Reen.

Dr. Gaskins asked for review of the general provisions in 18VAC60-21-260 for any needed changes. It was suggested and agreed that section D.2, which addresses patient information and records, should be expanded to require recording of height and weight or, when appropriate, Body Mass Index. Ms. Yeatts agreed to include the change in the draft that will be circulated.

ADJOURNMENT: Dr. Gaskins thanked everyone for their input and adjourned the meeting at 3:37 p.m.

Charles E. Gaskins, III, President

Sandra K. Reen, Executive Director

Date

Date

Virginia Department of Health Professions

DRAFT

Full Board Meeting & Retreat

May 5, 2016
10:00 a.m. - Board Room 2
9960 Mayland Dr, Henrico, VA 23233

In Attendance	Barbara Allison-Bryan, MD, Board of Medicine
	Robert J. Catron, Citizen Member
	Helene D. Clayton-Jeter, OD, Board of Optometry
	Kevin Doyle, Ed.D., LPC, LSATP, Board of Counseling
	James D. Watkins, DDS, Board of Dentistry
	Allen R. Jones, Jr., DPT, PT
	Robert H. Logan, III, Ph.D., Citizen Member
	Martha S. Perry, MS, Citizen Member
	Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language
	J. Paul Welch, II, Board of Funeral Directors and Embalmers
	James Wells, RPH, Citizen Member
	Jacquelyn M. Tyler, RN, Citizen Member
	Trula E. Minton, MS, RN, Board of Nursing
Absent	Ryan Logan, Board of Pharmacy
	Yvonne Haynes, LCSW, Board of Social Work
	Mark Johnson, DVM
DHP Staff	David E. Brown, D.C., Director DHP
	Lisa R. Hahn, MPA, Chief Deputy Director DHP
	Elizabeth A. Carter, Ph.D., Executive Director BHP
	Elaine Yeatts, Senior Policy Analyst DHP
	Yetty Shobo, Ph.D., Deputy Executive Director BHP
	Sandy Reen, Executive Director Board of Dentistry
	Leslie Knachel, Executive Director Boards of Optometry, Audiology and Speech-Language Pathology, Veterinary Medicine
	Diane Powers, Director of Communications DHP
	Matt Treacy, Communications Associate DHP
Attorney General Rep	Charis Mitchell
Emergency Egress	Dr. Carter
Observers	Bruce Keen signed-in; two others did not.

Call to Order

Acting Chair Mr. Catron **Time** 10:00 a.m.

Quorum Established

Public Comment

Comment item: Bruce Keeney commented in favor of BHP's review of examining Chiropractors' competence to conduct physical examination of commercial driver's licensure and learner's permit applicants. He offered to provide Dr. Carter and the board extensive documentation and will welcome working with BHP.

Approval of Minutes

Presenter Mr. Catron

Discussion

The February 11, 2016 10:00 a.m. Full Board meeting minutes were approved and properly seconded. All members in favor, none opposed.

Directors Report

Presenter Dr. Brown

Discussion

Dr. Brown discussed emerging issues in DHP's arena including a meeting by state taskforce involved in heroin and drug abuse prevention. Also, he noted that CDC is reviewing guidelines on opioid prescription for pain management. He shared that new legislation will mandate pharmacists and other dispensers to report prescribed opioids within 24 hours. Further, physicians who prescribe opioids for more than 14 days must check PMP. Investigations can be made for outliers. Board of Pharmacy and Board of Medicine are currently reviewing criteria to use to identify outliers. Other plans include education and awareness efforts. One will result in a website (VAways.com) to be launched July 1, 2016. This resource website will result from collaboration among several state agencies within the Health and Human Resources secretariat, including DHP. The Board of Medicine is providing funding for this project.

Legislative and Regulatory Report

Presenter Ms. Yeatts

Discussion

Ms. Yeatts presented two documents; one including a list of emergency regulations, emergency regulatory actions, regulatory actions by APA, and non-regulatory actions related to DHP from the 2016

General Assembly and the other document included Board by Board status on regulatory actions from past legislative sessions. One exempt regulatory action under the purview of BHP was HB574 which had to do with changes in specifications of who can be considered as a dietician or nutritionist.

Communications Report

Presenter Ms. Powers and Mr. Treacy

Key to fulfilling DHP's mission is providing information to the public. Increasingly, this includes leveraging digital capabilities and developing media relations. The team presented information on new digital promotion and projects including a video highlighting the DHP Healthcare Workforce Data Center. The team is eager to work with BHP's Education Committee on recommendations for additional products.

Executive Directors Report

Presenter Dr. Carter

Agency Performance

Dr. Carter reviewed the agencies performance measures in relation to clearance rate, age of pending caseload and time to disposition. Dr. Carter noted that an internal staff committee had been formed to explore potential causes for a recent drop in meeting the time to disposition 90 day goal. An update will be provided at the next Board meeting.

Healthcare Workforce Data Center

Dr. Carter presented an overview of the Department's Healthcare Workforce Data Center. She discussed current and future projects including survey going out to Funeral Service Providers and formal membership in the Virginia Longitudinal Data System. Future projects include updating Virginia Careforce data on Tumblr site. Board members raised the need to consider ways to gather data on interns and apprenticeships formally, frequency of profession surveys, and other health professional groups to consider surveying. Dr. Carter indicated that DHP resources leverage existing licensure application and renewal processes to establish and maintain a standard census of licensed healthcare practitioners. Broader pipeline issues are addressed through the Virginia Health Workforce Development Authority in conjunction with Area Health Education Centers.

Dr. Carter noted that healthcare workforce research still remains in its infancy. There are few studies, and they are ad hoc, with inconsistent methodologies making it difficult to compare over time even within the same profession. The U.S. Health and Human Services Health Resources Services Administration (HRSA) advocates for a standard minimum data set collection approach and has funded some efforts by national-level profession-specific organizations. Problems with relatively low response rates and lack focus on the workforce in individual states and regions within states. DHP will be presenting at the September 2016 annual meeting of the Council on Licensure and Regulation on HWDC's approach and the need for states' licensing boards to consider replicating the minimum data set approach adopted in Virginia in order to improve response rates and make possible a standard census of healthcare workforce that could provide a key reference for the individual states and enable direct comparisons across states.

Sanction Reference Article

An article titled "Implementing a Sanctioning Reference System for the Virginia Board of Nursing" written by Dr. Carter and Neal Kauder has been submitted and published by the *Journal of Nursing Regulation.*

Telehealth Review

Dr. Carter discussed the comments received from the Directors of the Board of Pharmacy and the Board of Optometry, Audiology, Speech and Language Pathology, and Veterinary Medicine, on the Telehealth report submitted by Andrew Feagans and Andrea Peeks. Members discussed how to present the report on the agency's website. Dr. Jones made a motion to include a cover letter that provides a framing overview of the report, its purpose, and source and directs readers to an addendum containing comments from Executive Directors of the various boards. The motion was properly seconded by Dr. Watkins. All members were in favor, none opposed.

2016 Workplan

Dr. Carter presented the 2016 workplan.

Chiropractic Commercial Truck Driver Physicals Review

Presenter Dr. Carter

Dr. Carter presented plans for the review and asked for at least two more Board members to join the Regulatory Research Committee.

Board Reports

Presenter Mr. Catron

No reports were offered at this time.

New Business

Presenter Mr. Catron

There was no new business to discuss.

Adjourned

Adjourned 11:40 a.m.

Retreat

Presenter Dr. Carter

The main purpose of the afternoon session was to do administrative "housekeeping" for BHP relating to regulations, guidance documents, and bylaws and to provide recommendations for topic area focus going forward.

Chapter 90 of the 2016 Acts of the Assembly, HB574, will amend §54.1-2731 of the *Code of Virginia* regarding Dietitian and Nutritionist title protection to preclude the need for Board of Health Professions regulations. By acclamation, the Board recommended rescinding these existing "Regulations Governing Standards for Dietitians and Nutritionists" (§18VAC75-30-10) once the new law becomes effective July 1, 2016.

Dr. Carter discussed the Board's existing Guidance Documents and By-Laws and requested feedback on any need for amendment. The members agreed to review and discuss suggestions at the next meeting.

Mr. Catron reported the need to fill certain committee seats. Dr. Clayton-Jeter volunteered to be the Chair of the Education Committee and Dr. Allison Bryan agreed to be a member. Dr Jones volunteered to chair the Enforcement Committee with Dr. Watkins, Mr. Wells, Dr. Doyle, Ms. Minton, and Ms. Verdun joining as members. Ms. Perry, Ms. Tyler, and Mr. Welch volunteered to be on the Regulatory Research Committee. Absent members are requested to contact Mr. Catron to indicate which committee they would like to join. An issue of concern is the potential impact of member turnover on the Committees. When asked whether committees could meet electronically, Board Counsel Ms. Mitchell office reminded that such meetings are possible but must ensure public accessibility from all locations.

Regarding future focus, the Board recommended updates to board member orientation and onboarding to incorporate Education Committee recommendations. Also recommended was that the respective boards communicate the importance of the HWDC survey data they provide.

It is understood that the current online HWDC surveys are incorporated into the licensure renewal process and cannot retain previous responses. Results are downloaded with each renewal and maintained separately. However, in to help reduce the burden of completing the full survey each time, it was recommended that technical options be explored that will allow the option for update rather than total completion each time.

The Board also recommended the Virginia Health Workforce Development Authority be consulted regarding a means to measure Virginia's pipeline of future healthcare providers.

The Board encouraged reporting on telehealth-related activities by each board as well as sharing insights about emerging team approaches in primary care.

Adjourned 1:40pm.

Acting Chair Robert Catron

Signature: _____ Date: ____/____/____

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

Signature: _____ Date: ____/____/____

American Association of Dental Boards
Mid-Year Meeting
Chicago, IL
April 10th-April 11th

Common themes presented during the meeting:

- **Licensure Portability**
- **Teledentistry**
- **Licensure Examinations: Transitioning to a new licensure model**
- **The evolving dental team—New roles in the dental workforce**

Theme I: Licensure Portability

Millennials or Generation "Y" are a highly mobile group of young professionals. In general, this group can be characterized by: multiple careers, an entrepreneurial spirit, they desire flexibility, they have more than one job and change jobs every three years. In addition, this group is less likely than previous generations to practice in the same state of the dental school they attended. This new group of dental professionals is voicing concerns about licensure portability. In addition, they are choosing licensure examinations which give them the most flexibility with respect to relocation to different states.

Dr. Kathleen T. O'Loughlin, ADA Executive Director stated in a presentation:

"Obtaining a state license to practice dentistry is still a significant issue for many ADA members, especially recent grads/new dentists. Barriers to true license portability still exist. "[There are] continued disagreements among regional examination agencies and state boards."

Occupational Licensing: A Framework for Policymakers (White House Paper Published July 2015)

> "Best practices in licensing can allow States, working together or individually, to safeguard the well-being of consumers while maintaining a modernized regulatory system that meets the needs of workers and businesses. Licensing best practices include:
>
> • Limiting licensing requirements to those that address legitimate public health and safety concerns to ease the burden of licensing on workers.
>
> • Applying the results of comprehensive cost-benefit assessments of licensing laws to reduce the number of unnecessary or overly-restrictive licenses.

• Within groups of States, harmonizing regulatory requirements as much as possible, and where appropriate entering into inter-State compacts that recognize licenses from other States to increase the mobility of skilled workers.

• Allowing practitioners to offer services to the full extent of their current competency, to ensure that all qualified workers are able to offer services" (p. 11)

"Since many occupations are licensed at the State level, licensed practitioners typically have to acquire a new license when they move across States. This alone entails various procedural hurdles, such as paying fees, filling out administrative paperwork, and submitting an application and waiting for it to be processed. Moreover, since each State sets its own licensing requirements, these often vary across State lines, and licensed individuals seeking to move to another State often discover that they must meet new qualifications (such as education, experience, training, testing, etc.) if they want to continue working in their occupation. The resulting costs in both time and money can discourage people from moving or lead them to exit their occupation. This system is especially burdensome for some populations, such as military spouses, who are very likely to move across State lines. Diminished mobility generates inefficiency in the labor market, with workers unable to migrate easily to the jobs in which they are most productive. In times of economic distress, this reduced mobility would be especially harmful, as workers would have a difficult time leaving – or for some practitioners, delivering services to – hard-hit areas."(p.13)

Theme II: Teledentistry

- IDENTIFICATION: Patient, Dentist, Dentist Credentials
- TYPES OF TRANSMISSIONS: Appointments, prescriptions, refills
- CONSENT TO TREATMENT: Appropriate for teledentistry encounter
- SECURITY MEASURES: Encryption, password
- POTENTIAL RISKS TO PRIVACY
- TECHNICAL FAILURES: Hold Harmless Clause
- EXPRESS PATIENT CONSENT TO FORWARD INFORMATION

Teledentistry also brings up the question of licensure portability. Recommended the provider has a license in the state the patient resides.

AADB recommended creating policy for teledentistry as prototype for state dental boards.

Theme III: Licensure Examinations---Transitioning to a new examination model

ADEA Resolution 5H-2014

ADEA Council of Deans and ADEA Council of Allied Dental Program Directors Recommendation for a Task Force and Report Toward Elimination of the Human Subject/Patient Component of the Clinical Licensure Examination.

- Recommendation 1: Increase awareness and understanding of emerging licensure models.
- Recommendation 2: Promote further development and piloting of alternative licensure models.
- Recommendation 3: Increase understanding of the accreditation process.
- Recommendation 4: Promote research and distribution of findings from alternative licensure models.
- Recommendation 5: Publicly recognize and collaborate with others engaged in alternative licensure models.

CEBJA/ADA Policy regarding CIF

"The ADA has voiced its position regarding the use of patients in clinical examinations through a series of resolutions culminating with the adoption of the 2005 House of Delegates' Resolution 20H-2005.8-10 This resolution reaffirms ADA support for the elimination of patients in the clinical licensure examination process while giving exception to a more recent methodology for testing known as the curriculum-integrated format (CIF). The 2006 ADA House of Delegates directed the ADA Council on Dental Education and Licensure to develop a definition of CIF and present it to the 2007 House of Delegates. The 2007 House adopted the following definition (1H:2007):

Curriculum Integrated Format: An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation. If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula. All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed."

Theme IV: The evolving dental team- New roles in the dental workforce

Community Dental Health Coordinators, Job Functions

- Coordinate care: Arrange transportation

- Reduce dental anxiety/support access
- Encourage patients to complete treatment
- Enhance cultural competency
- Educate the population about prevention
- Navigate Medicaid or other dental systems of care
- Enhance productivity and integration of oral health care

Types of CDHC Community Outreach

- Elementary Schools
- Diabetes Clinics
- Pre-schools
- HIV Clinics
- Perinatal patients
- Pediatric patients
- High Schools
- Senior Outreach
- Foster Children
- Men's Outreach
- Veteran's Center
- Rehab Facilities
- Juvenile Detention
- Head Start
- WIC Clinics

Steps to Implementation of CDHC

- Informing state members and leadership of program details.
- Conference call for discussion/informative article in Journal.
- Invitation to community colleges/dental training programs.
- In person presentation at dental school or state dental association offices.
- Curriculum review by community college hygiene or assisting program.
- Promotion of curriculum and student scholarships.

Trends Impacting the Dental Hygiene Profession: Oral Health Care Team Expands

- Teledentistry
- Integration of Oral Health into Medicine

- Emphasis on interprofessional education and practice: DH employed in hospitals, nursing homes, pediatric practices
- Development of new CDT codes
- New titles or professional recognition roles: RDHAP (registered Dental Hygienist in Alternative Practice)
- ECP (Extended Care Permit), Advanced Dental Therapists

New Descriptors of Professional Relationship between Dentists and Dental Hygienists

- Collaborative Practice
- Public Health Supervision
- Dental Service Organization Employment of Dental Hygienists

Roadmap to Accreditation of Dental Therapist Programs:

CODA's standards for dental therapy education programs are the nationally accepted educational requirements for this emerging discipline.

CODA has taken no position on the merits of dental therapy as a dental profession. It believes this is an issue for each state to determine. The scope of practice is also within the purview of each state, not CODA.

Program length -- Dental therapy program curriculum must be at least three academic years of full-time instruction at post-secondary level.

For the slide presentations made by guest speakers throughout the meeting, please log onto www.dentalboards.org and select the 2016 Mid-Year Meeting tab.

Respectfully submitted by: Tonya A. Parris-Wilkins, DDS

1. The American Dental Association ("ADA"), in conjunction with the American Dental Education Association ("ADEA"), sent a letter to many state dental boards expressing a "high level of concern" with regard to the status of licensure for dentists in the U.S. and licensure portability. These two groups are concerned that many state dental boards "continue to engage in conduct that restricts, rather than enhances, that portability." The main focus of the letter was on the five clinical test administration agencies for dentistry: the Commission on Dental Competency Assessments ("CDCA" formerly "NERB"); Central Regional Dental Testing Service, Inc. ("CRDTS"); Council of Interstate Testing Agencies, Inc. ("CITA"); the Southern Regional Testing Agency, Inc. ("SRTA"); and the Western Regional Examining Board ("WREB") and the examinations administered by each. The ADA/ADEA came to the conclusion that the exams "adhere to a common set of core design and content requirements that renders them conceptually comparable." The ADA/ADEA asserted in their letter to the selected state boards of dentistry that, given the commonality of the exams, the decision of those boards that received the letter to accept the test results of only a select number of clinical test administration agencies appears "highly arbitrary" and have an "arguably anticompetitive effect in restricting the mobility of dentists." The ADA/ADEA further went on to assert that "the whole concept of licensure is currently under attack because of its inherent effect on competition" and it is "incumbent on the dental profession to ensure that any such restraints are not susceptible to a claim that they are unreasonable in nature."

Several of the dental boards that received this letter have responded back to the ADA/ADEA that although the tests appear to be "conceptually comparable," they are not. As one state pointed out "[t]here are some differences including but not limited to the grading rubric, manikin exam, periodontal exam, the type of manikin typodont and type of teeth, amongst other." Several states have also responded to the ADA/ADEA letter that it is not the function of the ADA or ADEA to determine, tell or try to suggest the requirements for licensure of dentistry to the states dental boards.

2. The topic of teledentistry is being heavily discussed in many states. The discussion in many states focuses on how to establish the dentist/patient relationship, specifically: how to take the appropriate patient history and conduction an evaluation; how to verify the patient's identity and location; ensuring the patient is aware of the provider credentials; and ensuring informed consent for the treatment. There is concern amongst the state dental boards about also having a documented diagnosis, discussion of contraindications to treatment and a discussion about underlying conditions and what medications are appropriate to prescribe in these situations. The dental boards also recognize security issues exist for teledentistry (and telemedicine) regarding identification of the patient, types of transmissions, security measures that must be taken and how to identify privacy risks.

Of interest to dental boards is an anti-trust and commerce clause case out of Texas concerning the Texas Medical Board and a company known as Teladoc. The Texas Medical Board amended a code provision to require a face-to-face physical exam, especially on an initial visit, prior to prescribing "dangerous drugs or controlled substances." Teladoc filed for a preliminary injunction because they were providing

"audio-only" consultations and then prescribing controlled substances, which was clearly in violation of the amended statute. Teladoc argued that the Texas statute was anti-competitive in nature. The district court in Texas issued the preliminary injunction against the Texas Medical Board. The Texas Medical Board has appealed the decision.

3. Related to the Virginia Board of Dentistry's mandate to promulgate regulations providing for CE credits for those dentists/dental hygienists who provide health care services, without compensation, to low-income individuals receiving services through a local health department or free clinic, the WV Board of Dentistry is updating their continuing education requirements to allow dentists to earn up to 8 hours of credit and hygienists to earn up to 5 hours of credit for providing dental care to indigent patients. The WV Board of Dentistry specifically allots one-half hour credit for every hour of documented treatment.

ADEX

American Board of Dental Examiners, Inc.

12th Annual Meeting

SAVE THE DATES

August 5, 6, 7, 2016

ADEX Quality Assurance Committee

ADEX Dental Examination Committee &

Subcommittees

ADEX Dental Hygiene Examination Committee

ADEX Board of Directors

ADEX Reception

ADEX House of Representatives

Doubletree Hotel O'Hare – Rosemont, IL

Official information will be sent in May 2016

Questions contact ADEXOFFICE@aol.com

ADEX
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Stanwood Kanna, D.D.S., President
William Pappas, D.D.S., Vice-President
Jeffery Hartsog, D.M.D., Secretary
Conrad McVea, III, D.D.S., Treasurer
Bruce Barrette, D.D.S., Past President

June 5, 2016

Dear State Board of Dentistry,

In recent years there has been a strong move to create a uniform national dental and dental hygiene licensure examination driven by the American Board of Dental Examiners (ADEX), an exam development corporation and the Regional Testing Agencies that administer the ADEX developed dental licensure examination. Currently there are 41 States, 3 US Jurisdictions and the Country of Jamaica that accept the ADEX dental licensure examination for initial licensure. This is by far the most widely accepted initial dental licensure examination in the country.

The ADEX has committed itself to designing the most comprehensive, current and ethical clinical licensure examination in dentistry. As dentistry changes in its delivery and scope so must the licensure examination. Test design and guidelines of test development are uniform in order to be valid and reliable. The challenge with dental examinations in the past has been with its delivery or administration. Having a unique and critical component of the examination that necessitates clinical performance standards on patients has been in the past more focused on student (candidate) orientation than patient centered resulting in ethical challenges. The ADEX through its newly developed Patient Centered Curriculum Integrated Format has now addressed this concern by focusing the exam format to taking care of the needs of the patient. The result has been rewarding to both the patient and the candidate.

As you familiarize yourself with this new PC-CIF format be assured that ADEX in conjunction with educators, examiners and those testing agencies that deliver the ADEX exam are constantly working to provide your state with the most comprehensive, widely accepted, valid, reliable and ethical initial licensure exam in dentistry and dental hygiene. Please do not hesitate to contact ADEX or myself if you have any questions.

Sincerely,

Stanwood H. Kanna DDS, President
American Board of Dental Examiners, Inc. (ADEX)

Enclosures

P.O. Box 50718 • Mesa, AZ 85208
Telephone (503) 724-1104
ADEXOFFICE@aol.com
www.adexexams.org

ADEX

The Patient Centered Curriculum Integrated Format (PC CIF)

This new format of the ADEX CIF examination was originally called the "Buffalo Format" because it was developed in conjunction with the University at Buffalo and the New York Board of Dentistry and was successfully piloted at the University at Buffalo in 2015. In 2016 the PC CIF is currently being offered to all dental schools that would like to host this format

The PC CIF is a modification of the Curriculum Integrated (CIF) Format that focuses on patient care needs, rather than the candidate's examination. The examination itself is the identical ADEX Licensing Examination for initial licensure in dentistry. That is the content, criteria, scoring, and performance parameters are identical no matter which format is being administered.

The American Board of Dental Examiners, Inc. (ADEX) and it's testing agencies have introduced an examination format for candidates at dental schools, which is designed to focus on patient needs to enhance the patient experience in the sections of the examination that evaluate the care provided by the candidate during the examination process.

As context for this approach, the American Dental Association (ADA) has adopted a policy that the only acceptable examination format that includes providing patient treatment is the Curriculum Integrated Format with the adoption of ADA resolution 20 H– 2005, and defined the Curriculum Integrated Format in ADA resolution 1H-2007 which is included as Appendix A.

The ADEX examination was in compliance with the 2005 resolution and substantially in compliance with the 2007 resolution. However, ADEX and it's testing agencies wanted to comply with all provisions of the ADA definition, as well as adopting an examination format that would fulfill all of the ethical concerns identified in the ADA paper entitled, *Ethical Considerations When Using Patients in the Examination Process,* which had been recently revised in May, 2013. For readers interested in the full text of this document, please see the attached document.

As part of the validity argument for continuing to use the scores and decisions from this new approach, the ADEX examination content, criteria, scoring, and performance parameters remain identical to the previous examination. However, **the new examination administration format now allows the dental school to ensure that the care provided in the examination process is done on a patient of record, and provided within an appropriately sequenced treatment plan as defined by the dental school.** The examination assessments are given multiple times within the school year, to allow for candidate remediation and retake prior to graduation as well as patient scheduling and treatment plans concerns.

Equally important, is that follow-up patient care required as a result of candidate performance is completed under the supervision of the dental school faculty, utilizing the treatment protocols and philosophy of the host dental school. Finally, the patient care provided by the dental student, during the examination process, can also be independently evaluated by the dental school faculty to fulfill the CODA required competencies, if necessary. Patient informed consent is completed for both the dental school and the testing agency throughout the process.

Keeping in mind the technical and legal requirements for licensure examinations, **this format was developed in collaboration with educators, examiners, and representatives from organized dentistry.** The goal was to balance the responsibilities of maintaining the independence of the licensure process with a focus within the examination on the needs of the patient in a continuing effort to develop the most ethical examination process possible when patient care is a component.

The administrative format differences in the PC CIF Format are:

1. Calibrated school faculty may assist candidates in selection of patients of record at the school, for the ADEX Restorative and Periodontal examinations that meet the requirements set by ADEX for the examination process. The faculty's role is to validate that the patient's proposed care is appropriate to be provided under the school's treatment planning protocols.

2. The examiners have final determination about what lesions/cases are accepted for the examination and which are not. The patient's medical status and blood pressure are always evaluated at the time of care. Additionally, the proposed care is also evaluated to validate the treatment being provided meets examination requirements.

3. Faculty and the school's protocols have the final determination *if* care will be provided. The institutional treatment protocols of the dental school will determine the timing of care and the type of care provided. For example a dental school's proposed care based on the extent of caries is preserved; so that re-mineralization and the depth of caries prior to treatment is a school decision.

4. The faculty may also evaluate the treatment provided to the patients and this may or may not be incorporated as part of a school student competency program.

5. Faculty may also enter treatment provided into the school database as it occurs during the examination as dictated by school protocol.

6. The schools faculty will determine, schedule, and supervise any patient follow-up care that may be required.

7. Candidates who are unsuccessful will have their performance explained to them by their faculty and the faculty will supervise any required patient care.

8. The exam scheduling allows for multiple school visits and candidates challenging only those parts f the examination for which they have treatment-planned patients. In this respect the examination process is scheduled over multiple visits allowing the candidate to focus on the patient's needs rather than a single examination date.

Therefore, the school may wish to have several smaller PC CIF examinations at regular intervals rather than one large Perio/Restorative Examination as in the past. This is arranged between the school and the testing agency when scheduling the examination series. The school is usually allowed to schedule the candidates and their patients for each of these smaller exams. Candidates will challenge the procedures for which the school has approved the proposed patient treatment initially, but may take any one (or more) procedures not taken the first time at a later exam. Failing procedures can also be taken at a subsequent session.

American Dental Association Council on Ethics, Bylaws and Judicial Affairs

The following information is intended to assist dental licensure candidates, as well as examiners and educators involved in the testing process, in recognizing ethical considerations when patients are part of the clinical licensure process.

Background: Dental licensure is intended to ensure that only qualified individuals are licensed to provide dental treatment to the public. Most licensing jurisdictions have three general requirements: an educational requirement-graduation from a dental education program accredited by the Commission on Dental Accreditation; a written (theoretical) examination-to determine whether the applicant has achieved the theoretical bases at a level of competence that protects the health, welfare and safety of the public; and a clinical examination in which a candidate demonstrates the clinical knowledge, skills and abilities necessary to safely practice dentistry.

Anecdotal information and experiences reported in the literature by licensees and educators have raised ethical considerations when human subjects/patients are used in the examination process.[1-6] While others disagree, it is recognized that the profession must ensure that the welfare of patients is safeguarded in every step of the clinical licensure examination process.[7]

The licensure examination process is evolving. Many clinical examination agencies continue to monitor developments for applicability and affordability of alternatives to human subjects/patients in providing valid and reliable assessment of clinical competence.

The ADA has voiced its position regarding the use of human subjects/patients in clinical examinations through a series of resolutions culminating with the adoption of the 2005 House of Delegates' Resolution 20H-2005.[8-10] This resolution reaffirms ADA support for the elimination of human subjects/patients in the clinical licensure examination process while giving exception to a more recent methodology for testing known as the curriculum-integrated format (CIF). The 2006 ADA House of Delegates directed the ADA Council on Dental Education and Licensure to develop a definition of CIF and present it to the 2007 House of Delegates. The 2007 House adopted the following definition (1H:2007):

> Curriculum Integrated Format: An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.
>
> If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.
>
> All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

Given that currently there are no new technologies that completely eliminate the use of human subjects/patients in the clinical examination processes, the ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA)[11] called on major stakeholders, including the ADA's Council on Dental Education and Licensure (CDEL), to provide input for the development of a statement that would identify key ethical considerations and provide guidance to help ensure the welfare of the patient remains paramount.

Ethical Considerations When Using Human Subjects/Patients in the Examination Process

1. Soliciting and Selecting Patients: The ADA Principles of Ethics and Code of Professional Conduct[12] (ADA Code), Section 3, Principle: Beneficence states that the "dentist's primary obligation is service to the patient" and to provide "competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration given to the needs, desires and values of the patient." The current examination processes require candidates to perform restorative and periodontal treatments on patients. In light of the principle stated above, this may create an ethical dilemma for the candidate when seeking patients to sit for the exam. Candidates should refrain from the following:
    1. Reimbursements between candidates and patients in excess of that which would be considered reasonable (remuneration for travel, lodging and meals).
    2. Remuneration for acquiring patients between licensure applicants.
    3. Utilizing patient brokering companies.
    4. Delaying treatment beyond that which would be considered acceptable in a typical treatment plan (e.g. delaying treatment of a carious lesion for 24 months).

2. Patient Involvement and Consent: The ADA Code, Section 1, Principle: Patient Autonomy states that "the dentist's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient's needs, desires and abilities." Candidates and dental examiners support patient involvement in the clinical examination process by having a written consent form that minimally contains the following basic elements:
    1. A statement that the patient is a participant in a clinical licensure examination, that the candidate is not a licensed dentist, a description of the procedures to be followed and an explanation that the care received might not be complete.
    2. A description of any reasonably foreseeable risks or discomforts to the patient.
    3. A description of any benefits to the patient or to others which may reasonably be expected as a result of participation.
    4. A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the patient.
    5. An explanation of whom to contact for answers to pertinent questions about the care received.
    6. A statement that participation is voluntary and that the patient may discontinue participation at any time without penalty or loss of benefits to which the patient is otherwise entitled.

3. Patient Care: The ADA Code, Section 3, Principle: Beneficence states that the dentist has a "duty to promote the patient's welfare." Candidates can do this by ensuring that the interests of their patient are of primary importance while taking the exam. Examiners contribute to this by ensuring that candidates are adequately monitored during the exam process such that the following treatment does not occur:
    1. Unnecessary treatment of incipient caries.
    2. Unnecessary patient discomfort.
    3. Unnecessarily delaying examination and treatment during the test.

4. Follow-Up Treatment: The ADA Code, Section 2, Principle: Nonmaleficence states that "professionals have a duty to protect the patient from harm." To ensure that the patient's oral health is not jeopardized in the event that he/she requires follow-up care, candidates and dental examiners should make certain that the patient receives the following:
    1. A clear explanation of what treatment was performed as well as what follow-up care may be necessary.
    2. Contact information for pain management.
    3. Complete referral information for patients in need of additional dental care.
    4. Complete follow-up care ensured by the mechanism established by the testing agency to address care given during the examination that may need additional attention.

Sources:

1. Dr. Lloyd A. George Nov. 3, 2005 Letter to Dr. James W. Antoon, chair CEBJA
2. CEBJA March 2, 2006 Strategic Issue Discussion – Use of Patients in Clinical Licensure Examinations
3. Richard R. Ranney, D.D.S., et al., "A Survey of Deans and ADEA Activities on Dental Licensure Issues" Journal of Dental Education, October 2003
4. Allan J. Formicola, D.D.S., et al., "Banning Live Patients as Test Subjects on Licensing Examinations," Journal of Dental Education, May 2002
5. "The Agenda for Change," Objectives Developed at the Invitational Conference for Dental Clinical Testing Agencies by representatives of the clinical testing agencies and other organizations with an interest in dental licensure sponsored by the American Dental Association. It is considered informational and does not represent policy of the ADA. March 4, 1997
6. ASDA Resolution 202RC-2005, Revision of Policy L-1 Initial Licensure Pathways
7. Position Statement of the American Association of Dental Examiners in Response to ADA Resolution 64H, Oct. 12, 2001
8. ADA HOD Resolution 34-2006, Definition of Curriculum Integrated Format
9. ADA HOD Resolution 20H-2005, Elimination of the Use of Human Subjects in Clinical Licensure/Board Examinations
10. ADA House of Delegates (HOD) Resolution 64H-2000, Elimination of the Use of Human Subjects in Clinical Licensing/Board Examinations
11. CEBJA is the ADA agency responsible for providing guidance and advice and for formulating and disseminating materials on ethical and professional conduct in the practice and promotion of dentistry.
12. The entire text of the ADA Principles of Ethics and Code of Professional Conduct can be found on the ADA website at www.ada.org.

October 2008

UNAPPROVED

BOARD OF DENTISTRY
MINUTES OF REGULATORY–LEGISLATIVE COMMITTEE
Friday, May 6, 2016

TIME AND PLACE:	The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order on May 6, 2016 at 9:00 a.m. at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 3, Henrico, Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., Chair
COMMITTEE MEMBERS PRESENT:	John M. Alexander, D.D.S. Tonya A. Parris-Wilkins, D.D.S. Bruce S. Wyman, D.M.D.
OTHER BOARD MEMBERS PRESENT:	Charles E. Gaskins, III, D.D.S., Ex-Officio Al Rizkalla, D.D.S. Carol Russek, J.D., Citizen Member Tammy K. Swecker, R.D.H.
ESTABLISHMENT OF QUORUM:	All members of the Committee were present.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Executive Director Huong Q. Vu, Operations Manager Elaine Yeatts, DHP Policy Analyst
OTHER PRESENT:	James E. Rutkowski, Assistant Attorney General
PUBLIC COMMENT:	None
APPROVAL OF MINUTES:	Ms. Swain asked if Committee members had reviewed the February 12, 2016 minutes. Two grammatical corrections were agreed to by consensus and the minutes were approved as amended.
STATUS REPORT ON LEGISLATION AND REGULATORY ACTIONS:	Ms. Yeatts reported that the Board has two regulatory actions at the Secretary's office for review: one to require capnography equipment for monitoring anesthesia or sedation; and the other to amend 18VAC60-21-230 to be consistent with statutory requirements for a faculty license.
RECOMMENDATION ON PUBLIC PARTICIPATION GUIDELINES (PPG):	Ms. Yeatts advised that section 18VAC60-11-50 of the Board's regulations for public participation need to be amended to include a Code change which permits a person to be accompanied or represented by counsel at public comment opportunities. She asked the Committee to

advance this recommendation to the Board for adoption as a fast track action. Dr. Wyman moved to accept Ms. Yeatts' request. The motion was seconded and passed.

RECOMMENDATION ON THE AMENDMENT TO ALLOW VOLUNTEER HOURS TO COUNT TOWARD CE REQUIREMENTS (HB319):

Ms. Yeatts stated that HB319, as passed by the 2016 General Assembly, requires the Board to amend its regulations to provide continuing education credit (CE) to licensees who volunteer at a local health department or a free clinic. She offered proposed language to amend 18VAC60-21-250.5 and 18VAC60-25-190.3 and asked the Committee to recommend the number of hours that could be earned for what amount of service.

Discussion followed about the maximum number of hours that could be earned for volunteer activities and the number of volunteer hours needed to earn one hour of CE. Points of discussion included the purpose of CE is to address clinical competence; voluntary practice does not address competence; reasonable credit should be allowed to promote volunteer services; and volunteer hours must be documented by the host/sponsor for the volunteer activity to count toward the Board's CE requirement. Following consideration of several proposals, Dr. Wyman moved to recommend a maximum of two CE credits per renewal year. The motion was seconded and passed. Dr. Wyman moved to recommend requiring three documented volunteer hours for one hour of credit. The motion was seconded and passed.

RECOMMENDATION ON EXPANDING THE EXEMPTION FOR REGISTRATION REQUIREMENTS TO MOBILE DENTAL CLINICS OPERATED BY THE FEDERALLY QUALIFIED HEALTH CENTERS, AND FREE HEALTH CLINICS OR HEALTH SAFETY NET CLINICS (HB310):

Ms. Yeatts stated that HB310, as passed by the 2016 General Assembly, expands the exemptions for registration requirements to include mobile dental clinics operated by federally qualified health centers, free health clinics, and health safety net clinics. She reviewed her proposal to amend 18VAC60-21-430, which can be done as an exempt action and asked the Committee to advance the recommendation to the Board for adoption.

The fifth exemption for clinics serving non-ambulatory people was discussed as having the potential for abuse and inconsistency with standards for practice. Ms. Yeatts said the Board cannot delete or edit this provision because it is the language passed by the General Assembly. The 30 mile radius was questioned and Ms. Yeatts again explained that it could not be changed because it is established as law. Dr.

Wyman move to recommend the proposal as presented to the Board for adoption as an exempt action. The motion was seconded and passed.

RECOMMENDATION ON THE REQUIREMENTS OF THE REMOTE SUPERVISION OF DENTAL HYGIENISTS TO IMPLEMENT SB712:

Ms. Yeatts stated that SB712, as passed by the 2016 General Assembly, allows dental hygienists who are employed by a dentist to practice under remote supervision in free clinics and federally qualified health centers. She added that the required emergency regulations must be in effect within 280 days of enactment. She said the statute is very detailed and will be the primary reference so the proposed regulations include only the provisions needed to acknowledge the new practice model. She also offered a proposed guidance document which addresses the provisions for remote supervision in a question and answer format. She then reviewed the proposed regulatory language which includes:

- adding the definition of "remote supervision" to 18VAC60-21-10 and 18VAC60-25-10; and
- adding references to the Code in 18VAC60-21-140.C and in 18VAC60-25-60 to include the remote supervision as an option in the provisions for delegation to dental hygienists.

She added that questions had been raised about having an exemption from the mobile clinic registration requirement for dental hygienists to practice under remote supervision. She said this is not a required change but, for purposes of discussion, she added language in 18VAC60-21-430.

Discussion followed with agreement that:

- the definition of "remote supervision" in the Code for the Virginia Department of Health model should also be included in the definitions section to avoid confusion about the two meanings of the term; and
- the new recordkeeping requirements for dental hygienists practicing under remote supervision should be added in18VAC60-25-110.

The consultation requirement for a dental hygienist to provide hygiene services to patients with periodontal disease raised concerns. Addressing the level of disease that would require consultation was considered but not pursued based on advice of counsel. The limitation that only dental hygienists employed by a dentist can practice under the new definition and the ratio of dentist to dental hygienist were discussed without any action taken.

A motion made by Dr. Wyman to strike the proposed exemption for mobile clinic registration in 18VAC60-21-430 was seconded. In discussion, it was agreed that the new exemptions added by passage of HB 310 addresses the settings where dental hygienists might practice under remote supervision so the proposed exemption was not needed. The motion passed.

Ms. Yeatts reviewed the draft guidance document she prepared, *Guidance for Practice of a Dental Hygienist under Remote Supervision*. Ms. Reen asked that it clearly reference section F of §54.1-2722 since it only addresses the private practice model. It was agreed to present this draft at the June Board meeting for discussion.

Dr. Alexander moved to advance the emergency regulations as amended to the Board for discussion at the June meeting and adoption at its September meeting. The motion was seconded and passed.

NEXT MEETING: Ms. Swain reminded the Committee that it is scheduled to meet on Friday, October 14, 2016.

ADJOURNMENT: With all business concluded, Ms. Swain adjourned the meeting at 11:06 a.m.

Melanie C. Swain, R.D.H., Chair

Sandra K. Reen, Executive Director

Date

Date

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of May 24, 2016)

Chapter		Action / Stage Information
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Requirement for capnography for monitoring anesthesia or sedation [Action 4411]
		Proposed - *At Secretary's Office for 29 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Qualifications for restricted or temporary licenses [Action 4504]
		Fast-Track - *At Governor's Office for 5 days*

Agenda Item: Board action on Administration of Nitrous Oxide

Included in your agenda package are:

Copy of draft regulation

Staff Note:

A subcommittee of the Regulatory/Legislative Committee met on April 27, 2016 to consider separate regulations for minimal sedation and administration of nitrous only. Advisors to the subcommittee were invited to participate (see minutes in agenda package)

Board action:

To adopt the amendments as recommended by the subcommittee as a fast-track action

Project 4690 - none

BOARD OF DENTISTRY

Administration of nitrous oxide

Part I

General Provisions

18VAC60-21-10. Definitions.

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

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

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

"ADA" means the American Dental Association.

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

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

"Code" means the Code of Virginia.

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

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

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

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

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

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

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

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

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

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

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

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, or (iii) preparing the patient for dismissal following treatment.

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

"Analgesia" means the diminution or elimination of pain."

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

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

"Enteral" means any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).

"General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently

maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

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

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

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

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes "anxiolysis" (the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness) and includes "inhalation analgesia" ~~(the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness)~~ when used in combination with any anxiolytic agent administered prior to or during a procedure.

"Moderate sedation" (see the definition of conscious/moderate sedation).

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

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

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

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

Part VI

Controlled Substances, Sedation, and Anesthesia

18VAC60-21-260. General provisions.

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

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

C. Patient evaluation required.

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Review of medical history and current conditions, including the patient's weight and height or, if appropriate, the Body Mass Index (BMI);

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

4. Preoperative vital signs;

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

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

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

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

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

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

H. Emergency management.

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

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

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

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

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

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

K. Patient monitoring.

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

2. The person monitoring the patient shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Delegation of administration.

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

a. A dentist;

b. An anesthesiologist;

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

d. A dental hygienist with the training required by 18VAC60-25-90 B or C and under indirect supervision; or

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

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

a. A dental hygienist with the training required by 18VAC60-25-90 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

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

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

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

2. Mechanical (hand) respiratory bag; and

3. Suction apparatus.

E. Required staffing.

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

F. Monitoring requirements.

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

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

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

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

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

G. Discharge requirements.

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

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

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

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

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

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

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

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

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

C. Delegation of administration.

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

a. A dentist;

b. An anesthesiologist;

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

d. A dental hygienist with the training required by 18VAC60-25-90 B or C only for administration of nitrous oxide/oxygen and under ~~indirect~~ direct supervision; or

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

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

a. A dental hygienist with the training required by 18VAC60-25-90 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

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

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

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

1. Blood pressure monitoring equipment;

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

3. Mechanical (hand) respiratory bag;

4. Suction apparatus; and

5. Pulse oximeter.

E. Required staffing.

~~1.~~ The treatment team for minimal sedation ~~other than just inhalation of nitrous oxide/oxygen~~ shall consist of the dentist and a second person in the operatory with the patient to assist the dentist and monitor the patient. The second person shall be a licensed health care professional or a person qualified in accordance with 18VAC60-21-260 I~~; or~~

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

F. Monitoring requirements.

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

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

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

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

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

G. Discharge requirements.

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

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

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

Project 4690 - none

BOARD OF DENTISTRY

Administration of nitrous oxide

Part I

General Provisions

18VAC60-21-10. Definitions.

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

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

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

"ADA" means the American Dental Association.

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

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

"Code" means the Code of Virginia.

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

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

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

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

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

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

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

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

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

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

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

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, or (iii) preparing the patient for dismissal following treatment.

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

"Analgesia" means the diminution or elimination of pain."

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

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

"Enteral" means any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).

"General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently

maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

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

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

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

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes "anxiolysis" (the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness) and includes "inhalation analgesia" ~~(the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness)~~ when used in combination with any anxiolytic agent administered prior to or during a procedure.

"Moderate sedation" (see the definition of conscious/moderate sedation).

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

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

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

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

Part VI

Controlled Substances, Sedation, and Anesthesia

18VAC60-21-260. General provisions.

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

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

C. Patient evaluation required.

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Review of medical history and current conditions, including the patient's weight and height or, if appropriate, the Body Mass Index (BMI);

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

4. Preoperative vital signs;

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

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

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

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

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

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

H. Emergency management.

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

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

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

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

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

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

K. Patient monitoring.

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

2. The person monitoring the patient shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Delegation of administration.

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

a. A dentist;

b. An anesthesiologist;

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

d. A dental hygienist with the training required by 18VAC60-25-90 B or C and under indirect supervision; or

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

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

a. A dental hygienist with the training required by 18VAC60-25-90 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

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

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

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

2. Mechanical (hand) respiratory bag; and

3. Suction apparatus.

E. Required staffing.

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

F. Monitoring requirements.

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

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

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

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

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

G. Discharge requirements.

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

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

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

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

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

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

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

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

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

C. Delegation of administration.

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

a. A dentist;

b. An anesthesiologist;

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

d. A dental hygienist with the training required by 18VAC60-25-90 B or C only for administration of nitrous oxide/oxygen and under ~~indirect~~ direct supervision; or

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

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

a. A dental hygienist with the training required by 18VAC60-25-90 C to parenterally administer Schedule VI local anesthesia to persons 18 years of age or older; or

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

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

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

1. Blood pressure monitoring equipment;

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

3. Mechanical (hand) respiratory bag;

4. Suction apparatus; and

5. Pulse oximeter.

E. Required staffing.

~~1.~~ The treatment team for minimal sedation ~~other than just inhalation of nitrous oxide/oxygen~~ shall consist of the dentist and a second person in the operatory with the patient to assist the dentist and monitor the patient. The second person shall be a licensed health care professional or a person qualified in accordance with 18VAC60-21-260 I~~; or~~

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

F. Monitoring requirements.

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

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

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

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

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

G. Discharge requirements.

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

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

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

Agenda Item: Board action on Public Participation Guidelines (PPG)

Included in your agenda package are:

A copy of the applicable law in the Administrative Process Act (APA)

A copy of the applicable section of the Board's PPG regulations

Staff Note:

The action to conform the regulation to language in the Code is a recommendation from the Regulation Committee.

Board action:

To adopt the amendment to 18VAC60-11-50 as recommended.

Code of Virginia
Title 2.2. Administration of Government
Chapter 40. Administrative Process Act

§ 2.2-4007.02. Public participation guidelines.

A. Public participation guidelines for soliciting the input of interested parties in the formation and development of its regulations shall be developed, adopted, and used by each agency pursuant to the provisions of this chapter. The guidelines shall set out any methods for the identification and notification of interested parties and any specific means of seeking input from interested persons or groups that the agency intends to use in addition to the Notice of Intended Regulatory Action. The guidelines shall set out a general policy for the use of standing or ad hoc advisory panels and consultation with groups and individuals registering interest in working with the agency. Such policy shall address the circumstances in which the agency considers the panels or consultation appropriate and intends to make use of the panels or consultation.

B. In formulating any regulation, including but not limited to those in public assistance and social services programs, the agency pursuant to its public participation guidelines shall afford interested persons an opportunity to (i) submit data, views, and arguments, either orally or in writing, to the agency, to include an online public comment forum on the Virginia Regulatory Town Hall, or other specially designated subordinate and (ii) be accompanied by and represented by counsel or other representative. However, the agency may begin drafting the proposed regulation prior to or during any opportunities it provides to the public to submit comments.

2007, cc. 873, 916; 2012, c. 795.

Project 4681 - none

BOARD OF DENTISTRY

Conformity to Code

Part III

Public Participation Procedures

18VAC60-11-50. Public comment.

A. In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to (i) submit data, views, and arguments, either orally or in writing, to the agency; and (ii) be accompanied by and represented by counsel or other representative. Such opportunity to comment shall include an online public comment forum on the Town Hall.

1. To any requesting person, the agency shall provide copies of the statement of basis, purpose, substance, and issues; the economic impact analysis of the proposed or fast-track regulatory action; and the agency's response to public comments received.

2. The agency may begin crafting a regulatory action prior to or during any opportunities it provides to the public to submit comments.

B. The agency shall accept public comments in writing after the publication of a regulatory action in the Virginia Register as follows:

1. For a minimum of 30 calendar days following the publication of the notice of intended regulatory action (NOIRA).

2. For a minimum of 60 calendar days following the publication of a proposed regulation.

3. For a minimum of 30 calendar days following the publication of a reproposed regulation.

4. For a minimum of 30 calendar days following the publication of a final adopted regulation.

5. For a minimum of 30 calendar days following the publication of a fast-track regulation.

6. For a minimum of 21 calendar days following the publication of a notice of periodic review.

7. Not later than 21 calendar days following the publication of a petition for rulemaking.

C. The agency may determine if any of the comment periods listed in subsection B of this section shall be extended.

D. If the Governor finds that one or more changes with substantial impact have been made to a proposed regulation, he may require the agency to provide an additional 30 calendar days to solicit additional public comment on the changes in accordance with § 2.2-4013 C of the Code of Virginia.

E. The agency shall send a draft of the agency's summary description of public comment to all public commenters on the proposed regulation at least five days before final adoption of the regulation pursuant to § 2.2-4012 E of the Code of Virginia.

Agenda Item: Board action on Continuing Education Regulations

Included in your agenda package are:

A copy of HB319 of the 2016 General Assembly

A copy of the statutory authority in Chapter 27 of Title 54.1 to establish continuing education requirements

A copy of the DRAFT regulations as recommended by the Regulation Committee

Staff Note:

The legislation requires promulgation of regulations to allow some volunteer service time to count towards meeting CE requirements. The mandate does not take effect until January 1, 2017, but the Board has general statutory authority to promulgate regulations for continuing education and can take action at this meeting.

Board action:

1) **To adopt the amendments to Chapter 21 (Dentistry) and Chapter 25 (Dental Hygiene) as recommended for fast-track action; or**
2) **To modify the amendments recommended by the Committee and adopt a fast-track action; or**
3) **To delay action until the September meeting.**

2016 SESSION

CHAPTER 82

An Act to amend and reenact § 54.1-2400 of the Code of Virginia, relating to continuing education requirements; volunteer health services.

[H 319]
Approved March 1, 2016

Be it enacted by the General Assembly of Virginia:

1. That § **54.1-2400** of the Code of Virginia is amended and reenacted as follows:

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

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

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

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

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

4. To establish schedules for renewals of registration, certification, licensure, and the issuance of a multistate licensure privilege.

5. To levy and collect fees for application processing, examination, registration, certification or licensure or the issuance of a multistate licensure privilege and renewal that are sufficient to cover all expenses for the administration and operation of the Department of Health Professions, the Board of Health Professions and the health regulatory boards.

6. To promulgate regulations in accordance with the Administrative Process Act (§ **2.2-4000** et seq.) ~~which~~ *that* are reasonable and necessary to administer effectively the regulatory system, *which shall include provisions for the satisfaction of board-required continuing education for individuals registered, certified, licensed, or issued a multistate licensure privilege by a health regulatory board through delivery of health care services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those health services.* Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ **54.1-100** et seq.) and Chapter 25 (§ **54.1-2500** et seq.) ~~of this title~~.

7. To revoke, suspend, restrict, or refuse to issue or renew a registration, certificate, license or multistate licensure privilege which such board has authority to issue for causes enumerated in applicable law and regulations.

8. To appoint designees from their membership or immediate staff to coordinate with the Director and the Health Practitioners' Monitoring Program Committee and to implement, as is necessary, the provisions of Chapter 25.1 (§ **54.1-2515** et seq.) of this title. Each health regulatory board shall appoint one such designee.

9. To take appropriate disciplinary action for violations of applicable law and regulations, and to accept, in their discretion, the surrender of a license, certificate, registration or multistate licensure privilege in lieu of disciplinary action.

10. To appoint a special conference committee, composed of not less than two members of a health regulatory board or, when required for special conference committees of the Board of Medicine, not less than two members of the Board and one member of the relevant advisory board, or, when required for special conference committees of the Board of Nursing, not less than one member of the Board and one member of the relevant advisory board, to act in accordance with § **2.2-4019** upon receipt of information that a practitioner or permit holder of the appropriate board may be subject to disciplinary action or to consider an

application for a license, certification, registration, permit or multistate licensure privilege in nursing. The special conference committee may (i) exonerate; (ii) reinstate; (iii) place the practitioner or permit holder on probation with such terms as it may deem appropriate; (iv) reprimand; (v) modify a previous order; (vi) impose a monetary penalty pursuant to § **54.1-2401**, (vii) deny or grant an application for licensure, certification, registration, permit, or multistate licensure privilege; and (viii) issue a restricted license, certification, registration, permit or multistate licensure privilege subject to terms and conditions. The order of the special conference committee shall become final 30 days after service of the order unless a written request to the board for a hearing is received within such time. If service of the decision to a party is accomplished by mail, three days shall be added to the 30-day period. Upon receiving a timely written request for a hearing, the board or a panel of the board shall then proceed with a hearing as provided in § **2.2-4020**, and the action of the committee shall be vacated. This subdivision shall not be construed to limit the authority of a board to delegate to an appropriately qualified agency subordinate, as defined in § **2.2-4001**, the authority to conduct informal fact-finding proceedings in accordance with § **2.2-4019**, upon receipt of information that a practitioner may be subject to a disciplinary action. The recommendation of such subordinate may be considered by a panel consisting of at least five board members, or, if a quorum of the board is less than five members, consisting of a quorum of the members, convened for the purpose of issuing a case decision. Criteria for the appointment of an agency subordinate shall be set forth in regulations adopted by the board.

11. To convene, at their discretion, a panel consisting of at least five board members or, if a quorum of the board is less than five members, consisting of a quorum of the members to conduct formal proceedings pursuant to § **2.2-4020**, decide the case, and issue a final agency case decision. Any decision rendered by majority vote of such panel shall have the same effect as if made by the full board and shall be subject to court review in accordance with the Administrative Process Act. No member who participates in an informal proceeding conducted in accordance with § **2.2-4019** shall serve on a panel conducting formal proceedings pursuant to § **2.2-4020** to consider the same matter.

12. To issue inactive licenses or certificates and promulgate regulations to carry out such purpose. Such regulations shall include, but not be limited to, the qualifications, renewal fees, and conditions for reactivation of licenses or certificates.

13. To meet by telephone conference call to consider settlement proposals in matters pending before special conference committees convened pursuant to this section, or matters referred for formal proceedings pursuant to § **2.2-4020** to a health regulatory board or a panel of the board or to consider modifications of previously issued board orders when such considerations have been requested by either of the parties.

14. To request and accept from a certified, registered or licensed practitioner or person holding a multistate licensure privilege to practice nursing, in lieu of disciplinary action, a confidential consent agreement. A confidential consent agreement shall be subject to the confidentiality provisions of § **54.1-2400.2** and shall not be disclosed by a practitioner. A confidential consent agreement shall include findings of fact and may include an admission or a finding of a violation. A confidential consent agreement shall not be considered either a notice or order of any health regulatory board, but it may be considered by a board in future disciplinary proceedings. A confidential consent agreement shall be entered into only in cases involving minor misconduct where there is little or no injury to a patient or the public and little likelihood of repetition by the practitioner. A board shall not enter into a confidential consent agreement if there is probable cause to believe the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients or (ii) conducted his practice in such a manner as to be a danger to the health and welfare of his patients or the public. A certified, registered or licensed practitioner who has entered into two confidential consent agreements involving a standard of care violation, within the 10-year period immediately preceding a board's receipt of the most recent report or complaint being considered, shall receive public discipline for any subsequent violation within the 10-year period unless the board finds there are sufficient facts and circumstances to rebut the presumption that the disciplinary action be made public.

15. When a board has probable cause to believe a practitioner is unable to practice with reasonable skill and safety to patients because of excessive use of alcohol or drugs or physical or mental illness, the board, after preliminary investigation by an informal fact-finding proceeding, may direct that the practitioner submit to a mental or physical examination. Failure to submit to the examination shall constitute grounds for disciplinary action. Any practitioner affected by this subsection shall be afforded reasonable opportunity to demonstrate that he is competent to practice with reasonable skill and safety to patients. For the purposes of this subdivision, "practitioner" shall include any person holding a multistate licensure privilege to practice nursing.

2. That the provisions of this act shall become effective on January 1, 2017.

§ 54.1-2709. License; application; qualifications; examinations.

A. No person shall practice dentistry unless he possesses a current valid license from the Board of Dentistry…

E. The Board shall promulgate regulations requiring continuing education for any dental license renewal or reinstatement. The Board may grant extensions or exemptions from these continuing education requirements.

§ 54.1-2729. Continuing education.

The Board shall promulgate regulations requiring continuing education for any dental hygienist license renewal or reinstatement. The Board may grant exceptions or exemptions from these continuing education requirements.

Project 4716 - none

BOARD OF DENTISTRY

Volunteer hours for CE

18VAC60-21-250. Requirements for continuing education.

A. A dentist shall complete a minimum of 15 hours of continuing education, which meets the requirements for content, sponsorship, and documentation set out in this section, for each annual renewal of licensure except for the first renewal following initial licensure and for any renewal of a restricted volunteer license.

1. All renewal applicants shall attest that they have read and understand and will remain current with the laws and regulations governing the practice of dentistry and dental hygiene in Virginia.

2. A dentist shall maintain current training certification in basic cardiopulmonary resuscitation with hands-on airway training for health care providers or basic life support unless he is required by 18VAC60-21-290 or 18VAC60-21-300 to hold current certification in advanced life support with hands-on simulated airway and megacode training for health care providers.

3. A dentist who administers or monitors patients under general anesthesia, deep sedation, or conscious/moderate sedation shall complete four hours every two years of approved continuing education directly related to administration and monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.

4. Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.

5. Up to two hours of the 15 hours required for annual renewal may be satisfied through delivery of dental services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.

B. To be accepted for license renewal, continuing education programs shall be directly relevant to the treatment and care of patients and shall be:

1. Clinical courses in dentistry and dental hygiene; or

2. Nonclinical subjects that relate to the skills necessary to provide dental or dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, and stress management). Courses not acceptable for the purpose of this subsection include, but are not limited to, estate planning, financial planning, investments, business management, marketing, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any course, to include audio and video presentations, that meets the requirements in subsection B of this section and is given by one of the following sponsors:

1. The American Dental Association and the National Dental Association, their constituent and component/branch associations, and approved continuing education providers;

2. The American Dental Hygienists' Association and the National Dental Hygienists Association, and their constituent and component/branch associations;

3. The American Dental Assisting Association and its constituent and component/branch associations;

4. The American Dental Association specialty organizations and their constituent and component/branch associations;

5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;

6. The Academy of General Dentistry, its constituent and component/branch associations, and approved continuing education providers;

7. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Healthcare Organizations;

8. The American Heart Association, the American Red Cross, the American Safety and Health Institute, and the American Cancer Society;

9. A medical school accredited by the American Medical Association's Liaison Committee for Medical Education;

10. A dental, dental hygiene, or dental assisting program or advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association;

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic Education and Research Foundation;

14. The Dental Assisting National Board and its affiliate, the Dental Auxiliary Learning and Education Foundation; or

15. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, Council of Interstate Testing Agencies, or Western Regional Examining Board) when serving as an examiner.

D. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted prior to renewal of the license.

E. A licensee is required to verify compliance with the continuing education requirements in his annual license renewal. Following the renewal period, the board may conduct an audit of licensees to verify compliance. Licensees selected for audit must provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

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

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

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

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

18VAC60-25-190. Requirements for continuing education.

A. In order to renew an active license, a dental hygienist shall complete a minimum of 15 hours of approved continuing education. Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.

1. A dental hygienist shall be required to maintain evidence of successful completion of a current hands-on course in basic cardiopulmonary resuscitation for health care providers.

2. A dental hygienist who monitors patients under general anesthesia, deep sedation, or conscious/moderate sedation shall complete four hours every two years of approved continuing education directly related to monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.

3. Up to two hours of the 15 hours required for annual renewal may be satisfied through delivery of dental hygiene services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.

B. An approved continuing education program shall be relevant to the treatment and care of patients and shall be:

1. Clinical courses in dental or dental hygiene practice; or

2. Nonclinical subjects that relate to the skills necessary to provide dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, risk management, and recordkeeping). Courses not acceptable for the purpose of this subsection include, but are not limited to, estate planning, financial planning, investments, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any course, to include audio and video presentations, that meets the requirements in subdivision B 1 of this section and is given by one of the following sponsors:

1. The American Dental Association and the National Dental Association and their constituent and component/branch associations;

2. The American Dental Hygienists' Association and the National Dental Hygienists Association and their constituent and component/branch associations;

3. The American Dental Assisting Association and its constituent and component/branch associations;

4. The American Dental Association specialty organizations and their constituent and component/branch associations;

5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;

6. The Academy of General Dentistry and its constituent and component/branch associations;

7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;

8. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Healthcare Organizations;

9. The American Heart Association, the American Red Cross, the American Safety and Health Institute, and the American Cancer Society;

10. A medical school accredited by the American Medical Association's Liaison Committee for Medical Education or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association;

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic Education and Research Foundation;

14. The Dental Assisting National Board and its affiliate, the Dental Auxiliary Learning and Education Foundation;

15. The American Academy of Dental Hygiene, its constituent and component/branch associations; or

16. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, Council of Interstate Testing Agencies, or Western Regional Examining Board) when serving as an examiner.

D. Verification of compliance.

1. All licensees are required to verify compliance with continuing education requirements at the time of annual license renewal.

2. Following the renewal period, the board may conduct an audit of licensees to verify compliance.

3. Licensees selected for audit shall provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

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

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

E. Exemptions.

1. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following the licensee's initial licensure.

2. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted at least 30 days prior to the deadline for renewal.

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

Agenda Item: Board Discussion on Regulations for Remote Supervision

Included in your agenda package are:

A copy of the SB712 of the 2016 General Assembly

A copy of DRAFT regulations recommended by the Regulation Committee

A copy of DRAFT guidance (questions and answers) for implementation of remote supervision

Staff Note:

The 2nd enactment of SB712 requires adoption of emergency regulations. Since that must be done after July 1st (the effective date of the law), the Board will have to adopt regulations in September, but the Regulation Committee recommended a presentation at the June meeting to allow time for discussion and consideration of provisions of the law and regulation.

Board action:

No action will be requested at this meeting; the recommended language is on the agenda for discussion.

2016 SESSION

CHAPTER 497

*An Act to amend and reenact §§ **54.1-2722** and **54.1-2724** of the Code of Virginia, relating to dental hygienists; practicing under remote supervision.*

[S 712]

Approved March 25, 2016

Be it enacted by the General Assembly of Virginia:

1. That §§ **54.1-2722** and **54.1-2724** of the Code of Virginia are amended and reenacted as follows:

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

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

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

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

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

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

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

~~For the purposes of this section, "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 hygiene services are being provided.~~

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

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

hygienist when dental hygiene services are being provided.

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

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

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

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

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

Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal or written permission of any dentist who has treated the patient in the previous 12 months and can be identified by the patient.

After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision shall consult with the supervising dentist prior to providing further dental hygiene services if such patient is medically compromised or has periodontal disease.

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

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

§ **54.1-2724.** Limitations on the employment of dental hygienists.

The Board shall determine by regulation ~~how many~~ *the total number of* dental hygienists, *including dental hygienists under general supervision and dental hygienists under remote supervision, who* may work at one time for a dentist. *No dentist shall employ more than two dental hygienists who practice under remote supervision at one time.* The State Board of Health may employ the necessary number of hygienists in public school dental clinics, subject to regulations of the Board.

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

Project 4680 - none

BOARD OF DENTISTRY

Remote supervision

Part I

General Provisions

18VAC60-21-10. Definitions.

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

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

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

"ADA" means the American Dental Association.

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

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

"Code" means the Code of Virginia.

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

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

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

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

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

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

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

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

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

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

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

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, or (iii) preparing the patient for dismissal following treatment.

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

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

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

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

"Enteral" means any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).

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

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

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

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

consciousness) and includes "inhalation analgesia" (the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness).

"Moderate sedation" (see the definition of conscious/moderate sedation).

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

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

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

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

18VAC60-21-140. Delegation to dental hygienists.

A. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:

1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers, with any sedation or anesthesia administered.

2. Performing 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 the diagnosis.

3. Administering nitrous oxide or local anesthesia by dental hygienists qualified in accordance with the requirements of 18VAC60-25-100.

B. The following duties shall only be delegated to dental hygienists and may be performed under indirect supervision or may be delegated by written order in accordance with §§ 54.1-2722 D and 54.1-3408 J of the Code to be performed under general supervision:

1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers with or without topical oral anesthetics.

2. Polishing of natural and restored teeth using air polishers.

3. Performing a clinical examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets, or other abnormal conditions for further evaluation and diagnosis by the dentist.

4. Subgingival irrigation or subgingival application of topical Schedule VI medicinal agents pursuant to § 54.1-3408 J of the Code.

5. Duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist, with the exception of those listed as nondelegable in 18VAC60-21-130, those restricted to indirect supervision in subsection A of this section, and those restricted to delegation to dental assistants II in 18VAC60-21-150.

C. Delegation of duties to a dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 F of the Code. However, delegation of duties to a

public health dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 E of the Code.

Part I

General Provisions

18VAC60-25-10. Definitions.

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

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

"Active practice" means clinical practice as a dental hygienist for at least 600 hours per year.

"ADA" means the American Dental Association.

"Analgesia" means the diminution or elimination of pain in the conscious patient.

"CDAC" means the Commission on Dental Accreditation of Canada.

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

"Code" means the Code of Virginia.

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

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

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

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

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, or (iii) preparing the patient for dismissal following treatment.

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

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness.

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

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

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

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

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

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

18VAC60-25-60. Delegation of services to a dental hygienist.

A. In all instances and on the basis of his diagnosis, a licensed dentist assumes ultimate responsibility for determining with the patient or his representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with this chapter, Part III (18VAC60-21-110 et seq.) of the Regulations Governing the Practice of Dentistry, and the Code.

B. Dental hygienists shall engage in their respective duties only while in the employment of a licensed dentist or governmental agency or when volunteering services as provided in 18VAC60-25-50.

C. Duties that are delegated to a dental hygienist under general supervision shall only be performed if the following requirements are met:

1. The treatment to be provided shall be ordered by a dentist licensed in Virginia and shall be entered in writing in the record. The services noted on the original order shall be rendered within a specified time period, not to exceed 10 months from the date the dentist last performed a periodic examination of the patient. Upon expiration of the order, the dentist shall have examined the patient before writing a new order for treatment under general supervision.

2. The dental hygienist shall consent in writing to providing services under general supervision.

3. The patient or a responsible adult shall be informed prior to the appointment that a dentist may not be present, that only topical oral anesthetics can be administered to manage pain, and that only those services prescribed by the dentist will be provided.

4. Written basic emergency procedures shall be established and in place, and the hygienist shall be capable of implementing those procedures.

D. An order for treatment under general supervision shall not preclude the use of another level of supervision when, in the professional judgment of the dentist, such level of supervision is necessary to meet the individual needs of the patient.

E. Delegation of duties to a dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 F of the Code. However, delegation of duties to a public health dental hygienist practicing under remote supervision shall be in accordance with provisions of § 54.1-2722 E of the Code.

Part III

Standards of Conduct

18VAC60-25-110. Patient records; confidentiality.

A. A dental hygienist shall be responsible for accurate and complete information in patient records for those services provided by a hygienist or a dental assistant under direction to include the following:

1. Patient's name on each page in the patient record;

2. A health history taken at the initial appointment, which is updated when local anesthesia or nitrous oxide/inhalation analgesia is to be administered and when medically indicated and at least annually;

3. Options discussed and oral or written consent for any treatment rendered with the exception of prophylaxis;

4. List of drugs administered and the route of administration, quantity, dose, and strength;

5. Radiographs, digital images, and photographs clearly labeled with the patient's name, date taken, and teeth identified;

6. A notation or documentation of an order required for treatment of a patient by a dental hygienist practicing under general supervision as required in 18VAC60-25-60 C; and

7. Notation of each treatment rendered, date of treatment, and the identity of the dentist and the dental hygienist providing service.

B. A dental hygienist shall comply with the provisions of § 32.1-127.1:03 of the Code related to the confidentiality and disclosure of patient records. A dental hygienist shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the hygienist shall not be considered negligent or willful.

C. A dental hygienist practicing under remote supervision shall document in the patient record that he has obtained (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal or written permission of any dentist who has treated the patient in the previous 12 months and can be identified by the patient.

Guidance for Practice of a Dental Hygienist under Remote Supervision

References from § 54.1-2722 of the Code of Virginia

1. **What is meant by "remote supervision"**

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

2. **Who can employ a dental hygienist to practice dental hygiene under the remote supervision?**

   A dentist who holds an active, unrestricted license by the Virginia Board of Dentistry and who has a dental office physically located in the Commonwealth.

3. **What qualifications are necessary for a dental hygienist to practice under remote supervision?**

   The hygienist must have (i) completed a continuing education course offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of clinical experience.

4. **Are there other requirements for practice under remote supervision?**

   A dental hygienist practicing under remote supervision shall have professional liability insurance with policy limits acceptable to the supervising dentist.

5. **In what settings can a dental hygienist practice under remote supervision?**

   A hygienist can only practice dental hygiene under remote supervision at a community health center, charitable safety net facility, free clinic, long-term care facility, elementary or secondary school, Head Start program, or women, infants, and children program.

6. **What tasks can a dental hygienist practicing under remote supervision perform?**

   A hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer topical oral fluorides under an oral or

written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine pursuant to subsection V of §**54.1-3408**, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation.

7. **Is the dental hygienist allowed to administer local anesthetic or nitrous oxide?**

   No, a dental hygienist practicing under remote supervision is not allowed administer local anesthetic or nitrous oxide.

8. **What disclosures and permissions are required?**

   Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal or written permission of any dentist who has treated the patient in the previous 12 months and can be identified by the patient.

9. **How is the dental hygienist required to involve the dentist when practicing under remote supervision?**

   a) After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision shall consult with the supervising dentist prior to providing further dental hygiene services if such patient is medically compromised or has periodontal disease.
   b) A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a treatment plan for the patient and either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient.
   c) The supervising dentist shall review a patient's records at least once every 10 months.

10. **Is a dental hygienist who practicing under remote supervision allowed to also practice dental hygiene under general supervision whether as an employee or as a volunteer?**

    Yes, the requirements of § 54.1-2722 F do not prevent practice under general supervision.

11. **Are the requirements for remote supervision different for a public health dental hygienist employed by the Virginia Department of Health?**

    Yes, remote supervision in a public health setting is defined in § 54.1-2722 E:

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

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

ADEA | THE VOICE OF DENTAL EDUCATION

AMERICAN DENTAL EDUCATION ASSOCIATION

The mission of ADEA is to lead institutions and individuals in the dental education community to address contemporary issues influencing education, research and the delivery of oral health care for the overall health and safety of the public.

655 K Street, NW
Suite 800
Washington, DC 20001
Phone: 202.289.7201
Fax: 202.289.7204
adea.org

April 21, 2016

Dr. Charles E. Gaskins, III
President
Virginia Board of Dentistry
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dear Dr. Gaskins:

The American Dental Education Association (ADEA) represents all 66 U.S. dental schools and, subsequently, the deans of these schools. The ADEA Council of Deans (ADEA Council) met at the 2016 ADEA Annual Session & Exhibition in Denver and voted to send this communication to all U.S. state dental boards regarding the issue of portability of licenses and the use of human subjects in clinical licensure examinations.

The ADEA Council is aware that the American Dental Association (ADA) and the ADEA principal officers recently sent a letter to many state dental boards encouraging greater portability of licensure throughout the United States. Given the mobility of this society, the ADEA Council supports this general principle, as dentists now move more frequently and unexpectedly from state to state, often for reasons beyond their control. This is especially true for dentists within their first 10 years of practice, military dentists and dentists with partners in other highly mobile professions. Given the fact that some states and jurisdictions now recognize licenses from other states independent of the type of licensure exam taken initially, the ADEA Council respectfully requests that your board develop reciprocal licensure policies and agreements so that dentists who possess a valid, unrestricted license in any state or jurisdiction in the United States would be eligible for dental licensure and able to practice in your state.

Also, the ADEA Council wishes to reiterate its position in opposition to the use of human subject, patient-based components of clinical licensure examinations. The ADEA House of Delegates in March 2014 unanimously passed a resolution, ADEA 5H-2014, which "recommends the elimination of the human subject/patient-based components of clinical licensure examinations and the adoption of an alternative and validated process for the clinical assessment of candidates for licensure." At the 2016 ADEA Annual Session & Exhibition in March 2016, the ADEA Council reaffirmed its position on licensure and its support of Resolution 5H-2014.

Some dental schools have made individual decisions to participate in the Clinical Integrated Format (CIF), also known as the Buffalo Model (CIF-Buffalo), largely to assist their students in navigating the only examination track that currently exists for licensure in certain states. The ADEA Council wishes to state that the decision by dental schools to participate in the CIF-Buffalo version of ADEX examination offered by the Commission on Dental Competency Assessment (CDCA) should not be interpreted as an endorsement of that specific examination format, which still involves participation of human subjects.

In light of the aforementioned, we respectfully ask that you carefully consider the positions of the ADEA Council, as detailed above. These positions were formulated after many hours of thoughtful and careful deliberation and we believe they have the ability to profoundly affect oral health professionals in this country and their capacity to deliver the best care possible to this nation's population.

We welcome the opportunity to discuss these matters in greater detail.

Sincerely,

Marsha A. Pyle, D.D.S., M.Ed.
Chair, ADEA Council of Deans

R. Lamont MacNeil, D.D.S., M.Dent.Sc.
Board Director, ADEA Council of Deans

cc: ADEA Board of Directors
ADEA Council of Deans

ADA American Dental Association®
America's leading advocate for oral health

ADEA | THE VOICE OF DENTAL EDUCATION

February 26, 2016

Dr. Ronald F. Moser
President
Maryland State Board of Dental Examiners
Spring Grove Hospital Center/Benjamin Rush Building
5 Wade Avenue
Catonsville, MD 21228

Dear Doctor Moser:

We are writing to express the high level of concern that the American Dental Association (ADA), its Licensure Task Force and Council on Dental Education and Licensure, and the American Dental Education Association (ADEA) have with regard to the status of licensure for dentists in the United States. While licensure portability is an important matter to dental professionals, particularly to those pursuing initial licensure or attempting to relocate to another state, it is clear that the dental boards of a number of states, including your own, continue to engage in conduct that restricts, rather than enhances, that portability.

As you know, there are five clinical test administration agencies for dentistry: the Commission on Dental Competency Assessments (CDCA, formerly NERB); Central Regional Dental Testing Service, Inc. (CRDTS); Council of Interstate Testing Agencies, Inc. (CITA); the Southern Regional Testing Agency, Inc. (SRTA); and the Western Regional Examining Board (WREB). The ADA has conducted a careful analysis of the examinations administered by each of the clinical testing agencies (CDCA and CITA administer the American Board of Dental Examiners (ADEX) dental exam, while CRDTS, SRTA, and WREB administer their own exams) and has come to the conclusion that these examinations adhere to a common set of core design and content requirements that renders them conceptually comparable. In particular, each agency:

- utilizes the *Standards for Educational and Psychological Testing* as the guidelines for evaluating the validity of their exams;
- produces a publically available technical report that documents and summarizes available validity and reliability evidence concerning the examinations;
- utilizes conjunctive scoring, requiring candidates to pass each of a series of tests in order to pass the full examination;
- conducts a practice analysis on a regular basis to ensure that test content reflects normal, everyday tasks performed in general dental practice;
- reduces examiner bias and enhances fairness by ensuring that examiners do not know the identity of the candidate whose performance they are evaluating;

- requires three examiners to evaluate performance on each exam and sub-exam;
- requires examiners to participate in calibration exercises to align examiner perspectives and provide a common frame of reference;
- conducts prospective and retrospective evaluations of examiner consistency and reliability;
- makes a determination of candidate minimal competency in restorative dentistry on a patient-based exam for a Class III composite resin preparation and restoration and either a Class II amalgam or composite resin preparation and restoration;
- makes a determination of candidate minimal competency in periodontics on a patient-based exam for scaling and root planning; and
- utilizes simulation to determine minimal competency in prosthodontics (crown preparation) and endodontics.

Given the aforementioned commonality in design and content requirements, any apparent differences in the performance of these clinical examinations can be called into question and potentially interpreted as simply reflecting sampling error. In light of this, accepting the results from certain clinical examinations and not others appears specious. It has been a longstanding policy of the ADA that it represents unnecessary and meaningless duplication to require a candidate seeking licensure in different states to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction, especially when it is clear that the core requirements, administration, and outcomes are virtually indistinguishable between each examination.

It is our understanding that your state affirmatively elects not to accept the examination results from all of these test administration agencies. The decision of your board, as well as the boards of a number of other states, to accept the test results of only a select number of clinical test administration agencies appears highly arbitrary. Moreover, those decisions have an arguably anticompetitive effect in restricting the mobility of dentists wishing to move from one state to another. As you know, the whole concept of licensure is currently under attack because of its inherent effect on competition; it is therefore incumbent on the dental profession to ensure that any such restraints are not susceptible to a claim that they are unreasonable in nature. Indeed, the House of Delegates of the American Bar Association recently passed a resolution urging bar admission authorities in various states to adopt a Universal Bar Examination in order to facilitate mobility for new lawyers. This concept of mobility among professionals is obviously gaining additional momentum.

In light of these circumstances, we respectfully request that your Board pursue the necessary steps to accept successful completion of all of the clinical test administration agency examinations for dental licensure in your state. Recognizing that the dental board's primary mission is protecting the public in your state, we believe that the board has the authority and autonomy to pursue this change. It will increase portability of dental professionals and access to quality dental care for patients.

We would be pleased to meet with you or your board to further discuss this matter.

Sincerely,

Carol Gomez Summerhays, D.D.S., M.A.G.D.
President
American Dental Association

Huw F. Thomas, B.D.S., M.S., Ph.D.
Dean, Tufts University School of Dental Medicine
Chair of the ADEA Board of Directors

Gary L. Roberts, D.D.S.
President-elect

Cecile A. Feldman, D.M.D., M.B.A.
Dean, Rutgers School of Dental Medicine
Chair-elect of the ADEA Board of Directors

Gary E. Jeffers, D.M.D., M.S.
Chair
2016 ADA Licensure Task Force

Lily T. Garcia, D.D.S., M.S., FACP
Associate Dean for Education
University of Iowa College of Dentistry
Immediate Past Chair of the ADEA Board of Directors

Daniel J. Gesek, Jr., D.M.D.
Chair
Council on Dental Education and Licensure

KMH:eg

cc: Mr. Donald M. Russell, interim executive director, Maryland State Board of Dental Examiners
Dr. Mark A. Reynolds, dean, University of Maryland School of Dentistry
Dr. Thomas R. a'Becket, president, Maryland State Dental Association
Mr. Frank McLaughlin, executive director, Maryland State Dental Association
Dr. Jeffrey M. Cole, ADA Trustee, Fourth District
Dr. Kathleen O'Loughlin, executive director and chief operating officer (ADA)
Dr. Richard W. Valachovic, president and chief executive officer (ADEA)

JCNDE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

May 4, 2016

Dr. Charles E. Gaskins, III
Board President/Chair
c/o Virginia Board of Dentistry
Perimeter Center
9960 Mayland Dr., Suite 300
Henrico, VA 23233-1463

Dear Dr. Gaskins:

The Joint Commission on National Dental Examinations ("Joint Commission") appreciates the opportunity to assist your dental board by providing information concerning the cognitive skills of dental and dental hygiene candidates seeking licensure in your jurisdiction. In our continuing efforts to improve the quality, accuracy, and clinical relevance of information we provide, the Joint Commission is pleased to provide additional details concerning our efforts to introduce the Integrated National Board Dental Examination (INBDE), and share details concerning how and when implementation will occur.

The INBDE is a next generation assessment that will integrate the biomedical, behavioral, and clinical sciences, to provide dental boards with a summative evaluation concerning whether dental licensure candidates possess the level of cognitive skills necessary to safely practice dentistry. **The Joint Commission anticipates the INBDE will be available for administration on August 1, 2020, with full replacement of the National Board Dental Examination (NBDE) scheduled to occur by August 1, 2022.** This letter serves as the official "four years' notice" the Joint Commission indicated it would provide to stakeholders and communities of interest, concerning these important events.

In anticipation of the release of the INBDE and the discontinuation of Parts I and II, the Joint Commission recommends your dental board undertake the following activities to learn about the INBDE and prepare to use it in licensure decision making:

- Review and monitor INBDE information on the Joint Commission's website (www.ada.org/JCNDE/INBDE).
- Attend the National Dental Examiners' Advisory Forum (NDEAF) annually.
- Review INBDE validity evidence and the results of field testing as these studies occur.
- Prepare to receive INBDE results on the first day of its availability.
- Consider whether any modifications to practice acts, rules, policies, or procedures will be required.
- Prepare to accept candidates who have successfully completed the National Boards. This could occur under either of the following sequences: 1) INBDE or 2) NBDE Parts I and II.
- Communicate information concerning the acceptability of the INBDE to future licensure candidates.

The Joint Commission recommends your dental board begin working with these considerations now, to ensure your board is prepared for the upcoming changes. Details concerning the INBDE implementation plan are enclosed. Dates appearing in the plan represent a best-case scenario and are subject to change. The Joint Commission's website contains additional background information concerning the INBDE, as well as information concerning communications and presentations on this topic to dental boards and communities of interest since 2010.

Thank you for your consideration and attention to this important matter. If you have any questions, please contact the Joint Commission (nbexams@ada.org) and we will be happy to assist.

Sincerely,

Luis J Fujimoto DMD

Dr. Luis J. Fujimoto
Chair, Joint Commission on National Dental Examinations

Enclosure

INBDE Implementation Plan and Recommended Actions

JCNDE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS

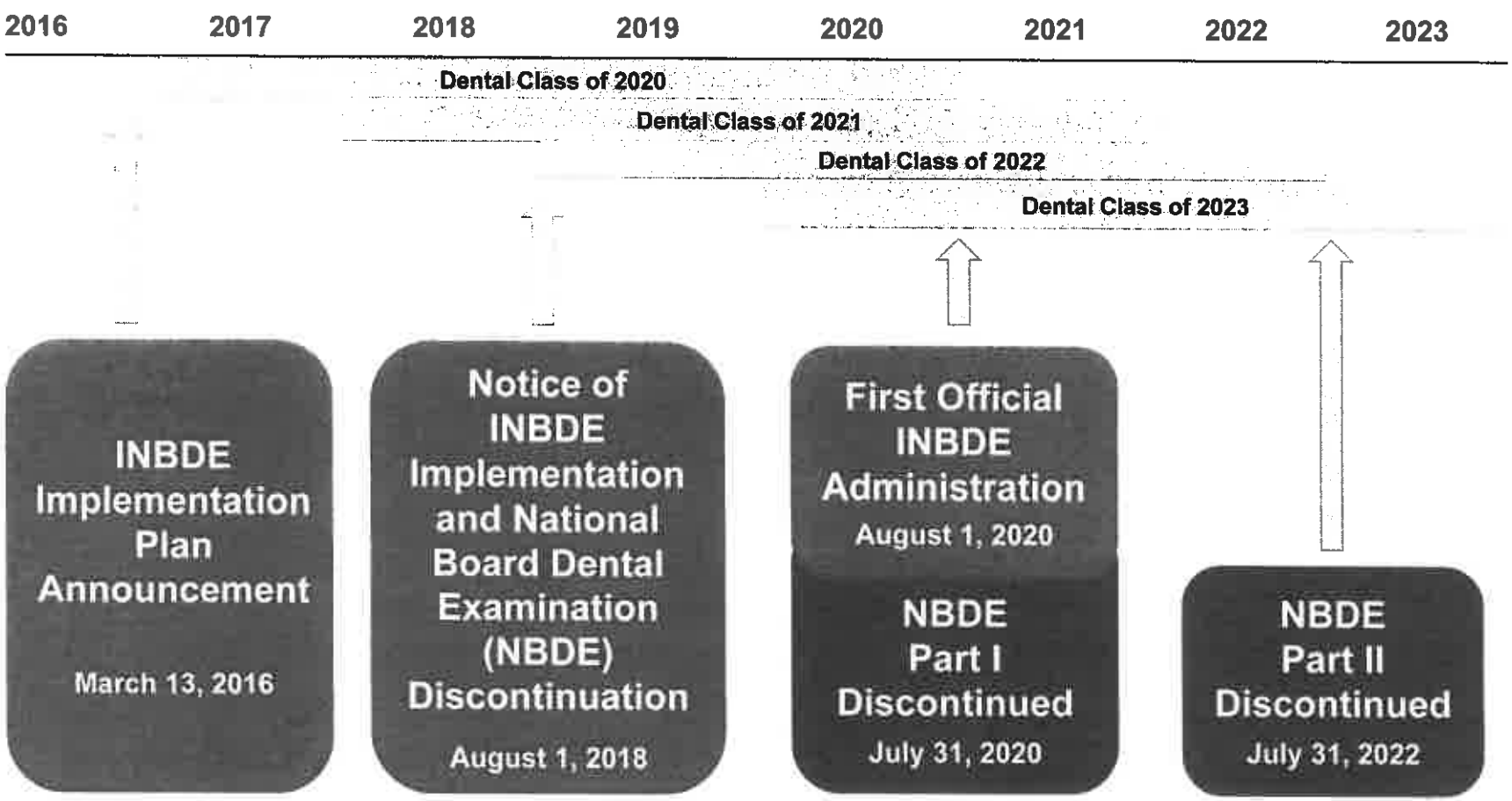
April 2016

P109

INBDE Implementation Plan

- The Integrated National Board Dental Examination (INBDE) is an examination that is currently in development by the Joint Commission on National Dental Examinations (JCNDE).
- The INBDE is intended to replace National Board Dental Examination (NBDE) Parts I and II. The INBDE is intended for use by state dental boards to help inform decision-making concerning the licensure of entry-level dentists.
- To address concerns from stakeholders and communities of interest regarding the timing of INBDE implementation, the JCNDE indicated it would provide four years' notice before the INBDE is implemented and the NBDE discontinued.
- The current presentation is designed to help address concerns regarding timing and provide this advance notification.
- This presentation provides stakeholders and communities of interest with information concerning how INBDE implementation will occur, the information that will be made available to help facilitate the transition, and recommended actions for stakeholders and communities of interest.
- The slide that follows shows key events associated with INBDE implementation, and the sequence of activity associated with the transition.

Integrated National Board Dental Examination (INBDE) Implementation Plan: "Best Case Scenario"



PRT: March 2016

Note: This implementation plan communicates the best case scenario. Dates presented should be interpreted as "no sooner than." Actual dates will be contingent upon field testing results. INBDE Practice Test Questions are anticipated for release in 2019.

INBDE Implementation Plan

- On August 1, 2018, the Joint Commission intends to provide stakeholders and communities of interest with notice of INBDE implementation and NBDE discontinuation. This notice will include the following:
  - The projected date when the INBDE will be first available for administration, the official name of the new examination, and how results will be reported.*
  - The dates when NBDE Part I and NBDE Part II will be discontinued.
  - Retesting policies, eligibility rules, and any additional rules needed to facilitate the transition.
- Two years after notification has been provided, NBDE Part I will be discontinued (approx. July 31, 2020). No Part I administrations will occur after this date.
- The first official administration of the INBDE is expected to take place on August 1, 2020.
- Two years after NBDE Part I is discontinued, NBDE Part II will be discontinued (approx. July 31, 2022). No Part II administrations will occur after this date.
- Notification of INBDE implementation and NBDE discontinuation is contingent upon successful completion of the INBDE Field Testing Program (not depicted in the preceding diagram).

* Similar to Part I and Part II, INBDE results will be reported as "Pass/Fail."

INBDE Implementation Plan

- In considering the dates provided, please note the following:
  - The plan as presented communicates the "best case scenario."
  - The dates provided may be delayed if difficulties are encountered. However, the dates will not be "moved up" (e.g., NBDE Part I will be discontinued no sooner than August 1, 2020).
  - The Joint Commission reserves the right to make changes to the plan at any time and as needed, in keeping with the Joint Commission's mission and purpose.
  - Any significant changes to this plan will be published as soon as information becomes available.
  - The final slide in the current presentation will provide a log of changes made.

Additional Information from the JCNDE

- Information concerning the INBDE is available via the Joint Commission's website (www.ada.org/JCNDE/INBDE).
- The following information is currently available and is updated as changes occur:
  - INBDE background
  - INBDE FAQ's
  - Domain of Dentistry and general validity evidence
  - Preliminary test specifications
  - Preliminary sample questions.
- The following information will be posted as soon as it becomes available:
  - INBDE practice test questions (anticipated one year in advance of initial INBDE administration)
  - Technical report(s) providing detailed information concerning validity.

INBDE Information from other Sources (not the JCNDE)

- INBDE eligibility rules for students of U.S. dental schools accredited by the Commission on Dental Accreditation (CODA).
  - These rules are determined by each dental school.

- Additional school requirements concerning the INBDE (e.g., linking successful completion of the INBDE to graduation requirements).
  - These rules are determined by each dental school.

- Written examination requirements for each state.
  - These requirements are determined by each state dental board.

INBDE Implementation Plan Considerations

- The requirements of key stakeholders and communities of interest were carefully considered in developing the implementation plan.
  - State Dental Boards
  - Dental Schools
  - US Dental Licensure Candidates
- The following slides indicate specific considerations involving the aforementioned groups, as well as recommended actions.
- The considerations indicated should NOT be regarded as comprehensive of all of the INBDE-related interests of the aforementioned groups.

State Dental Boards

Implementation Plan Requirement	How Requirement is Addressed

• Provide sufficient time for state dental boards to assess and understand INBDE validity evidence.
• Provide sufficient time for state dental boards to incorporate the INBDE into licensure decision-making and communicate its acceptability to future licensure candidates.
• Provide sufficient time for state dental boards to prepare to receive INBDE results on day one of availability.
• Consider whether any modifications to practice acts, rules, policies, or procedures will be required.
• Provide sufficient time for state dental boards to accept both exam sequences:
1) INBDE and
2) NBDE Parts I and II.
	• Post and update validity information on JCNDE website as it becomes available.
	• Communicate validity information on annual basis at National Dental Examiners' Advisory Forum (NDEAF).
	• Release details of implementation plan in 2016, and provide the following notifications:
	  • INBDE first administration possible as soon as 2020.
	  • NBDE Part I final administration possible in 2020.
	  • NBDE Part II final administration possible in 2022.
	• Provide notice in 2016 of JCNDE plans for indicating the official name of the INBDE and how results will be reported. Current discussions indicate the JCNDE is likely to associate the name "NBDE" with the INBDE, to ease the transition with regard to state rules and practice acts.

Recommended Actions for State Dental Boards

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website (www.ada.org/JCNDE/INBDE), and attend the National Dental Examiners' Advisory Forum (NDEAF) annually.
  - Review INBDE validity evidence and the results of field testing as these studies occur.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare to use the INBDE in licensure decision-making.
  - Consider whether any modifications to practice acts, rules, policies, or procedures will be required.
  - Prepare to receive INBDE results on day one of availability.
  - Prepare to accept candidates who have successfully completed the National Boards. This could occur under either of the following sequences: 1) INBDE or 2) NBDE Parts I and II.
  - Communicate information concerning the acceptability of the INBDE to future licensure candidates.

Dental Schools

Implementation Plan Requirement	How Requirement is Addressed

• Provide sufficient time for U.S. dental schools to adjust curricula and prepare students for the INBDE (also consistent with current CODA requirements).
• Provide sufficient time for U.S. dental schools to adjust academic policy for incoming students regarding eligibility to sit for National Board Examinations.
• Provide sufficient time for U.S. dental schools to adjust academic policy for incoming students regarding school utilization of NBDE Part I and II results (e.g., as prerequisites for students to continue their studies or as a graduation requirement).
	• Release details of implementation plan in 2016, and provide the following notifications:
	  • INBDE first administration possible as soon as 2020.
	  • NBDE Part I final administration possible in 2020.
	  • NBDE Part II final administration possible in 2022.
	• Post INBDE preliminary sample questions publicly in 2016.
	• Provide INBDE practice test questions one year before INBDE initial administration.
	• Provide updates on the INBDE annually at the ADEA conference and subsequently post the presentations online.

Note: For US candidates, dental schools now approve the eligibility of Part I and Part II examinees and will determine when their students will transition to the new exam, within the feasible available options. For international candidates, eligibility for Parts I and II involves providing proof of dental school graduation (through ECE). This practice is expected to continue for the INBDE.

Recommended Actions for Dental Schools

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website (www.ada.org/JCNDE/INBDE), and attend ADEA sessions on the INBDE.
  - Review INBDE validity evidence and field testing results as these studies occur.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare your school and students for the INBDE.
  - Review and revise curricula to prepare students for the INBDE and the updated CODA standards.
  - Review academic policy for incoming students and revise as needed concerning:
    - student eligibility to sit for National Board Dental Examinations.
    - school utilization of NBDE Part I and II results.

U.S. Dental Licensure Candidates

Implementation Plan Requirement	How Requirement is Addressed

• Provide U.S. dental licensure candidates with a reasonable opportunity to demonstrate competence with respect to the knowledge and skills required for licensure and measured by a written examination.
• Provide reasonable time and sufficient notice so candidates can plan ahead and take action to avoid being "caught between examination programs" (e.g., preparing for Parts I and II but then finding themselves forced to shift to the INBDE).
• Provide sufficient time for candidates to understand retesting policies concerning the INBDE and Parts I and II during the transition period, so candidates can plan and make decisions accordingly.
• Provide test specifications and practice materials so candidates can prepare for the INBDE and know what types of questions to expect.
	• Begin INBDE administrations before NBDE Part II is discontinued.
	• Release details of implementation plan in 2016, and provide the following notifications:
	  ◦ INBDE first administration possible as soon as 2020.
	  ◦ NBDE Part I final administration possible in 2020.
	  ◦ NBDE Part II final administration possible in 2022.
	• Provide practice test questions one year before initial INBDE administration, and post INBDE preliminary sample questions publicly in 2016.
	• Provide notice in 2018 concerning INBDE retest policy, and coordinate INBDE retest policy with NBDE retest policy.

Recommended Actions for U.S. Dental Licensure Candidates

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website (www.ada.org/JCNDE/INBDE).
  - Review INBDE test specifications and practice questions.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare for the National Board Examinations.
  - Determine which examination track to pursue (NBDE Parts I and II or the INBDE) in consultation with the most recent INBDE implementation plan and:
    - your dental school, its requirements, and your progress in meeting those requirements.
    - the dental boards of states where you intend to apply for licensure.
    - Joint Commission policies (e.g., retesting policies under both examination tracks).
  - Study the areas indicated in the test specifications of your intended examination track.

Implementation Plan Version History

Version	Date	Changes
1.0	3/13/2016	First publication. Presented to ADEA.
1.1	3/17/2016	Slide 4 – Further clarified that no administrations for Part I or II would be conducted after the dates listed.
1.2	4/25/2016	Slide 10 – State Boards – consider modifications to practice acts, etc. (Mirror information in previous slide.)

ADEX
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Stanwood Kanna, D.D.S., President
William Pappas, D.D.S., Vice-President
Jeffery Hartsog, D.M.D., Secretary
Conrad McVea, III, D.D.S., Treasurer
Bruce Barrette, D.D.S., Past President

May 17, 2016

Virginia Board of Dentistry
Perimeter Center
9960 Mayland Dr., Suite 300
Henrico, VA 23233-1463

Dear Members of the Virginia Board of Dentistry:

It has come to our attention that the ADA and ADEA have written to dental boards for several states and territories expressing a high level of concern over licensure portability. In the letters we have seen, the ADA and ADEA suggest that the ADA has "conducted a careful analysis of the examinations" offered by the various testing agencies (including those that offer the ADEX examination) and determined that the examinations are "conceptually comparable." The ADA and ADEA suggest that any state dental board that accepts fewer than all of the available clinical licensure examinations is acting arbitrarily and speciously and in an anticompetitive manner.

As a preliminary matter, the ADEX is not aware of any evaluation of its examination by the ADA. In fact, on May 10, 2016, Dr. Jeffers of the ADA Licensure Task Force wrote to the ADEX to request "the information necessary to understand the ADEX and the validity evidence that exists to support test usage and interpretation." Clearly the ADA had not conducted a "careful analysis" of the ADEX examination prior to its February letter.

We at ADEX are also perplexed by the ADA and ADEA stance on the best manner of increasing licensure portability. While licensure portability is more a matter of state practices regarding licensure by credential rather than an issue involving clinical licensure examinations, the ADA and ADEA letter does not even mention licensure by credential. Instead, the ADA and ADEA focus their letter on what we refer to as "test portability," i.e. the number of jurisdictions which accept a particular clinical licensure examination.

It is certainly true that test portability would be increased if every state dental board were to shirk its duty to evaluate the quality and validity of the various examinations and simply accept every available licensure examination. We at ADEX, however, believe a better way to improve test portability is to develop a better examination in an effort to obtain universal acceptance. That is what the ADEX has set out to do, and, as noted in Dr. Jeffers May 10, 2016 letter, the ADEX examination is now accepted in 45 jurisdictions. The ADEX is at a loss to understand the "high level of concern" regarding test portability voiced by the ADA and ADEA given the widespread acceptance of the ADEX examination.

What the ADA does not mention in its letter is that it has previously stated its intent to enter the clinical licensure testing arena. While it may be in the ADA's interest to pave the way for acceptance of its clinical licensure examination by urging dental boards to begin accepting all available examinations, it is likely not in the public interest to have dental boards stop paying careful attention to the qualities of dental licensure examinations.

P.O. Box 50718 • Mesa, AZ 85208
Telephone (503) 724-1104
ADEXOFFICE@aol.com
www.adexexams.org

We have asked our psychometrician Dr. Chad Buckendahl to review and respond to the technical assertions regarding test comparability in the letter from the ADA and ADEA. We have also asked our lawyer Andrew Cole of LeClairRyan to review the antitrust issues. Their joint response to the ADEX is enclosed.

Sincerely yours,

Stanwood H. Kanna, President
American Board of Dental Examiners, Inc.

Enclosures

Andrew L. Cole
LeClairRyan
180 Admiral Cochrane Drive, Suite 520
Annapolis, Maryland 21401

Chad Buckendahl, Ph.D.
ACS Ventures, LLC
11035 Lavender Hill Drive #160-433
Las Vegas, Nevada 89135

May 17, 2016

Dr. Stanwood Kanna
President
American Board of Dental Examiners, Inc.
P.O. Box 50718
Mesa, Arizona 85208

Dear Dr. Kanna,

We write at your request to address and respond to certain assertions made in a recent joint communication issued by the American Dental Association (ADA) and the American Dental Education Association (ADEA) (the "ADA/ADEA Letter"). In their letter, the ADA and ADEA make certain assertions regarding the comparability of clinical licensure examinations in dentistry offered by different agencies. Premised on this assertion, the ADA and ADEA recommend that state boards of dentistry relax their due diligence in evaluating testing options so as to foster portability of licenses across state lines and avoid antitrust concerns. We are concerned not only by the unsupported claims regarding comparability of licensure examinations and the possibility of antitrust concerns, but also by a clear conflict of interest that is not disclosed in the ADA/ADEA Letter.

We understand that the ADA has publicly declared that it is developing its own dental clinical licensure examination. It is unclear why the ADA would seek to become a participant in the dental licensure testing arena, an arena in which it purports to find no fault with *any* of the several existing clinical licensure examinations, unless its motivation is to capture some or all of the revenue stream from these examinations. The ADA's status as a potential future examination provider presents a clear conflict of interest and taints its recommendation that all states should accept all examinations. What is particularly insidious is that this recommendation is presented as though coming from a neutral observer.

In addition to this undisclosed conflict of interest, and the faulty reasoning behind the ADA's purported comparative analysis of examinations (discussed more fully below), the ADA has recently acknowledged that it has not, contrary to representations in the ADA/ADEA Letter, conducted the "careful analysis" of the various clinical licensure examinations suggested in the letter.

In a May letter to the ADEX, Dr. Jeffers, writing on behalf of the ADA Licensure Task Force,[1] acknowledges that the ADA has not in fact conducted any meaningful comparative evaluation or analysis of the various clinical licensure examinations.[2] In his letter Dr. Jeffers requests that the ADEX turn over its technical information so that the ADA may conduct the very analysis it previously claimed to have conducted. It is not clear why, in the first instance, the ADA feels it is responsible for undertaking a comparative analysis of clinical licensure examinations, but it is clear that the ADA has not, to date, actually performed any meaningful analysis.

Notwithstanding the fact that the ADA and ADEA have not, to date, conducted any meaningful comparative analysis of dental licensure examinations, the ADA/ADEA Letter purports to set forth information demonstrating the comparability of these tests. To assist you in understanding the technical components of test development and validation, and to explain why the technical aspects of the ADA/ADEA Letter are essentially meaningless, we highlight specific technical issues in the ADA/ADEA Letter and address them by providing a brief description of the key elements that stakeholders should consider when evaluating the comparability of clinical licensure examinations in dentistry. These key elements are based on a validation framework for licensure testing programs that prioritizes sources of evidence that are most important to supporting the interpretation and use of scores (Kane, 2006; Buckendahl & Plake, 2006). For licensure testing programs at risk for legal challenge, these key elements focus on 1) domain specification, 2) fairness for candidates, 3) reliability of scores and decisions, and 4) passing scores that reflect entry-level practice (see Buckendahl & Hunt, 2005).

Because some technical information for licensure testing programs is often proprietary and not publicly available, it is difficult for an external agency unfamiliar with program specifics to comment on the development and validation. Notwithstanding these difficulties, and the ADA's acknowledgement that it lacks sufficient information from which to make comparative determinations, the ADA/ADEA Letter suggests that this has occurred. Specifically, the ADA/ADEA Letter asserts that "The ADA has conducted a careful analysis of the examinations administered by each of the clinical testing agencies. . . .and has come to the conclusion that these examinations. . . .[are] conceptually comparable." The authors then continue to assert a number of characteristics of these examinations that are purported to be comparable to the point of interchangeable with respect to the resultant decisions about candidates' minimum competency.

Upon closer inspection of each of these bullet points, there are a number of problems with the authors' approach. Many of the statements are generic to the point of applying to virtually any credible licensure examination program (e.g., guidance from the *Test Standards*, documenting activities in a technical report, conducting a practice analysis, taking steps to

[1] Dr. Jeffers is also one of the signatories to the February 26, 2016 letter to state dental boards.
[2] As an aside, it is also not clear to us that the ADA possesses the requisite expertise necessary to conduct such an evaluation even if were free from conflicts of interest, and had sufficient information with which to do so.

reduce bias, conducting empirical analysis). It is not possible to evaluate the comparability of the substance of the examinations at such a cursory level. Fortune and Cromack (1995) provide a useful description of the characteristics of a clinical licensure examination program that could be considered in an independent evaluation. Further, some of the assertions are inaccurate.

Specifically, the authors indicate that each agency "makes a determination of candidate minimum competency in periodontics on a patient-based exam for scaling and root planning; and utilizes simulation to determine minimum competency in prosthodontics (crown preparation) and endodontics." Although the ADEX exams administered by CDCA and CITA, and the exams administered by SRTA provide a periodontal scaling examination as an option for States that require it, this is not a required component of the examination as determined by the programs' practice analysis. CRDTS and WREB do require a patient-based periodontal scaling examination. Similarly, ADEX, SRTA, and CRDTS examinations include a clinical skills performance prosthodontics examination, WREB's examinations do not. In addition, CRDTS does not include a diagnosis and treatment planning exam. The inclusion or exclusion of domains is a function of the practice analysis process and results; not merely a function of sampling error, as suggested by the authors. This mere topic level similarity is an insufficient basis from which to conclude comparability.

Although each agency has a restorative component in its examination, the scoring and evaluation criteria, its application, and the resultant decisions may be very different. For example, the differential interpretation of the impact of remaining caries in a restorative preparation by agencies is an important one to highlight. If one agency's scoring criteria defines this as a domain critical error that would fail a candidate on that exam versus another agency's interpretation that this represents something that may be characteristic of a passing candidate, the decision by the agency as well as the risk management decisions by a State board of dentistry cannot be interpreted as trivial.

A comprehensive evaluation of the comparability of examinations would include at a minimum: technical manuals, administration manuals (candidate and examiner), scoring criteria, and reliability and decision consistency evidence. This evidence is promulgated as a professional expectation in the *Standards for Educational and Psychological Testing* (AERA, APA, & NCME, 2014). The review and conclusions suggested by the ADA/ADEA Letter's authors do not suggest that an in-depth analysis of the unique aspects of these programs were considered.

The authors' inclusion of the example of efforts to create a Uniform Bar Exam does not support the premise or conclusion of the letter, nor is it a comparable example. The ADA and ADEA do not seek the adoption of a 'uniform' licensure examination, rather the ADA and ADEA suggest that every state should accept *every* available examination. That would be analogous to suggesting that in the legal profession every state accept the bar exam developed by every other state. We are aware of no move in the legal profession, or any other profession, to adopt such a policy.

Notwithstanding that the fact that the ADA has conducted no meaningful evaluation of the comparability of dental licensure examinations, the ADA/ADEA Letter asserts that the purported comparability of examinations means that any state dental board that accepts fewer than all of the examinations acts in an "arbitrary" and "specious" manner and in restraint of trade (by restricting interstate mobility of licenses). By raising the spectre of antitrust liability, the ADA and ADEA seek to bully state dental boards into abdicating their obligation to evaluate the various licensure examinations and instead simply accept all licensure examinations as the 'least anticompetitive' option.

Each state dental board is tasked by its state with vetting dental licensure exams. It is the duty of each State board to determine which test or tests best differentiate between qualified and non-qualified applicants for licensure in order to protect the public from the practice of dentistry by unqualified individuals.

Licensure, by its very nature, is anti-competitive in the sense that it restricts entry into a particular market. That being said, the Supreme Court has long recognized that some anti-competitive restrictions are necessary for certain professions in order to protect the public. As the Supreme Court noted in its recent decision *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, 135 S.Ct. 1101 (2015), "States . . . when acting in their respective realm need not adhere in all contexts to a model of unfettered competition. . . . [I]n some spheres, they impose restrictions on occupations . . . or otherwise limit competition to achieve public objectives. . . . If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States' power to regulate." *Id.* at 1104 (quoting *Exxon Corp. v. Governor of Maryland*, 437 U.S. 117, 133 (1978).

While State dental boards should certainly be mindful of antitrust concerns while carrying out their functions and duties, it is misplaced for the ADA/ADEA Letter to raise such concerns in the context of designating licensure examinations. Unlike the regulation of teeth whitening presented in *North Carolina State Board of Dental Examiners*, which involved extra-legislative action by the North Carolina State Board of Dental Examiners, virtually every state designates its approved licensure examination by statute, or by a legislative rule. This sort of deliberate state action is specifically protected from antitrust liability. As noted in *North Carolina State Board of Dental Examiners*, "State legislation . . . will satisfy [the] standard [for *Parker*[3] immunity] and *ipso facto* are exempt from the operation of the antitrust laws because they are an undoubted exercise of state sovereign authority." *Id.* at 1110.

It is worth pointing out that the ADA stated in its *Amicus* brief in *North Carolina State Board of Dental Examiners* that it "support[ed] the determination by state legislatures across this country that the health professions should be regulated by knowledgeable health care professionals who have practical experience in the profession that they are regulating." The ADA also stated that it believed "the public is best served when state regulatory boards duly

[3] The phrase *Parker* immunity refers to the Supreme Court's 1943 decision in *Parker v. Brown*, 317 U.S. 341 (1943) in which it held that States are immune from antitrust law when acting in their sovereign capacity.

constituted in accordance with state law are free to make decisions on public health issues based on clinical experience without fear of second-guessing under the federal antitrust laws." Now, contrary to its prior position, it appears the ADA, rather than supporting the independence of State dental boards,' suggests that the states should essentially abdicate their responsibility to protect the public from the unqualified practice of dentistry to the ADA, and simply follow the lead of the ADA in accepting all licensure examinations.

Please feel free to contact us with questions.

Sincerely,

Andrew L. Cole
Attorney at Law
LeClairRyan

Chad W. Buckendahl, Ph.D.
Partner
ACS Ventures, LLC

References

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education (2014). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.

Buckendahl, C. W. & Plake, B. S. (2006). Evaluating tests. In S. Downing & T. Haladyna (eds.), *Handbook of test development* (pp. 725-738). Mahwah, NJ: Lawrence Erlbaum Associates.

Buckendahl, C. W. & Hunt, R. (2005). Whose rules? The relation between the "rules" and "law" of testing. In R. Phelps (ed.), *Defending standardized testing* (pp. 147-158). Mahwah, NJ: Lawrence Erlbaum Associates.

Fortune, J. & Cromack, T. (1995). Developing and using clinical examinations. In J. C. Impara (ed.), *Licensure testing: Purposes, procedures, and practices* (pp. 149-166). Lincoln, NE: Buros Institute of Mental Measurements.

Kane, M. T. (2006). Validation. In R. L. Brennan (ed.), *Educational measurement*, 4th ed. (pp. 17-64). Westport, CT: American Council on Education and Praeger.

Disclosures of Conflict

Dr. Buckendahl has provided varying levels of consultation for the following organizations that are involved in dental licensure testing: American Dental Association, American Board of Dental Examiners, Commission on Dental Competency Assessments (formerly North East Regional Board of Dental Examiners), Council of Interstate Testing Agencies, CSW Computer Simulations, Kentucky Board of Dentistry, National Dental Examining Board of Canada, North Carolina Board of Dental Examiners, and Southern Regional Testing Agency.

ADA American Dental Association®
America's leading advocate for oral health

ADEA | THE VOICE OF DENTAL EDUCATION

February 26, 2016

Dr. Zebulon Vance Morgan IV
President
South Carolina Board of Dentistry
P.O. Box 11329
Columbia, SC 29211-1329

Dear Doctor Morgan:

We are writing to express the high level of concern that the American Dental Association (ADA), its Licensure Task Force and Council on Dental Education and Licensure, and the American Dental Education Association (ADEA) have with regard to the status of licensure for dentists in the United States. While licensure portability is an important matter to dental professionals, particularly to those pursuing initial licensure or attempting to relocate to another state, it is clear that the dental boards of a number of states, including your own, continue to engage in conduct that restricts, rather than enhances, that portability.

As you know, there are five clinical test administration agencies for dentistry: the Commission on Dental Competency Assessments (CDCA, formerly NERB); Central Regional Dental Testing Service, Inc. (CRDTS); Council of Interstate Testing Agencies, Inc. (CITA); the Southern Regional Testing Agency, Inc. (SRTA); and the Western Regional Examining Board (WREB). The ADA has conducted a careful analysis of the examinations administered by each of the clinical testing agencies (CDCA and CITA administer the American Board of Dental Examiners (ADEX) dental exam, while CRDTS, SRTA, and WREB administer their own exams) and has come to the conclusion that these examinations adhere to a common set of core design and content requirements that renders them conceptually comparable. In particular, each agency:

- utilizes the *Standards for Educational and Psychological Testing* as the guidelines for evaluating the validity of their exams;
- produces a publically available technical report that documents and summarizes available validity and reliability evidence concerning the examinations;
- utilizes conjunctive scoring, requiring candidates to pass each of a series of tests in order to pass the full examination;
- conducts a practice analysis on a regular basis to ensure that test content reflects normal, everyday tasks performed in general dental practice;
- reduces examiner bias and enhances fairness by ensuring that examiners do not know the identity of the candidate whose performance they are evaluating;

- requires three examiners to evaluate performance on each exam and sub-exam;
- requires examiners to participate in calibration exercises to align examiner perspectives and provide a common frame of reference;
- conducts prospective and retrospective evaluations of examiner consistency and reliability;
- makes a determination of candidate minimal competency in restorative dentistry on a patient-based exam for a Class III composite resin preparation and restoration and either a Class II amalgam or composite resin preparation and restoration;
- makes a determination of candidate minimal competency in periodontics on a patient-based exam for scaling and root planning; and
- utilizes simulation to determine minimal competency in prosthodontics (crown preparation) and endodontics.

Given the aforementioned commonality in design and content requirements, any apparent differences in the performance of these clinical examinations can be called into question and potentially interpreted as simply reflecting sampling error. In light of this, accepting the results from certain clinical examinations and not others appears specious. It has been a longstanding policy of the ADA that it represents unnecessary and meaningless duplication to require a candidate seeking licensure in different states to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction, especially when it is clear that the core requirements, administration, and outcomes are virtually indistinguishable between each examination.

It is our understanding that your state affirmatively elects not to accept the examination results from all of these test administration agencies. The decision of your board, as well as the boards of a number of other states, to accept the test results of only a select number of clinical test administration agencies appears highly arbitrary. Moreover, those decisions have an arguably anticompetitive effect in restricting the mobility of dentists wishing to move from one state to another. As you know, the whole concept of licensure is currently under attack because of its inherent effect on competition; it is therefore incumbent on the dental profession to ensure that any such restraints are not susceptible to a claim that they are unreasonable in nature. Indeed, the House of Delegates of the American Bar Association recently passed a resolution urging bar admission authorities in various states to adopt a Universal Bar Examination in order to facilitate mobility for new lawyers. This concept of mobility among professionals is obviously gaining additional momentum.

In light of these circumstances, we respectfully request that your Board pursue the necessary steps to accept successful completion of all of the clinical test administration agency examinations for dental licensure in your state. Recognizing that the dental board's primary mission is protecting the public in your state, we believe that the board has the authority and autonomy to pursue this change. It will increase portability of dental professionals and access to quality dental care for patients.

We would be pleased to meet with you or your board to further discuss this matter.

Sincerely,

Carol Gomez Summerhays, D.D.S., M.A.G.D.
President
American Dental Association

Huw F. Thomas, B.D.S., M.S., Ph.D.
Dean, Tufts University School of Dental Medicine
Chair of the ADEA Board of Directors

Gary L. Roberts, D.D.S.
President-elect

Cecile A. Feldman, D.M.D., M.B.A.
Dean, Rutgers School of Dental Medicine
Chair-elect of the ADEA Board of Directors

Gary E. Jeffers, D.M.D., M.S.
Chair
2016 ADA Licensure Task Force

Lily T. Garcia, D.D.S., M.S., FACP
Associate Dean for Education
University of Iowa College of Dentistry
Immediate Past Chair of the ADEA Board of Directors

Daniel J. Gesek, Jr., D.M.D.
Chair
Council on Dental Education and Licensure

KMH:eg

cc: Ms. Kate K. Cox, administrator, South Carolina Board of Dentistry
Dr. John J. Sanders, dean, Medical University of South Carolina James B. Edwards College of Dental Medicine
Dr. Christopher T. Griffin, president, South Carolina Dental Association
Mr. Phil Latham, executive director, South Carolina Dental Association
Dr. Julian Hal Fair, III, ADA Trustee, Sixteenth District
Dr. Kathleen O'Loughlin, executive director and chief operating officer (ADA)
Dr. Richard W. Valachovic, president and chief executive officer (ADEA)

Virginia Board of Dentistry
Policy on Sanctioning for
Failure to report to the Prescription Monitoring Program

Excerpts of Applicable Law, Regulation and Guidance

- The Board may sanction any licensee for violation of any provision of a state or federal law or regulation relating to manufacturing, distributing, dispensing or administering drugs. §54.1-2706(15)
- Any prescriber who is licensed in the Commonwealth to treat human patients and is authorized pursuant to §§ 54.1-3303 and 54.1-3408 to issue a prescription for a covered substance shall be registered with the Prescription Monitoring Program ("PMP") by the Department of Health Professions. §54.1-2522.1(A)
- The failure by any person subject to the reporting requirements set forth in §54.1-2521 and the Department's regulations to report the dispensing of covered substances shall constitute grounds for disciplinary action by the relevant health regulatory board. §54.1-2521(A)
- Data shall be transmitted to the Department or its agent within seven days of dispensing. 18VAC76-20-40.A
- Data shall be transmitted in a file layout provided by the Department and shall be transmitted by a media acceptable to the vendor contracted by the director for the program. 18VAC76-20-40.B
- If a dispenser does not dispense any controlled substances in Schedules II- IV during a seven day period, a "zero" report must be submitted. PRESCRIPTION MONITORING PROGRAM DATA COLLECTION MANUAL

Guidelines for Imposing Disciplinary Sanctions

1. A "Failure to Report" letter will be sent by the PMP to the dispenser concerning non-reporting. If the dispenser fails to submit the required data and provide PMP with confirmation of the submission within the time prescribed in the "Failure to Report" letter, or an inadequate response is received, PMP will then mail a certified "Failure to Report" letter to the dispenser.
2. Should the dispenser not submit the required data and provide PMP with confirmation of the submission within the time prescribed in the certified "Failure to Report" letter, or an inadequate response is received, PMP will refer the matter to the Board for disciplinary action.
3. The reviewing Board member or staff (the "Reviewer") shall offer a Pre-Hearing Consent Order ("PHCO") when probable cause is found that the dispenser failed to report dispensing data.
4. The Reviewer shall impose a $500.00 monetary penalty per each unreported period and require the immediate submission of the dispensing data.

ADA American Dental Association®
America's leading advocate for oral health

Sedation and Anesthesia Guidelines

The Council on Dental Education and Licensure is conducting, at the request of Resolution 77H adopted by the 2015 ADA House of Delegates, further review of its proposed revisions to the *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists and the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.*

NEW: Review and Comment Requested

The Council seeks comment from the communities of interest. Comments are due July 4, 2016. Review the proposed revisions and directions for responding here.

Next Steps:

1. CDEL and Anesthesiology Committee meet to review written comments and prepare report to Board of Trustees and ADA House of Delegates (early August)
2. CDEL report released to 2016 ADA House of Delegates (mid-August)
3. Town Hall Meeting during ADA2016 in Denver
4. Reference Committee Hearing and ADA House of Delegates meetings during ADA2016 in Denver

Resources:

- Current 2012 Sedation and Anesthesia Guidelines (PDF)
- Sedation and Anesthesia Guidelines Proposed to 2015 ADA House of Delegates (PDF)
- Report on the Risks and Benefits of Using Capnography In Dental Patients Undergoing Moderate Sedation (PDF)
- Written comments received by the Council Q1 2016 (PDF)

ADA American Dental Association®

Council on Dental Education and Licensure

April 20, 2016 Open Hearing Testimony Invited on Highlighted Sections

Proposed Revisions not approved by the 2015 ADA House of Delegates

Guidelines for the Use of Sedation and General Anesthesia by Dentists

Underscore denotes proposed additions
~~Strikethrough~~ denotes proposed deletions

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to *Section III. Educational Requirements.*

II. Definitions

Methods of Anxiety and Pain Control

~~**analgesia** - the diminution or elimination of pain.~~ [moved to Terms section]

~~**conscious sedation**[1] - a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.~~

~~In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.~~

~~**combination inhalation–enteral conscious sedation** (combined conscious sedation) - conscious sedation using inhalation and enteral agents.~~ [moved to Terms section]

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~ [moved to Terms section]

~~**local anesthesia** - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.~~ [Moved to Terms section]
~~*Note:* Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.~~ [Moved to Terms section]

---

[1] ~~*Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.*~~

~~**combination inhalation–enteral conscious sedation** (combined conscious sedation) - conscious sedation using inhalation and enteral agents.~~

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[2]

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

For children age 12 and under, ~~T~~ the use of preoperative sedatives ~~for children (aged 12 and under)~~ prior to arrival in the dental office~~, except in extraordinary situations,~~ must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Prescription medications intended to accomplish procedural sedation for children age 12 and under must not be administered without the benefit of direct supervision by a trained dental/medical provider. (Source: the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*)

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation via an enteral route:

maximum recommended (MRD) - maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

[2] *Portions excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014 ~~2004~~, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial ~~dose of the initial~~ drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment. For the purpose of enteral or combination enteral/inhalation sedation, when the MRD of a drug is exceeded or more than one drug is used in combination, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation apply.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[3]

> *Note*: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

> *titration* - administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[3]

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

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[3]

For all levels of sedation, the qualified dentist ~~practitioner~~ must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

> *enteral* - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

[3] *Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal - a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

analgesia – the diminution or elimination of pain [Moved from Definitions section]

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug. [Moved from Definitions section]

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents. [Moved from Definitions section]

qualified dentist - meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

operating dentist – dentist with primary responsibility for providing operative dental care while a qualifying dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or deep sedation or general anesthesia.

competency – displaying special skill or knowledge derived from training and experience

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should - indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[4]

ASA I - A normal healthy patient.
ASA II - A patient with mild systemic disease.
ASA III - A patient with severe systemic disease.
ASA IV - A patient with severe systemic disease that is a constant threat to life.
ASA V - A moribund patient who is not expected to survive without the operation.
ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.
E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

American Society of Anesthesiologists Fasting Guidelines*

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

*American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Anesthesiology 114:495. 2011. Reprinted with permission.

III. Educational Requirements

A. Minimal Sedation

1. To administer minimal sedation the dentist must demonstrate competency by having ~~have~~ successfully completed:

a. training ~~to the level of competency~~ in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*,

or

b. a comprehensive training ~~program in~~ moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

c. ~~b.~~ an advanced education program accredited by the ~~ADA~~ Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines;

and

c. a current certification in Basic Life Support for Healthcare Providers.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must demonstrate competency by having ~~have~~ successfully completed:

[4] *ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

b. an advanced education program accredited by the ~~ADA~~ Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines;

and

c. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent, e.g., Pediatric Advanced Life Support) or completion of an appropriate dental sedation/anesthesia emergency management course on the same recertification cycle that is required for ACLS.

2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must demonstrate competency by having ~~have~~ completed:

a. an advanced education program accredited by the ~~ADA~~ Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines; and

b. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent, e.g., Pediatric Advanced Life Support) or completion of an appropriate dental sedation/anesthesia emergency management course on the same re-certification cycle that is required for ACLS.

2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.

For all levels of sedation and anesthesia, dentists, who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to these educational requirements. However, all dentists providing sedation and general anesthesia in their offices or the offices of other dentists should comply with the Clinical Guidelines in this document.

IV. Clinical Guidelines

A. Minimal sedation

1. Patient Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should ~~may~~ consist of a review of their current medical history and medication use. ~~However~~, In addition, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-Operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs (blood pressure, pulse and respiration rates) must be obtained unless invalidated by the nature of the patient, procedure or equipment ~~the patient's behavior prohibits such determination~~.
- A focused physical evaluation must be performed as deemed appropriate, including recording the patient's body weight and BMI. In addition, body temperature should be measured when clinically indicated.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

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

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery system, must be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets ~~the~~ criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

Consciousness:

- Level of sedation (e.g., responsiveness to verbal commands) must be continually assessed.

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.
- Oxygen saturation by pulse oximetry must be used unless precluded or invalidated by the nature of the patient, procedure, or equipment ~~may be clinically useful and should be considered~~.

Ventilation:

- The dentist and/or appropriately trained individual must observe chest excursions continually.

- The dentist and/or appropriately trained individual must verify respirations continually.

Circulation:

- Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, time administered and route of administration, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient ~~returns~~ is returned to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

B. Moderate Sedation

1. Patient Evaluation

Patients considered for moderate sedation must undergo a pre-anesthesia evaluation prior to the administration of any sedative. ~~be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) t~~This should consist of at least a review at an appropriate time (ideally within the previous 30 days) of their ~~current~~ medical history and medication use. ~~However, p~~In addition, patients with significant medical considerations (e.g., ASA III, IV) may also require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.

- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs including blood pressure, pulse and respiration rates, and blood oxygen saturation by pulse oximetry must be obtained unless precluded by the nature of the patient, procedure or equipment ~~the patient's behavior prohibits such determination~~.
- A focused physical evaluation must be performed, including recording the patient's body weight and BMI. In addition, body temperature should be measured when clinically indicated ~~as deemed appropriate~~.
- ~~Preoperative dietary restrictions must be considered based on the sedative technique prescribed.~~
- Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.

3. Personnel and Equipment Requirements

Personnel:

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

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery system, must be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- End tidal CO2 must be monitored unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation may be monitored by evaluation by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- If parenteral sedation is administered, a secure intravenous access site must be maintained until the patient meets discharge criteria.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Consciousness:

- Level of sedation ~~consciousness~~ (e.g., responsiveness to verbal command) must be continually assessed.

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.

- Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:

- The dentist must observe chest excursions continually.
- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO2 unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation may be monitored by continual observation of qualitative signs, including ~~chest excursion and~~ auscultation of breath sounds with a precordial or pretracheal stethoscope. ~~This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO_2 or by verbal communication with the patient.~~

Circulation:

- The dentist must continually evaluate blood pressure and heart rate ~~(~~unless invalidated by the nature of the patient, procedure or equipment. ~~the patient is unable to tolerate~~ and this is noted in the time-oriented anesthesia record~~)~~.
- Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record).
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient~~,~~ and parent, escort, guardian or care giver.
- If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient ~~returns~~ is returned to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for*

Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

C. Deep Sedation or General Anesthesia

1. Patient Evaluation

Patients considered for deep sedation or general anesthesia must undergo a pre-anesthesia evaluation prior to ~~be suitably evaluated prior to the start~~ the administration of any sedative ~~procedure. In healthy or medically stable individuals (ASA I, II) t~~This must consist of at least a review of their ~~current~~ medical history and medication use and NPO status. In addition, ~~However~~, patients with significant medical considerations (e.g., ASA III, IV) may also require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs (including body weight, blood pressure, pulse rate, respiration rate, and blood oxygen saturation) must be obtained unless invalidated by the patient, procedure or equipment ~~the patient's behavior prohibits such determination.~~ In addition, body temperature should be measured when clinically appropriate.
- A focused physical evaluation must be performed including recording the patient's body weight and BMI. ~~as deemed appropriate~~ In addition, body temperature should be measured when clinically indicated.
- ~~Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.~~
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.
- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- A log of equipment maintenance, including monitors and anesthesia delivery systems, must be maintained. A pre-procedural check of equipment for each administration must be performed.

- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- End tidal CO2 must be monitored unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation may be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope. ~~If volatile anesthetic agents are utilized, a capnograph must be utilized and an inspired agent analysis monitor should be considered.~~
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Oxygenation:
- Color of mucosa, skin or blood must be continually evaluated.
- Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:
- Intubated patient: End-tidal CO_2 must be continuously monitored and evaluated.
- Non-intubated patient: ~~Breath sounds and auscultation and/or e~~ End-tidal CO_2 must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation may be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- ~~Respiration rate~~ must be continually monitored and evaluated.

NOT adopted by the 2023 ADA House of Delegates

Circulation:
- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:
- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:
- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record)
- Pulse oximetry and end-tidal CO_2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient~~,~~ and parent, escort, guardian or care giver.

6. Pediatric Patients and Those with Special Needs

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.

*****

Note regarding Section V: Additional Sources of Information as well as references supporting the Guidelines will become available on the ADA's website and no longer listed within the policy document.

~~V. Additional Sources of Information~~

~~American Dental Association. Example of a time oriented anesthesia record at www.ada.org.~~

~~American Academy of Pediatric Dentistry (AAPD). *Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update.* Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/policies.~~

~~American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics.* Available at http://www.perio.org/resources-products/posppr3-1.html *The AAP rescinded this policy in 2008.*~~

~~American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php~~

~~American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php~~

~~American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients*~~

Undergoing Elective Procedures. Available at https://ecommerce.asahq.org/p-178-practice-guidelines-for-preoperative-fasting.aspx

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.* Available at http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm

Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/115.aspx.

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/docs/94-100/

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502

ADA American Dental Association®

Council on Dental Education and Licensure

August 2015

Proposed Revisions:

Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

Underscore denotes proposed additions
~~Strikethrough~~ denotes proposed deletions

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of dentistry. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists.

Anxiety and pain control can be defined as the application of various physical, chemical and psychological modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental education from predoctoral through continuing education. They are designed to teach initial competency in pain control and minimal and moderate sedation techniques.

These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of anxiety and pain control techniques through a combination of instruction and experience. It is assumed that this has enabled these teachers and practitioners to meet the educational criteria described in this document.

It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education.

The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these *Guidelines.*

Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and techniques for administering these drugs enterally, parenterally and by inhalation as supplements to local anesthesia.

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of

treatment. Predoctoral dental students must complete a course in Basic Life Support for the Healthcare Provider. Though Basic Life Support courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.

II. Definitions

Methods of Anxiety and Pain Control

~~**analgesia** – the diminution or elimination of pain.~~ [Moved to Terms section]

~~**conscious sedation**[1] – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.~~

~~In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.~~

~~**combination inhalation–enteral conscious sedation** (combined conscious sedation) – conscious sedation using inhalation and enteral agents.~~

~~When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.~~

~~**local anesthesia** – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.~~ [Moved to Terms section]

~~[1] Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.~~

~~*Note:* Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.~~ [Moved to Terms section]

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[2]

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

For children age 12 and under, ~~T~~ the use of preoperative sedatives ~~for children (aged 12 and under)~~ prior to arrival in the dental office~~, except in extraordinary situations,~~ must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Prescription medications intended to accomplish procedural sedation for children age 12 and under must not be administered without the benefit of direct supervision by a trained dental/medical provider. (Source: the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

~~Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.~~

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation via an enteral route:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of ~~the initial dose of~~ the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial total dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment. For the

[2] *Portions excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014 ~~2004~~, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

purpose of enteral or combination enteral/inhalation sedation, when the MRD of a drug is exceeded or more than one drug is used in combination, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation apply.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[3]

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

titration - administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[3]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.[3]

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[3]

For all levels of sedation, the qualified dentist ~~practitioner~~ must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

---

[3] *Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014 ~~2004~~, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

analgesia – the diminution or elimination of pain [Moved from Definitions section]

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug. [Moved from Definitions section]
Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents. [Moved from Definitions section]

qualified dentist – meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines,* or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should -indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.
continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

Levels of Knowledge

familiarity - a simplified knowledge for the purpose of orientation and recognition of general principles.

in-depth - a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

Levels of Skill

exposed - the level of skill attained by observation of or participation in a particular activity.

competent - displaying special skill or knowledge derived from training and experience.

~~*proficient* - the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time (highest level of skill).~~

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[4]

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

American Society of Anesthesiologists' Fasting Guidelines*

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

*American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Anesthesiology 114:495, 2011. Reprinted with permission.

Education Courses

Education may be offered at different levels (competency, update, survey courses and advanced education programs). A description of these different levels follows:

1. Competency Courses are designed to meet the needs of dentists who wish to become competent ~~knowledgeable and proficient~~ in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. Update Courses are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. Survey Courses are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. Advanced Education Courses are a component of an advanced dental education program, accredited by the ~~ADA~~ Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental

[4] *ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.*

education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be competent ~~knowledgeable and proficient~~ in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.

III. Teaching Pain Control

These *Guidelines* present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predoctoral curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;
2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;
3. be competent in monitoring vital functions;
4. be competent in prevention, recognition and management of related complications;
5. ~~be familiar with~~ have in-depth knowledge of the appropriateness of and the indications for medical consultation or referral;
6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
   a. Observation
      (1) Central nervous system
      (2) Respiratory system
         a. Oxygenation
         b. Ventilation
      (3) Cardiovascular system
   b. Monitoring equipment
5. Pharmacologic aspects of anxiety and pain control
   a. Routes of drug administration
   b. Sedatives and anxiolytics
   c. Local anesthetics
   d. Analgesics and antagonists
   e. Adverse side effects
   f Drug interactions
   g. Drug abuse
6. Control of preoperative and operative anxiety and pain
   a. Patient evaluation
      (1) Psychological status
      (2) ASA physical status
      (3) Type and extent of operative procedure
   b. Nonpharmacologic methods
      (1) Psychological and behavioral methods

(a) Anxiety management
(b) Relaxation techniques
(c) Systematic desensitization
(2) Interpersonal strategies of patient management
(3) Hypnosis
(4) Electronic dental anesthesia
(5) Acupuncture/Acupressure
(6) Other

c. Local anesthesia
(1) Review of related anatomy, and physiology
(2) Pharmacology
(i) Dosing
(ii) Toxicity
(iii) Selection of agents
(3) Techniques of administration
(i) Topical
(ii) Infiltration (supraperiosteal)
(iii) Nerve block – maxilla-to include:
(aa) Posterior superior alveolar
(bb) Infraorbital
(cc) Nasopalatine
(dd) Greater palatine
(ee) Maxillary (2nd division)
(ff) Other blocks
(iv) Nerve block – mandible-to include:
(aa) Inferior alveolar-lingual
(bb) Mental-incisive
(cc) Buccal
(dd) Gow-Gates
(ee) Closed mouth
(v) Alternative injections-to include:
(aa) Periodontal ligament
(bb) Intraosseous

d. Prevention, recognition and management of complications and emergencies

C. Sequence of Pain Control Didactic and Clinical Instruction: Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients. The sedative care of pediatric patients and those with special needs requires advanced didactic and clinical training.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

D. Faculty: Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

IV. Teaching Administration of Minimal Sedation

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on Dental Accreditation's *Accreditation Standards* for dental education programs.

These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

These *Guidelines* are not intended for the management of enteral and/or combination inhalation-enteral minimal sedation in children, which requires additional course content and clinical learning experience.
[Moved from Section C]

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult and pediatric anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification ~~and~~ risk assessment, and pre-procedure fasting instructions.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.
10. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

Inhalation Sedation (Nitrous Oxide/Oxygen)

A. Inhalation Sedation Course Objectives: Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.

B. Inhalation Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment (i.e., pulse oximetry), with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of *14 hours* plus management of clinical dental cases, ~~including a clinical component~~ during which clinical competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should possess an active permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

Enteral and/or Combination Inhalation-Enteral Minimal Sedation

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives: Upon completion of a competency course in enteral and/or combination inhalation-enteral minimal sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support for Healthcare Providers.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal sedation).
9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral minimal sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.

14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration: Participants must be able to document current certification in Basic Life Support for Healthcare Providers and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.

~~These *Guidelines* are not intended for the management of enteral and/or combination inhalation-enteral minimal sedation in children, which requires additional course content and clinical learning experience.~~ [Moved to Section IV]

D. Participant Evaluation and Documentation of Instruction: Competency courses in combination inhalation-enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them to achieve competency. The course director must certify the competency of participants upon satisfactory completion of the course. Records of the course instruction must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should possess a current permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

V. Teaching Administration of Moderate Sedation

These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation. These include courses in enteral and parenteral moderate sedation ~~and parenteral moderate sedation~~. The teaching guidelines contained in this section on moderate sedation differ slightly from documents in medicine to reflect the differences in delivery methodologies and practice environment in dentistry. ~~For this reason, separate teaching guidelines have been developed for moderate enteral and moderate parenteral sedation.~~

Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining parenteral sedation with nitrous oxide-oxygen. [Moved from Section C]

A. Course Objectives: Upon completion of a course in moderate sedation, the dentist must be able to:

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.

3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.
9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.
13. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions.
4. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
6. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
8. Indications and contraindications for use of moderate sedation.
9. Review of dental procedures possible under moderate sedation.
10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs, ventilation/breathing and reflexes related to consciousness.
11. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
12. Prevention, recognition and management of complications and emergencies.
13. Description, maintenance and use of moderate sedation monitors and equipment.
14. Discussion of abuse potential.
15. Intravenous access: anatomy, equipment and technique.
16. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
17. Description and rationale for the technique to be employed.
18. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

~~**C. Moderate Enteral Sedation Course Duration:** A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate~~

~~sedation. Participants combining enteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.~~

~~Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult patients; this course in moderate enteral sedation is not designed for the management of children (aged 12 and under). Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted.~~

Moderate ~~Parenteral~~ Sedation Course Duration: A minimum of *60 hours* of didactic instruction, plus administration of sedation for ~~management of~~ *at least 20 individually-managed dental patients* by ~~the intravenous~~ any route per participant including intravenous administration, is required to demonstrate ~~achieve~~ competency in moderate sedation techniques. Of the 20 cases, all must be individually managed by the anesthesia operator dentist. ~~Participants combining parenteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.~~

~~Clinical experience in managing a compromised airway is critical to the prevention of emergencies. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in management of the airway. Typically, clinical experience will be provided in managing healthy adult patients.~~ **~~Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults.~~** ~~Successful completion of this course does result in clinical competency in moderate parenteral sedation. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted.~~

D. Participant Evaluation and Documentation of Instruction: Competency courses in moderate sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience and airway management. Records of the didactic instruction and clinical experience, including the number of patients managed by each participant in each anxiety and pain control modality must be maintained and available for review.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should possess a current permit or license to administer deep sedation and general anesthesia in at least one state, have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than ~~five~~ four-to-one when moderate ~~enteral~~ sedation is being taught allows for adequate supervision during the clinical phase of instruction. ~~A participant-faculty ratio of not more than three-to-one when moderate parenteral sedation is being taught allows for adequate supervision during the clinical phase of instruction; a~~ A one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.

*****

Note regarding Section V: Additional Sources of Information as well as references supporting the Guidelines will become available on the ADA's website and no longer listed within the policy document.

~~**VI. Additional Sources of Information**~~

~~American Dental Association. Example of a time oriented anesthesia record at www.ada.org.~~

~~American Academy of Pediatric Dentistry (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update.* Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/policies~~

~~American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics.* Available at http://www.perio.org/resources-products/posppr3-1.html. *The AAP rescinded this policy in 2008.*~~

~~American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php~~

~~American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition.* Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php~~

~~American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures.* Available at https://ecommerce.asahq.org/p-178-practice-guidelines-for-preoperative-fasting.aspx~~

~~American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.* Available at http://www.asahq.org/Home/For-Members/Practice-Management/Practice-Parameters#sedation~~

~~The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm~~

~~Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/115.aspx .~~

~~National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/docs/94-100/~~

~~Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502~~

Our specific comments are:

Lines 358 to 368	Expand the equipment requirements for moderate sedation to include capnography to read as follows: • A capnograph must be utilized and an inspired agent analysis monitor should be considered. The Board advocates the use of capnography in all instances where moderate sedation, deep sedation or general anesthesia is administered regardless of the agents utilized and the methods of administration employed.
Line 484	Strike the phrase "If volatile anesthetic agents are utilized," so that the language at this bullet would read as follows: • A capnograph must be utilized and an inspired agent analysis monitor should be considered. The Board advocates the use of capnography in all instances where moderate sedation, deep sedation or general anesthesia is administered regardless of the agents utilized and the methods of administration employed.
Lines 1229 – 1230	Add more information on the expected parameters for the three live clinical experiences and the role of the participants in managing these experiences. The Board understands that some continuing education providers involve the participants in the decision making process and administration while others have the faculty explain the steps being taken while the participants observe. Are both approaches acceptable? The language used in lines 1243 and 1244 is much clearer in stating the expectation for participants.
Lines 1236 1237	Expand the highlighted provision to read as follows: **…this course in moderate enteral sedation is not designed for the management of children (aged 12 and under) or for medically compromised adults.**
Lines 1251 – 1252	Strike the current bolded sentence "Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults." And replace it with: **This course in moderate parenteral sedation is not designed for the management of children (aged 12 and under) or for medically compromised adults.**

The current bolded sentence should be replaced because it implies that adding more clinical experiences, presumably involving children and compromised adults, is all that is needed to make this course acceptable for these special populations. This implication fails to respect the vulnerability of these populations and is inconsistent with the ADA's stated position in lines 65 – 68 regarding children. The proposed language is based on the language used in lines 1236 – 1237 as addressed above.

The Board looks forward to receiving information on the Council's discussion of the ADA Sedation and Anesthesia Guidelines and to an opportunity to review any proposed changes. Please contact me at sandra.reen@dhp.virginia.gov if you have any questions about our submission.

Sincerely,

Sandra K. Reen

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
TEL (804) 367-4400
FAX (804) 527-4475

Virginia Board of Dentistry
(804) 367-4538 FAX (804) 527-4428 denbd @dhp.virginia.gov

January 2, 2015

Dr. James M. Boyle, III, Chair
Council on Dental Education and Licensure
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Via email, care of: JasekJ@ada.org

Dear Dr. Boyle:

The Virginia Board of Dentistry (the Board) appreciates the opportunity to comment on the ADA Sedation and Anesthesia Guidelines as the Council conducts a comprehensive review of the current guidelines. We would like to preface our specific comments by letting you know that the competency course requirements in the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Guidelines) are incorporated in the Board's Regulations Governing Dental Practice as our education standard for issuance of conscious/moderate sedation permits and deep sedation and general anesthesia permits. The Guidelines are an invaluable resource and a much appreciated reference document.

As a frequent user, the Board has from time to time needed technical assistance from ADA staffers in understanding the intent of the language used in the Guidelines in order to evaluate a continuing education program's compliance with the specifications for a competency course. To date, we have received expert and extremely helpful assistance in identifying the provisions in the Guidelines that have a bearing on our inquiry but are left to draw our own conclusions. We encourage the Council to take an additional step to support implementation of the Guidelines. We request adoption of a process to interpret the Guidelines in response to specific fact situations when questions arise about the intent of a provision. This action on the part of the Council would facilitate consistency in the application of the Guidelines across the various users and could be modeled on the Advisory Opinion process used for the ADA Principles of Ethics and Code of Professional Conduct.

Disciplinary Board Report for June 10, 2016

Today's report reviews the 2016 calendar years case activity then addresses the Board's disciplinary case actions for the third quarter of fiscal year 2016 which includes the dates of January 1, 2016 through March 31, 2016.

Calendar Year 2016

The table below includes all cases that have received Board action since January 1, 2016 through May 24, 2016.

Calendar 2016	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
January	24	2	3	5
February	42	39	5	44
March	44	50	5	55
April	32	12	2	14
May 24th	21	30	8	38
June				
July				
August				
September				
October				
November				
December				
Totals	**163**	**133**	**23**	**156**

Q3 FY 2016

For the third quarter of 2016, the Board received a total of 74 patient care cases. The Board closed a total of 66 patient care cases for a 89% clearance rate, which is down from 282% in Q2 of 2016. The current pending caseload older than 250 days is 31%, which is down from 33% in Q2 of 2016. The Board's goal is 20%. In Q3 of 2016, 84% of the patient care cases were closed within 250 days, as compared to 79% in Q2 of 2016. The Board's goal is 90% of patient care cases closed within 250 days.[1]

License Suspensions

Between February 23, 2016 and May 24, 2016, the Board has not mandatorily or summarily suspended any licenses.

---

[1] The Agency's Key Performance Measures.

- DHP's goal is to maintain a 100% clearance rate of allegations of misconduct through the end of FY 2016.
- The goal is to maintain the percentage of open patient care cases older than 250 business days at no more than 20% through the end of FY 2016.
- The goal is to resolve 90% of patient care cases within 250 business days through the end of FY 2016.

Sedation Permit Inspections

Currently there are 207 Current Active Conscious/Moderate Sedation Permit Holders, 158 Current Active Enteral Conscious/Moderate Sedation Permit Holders, and 42 Current Active Deep Sedation/General Anesthesia Permit Holders. The Board has 442 separate and distinct Sedation Permit Holder Locations, with some locations having multiple permit holders and some permit holders having multiple locations.

As of 5/24/16, in the 19 months since the sedation inspection program began, there have been inspections completed at 52 permit holder locations with approximately 100 permit holders. The Board has completed review of 38 of those location inspections.

Informal Conference Schedule

We have approximately 22 informal conferences and 4 formal hearings currently scheduled out until September 2016. There are approximately 109 cases being investigated in Enforcement; approximately 155 at Probable Cause level, some of which could potentially require an informal conference; and 22 cases currently awaiting preparation of a notice in the Administrative Proceedings Division. Given these numbers, Board staff would like to add the following tentative dates to schedule informal conferences utilizing **any** three Board members available: July 22, 2016; August 19, 2016; October 28, 2016; and December 16, 2016.

Board Member concerns

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

BOARD OF DENTISTRY
PROPOSED 2017 CALENDAR

JANUARY

S	M	T	W	T	F	S	
1	2	3	4	5	6	7	SCC-C
8	9	10	11	12	13	14	
15	16	17	18	19	20	21	SCC-A
22	23	24	25	26	27	28	SCC-B
29	30	31					

FEBRUARY

S	M	T	W	T	F	S	
			1	2	3	4	
5	6	7	8	9	10	11	Committee Meeting
12	13	14	15	16	17	18	
19	20	21	22	23	24	25	SCC-C
26	27	28					

MARCH

S	M	T	W	T	F	S	
			1	2	3	4	SCC-A
5	6	7	8	9	10	11	Formals/ Board
12	13	14	15	16	17	18	SCC-B
19	20	21	22	23	24	25	
26	27	28	29	30	31		

APRIL

S	M	T	W	T	F	S	
						1	
2	3	4	5	6	7	8	SCC-C
9	10	11	12	13	14	15	SCC-A
16	17	18	19	20	21	22	SCC-B
23	24	25	26	27	28	19	
30							

MAY

S	M	T	W	T	F	S	
	1	2	3	4	5	6	
7	8	9	10	11	12	13	Committee Meeting
14	15	16	17	18	19	20	SCC-C
21	22	23	24	25	26	27	
28	29	30	31				

JUNE

S	M	T	W	T	F	S	
				1	2	3	SCC-A
4	5	6	7	8	9	10	Formals/ Board
11	12	13	14	15	16	17	SCC-B
18	19	20	21	22	23	24	
25	26	27	28	29	30		SCC-C

JULY

S	M	T	W	T	F	S	
						1	
2	3	4	5	6	7	8	
9	10	11	12	13	14	15	SCC-A
16	17	18	19	20	21	22	
23	24	25	26	27	28	29	SCC-B
30	31						

AUGUST

S	M	T	W	T	F	S	
		1	2	3	4	5	
6	7	8	9	10	11	12	SCC-C
13	14	15	16	17	18	19	
20	21	22	23	24	25	26	SCC-A
27	28	29	30	31			

SEPTEMBER

S	M	T	W	T	F	S	
					1	2	
3	4	5	6	7	8	9	SCC-B
10	11	12	13	14	15	16	Formals/Board
17	18	19	20	21	22	23	SCC-C
24	25	26	27	28	29	30	

OCTOBER

S	M	T	W	T	F	S	
1	2	3	4	5	6	7	
8	9	10	11	12	13	14	SCC-A
15	16	17	18	19	20	21	Committee Meeting
22	23	24	25	26	27	28	SCC-B
29	30	31					

NOVEMBER

S	M	T	W	T	F	S	
			1	2	3	4	SCC-C
5	6	7	8	9	10	11	
12	13	14	15	16	17	18	SCC-A
19	20	21	22	23	24	25	
26	27	28	29	30			

DECEMBER

S	M	T	W	T	F	S	
					1	2	
3	4	5	6	7	8	9	SCC-B
10	11	12	13	14	15	16	Formals/Board
17	18	19	20	21	22	23	
24	25	26	27	28	29	30	
31							

FORMAL HEARINGS	BOARD MEETINGS	Committee Meetings
March 9	March 10	Feb 10
June 8	June 9	May 12
September 14	September 15	Oct 20
December 14	December 15	

Red dates are National or State Holidays

SCC – A	SCC – B and Credentials	SCC – C
January 20	January 27	January 6
March 3	March 17	February 24
April 14	April 21	April 7
June 2	June 16	May 19
July 14	July 28	June 30
August 25	September 8	August 11
October 13	October 27	September 22
November 17	December 8	November 3

Adopted:

AUDITING CONTINUING EDUCATION
June 10, 2016 Board Meeting

Background
On March 11, 2016 the Board decided to annually conduct a random audit of licensees for compliance with continuing education requirements and agreed to consider a guidance document on implementing the audit program at its June 12, 2015 meeting. A draft guidance document is provided for discussion.

Requirements for continuing education in 18VAC60-21-250 and 18VAC60-25-190
Dentist and dental hygienist licensees are required to verify compliance with continuing education requirements on their annual renewal applications. Following a renewal period, the board may conduct an audit of licensees to verify compliance. Licensees **selected** for audit must provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted prior to renewal of the license.

Proposed Guidance Document Points of Discussion
- exemptions and extensions of time
- random sample size
    - License count report attached
    - Sample Size Calculator by Raosoft attached
- deciding annually the scope of the audit
- auditing selected licenses
- delegating audit review and action to staff

Virginia Board of Dentistry

Policy on Auditing Continuing Education and Sanctioning for Failure to Meet the Requirements

Excerpts of Applicable Law, Regulation and Guidance

- The Board shall promulgate regulations requiring continuing education (CE) for any dental license or reinstatement and may grant extensions or exemptions, §54.1-2709.E.
- The Board shall promulgate regulations requiring continuing education for any dental hygiene license or reinstatement and may grant extensions or exemptions, §54.1-2729.
- Dentists and dental hygienists are required to:
  - complete a minimum of 15 hours of approved continuing education and
  - maintain the required documentation of completion for a minimum of four years following each renewal. 18VAC60-21-250 and 18VAC60-25-190.
- The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted prior to renewal of the license. 18VAC60-21-250 and 18VAC60-25-190.
- Failure to comply with continuing education requirements may subject the licensee to disciplinary action, 18 VAC 60-20-21-250.I and 18VAC60-25-190.D.
- Confidential Consent Agreements may be used to address continuing education, Guidance Document: 60-1

Exemption Requests

The president of the Board shall review a licensee's request for an exemption which is made before license renewal.

Initiation of a CE Audit

After each April 1st to March 31st renewal cycle, the Executive Director shall report to the Board the current operational issues, staffing, and disciplinary caseload for consideration by the Board in deciding the scope of the audit to be conducted that year.

Scope of Audits

The Board may determine which of the following active licensees to audit for compliance with CE requirements:

- Active licensees who have completed the terms of a CCA or a Board Order which required completion of CE in addition to the 15 hour requirement;
- Active licensees who failed to respond or responded "no" to the CE renewal question on the annual renewal form and/or requested an exemption after license renewal;
- Active licensees who were granted an extension to meet the CE requirement; and/or
- A random sample of licensees selected from MLO by the DHP IT Department. The sample size shall be determined using the online Sample Size Calculator by Raosoft and the total number of licensees.

Auditing CE

- Selected licensees will be notified by email to submit the necessary documentation to verify CE completion. A second notice will be sent by USPS if there is no response.
- Documentation submitted to verify CE completion will be reviewed by Board staff for compliance with the regulations.
- Licensees who have met the CE requirements will be sent a thank you letter.
- Licensees who have not complied with the audit notification or CE requirements will be referred for possible disciplinary action.

A. Guideline for Offering a Confidential Consent Agreement (CCA)

1. The executive director or designee shall review the documentation received for probable cause and shall only offer a CCA for a first offense when:
    - there is only one finding of probable cause and that finding is that the licensee is unable to document completion of from 1 to 5 hours of acceptable continuing education (CE).
    - there are findings of probable cause for violations in addition to missing CE consistent with Guidance Document 60-1, Policy on CCAs/Confidential Consent Agreements.
2. The offered CCA shall include a finding that a violation occurred and shall request the licensee's agreement to obtain the missing hours within 45 days and to henceforth comply with the CE requirements. The CCA shall state that the hours obtained pursuant to the CCA shall not count toward the next license renewal.

B. Guidelines for Imposing Disciplinary Sanctions

1. In addition to a notice of an informal conference, a licensee shall be offered a Pre-Hearing Consent Order (PHCO) when the licensee:
    - falsely certified completion of the required CE for license renewal.
    - is unable to document completion of from 1 to 5 hours of acceptable CE in a subsequent audit.
    - is unable to document completion of from 6 to 15 hours of acceptable CE.
2. In cases where there are findings of probable cause for violations in addition to missing CE, a PHCO may be offered with a notice of an informal conference.
3. The following sanctioning guidelines shall be included in the PHCO:
    a. For falsely certifying completion for renewal – Reprimand and $1000 monetary penalty.
    b. For missing 1 to 5 hours – Subsequent Offenses – Reprimand, obtain the missing hours within 30 days and a $250 monetary penalty for each missing hour.
    c. For missing 6 to 15 hours – First offense - Reprimand and obtain the missing hours within 45 days.
    d. For missing 6 to 15 hours – Subsequent offenses – Reprimand, obtain the missing hours within 45 days and a $500 monetary penalty for each missing hour.

License Count Report for Dentistry

Board	Occupation	State	License Status	License Count
Dentistry				
	Conscious/Moderate Sedation			
*	Conscious/Moderate Sedation	Virginia	Current Active	207
	Conscious/Moderate Sedation	Out of state	Current Active	5
	Total for Conscious/Moderate Sedation			212
	Cosmetic Procedure Certification			
*	Cosmetic Procedure Certification	Virginia	Current Active	31
	Cosmetic Procedure Certification	Out of state	Current Active	2
	Total for Cosmetic Procedure Certification			33
	Deep Sedation/General Anesthesia			
*	Deep Sedation/General Anesthesia	Virginia	Current Active	42
	Deep Sedation/General Anesthesia	Out of state	Current Active	8
	Total for Deep Sedation/General Anesthesia			50
	Dental Assistant II			
No CE	Dental Assistant II	Virginia	Current Active	9
	Dental Assistant II	Out of state	Current Active	2
	Total for Dental Assistant II			11
	Dental Faculty			
	Dental Faculty	Virginia	Current Active	14
	Dental Faculty	Out of state	Current Active	2
	Total for Dental Faculty			16
	Dental Hygienist			
	Dental Hygienist	Virginia	Current Active	4,527
	Dental Hygienist	Virginia	Current Inactive	73
	Dental Hygienist	Out of state	Current Active	836
	Dental Hygienist	Out of state	Current Inactive	140
	Total for Dental Hygienist			5,576
	Dental Hygienist Faculty			
	Dental Hygienist Faculty	Virginia	Current Active	1
	Total for Dental Hygienist Faculty			1
	Dental Hygienist Restricted Volunteer			
No CE	Dental Hygienist Restricted Volunteer	Virginia	Current Active	1
	Total for Dental Hygienist Restricted Volunteer			1
	Dental Restricted Volunteer			
No CE	Dental Restricted Volunteer	Virginia	Current Active	18
	Dental Restricted Volunteer	Out of state	Current Active	2
	Total for Dental Restricted Volunteer			20
	Dentist			
	Dentist	Virginia	Current Active	5,338
	Dentist	Virginia	Current Inactive	82
	Dentist	Virginia	Probation - Currei	1
	Dentist	Out of state	Current Active	1,375
	Dentist	Out of state	Current Inactive	245
	Total for Dentist			7,041

Run Date: 5/21/2016 11:59

License Count Report for Dentistry

Board	Occupation	State	License Status	License Count
Dentistry				
	Dentist-Volunteer Registration			
No CE	Dentist-Volunteer Registration	Virginia	Current Active	3
	Dentist-Volunteer Registration	Out of state	Current Active	3
	Total for Dentist-Volunteer Registration			6
	Enteral Conscious/Moderate Sedation			
*	Enteral Conscious/Moderate Sedation	Virginia	Current Active	158
	Enteral Conscious/Moderate Sedation	Out of state	Current Active	5
	Total for Enteral Conscious/Moderate Sedation			163
	Mobile Dental Facility			
No CE	Mobile Dental Facility	Virginia	Current Active	9
	Mobile Dental Facility	Out of state	Current Active	5
	Total for Mobile Dental Facility			14
	Oral/Maxillofacial Surgeon Registration			
*	Oral/Maxillofacial Surgeon Registration	Virginia	Current Active	215
	Oral/Maxillofacial Surgeon Registration	Out of state	Current Active	40
	Total for Oral/Maxillofacial Surgeon Registration			255
	Sedation Permit Holder Location			
No CE	Sedation Permit Holder Location	Virginia	Current Active	442
	Sedation Permit Holder Location	Out of state	Current Active	2
	Total for Sedation Permit Holder Location			444
	Temporary Resident			
No CE	Temporary Resident	Virginia	Current Active	50
	Temporary Resident	Out of state	Current Active	14
	Total for Temporary Resident			64
Total for Dentistry				13,907

Raosoft®

Sample size calculator

What margin of error can you accept? 5% is a common choice	5 %	The margin of error is the amount of error that you can tolerate. If 90% of respondents answer *yes*, while 10% answer *no*, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55. Lower margin of error requires a larger sample size.
What confidence level do you need? Typical choices are 90%, 95%, or 99%	90 %	The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer *yes* would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone. Higher confidence level requires a larger sample size.
What is the population size? If you don't know, use 20000	13907	How many people are there to choose your random sample from? The sample size doesn't change much for populations larger than 20,000.
What is the response distribution? Leave this as 50%	50 %	For each question, what do you expect the results will be? If the sample is skewed highly one way or the other,the population probably is, too. If you don't know, use 50%, which gives the largest sample size. See below under **More information** if this is confusing.
Your recommended sample size is	**266**	This is the minimum recommended size of your survey. If you create a sample of this many people and get responses from everyone, you're more likely to get a correct answer than you would from a large sample where only a small percentage of the sample responds to your survey.

Alternate scenarios

With a sample size of	100	200	300	With a confidence level of	90	95	99
Your margin of error would be	**8.19%**	**5.77%**	**4.70%**	Your sample size would need to be	**266**	**374**	**634**

More information

If 50% of all the people in a population of 20000 people drink coffee in the morning, and if you were repeat the survey of 377 people ("Did you drink coffee this morning?") many times, then 95% of the time, your survey would find that between 45% and 55% of the people in your sample answered "Yes".

The remaining 5% of the time, or for 1 in 20 survey questions, you would expect the survey response to more than the margin of error away from the true answer.

When you survey a sample of the population, you don't know that you've found the correct answer, but you do know that there's a 95% chance that you're within the margin of error of the correct answer.

Try changing your sample size and watch what happens to the *alternate scenarios*. That tells you what happens if you don't use the recommended sample size, and how M.O.E and confidence level (that 95%) are related.

To learn more if you're a beginner, read **Basic Statistics: A Modern Approach** and **The Cartoon Guide to Statistics**. Otherwise, look at the **more advanced books**.

In terms of the numbers you selected above, the sample size n and margin of error E are given by

$$x = Z(^{c}/_{100})^{2} r(100-r)$$

$$n = {}^{Nx}/_{((N-1)E^2 + x)}$$

$$E = \mathrm{Sqrt}[{}^{(N-n)x}/_{n(N-1)}]$$

where N is the population size, r is the fraction of responses that you are interested in, and $Z(c/100)$ is the critical value for the confidence level c.

If you'd like to see how we perform the calculation, view the page source. This calculation is based on the Normal distribution, and assumes you have more than about 30 samples.

About **Response distribution**: If you ask a random sample of 10 people if they like donuts, and 9 of them say, "Yes", then the prediction that you make about the general population is different than it would be if 5 had said, "Yes", and 5 had said, "No". Setting the response distribution to 50% is the most conservative assumption. So just leave it at 50% unless you know what you're doing. The sample size calculator computes the critical value for the normal distribution. Wikipedia has good articles on statistics.

How do you like this web page? ○ **Good as-is** ○ **Could be even better**

Questions? Please let us know.

Print Done

Virginia Board of Dentistry
June 10, 2016

Review of the Alternatives Recommended by Commenters on the NOIRA to Require a Periodic Jurisprudence Examination

Notable Quotes

"We are kept abreast of any changes in the regulations and laws via email and mail." Pg 7 of 13
"The laws governing Dentistry have not changed much if at all in the 15 years I have had my license…" Pg 6 of 10
"Our elected officials should really focus their attention to other areas." Pg 8 of 10
"My concern is the frequency which dentists would have to take this exam relative to the infrequent changes made by the Board." Pg 7 of 12
"It seems we now get email updates about regulation changes that we never got in the past. I feel more up to date than I ever have in the past. Is this not working?" Pg 9 of 12
"If the VDA would keep us informed/up to date via emails we would not need this." Pg 4 of 11
"Presently, I would have to STOP my practice in order to read (and understand) ALL of the continually generated "regulations" to practice dentistry in VA." Pg 7 of 11

Alternatives

- Regular E-mails (frequently, monthly, quarterly, yearly)
  - Notice of changes in laws and regulations
  - Board actions , recurring violations
  - Layman's terms, clear, easy to understand, readability
  - Request a response
- Require an Exam for Initial Licensure, Violators, Re-entry
- Online CE course
  - Review of recent changes
  - Violations/common infractions/trends
  - Module to review
  - Add as a CE requirement
- A short written or online test at renewal
- Comprehensive guidance documents
- Friendly well organized meeting annually
- Positive education campaign

Excerpt from the 9/18/2015

Ms. Reen reported:

- The proposal advanced by the Ad Hoc Committee on Disciplinary Findings to amend the Sanction Reference Points guidance document to add a financial gain factor to the offense scoring tables will be presented at the December meeting. She added that Mr. Kauder of Visual Research has evaluated the effect of adding this offence and will present his findings at the Board's December meeting.
- There were several misstatements about the work of the Board in the VDA President's Message in the latest Virginia Dental Journal. The misstatements were:
  1. *Only 3 – 5% of licensees violate the laws and regulations dentists.* She said that in the last five years 8,358 dentists have held an active dental license and 1,472 of those dentists have had at least one case before the Board. This means that 17.6% of the dentists licensed in this five year snapshot were or are currently being investigated by the Board for possible violations of the laws and regulations which govern dental practice in Virginia.
  2. *The Board only communicates to interested third parties about changes.* The Board's Public Participation e-mail list of 167 individuals and organizations includes numerous dentists and dental organizations. BRIEFS which addresses the policy actions of the Board is sent to every licensee with an email address on record.
  3. *The Board used to publish a quarterly newsletter.* Looking back to 1988, the records indicate that a year or more passed between bulletins until 2010. Beginning in 2010, BRIEFS has been issued twice a year with the exception that only one was issued in 2014.

She also noted that Dr. Link encouraged VDA members to contact Board members to address their issues. Ms. Reen said that Board members are public officials who can hear comments from the public, but she went on to caution that questions should be referred to her since she is the spokesperson for the Board.

Board Home
Board Members
Staff Listing
Meetings & Minutes
Laws & Regulations
Applications & Forms
FAQ
Renew Online
Update Your Information
License Lookup
Case Decisions
Disciplinary Proceedings
Guidance Documents
Oral and Maxillofacial Surgeon Profiles
News & Info
File a Complaint
Administrative Proceedings Division

Virginia Board of Dentistry News and Information

- Newsletters
- Other Board News
- Case Decsions

Newsletters

Click on the link below to view the Virginia Board of Dentistry Newsletter.

- February 2016 Briefs
- August 2015 Briefs
- February 2015 Briefs
- February 2014 Briefs
- August 2013 Briefs
- February 2013 Briefs
- August 2012 Briefs
- January 2012 Briefs
- August 2011 Briefs
- January 2011 Briefs
- August 2010 Briefs
- March 2010 Briefs
- August 2007
- May 2006
- Winter 2003/2004

- Spring 2003
- Winter/Spring 2002 (PDF format)
- Summer 2002

Other Board News

Sedation and Anesthesia Permits and Inspections Q and A

Questions and answers regarding Sedation and Anesthesia Permits and Inspections (pdf)

Extension of renewal requirements for deployed military and spouses

Virginia law allows active duty service people or their spouses who are deployed outside the U.S. to have an extension of time for any requirement or fee pertaining to renewal until 60 days after the person's return from deployment. The extension cannot last beyond 5 years past the expiration date for the license. For more information, please read attached policy (pdf) and contact the applicable board for your license.

Address of record

The Department of Health Professions (DHP) is required to collect an official address of record from each health professional. This address is used by DHP for agency purposes and may be provided as public information. DHP is also required to give health professionals the opportunity to provide an alternate address for dissemination to the public. **If no second (public) address is provided, the official address of record is given to the public.** An individual is not required to submit a place of residence for either the official address of record or the public address. A post office box or a practice location is acceptable. Changes to either address are required within 30 days of any change and may be made at any time by accessing your licensure information through the online system or by written notification to the Board.

Advertising

Advertising: Are you in Compliance

Recordkeeping - Beyond the Regulatory Requirement

Recordkeeping - Beyond the Regulatory Requirement - a Power Point presentation, is posted as a resource for licensees who wish to evaluate their recordkeeping practices.

Duty to Report Adult or Child Abuse, Neglect or Exploitation

By law, the persons licensed as health care practitioners have a duty to report to the Virginia Department of Social Services or the local departments of social services any known or suspected incidences of abuse, neglect, or exploitation of children or elderly and incapacitated adults. Contact information and a copy of the law may be obtained at: Legal Requirements to Report Child Abuse and Adult Abuse

Board Case Decisions

Recent Case Decisions

- January 1, 2002 to December 31, 2002
- January 1, 2003 to December 31, 2003
- January 1, 2004 to December 31, 2004
- January 1, 2005 to December 31, 2005

To view the PDF files on this page you'll need the free Adobe Acrobat Reader
For the other files you'll need Microsoft Word or the free viewer.

Board of Dentistry
Charles E. Gaskins III, DDS President
Sandra Reen, Executive Director
Email: denbd@dhp.virginia.gov

Virginia Board of Dentistry
June 10, 2016

IMPLEMENTATION OF THE FOUR CHAPTERS

POSTING REQUIREMENTS

1. **Use wallet size for display**
2. **Objections to displaying DEA permit because the information can be taken used fraudulently**
3. **Volunteer exemption not referenced in the regulations**

- **§ 54.1-2721. Display of license.**
  Every person practicing dentistry in this Commonwealth shall display his license in his office in plain view of patients. Any person practicing dentistry without having his license on display shall be subject to disciplinary action by the Board.
  The provisions of this section shall not apply to any dentist while he is serving as a volunteer providing dental services in an underserved area of the Commonwealth under the auspices of 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.
- **18VAC60-21-30. Posting requirements.**
  A. A dentist who is practicing under a firm name or who is practicing as an employee of another dentist is required by § 54.1-2720 of the Code to conspicuously display his name at the entrance of the office. The employing dentist, firm, or company must enable compliance by designating a space at the entrance of the office for the name to be displayed.
  B. In accordance with § 54.1-2721 of the Code a dentist shall display his dental license where it is conspicuous and readable by patients in each dental practice setting. If a licensee practices in more than one office, a duplicate license obtained from the board may be displayed.
  C. A dentist who administers, prescribes, or dispenses Schedules II through V controlled substances shall display his current registration with the federal Drug Enforcement Administration with his current active license.
  D. A dentist who administers conscious/moderate sedation, deep sedation, or general anesthesia in a dental office shall display his sedation or anesthesia permit issued by the board or certificate issued by AAOMS.
- **Action on applications for registration: revocation or suspension of registration**
  §1301.35 Certificate of registration; denial of registration.
  (c) The Certificate of Registration (DEA Form 223) shall contain the name, address, and registration number of the registrant, the activity authorized by the registration, the schedules and/or Administration Controlled Substances Code Number (as set forth in **part 1308** of this chapter) of the controlled substances which the registrant is authorized to handle, the amount of fee paid (or exemption), and the expiration date of the registration. The registrant shall maintain the certificate of registration at the registered location in a readily retrievable manner and shall permit inspection of the certificate by any official, agent or employee of the Administration or of any Federal, State, or local agency engaged in enforcement of laws relating to controlled substances. [62 FR 13954, Mar. 24, 1997]

MAINTAINING A SAFE AND SANITARY PRACTICE

1. **Reference the CDC Guidelines or a similar resource to give licensees specific information on requirements**

- **§ 54.1-2706. Revocation or suspension; other sanctions.**
  The Board may refuse to admit a candidate to any examination, refuse to issue a license to any applicant, suspend for a stated period or indefinitely, or revoke any license or censure or reprimand any licensee or place him on probation for such time as it may designate for any of the following causes:
  11. Practicing or causing others to practice in a manner as to be a danger to the health and welfare of his patients or to the public;
- **18VAC60-21-60. General responsibilities to patients.**
  A. A dentist is responsible for conducting his practice in a manner that safeguards the safety, health, and welfare of his patients and the public by:

1. Maintaining a safe and sanitary practice, including containing or isolating pets away from the treatment areas of the dental practice. An exception shall be made for a service dog trained to accompany its owner or handler for the purpose of carrying items, retrieving objects, pulling a wheelchair, alerting the owner or handler to medical conditions, or other such activities of service or support necessary to mitigate a disability.

- **Centers for Disease Control - Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care**

  This document summarizes current infection prevention recommendations and includes a checklist that can be used to evaluate compliance. The information presented here is based primarily upon the previously published 2003 guideline (see below) and represents infection prevention expectations for safe care in dental settings.

  The Summary includes additional topics and information relevant to dental infection prevention and control published by CDC since 2003 including:

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

  The Summary is intended for use by anyone needing information about basic infection prevention measures in dental health care settings, but is not a replacement for the more extensive guidelines. Readers are urged to consult the full guidelines for additional background, rationale, and scientific evidence behind each recommendation.

  Resources:

  Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care[PDF-1MB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care.pdf)
  Infection Prevention Checklist for Dental Settings (Print-Friendly)[PDF-825 KB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care-checklist.pdf)
  Infection Prevention Checklist for Dental Settings (Fillable Form)[PDF-884 KB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/dentaleditable_tag508.pdf)
  Recommendations from the Guidelines for Infection Control in Dental Health-Care Settings, 2003[PDF-766 KB](http://www.cdc.gov/oralhealth/infectioncontrol/pdf/recommendations-excerpt.pdf)

REPORTIABLE EVENTS

1. Is a report required when there is an emergency treatment event related to local anesthesia?
2. Should there be an "or" between sedation and anesthesia in the last line?

- **18VAC60-21-100. Reportable events during or following treatment or the administration of sedation or anesthesia.**

  The treating dentist shall submit a written report to the board within 15 calendar days following an unexpected patient event that occurred intra-operatively or during the first 24 hours immediately following the patient's departure from his facility, resulting in either a physical injury or a respiratory, cardiovascular, or neurological complication that was related to the dental treatment or service provided and that necessitated admission of the patient to a hospital or in a patient death. Any emergency treatment of a patient by a hospital that is related to sedation anesthesia shall also be reported.

DELEGATION TO DENTAL HYGIENISTS

1. **Use of the term "gingival curettage"** - refer to "incidental removal of soft tissue that may occur during root instrumentation" and not to gingival curettage as a stand-alone procedure
2. **Explain the term "nonsurgical laser"** – is laser diode more accurate
3. **Are there education requirements for using a laser?**

- **§ 54.1-2722. License; application; qualifications; practice of dental hygiene.**
  D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.
- **§ 54.1-2706. Revocation or suspension; other sanctions.**
  The Board may refuse to admit a candidate to any examination, refuse to issue a license to any applicant, suspend for a stated period or indefinitely, or revoke any license or censure or reprimand any licensee or place him on probation for such time as it may designate for any of the following causes:
  12. Practicing outside the scope of the dentist's or dental hygienist's education, training, and experience;
- **18VAC60-21-130. Nondelegable duties; dentists.**
  Only licensed dentists shall perform the following duties:
  2. Performing surgical or cutting procedures on hard or soft tissue except a dental hygienist performing gingival curettage as provided in 18VAC60-21-140;
- **18VAC60-21-140. Delegation to dental hygienists.**
  A. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:
     1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers, with any sedation or anesthesia administered.

  B. The following duties shall only be delegated to dental hygienists and may be performed under indirect supervision or may be delegated by written order in accordance with §§ 54.1-2722 D and 54.1-3408 J of the Code to be performed under general supervision:
     1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and nonsurgical lasers with or without topical oral anesthetics.
- **18VAC60-25-40. Scope of practice.**
  C. The following duties shall only be delegated to dental hygienists under direction and may only be performed under indirect supervision:
     1. Scaling, root planing, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and non-surgical lasers with any sedation or anesthesia administered.

  D. The following duties shall only be delegated to dental hygienists and may be performed under indirect supervision or may be delegated by written order in accordance with § 54.1-2722 D of the Code to be performed under general supervision:
     1. Scaling, root planning, or gingival curettage of natural and restored teeth using hand instruments, slow-speed rotary instruments, ultrasonic devices, and non-surgical lasers with or without topical oral anesthetics.