VIRGINIA BOARD OF DENTISTRY

AGENDA

December 8-9, 2016

Department of Health Professions

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

PAGE

December 8, 2016

9:00 a.m. **Formal Hearing**

December 9, 2016

Board Business

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

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- September 15, 2016 Formal Hearing **P1**
- September 16, 2016 Public Hearing **P4**
- September 16, 2016 Business Meeting **P10**
- September 26, 2016 Telephone Conference Call **P17**

DHP Director's Report – Dr. Brown

2016 Workforce Reports for Dentistry and Dental Hygiene **(Copies to be distributed at meeting)**
Elizabeth A. Carter, Ph.D., Director
DHP Healthcare Workforce Data Center

Virginia's Prescription Monitoring Program
Ralph A. Orr, Director

Liaison/Committee Reports

- AADB 2016 Annual Meeting – Dr. Rizkalla **P19**
- ADEX – Dr. Rizkalla
- CITA Agreement on Travel – Dr. Rizkalla **P27**
- SRTA– Dr. Watkins
- BHP - Dr. Watkins
- Exam Committee – Dr. Watkins
- Regulatory-Legislative Committee - Dr. Wyman **P29**

Legislation and Regulation – Ms. Yeatts

- Status Report on Regulatory Actions **P34**
- Adoption of Final Amendments Requiring Capnography **P35**

- Respond to Petition for Rulemaking **P47**
- Adoption of Proposed Amendments on Moderate Sedation **P67**

Board Discussion/Action

- Review and Discussion of Public Comment Topics – Dr. Rizkalla
- Establishing a Guidance Document on Opioid Prescriptions **P119**
- VDA and VDHA Amendments to Remote Supervision **P120**
- Clarification of Regulatory Provisions
  See Regulatory-Legislative Committee Minutes

Disciplinary Activity Report/Business – Ms. Palmatier **P125**

Executive Director's Report/Business – Ms. Reen

1:00 pm **Reconvene Formal Hearing**

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
September 15, 2016

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 11:10am, on September 15, 2016 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: A. Rizkalla, D.D.S, President

MEMBERS PRESENT:
Patricia B. Bonwell, R.D.H., PhD
Nathanial C. Bryant, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
August A. Petticolas, Jr., D.D.S.
Tammy C. Ridout, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
Carol R. Russek, J.D., Citizen Member
John M. Alexander, D.D.S.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Christine M. Houchens, Licensing Manager
Donna M. Lee, Discipline Case Manager

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
James E. Schliessmann, Senior Assistant Attorney General
Tracy E. Robinson, Adjudication Specialist
Juan Ortega, Court Reporter

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

Hamada R. Makarita, D.D.S Reinstatement
Case Nos.: 86781,136371, 143367 and 152192

Dr. Makarita was present without legal counsel in accordance with the Notice of the Board dated August 10, 2016.

Dr. Rizkalla swore in the witnesses.

Following Dr. Makarita's opening statement; Dr. Rizkalla admitted into evidence Applicants exhibits 1through 3.

Following Mr. Schliessmann's opening statement, Dr. Rizkalla admitted into evidence Commonwealth's Exhibits 1-22.

Testifying on behalf of the Commonwealth were Gayle E. Miller, DHP Senior Investigator, Chery M. Hodgson, DHP Senior Investigator and witness "Patient D".

Testifying on behalf of Dr. Makarita were Erica Hess-Makarita, Ghajiibah Campbell and Dr. Sameh Kassem. Dr. Makarita testified on his own behalf.

Mr. Schliessmann moved to have the witnesses separated. The Board granted Mr. Schliessman's request.

At 3:30pm, Christine Houchens left hearing and Donna Lee took her place.

Closed Meeting:

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

Reconvene:

Dr. Parris-Wilkins moved 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:

Mr. Rutkowski reported that Dr. Makarita's license is reinstated and placed on indefinite suspension for a period of not less than two years from the date of entry of the Order. Said suspension shall remain stayed contingent on continued compliance with the following terms:

Dr. Makarita will not prescribe or dispense Schedule II, III, and IV drugs for two years from the date of entry of the Order.

Within 3 months from the date of entry of the Order, Dr. Makarita shall successfully complete a 7 hour continuing education course in the subject of principles of pharmacology and prescription writing; and a 4 hour continuing education course in the subject of the treatment of medically compromised patients.

Within 6 months from the date of entry of the Order, Dr. Makarita shall successfully complete a 10 hour continuing education course in the subject of diagnosis and treatment planning protocol; and a 7 hour continuing education course in the subject of principles of ethics for the dental professional.

The continuing education courses shall be obtained from a program accredited by the Commission on Dental Accreditation ("CODA") of the American Dental Association.

Dr. Makarita shall be subject to a random audit of ten (10) patient charts once a year for two (2) years from the date of this order.

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

ADJOURNMENT: The Board adjourned at 12:50 a.m.

A. Rizkalla, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
PUBLIC HEARING

September 16, 2016

Perimeter Center
9960 Mayland Drive, Suite 201
Richmond, VA 23233-1463
Board Room 3

TIME AND PLACE:	The meeting of the Board of Dentistry convened a Public Hearing at 9:15 a.m. on September 16, 2016, to receive commons on proposed Regulations to Require Capnography for Monitoring Sedation and Anesthesia.
PRESIDING:	A. Rizkalla, D.D.S., President
BOARD MEMBERS PRESENT:	John M. Alexander, D.D.S Tonya A. Parris-Wilkins, D.D.S. Patricia B. Bonwell, RDH, PhD Nathaniel C. Bryant, D.D.S. Augustus A. Petticolas Jr., D.D.S. Tammy C. Ridout, RDH James D. Watkins, D.D.S. Bruce S. Wyman, D.M.D.
BOARD MEMBERS ABSENT:	Carol R. Russek, J.D., Citizen Member
STAFF PRESENT:	Sandra K. Reen, Executive Director for the Board Kelley Palmatier, Deputy Executive Director for the Board Christine M. Houchens, Licensing Manager for the Board
COUNSEL PRESENT:	James E. Rutkowski, Assistant Attorney General
OTHERS PRESENT:	Lisa R. Hahn, Chief Deputy Director, DHP
COURT REPORTER:	Denise Holt, Court Reporter, Crane Snead & Associates
QUORUM	Not Required
PUBLIC COMMENT:	None

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

Dr. Rizkalla announced the deadline for submitting public comments is October 21, 2016 and indicated that the Board will consider all comments received before issuing final Regulations.

A. Rizkalla, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

VIRGINIA BOARD OF DENTISTRY

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The public hearing came on for hearing on Friday, September 16, 2016, at the Virginia Department of Health Professions Office, Perimeter Center, 9960 Mayland Drive, Hearing Room 3, Henrico, 23233, Virginia, before Denise M. Holt, VCR No. 0315066.

BEFORE: A. Rizkalla, Chairperson

PANEL: Tonya A. Parris-Wilkins, DDS

Patricia R. Bonwell, DDS

John M. Alexander, DDS

James D. Watkins, DDS

Bruce S. Wyman, DMD

Tammy C. Ridout, RDH

Augustus A. Petticolas, DDS

Nathaniel C. Bryant, DDS

Sandra K. Reen, Executive Director

Lisa R. Hahn, Chief Deputy Director

Kelley W. Palmatier, Deputy Executive Director

Christine Houchens, Board Staff

COUNSEL: James E. Rutkowski

DR. RIZKALLA: Good morning, I am Dr. Rizkalla. This is a public meeting for the Board of Dentistry. I will ask the board members to introduce themselves -- actually, staff and board members, starting from my left.

MS. PALMATIER: Kelley Palmatier, deputy executive director.

DR. PETTICOLAS: Gus Petticolas, board member.

MS. RIDOUT: Tammy Ridout, board member.

DR. WYMAN: Bruce Wyman, board member.

DR. WATKINS: Jim Watkins, board member.

MR. RUTKOWSKI: Jim Rutkowski, board counsel.

MS. REEN: Sandy Reen, executive director.

DR. ALEXANDER: John Alexander, board member.

DR. BRYANT: Nate Bryant, board member.

MS. BONWELL: Trish Bonwell, board member.

DR. PARRIS-WILKINS: Tonya Parris-Wilkins, board member.

MS. HAHN: Lisa Hahn, deputy chief or chief deputy for the Department of Health Professions.

MS. HOUCHENS: Christine Houchens, board staff.

DR. RIZKALLA: Thank you. Ms. Reen, would you please read the evacuation announcement.

MS. REEN: Yes. Good morning. In the case of -- in the event of a fire or other emergency in the building, alarms will sound. When the alarm sound, you must evacuate

this room immediately by leaving either of the two doors at the rear of the room. You turn right, you proceed down that hallway to the exit door, through the exit door, through the parking lot to the fence at the back and await instructions from security personnel.

If you need assistance exiting this room, please let myself or Ms. Houchens know -- Christine, will you raise your hand -- so that we can make security personnel aware of your needs. Thank you.

DR. RIZKALLA: Thank you. This is a public hearing to receive comments on proposed amendments to require capnography for monitoring anesthesia for conscious sedation. There are copies of the proposed regulations on the sign-up table. At this time, I would like to ask anyone who would like to speak to come to the front. Going once, twice, okay, we move on.

Before opening the floor for public comment -- since no one is speaking now, I will remind everyone that written comments on the proposed regulations should be directed to Sandra Reen, Executive Director of the Board, or electronic comment can be posted on Virginia Regulatory Townhall, wwwtownhallvirginia.gov or send by email.

The comment period will close on October 21, 2016. The Board will consider all comments before adoption of final regulations on December 9, 2016, and this concludes our

hearing.

CONCLUDED

CERTIFICATE OF COURT REPORTER

I, DENISE HOLT, hereby certify that the hearing was taken down by me in stenotype and therefore reduced to typewriting; that I am neither counsel for, related to, nor employed by any of the parties, and further, that I am not a relative or employee or employed by the parties hereto, nor financially or otherwise interested in the outcome of the hearing.

Given under my hand this 16th day of September, 2016.

Denise Holt
0315066

Un-Approved

VIRGINIA BOARD OF DENTISTRY
MINUTES
September 16, 2016

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:15 a.m. on September 16, 2016, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 3, Henrico, Virginia 23233.

PRESIDING: A. Rizkalla, D.D.S., President

BOARD MEMBERS PRESENT:
John M. Alexander, D.D.S
Tonya A. Parris-Wilkins, D.D.S.
Patricia Bonwell, R.D.H., PhD.
Nathaniel Bryant, D.D.S.
Augustus Petticolas, D.D.S.
Tammy Ridout, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

BOARD MEMBERS ABSENT: Carol Russek, J.D.

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Kelley Palmatier, Deputy Executive Director for the Board
Christine M. Houchens, Licensing Manager for the Board

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT: Lisa R. Hahn, Chief Deputy Director, DHP

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

Ms. Reen read the emergency evacuation procedures.

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

PUBLIC COMMENT: **Linda D. Wilkinson, MPA,** CEO of the Virginia Association of Free and Charitable Clinics, said the statute and regulations for practice of dental hygienists under remote supervision fail to address the intended purpose of facilitating free and low cost services in free clinics and federal health centers. She commented that her

organization serves 75,000 low income uninsured patients, in 60 free clinics which are staffed by 600 volunteer dentists and 197 volunteer dental hygienists. She noted her association's commitment to changing the statute in the upcoming General Assembly.

APPROVAL OF Minutes:

Dr. Rizkalla asked if there were any corrections to the June 9, 2016 Formal Hearing minutes; June 10, 2016 Business Meeting minutes; the June 10, 2016 Special Session Minutes, the June 30, 2016 and August 2, 2015 Telephone Conference Call minutes and the August 12, 2016 New Board Member Orientation minutes. These minutes were approved as published.

DHP DIRECTOR'S REPORT:

Ms. Hahn reported that on October 24, 2016 DHP will host a Board Member Training event intended for all current board members. She noted that the topics would be the Freedom of Information Act; appropriate conduct as a board member; and, the life of a field investigator. She added that Dr. Brown and Ms. Yeatts will discuss the roles and responsibilities of the boards and DHP as an umbrella agency.

Ms. Hahn addressed the work of Governor Terry McAuliffe's Prescription Drug Task Force and discussed the growing epidemic of prescription opioid and heroin overdoses in Virginia. She asked the Board to consider developing opioid prescription guidelines for dentists. It was noted that prescription opioid abuse is mostly associated with chronic pain. Dr. Alexander suggested that the guidelines should distinguish between acute and chronic pain.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Watkins stated he did not have anything to add to his written report.

AADB. Dr. Rizkalla noted that he, Dr. Alexander, Dr. Wyman and Ms. Reen will be attending the AADB Annual Meeting on October 18-19, 2016. He noted that the Board is paying for four memberships in the AADB to enable these four individuals to participate in the discussion of clinical examinations for licensure. Ms. Reen provided background information on the ADA's forum on creating a national objective structured clinical examination and the current clinical exam options available to states. She encouraged board members to develop an understanding of this issue.

ADEX. Dr. Rizkalla gave a brief overview of the 2016 annual ADEX meeting and the changes to the ADEX dental and dental hygiene exams. He stated that the ADA was present at this meeting and the pros and cons of ADA's involvement in testing was

discussed. Several Board members commented on the need for portability of dental licenses.

SRTA. Dr. Watkins reported on the annual SRTA meeting, noting that, since SRTA had left ADEX, the SRTA exam had to be rewritten. He stated that VCU will no longer host administration of the SRTA examinations which has hurt SRTA. He reported that SRTA is now exploring opportunities to administer in other states to provide competition to ADEX.

CITA. Dr. Rizkalla noted that CITA is now administering the ADEX exam at VCU and asked Ms. Reen to address examining for the Council of Interstate Testing Agencies. She reviewed CITA's policies for examiners and reported that Board members could elect to examine for CITA and accept reimbursement for actual expenses which are within the parameters of Virginia's State Travel Regulations when such travel was approved in advance. She explained that the per diem CITA pays examiners in addition to the actual expenses incurred could not be offered to or accepted by any Board member who examines for CITA. She further explained that the Board member would be personally responsible for any actual expenses incurred which exceeded those permitted for reimbursement in the State Travel Regulations. Ms. Reen was asked to correspond with CITA to report there are Virginia Board members interested in examining for CITA and to seek CITA's agreement to abide by Virginia's travel regulations for these members. Discussion followed in which portability of a license was identified as the major concern of several members.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Reen reported that the Board has four fast track regulatory actions underway addressing the Public Participation Guidelines; qualifications for restricted or temporary licenses; CE credit for volunteer hours; and the administration of nitrous oxide only. She said the regulatory action to require capnography for monitoring anesthesia or sedation is in the public comment period in the standard regulatory process. The comment period ends on 10/21/2016 and the Board will consider the comments received at its December meeting and decide how to proceed.

Adoption of Emergency Regulations on Remote Supervision of Dental Hygienists. Ms. Reen referred to the minutes of the May 6, 2016 Regulatory/Legislative Committee meeting and explained that the Board needed to adopt the regulations today to meet the enactment clause of the statute. She said the Board could not

address its concerns about the employment and periodontal provisions in the statute in this regulatory action because the regulations must reflect the language used in the statute. She added the Board can then begin the standard regulatory process for these regulations which may take 18 months or more to complete. She explained that the statute needed to be amended by the General Assembly to address the concerns about the employment and periodontal provisions which have been discussed with the VDA. Dr. Rizkalla asked the Board to allow him to contact and work with various groups to address the Board's concerns about the current statutory language. The motion by Dr. Petticolas to approve Dr. Rizkalla's request was seconded and passed. The motion by Dr. Watkins to adopt the emergency regulations as presented was seconded and passed.

Adoption of Guidance Document on Remote Supervision. Amending the term "periodontal disease" to read "severe periodontal disease" was proposed and Board Counsel advised that the document must be consistent with the language in the statute. Dr. Watkins moved to adopt the guidance document as presented. This motion was seconded and passed.

Adoption of Exempt Action on Regulations for Mobile Dental Clinics. Ms. Reen noted that the Board's adoption of this action will conform the provisions of 18VAC60-21-430 to changes made in the Code. Dr. Wyman's motion to adopt this action was seconded and passed.

Respond to Petition for Rulemaking. Ms. Reen said the petition, which was supported by the comments posted on the Town Hall, is to change the requirement in 18VAC60-21-30.C of the Regulations Governing Dental Practice so that DEA permits do not have to be posted in a conspicuous location as currently required. The petitioner's goal is to decrease the opportunity for individuals to easily obtain a dentist's DEA number and use it to create fraudulent prescriptions. Ms. Reen proposed amending the language to be consistent with the Federal requirement that DEA registrations be maintained in a "readily retrievable manner at each practice location". Ms. Ridout's motion to amend the regulations as proposed was seconded and adopted.

BOARD DISCUSSION/ ACTION

Guidance Document 60-5, Auditing Continuing Education. Ms. Reen explained the document was discussed and revised at the Board's June 10, 2016 meeting but there was no motion to adopt it as revised. Dr. Wyman moved to adopt the revised document. The motion was seconded and adopted.

Guidance Document 60-15, Standards for Professional Conduct. Ms. Reen explained that an amendment is needed to be consistent with the current regulatory requirement for maintaining patient records for not less than 6 years. The proposed amendment changes the wording from "three (3)" to "six (6)" years.

Dr. Alexander questioned the bullet on posting information concerning the time frame for record retention and destruction in the patient receiving area and asked if this should be included. Ms. Reen said there are no regulations requiring this. She explained that the information in this document was provided by the Board to address best practices as well as regulatory requirements. She said this was included as a best practice rather than a legal requirement and as such cannot be enforced. Dr. Wyman moved to strike the paragraph and the motion was seconded and passed. The revised guidance document was adopted by consensus.

Guidance Document 60-17, Recovery of Disciplinary Costs. Ms. Reen reported that this document is updated annually to adjust the costs to be assessed to reflect the actual expenses incurred in the last fiscal year. Dr. Watkins moved to adopt the revision. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported that from May 25, 2016 through August 25, 2016, the Board received 90 cases and closed 155. She said, in the fourth quarter of FY 2016:

- A total of 65 patient care cases were received and 66 patient care cases were closed for a 102% clearance rate;
- The current pending caseload older than 250 days is 29% and the Board's goal is 20%;
- 75% of the patient care cases were closed within 250 days and the Board's goal is 90%.

She added that one dental hygiene license had recently been mandatorily suspended.

Ms. Palmatier explained there has been an increase in the number of requests made by respondents to be allowed to take Board Ordered courses online and reported these requests are consistently denied on the basis that the requirement for face-to-face, interactive sessions is part of the sanction.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Ms. Reen noted the comments she submitted on behalf of the Board in response to the ADA's most recent request for comments on its sedation & anesthesia guidelines were provided as information and no action is required.

Ms. Reen noted that the regulatory proposal for a periodic law exam was withdrawn by the Board in March in response to the opposition of its licensees. She requested discussion of the alternatives recommended in the comments received on the proposal as better strategies to effectively communicate with licensees. She noted that some of the suggestions are already in place but apparently are not effective. The Board discussed various alternatives such as requiring completion of a course at license renewal, increasing the number of BRIEFS issued per year, addressing case issues and actions in BRIEFS, including a brief law exam during the online renewal process and requiring applicants for licensure and reinstatement, and disciplinary case respondents to take a law exam. It was agreed by consensus that:

- Ms. Ridout and Ms. Reen will develop a proposal for convening a focus group of recent licensees to discuss effective communication strategies.
- Dr. Parris-Wilkins and Ms. Reen will address the content in BRIEFS and add a third issue each year.
- Ms. Reen and Ms. Palmatier will explore creating a Facebook page for the Board.

Ms. Reen reviewed the following questions and concerns identified by licensees regarding implementation of the four chapters of regulations that went into effect on December 2, 2015:

- Is displaying the wallet license acceptable?
- Objections to displaying DEA permits which the Board addressed earlier in this meeting.
- The volunteer exemption for posting a license should be included in the regulations.
- The use of the term "non-surgical laser" needs to be removed/replaced as there is no such thing.
- Within the delegation to hygienists, the term "gingival curettage" should be removed as it is not a CDT billable procedure.
- An inconsistency between the regulations (18VAC60-21-140 & 18VAC60-25-40) addressing delegation to dental hygienists and the regulations (18VAC60-21-291 & 18VAC60-21-301) regarding the treatment team for conscious/moderate sedation and information in Guidance Document 60-4 needs to be addressed.

Dr. Rizkalla assigned these matters to the Regulatory/Legislative Committee for discussion.

ELECTION OF OFFICERS:

Dr. Rizkalla reviewed the Nominating Committee minutes from June 10, 2016 and asked for any additional nominations. There were no other nominations and the following officers were elected by acclamation:

- Dr. Rizkalla as President
- Dr. Alexander as Vice-President, and
- Dr. Parris-Wilkins as Secretary-Treasurer.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 1:18 p.m.

_____
Al Rizkalla, D.D.S., President

_____
Sandra K. Reen, Executive Director

_____
Date

_____
Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:21 p.m., on September 26, 2016, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: John M. Alexander, D.D.S., Vice-President

MEMBERS PRESENT:
Patricia B. Bonwell, R.D.H., PhD.
Nathaniel C. Bryant, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
Tammy C. Ridout, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
Augustus A. Petticolas, Jr., D.D.S.
Carol R. Russek, J.D.
Al. Rizkalla, D.D.S.

QUORUM: With seven members present, a quorum was established.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Lori Pound, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General, Board Counsel
Wayne T. Halbleib, Senior Assistant Attorney General

Charles French, II, D.M.D.
Case No.: 173171

The Board received information from Mr. Halbleib in order to determine if Dr. French's impairment from mental illness constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.

Closed Meeting: Dr. Parris-Wilkins moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Charles French. Additionally, Dr. Parris-Wilkins moved that Ms. Reen, Mr. Rutkowski, and Ms. Lee attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

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

DECISION: Dr. Wyman moved that the Board summarily suspend Dr. French's license to practice dentistry in the Commonwealth of Virginia in that he is unable to practice dentistry safely due to impairment resulting from mental illness and schedule him for a formal hearing. Also offer a consent order to indefinitely suspend the license of Dr. French to practice dentistry; with the suspension stayed upon proof of his entry into a Participation Contract with the Virginia Health Practitioners' Monitoring Program within 30 days of the date of entry of the consent order in lieu of proceeding with a formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 6:18 p.m.

John M. Alexander, D.D.S., Chair	Sandra K. Reen, Executive Director
Date	Date

American Association of Dental Boards 133rd Annual Meeting

October18-19, 2016

Denver, Co

1. Interstate Medical License Compact

A compact is an agreement between at least two states. It is an agreement that involves the alliance of the legislative, judicial, and executive branches of state governments. The benefits of a compact include:

1. Increased licensees
2. Increased portability
3. Attracts "clean record" practitioners with ease of license application

Cons include:

1. Significant increase in work, especially during development and early implementation
2. Early work happens way before initial license fees are collected
3. Will naturally lead to a two-tier fee system for license (traditional license, and "compact plus" fee)

Compact licensure likely requires a change to the State's Practice Act

The three phases of implementing a compact include in advisory phase of 4 to 6 months, a drafting phase of 8 to 12 months and an education and legislative enactment phase of 18 months, which is usually two sessions of the state legislature. State compacts are allowed in the US Constitution. Compacts are created to help a mobile society, aid in technical advances such as Teledentistry and help a population with a deficit of healthcare providers for the benefit of current and future generations. It will also advance the progression of reciprocity amongst states.

Some myths about compacts are: it is not like a driver's license where you get a license in one state and the motor vehicle compacts allow you to drive in any state. You need a license in each state in a dental or medical compact. Each state in a compact has license renewal at different times, which need to be followed closely by the practitioner. Each practitioner also needs to keep track of the rules in each state compared to the automobile license compact where almost all states have the same rules.

In order to create a compact, state legislation needs to be created and this usually takes at least two years. A commission needs to be created; each state usually has an active board member and an administrator contributing to each compact commission. Although the practitioner has a usual state registration fee, there is an added fee to join the compact, these fees are not collected until well after the system is set up and therefore it is a financial drain for the board during formulation of the compacts.

2. A panel of hygiene licensure issues:

Hygienists from four different states gave a review of many different hygiene programs evolving across the country. At present there are approximately 300 RDH programs that teach hygienists and the average credit hours for each is 84 hours, which takes approximately three years to complete.

Direct Access (American Dental Hygienists' Association):

The ability of a dental hygienist to initiate treatment based on their assessment of a patient's needs without the specific authorization of a dentist, and maintain a provider-patient relationship.

Florida has a "health access settings" where a dental hygienist may practice without a dentist affiliation. Examples: Head Start center, Program or an institution of the Department of children and Families, the Department of Health, the Department of Juvenile Justice. They can perform prophys, dental charting, taking and recording vital signs, record history, fluoride treatments and sealant applications.

Illinois allows a hygienist with at least two years of full-time experience and completed at least 42 clock hours of additional structured courses in dental education approved by rule in advanced areas specific to public health dentistry to practice in public health settings without collaboration with the dentist. The dental hygienist must also practice pursuant to a written public health supervision agreement with a dentist.

Arizona has a "affiliated practice dental hygienist" May practice, pursuant to a written affiliated practice agreement with a dentist, in a public health settings. (may utilize teledentitry?) They must have five years of clinical experience or holder of a bachelor's degree and other stringent requirements

Missouri allows no supervision in public health center settings to Medicaid-eligible children and can be directly reimbursed. The hygienist must have at least three years of experience; they now have implemented Teledentistry and this program must be provided in a government facility.

Oregon has pilot project. Hygienists are now training perform temporary restorations. They are developing 5 to 7 dental hygienist therapists a year to provide therapy in Indian reservation settings without a dentist present. They are also allowing expanded practice hygienists to practice in limited access areas with no collaboration with dentists; approximately 600 out of 4000 registered hygienists in Oregon are practicing in this situation. (Oregon Tribes Dental Health Aide- DHAT- Therapist Pilot Project)

Barriers facing a hygienist include inconsistent acceptance of regional exams in approximately 50% of the states, various licensing requirements. State compacts would increase mobility of all skilled workers,

including dental hygienists. Approximately 46 states now have temporary type licensing for military spouses while their permanent license application is being processed.

Expanded dental therapists are now getting a national CODA standard. Several people indicated that this development would have helped tremendously in developing several models of expanded dental therapists.

3. Ethics and Boundaries Assessment Services LLC

Provides an Essay Exam: Situational judgement test: Example Scenario

A licensed practitioner had a habit of pouring a cocktail for himself at the end of office hours. One evening he decided to invite his receptionist to join him. The receptionist agreed, but became uncomfortable when the nature of the conversation turned to comments about her large breast size. The next day when she tried to discuss her concerns about the previous evening, the practitioner responded by saying, "If you have issues, you can quit."

Focus response issues: Opinions statements, consequences, solutions, and public protection

Scoring Criteria:
4 points Outstanding: Comprehensive and relevant opinion statement
3 points Sufficient to Pass: Basic, yet relevant opinion statements
2 points: Insufficient to Pass: Nonspecific or unclear opinion statements
1 point: Extremely insufficient: Inappropriate, irrelevant, or unprofessional opinion statements regarding ethical or boundary issues.

4. CPEP- The Center for Personalized Education for Physicians.

Ethics Remediation for Lapses in Professionalism and Boundaries.
It is an intensive, non-adversarial, educational intervention targeted to each participant's *specific infraction*

Curriculum components:

1. Professional virtues
2. Dentist or hygienist- patient relationship
3. Boundary issues
4. Intra-and inter- professional accountability
5. Social contract between dental profession and society
6. Final essay

Objectives:

- To develop a capacity to think ethically about one's infraction
- To answer the question, "Why *should* my board or regulatory college care about what I did?"

Unconditional Pass:

Participant demonstrates:

- Why one should be held to account
- Taking other perspective(s)
- Explaining where their thinking had been flawed
- Applying ethical frameworks
- "Probing" into why it happened
- Offering future safeguards
- A capacity to think ethically about the behavior

Failure:

- Defensiveness
- Inability to take other perspectives
- Unwillingness/ inability to examine their flawed thinking
- Lack of seriousness or preparation
- Lack of attention to requirements of essay assignment
- Absent or inadequate evidence of a capacity to think ethically about the behavior

5. Board Attorney RoundTable 2016- Panel on Top Cases

Hot issues:

Mobility and Portability
Unauthorized Practice
Reporting Discipline
Antitrust
Turf Wars!

- **Why is mobility a hot issue?**

Physical movement of licensees?
Pressures from the federal government?
Pressures from trade associations?
Pressures from politicians?

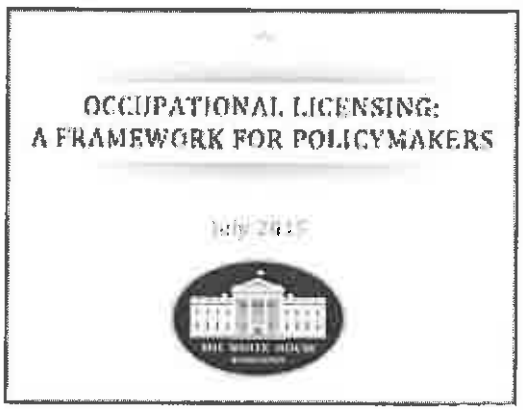
- Federalism v. State's Rights

10th Amendment to The United States Constitution

Eastwick College V New Jersey Board of Nursing

****National Association for the Advancement of Multijurisdictional Practice V Castille : Out-of state attorneys and public benefit corporation brought action against justices of Pennsylvania Supreme Court challenging constitutionality of Pennsylvania's reciprocal bar admissions rule. Pennsylvania's rule was upheld. The standard did not violate the 1st or 14th amendments.***

Reading Material: White House report critiquing and evaluating licensing requirements.



*****Cartels By Another Name: Should Licensed Occupations Face Antitrust Scrutiny?***

Aaron Edlin and Rebecca Haw, Cartels By Another Name: Should Licensed Occupations Face Antitrust Scrutiny?, 162 U. Pa. L. Rev. 1093 (2014),
Available at: http://scholarship.law.berkeley.edu/facpubs/2575

We contend that the state action doctrine should not prevent antitrust suits against state licensing boards that are comprised of private competitors deputized to regulate and to outright exclude their own competition, often with the threat of criminal sanction. At most, state action should immunize licensing boards from the per se rule and require plaintiffs to prove their cases under the rule of reason. We argue that the Fourth Circuit's recent decision, soon to be reviewed by the Supreme Court, to uphold a Federal Trade Commission (FTC) antitrust suit against a licensing board-denying state action immunity to a licensing board and thereby creating a circuit split-was a step in the right direction but did not go far enough. The Supreme Court should take the split as an opportunity to clarify that when competitors hold the reins to their own competition, they must answer to Senator Sherman.

- Is A Compact on Dental Licensure the answer? To be determined...

- Unlicensed and Unauthorized practice of dentistry

  Choong H. Lee, DMD, PLLC V Thaheld/Lee Dentist brought action against dental consultant seeking declaratory judgment, injunctive relief, and monetary damages arising from service

agreement that provided for consultant's administration of dentist's two dental practices. The Court of Appeals, held that:

1. Agreement violated statutory prohibition on corporate practice of dentistry, and
2. No part of agreement was enforceable, regardless of any inconsistency between agreement's terms and conduct of dentist and consultant following agreement's execution.

- Texas Dental Board's Remedial Plans
  A public non-reportable remediation plan

- DEA Reduces Amount of opioid Controlled Substances to be Manufactured in 2017 at least 25 percent.

- E-Bay Dental Supplies

Teledoc V Texas
Teledoc sues the Texas Medical Board and its members for Antitrust Violations.
Teledoc asserted that the Medical Board is illegally limiting competition by requiring an in-person visit before physicians are allowed to treat patients and that they were robbing the public of valuable telehealth benefits.
FTC weighs in with a letter to the 5th circuit siding with Teledoc
Texas files a motion to dismiss
5th circuit denies immunity for the Texas Medical Board
Cites North Carolina case and makes reference to anticompetitive acts

Potential future implications: All rule-making by Boards are subject to challenge.
Case remains ongoing

6. ADA Licensing Task Force

There was a report on the ADA's Licensing Task Force given by the chairman of the task force. It was formed in 2015 with the concern of lack of portability and fragmentation in the application process for dental licenses. This concept is being supported by the federal government, especially the Brookings Institute and the US Department of Labor. Only 61% of dental school graduates can take the clinical exam in their own school. The task force heard from clinical testing agencies as the ADA presented data on all of the exams. They concluded that public safety is assured in all the testing agency exams. The ADA asked five states to attend a meeting in August, 2016, which was described as quite contentious; the ADA pressured them to increase the acceptance of all regional examinations. The Task Force showed evidence of lack of portability in these states. Virginia now accepts candidates to submit results from any of the testing agencies and our application process is extremely quick relative to many other states. Thus, we do not have an issue with the portability as indicated by the ADA. As an aside, however, many

state boards require a criminal background check and Virginia does not. This background check can take as long as six weeks.

The ADA's policy is the elimination of the patient in the clinical exam due to ethical, financial, and practical challenges by developing an Objective Structured Clinical Examinations (OSCE) and wants to have dental boards to comply by changing state laws.

Representatives from various state boards present in the meeting voiced their concerns regarding such an exam and made it clear that a patient based exam is more desirable to evaluate hand and patient management skills of a candidate. The Dean on the University of Minnesota who administer the OSCE, admits that it is just one part of the candidate's evaluation; it works in their state because the board office is within walking distance from the dental school and board members frequently go back and forth and are familiar with the clinical progress of the students.

ADA representatives were advised to rethink moving the concept forward.

Also, the Curriculum Integrated Format- CIF, was felt is a good compromise. Testing agencies are able and have been administering a CIF at a number of dental schools

7. The AADB's "Assessment Series Program" (ASP)

It assists state boards by offering expert direction in operations concerning difficult, specific disciplinary cases. The three steps involved are all paid for by the respondent and are the following:

1. Expert review assessment by an outside opinion; the Association has 25 experts in all major specialties that review and report within 30 to 45 days of the board giving notice to the Association.
2. A comprehensive four to five day on-site review and evaluation program at either the University of Maryland, LSU or Marquette, which includes a clinical performance review and ultimately yields one of three recommendations to the state board: respondent should not practice again or should practice after suspension pending remediation or should practice immediately with concurrent remediation.

3. Remediation after the above, which could take place at either of the above three dental schools or Southeastern Nova University in Florida. The remediation would address the specific practice deficiencies after the state board approves the on-site and online combination curriculum. The respondent pays all fees, which are significant. The AADB is trying to promote this program as a revenue stream, but there have been almost no cases referred to it in the past and the dental schools are quite frustrated because of the lack of revenue from the program.

8. Open Forum:

There was also an open forum for each of the state boards to present relevant issues from the past year. One interesting finding from Hawaii was that they now require three hours per year of CE's in ethics in addition to all the previous CE requirements.

During an open forum of all the regional testing services, it was shown that they are all very much similar to each other and that the competition amongst each other generates continued improvement and changes as practice models change throughout the country.

9. Notable Mention:

Our own executive director, Ms. Sandra Reen was elected Vice-President of the American Association of Dental Administrators.

Submitted by VA representatives to the AADB:

John Alexander, DDS

Sandra Reen Executive Director

A.Rizkalla, DDS

Bruce Wyman, DDS

Agreement of the Council of Interstate Testing Agencies (CITA) to Abide by the Laws and Regulations of the Commonwealth of Virginia which Govern the Travel of Members of the Virginia Board of Dentistry (Board) while Conducting the Public Business of Examining for Licensure

PURPOSE

The **Code of Virginia § 54.1-2400** authorizes the Board to establish the qualifications for registration, certification and licensure and to examine or cause to be examined applicants for certification or licensure. In keeping with this authority, the Board seeks this agreement so that its members might examine potential dental and dental hygiene applicants who elect to take a CITA clinical examination.

VIRGINIA'S TRAVEL PROVISIONS

As provided in the Department of Accounts State Travel Regulations, exempt organizations such as CITA might pay for or reimburse Board members serving as Virginia public officials for actual expenses consistent with the following requirements which must be met:

- CITA is limited to paying or reimbursing for reasonable legitimate travel and related expenses incurred by a member of the Board.
- CITA cannot provide gifts, an honorarium, or compensation for services to a member of the Board.
- Reimbursement must comply with the funding organization's (CITA) travel policy.
- Each board member must obtain travel approval from the Director of the Department of Health Professions (Director) **in advance** of any travel to examine for CITA.
- If estimated travel expenses for a travel event exceed any of the guidelines established in Virginia State Travel Regulations, the Office of the Secretary of Health and Human Resources (OSHHR) must approve the travel **in advance**. This approval request must be submitted to the OSHHR no less than 10 days prior to the departure date.
- If the travel expenses which exceed the guidelines established in Virginia State Travel Regulations are not approved by the Secretary **in advance**, reimbursement of such expenses must be limited to the amounts authorized in the Virginia State Travel Regulations and approved by the Director.
- CITA, as an exempt organization, is allowed to pay expenses directly for the traveler (such as lodging and airfare) and may directly reimburse the traveler for out-of-pocket expenses based on CITA's travel policy.
- The traveler should submit reimbursement requests for out-of-pocket expenses to CITA on CITA's official reimbursement form in accordance with the funding organization's travel policy.
- Documentation of the actual reimbursement paid to a member of the Board must be provided by CITA to the Board and must be retained by the Board as set forth in Virginia's records retention requirements.

TRAVEL MANAGEMENT

- CITA staff and Board staff, in consultation with the respective member of the Board, will exchange information to facilitate travel planning immediately upon identifying the intent to use the member as an examiner.

- Board staff will gather the needed travel expense documentation and prepare the travel request for review by the executive director of the Board.
- Following review of the request, the executive director will follow the Department of Health Professions' procedures for submitting travel requests.
- Upon receipt of the decision on the travel request, Board staff will notify the member and CITA staff.
- Once travel is approved, travel arrangements can be made.
- Within 60 days following the travel event, CITA staff will provide to the Board written documentation of the reimbursement paid to the member by CITA.
- Board staff will include the documentation provided in its records addressing the travel.

TERMS

Both parties agree to fulfill the terms of this agreement until such time that it is amended or terminated.
Either party may request an amended agreement at any time.
Either party may terminate this agreement by giving written notice to the other party provided that any travel event initiated in keeping with this agreement will be completed as set forth in this agreement.

On September 16, 2016, the Virginia Board of Dentistry authorized its Executive Director to obtain an agreement with CITA to abide by the policies and regulations for travel as addressed in this agreement.

Sandra K Reen

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

October 28, 2016
Date

On November 7, 2016, the Council of Interstate Testing Agencies agreed to abide by the policies and regulations for travel of members of the Virginia Board of Dentistry as addressed in this agreement.

Cindy Jones

Cindy Jones
Executive Director
Council of Interstate Testing Agencies

November 7, 2016
Date

UNAPPROVED

BOARD OF DENTISTRY
MINUTES OF REGULATORY–LEGISLATIVE COMMITTEE
Friday, October 14, 2016

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order on October 14, 2016 at 9:05 a.m. at the Department of Health Professions, 9960 Maryland Drive, Suite 201, Board Room 4; Henrico, Virginia.

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

COMMITTEE MEMBERS PRESENT: John M. Alexander, D.D.S.
Tonya A. Parris-Wilkins, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Tammy C. Ridout, R.D.H

OTHER BOARD MEMBERS PRESENT: James D. Watkins, D.D.S.

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

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Christine M. Houchens, Licensing Manager
Elaine Yeatts, DHP Policy Analyst

PUBLIC COMMENT: Misty Mesimer, Program Director-Dental Assisting/Assistant Professor from Germanna Community College, said the DAII courses offered at Germanna have now received accreditation through the Virginia Community College System which allows students to earn college credit as well as receive student loans for these courses. She supported changing the DAII eligibility requirements to a competency based model. She advised against using the DANB Expanded Functions Exam because it doesn't cover all the duties delegable in Virginia.

Lori Turner, DAU Instructor at VCU School of Dentistry, stated that currently VCU does not have a DAII program but that there is interest. She supported moving to a competency based program which addresses the classification levels of procedures. She said dentists should be calibrated in teaching the procedures to ensure better understanding of competence of DAIIs.

APPROVAL OF MINUTES: Dr. Wyman asked for a motion on the May 6, 2016 minutes. Ms. Ridout's motion to accept the minutes as presented was seconded and passed.

REMOTE SUPERVISON LAWS AND REGULATIONS:

Terry Dickinson, DDS, VDA Executive Director, presented the recommended changes to the law governing remote supervision of dental hygienists which have been agreed to by the VDHA and the VDA. He said the current employment provision was changed to allow the clinics and facilities where remote supervision is allowed to employ the dental hygienist. He added that the current dental home language was simplified and the current medically compromised and periodontal disease provision was replaced with having a written protocol for addressing medical conditions and the presence of oral disease. In response to a question, Dr. Dickinson confirmed that the VDHA has seen and agreed to the propose changes. Elaine Yeatts congratulated the VDA and VDHA for working collaboratively and that she believes this will accomplish the initial intended goals. Ms. Reen said the Committee might accept the proposed changes by the VDA/VDHA as information, recommend that the Board support the proposed legislation, or identify any issues with the proposal the Board should address. She added the VDA/VDHA proposed language does address the three issues the Board identified in developing regulations to implement the remote supervision statute. Ms. Ridout's motion to recommend support of the proposed changes was seconded and passed.

STATUS REPORT ON LEGISLATION AND REGULATORY ACTIONS:

Ms. Yeatts reported that two regulatory actions will go into effect on November 16, 2016:

- The action amending Chapters 21 and 25 to include the new definition of remote supervision, the limitation on employment of dental hygienists for practice under remote supervision, and the delegation of duties under such supervision to conform to changes in §54.1-2722 and §54.1-2724 of the Code of Virginia.
- The action amending 18VAC60-21-430 to expand the exemptions for registration of mobile dental clinics to conform to changes in § 54.1-2708.3 of the Code of Virginia.

Ms. Yeatts reported that the action to change the requirement for posting a DEA permit to require that such a permit be maintained in a readily retrievable manner at each practice location is currently under review by the Department of Planning and Budget. She also stated the amendment of the Public Participation Guidelines to afford interested persons the right to be accompanied by and represented by counsel or other representative in making comments to the Board is pending publication as final regulations.

DISCUSSION ON POSSIBLE REVISIONS TO THE REQUIREMENTS FOR DENTAL ASSISTANT II REGISTRATION

Dr. Wyman said the question before the Committee is whether it wants to recommend either keeping the DAII regulations as they are or to amend them. Following extensive discussion of the reported barriers to obtaining registration under the current

regulations, the Committee agreed to pursue amendment of the regulations.

Ms. Mesimer responded to questions about the recognition of the DAII coursework by the Virginia Community College System and gave an overview of Germanna's program. She noted that the cost of the program is a major factor for enrollment and that the students can now receive financial aid because the courses qualify for college credit hours. She added that students are hesitant to enroll in the program because of the uncertainty of job prospects. She stressed the need to calibrate dentists who supervise the clinical experience.

Ms. Turner responded to questions about the expanded function dental assistant (EFDA) program requirements in Pennsylvania where she is registered as an EFDA. She discussed how she would convert the Board's current regulations to a competency based model. She recommended that an externship be evaluated on the number of procedures that need to be performed correctly. She also commented on the importance of dental oversight by dentists who have completed mandatory calibration exercises to guide the assessment of students. She added that the DAII requirements cannot be higher than requirements for dental students and noted that the needed chairside skills and techniques for CDAs are different from those needed by dental hygienists. She said, in Pennsylvania, DAIIs are employed in mostly high end practices of all practice types because it allows the dentist to see more patients. She added that her experience was that patients did not have qualms about being treated by an EFDA.

The Committee agreed by consensus that the education requirements should be changed to a competency based model as recommended in forums and in public comment. Ms. Yeatts advised that the Committee must take into account that other states regulate all dental assistants but Virginia doesn't. Dr. Petticolas moved that the Regulatory Advisory Panel be convened to review the DAII regulations and recommend changes to the regulations for consideration by the Committee. The motion was seconded and passed.

REVIEW ISSUES WITH IMPLEMENTATION OF THE FOUR CHAPTERS

Dr. Wyman called for discussion of the questions and statements of concern staff have received from licensees since issuance of the four chapters of regulations. The topics were addressed as follows:

- 18VAC60-21-30.B, 18VAC60-25-20.B, and 18VAC60-30-20.B, which require posting a license or registration, do appear to permit a licensee or registrant to post the wallet size license issued by the Board. Ms. Ridout made a motion to

recommend this interpretation to the Board. The motion was seconded and passed.

- 18VAC60-21-30.B, 18VAC60-25-20.B, and 18VAC60-30-20.B, which require posting a license or registration, do not address the exemptions in §§54.1-2721 and 54.1-2727 of the Code of Virginia for volunteer practice. The committee agreed by consensus to recommend that these sections be amended to reference the exemptions as proposed by Yeatts.

- Ms. Yeatts advised against incorporating the CDC Guidelines by reference in the regulations and recommended consideration of a guidance document. A motion by Dr. Parris-Wilkins to address safe and sanitary practice through a guidance document was seconded and passed.

- The Committee agreed by consensus to recommend that 18VAC60-21-100 should be interpreted to require reporting within 15 days of any emergency treatment related to local anesthesia is. It was also agreed by consensus to recommend that "or" be inserted between sedation and anesthesia in this section.

- By consensus, Ms. Yeatts was asked to research and propose terminology to replace the terms "gingival curettage" and "non-surgical" in 18VAC60-21-130. 18VAC60-21-140, and 18VAC60-25-40 for consideration by the Board.

- The inconsistency in regulatory provisions addressing dental hygiene practice in 18VAC60-21-140, 18VAC60-25-40, 18VAC60-21-291, and 18VAC60-21-30, and also in Guidance Document 60-4 related to treating patients under sedation and anesthesia was discussed. A motion by Dr. Alexander to recommend requiring a three-person treatment team for conscious/moderate sedation was seconded and passed. By consensus, Ms. Yeatts was asked to propose language addressing when a dental hygienist is allowed to treat patients who are sedated for consideration by the Board.

- Ms. Yeatts stated she would correct the regulatory citations in 18 VAC 60-21-280 as a technical amendment which does not require Board action.

NEXT MEETING:

Ms. Reen said she would work on scheduling the Regulatory Advisory Panel meeting for early January.

ADJOURNMENT:

With all business concluded, Dr. Wyman adjourned the meeting at

11:48 a.m.

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

Sandra K. Reen, Executive Director

Date

Date

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of November 14, 2016)

Chapter		Action / Stage Information
[18 VAC 60 - 11]	Public Participation Guidelines	Conforming to Code [Action 4577] Fast-Track - *Register Date: 10/31/16* *Effective: 12/15/16*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Requirement for capnography for monitoring anesthesia or sedation [Action 4411] Proposed - *Register Date: 8/22/16* *Comment period closed: 10/21/16* *Board to adopt final regulation: 12/9/16*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Credit for volunteer hours and extension of time for CE [Action 4597] Fast-Track - *At Governor's Office* [Stage 7617]
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Administration of nitrous oxide only [Action 4598] Fast-Track - *At Governor's Office* [Stage 7618]
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Posting of DEA registration [Action 4682] Fast-Track - *At Secretary's Office* [Stage 7721]
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Remote supervision of dental hygienists [Action 4665] Final - *Register Date: 10/17/16* *Effective: 11/16/16*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Mobile dental clinics [Action 4666] Final - *Register Date: 10/17/16* *Effective: 11/16/16*

Agenda Item: Board action on Capnography

Included in your agenda package are:

A copy of the Board's proposed regulations

A copy of public comment (There were no comments at the public hearing held on 9/16/16)

Board action:

To adopt the final amendments to 18VAC60-21-291 and 18VAC60-21-301 to require use of capnography in monitoring of patients after administration of conscious/moderate sedation, deep sedation, or general anesthesia.

Project 4438 - Proposed

BOARD OF DENTISTRY

Requirement for capnography for monitoring anesthesia or sedation

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

A. Delegation of administration.

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

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

a. A dentist with the training required by 18VAC60-21-290 D 2 to administer by an enteral method;

b. A dentist with the training required by 18VAC60-21-290 D 1 to administer by any method;

c. An anesthesiologist;

d. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1; or

e. A registered nurse upon his direct instruction and under the immediate supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1.

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

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

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

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

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

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

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

B. Equipment requirements. A dentist who administers conscious/moderate sedation shall have available the following equipment in sizes for adults or children as appropriate for the

patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

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

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

5. Pulse oximetry;

6. Blood pressure monitoring equipment;

7. Pharmacologic antagonist agents;

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

9. Mechanical (hand) respiratory bag;

10. Appropriate emergency drugs for patient resuscitation;

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

12. Defibrillator;

13. Suction apparatus;

14. Temperature measuring device;

15. Throat pack; ~~and~~

16. Precordial or pretracheal stethoscope; and

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

C. Required staffing. At a minimum, there shall be a two person treatment team for conscious/moderate sedation. The team shall include the operating dentist and a second person to monitor the patient as provided in 18VAC60-21-260 K and assist the operating dentist as provided in 18VAC60-21-260 J, both of whom shall be in the operatory with the patient throughout the dental procedure. If the second person is a dentist, an anesthesiologist, or a certified registered nurse anesthetist who administers the drugs as permitted in 18VAC60-21-291 A, such person may monitor the patient.

D. Monitoring requirements.

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

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

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

E. Discharge requirements.

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

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

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

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

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

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

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

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

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

B. Delegation of administration.

1. A dentist who does not meet the requirements of 18VAC60-21-300 shall only use the services of a dentist who does meet those requirements or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a dentist shall use either a dentist who meets the requirements of ~~18VAC60-20-300~~ 18VAC60-21-300, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist who meets the requirements of ~~18VAC60-20-300~~ 18VAC60-21-300 may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

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

b. An anesthesiologist; or

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

3. Preceding the administration of deep sedation or general anesthesia, a dentist who meets the requirements of ~~18VAC60-20-300~~ 18VAC60-21-300 may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

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

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

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

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

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

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

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

6. Mechanical (hand) respiratory bag;

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

8. Appropriate emergency drugs for patient resuscitation;

9. EKG monitoring equipment;

10. Temperature measuring devices;

11. Pharmacologic antagonist agents;

12. External defibrillator (manual or automatic);

13. ~~For intubated patients, an End-Tidal CO^2 monitor~~ An end-tidal carbon dioxide monitor (capnograph);

14. Suction apparatus;

15. Throat pack; and

16. Precordial or pretracheal stethoscope.

D. Required staffing. At a minimum, there shall be a three-person treatment team for deep sedation or general anesthesia. The team shall include the operating dentist, a second person to monitor the patient as provided in 18VAC60-21-260 K, and a third person to assist the operating dentist as provided in 18VAC60-21-260 J, all of whom shall be in the operatory with the patient during the dental procedure. If a second dentist, an anesthesiologist, or a certified registered nurse anesthetist administers the drugs as permitted in 18VAC60-21-301 B, such person may serve as the second person to monitor the patient.

E. Monitoring requirements.

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

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

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

F. Emergency management.

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

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

G. Discharge requirements.

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

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

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

Virginia.gov Agencies | Governor

Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Dentistry**

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

Action	Requirement for capnography for monitoring anesthesia or sedation
Stage	Proposed
Comment Period	Ends 10/21/2016

Back to List of Comments

Commenter: Jonathan L Wong, DMD, ASDA, ADSA, ADA, VCU Instructor * 8/24/16 8:05 pm

Importance of End Tidal CO2 Monitoring

To Whom It May Concern:

I would like to make a resounding endorsement of the use of End Tidal CO2 monitoring or capnography in sedation and anesthesia. The gold standard in monitoring for any sort of anesthesia or sedation procedure has always been the American Society of Anesthesiologists Guidelines to Monitoring. They have routinely recommended the monitoring of ventilation via multiple clinical methods since the guidelines were published. In 2010, they officially standardized the use of capnography for sedation. Here is the wording that has been used since 2011:

""During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.""

Dentistry has been hesitant to adopt such standards until recently. Whether such a decision was driven by antiquated standards, economic concerns, or because practitioners truly felt that dentistry precluded the use of CO2 monitoring, in 2016 this rational cannot persist. Patient safety must always be the number one goal in anesthesia, an anesthesiologists motto is "Vigalence." It has never been more important that dentistry stress the importance of this in anesthesia than now, as dentistry's track record of safe anesthesia delivery is being rightfully questioned by the public.

In addition, medicine is increasingly limiting the practice of operator anesthetists, a model that dentistry still touts as a safe standard of care. When an anesthetists is both in charge of monitoring a patient and completing a procedure, one has two, and sometimes conflicting, goals. In reality, many may in fact delegate monitoring to their dental assistants, whom may or may not be adequately trained to monitor adequate respiration before a problem emerges. Having the additional monitoring of capnography places another line of defense against potentially lethal and tragic complications of anesthesia.

In addition I believe it should also be considered that the use of End Tidal CO2 monitoring or Capnography should be required for monitoring patients, and not just required as equipment that must be present. In the anesthesia record, I would recommend that the qualitative presence of

CO2 on exhalation should be required (a quantitative number is often inaccurate unless the patient is intubated because of fresh gas flow to the patient.)

I believe the use of capnography updates the standard of care in dentistry to be more consistent with the medical standard of care. Therefore, I endorse the use of Capnography or End Tidal CO2 monitoring.

Thank you.

* Nonregistered public user

Agenda Item: Board action on Petition for Rulemaking

Included in your agenda package are:

A copy of the petition with attachments from Dr. Christine Barry

A copy comments from petitioner and Townhall

A copy of the applicable section of regulations

Board action:

1) **To accept the petition and initiate rulemaking with adoption of a NOIRA; or**

2) **To deny the request to amend regulations (the reasons for declining to initiate rulemaking must be stated by the Board).**

COMMONWEALTH OF VIRGINIA
Board of Dentistry

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

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

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

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

Petitioner's full name (Last, First, Middle initial, Suffix,)		
Dr. Barry, Christine L.		
Street Address 1314 La Salle Court	**Area Code and Telephone Number** 7737502249	
City Vista	**State** CA	**Zip Code** 92081
Email Address (optional) messine@roadrunner.com	**Fax (optional)** 9775164432	

Respond to the following questions:

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

   See attachment Page 1 and 2

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

   See attachment Page 2 to Page 11

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

   see attachment Page 12 and 13

Signature: Christine J Barry **Date:** 9/24/16

Dr. Christine Barry

1314 La Salle Court
Vista Ca 92081
Tel 773-750-2249 Fax 877-516-4432
Messine@roadrunner.com

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

Virginia Administrative Code
Title 18. Professional and Occupational Licensing
Agency 60. Board of Dentistry
Chapter 21. Regulations Governing the Practice of Dentistry

18VAC60-21-250

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

1. American Dental Association and the National Dental Association or its constituent or component/branches and approved continuing education providers;
2. American Dental Hygienists Association and the National Dental Hygiene Association or its constituent/component 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, and approved continuing education providers;
5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;
6. Academy of General Dentistry its constituent and component/branch associations;
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 organization 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 Associations Liaison Committee for Medical Education;

10. A dental, dental hygiene or dental assisting program accredited by the Commission on Dental Accreditation of the American Dental Association;
11. State or federal government agencies (i.e. military dental division, Veterans 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 Intestate Testing Agencies or Western Regional Examining Board (when serving as an examiner).

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

Petition to amend this section and add "16. And other continuing education organizations as approved by the board."

Introduction

All health care regulatory boards should recognize their responsibility towards professional development and lifelong learning based on certain key assumptions. First, that health care professionals are obligated to engage in lifelong learning. Secondly, they are accountable for meeting or exceeding performance standards in their field of expertise. There should be a spotlight on continuing competence through skill development and upholding of acceptable standards of practice. Further, there should be a goal towards attainment of advanced knowledge, skills and abilities for excellence in practice. Finally, direct a commitment to sustain and enhance the profession.

Health care regulatory boards have significant responsibility to the public in this area as they are required by law to ensure that providers licensed to practice in their state continue to be competent throughout their career. Continuing competency is essential to an ethical practice. Once credentials have been awarded, there are few genuine measures of a practitioner's growth, development and competency in practice. Most continuing education is self-directed.

The complexity of the business of health care continues to increase. It is important that health care regulatory boards be committed to help each provider to improve within their practice with appropriate training and knowledge building. Health care regulatory boards seek to support the role of leadership that each provider should

achieve so that they can respond to the needs of the practice. The common bond between Boards and continuing educations providers is their desire that every practitioner has access to the knowledge needed to harmonize their practice with the reality of the environment in which they practice.

The Shot Heard Around the Nation

For the last couple of decades the Federal Trade Commission (FTC) has been keeping an eye on the various regulations promulgated by regulatory boards nationwide in the context of anti-competitive activities. Several cases had been pursued and consent orders issued to resolve the various allegations. On a number of occasions the Federal Trade Commission sent warning letters against passing laws that might restrict the scope of practice of allied health professionals. State Legislatures in Florida, Georgia, Kentucky, Louisiana, Missouri, Maine, North Carolina and Tennessee all received these letters.

The American Medical Association (AMA) and the Federal of State Medical Boards (FSMB) were concerned about the impact of continuing enforcement against "anti-competitive behavior." One of the issues was that board members could be individually liable for triple damages in subsequent civil lawsuits if the FTC found them liable of restraining competition.

In June of 2010, the FTC filed a complaint against the North Carolina Board of Dental Examiners. The allegations were that the Dental Board was preventing non-dentist from providing teeth whitening services to the public. On February 25, 2015 the United States Supreme Court affirmed the position of the FTC by stating that a "state board on which a controlling number of decision makers are active market participants in the occupation the board regulates is not exempt from scrutiny or immune from liability unless the board is actively supervised by the state". This was the shot heard around the nation.

The Federal Trade Commission and Regulatory Boards
In the Matter of
The North Carolina Board of Dental Examiners
Docket No. 9343
Opinion of the Commission

The North Carolina Board of Dental Examiners (the Board)

- During the 1990's various companies started offering teeth whitening services throughout North Carolina in convenient locations (such as malls), without appointments and a lower costs than a visit to the Dentist.
- Complaints were lodged with the North Carolina Board of Examiners.
- Mostly the concerns were the lower rates that were charged and there was very little mention for public health or safety.

- The Board responded by sending out cease and desist letters to the non-whitening services, manufacturers and mall properties.
- The letters suggested that these services were providing dentistry and in violation of the Dental Practice Act.
- The Board had no authority to issue cease and desist orders under their enabling legislation.

The Federal Trade Commission (the FTC)

On June 10, 2010 the FTC issued a single count Complaint in this matter against the Board. The FTC concluded that the Board excluded non-dentist providers from the market of teeth whitening in violation of Section 5 of the Federal Trade Commission. The Administrative Law Judge (ALJ) stated that the "Respondent conduct constituted concerted action that Respondent's conduct had a tendency to harm competition and that Respondent has failed to advance a legitimate procompetitive justification."

The Commissions' Compliant stated that:

- The Boards action had the effect of restraining competition unreasonably;
- Injuring consumers in North Carolina by stopping non-dentist from providing teeth whitenening services;
- And reducing consumer choice for the provision of teeth whitening services.
- Further that the Board's action do not qualify for the state action defense.
- Meaning that the Board is controlled by practicing dentists and the Board must be actively supervised by the state for it to claim state action exemption from antitrust laws.
- The facts showed no such supervision.

Legal Framework – The Rule of Reason
Indiana Federation of Dentists

The Rule of Reason according to the Supreme Court (the Court) states that a "restraints may be adjudged unreasonable either because it fits within a class of restraints that have been held to be 'per se' unreasonable or because it violates what has come to be known as the 'Rule of Reason." In the case of Indiana Federation of Dentists "certain agreements or practices are so 'plainly uncompetitive' and so often lack any redeeming virtue that they are conclusively presumed to be illegal without further examination."

The Indiana Federation of Dentists case revolved around a group of dentist who agreed to withhold x-rays from dental insurance companies that requested their use in benefits determination. The dentists asserted that the "provision of x-rays might lead the insurers to make inaccurate determinations of the proper level of care and thus injure the health of the insured patients." Additionally, they affirmed that an insurance company's review of dental x-rays would constitute the unauthorized practice of

dentistry under state law. The Court applied the Rule of Reason and affirmed the Commissions' finding that the practice violated Section 1 of the Sherman Act.

The Court agreed that the:

- Practice was a "horizontal agreement" among participating dentists to withhold from their customers a particular service that they desired;
- That no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement;
- They had market power and that is a "surrogate for detrimental effects."

Finally, the Court stated that if "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets."

Opinion of the Court
Supreme Court of the United States
Feb 25, 2015
Justice Kennedy

This case is an example of an antitrust challenge of the Federal Trade Commission (FTC) directed towards the actions of the North Carolina Board of Dental Examiners (the Board). The Board's principle duty is to create, administer and enforce a licensing system for dentists. Six of the Board's members should be Dentists engaged in the active practice of dentistry. During the 1990s, Dentists in North Carolina began whitening teeth and by 2003, non-dentists began providing the service at lower rates. Dentists started to complain about the competitors and the lower prices.

In 2006, the Board decided to respond. They issued forty seven cease and desist letters to non-dentist teeth whitening providers and product manufacturers. This was followed by letters to mall operators advising them that they should expel these violators based on the premise that they were practicing unlicensed dentistry. These actions allegedly constituted a crime. All of these efforts were successful and all nondental teeth whitenening actions creased.

The Federal Trade Commission (FTC) filed an administrative complaint in 2010, charging the Board with violating the Federal Trade Commission Act. The actions of the Board constituted an anticompetitive and unfair method of competition. This was followed by a series of legal actions. The Board moved to dismiss alleging state-action immunity. An Administrative Law Judge (ALJ) denied the motion to dismiss. "The Board is a "public/private hybrid that must be actively supervised by the state to claim immunity." The Court of Appeals for the Fourth Circuit affirmed the FTC in all respects. The Supreme Court granted certiorari in 2014.

"Antitrust laws are the central tenet of our country's free market system. The Bill of Rights offers us personal freedom. The Federal Trade Commission Act is critical to the preservation of the economic freedom and free-enterprise system."

The Board stated that its members have the authority by the State of North Carolina and that they were cloaked in immunity. According to previous lawsuits (Parker vs. Brown) immunity is available only if it satisfies two requirements. First, "the challenged restraint ....be one that is clearly articulated and affirmatively expresses as state policy and second, that the policy be actively supervised by the State." The Sherman Act confers immunity on states for their own anticompetitive polices out of respect for federalism but it does not confer immunity when the state delegates control over a market to a non-sovereign actor.

It is critical that states accept the political accountability for anticompetitive conduct they permit and control. It is very easy for established ethical standards to merge with private anticompetitive behavior in such a way that the participants are not fully aware of the outcome of their motives. The result is that the actor cannot be allowed to regulate their own markets free from antitrust accountability. This is a core axiom of federal anti-trust policy. That is there are prohibitions against anticompetitive self-regulation by active market participants.

This question had been answered in California Retail Liquor Dealers Assn. v. Midcal Aluminum. The outcome of the case was the creation of two requirements to resolve the question of anti-competitive behavior. The first is clear articulation for a state policy. Some actors operating under state authority might diverge from the state's definition of public good and this can lead to self-dealing. The second requirement is active supervision requiring review and approval of policies by an entity claiming immunity. The mandate for supervision seeks to assure that a private party's anticompetitive behavior promotes state policy rather than the party's individual interests. It is very easy for a market participant to confuse their own interest with state's policy.

The Court had encountered such an example in Goldfarb. The Court denied immunity to a state agency (the Virginia State Bar) controlled by market participants (lawyers) because it was perceived that the agency had "joined in private anticompetitive activity" for "the benefits of its members." This was reaffirmed by Hallie where it was stated that agencies controlled by market participants are more similar to private trade association vested by states with regulatory authority than to the agencies considered by Hallie. The Court observed "there is no doubt that the members of such association often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm."

North Carolina argued that allowing the FTC order to stand would discourage dedicated citizens from serving on state agencies that regulate their own occupation. The Court responded that there is a long tradition of citizens devoting time, energy and talent to enhance the dignity of their calling. Ethical standards reach back to the

Hippocratic Oath. For dentists, it is best to refer to the American Dental Association's Principles of Ethics and a Code of Professional Conduct which "call upon dentists to follow high ethical standards," including "honesty, compassion, kindness, integrity, fairness and charity." The Board argued that in the context of civil rights suits, the "most talented candidates will decline public engagements if they do not receive the same immunity enjoyed by their public employee counterparts."

States can ensure immunity is available to active market participants if the state adopts clear policies to displace competition for agencies controlled by active market participants and that state may provide active supervision. Further that the inquiry regarding active supervision is flexible and context-dependent. Active supervision need not involve day to day involvement. Rather the state's review mechanisms provide "realistic assurance" that a nonsovereign actor's anticompetitive conduct "promotes state policy, rather than merely the party's individual interests."

Finally, the Court has identified only a few requirements for active supervision. First the Supervisor must review the substance of the anticompetitive decision and the supervisor must have the power to veto or modify the decision to ensure that they agree with state policy. Last but not least, the supervisor cannot be an active market participant.

The FTC has a particular concern that occupational licensing regimes can create artificial and in many cases, unnecessary barriers to entry for entrepreneurs. "Competition and competitive markets, supplemented by sound antitrust enforcement, where necessary-not excessive licensing-will promote entrepreurship in this country and provide the best platform for the least advantage in our economy to prosper."

The FTC has been focused for over forty years on opposing state laws and regulations concerning anticompetitive issues. The FTC testified, during July 2014, before the House of Representatives Committee on Small Business:

> "We have seen many examples of licensure restriction that likely impede competition and hamper entry into professional and services markets, yet offer few, if any, significant consumer benefits. In these situations, regulations may lead to higher prices, lower quality of services and products and less convenience for consumers. In the long term, they can cause lasting damages to competition and the competitive process by rendering markets less responsive to consumer demand and by dampening incentives for innovation in products, services and business models."

Any reform of occupational licensing practices will need to come from the states. A Brooking Institution blog notes that this should appeal to "those interested in expanding the employment prospects of low to middle income workers and keeping prices more affordable." It should also appeal to the more typical conservative views that are "those committed to expanding economic opportunities by promoting

entrepreneurship, the creation of small business and giving individuals the ability to pursue their vocational interests.

Boards Behaving Badly
Institute for Justice – Robert Everett Johnson

Mr. Johnson expressed concern about the bad behavior of state licensing boards and the decades that this has been going on. He interprets that members of licensing boards have been adopting anticompetitive behavior that harm consumers, stifle innovation and yield no real public benefit. In the dental case, the dentist sought to exclude non-dentists from teeth whitening because it threatened their income. Other cases have been the ability of funeral Boards to monopolize casket sales; veterinary boards monopolizing animal massages and cosmetology boards to monopolize traditional African braiding.

> "Licensing laws result in a loss of 2.86 million jobs nationwide and the cost to consumers from licensing laws has been estimated to be as high as $203 billion every year."
>
> "States have seized this opportunity to clean up their licensing laws will not only reduce their legal exposure, but also will promote economic growth and employment, while eliminating unnecessary restrictions on their citizens liberties."

How the U.S. Supreme Court Empowered
Political Accountability and Economic Growth
In Arkansas – Advance Arkansas Institute
Dan Greenberg,
Sep 9, 2015

Mr. Greenberg, a lawyer and former state legislator, is the current president of the Advance Arkansas Institute. In the matter of the North Carolina State Board of Dentistry v. Federal Trade Commission, he expressed concern on the impact of boards and commission who exercise rule-making and quasi-legislative authority since they are no longer immune from liability under federal anti-trust law. Mr. Greenberg's recommendation are that Arkansas legislators need to immediately make structural changes in their state boards and commission to avoid these potential liabilities.

The situation that occurred in North Carolina was a classic case that political scientists refer to as "regulatory capture." That is that the boards are structured in such a way that special interests come to control them. To avoid liability Mr. Greenberg suggested a "restructure of boards and commission so that their members are not self-interested." The other alternative is that the state could "firewall" those boards by adding "elements of sovereign accountability." One method for that is a legislative or gubernatorial review of regulations. This would include the creation by the Legislature

of "anti-competitive policies" for boards and commissions. He is looking for language that would clearly articulate the state policy for the boards and commissions. Further that the state must actively supervise the boards and commissions.

Conclusions

1. All health care regulatory boards should recognize their responsibility towards professional development and lifelong learning based on certain key assumptions.
2. First, health care professionals are obligated to engage in lifelong learning.
3. Secondly, they are accountable for meeting or exceeding performance standards in their field of expertise.
4. Health care regulatory boards have significant responsibility to the public in this area as they are required by law to ensure that providers licensed to practice in their state continue to be competent throughout their career. Continuing competency is essential to an ethical practice.
5. The complexity of the business of health care continues to increase. It is important that health care regulatory boards be committed to help each provider to improve within their practice with appropriate training and knowledge building. Health care regulatory boards should seek to support the role of leadership that each provider should achieve so that they can respond to the needs of the practice.
6. For the last couple of decades the Federal Trade Commission (FTC) has been keeping an eye on the various regulations promulgated by regulatory boards nationwide in the context of anti-competitive activities.
7. On February 25, 2015 the United States Supreme Court affirmed the position of the FTC by stating that a "state board on which a controlling number of decision makers are active market participants in the occupation the board regulates is not exempt from scrutiny or immune from liability unless the board is actively supervised by the state.
8. It is critical that states accept the political accountability for anticompetitive conduct they permit and control.
9. It is very easy for established ethical standards to merge with private anticompetitive behavior in such a way that the participants are not fully aware of the outcome of their motives.
10. The result is that the actor cannot be allowed to regulate their own markets free from antitrust accountability. This is a core axiom of federal anti-trust policy. That is there are prohibitions against anticompetitive self-regulation by active market participants.
11. The FTC has a particular concern that occupational licensing regimes can create artificial and in many cases, unnecessary barriers to entry for entrepreneurs. "Competition and competitive markets, supplemented by sound antitrust enforcement, where necessary-not excessive licensing-will promote entrepreurship in this country and provide the best platform for the least advantage in our economy to prosper."

12. The Court had encountered such an example in Goldfarb. The Court denied immunity to a state agency (the Virginia State Bar) controlled by market participants (lawyers) because it was perceived that the agency had "joined in private anticompetitive activity" for "the benefits of its members." This was reaffirmed by Hallie where it was stated that agencies controlled by market participants are more similar to private trade association vested by states with regulatory authority than to the agencies considered by Hallie. The Court observed "there is no doubt that the members of such association often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm."
13. It is possible that the Board regulations has the effect of restraining continuing education competition unreasonably and therefore, injuring consumers (Dentists) in Virginia from accessing continuing competency education.
14. Further that the current regulations are reducing consumer (Dentists) choice for continuing education alternatives.
15. It is very easy for a market participant to confuse their own interest with state's policy.
16. The Commonwealth of Virginia Code addresses some of the issues. Virginia Chapter 24 § 54.1-2400. General powers and duties of health regulatory boards.
17. § 54.1-2409.2. Board to set criteria for determining need for professional regulation. Section 6. Minimization of unreasonable or anti-competitive requirements that produce no demonstrable benefit.

Recommendations

The common bond between Boards and continuing educations providers is their desire that every practitioner has access to the knowledge needed to harmonize their practice with the reality of the environment in which they practice. This petition recommends the following:

1. The Statutory Regulations for the Board of Dentistry, Commonwealth of Virginia should engage in an inquiry for regulatory anticompetitive behavior that harm consumers, stifle innovation and yield no real public benefit.
2. Further that the inquiry regarding active supervision be flexible and context-dependent.
3. Additionally, require that any statutory change avoid causing damages to competition and the competitive process by rendering markets less responsive to consumer demand and by dampening incentives for innovation in products, services and business models.
4. Petition to amend this section (18VAC60-21-250) and add "16. And other continuing education organizations as approved by the board."

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

1. American Dental Association and the National Dental Association or its constituent or component/branches and approved continuing education providers;
2. American Dental Hygienists Association and the National Dental Hygiene Association or its constituent/component 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, and approved continuing education providers;
5. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;
6. Academy of General Dentistry its constituent and component/branch associations;
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 organization 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 Associations Liaison Committee for Medical Education;
10. A dental, dental hygiene or dental assisting program accredited by the Commission on Dental Accreditation of the American Dental Association;
11. State or federal government agencies (i.e. military dental division, Veterans 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 Intestate Testing Agencies or Western Regional Examining Board (when serving as an examiner).

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

Virginia Chapter 24

§ 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. (Effective until January 1, 2017) To promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title.

6. (Effective January 1, 2017) To promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) 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.).

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.

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.

§ 54.1-2409.2. Board to set criteria for determining need for professional regulation.

The Board of Health Professions shall study and prepare a report for submission to the Governor and the General Assembly by October 1, 1997, containing its findings and recommendations on the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession. Such criteria shall address at a minimum the following principles:

1. Promotion of effective health outcomes and protection of the public from harm.

2. Accountability of health regulatory bodies to the public.

3. Promotion of consumers' access to a competent health care provider workforce.

4. Encouragement of a flexible, rational, cost-effective health care system that allows effective working relationships among health care providers.

5. Facilitation of professional and geographic mobility of competent providers.

6. Minimization of unreasonable or anti-competitive requirements that produce no demonstrable benefit.

National Provider Compliance Corporation
1314 La Salle Court
Vista, California 92081
773.750.2249
Facsimile 877.516.4432

August 31, 2016

Kelley Palmatier, J.D, Deputy Executive Director
Elaine J. Yeatts, Agency Regulatory Coordinator
Department of Health Professions
Commonwealth of Virginia
9960 Maryland Drive, Suite 300
Henrico, Virginia 23233-1463

Dear Ms. Palmatier and Yeatts;

Thank you for your expeditious response to my petition. I appreciate knowing where I can find the information. I was wondering how I would be able to read the public comment. It would be very interesting to see what the feedback would be.

At National Provider Compliance Corporation we are a minority owned and women operated educational company that serves the continuing education community of dental and healthcare providers in all fifty states. This petition is a very serious matter for a small business in healthcare continuing education.

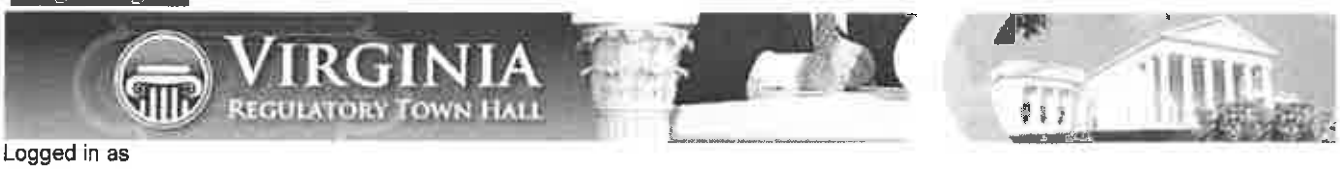
At National Provider Compliance Corporation (NPCC) we present coursework that is based on a goal to provide exceptional healthcare education and training. We are committed to deliver a standard of educational services that are responsible to the evolving needs of the healthcare community, patients, healthcare providers and dentists. We are dedicated to provide exceptional, quality training that is based on the fundamental principle of high standards in education.

If you have any questions of me, please feel free to call or email at messine@roadrunner.com.

I am respectfully

Dr. Christine Barry

Virginia.gov Agencies | Governor



Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Dentistry**

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

Back to List of Comments

Commenter: Marcel Lambrechts * 9/26/16 11:45 am

Seems like a non issue...maybe?

Based on what is provided on this web page and what the petition states, I would not have any problem with the petition. Although there isn't any easy way to see what this is being added to. It would be wise to see the piece of governance this is being added to next to the proposed change.

* Nonregistered public user

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.

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.

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 32, Issue 05, eff. December 2, 2015.

Agenda Item: Board action on revised ADA Guidelines

Included in your agenda package are:

A copy of the revised (October 2016) ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

A copy of draft amendments to regulations for consistency with the renamed Guidelines

Staff notes:

The proposed amendments to the Board's regulations address a major change made in the newly renamed and issued ADA Guidelines. Section V. Teaching Administration of Moderate Sedation no longer includes distinct provisions for administration by an enteral method. The same course requirements now apply to all methods of administration used to achieve moderate sedation. To avoid confusion, references to enteral administration need to be removed from regulations to make it clear that the course requirements for moderate sedation in the ADA Guidelines now apply.

Board action:

To consider adoption of the amended regulations by a fast-track action.

ADA American Dental Association®

Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

Adopted by the ADA House of Delegates, October 2016

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.

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

For children, 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.

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

minimal sedation (previously known as anxiolysis) - 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.[1]

Patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

dosing for minimal sedation via the enteral route – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

The administration of enteral drugs exceeding the maximum recommended dose during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

If more than one enteral drug is administered to achieve the desired sedation effect, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

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. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.

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.[1]

> *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.[1]

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.[1]

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.[1]

For all levels of sedation, the qualified dentist 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)].

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.

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

qualified dentist – a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.

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.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[2]

Classification	Definition	Examples, including but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, *ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or *ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
*The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)		

American Society of Anesthesiologists' Fasting Guidelines[3]

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

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 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 Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be competent 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. 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.

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.

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult 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 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 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, 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 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.

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. 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.

Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining moderate sedation with nitrous oxide-oxygen.

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 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.

Moderate Sedation Course Duration and Documentation:
The Course must include:

- A minimum of 60 hours of instruction plus administration of sedation for at least 20 individually managed patients.
- Certification of competence in moderate sedation technique(s).
- Certification of competence in rescuing patients from a deeper level of sedation than intended including managing the airway, intravascular or intraosseous access, and reversal medications.
- Provision by course director or faculty of additional clinical experience if participant competency has not been achieved in time allotted.
- Records of instruction and clinical experiences (i.e., number of patients managed by each participant in each modality/route) that are maintained and available for participant review.

D. Documentation of Instruction: The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience, managing the airway, intravascular/intraosseous access, and reversal medications.

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 or 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 four-to-one when moderate sedation is being taught allows for adequate supervision during the clinical phase of instruction. 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.

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1 Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists (ASA)

2 ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, Updated by ASA House of Delegates, October 15, 2014.

3 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.

Project 4975 - none

BOARD OF DENTISTRY

ADA requirements for moderate sedation

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:

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

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

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

"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.

18VAC60-21-30. 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~~ 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.

18VAC60-21-40. Required fees.

A. Application/registration fees.

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

B. Renewal fees.

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

C. Late fees.

1. Dental license - active	$100

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

D. Reinstatement fees.

1. Dental license - expired	$500
2. Dental license - suspended	$750
3. Dental license - revoked	$1000
4. Oral maxillofacial surgeon registration	$350
5. Cosmetic procedures certification	$225

E. Document fees.

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

F. Other fees.

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

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

H. For the renewal of licenses, registrations, certifications, and permits in 2016, the following fees shall be in effect:

1. Dentist - active	$210
2. Dentist - inactive	$105
3. Dental full-time faculty	$210
4. Temporary resident	$25
5. Dental restricted volunteer	$10

6. Oral/maxillofacial surgeon registration	$130
7. Cosmetic procedure certification	$75
8. ~~Conscious/moderate~~ Moderate sedation certification	$75
9. Deep sedation/general anesthesia	$75
10. Mobile clinic/portable operation	$110

18VAC60-21-90. Patient information and records.

A. A dentist shall maintain complete, legible, and accurate patient records for not less than six years from the last date of service for purposes of review by the board with the following exceptions:

1. Records of a minor child shall be maintained until the child reaches the age of 18 years or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative pursuant to § 54.1-2405 of the Code; or

3. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

B. Every patient record shall include the following:

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

2. A health history taken at the initial appointment that is updated (i) when analgesia, sedation, or anesthesia is to be administered; (ii) when medically indicated; and (iii) at least annually;

3. Diagnosis and options discussed, including the risks and benefits of treatment or nontreatment and the estimated cost of treatment options;

4. Consent for treatment obtained and treatment rendered;

5. List of drugs prescribed, administered, or dispensed and the route of administration, quantity, dose, and strength;

6. Radiographs, digital images, and photographs clearly labeled with patient name, date taken, and teeth identified;

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

8. Duplicate laboratory work orders that meet the requirements of § 54.1-2719 of the Code including the address and signature of the dentist;

9. Itemized patient financial records as required by § 54.1-2404 of the Code;

10. A notation or documentation of an order required for treatment of a patient by a dental hygienist practicing under general supervision as required in 18VAC60-21-140 B; and

11. The information required for the administration of ~~conscious/moderate~~ moderate sedation, deep sedation, and general anesthesia required in 18VAC60-21-260 D.

C. A licensee shall comply with the patient record confidentiality, release, and disclosure provisions of § 32.1-127.1:03 of the Code and shall only release patient information as authorized by law.

D. Records shall not be withheld because the patient has an outstanding financial obligation.

E. A reasonable cost-based fee may be charged for copying patient records to include the cost of supplies and labor for copying documents, duplication of radiographs and images, and postage if mailing is requested as authorized by § 32.1-127.1:03 of the Code. The charges

specified in § 8.01-413 of the Code are permitted when records are subpoenaed as evidence for purposes of civil litigation.

F. When closing, selling, or relocating a practice, the licensee shall meet the requirements of § 54.1-2405 of the Code for giving notice and providing records.

G. Records shall not be abandoned or otherwise left in the care of someone who is not licensed by the board except that, upon the death of a licensee, a trustee or executor of the estate may safeguard the records until they are transferred to a licensed dentist, are sent to the patients of record, or are destroyed.

H. Patient confidentiality must be preserved when records are destroyed.

18VAC60-21-130. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue except a dental hygienist performing gingival curettage as provided in 18VAC60-21-140;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-25-100, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

4. Authorization of work orders for any appliance or prosthetic device or restoration that is to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;

6. Administering and monitoring ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthetics except as provided for in § 54.1-2701 of the Code and Part VI (18VAC60-21-260 et seq.) of this chapter;

7. Condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-30-120;

8. Final positioning and attachment of orthodontic bonds and bands; and

9. Final adjustment and fitting of crowns and bridges in preparation for final cementation.

Part V

Licensure Renewal

18VAC60-21-240. License renewal and reinstatement.

A. The license or permit of any person who does not return the completed renewal form and fees by the deadline shall automatically expire and become invalid, and his practice of dentistry shall be illegal. With the exception of practice with a current, restricted volunteer license as provided in § 54.1-2712.1 of the Code practicing in Virginia with an expired license or permit may subject the licensee to disciplinary action by the board.

B. Every person holding an active or inactive license and those holding a permit to administer ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthesia shall annually, on or before March 31, renew his license or permit. Every person holding a faculty license, temporary resident's license, a restricted volunteer license, or a temporary permit shall, on or before June 30, request renewal of his license.

C. Any person who does not return the completed form and fee by the deadline required in subsection B of this section shall be required to pay an additional late fee.

D. The board shall renew a license or permit if the renewal form, renewal fee, and late fee are received within one year of the deadline required in subsection B of this section provided

that no grounds exist to deny said renewal pursuant to § 54.1-2706 of the Code and Part II (18VAC60-21-50 et seq.) of this chapter.

E. Reinstatement procedures.

1. Any person whose license or permit has expired for more than one year or whose license or permit has been revoked or suspended and who wishes to reinstate such license or permit shall submit a reinstatement application and the reinstatement fee. The application must include evidence of continuing competence.

2. To evaluate continuing competence, the board shall consider (i) hours of continuing education that meet the requirements of subsection G of 18VAC60-21-250; (ii) evidence of active practice in another state or in federal service; (iii) current specialty board certification; (iv) recent passage of a clinical competency examination accepted by the board; or (v) a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association.

3. The executive director may reinstate such expired license or permit provided that the applicant can demonstrate continuing competence, the applicant has paid the reinstatement fee and any fines or assessments, and no grounds exist to deny said reinstatement pursuant to § 54.1-2706 of the Code and Part II (18VAC60-21-50 et seq.) of this chapter.

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~~ 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.

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.

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~~ 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~~ 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~~ 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;

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~~ 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~~ 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~~ 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.

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

A. ~~After March 31, 2013, no~~ No dentist may employ or use ~~conscious/moderate~~ moderate sedation in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the board with reports that result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.

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

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

1. A completed application form ~~indicating one of the following permits for which the applicant is qualified:~~

~~a. Conscious/moderate sedation by any method;~~

~~b. Conscious/moderate sedation by enteral administration only; or~~

~~c. Temporary conscious/moderate sedation permit (may be renewed one time)~~;

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

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

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

D. Education requirements for a permit to administer ~~conscious/moderate~~ moderate sedation.

~~1. Administration by any method.~~ A dentist may be issued a ~~conscious/moderate~~ moderate sedation permit to administer by any method by meeting one of the following criteria:

a. Completion of training for this treatment modality according to the ADA's Guidelines for Teaching ~~the Comprehensive~~ Pain Control ~~of Anxiety~~ and ~~Pain~~ Sedation ~~in Dentistry~~ to Dentists and Dental Students in effect at the time the training

occurred, while enrolled in an accredited dental program or while enrolled in a post-doctoral university or teaching hospital program; or

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

~~2. Enteral administration only. A dentist may be issued a conscious/moderate sedation permit to administer only by an enteral method if he has completed a continuing education program that meets the requirements of 18VAC60-21-250 and consists of not less than 18 hours of didactic instruction plus 20 clinically oriented experiences in enteral or a combination of enteral and nitrous oxide/oxygen conscious/moderate sedation techniques. The course content shall be consistent with the ADA's Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry in effect at the time the training occurred. The certificate of completion and a detailed description of the course content must be maintained.~~

~~3. A dentist who self-certified his qualifications in anesthesia and moderate sedation prior to January 1989 may be issued a temporary conscious/moderate sedation permit to continue to administer only conscious/moderate sedation until May 7, 2015. After May 7, 2015, a dentist shall meet the requirements for and obtain a conscious/moderate sedation permit to administer by any method or by enteral administration only.~~

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

1. Hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers, such as ACLS or PALS as evidenced by a certificate of completion posted with the dental license; and

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

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

A. Delegation of administration.

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

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

a. ~~A dentist with the training required by 18VAC60-21-290 D 2 to administer by an enteral method;~~

~~b.~~ A dentist with the training required by 18VAC60-21-290 D 1 to administer by any method and who holds a moderate sedation permit;

~~c.~~b. An anesthesiologist;

~~d.~~c. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1 and who holds a moderate sedation permit; or

~~e.~~d. A registered nurse upon his direct instruction and under the immediate supervision of a dentist who meets the training requirements of 18VAC60-21-290 D 1 and who holds a moderate sedation permit.

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

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

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

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

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

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

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

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

1. Full face mask or masks;

2. Oral and nasopharyngeal airway management adjuncts;

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

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

5. Pulse oximetry;

6. Blood pressure monitoring equipment;

7. Pharmacologic antagonist agents;

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

9. Mechanical (hand) respiratory bag;

10. Appropriate emergency drugs for patient resuscitation;

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

12. Defibrillator;

13. Suction apparatus;

14. Temperature measuring device;

15. Throat pack; and

16. Precordial or pretracheal stethoscope.

C. Required staffing. At a minimum, there shall be a two person treatment team for ~~conscious/moderate~~ moderate sedation. The team shall include the operating dentist and a second person to monitor the patient as provided in 18VAC60-21-260 K and assist the operating dentist as provided in 18VAC60-21-260 J, both of whom shall be in the operatory with the patient throughout the dental procedure. If the second person is a dentist, an anesthesiologist, or a certified registered nurse anesthetist who administers the drugs as permitted in 18VAC60-21-291 A, such person may monitor the patient.

D. Monitoring requirements.

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

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

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

E. Discharge requirements.

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

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

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

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

Part II

Practice of Dental Hygiene

18VAC60-25-40. Scope of practice.

A. Pursuant to § 54.1-2722 of the Code, a licensed dental hygienist may perform services that are educational, diagnostic, therapeutic, or preventive under the direction and indirect or general supervision of a licensed dentist.

B. The following duties of a dentist shall not be delegated:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue, except as may be permitted by subdivisions C 1 and D 1 of this section;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist who meets the requirements of 18VAC60-25-100 C may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

4. Authorization of work orders for any appliance or prosthetic device or restoration that is to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;

6. Administration of deep sedation or general anesthesia and ~~conscious/moderate~~ moderate sedation;

7. Condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-30-120;

8. Final positioning and attachment of orthodontic bonds and bands; and

9. Final adjustment and fitting of crowns and bridges in preparation for final cementation.

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 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.

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 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 and gingival 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 subsection B of this section and those restricted to indirect supervision in subsection C of this section.

E. The following duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II:

1. Performing pulp capping procedures;

2. Packing and carving of amalgam restorations;

3. Placing and shaping composite resin restorations with a slow speed handpiece;

4. Taking final impressions;

5. Use of a non-epinephrine retraction cord; and

6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

F. A dental hygienist employed by the Virginia Department of Health may provide educational and preventative dental care under remote supervision, as defined in § 54.1-2722 D of the Code, of a dentist employed by the Virginia Department of Health and in accordance with the protocol adopted by the Commissioner of Health for Dental Hygienists to Practice in an Expanded Capacity under Remote Supervision by Public Health Dentists, September 2012, which is hereby incorporated by reference.

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~~ 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.

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.

18VAC60-30-50. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue except a dental hygienist performing gingival curettage as provided in 18VAC60-21-140;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist who meets the requirements of 18VAC60-25-100 may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

4. Authorization of work orders for any appliance or prosthetic device or restoration that is to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;

6. Administering and monitoring ~~conscious/moderate~~ moderate sedation, deep sedation, or general anesthetics except as provided for in § 54.1-2701 of the Code and subsections J and K of 18VAC60-21-260;

7. Condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-30-120;

8. Final positioning and attachment of orthodontic bonds and bands; and

9. Final adjustment and fitting of crowns and bridges in preparation for final cementation.

Establishing a Guidance Document on Opioid Prescriptions

As addressed in the September 16, 2016 minutes, the Board was asked by DHP Chief Deputy Director, Lisa Hahn, to consider issuing a guidance document on the appropriate use of opioids in the practice of dentistry.

Virginia Board of Dentistry
December 9, 2016

VDA and VDHA Amendments to Remote Supervision Statute

The Regulatory – Legislative Committee recommends that the Board support the proposed legislation.

SENATE BILL NO. _____ HOUSE BILL NO. _____

A BILL to amend and reenact § 54.1-2722 of the Code of Virginia, relating to practice of dental hygiene; remote supervision.

Be it enacted by the General Assembly of Virginia:

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

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

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

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

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

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist

may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

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

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

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

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

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

representative of the Virginia Dental Hygienists' Association. Such protocol shall be adopted by the Board as regulations.

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

F. For the purposes of this subsection, "remote supervision" means that a supervising dentist is accessible and available for communication and consultation with a dental hygienist ~~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~~ practice physically located in the Commonwealth. No dental hygienist shall practice under remote supervision unless he has (i) completed a continuing education course designed to develop the competencies needed to provide care under remote supervision offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of clinical experience. A dental hygienist practicing under remote supervision shall have professional liability insurance with policy limits acceptable to the supervising dentist. A dental hygienist shall only practice under remote supervision at a ~~community health center,~~federally qualified health center; charitable safety net facility~~,~~; free clinic~~,~~; long-term care facility~~,~~; elementary or secondary school~~,~~; Head Start program~~,~~; or women, infants, and children (WIC) program.

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

topical oral fluorides 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~~ confirmation from the patient that he does not have a dentist of record whom he is seeing regularly.

After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision ~~shall consult with the supervising dentist prior to providing~~ may provide further dental hygiene services ~~if such patient is medically compromised or has periodontal disease~~ following a written practice protocol developed and provided by the supervising dentist. Such written practice protocol shall consider, at a minimum, the medical complexity of the patient and the presenting signs and symptoms of oral disease.

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

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

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Disciplinary Board Report for December 9, 2016

Today's report reviews the 2016 calendar year case activity then addresses the Board's disciplinary case actions for the first quarter of fiscal year 2017 which includes the dates of July 1, 2016 through September 30, 2016.

Calendar Year 2016

The table below includes all cases that have received Board action since January 1, 2016 through August 25, 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	36	30	8	38
June	28	31	6	37
July	29	47	3	50
August	26	26	17	43
September	76	63	6	69
October	26	19	4	23
November 18th	11	3	6	9
December				
Totals	**374**	**322**	**65**	**387**

Q1 FY 2017

For the first quarter of 2017, the Board received a total of 58 patient care cases. The Board closed a total of 62 patient care cases for a 107% clearance rate, which is up from 102% in Q4 of 2016. The current pending caseload older than 250 days is 27%, which is down from 29% in Q4 of 2016. The Board's goal is 20%. In Q1 of 2017, 75% of the patient care cases were closed within 250 days, the same as in Q4 of 2016. The Board's goal is 90% of patient care cases closed within 250 days.[1]

License Suspensions

Between August 30, 2016 and November 18, 2016, the Board has summarily suspended one dental license.

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[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 2017.
- 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 2017.
- The goal is to resolve 90% of patient care cases within 250 business days through the end of FY 2017.

Board Ordered Continuing Education

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?