VIRGINIA BOARD OF DENTISTRY

September 15, 2017 AGENDA

Department of Health Professions
Perimeter Center - 2nd Floor Conference Center, Board Room 4
9960 Mayland Drive, Henrico, Virginia 23233

Board Business **Page**

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

Evacuation Announcement – Ms. Reen

Public Comment – Dr. Alexander

Approval of Minutes - Dr. Alexander

- June 8, 2017 Formal Hearing P. 1
- June 9, 2017 Business Meeting P. 4
- June 9, 2017 Formal Hearing P. 9
- July 26, 2017 New Member Orientation P. 13

Director's Report – Dr. Brown

Liaison/Committee Reports

- **Dr. Watkins**
  *Nominating Committee P. 15
  *SRTA P. 16
  *BHP
  *Exam Committee
- **Dr. Bonwell**
  *SRTA P. 18
- **Dr. Petticolas**
  *Regulatory – Legislative Committee P. 19
- **Dr. Bryant**
  *ADEX P. 23
- **Dr. Alexander**
  *AADB
  *Advisory Panel on Opioids

Legislation and Regulation – Ms. Yeatts

- Status Report on Regulatory Actions P. 25
- Proposed regulations to conform to ADA Guidelines on moderate sedation P. 26
- Emergency regulations for CE requirement for dental hygienist to practice under remote supervision P. 76
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- Notice of Intended Regulatory Action on Dental Assistants II P. 139

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
June 08, 2017

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 1:00 p.m., on June 08, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: A. Rizkalla, D.D.S

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

MEMBERS ABSENT: Carol R. Russek, JD

STAFF PRESENT:
Sandra K. Reen, Executive Director
Sheila Beard, Executive Assistant

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT:
Wayne Halbleib, Senior Assistant Attorney General
Elena Callwood, Adjudication Specialist
Lori Larsen, Court Reporter

ESTABLISHMENT OF A QUORUM: With 9 Board members present, a quorum was established.

Bethany P. Helms, R.D.H Mrs. Helms was present without legal counsel in accordance with the Notice of the Board dated May 9, 2017.

Case No. 178492 Dr. Rizkalla swore in the witnesses.

Prior to opening statements, Mr. Halbleib noted that the respondent has admitted to the findings of fact and conclusions of law set forth in allegations #1-4 of the Statement of Allegations so he will not go over them.

Mrs. Helms stated that she was somewhat familiar with the order of proceedings. Dr. Rizkalla read the order of proceedings to Mrs. Helms.

Following Mr. Halbleib's opening statement; Dr. Rizkalla admitted into evidence Commonwealth's exhibits 1-5.

Following Mrs. Helm's opening statement; Dr. Rizkalla admitted into evidence Respondent's Exhibits A-B.

Testifying on behalf of the Commonwealth was Joyce Shelton-Jones, DHP Senior Investigator.

Mrs. Helms testified on her own behalf.

Closed Meeting: Dr. Alexander 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 Mrs. Helms. Additionally, he moved that Board staff, Ms. Reen, Ms. Beard, 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. Alexander moved to certify that the Board heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

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

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

Mr. Rutkowski reported that Mrs. Helms did not get three–fourths of the votes as required for reinstatement of her license so her application is denied.

Dr. Alexander moved the adoption of the sanction imposed as read by Mr. Rutkowski. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 4:07 p.m.

A. Rizkalla D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY
MINUTES
June 9, 2017

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:05 a.m. on June 9, 2017, at the Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, 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.
Nathaniel C. Bryant, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Tammy C. Ridout, R.D.H.
Patricia B. Bonwell, R.D.H., PhD
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

BOARD MEMBER ABSENT: Carol R. Russek, JD

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Sheila Beard, Executive Assistant for the Board

COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT: David E. Brown, 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: Written comment requesting that a PGYI program be accepted for licensure was received as information.

APPROVAL OF MINUTES: Dr. Rizkalla asked if there were any corrections to the March 9, 2017 Formal Hearing minutes. A motion by Dr. Watkins to adopt these minutes was seconded and passed.

Dr. Rizkalla asked if there were any corrections to the March 10, 2017 Business Meeting minutes. A motion by Dr. Petticolas to adopt these minutes was seconded and passed.
Dr. Rizkalla asked if there were any corrections to either set of May 12, 2017 Formal Hearing minutes. A motion by Dr. Petticolas to adopt these minutes was seconded and passed.

DHP DIRECTOR'S MINUTES:

Dr. Brown complimented and thanked the Board for its work on emergency regulations which address prescribing opioids for acute and chronic dental pain. He added that Secretary Hazel will convene a work group for the purpose of creating a course curriculum on pain management, opioids and addiction to be taught in schools training health professionals who will prescribe or dispense medication. Also, legislation was passed which requires all prescriptions for opioids to be done by e-prescribing by the year 2020.

Dr. Brown welcomed Michelle Schmitz as the new Director of Enforcement at DHP.

LIAISON/COMMITTEE REPORTS:

ADEX. Dr. Bryant said he will be attending the annual conference on August 11-13, 2017 in Chicago, IL.

SRTA. Dr. Watkins stated the licensure exams are going well and the annual meeting will be held August 4-6 in Myrtle Beach, SC. He said VCU, University of South Carolina, and University of Louisville have pulled out of SRTA and SRTA is actively pursuing other schools. He added that SRTA has expanded the test sites for the hygiene exam. He also reported the Executive Director of SRTA, Kathleen White, will be retiring in December.

Advisory Panel on Opioids. Dr. Alexander reported that work on the Board's regulations continues. He also showed the cover of a recent AARP magazine which addresses how the Opioid crisis is affecting the elderly.

Regulatory-Legislative Committee. Dr. Wyman stated the Committee will be looking at the RAP's recommendations for changing the education requirements for Dental Assistants II (DAII) at its June 30, 2017 meeting because there are very few registrants in Virginia as compared to Pennsylvania and other states. He said using a DAII frees up dentists from doing basic restoration treatments.

AADB. Dr. Wyman said the recent conference he attended with Dr. Rizkalla and Ms. Reen in Chicago, IL was very lively and that he

was impressed by AADB's efforts to improve its meetings and to increase its membership. He then noted highlights from his report.

Dr. Rizkalla reviewed his report then addressed the discussion which occurred regarding the ADA's development of a licensing exam using a Power Point presentation.

Exam Committee. Dr. Watkins noted that a motion from the Committee to accept PGY1 for licensure will be addressed later in the agenda then asked if there were any questions about the information in the Committee's April 28, 2017 minutes.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported on the following Regulatory Actions:

- The comment period on the NOIRA to replace the Emergency Opioid regulations ends on June 14, 2017, noting the Board would consider the comments received and amendment of the regulations at its next meeting.
- Amending the emergency regulations for Opioid Prescribing to clarify when the required course could be taken. Following discussion, a motion by Ms. Ridout to adopt the proposed amendment was seconded and passed.
- The amendments to conform to the ADA Guidelines for teaching moderate sedation and to add capnography equipment to the requirements for moderate sedation, deep sedation and general anesthesia go into effect on June 14, 2017.
- Amending the remote supervision regulations to conform to changes in the Code of Virginia. Following discussion, a motion by Dr. Wyman to adopt the proposed amendment was seconded and passed. The Regulatory-Legislative Committee was charged with developing language to address the length and content of the required continuing education course and to address what constitutes an emergent circumstance.

BOARD DISCUSSION/ACTION:

Adding PGY1 Pathway for Licensure. Dr. Watkins offered the Exam Committee motion to add another pathway to qualify for licensure by accepting completion of a one-year post graduate advanced residency. Discussion followed about assuring that an acceptable post graduate program would be a full year and it was agreed that 12 months should be specified rather than one calendar year. It was also agreed that applicants qualifying by PGY1 would not need to pass a clinical examination to qualify for licensure. The question was called and the motion to add completion of a PGY1 program as a pathway was passed. Ms. Yeatts stated she would draft the proposed regulation for review at the September meeting.

Continuing Education Tracking Services. Dr. Rizkalla stated there are various boards in many states that are utilizing tracking services for continuing education. Ms. Reen provided information on other states' tracking programs and indicated she would be contacting the companies that manage the services to get comparative information.

OSCE Presentation. Dr. Rizkalla discussed his findings from his recent trip to Canada to observe the administration of the Canadian OSCE (Objective Structured Clinical Examination) indicating the test is a multiple-choice question test that does assess cognitive knowledge but not fine hand-motor skill. He then explained the interaction that has occurred between AADB and the ADA prior to, at, and after the April AADB meeting regarding the ADA's development of the Dental Licensure Objective Structured Clinical Examination (DLOSCE). He concluded by saying he didn't think now is the time for the Board to send a letter to the ADA.

The Board discussed adding the term "patient-based" in the regulations addressing the requirement for a clinical competency examination but took no action.

Proposed New ADA Agency Comment. Ms. Reen reviewed the May 17, 2017 announcement of a proposed new ADA agency, the National Commission on Recognition of Dental Specialties and Certifying Boards. The announcement invites comments on the proposed agency for consideration by the ADA Task Force on Specialty and Specialty Certifying Board Recognition. She noted that comments are due by June 30, 2017.

BOARD COUNSEL REPORT:

Mr. Rutkowski explained that the Board needs to adopt an expert admissibility standard then reviewed the two options, the traditional Virginia Standard and the Virginia Medical Malpractice Standard. He responded to questions and recommended adoption of the Virginia Standard. Ms. Ridout moved to adopt the Virginia Standard. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reviewed her report noting that from January 1, 2017 through May 19, 2017, 126 cases were received and 135 were closed. She also noted that in Q3 of 2017 62 patient care cases were received and 69 were closed for a 111% clearance rate; which is down from the 171% in Q2 of 2017. She added that between February 24, 2017 and May 22, 2017, the Board summarily rescinded the stay of one dental license.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

2018 Calendar of Meetings. Ms. Reen asked the Board to adopt the meeting calendar for 2018 that had been sent to each member

for review in advance of the meeting. In response to a question, Ms. Palmatier said Special Conference Committee "A" had agreed to switch its meetings to Monday. Ms. Reen said staff would change the scheduled dates for Special Conference Committee "A" to Mondays based on conference room availability then send out a revised calendar, noting that it may not be possible to change all the dates. Dr. Petticolas moved to adopt the calendar to include the available Monday dates for the Special Conference Committee "A". The motion was seconded and passed.

CLOSED SESSION: **Review Proposed Law Exam Questions.** Dr. Alexander moved that the Board go into a closed session pursuant to Section 2.2-3711.A(11) in order to review the proposed law exam questions.

OPEN SESSION: Dr. Alexander moved to certify that the Board 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 as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

Ms. Ridout moved the adoption of the law exam questions as amended by the Board. The motion was seconded and passed. The Board agreed with Ms. Reen's request to evaluate having the examination administered by staff before pursuing request for proposals.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 12:44 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
June 09, 2017

TIME AND PLACE:	The meeting of the Virginia Board of Dentistry was called to order at 1:10 p.m., on March 09, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.
PRESIDING:	A. Rizkalla, D.D.S
MEMBERS PRESENT:	Nathanial C. Bryant, D.D.S. Tonya A. Parris-Wilkins, D.D.S. James D. Watkins, D.D.S. Tammy C. Ridout, R.D.H. Bruce S. Wyman, D.M.D.
MEMBERS ABSENT:	Patricia B. Bonwell, R.D.H., PhD
STAFF PRESENT:	Sandra K. Reen, Executive Director Sheila Beard, Executive Assistant
COUNSEL PRESENT:	James E. Rutkowski, Assistant Attorney General
OTHERS PRESENT:	Julia Bennett, Assistant Attorney General Lori L. Pound, Adjudication Specialist Juan Ortega, Court Reporter
ESTABLISHMENT OF A QUORUM:	With 6 Board members present, a quorum was established.
Rebecca Mostatab, D.M.D	Rebecca Mostatab was present without legal counsel in accordance with the Notice of the Board dated May 5, 2017.
Case No. 173391	Dr. Rizkalla swore in the witnesses. Prior to opening statements, Dr. Mostatab asked to withdraw her application. Ms. Bennett stated Dr. Mostatab requested the formal hearing and the Commonwealth is prepared to go forward. Ms. Bennett then asked that the Board discuss in closed session whether to go forward with case or grant Dr. Mostatab' s request to withdraw her application for a dental license in Virginia.
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. Mostatab. Additionally, she moved that Board staff, Ms. Reen, Ms. Beard, 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 to certify that the Board 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.

Dr. Rizkalla reported that the Board decided to proceed with the hearing.

Dr. Mostatab gave her opening statement.

Following Ms. Bennett's opening statement; Dr. Rizkalla admitted into evidence Commonwealth's exhibits 1-2.

Testifying on behalf of the Commonwealth was Joyce Shelton-Jones, DHP Senior Investigator.

Dr. Mostatab testified on her own behalf.

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. Mostatab. Additionally, she moved that Board staff, Ms. Reen, Ms. Beard, 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 to certify that the Board 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.

Virginia Board of Dentistry
Formal Hearing
June 9, 2017

Decision:

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

Mr. Rutkowski reported that Dr. Mostatab's application for a dental license in Virginia is denied.

Dr. Parris-Wilkins moved the adoption of the sanction imposed as read by Mr. Rutkowski. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 2:30 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED - DRAFT

BOARD OF DENTISTRY
MINUTES of the NOMINATING COMMITTEE MEETING

Friday, June 30, 2017

Perimeter Center
9960 Mayland Drive, Suite 200
Richmond, VA 23233
Board Room 3

CALL TO ORDER: The meeting was called to order at 12:09 p.m.

PRESIDING: Al Rizkalla, D.D.S., Chair

MEMBER PRESENT: James D. Watkins, D.D.S.,

MEMBER ABSENT: Nathanial C. Bryant, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director for the Board

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

NOMINATIONS: The Committee discussed possible candidates and agreed by consensus to nominate Dr. Alexander for president, Dr. Parris-Wilkins for vice-president and Dr. Petticolas for secretary-treasurer.

APPROVAL OF MINUTES: Ms. Reen requested approval of the June 10, 2016 and August 14, 2015 meeting minutes. The Committee agreed by consensus to approve these minutes.

ADJOURNMENT: With all business concluded, the Committee adjourned at 12:13 p.m.

Al Rizkalla D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

BOARD OF DENTISTRY
NEW MEMBER ORIENTATION

Wednesday, July 26, 2017

Department of Health Professions
9960 Mayland Drive, Suite 200
Henrico, Virginia

CALL TO ORDER: The meeting was called to order at 1:09 p.m.

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

MEMBERS PRESENT: Sandra J. Catchings, D.D.S.
Jamiah Dawson, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Sheila M. Beard, Executive Assistant

OTHER: James E. Rutkowski, Assistant Attorney General, Board Counsel

ORIENTATION: Dr. Alexander welcomed both new Board Members. Dr. Alexander reviewed the Board's current issues involving opiods, anesthesia, DA II, and remote supervision.

Ms. Reen went over the laws, regulations and policies in the Board Member's notebook to include the bylaws and Code of Conduct for the members. She then explained the Board's three areas of work; licensure, regulation, and discipline. She gave an overview of the Board's structure, staffing, and memberships in AADB, SRTA and ADEX.

Mr. Rutkowski explained his role with the Board and discussed the powers and duties of health regulatory boards, the Administrative Process Act, the Freedom of Information Act, and the Conflict of Interest provisions.

Ms. Beard reviewed the state's policies on travel and per diems then confirmed completion of the conflict of interest training information done by both new members.

Ms. Palmatier explained the disciplinary case process and the Probable Cause Review form and discussed the information needed to close a case and to move a case forward for issuance of an advisory letter, confidential consent agreement, pre-hearing consent order and notice for an informal conference. She also reviewed the guide for case reviews, probable cause decisions

and disciplinary action. She encouraged members to use it to help work through cases and to call staff with any questions about a case.

ADJOURNMENT The training was adjourned at 2:30 p.m.

John M. Alexander, D.D.S., President

Date

Sandra K. Reen, Executive Director

Date

UNAPPROVED - DRAFT

BOARD OF DENTISTRY
MINUTES of the NOMINATING COMMITTEE MEETING

Friday, June 30, 2017

Perimeter Center
9960 Mayland Drive, Suite 200
Richmond, VA 23233
Board Room 3

CALL TO ORDER:	The meeting was called to order at 12:09 p.m.
PRESIDING:	Al Rizkalla, D.D.S., Chair
MEMBER PRESENT:	James D. Watkins, D.D.S.,
	MEMBER ABSENT: Nathanial C. Bryant, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director for the Board
QUORUM:	With two members present, a quorum was established.
NOMINATIONS:	The Committee discussed possible candidates and agreed by consensus to nominate Dr. Alexander for president, Dr. Parris-Wilkins for vice-president and Dr. Petticolas for secretary-treasurer.
	APPROVAL OF MINUTES: Ms. Reen requested approval of the June 10, 2016 and August 14, 2015 meeting minutes. The Committee agreed by consensus to approve these minutes.
ADJOURNMENT:	With all business concluded, the Committee adjourned at 12:13 p.m.

Al Rizkalla D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

2017 Annual SRTA meeting held August 3-5 at the Hilton Resort, Myrtle Beach, SC

Attended the Thursday dental calibration meeting which began at 8am and ended at 5:30pm:

1. Held hands-on calibration for the fixed prosthodontics and the endodontics
2. Reviewed and revised the entire dental candidate manual for 2018 and only slight changes were made
3. Reviewed new bank of images from 2017 exam period for new questions for 2018
4. Reviewed current typodont models to insure consistency
5. Recommended new probes be purchased for calibration and grading
6. Recommended that the examiners review the calibration powerpoint presentation online ONCE annually and prior to giving their first exam
7. Fabrication and use of stents for prosthodontics remain mandatory for candidates
8. Recommended that Acadental start placing the fixed prosthodontic sextants first so that candidates may do the prosthodontics first during the exam. (may have pilot done first)
9. Acadental to replace endo-molar with a new tooth for 2018 exam cycle (access will be more towards the mesial)
10. New Calibration Committee Chair for 2018 is Dr. Glenn Young of Virginia.

Attended the Friday dental examination committee meeting which began at 8am and ended at noon:

1. Extensive discussion on how Pre-approval of patient lesions went at pilot sites during the 2017 exam cycle and it was determined that all went well and should be expanded to all exam sites
2. Reviewed changes recommended by the calibration committee
3. Suggested changes for the Examiners manual for 2018 as per Calibration committee
4. The use of digital scanners was discussed but because all schools do not have them available; this discussion was tabled until a later time
5. Dental educators met at the end of this committee meeting
6. Dr. Vance Morgan of South Carolina is the new Dental Exam committee Chair for 2018.

BUSINESS SESSION OF SRTA WAS HELD ON SATURDAY BEGINNING AT 8AM:

1. Finance committee announced a budget for 2018 that projects a loss of $200,000
2. Options available to SRTA for continued success include realignment with ADEX; aligning with another testing agency or creating a new market making other states available for their exam
3. New SRTA officers elected are Dr. George Martin of Arkansas as president-elect; Dr. Robert Hall of Virginia as Treasurer and Ms. Tanya Riffe, RDH of South Carolina as Secretary
4. 2018 Annual meeting will be held in Charlotte, NC (hotel site TBA later).

THE RETIREMENT AT THE END OF 2017 FOR EXECUTIVE DIRECTOR, MS. KATHLEEN WHITE, WAS ANNOUNCED AT THIS MEETING AND HER REPLACEMENT SEARCH WILL BEGIN IMMEDIATELY. SRTA BOARD OF DIRECTORS VOTED TO RE-APPLY TO GIVE THE ADEX ASAP. AFTER EXTENSIVE DISCUSSION ON THIS MATTER, THE GENERAL ASSEMBLY VOTED TO PURSUE APPLICATION TO ADEX AND ALLOW THE PRESIDENT AND PRESIDENT-ELECT THE POWER TO NEGOTIATE WITH THE ADEX EXECUTIVE COMMITTEE.

Many thanks to DHP and our Board for allowing me to attend this meeting,

Respectfully submitted, James D. Watkins, DDS

SRTA ANNUAL MEETING 2017 – DENTAL HYGIENE REPORT

By Trudy Levitin, RDH

At 8:00 AM on Thursday, August 3, 2017 the Dental Hygiene Examination Development Committee met at the Hilton Hotel in Myrtle Beach, South Carolina. The Committee reviewed each portion of the 2017 Dental Hygiene Exam and recommended only slight changes to be made for the Clinical Exam for the year 2018. The biggest change that was proposed for the 2018 Dental Hygiene Exam will be the addition of a written test for a *"Head & Neck Exam"* that contains slides, photographs and x-rays with multiple choice questions. This addition is in response to the 6 states that require a "Head & Neck Exam" for Dental Hygiene Licensure and the Dental Hygiene Candidates that want total portability to each state. In preparation for this meeting I reviewed 157 slides and selected 91 which I felt were suitable for the Test and 3 that needed modifying and discarded the remaining 63 slides/questions. The Committee hopes to have a pool of 100 slides/questions from which to make their selections for the test each year.

At 7:45 AM on Friday, August 4, 2017 the Dental Hygiene Exam Committee met and received the report from the new committee, the Dental Hygiene Examination Development Committee (DHEDC), which was formed to take the place of the Dental Hygiene Coordinator (a formerly paid SRTA position which was eliminated in August 2016). The DHEDC develops the manuals, presentations and software changes needed for the examination.
After a thorough review of the proposed 2018 Examination which saw few changes and recommended fine-tuning the 2017 examination, a vote was taken & passed to adopt the proposed 2018 Dental Hygiene Examination.

At 8:00 AM on Saturday, August 5, 2017 the SRTA General Assembly met for the 42nd SRTA Annual Meeting. All committee reports were received. After the Election of Officers there was a proposal for the new incoming president and president-elect to travel to meet with ADEX for the purpose of having SRTA rejoin ADEX. After a lengthy discussion on the proposal a vote was taken and passed.

SRTA Annual Meeting
July 3-5, 2017
Report Presented by Dr. Patricia Bonwell, RDH, PhD
Virginia Board of Dentistry Member

Friday, August 4, 2017

A. Dental Hygiene Educators Forum

1. This was the first meeting/forum of its kind as SRTA works to impove implementing and evaluating dental hygiene clinical exams.
    a. Because required by some states for licensure, an electronic EOE/IOE portion will be added to the exam. This will aid in increasing portability of the SRTA exam. Hoping to not charge extra for this portion of the exam. Best if done via live feed to the school site and presented as a proctored exam on dates and times that work best for the institution.
2. Callibration for scaling - will be providing schools and examiners with models presenting mod/heavy calculus as will be detected for the exam. Help decrease variance.
3. Discussed issue of how some students are having to pay patients to participate in the board exam and are often extorted - extortion laws are applicable. (use consent or disclaimer)

B. Dental Hygiene Examination Committee Meeting

1. EOE/IOE portion being added to exam
2. Changing 8,5,3 to 3,5,8 (calculus: 3 molars, 5 interproximal, 8 posteriors)
3. Scoring plaque, stain, calculus and reversible trauma
4. Use of anesthesia aligned with dental exam guidelines
5. Examiners are now given 90 days instead of 60 days to retake the on-line examiner's quiz before examining again.

Saturday, August 5, 2017 - General Assembly

Discussion focused primarily on SRTA re-joining and working with ADEX for administering clinical board exams. Newly elected president and another member will be attending the ADEX annual meeting, being held this coming weekend, and scheduled a meeting with ADEX higher ups to discuss the possibility and moving forward with joining and working together. Issue around membership/application fee and possible money owed to ADEX was discussed and Board members and general assembly members wanted this issue to be clarified with ADEX in order to move forward as expeditously as possible.

Ammended by-laws were reviewed and agreed upon via voting.

UNAPPROVED

BOARD OF DENTISTRY
MINUTES OF REGULATORY LEGISLATIVE COMMITTEE
Friday, June 30, 2017

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order on June 30, 2017 at 1:02 p.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
Al Rizkalla, 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
Sheila Beard, Executive Assistant
Elaine Yeatts, DHP Policy Analyst
Jim Rutkowski, Board Counsel

PUBLIC COMMENT: Susan Pharr stated that the Virginia Dental Hygienist Association has developed a CE course for practicing under remote supervision to be offered online for 1.5 hours. She added that copies of the course were provided for consideration during the Committee's discussion of the regulatory requirements for the content and length of the required course.

Lauren Schmitt asked that another pathway be established for dental hygienists to qualify as a Dental Assistant II which does not require holding the Certified Dental Assistant credential.

Robert Strauss, DDS, said the Virginia Association of Oral and Maxillofacial Surgeons opposes recognition of the American Board of Dental Specialties which he believes will jeopardize the public.

APPROVAL OF MINUTES: Dr. Wyman asked for motions on the minutes of previous meetings.
The motion by Dr. Watkins to adopt the October 16, 2015 minutes as presented was seconded and passed.
The motion by Dr. Petticolas to adopt the October 14, 2016 minutes with a correction on page 9 was seconded and passed.
The motion by Ms. Ridout to adopt the January 05, 2017 minutes with corrections to pages 11 and 12 was seconded and passed.

LEGISLATION AND REGULATIONS:

Ms. Yeatts reported that the re-adopted emergency regulations on prescribing opioids for pain management are at the Governor's Office for review. She said that the regulations conforming to the ADA guidelines on teaching moderate sedation and the regulation adding capnography to the monitoring requirements for sedation both go into effect on June 14, 2017.

Ms. Yeatts explained that the Committee needs to address the content and length of the course a dental hygienist must complete before practicing under remote supervision so that the Board can adopt final regulation at its September meeting. She said not addressing this in the regulations would lead to inconsistencies across continuing education providers.

Discussion followed about the appropriate length of the course being 1.5 hours as proposed by VDHA or 2 hours. Dr. Alexander moved to require 2 hours. The motion was seconded and passed.

Discussion turned to the required content for the course and the VDHA competencies were discussed. There was agreement that competencies numbered 3 through 9 should be required. Risk management was identified as an additional topic. Ms. Ridout moved to include the VDHA competencies 3 through 9 and add risk management in the regulatory proposal. This motion was seconded and passed.

DR. MAYBERRY'S PETITION:

Dr. Wyman opened the discussion of the petition for recognition of the American Board of Dental Specialties as a bona fide dental specialty certifying organization. Mr. Rutkowski was asked for his guidance and he advised the Committee to go into closed session for legal advice.

Dr. Alexander moved that the Committee convene in a closed meeting pursuant to Section 2.2-3711 (a) (7) of the Code of Virginia for consultation with legal counsel pertaining to actual or probable litigation as addressed in the petition. Additionally, he moved that Board staff, Sandra Reen and Sheila Beard, Board Counsel, James Rutkowski, and DHP Policy Analyst, Elaine Yeatts, attend the closed meeting because their presence is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

Dr. Alexander moved to certify that the Committee 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.

Dr. Alexander moved to recommend that the Board defer to §54.1-2718 (B) of the Code of Virginia which addresses trade names and strike 18VAC-60-21-80 (G) (3) and 18VAC60-20-80 (G) (4) of the Regulations Governing the Practice of Dentistry which address advertising as a specialist.

DR. CARNEY'S PETITION:

Dr. Wyman opened the discussion of the petition for clarification of the regulatory requirements regarding pre-operative, peri-operative and post-operative vital signs in sections 18VAC60-21-280, 18VAC60-21-291 and 18VAC60-21-301 of the Regulations Governing the Practice of Dentistry. Following discussion, the Committee agreed by consensus to have a subgroup of the Committee work with a Regulatory Advisory Panel (RAP) to review and propose changes to Part VI. Controlled Substances, Sedation and Anesthesia. It was also agreed that Dr. Alexander would chair the RAP.

DAII REGULATIONS:

Ms. Reen asked the Committee to work with the new draft of the proposed changes to the Regulations Governing the Practice of Dental Assistants which includes the latest comments received from members of the Regulatory Advisory Panel. Discussion followed about the two options advanced for redefining Dental Assistants I to either require certification as a Certified Dental Assistant or to require completion of a Radiation Health and Safety course and an Infection Control course. Dr. Petticolas moved to leave the definition as it currently stands. This motion was seconded and passed.

Discussion turned to review of Part IV of the regulations including the number of hours specified for clinical experience in composite resin restorations. Following discussion, Dr. Alexander moved to recommend adoption of the changes proposed to Part IV as drafted. The motion was seconded and passed.

DENTAL ASSISTANTS USING CAVITRONS:

Ms. Reen asked the Committee to consider the current regulation, 18VAC60-21-140, which restricts scaling of natural and restored teeth to dental hygienists and also specifically restricts the use of ultrasonic devices such as a Cavitron for scaling to dental hygienists. Dr. Petticolas moved to reaffirm the regulatory restrictions which make it illegal to delegate scaling to dental assistants. The motion was seconded and passed.

NEXT MEETING:	It was agreed by consensus to schedule the next meeting for October 20, 2017.
ADJOURNMENT:	With all business concluded, Dr. Wyman adjourned the meeting at 3:16 p.m.

Augustus A. Petticolas, Jr, D.D.S. Chair

Sandra K. Reen, Executive Director

Date

Date

ADEX
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

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

Highlights of the 13th Annual American Board of Dental Examiners, Inc. (ADEX) House of Representatives August 13, 2017 Rosemont, IL

The following are highlights of the 13th Annual ADEX House of Representatives:

The ADEX House of Representatives consists of Member States and Jurisdictions, District Hygiene and District Consumer Representatives which total 60 representatives, 48 representatives were present.

2017 – 2018 Officers were elected: Dr. Stanwood Kanna, HI, President; Dr. William Pappas, NV, Vice-President; Dr. Jeffery Hartsog, MS, Secretary; Dr. Conrad "Chip" McVea, III, LA, Treasurer. Dr. Bruce Barrette, WI, remains as Immediate Past President.

Because of a major revision to the ADEX Bylaws the election of the Board of Directors and the election of Dental Hygiene Members to the Dental Hygiene Examination Committee and the ADEX House of Representatives was delayed until the 2018 ADEX House of Representatives.

ADEX Board of Directors:

- Appointment of a new Dental Examination Committee Chair – Dr. Stephen DuLong of Massachusetts to replace Dr. John Dixon of West Virginia who completed his three-year term.

Changes to the ADEX Dental Examination:

RESTORATIVE

- ALL restoration criteria for marginal deficiencies redefined. New SUB criteria is less than or equal to .5 mm. New DEF criteria is greater than .5 mm.
- Change from the use of **ACC** for acceptable criteria to **ATC,** meaning Adheres To Criteria which better defines what the scoring reflects, adheres to a minimal acceptable standard.
- Separate criteria now to be used for lower anterior incisors vs. maxillary anterior teeth And lower cuspids.

PROSTHODONTICS

- The changes this year proposed and approved from the Prosthodontic Subcommittee Involved clarification of the use of Stents for grading. All failures will be determined by use of the custom candidate fabricated stent where appropriate. In addition, minor undercuts of less than 0.5 mm will not result in failure unless they compromise the margin when blocked out.

ENDODONTICS

- The endodontic subcommittee met and proposed minor changes to the posterior endodontic criteria which were necessary to work with the new more anatomically correct Acadental molar tooth. The changes were approved

PERIODONTICS

- No changes to periodontal scaling exercise for next year. The periodontal subcommittee met in conjunction with periodontal ad hoc committee. Moving forward the two committees will be combined as the periodontal exam subcommittee. The committee is continuing to work on a new periodontal OSCE examination and is awaiting the results of the new occupational analysis as they develop the new examination.

SCORING

- The Scoring subcommittee met and worked on clarification of the exam rules. Clarification To the **18 Month rule,** the **Timing out Guidelines**, and the **Three Sub rule** were reviewed, **finalized** and approved.

Changes to the ADEX Dental Hygiene Examination:

- Periodontal Probing Exercise will be conducted Post Treatment by both the examiners and candidates on two teeth assigned from within the Case Selection. Implementation in 2018.

- Retain the current criteria that 4 minor tissue trauma errors convert to a major tissue trauma violation and a 100-point penalty.

- Criteria to be utilized in determining the diagnostic quality of the radiographs submitted for the dental hygiene exam will be developed and published in the appropriate manuals, orientations, calibrations and presentations directed at examiners and candidates. Implementation in 2018.

- The 3 criteria included in the Initial Case Presentation Section must **all** be Acceptable to accrue the 3 points assigned to that section of the examination. (Scoring is 0 or 3) Implementation in 2018.

- After a thorough review of the 2016 and 2017 dental hygiene examination data relative to the 12 Selected Surfaces of qualifying calculus in the Calculus Removal Section, it was determined that ADEX will retain the current scoring model relative to Case Acceptance and not implement a Second Submission Policy for the Dental Hygiene Examination.

- The process of stopping the exam after Pre-Treatment Evaluation if the candidate has not accrued enough points to possibly pass the examination has been piloted and will be implemented in 2018.

ADEX House of Representatives:

- Bylaws

  A major revision to the ADEX Bylaws was reviewed and approved by the ADEX House of Representative including a minor amendment that delayed the election of Members of Board of Directors and the election of Dental Hygiene Members to the Dental Hygiene Examination Committee and the ADEX House of Representatives until the 2018 ADEX House of Representatives

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14th Annual ADEX House of Representatives Meeting is scheduled on Saturday, August 11, 2018, Doubletree Hotel, Rosemont, IL.

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of August 25, 2017)

Board **Board of Dentistry**

Chapter		Action / Stage Information
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Prescribing opioids for pain management [Action 4778] Emergency/NOIRA - *Register Date: 8/7/17* [Stage 7948] Comment closed: 6/14/17 Board to adopt proposed regulation: 9/15/17
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Conforming rules to ADA guidelines on moderate sedation [Action 4748] NOIRA - *Register Date: 5/15/17* [Stage 7854] Comment closed: 6/14/17 Board to adopt proposed regulation: 9/15/17
[18 VAC 60 - 25]	Regulations Governing the Practice of Dental Hygienists	Conforming to Code on remote supervision [Action 4857] Final - *Register Date: 9/4/17* [Stage 7980] Effective: 10/4/17

Agenda Item: Board action on revised ADA Guidelines

Included in your agenda package are:

A copy NOIRA published on Regulatory Townhall

A copy of comment on NOIRA

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

Staff notes:

- Regulation was originally adopted by a fast-track action, but deemed by the Department of Planning and Budget to not be approval for fast-track.
- A NOIRA was published with one comment in response about the general ADA guidelines on anesthesia.
- Education requirements for a permit to administer moderate sedation are already required to follow ADA Guidelines, so changes regulations are for consistency with the current guidelines.

Board action:

To adopt the amended regulations by as a proposed action.

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Logged in as
Elaine J. Yeatts

Department of Health Professions

Board **Board of Dentistry**

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

Action: Conforming rules to ADA guidelines on moderate sedation

Action 4748 / Stage 7854

Notice of Intended Regulatory Action (NOIRA)

Edit Stage | Withdraw Stage | Go to RIS Project

Documents		
Preliminary Draft Text	3/1/2017 2:00 pm	Sync Text with RIS
Agency Statement	3/1/2017	Upload / Replace
Governor's Approval Memo	4/14/2017	
Registrar Transmittal	4/17/2017	

Status	
Public Hearing	Will be held at the **proposed** stage
Exempt from APA	No, this stage/action is subject to article 2 of the *Administrative Process Act* and the standard executive branch review process.
DPB Review	Submitted on 3/1/2017 Economist: Amy Hunter Policy Analyst: Larry Getzler Review Completed: 3/8/2017 *DPB's policy memo is "Governor's Confidential Working Papers"*
Governor's Review	Review Completed: 4/14/2017 Result: Approved
Virginia Registrar	Submitted on 4/17/2017 The Virginia Register of Regulations Publication Date: 5/15/2017 Volume: 33 Issue: 19
Comment Period	Ended 6/14/2017 1 comments

Contact Information

Name / Title:	Sandra Reen / *Executive Director*
Address:	9960 Mayland Drive Suite 300 Richmond, VA 23233
Email Address:	**sandra.reen@dhp.virginia.gov**
Telephone:	(804)367-4437 FAX: (804)527-4428 TDD: ()-

This person is the primary contact for this board.
13

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VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Department of Health Professions

Board **Board of Dentistry**

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

Action	Conforming rules to ADA guidelines on moderate sedation
Stage	NOIRA
Comment Period	Ends 6/14/2017

Back to List of Comments

Commenter: Jonathan Wong 5/18/17 9:36 pm

Conforming to ADA Sedation Guidelines

The proposed changes should also be updated to reflect items B.3 and B.4 of the ADA Oct 2016 Sedation guidelines. For example, under B.3 the equipment recommendations state the following:

"A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.

When inhalation equipment is used, it must have a fail-safe system that is appropriately checked andcalibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

The equipment necessary for monitoring end-tidal CO2 and auscultation of breath sounds must be immediately available.

An appropriate scavenging system must be available if gases other than oxygen or air are used.

The equipment necessary to establish intravascular or intraosseous access should be available until thepatient meets discharge criteria."

As such, the proposed change does not reflect the need for moderate sedation providers to keep IV access or IO access equipment available. One of the intents of the updated ADA guidelines was to enforce the importance of the competency in establishing parenteral access for sedation dentists. This is further supported by the ADA changes to the educational requirements for moderate sedation.

In addition, the appropriate verification of the fail-safes against delivering hypoxic gas mixtures is being addressed by requiring an antihypoxic device or inline gas analyzer.

Perhaps most importantly though, section B.3 supports the use of checklists in the perioperative period to ensure that equipment is maintained and in working condition prior to delivering anesthesia care. The use of checklists has been instrumental in the safety of anesthesia care in

hospitals and should be encouraged. For further support of this, please feel free to refer to "To Err is Human" by the Institute of Medicine and "The Checklist Manifesto" by Atul Gawande.

In section B.4, the ADA guidelines reinforce the use of capnography (end tidal CO2) unless invalidated or precluded, whereas the VA update only requires that capnography be available. Secondly, the ADA guidelines expressly describe when recovery can be delegated to a dental assistant and the sedationist can leave the room as when the patient returns to a level of minimal sedation. This too is not addressed in the updates.

Reen, Sandra (DHP)

Subject: FW: AGD communique; ADA response
Attachments: Letter to State Dental Boards re AGD Comments on Sedation (3).pdf; AGD Statement on Sedation.pdf

---------- Forwarded message ----------
From: **Jasek, Jane F.** <jasekj@ada.org>
Date: Mon, Jul 31, 2017 at 9:46 AM
Subject: AGD communique; ADA response
To: "Andrew Herlich (herlicha@upmc.edu)" <herlicha@upmc.edu>, Antwan Treadway <drtreadway@aol.com>, Bryan Moore <bryan@bryanmooredds.com>, "d.sarasin@mchsi.com" <d.sarasin@mchsi.com>, "David C. Sarrett (dcsarrett@vcu.edu)" <dcsarrett@vcu.edu>, "Dr. Gesek" <dsgesek@comcast.net>, "drliu@eastsidepediatricdental.com" <drliu@eastsidepediatricdental.com>, "eginsberg@gmail.com" <eginsberg@gmail.com>, "jag74@pitt.edu" <jag74@pitt.edu>
Cc: "Hart, Karen" <hartk@ada.org>, "Ziebert, Anthony J." <zieberta@ada.org>, "Dr. Jill Price" <jpricedmd@gmail.com>

Dear Anesthesiology Committee Members:

The ADA has responded to a sedation and anesthesia communique sent last week by the Academy of General Dentistry (AGD). As you may know, the AGD statement was sent to state dental boards and contained some factual errors regarding the ADA Sedation and Anesthesia Guidelines. The ADA's communication was distributed to both the state dental boards and to state dental societies.

Please see the attached. If you have any questions, feel free to contact me.

Sincerely, Jane

Jane Forsberg Jasek, MPA jasekj@ada.org
Manager, Dental Education and Licensure Matters
Council on Dental Education and Licensure (CDEL)
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SENT VIA EMAIL TO THE STATE DENTAL BOARD DIRECTORS

July 28, 2017

Dear Colleagues:

The American Dental Association (ADA) is aware of a recent letter sent by the Academy of General Dentistry (AGD) to members of State Dental Boards and their Executive Directors in apparent response to a NBC news story about the tragic deaths in California of two children while undergoing in-office sedation and dental procedures. We are concerned that the letter contains a number of misstatements and, most importantly, improperly suggests a relationship between the tragedies described in that story and the recent revisions to the **adult** *Guidelines for the Use of Sedation and General Anesthesia by Dentists* (Appendix 1) and *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (Appendix 2). The AGD letter also creates the misconception that the ADA Guidelines run contrary to the AAP/AAPD *Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures* for care and management of pediatric patients. These misstatements and mischaracterizations are very disturbing.

At a time when the dental profession should be united in working toward the goal that such events never happen again, and in assuring the public that guidelines are in place to prevent such tragedies, the ADA does not understand the AGD's purpose in disparaging the adult sedation guidelines and falsely suggesting that they create a risk of harm to the public. We are concerned this might lead to confusion and distrust among our patients and public officials, the opposite of what is needed when these events occur.

The ADA stands behind the efficacy of its adult sedation guidelines. The revision of those guidelines was a process that occurred over more than two years, and was based on the most current peer-reviewed literature. Input was solicited from **all** communities of interest, including a special meeting at the ADA Building in June 2016; town hall meetings at the ADA Annual Meeting; calls for written testimony throughout the process; and utilization of the expertise of the members of the ADA Council on Scientific Affairs. The authors of the revision, the Council on Dental Education and Licensure's (CDEL) Anesthesia Committee, are undisputed experts in the field of sedation and anesthesia who all have impeccable credentials. They carefully and thoughtfully reviewed all comments submitted by all of the communities of interest, including the AGD. In the end, the revision process was centered around utilizing the best, most relevant scientific evidence available for the benefit to, and safety of, the patients we serve.

In particular, the ADA takes strong exception to three AGD statements. First, it is a mischaracterization to suggest that the American Dental Association is at odds in any way with the AAP/AAPD *Guidelines,* whether in regard to the use of capnography or in any other detail. The AAPD has expressly stated, in both written and verbal testimony, that this revision is aligned with their own guidelines. Further, the ADA is not alone in its conclusion about the importance of

including capnographic measure in the monitoring of the moderately sedated dental patient. The American Association of Oral and Maxillofacial Surgeons (AAOMS) has required capnography for the monitoring of moderately sedated patients in outpatient facilities since January 1, 2014 (Appendix 3).

Second, it is a mischaracterization for AGD to suggest that "the revisions...mandate a capnograph (with no other options) for moderate sedation..." and that "...use of a capnograph can produce false-positives and endanger the patient in an open-airway environment." The revised guidelines are quite clear that the clinician has the option to utilize other methods of monitoring respiration based on his/her clinical judgment:

> "The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO2 unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation should be monitored by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope."
>
> *(Guidelines for the Use of Sedation and General Anesthesia by Dentists,* p. 11, 13.)

In addition, while agreeing that the use of a capnography can, like all methods of monitoring respiration, produce false-positives, the ADA conducted a meta-analysis evaluating ability of capnography to detect respiratory complications, most commonly reported as apnea or altered ventilation, during moderate procedural sedation and analgesia. Using a random-effects model of ten studies (Appendix 4) involving 839 adults receiving procedural sedation and anesthesia, the ADA found that the weighted odds ratio of adverse respiratory events was 10.48 (95% CI: 3.64, 30.23), indicating that the odds of correctly detecting adverse respiratory events in patients undergoing moderate procedural sedation may be 10.48 greater if monitoring included capnography than if it did not. The ADA suggests that this improvement in patient safety outweighs the inconvenience of taking the time to check a patient subsequently determined to have a false-positive event.

Finally, although the guidelines have revised the training requirements, it is false to state that the ADA has "relaxed" the intravenous training requirement. In fact the training requirements were not reduced. The number of training hours for moderate sedation, regardless of agent, is 60 hours in the 2016 Guidelines. The ADA Guidelines include a new statement to support this: "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."

Further the 2016 Guidelines reinforced training by requiring that courses include:

- A minimum of 60 hours of instruction plus administration of sedation for at least 20 individually managed patients.
- Certification of **competence** [emphasis added] in moderate sedation technique(s).
- Certification of **competence** [emphasis added] 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.

To the extent that AGD is suggesting that these training requirements are deficient, we note "competent" is defined in the 2016 ADA Guidelines as follows: "*competent* – displaying special skill or knowledge derived from training and experience." Demonstration of competence is certainly more rigorous than simply mandating a random number of procedures performed without any evaluation of whether the clinician is actually performing to an acceptable level. In other words, under the old guidelines, a clinician could complete administration of sedation for at least 20 individually managed patients very poorly, and yet still meet the training requirements.

In conclusion, let us reiterate that the issues raised by the AGD have nothing to do with the tragic deaths of children reported in the media. The ADA is very disappointed that the AGD has chosen to utilize the deaths of two children to highlight its continued disagreement with the ADA revised adult sedation guidelines, especially in light of the fact it was afforded ample opportunity at several levels of review to make a scientific-based argument in its favor. As noted, it is much more important to provide assurance to the public that the adherence to the guidelines adopted by the AAPD and by the ADA, respectively, will result in minimizing these unfortunate events.

Sincerely,

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

Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

GLR/KTO/AZ:ns
Enclosures
cc: Officers and Members of the ADA Board of Trustees
American Association of Dental Boards
State Dental Association Executive Directors
Dr. Maria A. Smith, president, Academy of General Dentistry
Mr. Daniel Buksa, associate executive director of public affairs, Academy of General Dentistry

ACADEMY of GENERAL DENTISTRY
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The Academy of General Dentistry believes that all levels of training should be available to general dentists. However, as general dentists, we primarily provide minimal or moderate sedation, or conscious sedation. We rarely provide deep sedation or general anesthesia. Cases such as that of Caleb Sears or others profiled on NBC's "Sunday Nights with Megyn Kelly" on July 9, 2017 primarily deal with deep sedation or general anesthesia, with some exceptions.

Regardless of level of sedation, we believe that dentists should comply with the use and training requirements within their states regarding sedation and anesthesia.

In 2016, the AGD supported the revised American Academy of Pediatrics (AAP)/American Academy of Pediatric Dentists (AAPD) *Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures*. Updated in 2016, these AAP/AAPD guidelines include having a separate person from the operating dentist to monitor and administer general anesthesia and deep sedation. This is consistent with Caleb's Law. (Caleb's Law **increases the safety of administering and monitoring general anesthesia/deep sedation to children during dental procedures.)**

The AGD also supports the AAP/AAPD's position that dentists should have a choice of capnograph or precordial/pretracheal stethoscope to monitor breathing during moderate sedation, and opposes the American Dental Association's (ADA) 2016 revisions to the *Guidelines for the Use of Sedation and General Anesthesia by Dentists* and *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (the "ADA sedation guidelines") that mandate a capnograph (with no other options) for moderate sedation, because use of a capnograph can produce false-positives and endanger the patient in an open-airway environment. In speaking against the 2016 revisions to the ADA sedation guidelines, the AGD also advocated for the safety of patients by opposing the ADA's proposal to relax intravenous (IV) sedation training requirements. ADA's revision enables dentists to provide IV moderate sedation without ever having trained in administering an IV on a live patient; the revision allows live patient training for IV practice to be by any administration technique, including oral administration. The AGD fought to maintain the old requirement that dentists who wish to practice IV sedation have had training providing IV sedation to at least 20 live patients.

For specific questions on this report, please contact AGD Director of Communications Kristin Gover. For policy questions related to sedation and anesthesia, please contact AGD Director of Dental Pracitce and Policy Srini Varadarajan.

Reen, Sandra (DHP)

From: Sandy Guenther <sguenther@aaoms.org>
Sent: Tuesday, August 15, 2017 3:32 PM
Subject: AAOMS Statement on Anesthesia
Attachments: Anesthesia Response to AGD.final.kw.pdf

Dear State Dental Board Executive Directors:

On behalf of Dr. Douglas W. Fain, AAOMS President, and the AAOMS Board of Trustees, please see the attached letter regarding anesthesia and patient safety.

Thank you,

Sandy Guenther
Senior Staff Associate, Governmental Affairs
American Association of Oral and Maxillofacial Surgeons
9700 West Bryn Mawr Ave. I Rosemont, IL 60018
800.822.6637, ext. 4388 I fax: 847.678.4619
sguenther@aaoms.org I www.aaoms.org

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aaoms.org

Douglas W. Fain, DDS, MD, FACS
President

Scott Ferrell, MBA, CPA
Executive Director

American Association of Oral and Maxillofacial Surgeons

SENT VIA EMAIL

August 15, 2017

Dear Colleagues:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) and its fellows and members are dedicated to provide safe and accessible anesthesia services for our adult and pediatric patients. We have provided cost-effective anesthesia in the outpatient setting with an unparalleled safety record for more than 60 years.

AAOMS and its Board of Trustees have embraced a multifaceted approach to support our strong and long-held beliefs in a culture of safety and, especially, anesthesia patient safety. These efforts include a wide scope of initiatives that exemplify our level of ongoing commitment to a culture of anesthesia safety in the practice of oral and maxillofacial surgery, including:

- Stewardship of OMS residency education standards that require a five-month rotation on the medical anesthesia service as well as a continuous outpatient experience, whereby OMS residents participate in the delivery of all levels of anesthesia through their four to six years of training.
- A self-imposed mandatory Office Anesthesia Evaluation program, in place for more than 25 years.
- Development of the Dental Anesthesia Assistant National Certification Examination (DAANCE), which strengthens our anesthesia team model and augments our multiple educational programs for anesthesia assistants.
- Our recently developed anesthesia emergency management simulation training modules in cooperation with the Medical University of South Carolina Simulation Center. These courses will maintain critical skills as well as further enhance and promote patient safety and excellence for the OMS anesthesia team.
- AAOMS being the first dental specialty to embrace the mandatory requirement of end-tidal carbon dioxide monitoring in the delivery of outpatient anesthesia.
- Active support of the recent revisions of the American Dental Association's Council on Dental Education and Licensure's anesthesia guidelines.

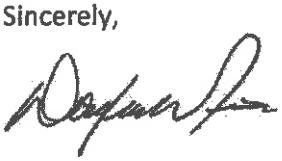
Oral and maxillofacial surgeons perform millions of outpatient anesthetic procedures throughout the United States every year. Despite the highest levels of quality care and a continuous focus on patient safety, a small number of adverse events still occur – not unlike

any specialty that delivers anesthesia. These rare events create negative publicity, which can have devastating consequences to all dentists who deliver anesthesia and the overall profession of dentistry. Recently, pediatric sedation/anesthesia has become a particular focus of the news media. Adverse events in this age group are understandably disturbing. With the intense media focus, emotions – instead of science and evidence-based medicine – are being used to enact changes to state anesthesia rules.

Responses to these unfortunate events have promulgated communications from various groups (e.g., AGD) that, in many cases, are less familiar with sedation and anesthesia in general. More significantly, these groups appear to be unaware of the unparalleled safety record of the oral and maxillofacial surgeon and our team model of anesthesia delivery. These same groups also suggest or demand changes without having scientific or evidence-based studies to support such actions. An example of this is the fallout from Caleb's Law in California. The related legislation that followed – had it passed without modification – would have done significant harm by reducing access to care and limiting resources available to the most at-risk populations, with no evidence there would be improved outcomes.

All stakeholders, including state dental boards, should recognize the long-standing commitment that AAOMS and its fellows and members have made to ensure the continued safe delivery of office-based anesthesia. AAOMS strives to achieve visionary education and training for our members and future members. It is our hope that our dental colleagues would embrace rather than challenge this commitment. Sending out unfounded critical communiqués is not productive nor collaborative. Instead, we welcome all areas of dentistry to join us in our pursuit to improve the safety record for all patients.

Sincerely,



Douglas W. Fain, DDS, MD, FACS
President
American Association of Oral and Maxillofacial Surgeons

Appendix 3

Capnography is coming to the OMS office in 2014[1]

In recent years, capnography monitoring equipment, long a standard of care in the hospital OR, has been improved and now offers real benefits in such outpatient surgery sites as the OMS office. Following the lead of the American Society of Anesthesiologists (ASA), the American Heart Association and other organizations that develop parameters of care and practice guidelines for their dental and medical surgical specialists, the AAOMS Board of Trustees approved the following revised guidelines requiring capnography equipment in the OMS office beginning in 2014:

> During moderate or deep sedation and general anesthesia 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; and

> Improvements in monitoring exhaled CO_2 during anesthesia continue to evolve. Beginning in 2014, AAOMS Office Anesthesia Evaluations will require capnography for moderate sedation, deep sedation and general anesthesia unless precluded or invalidated by the nature of the patient, procedure or equipment.

The statements appear in the *2012 Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 12), version 5.0*, which is also a component of the revised *Office Anesthesia Evaluation Manual, 8th edition*. Additional information about the new capnography guidelines will be provided in the July/August issue of *AAOMS Today*.

[1] June 2012 American Association of Oral and Maxillofacial Surgeons Message from the President (http://www.aaoms.org/president/062012.html#2)

Project 4975 - NOIRA

BOARD OF DENTISTRY

Conforming rules to ADA guidelines on 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.~~1. 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.~~2. Completion of a continuing education course that meets the requirements of 18VAC60-21-250 and consists of (i) 60 hours of didactic instruction plus the management of at least 20 patients per participant, (ii) demonstration of competency and clinical experience in ~~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 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;

16. Precordial or pretracheal stethoscope; and

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

C. Required staffing. At a minimum, there shall be a two-person treatment team for ~~conscious/moderate~~ 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, end-tidal carbon dioxide, 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.

Agenda Item: Board Action on Regulations for Remote Supervision

Included in your agenda package are:

A copy of HB1474 as passed by the 2017 General Assembly with 2nd enactment authorizing adoption of emergency regulations.

A copy of DRAFT emergency regulations on the continuing education course required for a dental hygienist to practice under remote supervision, as recommended by the Regulatory/Legislative Committee

Board action:

Adoption of draft regulations as an emergency action and approval of a Notice of Intended Regulatory Action to replace the emergency regulation.

Motion to read:

"I move that the Board adopt the amendments to 18VAC60-25-190 as an emergency action and to approve a NOIRA to replace the emergency regulation."

2017 SESSION

CHAPTER 410

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

[H 1474]
Approved March 13, 2017

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.

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

Project 5208 - Emergency

BOARD OF DENTISTRY

Competencies for remote supervision

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic Education and Research Foundation;

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

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

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

D. Verification of compliance.

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

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

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

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

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

E. Exemptions.

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

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

F. The board may grant an extension for up to one year for completion of continuing education upon written request with an explanation to the board prior to the renewal date.

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

H. In order to practice under remote supervision, a dental hygienist shall complete a continuing education course of no less than two hours in duration that is offered by an accredited dental

education program or a sponsor listed in subsection C of this section and that includes the following course content:

1. Intent and definitions of remote supervision;

2. Review of dental hygiene scope of practice and delegation of services;

3. Administration of controlled substances;

4. Patient records/documentation/risk management;

5. Remote supervision laws for dental hygienists and dentists;

6. Written practice protocols; and

7. Settings allowed for remote supervision.

Agenda Item: Board Action on Regulations for Opioid Prescribing

Included in your agenda package are:

A copy of re-adopted emergency regulations which became effective on July 21, 2017
A copy of comment on the emergency regulations

Staff Note:

Primarily, the comments note concerns about the 50 MME/day limitation and the requirement for a prescription for naloxone when there is concomitant use of benzodiazepine.

Board action:

Adoption of a proposed regulation to replace the emergency regulation - either identical to the emergency regulation or with changes in response to public comment.

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Department of Health Professions

Board **Board of Dentistry**

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

Action	Prescribing opioids for pain management
Stage	Emergency/NOIRA
Comment Period	Ends 6/14/2017

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Anonymous 5/16/17 3:58 pm

Record for prescribing acute pain

If one prescribes an opoid for anticipated acute pain such as after a tooth extraction, what should be documented? The law states a description of pain and presumptive diagnosis is required but the prescription is given prior to discomfort in order to prevent post operative pain.

Commenter: Berkeley Pemberton, DDS 5/16/17 6:49 pm

Regarding MME

The regulation seems to require the practitioner to reference MME but gives no chart giving the MME of various opioid analgesics. As a dentist practicing 45 years, I've never heard of MME until now. It seems to me an undo burden for a general dentist to have to look up and figure out this arcane information in order to prescribe for an acute dental problem. Perhaps an oral surgeon or perio surgeon would have to be more aware.

Commenter: Paul K. Hartmann, DDS 5/16/17 9:39 pm

Naloxone requirement

Upon my review of the opioid emergency regulations, the requirement to provide a prescription for Naloxone is neither practical nor likely efficatious. This is intended to give the patient an emergency drug to reverse the additive respiratory depression for patients simultaneouly taking benzodiazopines along with the newly prescribed narcotic analgesic. It is higly unlikely that it could be used as intended or, for that matter, would be necessary at normal analgesic dosing. If there occurs an inadvertant overdose, administration of this drug (Naloxone) in untrained hands would be difficult. Apparently, it can be prepared as a nasal spray, but it does not come this way, and to expect a patient to use it properly and at the appropriate time is unrealistic. In the hands of a first responder, it can be a lifesaver, but not in this situation. Please strike this requirement from your

emergency regulations.

Commenter: Anonymous 5/18/17 3:22 pm

Preoperative benzodiazepine

What are the guidelines for prescribing a one time Benzodiazepine preopratively if patient on pain medication from another provider or using pain medication for acute problem.

Commenter: Jonathan Wong 5/19/17 12:41 pm

MME, Benzodiazapenes, and Naloxone

There is no question that something needs to be done about the opiod epidemic, as it is costing too many lives in the US (as well as Canada). I am a firm believer that much of this epidemic is driven by the unintended consequences of making pain the 5th vital sign, emphasis on patient satisfaction scored (HCAHPS) and their effect on reimbursements. I bring this up only because I wish to point out some unintended consequences of the current proposed regulatory changes.

1) Milligram Morphine Equivalencies - this is a topic that comes from pain medicine and equianalgesic doses. It has been increasingly emphasized due to the CDC recommendations. However, the CDC recommendations were meant to be guidelines for consideration by practitioners and not laws. The CDC was clear on this, and made such recommendations because of the public health crisis posed by the Opioid Epidemic. Dentists are not trained on this. I would say few understand that hydrocodone has a 1:1 equivalency with ORAL morphine (IV morphine is 3 times that of oral morphine due to bioavailability) or Oxycodone is 1:5 : 1. Codeine shows a major flaw in this equianalgesic / equavalency paradigm, as it is completely dependent on metabolism of a prodrug into active metabolites. Each individual does so differently. However, the MME helps to study effects across the plethora of different opioid drugs.

This becomes problematic when a dentist prescribes medications for a 3-5 day period that is typical after dental surgical procedures. It was long taught that dentists should prescribe Hydrocodone / Acetaminophen 5/325 as 1-2 tabs every 4-6 hrs as needed for pain, perhaps with 16-20 pills. This allows the patient to adjust their dosing within a safe range depending on pain levels. A pharmacist will review this Rx as 60 MME daily. This is regarded as equivalent to an MD prescribing Hydrocodone / Acetaminophen 5/325 2 every 4 hours for 30 days, or 360 pills. Dentists should be encourages to prescribe for less than 7 days (as noted in these changes) for acute pain, not necessary on the basis of MMEs. Most of our crisis is due to misuse, especially of extra supply of medications.

2) Naloxone requires some training to use. Dentists being encouraged to prescribe these items to patients and their families will require thorough understanding of respiratory depression secondary to excess narcotics and how to use naloxone. Intranasal naloxone requires expensive Mucosal atomization devices, and requires high volumes of drug (although there are now more expensive conentrated versions of naloxone), approximately 4 ml. Intramuscular devices are like epi pens and cost upwards of 600 dollars. Even the original naloxone formulation has had a price increase of nearly 300% since these rules, going from appoximately 9 dollars to 30 dollars on my most recent order - and it is getting worse.

3) Naloxone with any concomitant use of benzodiazapene - we use benzodiazepenes frequently in dentistry for sedation and anesthesia. Should we give every patient that gets an opioid prescription Naloxone then? This would basically mean every patient receiving sedation or anesthesia would need a prescription for Naloxone. It is true that there can be a synergistic effect of narcotics and benzodiazapenes on respiratory depression, but such a blanket "must" is, in my opinion, a waste of medical resources.

In summary, I would ask you to reconsider the wording of the Naloxone requirements for the reasons above. I also believe that it is more efficacious for dentists to be encouraged to maximize non-narcotic analgesic techniques first and to limit narcotics to breakthrough pain during the acute phase of recovery (5-7 days maximum) either in addition to or in leui of focussing solely on MMEs.

Commenter: Gregory Engel, DMD, MS 5/24/17 10:20 am

Naloxone requirement

Having read the previous comments, I agree with each of their points and do not wish to reiterate all those points. I'll concur that there is an opiod problem which needs to be addressed. In general, acute dental pain management usually last just a few days. Therefore, the amount of a particular opiod that we would prescribe is generally 20 pills or under. The patients to which I would prescribe opiods are absolutely in need of them. Should their pain persist longer than the usual time period, then the provider should re-examine the patient and re-prescribe as necessary thus avoiding a hefty amount of pills being presribed initially. How many of these overdoses have been ascribed to dentally related prescriptions? Not to make an undue burden on our pharmacist collegues, but if there is a requirement for the use of naloxone, doesn't it make sense for the pharmacist to co-distribute the naloxone (along with the detailed instructions on how to use it to family members) as a standard protocol for those dosings in which the MME is much higher or the amount of distributed pill is much greater?

Commenter: Dean DeLuke, DDS, MBA 5/30/17 11:38 am

Naloxone and concomitant use of benzodiazepine

While I support this overall initiative, I would respectfully request reconsideration of the requirement to prescribe naloxone whenever there is concomitant use of a benzodiazepine. I see many patients in our clinics at VCU who may take daily or PRN doses of benzodiazepines, and if I believe a narcotic analgesic is indicated, I routinely consider dose reduction, and I counsel the patient regarding additive effects of the medications. However, to require a naloxone prescription for this entire group of patients is not, in my opinion, indicated.

Commenter: Suzanne Ferrell 6/6/17 9:56 pm

People already in treatment for a long time

TDo these regs even speak to people who have already been in treatment for a long time? My husband has Tardive Dyskinesia, a disorder that causes spasms and severe pain in his mouth, jaw, and tongue. It has no cure. The primary treatment is drugs that help control the spasms and pain. A well respected and compassionate oral and maxillo facial surgeon diagnosed this about 14 years ago after my husband had suffered for more than a year. The doctor has been managing his treatment ever since. He literally gave my husband a life! The doctor told us recently that due to the changes in the law, he would not be able to continue caring for my husband and that we should look for a Pain Management doctor. I'm not sure why the doctor believes that to be true. But my husband is a chronic pain patient and the care he receives is palliative in nature. It appears 18VAC60-21-105 may allow him to continue treating my husband as long as he complies with the Board of Medicine regs. I'm not sure because I'm not an attorney. My husband's condition has been worsening recently and the loss of his doctor would be devestating to him. Besides that, I contacted 50-75 Pain Management doctors and all except 2 were anesthesiology pain management and didn't manage medications. Of the 2 exceptions, one said my husband's case was too complex. The other, who had assured me they could handle his case, backed out of that

assurance when I called to make an appointment. In addition, I contacted the hospital's physician referral service and placed notifications on social media and on online medical forums. Those resulted in zero success. I just don't know what else I can do at this point. My husband did not ask for the disorder he has. It came about because some doctor failed to warn him of the serious side effects of drugs he prescribed. My husband is in his 60s and he does not abuse or divert the drugs he is prescribed. All he wants is to live his life in some semblance of comfort. If he should be made to suffer because of laws that are promulgated due to the bad acts of others, it would be a real travety.ype over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Greg Zoghby 6/9/17 5:55 pm

Naloxone for patient on benzodiazepines getting narcotics

The number of patients on scheduled or prn benzodiazepines has grown significantly. The requirement to give naloxone is absurd. Half of my patients would be getting naloxone. I have called three different pharmacies and none of them even stock the 1mg/1ml SQ dose. One pharmacy had the nasal dosing at 150.00 dollars. This regulation needs more thought. It is unworkable at this time.

Commenter: Thomas B Padgett D.M.D. 6/12/17 10:44 am

Naloxone requirement for concomitent of Benzodiazapines with an Opioid.

I have also read the previous comments and agree with their conclusions. If indeed this goes through as written I would like to know how to address the patient who is already taking high dose Opioids and concomitent Benzodiazapines prescribes by their physician. Even if I do not prescribe additional Opioids am I now responsible for prescribing the Naloxone? Does the Board of Medicine require this as well or just the BOD. Due to the costs of the nasal spray Naloxone I feel many patients will forgo filling the prescription. May be we should just review the History and concerns with the patient and family then asked them if they would like the Naloxone RX. It sounds more like a feel good rule and more thought needs to be done before implimenting it.

Project 5064 - Emergency/NOIRA

BOARD OF DENTISTRY

Prescribing opioids for pain management

Part III

Prescribing for pain management

18VAC60-21-101. Definitions.

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

"Acute pain" means pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months.

"Chronic pain" means nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months.

"Controlled substance" means drugs listed in The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) in Schedules II through IV.

"MME" means morphine milligram equivalent.

"Prescription Monitoring Program" means the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

18VAC60-21-102. Evaluation of the patient in prescribing for acute pain.

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the

dentist shall follow the regulations for prescribing and treating with opioids in 18VAC60-21-103 and 18VAC60-21-104.

B. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the dentist shall perform a health history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance abuse.

18VAC60-21-103. Treatment of acute pain with opioids.

A. Initiation of opioid treatment for all patients with acute pain shall include the following:

1. A prescription for an opioid shall be a short-acting opioid in the lowest effective dose for the fewest number of days, not to exceed seven days as determined by the manufacturer's directions for use, unless extenuating circumstances are clearly documented in the patient record.

2. The dentist shall carefully consider and document in the patient record the reasons to exceed 50 MME/day.

3. Prior to exceeding 120 MME/day, the dentist shall refer the patient to or consult with a pain management specialist and document in the patient record the reasonable justification for such dosage.

4. Naloxone shall be prescribed for any patient when any risk factor of prior overdose, substance abuse, doses in excess of 120 MME/day, or concomitant use of benzodiazepine is present.

B. If another prescription for an opioid is to be written beyond seven days, the dentist shall:

1. Reevaluate the patient and document in the patient record the continued need for an opioid prescription; and

2. Check the patient's prescription history in the Prescription Monitoring Program.

C. Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the dentist shall only co-prescribe these substances when there are extenuating circumstances and shall document in the patient record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

18VAC60-21-104. Patient recordkeeping requirement in prescribing for acute pain.

The patient record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan, and the medication prescribed (including date, type, dosage, strength, and quantity prescribed).

18VAC60-21-105. Prescribing of opioids for chronic pain.

If a dentist treats a patient for whom an opioid prescription is necessary for chronic pain, he shall either:

1. Refer the patient to a medical doctor who is a pain management specialist; or

2. Comply with regulations of the Board of Medicine, 18VAC85-21-60 through 18VAC85-21-120 (see 33:16 VA.R. 1930-1931 April 3, 2017), if he chooses to manage the chronic pain with an opioid prescription.

18VAC60-21-106. Continuing education required for prescribers.

Any dentist who prescribes Schedules II through IV controlled substances after April 24, 2017 shall obtain two hours of continuing education on pain management, which must be taken by March 31, 2019. Thereafter, any dentist who prescribes Schedule II through IV controlled substances shall obtain two hours of continuing education on pain management every two years. Continuing education hours required for prescribing of controlled substances may be included in the 15 hours required for renewal of licensure.

Agenda Item: Board action on Committee recommendation on use of dental specialties

Included in your agenda package are:

Copy of Board action on petition from Dr. Rodney Mayberry to recognize the American Board of Dental Specialties and to be able to advertise as a Dental Implant Specialist

Copy of amended regulation and applicable Code section as recommended by the Regulatory/Legislative Committee

Board action:

To accept the recommendation of the Committee and adopt the regulation as a fast-track action or take other such action as determined by the Board.

Board Action on Draft Regulations for Opioid Prescribing. Following Ms. Yeatts review of the draft, the Board made the following amendments:

- In 18VAC60-21-103(C) the term "medical record" was changed to "patient record".
- In 18VAC60-21-105(1) the terminology was changed to address a "pain management specialist" to be consistent with 18VAC60-21-103(B)(3).
- 18VAC60-21-106 was changed to require dentists who prescribes any Schedule II through IV controlled substances to obtain two hours of continuing education on pain management during the renewal cycle following the effective date of the regulations which may be included in the 15 hours required for license renewal.

Dr. Watkins moved to adopt the amended regulations. The motion was seconded and passed.

Board Action on Petitions for Rulemaking.

- Dr. Carney petitioned the Board to amend three regulatory sections which address the requirements for taking vital signs when sedation is being administered. Following discussion, Dr. Petticolas moved to refer this matter to the Legislative-Regulatory Committee. The motion was seconded and passed.
- Dr. Mayberry petitioned the Board to recognize the American Board of Dental Specialties as a bona fide dental specialty certifying organization and to authorize dentists who were certified by the American Board of Implantology/Implant Dentistry be recognized as Dental Implant Specialists. Ms. Ridout moved to refer this matter to the Legislative-Regulatory Committee. The motion was seconded and passed.

BOARD DISCUSSION/ACTION:

Exam Committee Motion that the Board Reaffirm its Position of Requiring Live Patient Exams.
Dr. Watkins offered the motion for discussion. Following a brief discussion in support of the motion, it was passed.

How Should the Board Address the Use of a Cavitron Device.
Dr. Watkins explained that during a recent informal conference, Special Conference Committee C discussed its concern that dentists are allowing dental assistants to use Cavitrons for scaling. He asked if the Board should issue a guidance document to inform licensees that dental assistants cannot use Cavitrons. Ms. Reen suggested that the Board review 18VAC60-21-140 which restricts delegation of scaling to only dental hygienists. Discussion followed about how to proceed and Ms. Ridout made a motion to refer this matter to the Legislative-Regulatory Committee. The motion was seconded and passed.

Project 5206 - none

BOARD OF DENTISTRY

Advertising dental specialties

18VAC60-21-80. Advertising.

A. Practice limitation. A general dentist who limits his practice to a dental specialty or describes his practice by types of treatment shall state in conjunction with his name that he is a general dentist providing certain services (e.g., orthodontic services).

B. Fee disclosures. Any statement specifying a fee for a dental service that does not include the cost of all related procedures, services, and products that, to a substantial likelihood, will be necessary for the completion of the advertised services as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of fees for specifically described dental services shall not be deemed to be deceptive or misleading.

C. Discounts and free offers. Discount and free offers for a dental service are permissible for advertising only when the nondiscounted or full fee, if any, and the final discounted fee are also disclosed in the advertisement. In addition, the time period for obtaining the discount or free offer must be stated in the advertisement. The dentist shall maintain documented evidence to substantiate the discounted fee or free offer.

D. Retention of advertising. A prerecorded or archived copy of all advertisements shall be retained for a two-year period following the final appearance of the advertisement. The advertising dentist is responsible for making prerecorded or archived copies of the advertisement available to the board within five days following a request by the board.

E. Routine dental services. Advertising of fees pursuant to this section is limited to procedures that are set forth in the American Dental Association's "Dental Procedures Codes," published in Current Dental Terminology in effect at the time the advertisement is issued.

F. Advertisements. Advertisements, including but not limited to signage, containing descriptions of the type of dentistry practiced or a specific geographic locator are permissible so long as the requirements of §§ 54.1-2718 and 54.1-2720 of the Code are met.

G. False, deceptive, or misleading advertisement. The following practices shall constitute false, deceptive, or misleading advertising within the meaning of subdivision 7 of § 54.1-2706 of the Code:

1. Publishing an advertisement that contains a material misrepresentation or omission of facts that causes an ordinarily prudent person to misunderstand or be deceived, or that fails to contain reasonable warnings or disclaimers necessary to make a representation not deceptive;

2. Publishing an advertisement that fails to include the information and disclaimers required by this section;

3. Publishing an advertisement that ~~contains a false claim of professional superiority, contains a claim to be a specialist, or uses any terms to designate a dental specialty unless he is entitled to such specialty designation under the guidelines or requirements for specialties approved by the American Dental Association (Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, November 2013), or such guidelines or requirements as subsequently amended; or~~

~~4. Representation by a dentist who does not currently hold specialty certification that his practice is limited to providing services in such specialty area without clearly disclosing that he is a general dentist~~ is not in compliance with § 54.1-2718 of the Code of Virginia.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 27. Dentistry

§ 54.1-2718. Practicing under firm or assumed name

A. No person shall practice, offer to practice, or hold himself out as practicing dentistry, under a name other than his own. This section shall not prohibit the practice of dentistry by a partnership under a firm name, or a licensed dentist from practicing dentistry as the employee of a licensed dentist, practicing under his own name or under a firm name, or as the employee of a professional corporation, or as a member, manager, employee, or agent of a professional limited liability company or as the employee of a dental clinic operated as specified in subsection A of § 54.1-2715.

B. A dentist, partnership, professional corporation, or professional limited liability company that owns a dental practice may adopt a trade name for that practice so long as the trade name meets the following requirements:

1. The trade name incorporates one or more of the following: (i) a geographic location, e.g., to include, but not be limited to, a street name, shopping center, neighborhood, city, or county location; (ii) type of practice; or (iii) a derivative of the dentist's name.

2. Derivatives of American Dental Association approved specialty board certifications may be used to describe the type of practice if one or more dentists in the practice are certified in the specialty or if the specialty name is accompanied by the conspicuous disclosure that services are provided by a general dentist in every advertising medium in which the trade name is used.

3. The trade name is used in conjunction with either (i) the name of the dentist or (ii) the name of the partnership, professional corporation, or professional limited liability company that owns the practice. The owner's name shall be conspicuously displayed along with the trade name used for the practice in all advertisements in any medium.

4. Marquee signage, web page addresses, and email addresses are not considered to be advertisements and may be limited to the trade name adopted for the practice.

Code 1950, § 54-184; 1970, c. 639; 1975, c. 479; 1988, c. 765; 1992, c. 574; 2004, c. 48;2005, cc. 505, 587.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

On vote, Resolution 65 was adopted.

65H-2016. Resolved, that Section 5.H. of the ADA Principles of Ethics and Code of Professional Conduct be amended as set forth below (additions underscored, deletions stricken through):

5.H. ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE.

This section and Section 5.I are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program. A dentist may ethically announce as a specialist to the public in any of the The dental specialties recognized by the American Dental Association including and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics., and in any other areas of dentistry for which specialty recognition has been granted under the standards required or recognized in the practitioner's jurisdiction, provided the dentist

meets the educational requirements required for recognition as a specialist adopted by the American Dental Association or accepted in the jurisdiction in which they practice.* Dentists who choose to announce specialization should use "specialist in" or "practice limited to" and shall devote a sufficient portion of their practice to the announced specialty or specialties to maintain expertise in that specialty or those specialties, Dentists whose practice is devoted exclusively to an announced specialty or specialties may announce that their practice "is limited to" that specialty or those specialties. limit their practice exclusively to the announced dental specialties, provided at the time of the announcement such dentists have met in each recognized specialty for which they announce the existing educational requirements and standards set forth by the American Dental Association. Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are qualified to announce themselves as specialists.

GENERAL STANDARDS.

The following are included within the standards of the American Dental Association for determining the education, experience and other appropriate requirements for announcing specialization and limitation of practice:

1. The special area(s) of dental practice and an appropriate certifying board must be approved by the American Dental Association or be recognized by the jurisdiction in which the dentist practices.

2. Dentists who announce as specialists must have successfully completed an educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education and Licensure, or be diplomates of an American Dental Association recognized certifying board recognized by the American Dental Association or the jurisdiction in which the announcing dentist practices. The scope of the individual specialist's practice shall be governed by the educational standards for the specialty in which the specialist is announcing.

3. The practice carried on by dentists who announce as specialists shall be limited exclusively to the special area(s) of dental practice announced by the dentist.

STANDARDS FOR MULTIPLE-SPECIALTY ANNOUNCEMENTS.

The educational criterion for announcement of limitation of practice in additional specialty areas is the successful completion of an advanced educational program accredited by the Commission on Dental Accreditation (or its equivalent if completed prior to 1967) in each area for which the dentist wishes to announce. Dentists who are presently ethically announcing limitation of practice in a specialty area and who wish to announce in an additional specialty area must submit to the appropriate constituent society documentation of successful completion of the requisite education in specialty programs listed by the Council on Dental Education and Licensure or certification as a diplomate in each area for which they wish to announce.

* In the case of the ADA, the educational requirements include successful completion of an advanced educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education and Licensure, or being a diplomate of an American Dental Association recognized certifying board for each specialty announced.

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July 17, 2017

Ms. Sandra K. Reen
Executive Director
Virginia Board of Dentistry
Perimeter Center
9960 Maryland Drive, Suite 300
Henrico, VA 23233-1463

RE: Dental Specialty Advertising

Dear Ms. Reen,

We serve as legal counsel to the American Board of Dental Specialties (ABDS), and the four respective boards currently comprising the ABDS. As you may be aware, a recent case decided in the US Court of Appeals for the Fifth Circuit relates to these individual boards and the ability of their respective Diplomates to advertise themselves as 'specialists.' That decision is enclosed.

Your Board's current regulations, de facto or de jure, limit specialty/specialist advertising to ADA recognized specialties. I am writing to formally request that the Board of Dentistry recognize the ABDS boards/areas of practice as specialties and include them, and any future ABDS recognized specialties, under the applicable law of your State.

The ABDS was formed to offer a specialty recognition process, similar to the American Board of Medical Specialties (ABMS), which is not controlled by a private professional Association such as the American Dental Association, or any Council or Commission of the ADA. The focus of the ABDS is on recognizing certifying boards as "specialty boards." To be recognized by the ABDS, a certifying board seeking recognition must require a minimum of two (2) full-time, formal, advanced educational programs that are a minimum of two (2) years in duration and are

presented by recognized educational institutions; or require 400 didactic hours of post dental school education and the equivalent of one (1) year of clinical practice. A certifying board that is seeking membership in the American Board of Dental Specialties must: 1) reflect a distinct and well-defined area of expertise in dental practice; 2) develop a rigorous standard of preparation and evaluation in the area of dentistry; 3) provide evidence of psychometric evaluation of a written and oral examination; 4) provide an effective mechanism to maintain certification; and 5) exist as an independent, self-governing entity comprised of dentists whose main purpose is to evaluate candidates for board certification. The documentation and application requirements are numerous, and I am confident that the Board of Dentistry will be satisfied that the ABDS maintains rigorous standards for recognition.

Moreover, as you may know, the ADA recently revised its Code of Ethics to allow dentists to advertise a specialty not recognized by the ADA. I am enclosing ADA Resolution No. 65, along with the explanatory preface and the amended Section 5.H of the ADA Principles of Ethics and Code of Professional Conduct. As you can see, the ADA itself has determined that its specialty list is nonexclusive, and its Code of Ethics no longer prohibits lawfully advertising non-ADA specialties. To that end, I would urge your Board to modify its existing regulations to comport with the relevant court decisions, and in accordance with Resolution 65 of the ADA.

Lastly and importantly, recognizing the ABDS and its certifying boards would avoid First Amendment issues related to commercial free speech and the attendant liability under 42 U.S.C. § 1983, as well as eliminate any antitrust concerns.

Thank you.

Sincerely,

Frank R. Recker/sle

Frank R. Recker, DDS

Enclosures
FRR/sle

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 16-50157

AMERICAN ACADEMY OF IMPLANT DENTISTRY; AMERICAN SOCIETY OF DENTIST ANESTHESIOLOGISTS; AMERICAN ACADEMY OF ORAL MEDICINE; AMERICAN ACADEMY OF OROFACIAL PAIN; JAY E. ELLIOTT, D. D. S.; MONTY BUCK, D. D. S.; JAROM C. HEATON, D. D. S.; MICHAEL A. HUBER, D. D. S.; EDWARD F. WRIGHT, D. D. S., M. S.,

Plaintiffs - Appellees

v.

KELLY PARKER, in her official capacity as Executive Director of the Texas State Board of Dental Examiners, TAMELA L. GOUGH, D. D. S., M. S., in her official capacity as a Member of the Texas Board of Dental Examiners; STEVE AUSTIN, D. D. S., in his official capacity as a Member of the Texas Board of Dental Examiners; TIM O'HARE, in his official capacity as a Member of the Texas Board of Dental Examiners; KIRBY BUNEL, JR., D. D. S., in his official capacity as a Member of the Texas Board of Dental Examiners; WILLIAM R. BIRDWELL, D. D. S., in his official capacity as a Member of the Texas Board of Dental Examiners; EMILY A. CHRISTY, in her official capacity as a Member of the Texas Board of Dental Examiners; JAMES W. CHANCELLOR, D. D. S., in his official capacity as a Member of the Texas Board of Dental Examiners; RODOLFO G. RAMOS, JR., D. D. S., in his official capacity as a Member of the Texas Board of Dental Examiners; LEWIS WHITE, in his official capacity as a Member of the Texas Board of Dental Examiners; WHITNEY HYDE, in her official capacity as a Member of the Texas Board of Dental Examiners; RENEE CORNETT, R. D. H., in her official capacity as a Member of the Texas Board of Dental Examiners; D. BRADLEY DEAN, D. D. S., in his official capacity as a Member of the Texas Board of Dental Examiners; CHRISTIE LEEDY, D. D. S., in her official capacity as a Member of the Texas Board of Dental Examiners; LOIS PALERMO, R. D. H., in his official capacity as a Member of the Texas Board of Dental Examiners; EVANGELIA MOTE, in her official capacity as a Member of the Texas Board of Dental Examiners,

Defendants - Appellants

No. 16-50157

Appeals from the United States District Court
for the Western District of Texas

Before ELROD, SOUTHWICK, and GRAVES, Circuit Judges.

LESLIE H. SOUTHWICK, Circuit Judge:

The plaintiffs challenge a provision in the Texas Administrative Code regulating advertising in the field of dentistry. The district court held that the provision violated the plaintiffs' First Amendment right to engage in commercial speech. It therefore enjoined enforcement of the provision as applied to the plaintiffs. The defendants appealed. We AFFIRM.

FACTUAL AND PROCEDURAL BACKGROUND

Texas law prohibits dentists from advertising as specialists in areas that the American Dental Association ("ADA") does not recognized as specialties. *See* TEX. ADMIN. CODE § 108.54. The plaintiffs seek to enjoin enforcement of Section 108.54, as they wish to advertise in areas recognized as specialties by other dental organizations but not by the ADA. They argue the First and Fourteenth Amendments give them the right to do so.

This appeal involves several plaintiffs. The organizational plaintiffs include the American Academy of Implant Dentistry, the American Society of Dental Anesthesiologists, the American Academy of Oral Medicine, and the American Academy of Orofacial Pain. These organizations are national organizations with member dentists. The purpose of each organization is to advance the interests of dentists practicing in the organization's respective practice area. Each organization sponsors a credentialing board and offers credentials to members who demonstrate expertise in their respective field.

The individual plaintiffs are five dentists, three of whom are in private practice and two of whom are professors at the University of Texas Health Science Center School of Dentistry. The individual plaintiffs limit their practice to one of the following practice areas: implant dentistry, dental anesthesiology, oral medicine, and orofacial pain. Each of the individual plaintiffs has been certified as a "diplomate" by one of the organizational plaintiffs' credentialing boards, indicating that the plaintiff has achieved that board's highest honor by meeting certain requirements set by the board "including training and experience beyond dental school."

The Texas Occupations Code provides that the Texas State Board of Dental Examiners may "adopt and enforce reasonable restrictions to regulate advertising relating to the practice of dentistry . . . ." *See* TEX. OCC. CODE § 254.002(b). The plaintiffs take issue with one of the Board's regulations, Texas Administrative Code Section 108.54. Section 108.54 provides:

> A dentist may advertise as a specialist or use the terms "specialty" or "specialist" to describe professional services in recognized specialty areas that are: (1) recognized by a board that certifies specialists in the area of specialty; and (2) accredited by the Commission on Dental Accreditation of the American Dental Association.

TEX. ADMIN. CODE § 108.54(a). Part (b) lists the ADA's nine recognized specialty areas as the ones that meet the requirements of part (a).[1] The Board does not itself certify specialties but instead relies exclusively on the ADA for that purpose. Section 108.54 also requires certain ADA-related education or board-certification qualifications in order to advertise as a specialist. *See* TEX. ADMIN. CODE § 108.54(c).

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[1] Those recognized specialty areas are endodontics, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, dental public health, oral and maxillofacial pathology, and oral and maxillofacial radiology. *See* TEX. ADMIN. CODE § 108.54(b).

Section 108.54 prohibits the individual plaintiffs from advertising as specialists or referring to their practice areas as specialties because their practice areas are not recognized as such by the ADA. The ADA has considered whether to grant specialty recognition to the plaintiffs' respective practice areas, but thus far it has denied that recognition. Nevertheless, the plaintiffs are not completely forbidden from advertising their practice areas. In 2012, two of the individual plaintiffs in this case and the American Academy of Implant Dentistry challenged a separate provision of the Texas Administrative Code that restricted the plaintiffs from advertising their credentials and holding themselves out as specialists in implant dentistry. The Board responded by revising an existing regulation and adding another. *See* TEX. ADMIN. CODE §§ 108.55, 108.56. Section 108.55 allows general dentists who do some work related to the specialty areas listed in Section 108.54(b) to advertise those services as long as they include a disclaimer that they are a general dentist and do not imply specialization. Section 108.56 provides that dentists may advertise "credentials earned in dentistry so long as they avoid any communications that express or imply specialization . . . ." *See also* TEX. ADMIN. CODE § 108.57 (prohibiting false, misleading, or deceptive advertising).

Under the current regulations, the plaintiffs may advertise credentials they have earned and the services they provide only if they clearly disclose that they are a "general dentist" and do not "imply specialization." *See* TEX. ADMIN. CODE §§ 108.55, 108.56. The plaintiffs complain that this regime prevents them from truthfully holding themselves out as "specialists" in their fields.

In March 2014, the plaintiffs brought this action against the executive director and members of the Board in their official capacities. The plaintiffs challenged Section 108.54 on First and Fourteenth Amendment grounds, and the parties eventually filed cross-motions for summary judgment. The district court granted summary judgment to the plaintiffs in part, concluding that

Section 108.54 "is an unconstitutional restriction on Plaintiffs' First Amendment right to free commercial speech." The court enjoined the defendants "from enforcing Texas Administrative Code § 108.54 to the extent it prohibits Plaintiffs from advertising as specialists or using the terms 'specialty' or 'specialist' to describe an area of dentistry not recognized as a specialty by the American Dental Association, or any other provision of Texas law inconsistent with [the district court's] opinion." The court determined the plaintiffs' "remaining Fourteenth Amendment claims are without merit" and granted summary judgment to the defendants on those claims. The defendants appealed.

DISCUSSION

We review a judgment on cross-motions for summary judgment *de novo* "with evidence and inferences taken in the light most favorable to the nonmoving party." *White Buffalo Ventures, LLC v. Univ. of Texas at Austin*, 420 F.3d 366, 370 (5th Cir. 2005). Summary judgment is proper when "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a).

This case involves commercial speech, which is protected by the First Amendment. *See Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 761–62 (1976). "Commercial expression not only serves the economic interest of the speaker, but also assists consumers and furthers the societal interest in the fullest possible dissemination of information." *Central Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of New York*, 447 U.S. 557, 561–62 (1980).

Though commercial speech is protected by the First Amendment, courts give to it "lesser protection . . . than to other constitutionally guaranteed expression." *Id.* at 563. A four-part test applies:

> At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come within that provision, it at least must concern lawful activity and not be misleading. Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine whether the regulation directly advances the governmental interest asserted, and whether it is not more extensive than is necessary to serve that interest.

Id. at 566. "The party seeking to uphold a restriction on commercial speech carries the burden of justifying it." *Bolger v. Youngs Drug Prods. Corp.*, 463 U.S. 60, 71 n.20 (1983). Within this framework, we consider the plaintiffs' challenge to Section 108.54. We conclude that the Board fails to justify Section 108.54 under the *Central Hudson* analysis. We do not reach the plaintiffs' Fourteenth Amendment argument.

Before we begin our analysis, we measure the reach of the district court's ruling. The parties dispute whether the district court enjoined Section 108.54 facially or as applied. We find that answer in the district court's own words: Section 108.54 "is an unconstitutional restriction on Plaintiffs' First Amendment right to free commercial speech." We interpret that language to mean that Section 108.54 is held to be unconstitutional only as applied to these plaintiffs. Neither the district court nor we address whether this language would also fail a facial challenge.

I. Lawful Activity, Not Misleading

In order for commercial speech to be protected under the First Amendment, "it at least must concern lawful activity and not be misleading." *Central Hudson*, 447 U.S. at 566. "The first part of the test is really a threshold determination whether the speech is constitutionally protected . . . ." *Byrum v. Landreth*, 566 F.3d 442, 446 (5th Cir. 2009).

The parties do not dispute that the relevant speech in this case concerns lawful activity. Texas law permits the individual plaintiffs to limit their practice to the fields of implant dentistry, dental anesthesiology, oral medicine, and orofacial pain. We agree, then, that advertising as a specialist in one of these practice areas concerns lawful activity.

The parties disagree as to whether the speech would be misleading or just potentially misleading. The distinction is important. "States may not place an absolute prohibition on certain types of potentially misleading information . . . if the information also may be presented in a way that is not deceptive." *In re R.M.J.*, 455 U.S. 191, 203 (1982). "But when the particular content or method of the advertising suggests that it is inherently misleading or when experience has proved that in fact such advertising is subject to abuse, the States may impose appropriate restrictions." *Id.*

The Board argues that the relevant speech here is inherently misleading because the term "specialist," in the context of unregulated dental advertising, is devoid of intrinsic meaning. The Board urges us to categorize the term "specialist" in a completely unregulated context, reasoning "the State need only show that an unregulated, unadorned, and unexplained claim of 'specialist' status in a particular practice area is inherently misleading[.]" In support, the Board offers witness testimony from several dentists regarding what they perceive "specialist" to mean. Observing that the witnesses characterize "specialist" differently, the Board reasons the term "specialist" has no agreed-upon meaning, is devoid of intrinsic meaning, and is therefore inherently misleading.

It has been "suggested that commercial speech that is devoid of intrinsic meaning may be inherently misleading, especially if such speech historically has been used to deceive the public." *Peel v. Attorney Registration & Disciplinary Comm'n of Illinois*, 496 U.S. 91, 112 (1990) (Marshall, J. &

Brennan, J., concurring in the judgment). The Court noted, for example, that a trade name is "a form of commercial speech that has no intrinsic meaning." *Friedman v. Rogers*, 440 U.S. 1, 12 (1979). "A trade name conveys no information about the price and nature of the services offered . . . until it acquires meaning over a period of time . . . ." *Id.* The term "specialist," by contrast, is not devoid of intrinsic meaning. All of the testimony offered by the Board demonstrates that the term "specialist" conveys a degree of expertise or advanced ability. Although different consumers may understand the degree of expertise in different ways, that only shows the term has the potential to mislead. It does not mean the term is devoid of intrinsic meaning and, therefore, inherently misleading.

The Board nevertheless urges that the use of the term "specialist" is unprotected because, unlike in *Peel*, the "specialist" designation might be used without reference to any certifying organization. The Court in *Peel* considered a claim of "certification as a 'specialist' by an identified national organization[.]" *Peel*, 496 U.S. at 105. The problem here is the absence of any group imprimatur behind the label "specialist." Nonetheless, the term "specialist" is not rendered devoid of intrinsic meaning, and thereby inherently misleading, simply because the organization responsible for conferring specialist credentials on a particular dentist is not identified in the advertisement. *See Ibanez v. Florida Dep't of Bus. & Prof'l Regulation, Bd. of Accountancy*, 512 U.S. 136, 145 & n.9 (1994). Whether the absence of that information contributes to the potentially misleading character of the speech is a separate question.

Moreover, there is no evidence that the term "specialist" has been or will be used in a way that is distinct from its ordinary meaning. In one appeal, we held that the use of the term "invoice" in automobile advertising was inherently misleading because it was "calculated to confuse the consumer[.]"

Joe Conte Toyota, Inc. v. Louisiana Motor Vehicle Comm'n, 24 F.3d 754, 757 (5th Cir. 1994) (quotation marks omitted). It was misleading because an advertised price of "$49.00 over invoice" could mean a multitude of prices other than the dealer's true cost because "holdbacks, incentives, and rebates" were included in the dealer's cost. *Id.* The word "invoice" did "not mean what it appear[ed] to mean" and conveyed no useful information to the consumer. *Id.*

Here, the individual plaintiffs intend to use "specialist" in the same manner as dentists practicing in ADA-recognized specialties, namely, to convey useful, truthful information to the consumer. Unlike in *Joe Conte*, the relevant term — "specialist" as opposed to "invoice" — will be used in a way that is consistent with its ordinary meaning.

Finally, the Board suggests that the plaintiffs' proposed speech is inherently misleading simply because it does not comply with the regulatory requirements imposed by the Board. According to the Board, Section 108.54 "is what gives 'specialist' a standardized, reliable meaning in dental advertising in Texas." The Board's argument would grant it the ability to limit the use of the term "specialist" simply by virtue of having created a regime that defines recognized and non-recognized specialties. *See Byrum*, 566 F.3d at 447. Even if appropriate regulation is warranted because the "specialist" designation might be potentially misleading, it is not inherently misleading merely because it does not align with the Board's preferred definition of that term.

Our fundamental issue is whether the speech is subject to First Amendment protection. "Truthful advertising related to lawful activities is entitled to the protections of the First Amendment." *In re R.M.J.*, 455 U.S. at 203. The dentists' proposed speech "may be presented in a non-deceptive manner and [is] not 'inherently likely to deceive' the public." *See Pub. Citizen, Inc. v. Louisiana Attorney Disciplinary Bd.*, 632 F.3d 212, 219 (5th Cir. 2011)

(quoting *In re R.M.J.*, 455 U.S. at 202). "Given the complete absence of any evidence of deception, the Board's concern about the possibility of deception in hypothetical cases is not sufficient to rebut the constitutional presumption favoring disclosure over concealment." *Ibanez*, 512 U.S. at 145 (quotation marks and citations omitted). By completely prohibiting dentists from advertising as specialists simply because their practice area is one not recognized as a specialty by the ADA, "truthful and nonmisleading expression will be snared along with fraudulent or deceptive commercial speech[.]" *See Edenfield v. Fane*, 507 U.S. 761, 768–69 (1993).

The plaintiffs' proposed speech is not inherently misleading. Even so, the Board may regulate potentially misleading speech if the regulation satisfies the remaining elements of the *Central Hudson* test. *See id.* at 769. In order to meet its burden, the Board must "show[] that the restriction directly and materially advances a substantial state interest in a manner no more extensive than necessary to serve that interest." *Ibanez*, 512 U.S. at 142 (citing *Central Hudson*, 447 U.S. at 566). We now look at those issues.

II. Substantial Interests

The parties agree that the Board has asserted substantial interests. The plaintiffs dispute two of the interests articulated by the Board: "preventing the public from being misled to believe that qualification as a 'specialist' under non-ADA-approved criteria is equivalent to qualification as a 'specialist' under ADA-approved criteria," and "exercising its 'power to establish standards for licensing practitioners,' *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 792 (1975)[.]" The plaintiffs argue that these are not substantial interests.

These interests appear to be related to the state's interest in "ensuring the accuracy of commercial information in the marketplace, establishing uniform standards for certification and protecting consumers from misleading

professional advertisements." The Board considers the plaintiffs' objections to be "inconsequential" because the plaintiffs concede "the State has a substantial interest in protecting the public from misleading advertising[.]" As the plaintiffs point out, however, the Board may not assert a substantial interest in Section 108.54 itself simply because "States have a compelling interest in the practice of professions within their boundaries[.]" *See also Goldfarb*, 421 U.S. at 792.

Regardless of these questions, we agree with the district court that the Board has a substantial interest in "ensuring the accuracy of commercial information in the marketplace, establishing uniform standards for certification and protecting consumers from misleading professional advertisements." These interests satisfy this part of *Central Hudson*.

III. Directly Advances the Governmental Interest

Next, we turn to whether the regulation directly advances the substantial governmental interests asserted. *See Central Hudson*, 447 U.S. at 566. This step of the *Central Hudson* analysis "concerns the relationship between the harm that underlies the State's interest and the means identified by the State to advance that interest." *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 555 (2001). The Board's burden on this point is significant: "the free flow of commercial information is valuable enough to justify imposing on would-be regulators the costs of distinguishing the truthful from the false, the helpful from the misleading, and the harmless from the harmful." *Ibanez*, 512 U.S. at 143 (quotation marks omitted). "This burden is not satisfied by mere speculation or conjecture; rather, a governmental body seeking to sustain a restriction on commercial speech must demonstrate that the harms it recites are real and that its restriction will in fact alleviate them to a material degree." *Edenfield*, 507 U.S. at 770–71. The Board may satisfy its burden with

"empirical data, studies, and anecdotal evidence," or "'history, consensus, and simple common sense.'" *See Pub. Citizen*, 632 F.3d at 221 (quoting *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 628 (1995)).

The Board says it is common sense that Section 108.54 advances the interest in establishing a uniform standard for specialization and allows consumers to distinguish between general dentists and specialists. The Board also submits that Section 108.54 protects consumers from potentially misleading speech. We note that the Board has not done much heavy lifting here. Indeed, it points to the fact that Section 108.54 provides a standard, but it offers no justification for the line that it draws other than its unsupported assertion that the ADA "should maintain the national gold standard . . . ." Its only suggestion as to why the plaintiffs' proposed speech would be misleading is that the speech does not comport with the ADA's list of designated specialties.

The Board attempts to support its position with the personal experiences of Board members and two surveys considered in another case. *See Borgner v. Brooks*, 284 F.3d 1204, 1211–13 (11th Cir. 2002). The personal experiences of the Board members add little to the Board's argument, and the *Borgner* surveys hardly bolster its position. The *Borgner* surveys are not in the record and the district court could not "mak[e] an independent evaluation of their applicability to the facts before it . . . ." Moreover, those surveys were provided in support of a different regulatory regime that permitted "advertisement of an implant dentistry specialty" and membership in a credentialing organization "so long as these statements are accompanied by the appropriate disclaimers." *Id.* at 1210. Doubt has also been raised as to the validity of the surveys. *See id.* at 1217 n.5 (Hill, J., dissenting); *see also Borgner v. Florida Bd. of Dentistry*, 123 S. Ct. 688, 689 (2002) (Thomas, J. & Ginsburg, J., dissenting from denial of certiorari).

The Board also discusses its long history of reliance on the ADA's recognition of specialties. Other states have taken a similar approach. In supplemental briefing, however, the parties identified a recent change in the ADA's own approach to dental-specialty advertising under the ADA Principles of Ethics and Code of Professional Conduct. The ADA now concludes it is ethical for dentists, within certain parameters, to "announce as a specialist to the public" in any of the nine practice areas recognized as specialties by the ADA and "in any other areas of dentistry for which specialty recognition has been granted under the standards required or recognized in the practitioner's jurisdiction . . . ." The ADA observed that "states have begun to recognize specialties beyond the nine dental specialties recognized by the ADA."

The Board has provided little support in its effort to show that Section 108.54 advances the asserted interests in a direct and material way. *See Went For It*, 515 U.S. at 625–26. Ultimately, though, the Board's position collapses for a more fundamental reason: it fails at the outset to "demonstrate that the harms it recites are real . . . ." *See Edenfield*, 507 U.S. at 771. The Board attempts to meet its burden on this point with testimony from several witnesses describing complications experienced when patients visited a general dentist for a procedure that should have been performed by a specialist. One of the Board's members, for example, described treating a patient who experienced complications after visiting a general dentist to have nine implants placed. The patient said, "if I had only known that there was a specialist[.]" Another Board member described a similar problem, testifying that "patients will come to [his specialty] practice after experiencing a complication in a general dentist's office." A third witness testified that the "overall failure rate and complication rate was higher for nonspecialists who were placing dental implants." Nevertheless, harm from a general dentist performing work within an ADA-recognized specialty at a lower quality than

would a specialist is not a harm that Section 108.54 remedies.[2] Section 108.54 regulates how a dentist may advertise his or her practice, not the kind of services a dentist can provide. The Board does not suggest that any of the complications described in the witness testimony were experienced by patients visiting dentists who held themselves out as specialists, but who were not qualified to do so.

In summary, we must examine "the relationship between the harm that underlies the State's interest and the means identified by the State to advance that interest." *Lorillard*, 533 U.S. at 555. The Board does not identify anything else to demonstrate real harms that Section 108.54 alleviates to a material degree. *See Edenfield*, 507 U.S. at 771. Absent that demonstration, and with little support behind its chosen means, we conclude that the Board has not met its burden at this step of the *Central Hudson* analysis.

IV. Not More Extensive than is Necessary

Even if the Board demonstrated that Section 108.54 directly advanced the interests asserted, it fails to demonstrate that it is "not more extensive than is necessary to serve" those interests. *See Central Hudson*, 447 U.S. at 566. This last step "complements" the third step of the analysis. *See Lorillard*, 533 U.S. at 556. Here, "the Constitution requires 'a fit between the legislature's ends and the means chosen to accomplish those ends—a fit that is not necessarily perfect, but reasonable; that represents not necessarily the single best disposition but one whose scope is in proportion to the interest served.'" *Byrum*, 566 F.3d at 448 (quoting *Bd. of Trs. of the State Univ. of New*

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[2] In his deposition, one of the plaintiffs in this case stated he was "aware of . . . instances where general dentists, without any form of specialty, have advertised as implant experts and that [has] been a problem[.]" The "problem" was business competition, as the plaintiff wished to advertise that he — unlike those other dentists — was a specialist.

York v. Fox, 492 U.S. 469, 480 (1989)). "[T]he existence of 'numerous and obvious less-burdensome alternatives to the restriction on commercial speech . . . is certainly a relevant consideration in determining whether the "fit" between ends and means is reasonable.'" *Went For It*, 515 U.S. at 632 (quoting *Cincinnati v. Discovery Network, Inc.*, 507 U.S. 410, 417 n.13 (1993)). The cost of the restriction must be "carefully calculated," and the Board "must affirmatively establish the reasonable fit . . . require[d]." *Fox*, 492 U.S. at 480.

Section 108.54 completely prohibits the plaintiffs from advertising as specialists in their fields solely because the ADA has not recognized their practice areas as specialties. The Board has not justified Section 108.54 with argument or evidence. Without more in the record, we find an improper fit between the means and the objective.

The Board has not suggested it considered less-burdensome alternatives. To the extent that advertising as a specialist is potentially misleading, "a State might consider . . . requiring a disclaimer about the certifying organizations or the standards of a specialty." *See Peel*, 496 U.S. at 110 (plurality opinion). Sufficient disclaimers are a means to address consumer deception. *Pub. Citizen*, 632 F.3d at 223. Indeed, we held in *Public Citizen* that the State failed to meet its burden where it merely submitted a "conclusory statement that a disclaimer could not alleviate [the] concerns" it earlier identified. *Id.* A State might also consider "screening certifying organizations . . . ." *See Peel*, 496 U.S. at 110 (plurality opinion). The California legislature took precisely that approach when regulating the use of the term "board certified" among physicians and surgeons. *See Am. Acad. of Pain Mgmt. v. Joseph*, 353 F.3d 1099, 1107, 1111 (9th Cir. 2004). Similarly, the district court in our case noted that "[o]ne obvious less-burdensome alternative would be to peg the term 'specialty' or 'specialist' to a set of statutory or regulatory qualifications that signify the credentialing board has met some uniform standard of minimal

competence." This is not a novel approach. For example, one court believed California's regulatory scheme "appeared to rely upon the ADA in making recognition decisions," but in response to a predecessor lawsuit the dental board "developed its own recognition standards which [were] reduced to a proposed regulation." *See Bingham v. Hamilton*, 100 F. Supp. 2d 1233, 1235 (E.D. Cal. 2000). We express no opinion regarding the merits of these alternative approaches, but we note the existence of several less-burdensome alternatives. *See Went For It*, 515 U.S. at 632.

The Board submits that the individual plaintiffs can "engage in a substantial amount of commercial speech regarding their dental practices." The plaintiffs can advertise the credentials they have earned and the services that they provide, albeit within certain parameters. *See* TEX. ADMIN. CODE §§ 108.55, 108.56. Nonetheless, the existence of other forms of commercial speech does not eliminate the overbreadth of the regulation on specialty advertising that is truthful and has not been shown to be misleading commercial speech. The Board's position is especially troublesome because there is no indication whatsoever that it "carefully calculated" the costs associated with Section 108.54. *See Fox*, 492 U.S. at 480.

We do not suggest that the Board may not impose appropriate restrictions in the area of dental specialist advertising. The plaintiffs agree that advertising as a specialist is potentially misleading and that reasonable regulation is appropriate. We hold only that the Board has not met its burden on the record before us to demonstrate that Section 108.54, as applied to these plaintiffs, satisfies *Central Hudson*'s test for regulation of commercial speech. We reiterate a limitation noted by the district court: "While the challenged restriction *might* be permissible in the abstract, it is not permissible on the record currently before the Court."

Although the Board has not met its burden in this case, a "regulation that fails *Central Hudson* because of a lack of sufficient evidence may be enacted validly in the future on a record containing more or different evidence." *See Pub. Citizen*, 632 F.3d at 221. Our holding neither forbids nor approves the enactment of a similar regulation supported by better evidence.

* * *

The Texas Academy of Pediatric Dentistry, the Texas Society of Oral and Maxillofacial Surgeons, and the Texas Association of Orthodontists submitted an opposed motion to file an amicus brief. That motion was carried with the case. The motion is DENIED.

AFFIRMED.

No. 16-50157

JAMES E. GRAVES, JR., Circuit Judge, dissenting:

I disagree with the majority that Rule 108.54[1] of the Texas Administrative Code is unconstitutional as applied to the plaintiffs (hereinafter collectively referred to as "Academy"). The advertising proposed by Academy is inherently misleading. Misleading commercial speech is not entitled to First Amendment protection. Because I would reverse the district court's grant of summary judgment on Academy's First Amendment claim and its enjoinment of the provision as applied to Academy, I respectfully dissent.

Academy wants to advertise as specialists in certain subsets of dentistry that are not recognized as specialties by the American Dental Association ("ADA") and are prohibited from doing so by the rules of the Texas State Dental Board of Dental Examiners (the "Board"). Academy brought a facial and as-applied constitutional challenge against the Board arguing that Rule 108.54, which regulates specialty advertising for dentists, unconstitutionally infringes on commercial speech protected by the First Amendment.

The district court partially granted both parties' cross-motions for summary judgment. Academy was granted summary judgment on its First Amendment claim, invalidating the ordinance as applied to Academy. The Board was granted summary judgment on Academy's equal protection and due process claims. The Board appeals the First Amendment claim. Academy failed to file a cross-appeal, but then attempts to revive a Fourteenth Amendment due process claim in the appellees' brief.

As the majority correctly states, we apply the four-part test from *Central Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of New York*, 447 U.S. 557 (1980), as follows:

> At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come

[1] See Appendix, No. 1, herein for 22 Tex. Admin. Code § 108.54 in its entirety.

> within that provision, it at least must concern lawful activity and not be misleading. Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine whether the regulation directly advances the governmental interest asserted, and whether it is not more extensive than is necessary to serve that interest.

Id. at 566.

As a threshold determination, for commercial speech to be protected under the First Amendment, "it at least must concern lawful activity and not be misleading." *Central Hudson*, 447 U.S. at 566. Advertising that is inherently misleading receives no protection, while advertising that is potentially misleading may receive some if it may be presented in a way that is not deceptive. *In re R.M.J.*, 455 U.S. 191, 203 (1982).

This case is analogous to *American Board of Pain Management v. Joseph*, 353 F.3d 1099 (9th Cir. 2004), which involved a California statute that limits a physician from advertising as board certified in a medical specialty without meeting certain requirements. There, the Ninth Circuit said:

> The State of California has by statute given the term "board certified" a special and particular meaning. The use of that term in advertising by a board or individual physicians who do not meet the statutory requirements for doing so, is misleading. The advertisement represents to the physicians, hospitals, health care providers and the general public that the statutory standards have been met, when, in fact, they have not.
>
> Because the Plaintiffs' use of "board certified" is inherently misleading, it is not protected speech. But even if the Plaintiffs' use of "board certified" were merely potentially misleading, it would not change the result in this case, as consideration of the remaining three Hudson factors confirms that the State may restrict the use of the term "board certified" in advertising.

Joseph, 353 F.3d at 1108.

Such is the case here. Texas has by statute given the term specialist a particular meaning. *See* 22 Tex. Admin. Code § 108.54; *see also* 22 Tex. Admin. Code §§ 119.1-119.9 (setting out special areas of dental practice).

Additionally, it is only "in the context of unregulated dental advertising" that the Board contends the term "specialist" is devoid of intrinsic meaning and is inherently misleading. But with regard to the regulated dental advertising and the recognized specialty areas, the term has a special meaning and special requirements.

Further, the areas that Academy seeks to have designated as specialties are actually more like subsets, which are already encompassed within general dentistry and multiple of the existing recognized specialties. *See* 22 Tex. Admin. Code §§ 119.1-119.9; *see also* Tex. Occ. Code § 251.003 (setting out the provisions of the practice of dentistry). The majority opinion allows that, instead of a general dentist having to comply with the academic, educational or certification necessary to become, for example, a prosthodontist, a general dentist can simply get "certified" in one small aspect of the branch of prosthodontics, i.e., implants, and advertise at the same level as someone who actually completed an advanced degree in an accredited specialty.[2]

The majority relies on *Peel v. Attorney Registration and Disciplinary Commission of Illinois*, 496 U.S. 91 (1990), to conclude that "specialist" is not devoid of intrinsic meaning. In *Peel*, the issue involved letterhead and a statement that the attorney was a "certified civil trial specialist by the National Board of Trial Advocacy." The Court concluded that this was not inherently misleading, saying that "it seems unlikely that petitioner's

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[2] "Prosthodontics is that branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance, and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes." 22 Tex. Admin. Code § 119.8.

statement about his certification as a 'specialist' by an identified national organization necessarily would be confused with formal state recognition." *Id.* at 104-05. The Court further reiterated that a "State may not, however, completely ban statements that are not actually or inherently misleading, such as certification as a specialist by bona fide organizations such as NBTA" and pointed out that "[t]here is no dispute about the bona fides and the relevance of NBTA certification." *Id.* at 110. However, that is not the case here where, as the Board correctly asserts, the term "specialist" may be used without reference to any identified certifying organization and there is a dispute about the bona fides and relevance of the certifications.

Thus, despite what the majority says, the problem is not merely that "the organization responsible for conferring specialist credentials on a particular dentist is not identified in the advertisement." Nevertheless, *Ibanez v. Florida Dep't of Bus. & Prof'l Regulation, Bd. of Accountancy*, 512 U.S. 136, 145, n.9 (1994), is also distinguishable. *Ibanez* involved an attorney who advertised her credentials as CPA (Certified Public Accountant) and CFP (Certified Financial Planner). Again, there were no questions about the certifications. Further, footnote 9, which addressed only a point raised in a separate opinion, says that a consumer could easily verify Ibanez' credentials – as she was indeed a licensed CPA through the Florida Board of Accountancy and also a CFP. More importantly, Ibanez was not practicing accounting. Further, under 22 Tex. Admin. Code §§ 108.56 additional credentials or certifications are clearly allowed to be advertised in Texas.[3]

In *Joe Conte Toyota, Inc. v. Louisiana Motor Vehicle Commission*, 24 F.3d 754 (5th Cir. 1994), this court relied on evidence in the record to support the district court's finding that the use of the term "invoice" in the automobile

[3] See Appendix, No. 3, herein for 22 Tex. Admin. Code § 108.56 in its entirety.

industry was inherently misleading. That evidence included testimony of various car dealers that "invoice" means different things. *Id.* at 757. Here, we have testimony that "specialist" in unregulated dental advertising means different things. The majority's statement that "[h]ere, the individual plaintiffs intend to use 'specialist' in the same manner as dentists practicing in ADA-recognized specialties" is erroneous. In fact, the plaintiffs intend to use "specialist" to encompass subsets of existing specialties that do not necessarily require the same academic, educational or certification required of the specialties recognized by both the ADA and Texas.

For these reasons, I would conclude that the term "specialist" in the context of unregulated dental advertising is inherently misleading and, thus, not protected by the First Amendment.

Moreover, even if Academy's proposed speech was only potentially misleading, the Board would still be able to regulate it under the remaining elements of the *Central Hudson* test quoted previously herein. As the Board asserts, the evidence provided, at the very least, creates a question of fact sufficient to survive summary judgment.

The Supreme Court said in *Ibanez*:

> Commercial speech that is not false, deceptive, or misleading can be restricted, but only if the State shows that the restriction directly and materially advances a substantial state interest in a manner no more extensive than necessary to serve that interest. *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y.*, 447 U.S. 557, 566, 100 S.Ct. 2343, 2351, 65 L.Ed.2d 341 (1980); *see also id.*, at 564, 100 S.Ct., at 2350 (regulation will not be sustained if it "provides only ineffective or remote support for the government's purpose"); *Edenfield v. Fane*, 507 U.S. 761, 767, 113 S.Ct. 1792, 1798, 123 L.Ed.2d 543 (1993) (regulation must advance substantial state interest in a "direct and material way" and be in "reasonable proportion to the interests served"); *In re R.M.J.*, 455 U.S., at 203, 102 S.Ct., at 937 (State can regulate commercial

> speech if it shows that it has "a substantial interest" and that the interference with speech is "in proportion to the interest served").

Ibanez, 512 U.S. at 142-43.

The majority acknowledges that the Board has a substantial interest. But, the majority then concludes that the Board has not demonstrated that Rule 108.54 directly advances the asserted interests. I disagree. The Board presented evidence demonstrating how Rule 108.54 would directly and materially advance the asserted interests. That evidence included "empirical data, studies, and anecdotal evidence" or "history, consensus, and simple common sense." *See Pub. Citizen Inc. v. La. Attorney Disciplinary Bd.*, 632 F.3d 212 (5th Cir. 2011).

The majority dismisses the empirical data and studies referenced in *Borgner v.* Brooks, 284 F.3d 1204, 1211-13 (11th Cir. 2002), because the actual studies are not in the record. The absence of those studies in the record does not undermine the reliability or persuasiveness of the Eleventh Circuit's analysis and conclusions about those same studies including, but not limited to, the following:

> These two surveys, taken together, support two contentions: (1) that a substantial portion of the public is misled by AAID and implant dentistry advertisements that do not explain that AAID approval does not mean ADA or Board approval; and (2) that ADA certification is an important factor in choosing a dentist/specialist in a particular practice area for a large portion of the public.

Id. at 1213.

Additionally, the majority dismisses deposition testimony and evidence of complications saying, in part, that the harms would not be remedied by Rule 108.54 because it merely regulates how a dentist may advertise. I disagree. Rule 108.54 regulates what a dentist may hold himself out as being to the public, i.e., a general dentist with or without certain credentials or a specialist.

The majority further dismisses witness testimony because it does not necessarily pertain to general dentists who violated the existing rule by holding themselves out as specialists in advertisements. The point of the testimony was to offer support for the fact that an ADA-recognized specialist has a higher success rate and fewer complications than a general dentist who may perform a subset of those recognized specialties. Also, what the Board does clearly establish is that the harms Rule 108.54 seeks to prevent are very real. This was established by way of both anecdotal evidence and simple common sense. With regard to consensus, the Board introduced evidence that numerous other states limit dental-specialty advertising.

Rules 108.55-56 allow any pertinent information about individual plaintiffs' qualifications to be advertised to consumers. *See* 22 Tex. Admin. Code §§ 108.55-56.[4] Rules 108.55-56 also clearly establish that Rule 108.54 is not more extensive than necessary. Dentists are able to advertise any and all dental credentials and certifications so long as they do not hold themselves out as specialists in areas where they have not complied with the statutory requirements.

Thus, even if the speech was only potentially misleading, I would conclude that the Board can still regulate it under the *Central Hudson* test.

For these reasons, I would reverse the district court's grant of summary judgment on Academy's First Amendment claim and its enjoinment of the provision as applied to Academy. Therefore, I respectfully dissent.

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[4] See Appendix, No. 2, herein for 22 Tex. Admin. Code § 108.55 in its entirety.

No. 16-50157

APPENDIX

1. Rule 108.54 states:

(a) Recognized Specialties. A dentist may advertise as a specialist or use the terms "specialty" or "specialist" to describe professional services in recognized specialty areas that are:

(1) recognized by a board that certifies specialists in the area of specialty; and

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

(b) The following are recognized specialty areas and meet the requirements of subsection (a)(1) and (2) of this section:

(1) Endodontics;
(2) Oral and Maxillofacial Surgery;
(3) Orthodontics and Dentofacial Orthopedics;
(4) Pediatric Dentistry;
(5) Periodontics;
(6) Prosthodontics;
(7) Dental Public Health;
(8) Oral and Maxillofacial Pathology; and
(9) Oral and Maxillofacial Radiology.

(c) A dentist who wishes to advertise as a specialist or a multiple-specialist in one or more recognized specialty areas under subsection (a)(1) and (2) and subsection (b)(1)-(9) of this section shall meet the criteria in one or more of the following categories:

(1) Educationally qualified is a dentist who has successfully completed an educational program of two or more years in a specialty area accredited by the Commission on Dental Accreditation of the American Dental Association, as specified by the Council on Dental Education of the American Dental Association.

(2) Board certified is a dentist who has met the requirements of a specialty board referenced in subsection (a)(1) and (2) of this section, and who has received a certificate from the specialty board, indicating the dentist has achieved diplomate status, or has complied with the provisions of § 108.56(a) and (b) of this subchapter (relating to Certifications, Degrees, Fellowships, Memberships and Other Credentials).

(3) A dentist is authorized to use the term 'board certified' in any advertising for his/her practice only if the specialty

board that conferred the certification is referenced in subsection (a)(1) and (2) of this section, or the dentist complies with the provisions of § 108.56(a) and (b) of this subchapter.

(d) Dentists who choose to communicate specialization in a recognized specialty area as set forth in subsection (b)(1)-(9) of this section should use "specialist in" or "practice limited to" and should limit their practice exclusively to the advertised specialty area(s) of dental practice. Dentists may also state that the specialization is an "ADA recognized specialty." At the time of the communication, such dentists must have met the current educational requirements and standards set forth by the American Dental Association for each approved specialty. A dentist shall not communicate or imply that he/she is a specialist when providing specialty services, whether in a general or specialty practice, if he or she has not received a certification from an accredited institution. The burden of responsibility is on the practice owner to avoid any inference that those in the practice who are general practitioners are specialists as identified in subsection (b)(1)-(9) of this section.

22 Tex. Admin. Code § 108.54.

2. Rule 108.55 states:

(a) A dentist whose license is not limited to the practice of an ADA recognized specialty identified under § 108.54(b)(1)-(9) of this subchapter (relating to Advertising of Specialties), may advertise that the dentist performs dental services in those specialty areas of practice, but only if the advertisement also includes a clear disclosure that he/she is a general dentist.

(b) Any advertisement of any specific dental service or services by a general dentist shall include the notation "General Dentist" or "General Dentistry" directly after the name of the dentist. The notation shall be in a font size no smaller than the largest font size used to identify the specific dental services being advertised. For example, a general dentist who advertises "ORTHODONTICS" and "DENTURES" and/or "IMPLANTS" shall include a disclosure of "GENERAL DENTIST" or "GENERAL DENTISTRY" in a font size no smaller than the largest font size used for terms 'orthodontics,' 'dentures' and/or 'implants.' Any form of broadcast

advertising by a general dentist (radio, television, promotional DVDs, etc) shall include either "General Dentist" or "General Dentistry" in a clearly audible manner.
(c) A general dentist is not prohibited from listing services provided, so long as the listing does not imply specialization. A listing of services provided shall be separate and clearly distinguishable from the dentist's designation as a general dentist.
(d) The provisions of this rule shall not be required for professional business cards or professional letterhead.

22 Tex. Admin. Code § 108.55.

3. Rule 108.56 states:

(a) Dentists may advertise credentials earned in dentistry so long as they avoid any communications that express or imply specialization in a recognized specialty, or specialization in an area of dentistry that is not recognized as a specialty, or attainment of an earned academic degree.

(b) A listing of credentials shall be separate and clearly distinguishable from the dentist's designation as a dentist. A listing of credentials may not occupy the same line as the dentist's name and designation as a dentist. Any use of abbreviations to designate credentials shall be accompanied by a definition of the acronym immediately following the credential.
[Image with examples]

(c) The provisions of subsection (b) of this section shall not be required in materials not intended for business promotion or public dissemination, such as peer-to-peer communications.

22 Tex. Admin. Code § 108.56.

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BILL OF COSTS

NOTE: The Bill of Costs is due in this office *within 14 days from the date of the opinion, See* FED. R. APP. P. & 5TH CIR. R. 39. Untimely bills of costs must be accompanied by a separate motion to file out of time, which the court may deny.

_____ **v.** _____ **No.** _____

The Clerk is requested to tax the following costs against: _____

COSTS TAXABLE UNDER Fed. R. App. P. & 5th Cir. R. 39	REQUESTED				ALLOWED (If different from amount requested)			
	No. of Copies	Pages Per Copy	Cost per Page*	Total Cost	No. of Documents	Pages per Document	Cost per Page*	Total Cost
Docket Fee ($500.00)								
Appendix or Record Excerpts								
Appellant's Brief								
Appellee's Brief								
Appellant's Reply Brief								
Other:								
				Total $				Costs are taxed in the amount of $

Costs are hereby taxed in the amount of $ _____ **this** _____ **day of** _____, _____

LYLE W. CAYCE, CLERK

State of
County of _____

By _____
Deputy Clerk

I _____, **do hereby swear under penalty of perjury that the services for which fees have been charged were incurred in this action and that the services for which fees have been charged were actually and necessarily performed. A copy of this Bill of Costs was this day mailed to opposing counsel, with postage fully prepaid thereon. This** _____ **day of** _____, _____.

_____
(Signature)

***SEE REVERSE SIDE FOR RULES GOVERNING TAXATION OF COSTS**

Attorney for _____

FIFTH CIRCUIT RULE 39

39.1 Taxable Rates. *The cost of reproducing necessary copies of the brief, appendices, or record excerpts shall be taxed at a rate not higher than $0.15 per page, including cover, index, and internal pages, for any for of reproduction costs. The cost of the binding required by 5TH CIR. R. 32.2.3that mandates that briefs must lie reasonably flat when open shall be a taxable cost but not limited to the foregoing rate. This rate is intended to approximate the current cost of the most economical acceptable method of reproduction generally available; and the clerk shall, at reasonable intervals, examine and review it to reflect current rates. Taxable costs will be authorized for up to 15 copies for a brief and 10 copies of an appendix or record excerpts, unless the clerk gives advance approval for additional copies.*

39.2 Nonrecovery of Mailing and Commercial Delivery Service Costs. *Mailing and commercial delivery fees incurred in transmitting briefs are not recoverable as taxable costs.*

39.3 Time for Filing Bills of Costs. *The clerk must receive bills of costs and any objections within the times set forth in FED. R. APP. P. 39(D). See 5TH CIR. R. 26.1.*

FED. R. APP. P. 39. COSTS

(a) ***Against Whom Assessed.*** The following rules apply unless the law provides or the court orders otherwise;

(1) if an appeal is dismissed, costs are taxed against the appellant, unless the parties agree otherwise;

(2) if a judgment is affirmed, costs are taxed against the appellant;

(3) if a judgment is reversed, costs are taxed against the appellee;

(4) if a judgment is affirmed in part, reversed in part, modified, or vacated, costs are taxed only as the court orders.

(b) ***Costs For and Against the United States.*** Costs for or against the United States, its agency or officer will be assessed under Rule 39(a) only if authorized by law.

©) ***Costs of Copies*** Each court of appeals must, by local rule, fix the maximum rate for taxing the cost of producing necessary copies of a brief or appendix, or copies of records authorized by rule 30(f). The rate must not exceed that generally charged for such work in the area where the clerk's office is located and should encourage economical methods of copying.

(d) ***Bill of costs: Objections; Insertion in Mandate.***

(1) A party who wants costs taxed must – within 14 days after entry of judgment – file with the circuit clerk, with proof of service, an itemized and verified bill of costs.

(2) Objections must be filed within 14 days after service of the bill of costs, unless the court extends the time.

(3) The clerk must prepare and certify an itemized statement of costs for insertion in the mandate, but issuance of the mandate must not be delayed for taxing costs. If the mandate issues before costs are finally determined, the district clerk must – upon the circuit clerk's request – add the statement of costs, or any amendment of it, to the mandate.

(e) ***Costs of Appeal Taxable in the District Court.*** The following costs on appeal are taxable in the district court for the benefit of the party entitled to costs under this rule:

(1) the preparation and transmission of the record;

(2) the reporter's transcript, if needed to determine the appeal;

(3) premiums paid for a supersedeas bond or other bond to preserve rights pending appeal; and

(4) the fee for filing the notice of appeal.

United States Court of Appeals

FIFTH CIRCUIT
OFFICE OF THE CLERK

LYLE W. CAYCE
CLERK

TEL. 504-310-7700
600 S. MAESTRI PLACE
NEW ORLEANS, LA 70130

June 19, 2017

MEMORANDUM TO COUNSEL OR PARTIES LISTED BELOW

Regarding: Fifth Circuit Statement on Petitions for Rehearing or Rehearing En Banc

No. 16-50157 Amer Acdmy of Implant Dentry, et al v. Kelly Parker, et al
USDC No. 1:14-CV-191

Enclosed is a copy of the court's decision. The court has entered judgment under FED R. APP. P. 36. (However, the opinion may yet contain typographical or printing errors which are subject to correction.)

FED R. APP. P. 39 through 41, and 5TH CIR. R.s 35, 39, and 41 govern costs, rehearings, and mandates. **5TH CIR. R.s 35 and 40 require you to attach to your petition for panel rehearing or rehearing en banc an unmarked copy of the court's opinion or order.** Please read carefully the Internal Operating Procedures (IOP's) following FED R. APP. P. 40 and 5TH CIR. R. 35 for a discussion of when a rehearing may be appropriate, the legal standards applied and sanctions which may be imposed if you make a nonmeritorious petition for rehearing en banc.

Direct Criminal Appeals. 5TH CIR. R. 41 provides that a motion for a stay of mandate under FED R. APP. P. 41 will not be granted simply upon request. The petition must set forth good cause for a stay or clearly demonstrate that a substantial question will be presented to the Supreme Court. Otherwise, this court may deny the motion and issue the mandate immediately.

Pro Se Cases. If you were unsuccessful in the district court and/or on appeal, and are considering filing a petition for certiorari in the United States Supreme Court, you do not need to file a motion for stay of mandate under FED R. APP. P. 41. The issuance of the mandate does not affect the time, or your right, to file with the Supreme Court.

Court Appointed Counsel. Court appointed counsel is responsible for filing petition(s) for rehearing(s) (panel and/or en banc) and writ(s) of certiorari to the U.S. Supreme Court, unless relieved of your obligation by court order. If it is your intention to file a motion to withdraw as counsel, you should notify your client promptly, **and advise them of the time limits for filing for rehearing and certiorari**. Additionally, you MUST confirm that this information was given to your client, within the body of your motion to withdraw as counsel.

The judgment entered provides that defendants-appellants pay to plaintiffs-appellees the costs on appeal.

Sincerely,

LYLE W. CAYCE, Clerk

By: _____
Allen C. McIlwain, Deputy Clerk

Enclosure(s)

Mr. Bill L. Davis
Mr. Renea Hicks
Mr. Frank R. Recker
Ms. Amy Lynne Rudd

Resolution No. 65 New

Report: N/A Date Submitted: August 2016

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

AMENDMENT TO SECTION 5.H. OF THE ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT

Background: The professional landscape concerning the recognition of specialties has undergone dramatic change. Over the past several years, compelled by court decisions, states have begun to recognize specialties beyond the nine dental specialties recognized by the ADA. The Council on Ethics, Bylaws and Judicial Affairs (the Council) has been advised that the trend of states recognizing specialties in addition to those recognized by the ADA is expected to continue, either through voluntary state action or as the result of additional litigation. Faced with the changing environment concerning recognition, the Council has examined the ADA *Principles of Ethics and Code of Profes* (the *Code*), and in particular Section 5.H. of the *Code, Announcement of Specialization Practice*, to ensure that the *Code* remains aligned with the legal landscape of specialty jurisdictions and hereby proposes amendments to that section of the *Code*. Section 5.I amendments proposed by the Council is appended hereto as **Appendix 1**.

Status

Broadening the Specialties that can be Ethically Announced. Section 5.H. of the *Cod* dental specialties recognized by the American Dental Association and the designatior announcement and limitation of practice are..." and then proceeds to list the nine der recognized by the ADA. As noted above, however, there is movement in certain juris areas of dentistry as specialties beyond those recognized through the specialty reco established by the ADA.

Consider a jurisdiction that recognizes oral medicine as a specialty and allows a dentist who has successfully completed an advanced dental education program in oral medicine accredited by the Commission on Dental Accreditation to announce as a specialist in oral medicine. A dentist who did so, however, might be accused of violating the *Code* because oral medicine is not one of the nine specialties recited for which "ethical specialty announcement" is presently permitted.

The Council proposes to amend Section 5.H. of the *Code* so that it aligns with the changes in the scope of specialty recognition in some jurisdictions. The amendment to Section 5.H. of the *Code* would permit educationally qualified dentists practicing in areas of dentistry recognized as specialties in their jurisdictions, but not by the ADA, to announce as specialists. The Council requested that the Council on Dental Education and Licensure (CDEL) review and comment on this proposed revision of Section 5.H. of the *Code* and have been informed that CDEL is supportive of the amendment.

Exclusivity of Practice. The other portion of Section 5.H. of the *Code* reviewed by the Council is that which requires dentists announcing as specialists to limit their practices exclusively to the announced specialty. Thus, as presently written, dentists cannot ethically practice any aspect of dentistry except for the announced specialty or specialties. This is so even though the specialist dentists hold D.D.S. or D.M.D. degrees and, in many jurisdictions, hold the exact same licenses awarded to general dentists after successfully completing the exact same licensing examination as general dentists. Consequently, the Council examined amending Section 5.H. to remove the exclusivity limitation

When the Council requested comment from CDEL with respect to this proposed amendment to Section 5.H. of the *Code*, CDEL responded that it had reservations concerning the proposal and suggested that the Council request input from the specialty organizations concerning the exclusivity provisions of Section 5.H. The Council did so, asking the nine specialty organizations for their input on whether it was necessary for specialists to practice exclusively in their areas of specialty in order to maintain the skill and expertise needed to announce as a specialist and whether there were reasons other than maintenance of skill and expertise for limiting a specialist's practice to an announced specialty.

Responses from six specialty organizations were received. One reply was not responsive of the inquiries made and instead addressed the issue of a general dentist practicing in areas within the scope of a specialty and general dentists using specialist designations in practice announcements. Four responses indicated that exclusivity of practice was not believed to be required in order for specialists to maintain their expertise in the specialty (although one response indicated that ability to maintain the appropriate level of expertise in the specialty must be considered on an individual basis). In addition, three of the responses received knew of no reason to restrict an announced specialist to practicing solely in the announced specialty except if there was such a restriction imposed by license. Two responses received from the specialty organizations indicated that the limitation of practice to the announced specialty is needed to assure, protect and or inform the public and third parties such as payment programs and professional liability insurers concerning the practitioner's expertise and concentration in providing competent care in the specialty.

Having carefully considered the reservations expressed by CDEL and the views expressed by the specialty organizations that responded to the Council's inquiries, the Council is of the belief that dentists holding specialty degrees should be permitted to announce their specialty to the public and also be permitted to practice to the full scope of the dental licenses that they hold so long as they maintain adequate expertise in the specialty. A dentist's training – be it D.D.S. or D.M.D. degree alone, the successful completion of a residency in general dentistry or the awarding of a specialty degree – is a fact that is reasonably easy to verify.

Moreover, the Council does not believe there is any ethical impropriety in, for example, a dentist announcing as a specialist while practicing other areas of dentistry so long as the dentist is permitted to do so under the licensing provisions of the jurisdiction in which the dentist practices, the public is not misled by the dentist's announcement, the announcement is not false in any material respect, and the dentist maintains his or her level of skill and expertise in the specialty practice area and is clinically competent in the other areas of dentistry in which the dentist practices. To the contrary, the existing provision requiring exclusivity may be viewed as restricting dentists' ability to engage in free competition and as creating a legal risk to the association. The removal of this restriction will alleviate that risk.

With respect to the concerns that the exclusivity provisions of Section 5.H. of the *Code* serve to assure, inform and protect patients and the public, the Council notes that other provisions of the *Code* serve to provide that protection. Section 2 of the *Code*, Nonmaleficence, reminds dentists that they have the duty to refrain from harming patients. Section 2.A., Education, imposes the duty for dentists to keep their knowledge and skills current, while Section 2.B., Consultation and Referral, obligates dentists to refer patients whenever the welfare of the patient will be safeguarded or advanced by the referral. Section 4 of the *Code* provides that dentists shall treat patients fairly; Section 5 imposes the duty to communicate truthfully while Section 5.F. admonishes that dentists should not advertise in a manner that is false or

misleading in any material respect. The Council believes that, taken as a whole, the *Code* places sufficient ethical obligations upon dentists who announce as specialists and who wish to practice beyond the scope of the specialty to provide ample protection to the public.

The amendments proposed by the Council will support the primary goal of dentists as set forth in the Preface to the *Code* – benefitting the patient. For example, general dentists in rural parts of the country often by necessity refer patients to specialists located a substantial distance from where the referring dentist and patient are located. With the amendments proposed by the Council, the referring dentist and specialist can confer and agree, with the consent of the patient, to the completion of dental treatments by the specialist where the completion requires treatment beyond the scope of the specialty involved. Allowing treatment completion by specialists will save the patient time, as the treatment will be able to be completed without an additional trip to the referring dentist's office and potential discomfort that might arise between the visit to the specialist and the return visit to the referring dentist.

Based on the Council's considered review of Section 5.H. of the Code as summarized above, the Council recommends the adoption of Resolution 65.

Resolution

65. Resolved, that Section 5.H. of the ADA Principles of Ethics and Code of Professional Conduct be amended as set forth below (additions underscored, deletions ~~stricken through~~):

5.H. ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE.
~~This section and Section 5.I are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program.~~ A dentist may ethically announce as a specialist to the public in any of the ~~The~~ dental specialties recognized by the American Dental Association including ~~and the designation for ethical specialty announcement and limitation of practice are:~~ dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics~~.~~, and in any other areas of dentistry for which specialty recognition has been granted under the standards required or recognized in the practitioner's jurisdiction, provided the dentist meets the educational requirements required for recognition as a specialist adopted by the American Dental Association or accepted in the jurisdiction in which they practice. Dentists who choose to announce specialization should use "specialist in" ~~or "practice limited to"~~ and shall devote a sufficient portion of their practice to the announced specialty or specialties to maintain expertise in that specialty or those specialties. Dentists whose practice is devoted exclusively to an announced specialty or specialties may announce that their practice "is limited to" that specialty or those specialties. ~~limit their practice exclusively to the announced dental specialties, provided at the time of the announcement such dentists have met in each recognized specialty for which they announce the existing educational requirements and standards set forth by the American Dental Association.~~ Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are qualified to announce themselves as specialists.

~~**GENERAL STANDARDS.**~~
~~The following are included within the standards of the American Dental Association for determining the education, experience and other appropriate requirements for announcing specialization and limitation of practice:~~

~~1. The special area(s) of dental practice and an appropriate certifying board must be approved by the American Dental Association or be recognized by the jurisdiction in which the dentist practices.~~

~~2. Dentists who announce as specialists must have successfully completed an educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education and Licensure, or be diplomates of an American Dental Association recognized certifying board recognized by the American Dental Association or the jurisdiction in which the announcing dentist practices. The scope of the individual specialist's practice shall be governed by the educational standards for the specialty in which the specialist is announcing.~~

~~3. The practice carried on by dentists who announce as specialists shall be limited exclusively to the special area(s) of dental practice announced by the dentist.~~

~~STANDARDS FOR MULTIPLE SPECIALTY ANNOUNCEMENTS.~~
~~The educational criterion for announcement of limitation of practice in additional specialty areas is the successful completion of an advanced educational program accredited by the Commission on Dental Accreditation (or its equivalent if completed prior to 1967) in each area for which the dentist wishes to announce. Dentists who are presently ethically announcing limitation of practice in a specialty area and who wish to announce in an additional specialty area must submit to the appropriate constituent society documentation of successful completion of the requisite education in specialty programs listed by the Council on Dental Education and Licensure or certification as a diplomate in each area for which they wish to announce.~~

* In the case of the ADA, the educational requirements include successful completion of an advanced educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education and Licensure, or being a diplomate of an American Dental Association recognized certifying board for each specialty announced.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

APPENDIX 1

5.H. ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE.

A dentist may ethically announce as a specialist to the public in any of the dental specialties recognized by the American Dental Association including dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics, and in any other areas of dentistry for which specialty recognition has been granted under the standards required or recognized in the practitioner's jurisdiction, provided the dentist meets the educational requirements required for recognition as a specialist adopted by the American Dental Association or accepted in the jurisdiction in which they practice. Dentists who choose to announce specialization should use "specialist in" and shall devote a sufficient portion of their practice to the announced specialty or specialties to maintain expertise in that specialty or those specialties. Dentists whose practice is devoted exclusively to an announced specialty or specialties may announce that their practice "is limited to" that specialty or those specialties. Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are qualified to announce themselves as specialists.

In the case of the ADA, the educational requirements include successful completion of an advanced educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education and Licensure, or being a diplomate of an American Dental Association recognized certifying board for each specialty announced.

Substance of Notice of Intended Regulatory Action

Requirements for Registration as a Dental Assistant II

Substance

Please briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.

Following recommendations from the Regulatory Advisory Panel, the Board intends to amend the educational requirements to become a dental assistant II from a program based on completion of required hours to a competency-based program based on satisfactory completion of didactic course work and clinical experiences.

There will be a new section (18VAC60-30-116) to specify the requirements for educational programs training persons for registration as dental assistants II, which will likely include the following:

1. The program shall be provided by an educational institution which is accredited by the Commission on Dental Accreditation of the American Dental Association.
2. The program shall have a program coordinator who is registered in Virginia as a dental assistant II or licensed in Virginia as a dental hygienist or dentist. The program coordinator shall have administrative responsibility and accountability for operation of the program.
3. The program shall have a clinical practice advisor who must be a licensed dentist in Virginia. The clinical practice advisor shall assist in the laboratory training component of the program and conduct the calibration exercise for dentists who supervise the student clinical experience.
4. A dental hygienist who assists in teaching the laboratory training component of the program must have a minimum of two years' experience in performing clinical dental assisting.
5. The program shall enter into a participation agreement with any dentist who agrees to supervise clinical experience. The dentist shall successfully complete a calibration exercise on evaluating the clinical skills of a student. The dentist supervisor may be the employer of the student.
6. Each program shall enroll practice sites for clinical experience which may be a dental office, non-profit dental clinic or at an educational institution clinic.
7. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.

The Board intends to amend Section 120 by making the following changes from completion of a certain number of hours to a competency-based program:

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

B. To be registered as a dental assistant II, a person shall complete ~~the following requirements~~ a competency-based program from an educational institution that ~~maintains a program in dental assisting, dental hygiene or dentistry accredited by CODA~~ meets the requirements of 18VAC60-30-116 and includes all of the following:

1. ~~At least 50 hours of didactic~~ Didactic course work in dental anatomy ~~and operative dentistry that may be completed online~~ that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation, occlusion and function, muscles of mastication and any other item related to the restorative dental process.

2. Didactic course work in operative dentistry to include materials used in direct and indirect restorative techniques, economy of motion, fulcrum techniques, tooth preparations, etch and bonding techniques and systems, and luting agents.

~~2.~~3. Laboratory training ~~that may~~ to be completed in the following modules ~~with no more than 20% of the specified instruction to be completed as homework in a dental office~~:

a. ~~At least 40~~ No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations and pulp capping procedures and no less than 6 class I and 6 class II restorations completed on a manikin simulator to competency;

b. ~~At least 60~~ No less than 40 hours of placing and shaping composite resin restorations and pulp capping procedures and no less than 12 class I, 12 class II, 5 class III, 5 class IV, and 5 class V restorations completed on a manikin simulator to competency;

c. At least ~~20~~ 10 hours of taking final impressions ~~and use~~, placement of a non-epinephrine retraction cord~~; and~~, and final cementation of crowns and bridges after preparation, adjustment and fitting by the dentist and no less than 4 crown impressions, 2 placements of retraction cord, 5 crown cementations, and 2 bridge cementations on a manikin simulator to competency

~~d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist~~.

~~3.~~4. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training ~~that may be completed in a dental office~~, in the following modules:

a. At least ~~80~~ 30 hours of placing, packing, carving, and polishing of amalgam restorations and no less than 6 class I and 6 class II restorations completed on a live patient to competency;

b. At least ~~120~~ 60 hours of placing and shaping composite resin restorations and no less than 6 class I, 6 class II, 5 class III, 3, class IV and 5 class V restorations completed on a live patient to competency;

c. ~~At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and~~ At least 30 hours of taking final impressions, placement of non-epinephrine retraction cord, and final cementation of crowns and bridges after preparation, adjustment and fitting by the dentist and no less than 4 crown impressions, 2 placements of retraction cord, 5 crown cementations, and 2 bridge cementations on a live patient to competency.

~~d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist~~.

~~4.~~5. Successful completion of the following competency examinations given by the accredited educational programs:

a. A written examination at the conclusion ~~of the 50 hours~~ of didactic coursework; and

b. ~~A practical examination at the conclusion of each module of laboratory training; and~~

~~c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules.~~ A clinical competency exam.

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

In adoption of proposed regulations, the Board will determine whether the didactic course work required as a prerequisite for the clinical experiences may be completed on-line or in a classroom setting.

The Board also intends Section 140 on Registration by endorsement as a dental assistant II to specify that an applicant must hold a registration or credential in another U. S. jurisdiction with qualification substantially equivalent to those set out in Section 120.

Finally, the Board will consider any editorial changes necessary for clarity.

Disciplinary Board Report for September 15, 2017

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

Calendar Year 2017

The table below includes all cases that have received Board action since January 1, 2017 through August 25, 2017.

Calendar 2017	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
January	36	12	7	19
February	18	12	5	17
March	37	50	8	58
April	20	7	5	12
May	30	29	3	32
June	49	45	6	51
July	23	14	2	16
August 25th	23	24	4	28
Totals	**236**	**193**	**40**	**233**

Q4 FY 2017

For the fourth quarter of 2017, the Board received a total of 60 patient care cases. The Board closed a total of 66 patient care cases for a 110% clearance rate, which is down from 111% in Q3 of 2017. The current pending caseload older than 250 days is 34%, which is up from 32% in Q3 of 2017. The Board's goal is 20%. In Q4 of 2017, 87 % of the patient care cases were closed within 250 days, whereas 79% of the patient care cases were closed within 250 days in Q3 of 2017. The Board's goal is 90% of patient care cases closed within 250 days.[1]

License Suspensions

There were no mandatory or summary suspensions by the Board between May 23, 2017 and August 25, 2017.

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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.

Sanctions

With the appointment of 7 Board members in the past 14 months, staff has observed a trend away from the sanctioning practices previously endorsed by the Board as discussed below. Staff is requesting consideration of these trends and guidance on the standards to be followed regarding sanctioning so that the terms imposed for similar violations are reasonably consistent across all committees during informal conferences and in offering Pre Hearing Consent Orders.

Reprimands
Virginia Code §54.1-2400(10) permits the imposition of a Reprimand. The Board has imposed a Reprimand in cases where first time conduct of the Respondent has been egregious or the Respondent has had multiple cases with the Board with similar conduct.

Probation
Virginia Code §54.1-2400(10) also permits the imposition of Probation. The Board has placed a Respondent on Probation when their conduct raises concerns for patient safety.

Monetary Penalties
Virginia Code §54.1-2400(10) and 2401 permits the imposition of a monetary penalty if the board or any special conference committee determines that a respondent has violated any provision of statute or regulation pertaining to the practice of dentistry. The board or special conference committee is required to determine the amount of any monetary penalty to be imposed for the violation, which shall not exceed $5,000. The precedent set by the Board has been to use $1000 as the standard monetary penalty per violation. The purpose of the standard monetary penalty is consistency and predictability in sanctioning. The probable cause reviewer and committee can and should consider aggravating and/or mitigating circumstances as a reason for departure from this standard when such circumstances have been clearly articulated as an additional finding.

Continuing Education
Virginia Code §54.1-2400(10) permits the imposition of terms as deemed appropriate. The Board generally requires continuing education of a Respondent in the areas of dentistry where standard of care violations or recordkeeping violations were substantiated.

At a minimum, all of these sanctions should be considered for every consent order offered or every order to be issued consistent with all the findings of fact in a case. Staff is concerned that recently there is movement away from considering all of these sanctions independently of each other which is resulting in inconsistent sanctions for similar violations. Staff is recommending that the Board reaffirm its practice of imposing similar sanctions for similar violations.

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?

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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MEMORANDUM

TO: Members, Board of Dentistry

FROM: David E. Brown, D.C.

DATE: August 11, 2017

SUBJECT: Revenue, Expenditures, & Cash Balance Analysis

Virginia law requires that an analysis of revenues and expenditures of each regulatory board be conducted at least biennially. If revenues and expenditures for a given board are more than 10% apart, the Board is required by law to adjust fees so that the fees are sufficient, but not excessive, to cover expenses. The action by the Board can be a fee increase, a fee decrease, or it can maintain the current fees.

The Board of Dentistry ended the 2014 - 2016 biennium (July 1, 2014, through June 30, 2016) with a cash balance of $ 3,429,213. Current projections indicate that revenue for the 2016 - 2018 biennium (July 1, 2016, through June 30, 2018) will exceed expenditures by approximately $699,726. When combined with the Board's $3,429,213 cash balance as of June 30, 2016, the Board of Dentistry projected cash balance on June 30, 2018, is $4,128,939.

We recommend the Board consider a one-time renewal fee decrease. Please note that these projections are based on internal agency assumptions and are, therefore, subject to change based on actions by some other state agencies, the Governor and\or the General Assembly.

We are grateful for continued support and cooperation as we work together to manage the fiscal affairs of the Board and the Department.

Please do not hesitate to call me if you have questions.

CC: Sandra Reen, Executive Director
Lisa R. Hahn, Chief Deputy Director
Charles E. Giles, Budget Manager
Elaine Yeatts, Senior Policy Analyst

Virginia Department of Health Professions
Cash Balance
As of June 30, 2017

	103- Dentistry
Board Cash Balance as of June 30, 2016	$ 3,429,213
YTD FY17 Revenue	2,887,943
Less: YTD FY17 Direct and In-Direct Expenditures	2,303,613
Board Cash Balance as June 30, 2017	4,013,542

irginia Department of Health Professions
Revenue and Expenditures Summary
Department 10300 - Dentistry
For the Period Beginning July 1, 2016 and Ending June 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	237,775.00	158,640.00	(79,135.00)	149.88%
4002406	License & Renewal Fee	2,382,270.00	2,400,280.00	18,010.00	99.25%
4002407	Dup. License Certificate Fee	46,010.00	4,040.00	(41,970.00)	1138.86%
4002408	Board Endorsement - In	55,050.00	33,750.00	(21,300.00)	163.11%
4002409	Board Endorsement - Out	23,610.00	8,400.00	(15,210.00)	281.07%
4002421	Monetary Penalty & Late Fees	23,245.00	3,500.00	(19,745.00)	664.14%
4002432	Misc. Fee (Bad Check Fee)	35.00	70.00	35.00	50.00%
4002660	Administrative Fees	119,147.58	138,100.00	18,952.42	86.28%
	Total Fee Revenue	2,887,142.58	2,746,780.00	(140,362.58)	105.11%
4003000	Sales of Prop. & Commodities				
4003020	Misc. Sales-Dishonored Payments	100.00	-	(100.00)	0.00%
	Total Sales of Prop. & Commodities	100.00	-	(100.00)	0.00%
4009000	Other Revenue				
4009060	Miscellaneous Revenue	700.00	-	(700.00)	0.00%
	Total Other Revenue	700.00	-	(700.00)	0.00%
	Total Revenue	2,887,942.58	2,746,780.00	(141,162.58)	105.14%
5011110	Employer Retirement Contrib.	47,143.54	51,604.00	4,460.46	91.36%
5011120	Fed Old-Age Ins- Sal St Emp	26,154.97	29,280.00	3,125.03	89.33%
5011130	Fed Old-Age Ins- Wage Earners	5,852.56	10,197.00	4,344.44	57.39%
5011140	Group Insurance	4,689.24	5,012.00	322.76	93.56%
5011150	Medical/Hospitalization Ins.	88,204.00	96,444.00	8,240.00	91.46%
5011160	Retiree Medical/Hospitalizatn	4,220.05	4,514.00	293.95	93.49%
5011170	Long term Disability Ins	2,372.09	2,525.00	152.91	93.94%
	Total Employee Benefits	178,636.45	199,576.00	20,939.55	89.51%
5011200	Salaries				
5011230	Salaries, Classified	361,157.44	382,535.00	21,377.56	94.41%
5011250	Salaries, Overtime	53.15	214.00	160.85	24.84%
	Total Salaries	361,210.59	382,749.00	21,538.41	94.37%
5011300	Special Payments				
5011310	Bonuses and Incentives	1,369.76	-	(1,369.76)	0.00%
5011380	Deferred Compnstn Match Pmts	1,480.00	3,360.00	1,880.00	44.05%
	Total Special Payments	2,849.76	3,360.00	510.24	84.81%
5011400	Wages				
5011410	Wages, General	77,641.51	133,268.00	55,626.49	58.26%
	Total Wages	77,641.51	133,268.00	55,626.49	58.26%
5011600	Terminatn Personal Svce Costs				
5011660	Defined Contribution Match - Hy	1,456.52	-	(1,456.52)	0.00%
	Total Terminatn Personal Svce Costs	1,456.52	-	(1,456.52)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	621,794.83	718,953.00	97,158.17	86.49%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	2,378.71	622.00	(1,756.71)	382.43%

Irginia Department of Health Professions
Revenue and Expenditures Summary
Department 10300 - Dentistry
For the Period Beginning July 1, 2016 and Ending June 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012120	Outbound Freight Services	-	75.00	75.00	0.00%
5012130	Messenger Services	172.10	-	(172.10)	0.00%
5012140	Postal Services	14,949.09	14,000.00	(949.09)	106.78%
5012150	Printing Services	294.35	425.00	130.65	69.26%
5012160	Telecommunications Svcs (VITA)	2,644.90	3,800.00	1,155.10	69.60%
5012170	Telecomm. Svcs (Non-State)	540.00	-	(540.00)	0.00%
5012190	Inbound Freight Services	5.67	-	(5.67)	0.00%
	Total Communication Services	20,984.82	18,922.00	(2,062.82)	110.90%
5012200	Employee Development Services				
5012210	Organization Memberships	2,120.00	5,600.00	3,480.00	37.86%
5012220	Publication Subscriptions	2.12	-	(2.12)	0.00%
5012240	Employee Trainng/Workshop/Conf	6,059.70	2,000.00	(4,059.70)	302.99%
5012270	Emp Trning- Trns, Ldgng & Meals	-	2,000.00	2,000.00	0.00%
	Total Employee Development Services	8,181.82	9,600.00	1,418.18	85.23%
5012300	Health Services				
5012360	X-ray and Laboratory Services	105.08	126.00	20.92	83.40%
	Total Health Services	105.08	126.00	20.92	83.40%
5012400	Mgmnt and Informational Svcs	-			
5012420	Fiscal Services	46,730.05	40,820.00	(5,910.05)	114.48%
5012440	Management Services	610.25	475.00	(135.25)	128.47%
5012460	Public Infrmtnl & Relatn Svcs	2.00	-	(2.00)	0.00%
5012470	Legal Services	3,344.00	1,040.00	(2,304.00)	321.54%
	Total Mgmnt and Informational Svcs	50,686.30	42,335.00	(8,351.30)	119.73%
5012600	Support Services				
5012640	Food & Dietary Services	4,075.14	2,100.00	(1,975.14)	194.05%
5012660	Manual Labor Services	5,790.85	3,500.00	(2,290.85)	165.45%
5012670	Production Services	34,048.21	19,730.00	(14,318.21)	172.57%
5012680	Skilled Services	47,510.18	64,314.00	16,803.82	73.87%
	Total Support Services	91,424.38	89,644.00	(1,780.38)	101.99%
5012700	Technical Services				
5012780	VITA InT Int Cost Goods&Svs	4,742.09	-	(4,742.09)	0.00%
	Total Technical Services	4,742.09	-	(4,742.09)	0.00%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	10,222.09	7,600.00	(2,622.09)	134.50%
5012830	Travel, Public Carriers	4,614.95	3,900.00	(714.95)	118.33%
5012850	Travel, Subsistence & Lodging	13,856.50	10,400.00	(3,456.50)	133.24%
5012880	Trvl, Meal Reimb- Not Rprtble	5,732.50	4,800.00	(932.50)	119.43%
	Total Transportation Services	34,426.04	26,700.00	(7,726.04)	128.94%
	Total Contractual Svs	210,550.53	187,327.00	(23,223.53)	112.40%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013120	Office Supplies	6,198.13	2,500.00	(3,698.13)	247.93%
5013130	Stationery and Forms	110.43	400.00	289.57	27.61%
	Total Administrative Supplies	6,308.56	2,900.00	(3,408.56)	217.54%
5013200	Energy Supplies				

.irginia Department of Health Professions
Revenue and Expenditures Summary
Department 10300 - Dentistry
For the Period Beginning July 1, 2016 and Ending June 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5013230	Gasoline	13.87	-	(13.87)	0.00%
	Total Energy Supplies	13.87	-	(13.87)	0.00%
5013300	Manufctrng and Merch Supplies				
5013350	Packaging & Shipping Supplies	-	40.00	40.00	0.00%
	Total Manufctrng and Merch Supplies	-	40.00	40.00	0.00%
5013500	Repair and Maint. Supplies				
5013520	Custodial Repair & Maint Matrl	13.14	-	(13.14)	0.00%
	Total Repair and Maint. Supplies	13.14	-	(13.14)	0.00%
5013600	Residential Supplies				
5013620	Food and Dietary Supplies	74.43	75.00	0.57	99.24%
5013630	Food Service Supplies	50.60	100.00	49.40	50.60%
	Total Residential Supplies	125.03	175.00	49.97	71.45%
5013700	Specific Use Supplies				
5013730	Computer Operating Supplies	98.00	50.00	(48.00)	196.00%
	Total Specific Use Supplies	98.00	50.00	(48.00)	196.00%
	Total Supplies And Materials	6,558.60	3,165.00	(3,393.60)	207.22%
5014000	Transfer Payments				
5014100	Awards, Contrib., and Claims				
5014130	Premiums	340.00	70.00	(270.00)	485.71%
	Total Awards, Contrib., and Claims	340.00	70.00	(270.00)	485.71%
	Total Transfer Payments	340.00	70.00	(270.00)	485.71%
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				
5015160	Property Insurance	153.56	163.00	9.44	94.21%
	Total Insurance-Fixed Assets	153.56	163.00	9.44	94.21%
5015300	Operating Lease Payments				
5015340	Equipment Rentals	3,606.64	3,296.00	(310.64)	109.42%
5015350	Building Rentals	38.88	-	(38.88)	0.00%
5015360	Land Rentals	-	35.00	35.00	0.00%
5015390	Building Rentals - Non State	52,144.58	50,489.00	(1,655.58)	103.28%
	Total Operating Lease Payments	55,790.10	53,820.00	(1,970.10)	103.66%
5015500	Insurance-Operations				
5015510	General Liability Insurance	551.18	613.00	61.82	89.92%
5015540	Surety Bonds	32.52	37.00	4.48	87.89%
	Total Insurance-Operations	583.70	650.00	66.30	89.80%
	Total Continuous Charges	56,527.36	54,633.00	(1,894.36)	103.47%
5022000	Equipment				
5022100	Computer Hrdware & Sftware				
5022170	Other Computer Equipment	390.00	-	(390.00)	0.00%
5022180	Computer Software Purchases	1,157.82	-	(1,157.82)	0.00%
	Total Computer Hrdware & Sftware	1,547.82	-	(1,547.82)	0.00%
5022200	Educational & Cultural Equip				
5022240	Reference Equipment	47.00	-	(47.00)	0.00%
	Total Educational & Cultural Equip	47.00	-	(47.00)	0.00%

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10300 - Dentistry
For the Period Beginning July 1, 2016 and Ending June 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5022600	Office Equipment				
5022630	Office Incidentals	-	90.00	90.00	0.00%
	Total Office Equipment	-	90.00	90.00	0.00%
	Total Equipment	1,594.82	90.00	(1,504.82)	1772.02%
	Total Expenditures	897,366.14	964,238.00	66,871.86	93.06%
	Allocated Expenditures				
30100	Data Center	337,052.20	416,236.00	79,183.79	80.98%
30200	Human Resources	48,305.91	83,146.65	34,840.74	58.10%
30300	Finance	86,036.22	93,572.42	7,536.20	91.95%
30400	Director's Office	48,121.20	55,036.27	6,915.07	87.44%
30500	Enforcement	513,590.45	641,928.21	128,337.76	80.01%
30600	Administrative Proceedings	227,863.41	200,362.70	(27,500.71)	113.73%
30700	Impaired Practitioners	3,436.48	3,312.60	(123.88)	103.74%
30800	Attorney General	88,997.91	87,838.65	(1,159.26)	101.32%
30900	Board of Health Professions	23,190.91	36,290.16	13,099.25	63.90%
31000	SRTA	-	4,229.00	4,229.00	0.00%
31100	Maintenance and Repairs	-	1,277.68	1,277.68	0.00%
31300	Emp. Recognition Program	2,136.83	1,064.07	(1,072.77)	200.82%
31400	Conference Center	795.01	671.80	(123.21)	118.34%
31500	Pgm Devlpmnt & Implmentn	26,720.16	28,143.86	1,423.70	94.94%
	Total Allocated Expenditures	1,406,246.68	1,653,110.04	246,863.36	85.07%
	Net Revenue in Excess (Shortfall) of Expenditures	$ 584,329.76	$ 129,431.96	$ (454,897.80)	451.46%

Guidance document: 60-13 Adopted: ~~September 16, 2016~~

PROPOSED REVISION

Practice of a Dental Hygienist under Remote Supervision

References from § 54.1-2722 of the Code of Virginia

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

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

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

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

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

   The hygienist must have (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.

4. **What are the requirements for the remote supervision continuing education course?**

   Answer will be added based on action taken on 9/15/17.

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

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

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

   A hygienist can only practice dental hygiene under remote supervision at a ~~community~~ 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.

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

   A hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine pursuant to subsection V of §**54.1-3408**, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation.

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

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

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

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

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

    a) After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision ~~shall consult with the supervising dentist prior to providing~~ 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.

    b) A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a diagnosis and treatment plan for

the patient and either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient.

c) The supervising dentist shall review a patient's records at least once every 10 months.

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

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

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

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

E. *For the purposes of this subsection, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.*
Notwithstanding any provision of law, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the Commonwealth under the remote supervision of a dentist employed by the Department of Health. A dental hygienist providing such services shall practice pursuant to a protocol adopted by the Commissioner of Health on September 23, 2010, having been developed jointly by (i) the medical directors of the Cumberland Plateau, Southside, and Lenowisco Health Districts; (ii) dental hygienists employed by the Department of Health; (iii) the Director of the Dental Health Division of the Department of Health; (iv) one representative of the Virginia Dental Association; and (v) one representative of the Virginia Dental Hygienists' Association. Such protocol shall be adopted by the Board as regulations.

Guidance Document: 60-17

Effective: November 21, 2012
Revised: September 1, 2017

PROPOSED REVISION

Virginia Board of Dentistry

Policy on Recovery of Disciplinary Costs

Applicable Law and Regulations

- §54.1-2708.2 of the Code of Virginia.
  The Board of Dentistry (the Board) may recover from any licensee against whom disciplinary action has been imposed reasonable administrative costs associated with investigating and monitoring such licensee and confirming compliance with any terms and conditions imposed upon the licensee as set forth in the order imposing disciplinary action. Such recovery shall not exceed a total of $5,000. All administrative costs recovered pursuant to this section shall be paid by the licensee to the Board. Such administrative costs shall be deposited into the account of the Board and shall not constitute a fine or penalty.

- 18VAC60-20-18 of the Regulations Governing Dental Practice. The Board may assess:
  - the hourly costs to investigate the case,
  - the costs for hiring an expert witness, and
  - the costs of monitoring a licensee's compliance with the specific terms and conditions imposed

  up to $5,000, consistent with the Board's published guidance document on costs. The costs being imposed on a licensee shall be included in the order agreed to by the parties or issued by the Board.

Policy

In addition to the sanctions to be imposed which might include a monetary penalty, the Board will specify the costs to be recovered from a licensee in each pre-hearing consent order offered and in each order entered following an administrative proceeding. The amount to be recovered will be calculated using the assessment of costs specified below and will be recorded on a Disciplinary Cost Recovery Worksheet (the worksheet). All applicable costs will be assessed as set forth in this guidance document. Board staff shall complete the worksheet and assure that the cost to be assessed is included in Board orders. The completed worksheets shall be maintained in the case file. Assessed costs shall be paid within 45 days of the effective date of the Order.

Assessment of Costs

Based on the expenditures incurred in the state's fiscal year which ended on June 30, ~~2015~~ 2017, the following costs will be used to calculate the amount of funds to be specified in a board order for recovery from a licensee being disciplined by the Board:

- ~~$107~~ 112 per hour for an investigation multiplied by the number of hours the DHP Enforcement Division reports having expended to investigate and report case findings to the Board.
- ~~$114~~ 137 per hour for an inspection conducted during the course of an investigation, multiplied by the number of hours the DHP Enforcement Division reports having expended to inspect the dental practice and report case findings to the Board.
- If applicable, the amount billed by an expert upon acceptance by the Board of his expert report.
- The applicable administrative costs for monitoring compliance with an order as follows:

PROPOSED REVISION

o	$ ~~123.50~~	**128.25**	Base cost to open, review and close a compliance case
o	~~68.75~~	**72.00**	For each continuing education course ordered
o	~~18.25~~	**18.75**	For each monetary penalty and cost assessment payment
o	~~18.25~~	**18.75**	For each practice inspection ordered
o	~~36.50~~	**37.50**	For each records audit ordered
o	~~109.50~~	**112.50**	For passing a clinical examination
o	~~101.00~~	**102.00**	For each practice restriction ordered
o	~~82.75~~	**83.25**	For each report required.

Inspection Fee

In addition to the assessment of administrative costs addressed above, a licensee shall be charged $350 for each Board-ordered inspection of his practice as permitted by 18VAC60-20-30 of the *Regulations Governing Dental Practice.*

Virginia Board of Dentistry

Disciplinary Cost Recovery Worksheet

Case # _____ **Order Entered:** _____

Licensee: _____

Investigation Cost/hr	Enforcement Hour (# of hour x 112)		Sr. Inspectors Hour (# of hour x 137)	
# of Hours		$0.00		$0.00
# of Hours		$0.00		$0.00
Record Duplication		$0.00		$0.00
Expert Witness		$0.00		$0.00
Other		$0.00		$0.00
Total	**$0.00**		**$0.00**	
Grand Total	**$0.00**			

Monitoring Cost/hr	Enter Each Cost That Applies (# of unit x cost per unit)	
Base Administrative Cost - $128.25/case		$128.25
Continuing Education - $72.00/course		$0.00
Monetary Penalty - $18.75/payment		$0.00
Administrative Cost - $18.75/payment		$0.00
Practice Inspection - $18.75/inspection		$0.00
Clinical Exam - $112.50		$0.00
Record Audits - $37.50/audit		$0.00
Practice Restriction - $102.00/restriction		$0.00
Reporting Requirement - $83.25/report		$0.00
Total	**$128.25**	

Total for costs : **$128.25**

Maximum recovery is $5,000

Virginia Board of Dentistry
Calculation of Costs for Recovery
Based on FY18 Expenditures

COMPLIANCE WITH SANCTIONS	Compliance Case Manager (CCM)		Executive Director (ED)		Combined Costs	FY16 PROPOSED CHARGE
Base cost to open, review and close a compliance case ($ per hr * 1.25 hrs) - CCM ($ per hr * .25 hr) - ED	75.00	$93.75	138.00	$34.50	$128.25	$128.25
For each continuing education course order ($ per hr * .5 hr) - CCM ($ per hr * .25 hr) - ED	75.00	$37.50	138.00	$34.50	$72.00	$72.00
For each moneytary penalty and cost assessment payment ($ per hr * .25 hr) - CCM only	75.00	$18.75				$18.75
For each practice inspection ordered ($ per hr * .25 hr) - CCM only	75.00	$18.75				$18.75
For each records audit ordered ($ per hr *.5 hr) - CCM only	75.00	$37.50				$37.50
For passing a clinical examination ($ per hr * 1.5 hr) - CCM only	75.00	$112.50				$112.50
For each practice restriction ordered ($ per hr * .5 hr) - CCM ($ per hr * .5 hr) - ED	75.00	$37.50	129.00	$64.50	$102.00	$102.00
For each report required ($ per hr * .25 hr) - CCM ($ per hr * .5 hr) - ED	75.00	$18.75	129.00	$64.50	$83.25	$83.25

Status of Adding PGY1 Pathway for Licensure

On June 9, 2017, the Board adopted the Exam Committee motion to add another pathway to qualify for licensure by accepting completion of a one-year post graduate advanced residency program without requiring passage of a clinical examination. Subsequently, it was determined that §54.1-2709.B of the Code of Virginia would have to be amended before regulatory action to implement this motion could be initiated because passage of a clinical examination is a statutory requirement. This Code provision is attached.

The deadline for the Board to submit proposed legislation for administrative review for the 2018 General Assembly Session has passed.

The Board may adopt a motion to direct staff to prepare a draft legislative proposal for the 2019 General Assembly Session for Board action on December 15, 2017.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 27. Dentistry

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

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

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 an accredited dental school or college, or dental department of an institution of higher education; (iii) has passed all parts of the examination given by the Joint Commission on National Dental Examinations; (iv) has successfully completed a clinical examination acceptable to the Board; and (v) has met other qualifications as determined in regulations promulgated by the Board.

C. The Board may grant a license to practice dentistry 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 dentistry in another jurisdiction in the United States and is certified to be in good standing by each jurisdiction in which he currently holds or has held a license; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) has been in continuous clinical practice for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in the dental corps of the United States Armed Forces, volunteer practice in a public health clinic, or practice in an intern or residency program may be accepted by the Board to satisfy this requirement.

D. The Board shall provide for an inactive license for those dentists who hold a current, unrestricted dental license 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. The Board shall promulgate regulations requiring continuing education for any dental license renewal or reinstatement. The Board may grant extensions or exemptions from these continuing education requirements.

Code 1950, §§ 54-168 through 54-171, 54-175; 1968, c. 604; 1972, cc. 805, 824; 1973, c. 391; 1974, c. 411; 1976, c. 327; 1977, c. 518; 1981, c. 216; 1988, c. 765; 1997, c. 855; 2005, cc. 505, 587; 2007, c. 20; 2012, cc. 20, 116.

Department of Health Professions

Policy Implementation(76-90)
Compensation for members of appointed bodies(76-90.04)
Adopted Date: 7/26/2017
Approved By:_____

Policy Name	Compensation for members of appointed bodies			Policy Number	76-90.04
Section Title	Policy Implementation	Section Number	76-90	Previous Policy No.	76-5.4
Approval Authority	Agency Director			Effective Date	7/26/2017
Responsible Executive	Agency Director			Revised Date	4/27/2017
Responsible Office	Director's Office			Last Reviewed	7/26/2017
Responsible Reviewer	Yeatts,Elaine				

Purpose:

To compensate board members and provide for adequate controls for purposes of budgeting and payment of such members.

Policy:

The Department of Health Professions recognizes the valuable contribution provided by citizens of the Commonwealth who devote their time and talent to the appropriate regulation of health care providers. To this end the agency will budget for and compensate members consistent with the 2017 Budget Bill and § 2.2-2813 of the *Code of Virginia.*

Authority:

The Budget Bill for 2017-18:
Notwithstanding any other provision of law, any citizen member of any body described in this paragraph who is appointed at the state level, or designated an official member of such body, pursuant to an act of the General Assembly or a resolution of a house of the General Assembly that provides for the appointment or designation, shall receive compensation solely for each day, or portion thereof, of attendance at an official meeting of the same. In no event shall any citizen member be paid compensation for attending a meeting of an advisory committee or other advisory body. Subject to any contrary law that provides for a higher amount of compensation to be paid, compensation shall be paid at the rate of $50 for each day, or portion thereof, of attendance at an official meeting.
§ 2.2-2813. Definitions; compensation and expense payments from state funds for service on collegial bodies.
A. As used in this chapter:
"Compensation" means any amount paid in addition to reimbursement for expenses.
"Expenses" means all reasonable and necessary expenses incurred in the performance of duties.
"Salary" means a fixed compensation for services, paid to part-time and full-time employees on a regular basis.
B. Subject to the provisions of subsections C and D, members of boards, commissions, committees, councils and other collegial bodies, who are appointed at the state level, shall be compensated at the rate of $50 per day, unless a different rate of compensation is specified by statute for such members, plus expenses for each day or portion thereof in which the member is engaged in the business of that body. The funding for the compensation and reimbursement of expenses of members shall be provided by the collegial body or, if funds are not appropriated to the collegial body for

such purpose, by the entity that supports the work of the collegial body. The collegial body or supporting agency shall reimburse the Clerk of the Senate and the Clerk of the House of Delegates for expenditures incurred in providing compensation and expenses of their respective members for service on the collegial body.
C. Full-time employees of the Commonwealth or any of its local political subdivisions, including full-time faculty members of public institutions of higher education, shall be limited to reimbursement for such employee's expenses.
D. No member shall receive total compensation for a single day of more than one payment of the highest per diem amount specified in subsection B for attending meetings and for services performed that day for all boards, commissions, or other similar bodies, of which such person is a member, including all committees, subcommittees, or other related entities of such boards, commissions, or other similar bodies. Whenever a member performs services or attends two or more meetings in a single day for two or more boards, commissions, etc., compensation and expenses shall be prorated among the bodies served.
E. A nonlegislative member of a state board, commission, committee, council, or other state collegial body, which body is required by law to meet at least three times per year, shall, for any compensation or expense reimbursement from funds drawn from the state treasury, be required to participate in the Electronic Data Interchange Program administered or authorized by the Department of Accounts as a condition of accepting such appointment.

Procedures:

1. Members of any standing body whose establishment and membership is specifically required pursuant to Subtitle III of Title 54.1 of the *Code of Virginia* shall be deemed eligible for $50.00 per day plus reasonable and necessary expenses for each day or portion thereof in which the member is attending an official meeting;

2. Nothing in this policy shall be construed as authorizing more than $50 in compensation per day per member including circumstances where a person is holding seats on more than one body. Compensation may be prorated among bodies for service among bodies.

3. Nothing contained in the policy shall be construed as authorizing per diem payment for full time employees of the Commonwealth or its political subdivisions which is prohibited by §2.2-2813.C of the *Code*.

4. Nothing contained in this policy shall be construed to authorize per diem compensation for members of ad hoc or advisory bodies that are not created in statute.

5. The Accounting Director may require the registration of members to include membership, address, social security number and employment status to facilitate compliance with law, regulation, requirements of the State Comptroller, or this policy.