AGENDA
March 19, 2021
Virtual Meeting

Virginia Department of Health Professions

MEETING OF THE VIRGINIA BOARD OF DENTISTRY
BOARD BUSINESS MEETING

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Virginia Department of Health Professions

VIRGINIA BOARD OF DENTISTRY
BOARD BUSINESS MEETING AGENDA
FRIDAY, MARCH 19, 2021

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10:00 a.m.	**Call to Order – Dr. Augustus A. Petticolas, Jr., President**	
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Legislation and Regulation - Ms. Yeatts

Board Counsel Report – Mr. Rutkowski

Deputy Executive Director's Report – Ms. Sacksteder

Executive Director's Report – Ms. Reen

Board, but not Boring – Barbara Allison-Bryan, MD **--**

Sandra Reen

From: Lawrence, Trey <tlawrence@aaortho.org> on behalf of Lawrence, Trey
Sent: Monday, March 1, 2021 11:08 AM
To: brad@dentalboard.org; brian.barnett@pr.mo.gov; amber.treston@Alaska.gov; ryan.edmonson@dentalboard.az.gov; fchurch246@gmail.com; karen.fischer@dca.ca.gov; jenny.alber@state.co.us; chris.andresen@ct.gov; vito.delvento@dc.gov; Pamela.zickafoose@state.de.us; jennifer.wenhold@flhealth.gov; tbattle@dch.ga.gov; smatsush@dcca.hawaii.gov; susan.miller@isbd.idaho.gov; jerry.r.miller@illinois.gov; cvaught@pla.in.gov; steven.garrison@iowa.gov; lane.hemsley@ks.gov; robertzenamd@gmail.com; ahickman@lsbd.org; penny.vaillancourt@maine.gov; alexis.mccamey@maryland.gov; barbara.a.young@state.ma.us; DitschmanA@michigan.gov; john.manahan@state.mn.us; executivedirector@dentalboard.ms.gov; dlibsdden@mt.gov; dhhs.medicaloffice@nebraska.gov; dashaffer@nsbde.nv.gov; john.cafasso@oplc.nh.gov; eisenmengerj@dca.lps.state.nj.us; roberta.perea@state.nm.us; dcottrel@mail.nysed.gov; cgoode@ncdentalboard.org; rita@nddentalboard.org; harry.kamdar@den.ohio.gov; susan.rogers@dentistry.ok.gov; stephen.prisby@state.or.us; St-DENTISTRY@pa.gov; robert.bartro@health.ri.gov; rita.melton@llr.sc.gov; brittany@sdboardofdentistry.com; dea.smith@tn.gov; wbush@tsbde.texas.gov; lmarx@utah.gov; diane.lafaille@sec.state.vt.us; sandra.reen@dhp.virginia.gov; jennifer.santiago@doh.wa.gov; wvbde@suddenlinkmail.com; dsps@wi.gov; emily.cronbaugh@wyo.gov
Cc: Roberts, Chris; Gordon, Lynne Thomas
Subject: FW: AADB Letter
Attachments: AADB Group Letter 3.1.21 (final).docx

Dear State Dental Board representatives:

The American Association of Orthodontists would like to bring to your attention a letter that was emailed this morning to the American Association of Dental Boards by the AAO, the American Academy of Pediatric Dentists, and the American Association of Oral and Maxillofacial Surgeons. A copy of that letter is attached.

Please do not hesitate to contact me if the AAO can be of assistance to you in any way regarding this or any other matter.

Sincerely,

Trey Lawrence
Vice President, Advocacy and General Counsel
American Association of Orthodontists
401 N Lindbergh Blvd
St. Louis, MO 63141
Office phone: 314.292.6525
Office phone: 800.424.2841 X525
Cell: 314.532.5491

From: Lawrence, Trey
Sent: Monday, March 1, 2021 10:01 AM
To: Tonia Socha-Mower <tsochamower@dentalboards.org>; robertzenadmd <robertzenadmd@gmail.com>; drjasparks@cox.net; brian.barnett@pr.mo.gov; info@dentalboards.org
Cc: Roberts, Chris <croberts@aaortho.org>; Gordon, Lynne Thomas <lthomasgordon@aaortho.org>; Rutkauskas, John <jrutkauskas@aapd.org>; Scott Litch, AAPD <slitch@aapd.org>; sfarrell@aaoms.org
Subject: AADB Group Letter 3.1.21 (final)

Dear Ms. Socha-Mower, Dr. Zena, and Dr. Sparks,

On behalf of the American Association of Orthodontists, the American Academy of Pediatric Dentists, and the American Association of Oral and Maxillofacial Surgeons, please find attached a letter from these three organizations. Because the AADB does not make public the email addresses for the members of its Board of Directors, and we were otherwise unable to locate them online, please ensure that a copy of this letter is also distributed to each of the individual members of your Board of Directors by email.

Thank you, and please do not hesitate to contact me for any reason concerning this matter.

Sincerely,

Trey Lawrence
Vice President, Advocacy and General Counsel
American Association of Orthodontists
401 N Lindbergh Blvd
St. Louis, MO 63141
Office phone: 314.292.6525
Office phone: 800.424.2841 X525
Cell: 314.532.5491

March 1, 2021

Board of Directors
American Association of Dental Boards
211 E. Chicago Ave., Ste. 760
Chicago, IL 60611

Dear Directors:

We are writing on behalf of the American Association of Orthodontists, the American Academy of Pediatric Dentists and the American Association of Oral and Maxillofacial Surgeons to express concerns regarding the new for-profit corporate sponsorships instituted by the AADB and the potential conflicts of interest these appear to have created.

As an initial matter, we are concerned the Directors and/or Staff of the AADB have exceeded their authority in establishing a new level of AADB membership, the "AADB Corporate Member." However, the AADB has already begun accepting new members under this classification. Section 5 of the Bylaws of the AADB establishes the types of Membership in this organization, and there is currently no "Corporate Member" level included therein. As a Member-Governed organization, it is concerning that the AADB's leadership appear to have made this material change without the direction or approval of its General Assembly, the body to which the Bylaws grant the authority to "determine the policies which govern the Association" and "the power to enact, amend and repeal the Bylaws of this Association."

Further, by allowing membership of "any for-profit business involved in the practice or regulation of dentistry," the AADB may invite participation from entities whose interests directly conflict with the Association's own objectives—even so far as entities currently involved in litigation against state board members of the AADB. One such for-profit business granted Membership under the new Corporate Member classification, SmileDirectClub, is currently involved in multiple lawsuits it brought against Members and Agency Members of the AADB. These lawsuits challenge actions the Members/Agency Members believed to be in the best interest of patient health and safety. Allowing for such conflict of interest between Member entities, or between Member entities and the Association itself, is unlikely to be in the best interest of the AADB.

In addition to the above, it appears the Directors and/or Staff of the AADB have instituted a new level of meeting sponsorship, the "Diamond Sponsor" (at a rate significantly greater than those of previous meeting sponsorships), which may create similar instances of conflicts of interest. While obtaining sponsors for AADB events is certainly important to managing the Association's costs, decisions to accept for-profit corporate sponsorships should not be made without consideration for the conflicts of interest that could arise. For the reasons previously discussed, accepting SmileDirectClub as a sponsor for the Mid-Year Meeting may have created such a conflict. In particular, the AADB may not wish to put its Members/Agency Members in the position of attending a meeting whose primary sponsor is a for-profit company currently suing them.

We hope that you understand our concerns and appreciate your attention to this matter.

Please contact any of the undersigned if you would like to discuss further.

Sincerely,

American Association of Orthodontists

American Academy of Pediatric Dentistry

American Association of Oral and Maxillofacial Surgeons

Sandra Reen

From: denbd@dhp.virginia.gov
Sent: Friday, March 5, 2021 5:08 PM
To: Sandra Reen; jamie.sacksteder@dhp.virginia.gov
Subject: FW: Dental Scope of Practice & Sleep Apnea Concerns
Attachments: Dental Scope of Practice Final Joint Letter.pdf

From: Kannan Ramar, MD <kramar@aasm.org>
Sent: Friday, March 5, 2021 4:22 PM
To: denbd@dhp.virginia.gov
Cc: Eric Albrecht <ealbrecht@aasm.org>
Subject: Dental Scope of Practice & Sleep Apnea Concerns

Sandra Reen,

Attached for your review is a letter requiring your immediate attention. The American Academy of Sleep Medicine, American Thoracic Society, American Academy of Neurology, and American Academy of Otolaryngology – Head and Neck Surgery would like to express our concerns regarding a recently published position statement issued by the American Academy of Dental Sleep Medicine on the use of home sleep apnea tests (HSATs) by dentists. Please see the attached letter outlining our concerns; we urge you to adopt language clarifying the scope of practice for dentists in your state in relation to the use of HSAT.

Contact Eric Albrecht, AASM Advocacy Program Manager, at ealbrecht@aasm.org with any questions regarding this.

Kannan Ramar, MD
AASM President

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March 5, 2021

Dear Dental Board:

On behalf of the undersigned organizations, we are writing to express our concerns regarding a recently published position issued by the American Academy of Dental Sleep Medicine (AADSM). This statement encourages the use of home sleep apnea tests by dentists for the diagnosis of obstructive sleep apnea (OSA). We argue that ordering, administering, and interpreting home sleep apnea tests is outside the scope of practice for dentists, and herein are requesting that your board protect both patients and dentists in your state by adopting a policy to clarify this fact.

The AADSM position states that it is within the scope of practice for dentists to identify patients who are at risk for OSA and then order or administer diagnostic home sleep apnea tests. Furthermore, since most state dental boards have no policy addressing this issue, the AADSM position indicates that this "silence" gives dentists tacit permission to provide this medical service, which is a dangerous interpretation. This position statement is in direct conflict with that of the American Academy of Sleep Medicine (AASM) and a policy of the American Medical Association (AMA), both of which emphasize that a home sleep apnea test is a medical assessment that must be ordered by a medical provider and, moreover, must be reviewed and interpreted by a physician who is either board-certified in sleep medicine or overseen by a board-certified sleep medicine physician. The AADSM position also is not supported by the policy statement of the American Dental Association (ADA) or by a white paper from the American Association of Orthodontists (AAO).

An evidence-based AASM clinical practice guideline indicates that the decision to order a home sleep apnea test should be made by a medical provider only after reviewing the patient's medical history and conducting a face-to-face examination. The medical evaluation should include a thorough sleep history and a physical examination of the respiratory, cardiovascular, and neurologic systems. The sleep history is important because many patients have more than one sleep disorder or present with atypical sleep apnea symptoms. The medical provider also should identify chronic diseases and conditions that are associated with increased risk for OSA, such as obesity, hypertension, stroke, and congestive heart failure. An evaluation by a medical provider also is necessary to rule out conditions that place the patient at increased risk of central sleep apnea and other forms of non-obstructive sleep-disordered breathing, which typical home sleep apnea tests are insufficient to detect. While dentists can use questionnaires and examine the oral structures to screen patients for symptoms of OSA, they are untrained in conducting the comprehensive medical evaluation needed to assess OSA risk.

Based on this medical evaluation, the medical provider can determine if diagnostic testing is indicated to confirm a clinical suspicion of OSA. The selection of the appropriate diagnostic test — either in-lab polysomnography or a home sleep apnea test — is critical. Because a home sleep apnea test is less sensitive than polysomnography, it is more likely to produce false negative results when ordered inappropriately. The resulting misdiagnosis can lead to significant harm for the patient. Because dentists lack the required medical education and training needed to order, administer, and interpret diagnostic tests for OSA, implementing the AADSM position could jeopardize the quality of patient care.

In addition, the AADSM position does not align with the current national and local coverage determination policies of the Centers for Medicare & Medicaid Services (CMS) and the policies of private insurers for reimbursement of home sleep apnea tests and oral appliances for OSA.

These medical insurance policies also require a comprehensive clinical evaluation by a medical provider to determine that the test or treatment is reasonable and necessary. Patients will have to pay full price for the uncovered services provided by a dentist, dramatically increasing their out-of-pocket costs.

It is for the aforementioned reasons that our organizations urge your board to adopt a policy clarifying that ordering and administering a home sleep apnea test is outside the scope of practice for dentists in your state. We encourage you to use as a model the policy adopted by the Georgia Board of Dentistry, "Prescribing and Fabrication of Sleep Apnea Appliances":

> *Depending upon the diagnosis of the type and severity, one possible treatment option for obstructive apnea is the use of oral appliances. The design, fitting and use of oral appliances and the maintenance of oral health related to the appliance falls within the scope of practice of dentistry. The continuing evaluation of a person's sleep apnea, the effect of the oral appliance on the apnea, and the need for, and type of, alternative treatment do not fall within the scope of dentistry. Therefore, the prescribing of sleep apnea appliance does not fall within the scope of the practice of dentistry. It is the position of the Board that a dentist may not order a sleep study. Home sleep studies should only be ordered and interpreted by a licensed physician. Therefore, only under the orders of a physician should a dentist fabricate a sleep apnea appliance for the designated patient and conduct only those tasks permitted under O.C.G.A. Title 43, Chapter 11. (adopted 04/01/16)*

We thank you for your consideration of our concerns. For any additional information or to discuss this issue, please contact AASM Executive Director Steve Van Hout at (630) 737-9700.

Sincerely,

Kannan Ramar, MD, FAASM
American Academy of Sleep Medicine
President

James C. Stevens, MD, FAAN
American Academy of Neurology
President

Carol R. Bradford, MD, MS
American Academy of Otolaryngology-Head and Neck Surgery
President

Juan C. Celedón, MD, DrPH, ATSF
American Thoracic Society
President

Sandra Reen

From:	Jessica Bui <jbui@srta.org> on behalf of Jessica Bui
Sent:	Wednesday, March 10, 2021 4:32 PM
To:	Augustus Petticolas (apetticolas@aol.com); Nathaniel Bryant; tbonwell@embarqmail.com; meglemaster@gmail.com; Sandra Reen; Donna Lee; Sacksteder, Jamie; kathryn.brooks@dhp.virginia.gov
Subject:	SRTA Letter to the Virginia Board of Dentistry
Attachments:	SRTA VA Letter 03 10 2021.pdf
Importance:	High

Dear Members of the Virginia Dental Board,

Please see the attached letter from SRTA.

Thank you,

Jessica L. Bui
Executive Director

Southern Regional Testing Agency, Inc.
4698 Honeygrove Road, Suite 2
Virginia Beach, VA 23455
Telephone: 757.318.9084
Fax: 757.318.9085
jbui@srta.org

Southern Regional Testing Agency, Inc.
4698 Honeygrove Road, Suite 2 | Virginia Beach, Virginia 23455-5934
Tel. (757) 318-9082 | Fax (757) 318-9085 | www.srta.org

March 10, 2021

Virginia Board of Dentistry
Attention: President Augustus Petticolas, Jr., DDS
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dear Dr. Petticolas and the Virginia Board members,

On March 5th, 2021, the Virginia Board of Dentistry Exam Committee met and there seems to be misinformation about the administration of the SRTA examinations. I want to ensure you and the Virginia board members that Southern Regional Testing Agency, Inc. is currently still administering dental and dental hygiene examinations and operating as usual. There was no notification to submit for public comment for the exam committee meeting, however Mrs. Bui was present on the call.

There was a motion to only accept the ADEX examination for dental and dental hygiene and was accepted by the exam committee members. Based on the information provided to you and the members of the committee, SRTA does meet the requirements for licensure within Virginia. We continue to provide a comprehensive and conjunctive scoring methodology for both the dental and dental hygiene clinical exams. We also utilize the same manufacturer for our manikin teeth and hygiene manikin models as ADEX does.

If this motion were to pass, it could potentially cause issues for prospective applicants to obtain a license within Virginia, especially if they took the SRTA examination out of state. SRTA continues to administer examinations in Tennessee and West Virginia, both which border Virginia.

Although, SRTA does not administer the examination at Virginia Commonwealth University, we are continuously working with other schools within Virginia regarding hosting the SRTA examination. We believe that students should be offered options as to which examination they would like to take. By only allowing one type of examination to be accepted results in a monopoly and restriction of trade within the testing realm.

SRTA and Virginia have a very long history with Virginia being one of the founding member states of SRTA. Therefore, we humbly request that the exam committee and the Virginia Board of Dentistry members reconsider and continue accepting the SRTA examination results for dental and dental hygiene licensure within Virginia.

Thank you,

Dr. Thomas G. Walker, DMD, President

Jessica Bui, Executive Director

VIRGINIA BOARD OF DENTISTRY
BUSINESS MEETING MINUTES
December 11, 2020

TIME AND PLACE: The virtual meeting of the Virginia Board of Dentistry was called to order at 9:56 a.m., on December 11, 2020, at the Perimeter Center, 9960 Mayland Drive, Henrico, Virginia 23233.

CALL TO ORDER: Dr. Petticolas called the meeting to order.

Consistent with Amendment 28 to HB29 (the Budget Bill for 2018-2020) and the applicable provisions of § 2.2-3708.2 in the Freedom of Information Act, the Board is convening today's meeting virtually to consider such regulatory and business matters as are presented on the agenda necessary for the board to discharge its lawful purposes, duties, and responsibilities.

Dr. Petticolas provided the Board members, staff, and the public with contact information should the electronic meeting be interrupted.

BOARD MEMBERS PRESENT AT THE PERIMETER CENTER:
Augustus A. Petticolas, Jr., D.D.S., President
Sandra J. Catchings, D.D.S., Vice-President

BOARD MEMBERS PRESENT VIRTUALLY:
Patricia B. Bonwell, R.D.H., PhD
Nathaniel C. Bryant, D.D.S.
Sultan E. Chaudhry, D.D.S.
Jamiah Dawson, D.D.S.
Perry E. Jones, D.D.S.
Margaret F. Lemaster, R.D.H.
J. Michael Martinez de Andino, J.D.
Mike Nguyen, D.D.S.

STAFF PRESENT AT THE PERIMETER CENTER:
Sandra K. Reen, Executive Director of the Board
Jamie C. Sacksteder, Deputy Executive Director
Tracey Arrington-Edmonds, Licensing Manager
Donna Lee, Discipline Case Manager

STAFF PRESENT VIRTUALLY:
David C. Brown, D.C., Director, Department of Health Professions
Barbara Allison-Bryan, M.D., Chief Deputy Director, Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

COUNSEL PRESENT AT THE PERIMETER CENTER: James E. Rutkowski, Assistant Attorney General

ESTABLISHMENT OF A QUORUM: A roll call of the Board members and staff was completed. With ten members of the Board present, a quorum was established.

PUBLIC COMMENT:

Dr. Petticolas explained the parameters for public comment and opened the public comment period. Dr. Petticolas also stated that written comments were received from Mr. Matthew Glans and Dr. E. Thomas Elsnter, Jr., which are included in the agenda package; and written comments received from Ms. Beth Cole were sent by email to Board members and the Public Participation list and will be posted with the draft minutes.

Dr. Richard Archer, Senior Associate Dean for Clinical Education, VCU School of Dentistry - Dr. Archer stated that when the Board made the decision to accept all Board exams, portability was the main concern and goal. He recommended that the ADEX exam be the only exam accepted in Virginia because it is a uniform exam, the Board has input on the exam by Board representation, it is an interactive exam, and administered by two different agencies. He also stated that the ADEX exam is accepted in all other states except Delaware and New York.

Dr. Sharon Popp – Testing Specialist for WREB – Dr. Popp encouraged the Board to review the WREB paper that Ms. Cole submitted regarding testing procedures followed by WREB. She also noted that their scorecard was updated to show if the candidate completed a simulated or live patient portion of the examination.

APPROVAL OF MINUTES:

Dr. Petticolas asked if there were any edits or corrections to any of the 6 sets of draft minutes included in the agenda package. Dr. Bonwell stated that on page 21 of the agenda, in the October 23, 2020 Business Meeting Minutes, the last paragraph, line 7, the sentence that starts with "Dr. Bonwell" the word should be "stating" and not "state". Dr. Catchings moved to approve the six sets of minutes with the change noted by Dr. Bonwell. Following a second, a roll call vote was taken. The motion passed.

Ms. Reen informed the Board that the meeting minutes from the two public hearings held on November 13, 2020, are in the agenda package for informational purposes.

ADEX REPORT:

Dr. Bryant stated that the ADEX meeting was held virtually. He reported that the passing rate for the manikin exams and for the live patient tests were very similar at about 94%. He added that the typodont allows testing at different depths which is not possible in the live patient exam. He also said ADEX is working on developing a more natural tooth for the dental hygiene exam.

CITA REPORT:

Dr. Petticolas stated that CITA has not met since the last meeting.

BOARD OF HEALTH PROFESSIONS REPORT:

Dr. Catchings announced her appointment to this Board and stated that she has yet to attend a meeting because her first meeting was cancelled.

DIRECTOR'S REPORT:

Dr. Brown praised Dr. Petticolas for helping Dr. Carey, the Secretary of Health and Human Resources, with various initiatives. He then reported that the Legislative session coming up in January will be a short session, only 30 days. He said no DHP bills are expected to move ahead and that legalizing medical and recreational use of marijuana will be addressed. Dr. Brown also stated that for very potent marijuana, prescribers and patients may be required to register with the Board of Pharmacy.

Dr. Allison-Bryan stated that by the end of the day, the FDA is expected to approve the emergency use authorization of the Pfizer vaccine for the COVID-19 virus, which will be distributed almost immediately to Virginia. She stated that 1A classification healthcare providers, and long-term care facilities' residents and staff will have priority in receiving the vaccination, which will be given by CVS and Walgreen pharmacists. Dr. Allison-Bryan encouraged everyone to go to the Virginia Department of Health's website to learn about the distribution plans for the vaccine in Virginia.

LEGISLATION AND REGULATION:

Status Report on Regulatory Actions Chart. Ms. Yeatts reviewed the updated Regulatory Actions. The following proposed regulations are currently at the Governor's Office:

- training and supervision of digital scan technicians;
- amendment to restriction on advertising dental specialties;
- technical correction to fees; and
- training in infection control.

The regulations pertaining to the waiver for e-prescribing and the education and training for dental assistants II are under review by the Secretary of Health and Human Resources.

Petition for Rulemaking – Scope of practice for dentistry to include administration of Botox and dermal filler injectables.
Ms. Yeatts stated the petition is to amend the regulations to allow general dentists with additional training to administer BOTOX and dermal filler injectables. She recommended that the Board consider the current statute allowing oral maxillofacial surgeons with proper training and certification to perform those functions and review the current definition of dentistry.

After discussion, the Board had concerns about the extraoral administration of Botox and dermal filler injectables by a general dentist and possible complications with patients. The Board also had questions about the specific type of training that would be required of a general dentist.

Dr. Catchings moved to deny the petitioner's request for rulemaking at this time. Following a second, a roll call vote was taken. The motion passed.

By consensus, the Board requested that the petitioners be notified that additional information about training should be submitted to the Board for review.

Adoption of Amendments to 18VAC60-25-40 – Practice by Public Health dental hygienists under remote supervision. Ms. Yeatts explained that the Board is voting whether or not to adopt the amendments to 18VAC60-25-40 as a final action.

Dr. Catchings moved to accept the amendments to 18VAC60-25-40 pertaining to practice by Public Health dental hygienists under remote supervision. Following a second, a roll call vote was taken. The motion passed.

Adoption of Proposed Regulation on Administration of Sedation & Anesthesia.

- 18VAC60-21-291(C) - Ms. Yeatts reviewed the comments received pertaining to requiring a 3-person treatment team for moderate sedation instead of a 2-person team. The Board discussed the current practices and guidelines.

Dr. Bonwell moved that 18VAC60-21-291(C) be amended to require a 2-person treatment team for moderate sedation. Following a second, a roll call vote was taken. The motion passed.

- 18VAC60-21-291(A)(1) – Ms. Yeatts explained this is a request for modification to allow CRNAs to administer sedation in dental offices with non-permitted dentists. The Board reviewed the practices of a CRNA in an outpatient surgery center versus a dental office setting.

Dr. Dawson moved that 18VAC60-21-291(A)(1) be modified to allow CRNAs to administer sedation in dental offices with non-permitted dentists. Following a second, a roll call vote was taken. The motion passed.

- 18VAC60-21-301(E)(2) – Ms. Yeatts stated the Board had to decide whether the required information being recorded should be every five minutes.

Dr. Catchings moved that 18VAC60-21-301(E)(2) be amended to add "every five minutes". Following a second, a roll call vote was taken. The motion passed.

Dr. Catchings moved to adopt the proposed regulation as recommended by the Regulatory/Legislative Committee and amended By the Board. Following a second, a roll call vote was taken. The motion passed.

Following a break, a roll call was taken to establish that a quorum of the Board was present.

BOARD DISCUSSION/ACTION:

Review Discussion of Clinical Examination Acceptance – Ms. Reen explained her research and findings in developing a draft guidance document requested by the Board to require equivalency across the five regional testing agencies accepted by the Board. Ms. Reen stated that there is no public documentation available to determine if all five exams are equivalent. She explained each testing agency's scoring methodology and standards for testing are proprietary records that are shared only with the dental boards that are members of the respective agency. She said the redacted score cards show there are variances across the testing agencies but they are similar. She said adopting this guidance document will slow down licensure and require that more applications be addressed by Special Conference Committees. She said the Board is and can only be a member of one testing agency. The Board is a member of the Council of Interstate Testing Agencies (CITA) and it is a member of the test development agency American Board of Dental Examiners (ADEX). She added that CITA administers the ADEX exam. These memberships give the Board a voice in test development and implementation by these two agencies.

In response to discussion, Ms. Reen noted that the Board could establish two policies: one for licensure by examination and another for licensure by credentials.

Ms. Sacksteder addressed the Board's March 2020 decision to not accept exam results that were calculated using compensatory scoring and passage of specific categories of the clinical exam. She said that she understands that CRDTS and WREB both do compensatory scoring for some sections of their exams and that there are testing agencies which give candidates the option of taking either the prosthodontic portion or the periodontal portion of the exam.

Dr. Petticolas stated that Board staff was asked to develop a guidance document for the testing exams to determine if there was a level of equivalency, and that was done. The conclusion is that there is not equivalency with the five testing agencies for the different reasons that were stated by Ms. Reen and Ms. Sacksteder.

Dr. Catchings moved to reject the draft guidance document that was prepared pertaining to clinical examination acceptance. Following a second, a roll call vote was taken. The motion passed.

By consensus, the Board requested that the Exam Committee discuss the testing agency exams in more detail, considering a timeframe to require passage of the ADEX exam, and report its findings to the Board.

Ms. Reen requested approval by the Board to hire a VCU consultant to assist the Exam Committee. Dr. Catchings moved to have a consultant work with the Committee. Following a second, a roll call vote was taken. The motion passed.

Bylaws (Guidance Document 60-14) - Dr. Petticolas encouraged the Board members to assist in the biennial review of the Bylaws. He asked for discussion of adding a provision to allow emergency action by the Executive Committee and/or polling each board member when there is a need for emergency action. Ms. Reen explained that the first attempt to take emergency action on the exam requirements for 2020 failed because there was not 100% unqualified agreement of the Board members so it is important to have a clearly defined policy. Discussion supported adding a provision for emergencies. Dr. Petticolas asked for any ideas and said amendment of the Bylaws will be discussed at the March 2021 Board meeting.

Policy on Recovery of Disciplinary Costs (Guidance Document 60-17) – Ms. Reen provided the Board with an update of the costs assessed for the upcoming year, and that there have been no issues with the current process. Dr. Brown stated that the Board of Dentistry is the only board in the Department of Health Professions that does disciplinary costs and he wants to treat all licensees with fairness.

Ms. Reen explained that the Virginia Dental Association was concerned that renewal fees were paying for discipline costs so they pursued legislation to have a statute implemented to assess disciplinary costs. Ms. Reen further stated that the statute is permissive and would not have to be eliminated if the Board wanted to eliminate the fees.

Ms. Yeatts suggested that the guidance document stay in place, but the Board can decide not to collect fees for a certain period of time and then may re-impose fees.

Dr. Bonwell moved to adopt Guidance Document 60-17 as drafted and to not assess disciplinary costs for calendar year 2021. The motion was seconded and passed.

BOARD COUNSEL REPORT:

Mr. Rutkowski did not have any report for the Board.

ADJOURNMENT:

The Deputy Executive Director's report and the Executive Director's report were suspended for this meeting because a formal hearing was scheduled to take place in 15 minutes. The reports will be discussed at the March 2021 Board meeting.

With all business concluded, the Board adjourned at 1:12 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

Sandra Reen

From: Beth Cole <bcole@wreb.org> on behalf of Beth Cole
Sent: Monday, December 7, 2020 4:45 PM
To: Sandra Reen
Subject: FW: September 11, 2020 Board Business Meeting Agenda - Corrected Copy
Attachments: WREB Dental Scoring and Decision making overview for VA oct122020.pdf

Hi Sandy,

I noticed that the information you requested on our scoring was not included in the Board packet for your upcoming meeting. I am resending it just in case you think it would help your discussion. Also, because it contains a more updated version of our score report.

Also, in reading your materials I saw in your notes to the Board, a reference regarding membership in testing agencies. I can't speak for other agencies, but WREB does not prohibit a member state from joining and participating in other agencies as well. Virginia is welcome to join and participate in WREB at any time.

I did want to reiterate that our scoring system is conjunctive. The Operative section has a compensatory element, however, as you can see from the score reports in the attached document, one can easily determine that a candidate has passed both of the operative procedures if one chooses not to utilize WREB's scoring protocol.

Please let me know if you have any questions.

Beth

Beth Cole
Chief Executive Officer, Western Regional Examining Board
23460 N 19th Ave Suite 210 Phoenix, AZ 85027
623-209-5411 | bcole@wreb.org | wreb.org

WREB Dental Examination
Overview of Decision-Making Approach and Scoring Determination

WREB ensures that all examinations are scored accurately, fairly, and in accordance with the *Standards for Educational and Psychological Testing*.[1] Practices relevant to examination scoring include the decision-making approach and methods of score determination. An overview of each for the WREB Dental Examination is provided in this document. Additional details regarding the Dental Examination or for related information regarding WREB's Dental Hygiene Examinations are available upon request.

Examination Decision-Making Approach

The terms *compensatory* and *conjunctive* refer to decision-making approaches that may be employed when results from multiple assessments are combined. A compensatory approach averages scores across multiple assessment scores to obtain one final overall score, which allows higher performance on one assessment to compensate for lower performance on another assessment. In contrast, a conjunctive approach requires that performance on each assessment meet or exceed a standard set for that assessment. WREB employs a conjunctive approach to determine the pass or fail decision based on multiple sections of the overall examination. For WREB's Dental Examination, all sections are independent and must be passed at the competency standard for a candidate to pass the Dental Examination.

Methods of Score Determination

The pass or fail decision regarding candidate performance on each examination section is based on the final score, which is derived from a raw score. The raw score is equal to the final score if no deductions or penalties are applied. A candidate's final score on each examination section must meet or exceed the passing score to pass the Dental Examination, in accordance with the conjunctive model of combining results from different tests. Additional details for each examination section regarding scoring are provided, below.

Periodontics Section. The raw score for the Dental Periodontics section is based on the percentage of examiner-validated error-free tooth surfaces. The Dental Periodontics section utilizes error/no-

error grading, where the median grade of the three independent examiners will always reflect exact agreement by at least two of the examiners. For each error that is validated by at least two examiners, the candidate's score is reduced by a proportion of the maximum points available. Penalties (e.g., unacceptable patient submissions) result in deductions from the Periodontics section score, if applicable and validated. A validated critical error (e.g., major tissue trauma) or a finding of egregious performance results in examination failure.

Comprehensive Treatment Planning (CTP), Operative Dentistry, Endodontics, and Prosthodontics sections. Raw scores for the Comprehensive Treatment Planning (CTP), Operative, Endodontics, and Prosthodontics sections are calculated by summing and/or averaging the median of ratings (i.e., grades) assigned by the Grading Examiners for each scoring criterion, according to defined ordinal levels of performance. As described in the previous section regarding the pass/fail decision-making approach, a conjunctive approach is employed for combining results across the different Dental Examination sections; however, a compensatory scoring approach (i.e., summing and/or averaging) is recommended for scoring related tasks and abilities assessed *within* a single test. Median grades are summed and averaged across multiple criteria and procedures, rather than requiring candidates to "pass" every criterion or procedure as if each were a separate test. Unless the candidate's performance has prompted a validated critical error, which results automatically in section failure, it is possible that a small variation from the cut score can be off-set by performance in other areas that exceed the minimal competency definition, to arrive at a final score that meets or exceeds the minimal competency standard. The converse is also possible; adequate performance in one area may be offset by inadequate performance in other areas, resulting in section failure.

Compensatory scoring *within* each examination section is consistent with research on standard-setting methods for performance-based tasks. For example, Hambleton and Slater[2] demonstrated that decision consistency and decision accuracy decrease with the number of separate tasks assessed under a conjunctive scoring approach. Haladyna and Hess[3] also found reliability and rater consistency to be lower with conjunctive scoring of performance-based tasks. They recommend that the choice of scoring strategy be supported by suitable definitions from subject matter experts corroborated by empirical evidence that demonstrates the degree of

relatedness among the scored elements. WREB examination committees review grading criteria, scoring procedures, and criterion weighting regularly. Analyses of content dimensionality and correlations among graded criteria and procedures are also conducted regularly to determine and support scoring methods. Dental grading criteria and procedures within each examination section are highly related, indicating summing and averaging as the preferred approach to scoring. For example, performance on the two Operative restorations is highly related; approximately 90% of attempts, historically, have the same outcome per procedure (*i.e.*, both below the standard for competence or both at or above the standard for competence).

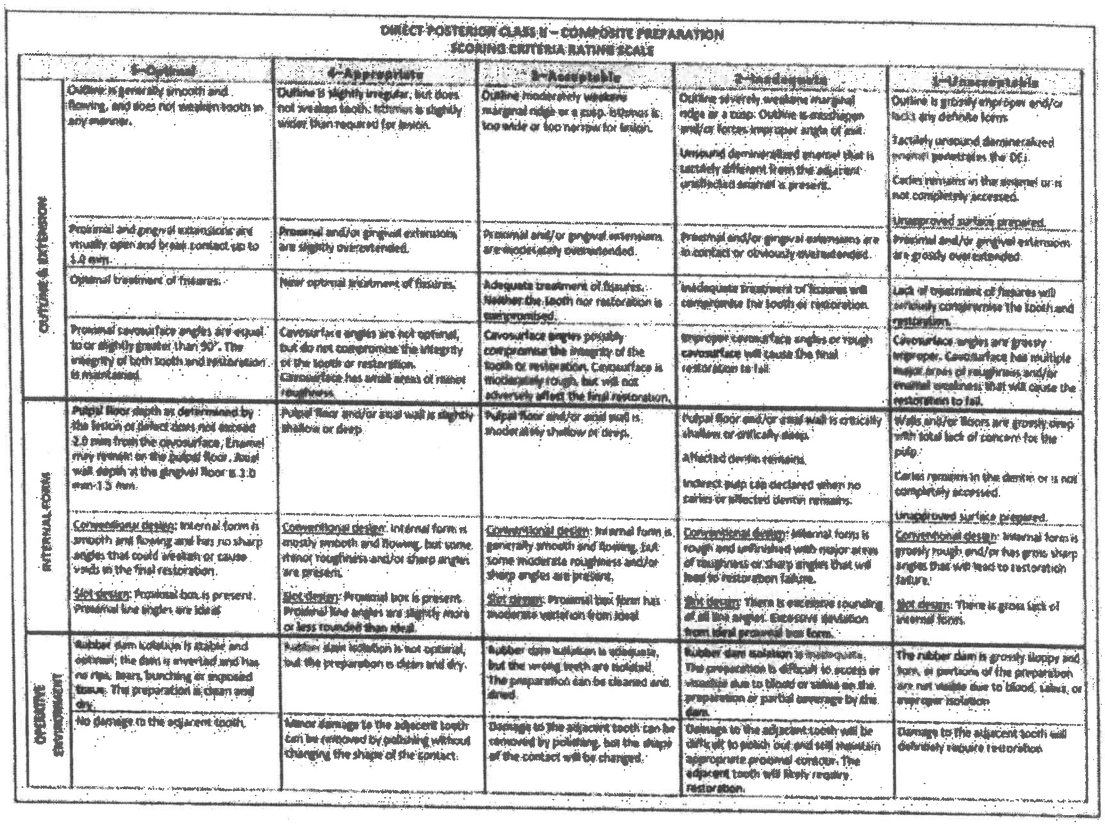
The Comprehensive Treatment Planning (CTP), Operative, Endodontics and Prosthodontics sections are graded according to published scoring rubrics, that define performance at multiple levels for various criteria. Each grading criterion is defined at five (5) levels of performance for each procedure, with a grade of "3" representing minimal competence. A grade of "5" is defined generally to represent optimal performance, with grades of 4, 3, 2, and 1 corresponding to appropriate, acceptable, inadequate, and unacceptable performance, respectively. All scoring criteria are available in the Dental Exam Candidate Guide and CTP Exam Candidate Guide for the current season at:

https://wreb.org/Candidates/Dental/2020_Dental_PDFs/2020_Dental_Candidate_Guide.pdf and https://wreb.org/candidates/dental/dentalpdfs/2021_CTP_Candidate_Guide.pdf .

An example of scoring criteria for grading the Preparation stage of the Posterior Class II composite is displayed in Figure 1, on the following page.

For each criterion, the median of the three examiner grades is weighted to reflect the level of criticality relevant to minimally competent treatment. For example, for the Operative Dentistry section, Outline and Extension accounts for 46% of the Preparation score and Operative Environment accounts for only 15%. Weighted criterion medians are summed to attain procedure scores or CTP case-level scores. The average of the procedure or case-level scores is the raw score for the Operative Dentistry, Prosthodontics, and CTP sections. The sum of weighted criteria is the

raw score for the Endodontics section. Final scores also reflect score deductions if any penalties have been assessed.



DIRECT POSTERIOR CLASS II – COMPOSITE PREPARATION
SCORING CRITERIA RATING SCALE

	5—Optimal	4—Appropriate	3—Acceptable	2—Inadequate	1—Unacceptable
OUTLINE & EXTENSION	Outline is generally smooth and flowing, and does not weaken tooth in any manner.	Outline is slightly irregular, but does not weaken tooth. Isthmus is slightly wider than required for finish.	Outline moderately weakens marginal ridge or a pulp. Isthmus is too wide or too narrow for finish.	Outline severely weakens marginal ridge or a pulp. Outline is misshapen and/or forces improper angle of exit. Unsound demineralized enamel that is tactilely different from the adjacent unaffected enamel is present.	Outline is grossly improper and/or lacks any definite form. Tactilely unsound demineralized enamel penetrates the DEJ. Caries remains in the enamel or is not completely accessed. Unapproved surface prepared.
	Proximal and gingival extensions are virtually open and break contact up to 1.0 mm.	Proximal and/or gingival extensions are slightly overextended.	Proximal and/or gingival extensions are moderately overextended.	Proximal and/or gingival extensions are in contact or obviously overextended.	Proximal and/or gingival extension are grossly overextended.
	Optimal treatment of fissures.	New optional treatment of fissures.	Adequate treatment of fissures. Neither the tooth nor restoration is compromised.	Inadequate treatment of fissures will compromise the tooth or restoration.	Lack of treatment of fissures will seriously compromise the tooth and restoration.
	Proximal cavosurface angles are equal to or slightly greater than 90°. The integrity of both tooth and restoration is maintained.	Cavosurface angles are not optimal, but do not compromise the integrity of the tooth or restoration. Cavosurface has small areas of minor roughness.	Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough, but will not adversely affect the final restoration.	Improper cavosurface angles or rough cavosurface will cause the final restoration to fail.	Cavosurface angles are grossly improper. Cavosurface has multiple major areas of roughness and/or enamel weakness that will cause the restoration to fail.
INTERNAL FORM	Pulpal floor depth as determined by the lesion or defect does not exceed 2.0 mm from the cavosurface. Enamel may remain on the pulpal floor. Axial wall depth at the gingival floor is 3.0 mm-1.5 mm.	Pulpal floor and/or axial wall is slightly shallow or deep.	Pulpal floor and/or axial wall is moderately shallow or deep.	Pulpal floor and/or axial wall is critically shallow or critically deep. Affected dentin remains. Indirect pulp cap declared when no caries or affected dentin remains.	Walls and/or floors are grossly deep with total lack of concern for the pulp. Caries remains in the dentin or is not completely accessed. Unapproved surface prepared.
	Conventional design: Internal form is smooth and flowing and has no sharp angles that could weaken or cause voids in the final restoration. Slot design: Proximal box is present. Proximal line angles are ideal.	Conventional design: Internal form is mostly smooth and flowing, but some minor roughness and/or sharp angles are present. Slot design: Proximal box is present. Proximal line angles are slightly more or less rounded than ideal.	Conventional design: Internal form is generally smooth and flowing, but some moderate roughness and/or sharp angles are present. Slot design: Proximal box form has moderate variation from ideal.	Conventional design: Internal form is rough and unfinished with major areas of roughness or sharp angles that will lead to restoration failure. Slot design: There is excessive rounding of all line angles. Excessive deviation from ideal proximal box form.	Conventional design: Internal form is grossly rough and/or has gross sharp angles that will lead to restoration failure. Slot design: There is gross lack of internal form.
OPERATIVE ENVIRONMENT	Rubber dam isolation is stable and optimal; the dam is inverted and has no rips, tears, bunching or exposed tissue. The preparation is clean and dry.	Rubber dam isolation is not optimal, but the preparation is clean and dry.	Rubber dam isolation is adequate, but the wrong teeth are isolated. The preparation can be cleaned and dried.	Rubber dam isolation is inadequate. The preparation is difficult to access or visualize due to blood or saliva on the preparation or partial coverage by the dam.	The rubber dam is grossly sloppy and torn, or portions of the preparation are not visible due to blood, saliva, or improper isolation.
	No damage to the adjacent tooth.	Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.	Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	Damage to the adjacent tooth will definitely require restoration.

Figure 1. Scoring criteria definitions for the Preparation stage of the Direct Posterior Class II Composite procedure, 2020.

Examiners are trained to assign a particular grade only when *all* aspects of performance described for that level have been demonstrated. For example, if performance on the criterion under review meets most of the definition for a grade of "3" but does not quite meet the standard for even one aspect of the definition for a "3," the grade assigned will be a "2," at most. This holds for all graded criteria.

Where applicable, raw scores are scaled and/or equated to facilitate interpretability and to ensure comparability of scores on different test forms and across years. For example, the patient

cases that comprise the Comprehensive Treatment Planning examination are equated to ensure comparability of test forms. Equating of test forms must be conducted because the raw passing score on a difficult form of a test may be lower than the raw passing score on a less challenging form of the test. Scaling and equating procedures allow for unambiguous interpretation of comparable performance on each form. Scaling is a linear or proportional conversion to another, more interpretable, numeric score scale, analogous to converting from degrees Celsius to degrees Fahrenheit. Pass or fail decisions based on final scores, after applicable weighting, equating, and scaling, reflect accurately the passing standards set by examination committees and ensure that candidates of comparable proficiency will be equally likely to pass the examination, regardless of test form or date of administration.

Conclusion

The scores on the two restorations for the WREB Operative Dentistry section have been averaged for many years, and at least one other dental testing agency, CRDTS, also averages the scores attained on different procedures within an examination section, including their dental restorative section.[4] Misinformation has been provided to some State Boards that characterizes this aspect of scoring as somehow improper or not rigorous, which is not accurate. As noted above, averaging the scores on the two Operative restorations is the recommended approach for scoring multiple tasks or test items that are related *within* one assessment. Averaging the scores for the two procedures requires the candidate who underperforms on the first procedure to demonstrate performance that *exceeds* the cut-point by at least as much on the second procedure in order to achieve a passing score and instill confidence in an inference of competence. Candidates who incur a critical error on the first procedure, or are dismissed for egregious performance or ethical violations, fail the Operative Dentistry section at once and are not allowed to perform a second procedure. Every criterion grade assigned (out of six criteria per restoration) reflects the *least* competent aspect of the performance demonstrated, regardless of higher competence demonstrated within the same criterion under evaluation. The decision-making approach used to determine the overall outcome of the multi-section WREB dental examination is completely conjunctive, *i.e.*, candidates must demonstrate competence at the passing standard on *every* section to be successful, overall.

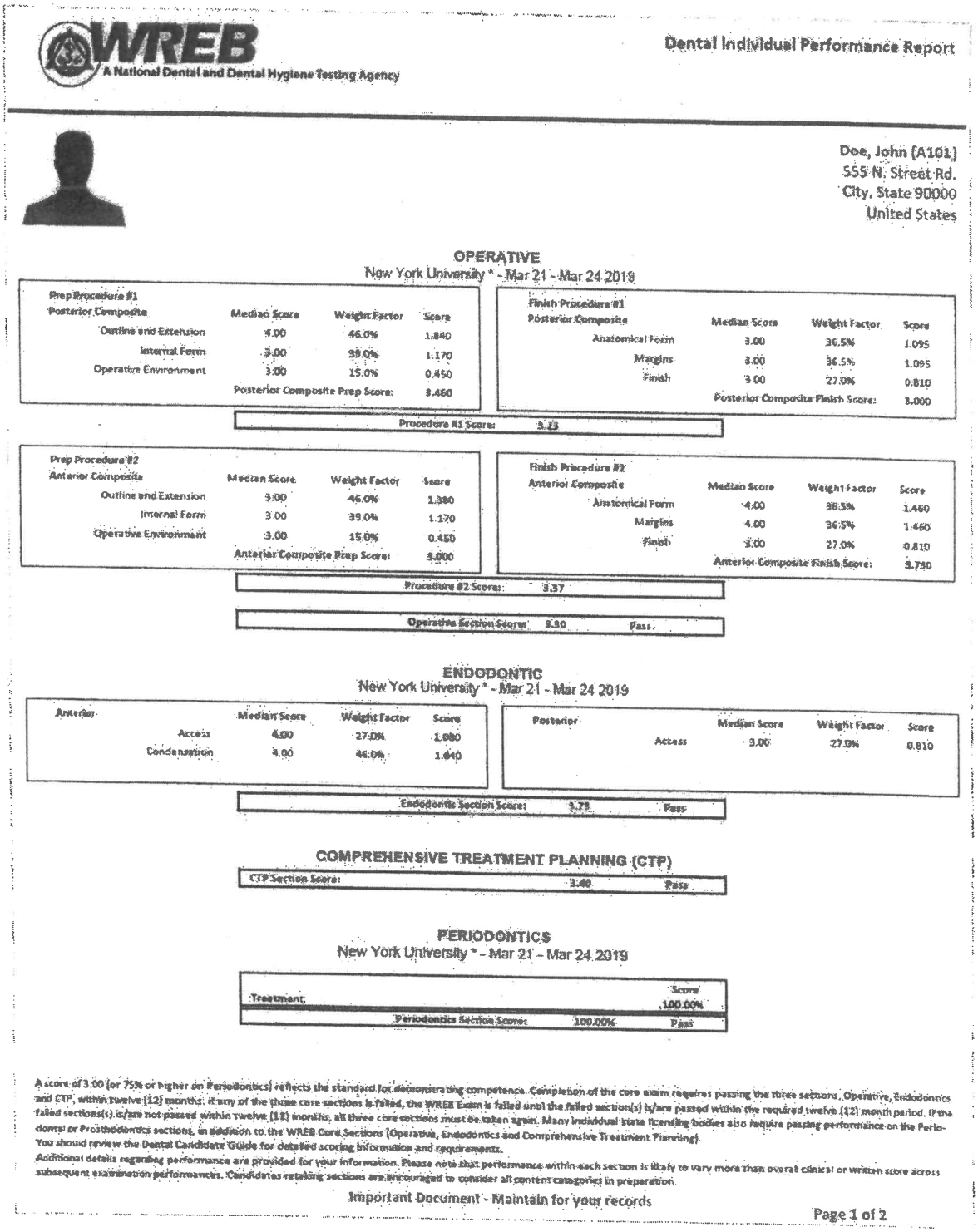
WREB continues to accumulate evidence that supports the validity and integrity of its scoring system but recognizes that some states may be more familiar with an alternative scoring model. Reinterpreting the structure of a test to alter the pass or fail outcome requires a comprehensive standard setting process and justification to maintain defensibility[5, 6] and is not recommended by WREB. However, if a state chooses to require independent passage of each restoration in the Operative Dentistry section (i.e., a conjunctive decision *within* the test), the score attained on each procedure can be easily verified on the WREB dental score report. The score report allows State Boards of Dentistry to see details of the candidate's performance, such as the scores for each restoration and the raw median grades for each Operative Dentistry section criterion. The report provides clarity regarding WREB's scoring system, revealing each median score, criterion weight, and details for any penalties assessed. An example score report is displayed in the Appendix (p. 7 – 8).

References

1. American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. *Standards for Educational and Psychological Testing.* Washington, DC: American Educational Research Association; 2014.
2. Hambleton RK, Slater SC. Reliability of credentialing examinations and the impact of scoring models and standard-setting policies. *Applied Measurement in Education* 1997; *10*(1), 19-38.
3. Haladyna TM, Hess RK. An evaluation of conjunctive and compensatory standard-setting strategies for test decisions. *Educational Assessment* 1999; *6*(2), 129-153.
4. Central Regional Dental Testing Service, Inc. *Dental Examination Candidate Manual, Class of 2020.* Topeka, KS: CRDTS. At: https://www.crdts.org/uploads/2020%20DENTAL%20CANDIDATE%20MANUAL.pdf . Accessed 20 Jan. 2020.
5. Cizek GJ, Bunch MB. *Standard Setting: A Guide to Establishing and Evaluating Performance Standards on Tests.* Thousand Oaks, CA: Sage, 2007.
6. Mattar J, Hambleton RK, Copella JM, Finger, MS. Reviewing or revalidating performance standards on credentialing examinations. In G. J. Cizek (Ed.), *Setting Performance Standards: Concepts, Methods, and Innovations* (pp. 399-412). New York: Routledge, 2012.

Appendix

Example WREB Dental Examination Individual Performance Report



WREB
A National Dental and Dental Hygiene Testing Agency

Dental Individual Performance Report

Doe, John (A101)
555 N. Street Rd.
City, State 90000
United States

OPERATIVE
New York University * - Mar 21 - Mar 24 2019

Prep Procedure #1 Posterior Composite	Median Score	Weight Factor	Score
Outline and Extension	4.00	46.0%	1.840
Internal Form	3.00	39.0%	1.170
Operative Environment	3.00	15.0%	0.450
	Posterior Composite Prep Score:		3.460

Finish Procedure #1 Posterior Composite	Median Score	Weight Factor	Score
Anatomical Form	3.00	36.5%	1.095
Margins	3.00	36.5%	1.095
Finish	3.00	27.0%	0.810
	Posterior Composite Finish Score:		3.000

Procedure #1 Score: 3.23

Prep Procedure #2 Anterior Composite	Median Score	Weight Factor	Score
Outline and Extension	3.00	46.0%	1.380
Internal Form	3.00	39.0%	1.170
Operative Environment	3.00	15.0%	0.450
	Anterior Composite Prep Score:		3.000

Finish Procedure #2 Anterior Composite	Median Score	Weight Factor	Score
Anatomical Form	4.00	36.5%	1.460
Margins	4.00	36.5%	1.460
Finish	3.00	27.0%	0.810
	Anterior Composite Finish Score:		3.730

Procedure #2 Score: 3.37

Operative Section Score: 3.30 Pass

ENDODONTIC
New York University * - Mar 21 - Mar 24 2019

Anterior	Median Score	Weight Factor	Score
Access	4.00	27.0%	1.080
Condensation	4.00	46.0%	1.840

Posterior	Median Score	Weight Factor	Score
Access	3.00	27.0%	0.810

Endodontic Section Score: 3.73 Pass

COMPREHENSIVE TREATMENT PLANNING (CTP)

CTP Section Score: 3.40 Pass

PERIODONTICS
New York University * - Mar 21 - Mar 24 2019

Treatment:		Score
		100.00%
Periodontics Section Score:	100.00%	Pass

A score of 3.00 (or 75% or higher on Periodontics) reflects the standard for demonstrating competence. Completion of the core exam requires passing the three sections, Operative, Endodontics and CTP, within twelve (12) months. If any of the three core sections is failed, the WREB Exam is failed until the failed section(s) is/are passed within the required twelve (12) month period. If the failed section(s) is/are not passed within twelve (12) months, all three core sections must be taken again. Many individual state licensing bodies also require passing performance on the Periodontal or Prosthodontics sections, in addition to the WREB Core Sections (Operative, Endodontics and Comprehensive Treatment Planning).
You should review the Dental Candidate Guide for detailed scoring information and requirements.
Additional details regarding performance are provided for your information. Please note that performance within each section is likely to vary more than overall clinical or written score across subsequent examination performances. Candidates retaking sections are encouraged to consider all content categories in preparation.

Important Document - Maintain for your records

Page 1 of 2

WREB
A National Dental and Dental Hygiene Testing Agency

Dental Individual Performance Report

Doe, John (A101)
555 N. Street Rd.
City, State 90000
United States

PROSTHODONTIC
New York University* - Mar 21 - Mar 24 2019

Anterior Crown	Median Score	Weight Factor	Score
Occlusal Reduction	3.00	30.0%	0.900
Axial Reduction	4.00	25.0%	1.000
Margins & Finish Line	4.00	35.0%	1.400
Operative Environment	4.00	10.0%	0.400
	Anterior Crown Prep Score:		3.700

Anterior Bridge Abutment	Median Score	Weight Factor	Score
Occlusal Reduction	4.00	30.0%	1.200
Axial Reduction	4.00	25.0%	1.000
Margins & Finish Line	3.00	35.0%	1.050
Operative Environment	4.00	10.0%	0.400
	Anterior Bridge Abutment Prep Score:		3.650

Posterior Bridge Abutment	Median Score	Weight Factor	Score
Occlusal Reduction	4.00	30.0%	1.200
Axial Reduction	4.00	25.0%	1.000
Margins & Finish Line	3.00	35.0%	1.050
Operative Environment	4.00	10.0%	0.400
	Posterior Bridge Abutment Prep Score:		3.650

Prosthodontic Section Score:	3.67	Pass

A score of 3.00 (or 75% or higher on Periodontics) reflects the standard for demonstrating competence. Completion of the core exam requires passing the three sections, Operative, Endodontics and CTP, within twelve (12) months. If any of the three core sections is failed, the WREB Exam is failed until the failed section(s) is/are passed within the required twelve (12) month period. If the failed section(s) is/are not passed within twelve (12) months, all three core sections must be taken again. Many individual state licensing bodies also require passing performance on the Periodontal or Prosthodontics sections, in addition to the WREB Core Sections (Operative, Endodontics and Comprehensive Treatment Planning).
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Additional details regarding performance are provided for your information. Please note that performance within each section is likely to vary more than overall clinical or written score across subsequent examination performances. Candidates retaking sections are encouraged to consider all content categories in preparation.

Important Document - Maintain for your records

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING MINUTES
December 11, 2020

TIME AND PLACE:

The virtual formal hearing of the Virginia Board of Dentistry was called to order at 1:47 p.m., on December 11, 2020, at the Perimeter Center, 9960 Mayland Drive, Henrico, Virginia 23233.

CALL TO ORDER:

Dr. Catchings called the meeting to order.

Consistent with Amendment 28 to HB29 (the Budget Bill for 2018-2020) and the applicable provisions of § 2.2-3708.2 in the Freedom of Information Act, the Board is convening today's meeting virtually to consider such regulatory and business matters as are presented on the agenda necessary for the board to discharge its lawful purposes, duties, and responsibilities.

Dr. Catchings provided the Board members, staff, and the public with contact information should the electronic meeting be interrupted.

BOARD MEMBERS PRESENT AT THE PERIMETER CENTER:

Sandra J. Catchings, D.D.S., Vice-President

BOARD MEMBERS PRESENT VIRTUALLY:

Sultan E. Chaudhry, D.D.S.
Perry E. Jones, D.D.S.
Margaret F. Lemaster, R.D.H.
J. Michael Martinez de Andino, J.D.

STAFF AND OTHERS PRESENT AT THE PERIMETER CENTER:

Jamie C. Sacksteder, Deputy Executive Director
Tracey Arrington-Edmonds, Licensing Manager
Essence Brown, Court Reporter

COUNSEL PRESENT AT THE PERIMETER CENTER:

James E. Rutkowski, Assistant Attorney General, Board Counsel

OTHERS PRESENT VIRTUALLY:

James E. Schliessmann, Senior Assistant Attorney General
Shevaun Roukous, Adjudication Analyst
Moustapha Sy, D.D.S., Applicant
Robert H. Gibbs, Jr., Esquire, Counsel for Applicant

ESTABLISHMENT OF A PANEL:

A roll call of the Board members and staff was completed. With five members of the Board present, a panel was established.

Moustapha Sy, D.D.S., Applicant
Case No.: 199533

Dr. Sy was present with legal counsel in accordance with the Notice of the Board dated October 30, 2020.

Dr. Catchings swore in the witnesses.

Following Mr. Gibb's opening statement, Dr. Catchings admitted into evidence Applicant's Exhibits A-D.

Following Mr. Schliessmann's opening statement, Dr. Catchings admitted into evidence Commonwealth's Exhibits 1-5.

Dr. Sy testified on his own behalf. Sandra K. Reen, Executive Director for the Board of Dentistry, was called as a witness for the Applicant and testified virtually.

Testifying virtually on behalf of the Commonwealth was Sarah Rogers, DHP Senior Investigator.

Mr. Gibbs and Mr. Schliessmann provided closing statements.

CLOSED MEETING:

Dr. Jones moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) and § 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Moustapha Sy, D.D.S. Additionally, he moved that Board staff, Tracey Arrington-Edmonds, and Board counsel, Mr. Rutkowski, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. Following a second, a roll call vote was taken. The motion passed.

RECONVENE:

A roll call was taken when the Board returned from open session, and all parties were present.

Dr. Jones 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. Following a second, a roll call vote was taken. The motion passed.

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

DECISION:

Dr. Jones moved to accept the Findings of Facts and Conclusions of Law as presented by the Commonwealth, amended by the Board and read by Mr. Rutkowski. Following a second, a roll call vote was taken. The motion passed.

Mr. Rutkowski reported that Dr. Sy's application for a license to practice dentistry in the Commonwealth of Virginia was denied.

Dr. Jones moved the adoption of the decision as read by Mr. Rutkowski. Following a second, a roll call vote was taken. The motion passed.

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

Sandra J. Catchings, D.D.S., Vice-President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION – TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:16 p.m., on January 7, 2021, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 1, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Augustus A. Petticolas, Jr., D.D.S., President

MEMBERS PRESENT:
Nathaniel C. Bryant, D.D.S.
Sandra J. Catchings, D.D.S.
Sultan E. Chaudhry, D.D.S.
Perry E. Jones, D.D.S.
Margaret F. Lemaster, R.D.H.
J. Michael Martinez de Andino

MEMBERS ABSENT:
Patricia B. Bonwell, R.D.H., PhD
Jamiah Dawson, D.D.S.
Mike Nguyen, D.D.S.

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

STAFF PRESENT:
Sandra K. Reen, Executive Director
Jamie C. Sacksteder, Deputy Executive Direcotr
Donna M. Lee, Discipline Case Manager

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General, Board Counsel
Sean Murphy, Assistant Attorney General
Anne Joseph, Adjudication Consultant

Matthew Mower, D.D.S.
Case No.: 201957

The Board received information from Mr. Murphy in order to determine if Dr. Mower's impairment from substance abuse, and/or mental or physical incompetence constitute a substantial danger to public health and safety. Mr. Murphy reviewed the case and responded to questions.

Closed Meeting:

Dr. Catchings moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Case No. 201957. Additionally, Dr. Catchings moved that Ms. Reen, Ms. Sacksteder, Ms. Lee, and Mr. Rutkowski attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

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

DECISION: Dr. Catchings moved that the Board summarily suspend Dr. Mower's license to practice dentistry in the Commonwealth of Virginia in that he is unable to practice dentistry safely due to impairment, resulting from substance abuse, and/or mental or physical incompetence. The motion was seconded and passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:50 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING MINUTES
February 26, 2021

TIME AND PLACE:

The virtual formal hearing of the Virginia Board of Dentistry was called to order at 2:03 p.m., on February 26, 2021, at the Perimeter Center, 9960 Mayland Drive, Henrico, Virginia 23233.

CALL TO ORDER:

Dr. Petticolas called the meeting to order.

Consistent with Amendment 28 to HB29 (the Budget Bill for 2018-2020) and the applicable provisions of § 2.2-3708.2 in the Freedom of Information Act, the Board is convening today's meeting virtually to consider such regulatory and business matters as are presented on the agenda necessary for the board to discharge its lawful purposes, duties, and responsibilities.

Dr. Petticolas provided the Board members, staff, and the public with contact information should the electronic meeting be interrupted.

BOARD MEMBERS PRESENT VIRTUALLY:

Augustus A. Petticolas, Jr., D.D.S., President
Patricia B. Bonwell, R.D.H., PhD
Nathaniel C. Bryant, D.D.S.
Sandra J. Catchings, D.D.S.
Sultan E. Chaudhry, D.D.S.
Jamiah Dawson, D.D.S.
Perry E. Jones, D.D.S.
Margaret F. Lemaster, R.D.H.
J. Michael Martinez de Andino, J.D.
Dagoberto Zapatero, D.D.S.

STAFF PRESENT AT THE PERIMETER CENTER:

Sandra K. Reen, Executive Director, Board of Dentistry
Donna M. Lee, Discipline Case Manager, Board of Dentistry

COUNSEL PRESENT VIRTUALLY:

James E. Rutkowski, Assistant Attorney General

OTHERS PRESENT VIRTUALLY:

Jamie C. Sacksteder, Deputy Executive Director, Board of Dentistry
Anne Joseph, Adjudication Consultant, Administrative Proceedings Div.
M. Pamela Lima Vasquez, Court Reporter
Matthew S. Mower, D.M.D., Respondent

ESTABLISHMENT OF A QUORUM:

A roll call of the Board members and staff was completed. With ten members of the Board present, a quorum was established.

Matthew Mower, D.M.D.
Case No.: 201957

Dr. Mower was present virtually without legal counsel in accordance with the Notice of the Board dated January 13, 2021.

Dr. Mower submitted a written objection to Commonwealth's Exhibit 3.

Dr. Petticolas overruled Dr. Mower's objection and informed Dr. Mower he could address his concerns in his testimony to the Board.

Dr. Bryant and Dr. Bonwell informed the Board that they did not receive Commonwealth's Exhibit 3.

Dr. Petticolas stated that on the advice of counsel, since a quorum could be established without Dr. Bryant and Dr. Bonwell, the hearing would proceed without their participation.

Dr. Petticolas swore in the witnesses.

Following Ms. Joseph's opening statement, Dr. Petticolas admitted into evidence Commonwealth's Exhibits 1-3.

Following Dr. Mower's opening statement, Dr. Petticolas admitted into evidence Respondent's Exhibit A.

Testifying on behalf of the Commonwealth was Dr. Glenn Evans, Radford Family Dentistry; Dr. Cameron Egan, Radford Family Dentistry; Parke Slater, DHP Senior Investigator; and Pamela Twombly, Deputy Director, DHP Enforcement Division.

During the testimony of Pamela Twombly, the Board went into a closed meeting to discuss Dr. Mower's medical and mental health records.

Closed Meeting:

Dr. Catchings moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(16) of the Code of Virginia for the purpose of consideration and discussion of medical and mental health records of Matthew Mower that are excluded from the Freedom of Information Act by Virginia Code Section 2.2-3705(A)(5). Additionally, she moved that Board staff, Ms. Reen, Ms. Lee, and Board counsel, Mr. Rutkowski, Ms. Twombly, and Dr. Mower attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

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

Dr. Mower testified on his own behalf.

Closed Meeting:

Dr. Catchings moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(16) of the Code of Virginia for the purpose of consideration and discussion of medical and mental health records of Matthew Mower that are excluded from the Freedom of Information Act by Virginia Code Section 2.2-3705(A)(5). Additionally, she moved that Board staff, Ms. Reen, Ms. Lee, Board counsel, Mr. Rutkowski, and Dr. Mower attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

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

Ms. Joseph and Dr. Mower provided closing statements.

Closed Meeting:

Dr. Catchings moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) and § 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Matthew Mower, D.M.D. Additionally, she moved that Board staff, Ms. Reen, Ms. Lee, and Board counsel, Mr. Rutkowski, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. Following a second, a roll call vote was taken. The motion passed.

Reconvene:

Dr. Catchings 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. Following a second, a roll call vote was taken. The motion passed.

DECISION:

Dr. Catchings moved to accept the Findings of Facts and Conclusions of Law as presented by the Commonwealth, and read by Mr. Rutkowski. Following a second, a roll call vote was taken. The motion passed.

Mr. Rutkowski reported that Dr. Mower's license to practice dentistry is continued on indefinite suspension; with said suspension stayed, upon proof of entry into a contract with the Virginia Health Practitioners' Monitoring Program. Dr. Mower was also issued a reprimand and assessed a monetary penalty of $2,500.00. Dr. Mower shall not practice dentistry until the successful completion of 10 continuing education hours each in the subjects of risk management, endodontics, anger management, and safe ethical prescribing.

Dr. Catchings moved to accept the Board's decision as read by Mr. Rutkowski. Following a second, a roll call vote was taken. The motion passed.

ADJOURNMENT:

With all business concluded, the Board adjourned at 6:55 p.m.

_____
Augustus A. Petticolas, Jr., D.D.S., President

_____
Sandra K. Reen, Executive Director

_____
Date

_____
Date

VIRGINIA BOARD OF DENTISTRY
EXAM COMMITTEE MEETING MINUTES
March 5, 2021

TIME AND PLACE: The virtual Exam Committee Meeting ("Committee") of the Virginia Board of Dentistry was called to order at 9:07 a.m., on March 5, 2021, at the Perimeter Center, 9960 Mayland Drive, Henrico, Virginia 23233.

CALL TO ORDER: Dr. Bryant called the meeting to order.

Consistent with Amendment 28 to HB29 (the Budget Bill for 2018-2020) and the applicable provisions of § 2.2-3708.2 in the Freedom of Information Act, the Board is convening today's meeting virtually to consider such regulatory and business matters as are presented on the agenda necessary for the board to discharge its lawful purposes, duties, and responsibilities.

Dr. Bryant provided the Board members, staff, and the public with contact information should the electronic meeting be interrupted.

COMMITTEE MEMBERS PRESENT VIRTUALLY:
Nathaniel C. Bryant, D.D.S., Chair
Jamiah Dawson, D.D.S.
Margaret F. Lemaster, R.D.H.
Dagoberto Zapatero, D.D.S.

OTHER PARTICIPATING BOARD MEMBERS PRESENT VIRTUALLY: Augustus A. Petticolas, Jr., D.D.S.

STAFF PRESENT AT THE PERIMETER CENTER:
Jamie C. Sacksteder, Deputy Executive Director, Board of Dentistry
Donna M. Lee, Discipline Case Manager, Board of Dentistry

OTHERS PRESENT VIRTUALLY:
Sandra K. Reen, Executive Director, Board of Dentistry
Richard Archer, D.D.S., VCU School of Dentistry, Board Consultant

ESTABLISHMENT OF A QUORUM: A roll call of the Board members and staff was completed. With four members of the Committee present, a quorum was established.

PUBLIC COMMENT: Dr. Bryant explained the parameters for public comment and opened the public comment period. Dr. Bryant also stated that written comments were received from Brett Seigel, Dr. Bruce D. Horn, Dr. Frank Iuorno, Jr., and Tracey Martin, R.D.H, which were sent by email to Committee members and will be posted with the draft minutes.

Brett Seigel, VCU ASDA Chapter President Elect – Mr. Seigel addressed the Committee concerning the negative impact of using human subjects in clinical licensing examinations by candidates seeking a dental license, which the ASDA is convinced is flawed and unethical. The ASDA would support alternatives that are preferable to the current process of using human subjects.

Bruce D. Horn, D.D.S., Director of Dental Examinations with the Western Regional Examination Board – Dr. Horn stated that it was not the content of the WREB examination that is in question; however, the score report seems to be an issue with the Board. He submitted the current WREB score report that has been used for about one year, which contains the Operative score of each procedure, Class III anterior composite, and Class II alloy or composite that is clearly detailed for conjunctive assessment by the Board. Dr. Horn requested that candidates who use the WREB exam be permitted to come to Virginia with those results.

APPROVAL OF MINUTES:

Dr. Bryant asked if there were any edits or corrections to the January 31, 2020 minutes. Ms. Lemaster stated that the time for the adjournment of the meeting has 11:27 p.m. instead of 11:27 a.m. Dr. Zapatero moved to approve the minutes with the correction noted by Ms. Lemaster. Following a second, a roll call vote was taken. The motion passed.

EXAM ACTION TIMELINE AND EXAM COMPARISON:

Dr. Bryant stated that the Board voted to have the Exam Committee discuss the testing agency exams in more detail, consider a timeframe to require passage of the ADEX exam, and report its findings to the Board.

Ms. Sacksteder reviewed the exam action timeline, which started in November 2019 through December 2020, and discussed the outcome and/or recommendations from each meeting. She also explained the dental exams chart, dental hygiene exams chart, and the ADA exam comparison chart.

Dr. Archer stated that VCU has only used ADEX for the last five years. He also stated that the manikin exam has really evolved and that ADEX is accepted in all states except for Delaware and New York. Dr. Archer answered questions from the Committee pertaining to the cost comparison for students to take the exam, the quality of the typodont used for testing, what parties would feel aggrieved if only the ADEX exam is accepted, and test preparation differences between live patients and a typodont.

Dr. Archer further explained that there are fewer differences for the dental hygiene exam and it is a successful and reliable exam. Ms. Lemaster informed the Committee that there are 5 different typodonts and the selection is randomized, and is not able to be memorized.

ADEX EXAM:

Ms. Sacksteder reiterated that the ADEX acceptance map indicated that the exam is not accepted in New York and Delaware for dentists; and the ADEX acceptance map for dental hygiene showed the exam is not accepted in Nebraska, Delaware and Georgia.

Ms. Lemaster moved that the Committee recommend to the Board that it only accept the ADEX Exam for dentists. Following a second, a roll call vote was taken. The motion passed.

Ms. Lemaster moved that the Committee recommend to the Board that it only accept the ADEX Exam for dental hygiene. Following a second, a roll call vote was taken. The motion passed.

PROPOSED DEFINITIONS:

Ms. Sacksteder explained the proposed drafted language for the following definitions: Clinical Competency Exam; Compensatory Scoring; Conjunctive Scoring; and Substantially Equivalent. She informed the Committee that the Executive Director recommended that the definition for Clinical Competency Exam be changed to read as follows: "means a formal test of knowledge and proficiency in the evaluation, diagnosis, and treatment of dental conditions and the prevention of dental diseases which includes live patient and/or manikin based testing methods to demonstrate the skills needed to safely provide care and treatment of patients."

After discussion, the Committee unanimously agreed by consensus to change the word "proficiency" to "competence" in the proposed definition recommended by the Executive Director for Clinical Competency Exam.

Ms. Lemaster moved that the Committee recommend to the Board that it adopt the definitions, as amended, into regulations and/or guidance document and applications. Following a second, a roll call vote was taken. The motion passed.

REQUIRED CLINICAL EXAM COMPONENTS FOR DENTAL APPLICANTS:

Ms. Sacksteder provided an overview of the required clinical exam components and scoring requirements for dental applicants by examination and credentials. The Committee agreed by consensus to accept the exam components and scoring requirements presented.

Dr. Dawson moved that the Committee recommend to the Board to adopt the amended required clinical exam components for dental applicants into regulations. Following a second, a roll call vote was taken. The motion passed.

REQUIRED CLINICAL EXAM COMPONENTS FOR DENTAL HYGIENE APPLICANTS:

Ms. Sacksteder presented the required clinical exam components and scoring requirements for dental hygiene applicants by examination and credentials.

Dr. Dawson moved that the Committee recommend to the Board to adopt the required clinical exam components for dental hygiene applicants into regulations. Following a second, a roll call vote was taken. The motion passed.

Dr. Petticolas moved that the Committee address with Board counsel at the March Board meeting a recommendation that requires clinical exam components for dental and dental hygiene applicants be adopted into the applications and/or guidance document. Following a second, a roll call vote was taken. The motion passed.

SCORE CARDS:

Ms. Sacksteder provided sample score cards and reports that are received by the Board from applicants in the past and also reviewed the drafted language for acceptable score cards and reports.

Dr. Dawson moved that the Committee recommend to the Board to adopt these required components of a score card into regulation and/or guidance document and applications. Following a second, a roll call vote was taken. The motion passed.

Dr. Dawson moved that the Committee address with Board counsel at the March Board meeting a recommendation that required components of a score card be added into the applications and/or guidance document. Following a second, a roll call vote was taken. The motion passed.

ADJOURNMENT: With all business concluded, the Committee adjourned at 10:55 a.m.

Nathaniel C. Bryant, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

Dear Board of Dentistry and Exam Committee,

Each year thousands of Americans are used as test subjects in clinical licensing examinations by candidates seeking a dental license. Irreversible surgical procedures are performed on these patients without the same comprehensive supervision they typically receive within an accredited dental school setting to ensure their protection. The outcomes of these clinical exams never result in a 100 percent pass rate; and failure rates have been as high as 80 percent in some years. These failed procedures left patients with substandard dental surgery outcomes and the need to seek follow-up care from a licensed dentist to restore the failed procedures. Despite the best efforts of the dental candidates and those proctoring the examinations, not all test subjects receive follow-up care and could suffer from permanent damage to their teeth. The use of human subjects in clinical dental licensing examinations began in the early 1900s; and the debate over the validity, reliability and ethical nature of this practice has been widespread within dentistry for more than half a century. Despite the dialogue, thousands of Americans are still being used each year as test subjects in these examinations. Alternatives exist, though the vast majority of state dental boards have ignored the glaring reliability, validity and ethical issues that accompany the administration of clinical licensure examinations. Members of the American Student Dental Association (ASDA)—the students who are required to perform irreversible surgical procedures on our fellow man— stand firm in our conviction that the practice of using human subjects in clinical licensing examinations is flawed and unethical. Patients should not be put into a situation where there is a possibility they will receive substandard treatment that may irreparably harm them. We stand by the American Dental Association (ADA), the American Dental Education Association (ADEA), the Student Professionalism and Ethics Association in Dentistry (SPEA) and many dental school deans across the country, among others, who believe that to protect the public, maintain the integrity of the profession of dentistry and ensure that only competent dental school graduates can gain a dental license, performing exams on human subjects in a high-stakes, one-shot scenario must end. ASDA understands alternatives that are preferable to the current process exist, however the Association believes an ideal licensure exam:

- Does not use human subjects in a live clinical testing scenario
- Is psychometrically valid and reliable in its assessment
- Is reflective of the scope of current dental practice
- Is universally accepted

The Best,

Brett Siegel

VCU ASDA Chapter President Elect

Commonwealth of Virginia

Lee, Donna <donna.lee@dhp.virginia.gov>

Fwd: WREB Dental Examination Individual Scoring Report

1 message

Sacksteder, Jamie <jamie.sacksteder@dhp.virginia.gov> Thu, Mar 4, 2021 at 10:30 AM
To: Donna Lee <donna.lee@dhp.virginia.gov>

From: Bruce Horn <bdhorn@sbcglobal.net>
Sent: Wednesday, March 3, 2021 11:39:26 AM
To: [redacted] Beth Cole <bcole@wreb.org>; sharon Popp <sosbornpopp@wreb.org>
Subject: WREB Dental Examination Individual Scoring Report

Dr. Bryant,
I am attaching the current WREB score report available to all state Dental Boards. As I mentioned the Operative score of each procedure , Class III anterior composite and class II alloy or composite, is clearly detailed for conjunctive assessment by the Virginia Board. Please have staff replace the incorrect WREB document that appears on Page 25 of the Examination Committee minutes of January 31,2020 with the attachment please for your consideration in continuing to allow candidates to successfully apply for initial licensure in Virginia.
Thank you for your time in speaking with me this morning and it is my hope that qualified applicants can continue to seek licensure in your state.

Bruce D.Horn, DDS
Director of Dental Examinations
Western Regional Examining Board

RECEIVED
MAR 03 2021
Virginia Board of Dentistry

WREB Sample Dental Score Report(3).pdf
688K

Sample WREB Dental Examination Individual Performance Report

WREB
A National Dental and Dental Hygiene Testing Agency

Dental Individual Performance Report

Doe, John (A101)
555 N. Street Rd.
City, State 90000
United States

OPERATIVE

New York University * - Mar 21 - Mar 24 2019

Prep Procedure #1 Posterior Composite	Median Score	Weight Factor	Score
Outline and Extension	4.00	46.0%	1.840
Internal Form	3.00	39.0%	1.170
Operative Environment	3.00	15.0%	0.450
	Posterior Composite Prep Score:		3.460

Finish Procedure #1 Posterior Composite	Median Score	Weight Factor	Score
Anatomical Form	3.00	36.5%	1.095
Margins	3.00	36.5%	1.095
Finish	3.00	27.0%	0.810
	Posterior Composite Finish Score:		3.000

Procedure #1 Score:	3.23

Prep Procedure #2 Anterior Composite	Median Score	Weight Factor	Score
Outline and Extension	3.00	46.0%	1.380
Internal Form	3.00	39.0%	1.170
Operative Environment	3.00	15.0%	0.450
	Anterior Composite Prep Score:		3.000

Finish Procedure #2 Anterior Composite	Median Score	Weight Factor	Score
Anatomical Form	4.00	36.5%	1.460
Margins	4.00	36.5%	1.460
Finish	3.00	27.0%	0.810
	Anterior Composite Finish Score:		3.730

Procedure #2 Score:	3.37

Operative Section Score:	3.30	Pass

ENDODONTIC

New York University * - Mar 21 - Mar 24 2019

Anterior	Median Score	Weight Factor	Score
Access	4.00	27.0%	1.080
Condensation	4.00	46.0%	1.840

Posterior	Median Score	Weight Factor	Score
Access	3.00	27.0%	0.810

Endodontic Section Score:	3.73	Pass

COMPREHENSIVE TREATMENT PLANNING (CTP)

CTP Section Score:	3.40	Pass

PERIODONTICS

New York University * - Mar 21 - Mar 24 2019

Treatment:	Score 100.00%
Periodontics Section Score: 100.00%	Pass

A score of 3.00 (or 75% or higher on Periodontics) reflects the standard for demonstrating competence. Completion of the core exam requires passing the three sections, Operative, Endodontics and CTP, within twelve (12) months. If any of the three core sections is failed, the WREB Exam is failed until the failed section(s) is/are passed within the required twelve (12) month period. If the failed sections(s) is/are not passed within twelve (12) months, all three core sections must be taken again. Many individual state licensing bodies also require passing performance on the Periodontal or Prosthodontics sections, in addition to the WREB Core Sections (Operative, Endodontics and Comprehensive Treatment Planning).
You should review the Dental Candidate Guide for detailed scoring information and requirements.
Additional details regarding performance are provided for your information. Please note that performance within each section is likely to vary more than overall clinical or written score across subsequent examination performances. Candidates retaking sections are encouraged to consider all content categories in preparation.

Important Document - Maintain for your records

Page 1 of 2

WREB
A National Dental and Dental Hygiene Testing Agency

Dental Individual Performance Report

Doe, John (A101)
555 N. Street Rd.
City, State 90000
United States

PROSTHODONTIC
New York University * - Mar 21 - Mar 24 2019

Anterior Crown	Median Score	Weight Factor	Score
Occlusal Reduction	3.00	30.0%	0.900
Axial Reduction	4.00	25.0%	1.000
Margins & Finish Line	4.00	35.0%	1.400
Operative Environment	4.00	10.0%	0.400
		Anterior Crown Prep Score:	3.700

Anterior Bridge Abutment	Median Score	Weight Factor	Score
Occlusal Reduction	4.00	30.0%	1.200
Axial Reduction	4.00	25.0%	1.000
Margins & Finish Line	3.00	35.0%	1.050
Operative Environment	4.00	10.0%	0.400
		Anterior Bridge Abutment Prep Score:	3.650

Posterior Bridge Abutment	Median Score	Weight Factor	Score
Occlusal Reduction	4.00	30.0%	1.200
Axial Reduction	4.00	25.0%	1.000
Margins & Finish Line	3.00	35.0%	1.050
Operative Environment	4.00	10.0%	0.400
		Posterior Bridge Abutment Prep Score:	3.650

Prosthodontic Section Score:	3.67	Pass

A score of 3.00 (or 75% or higher on Periodontics) reflects the standard for demonstrating competence. Completion of the core exam requires passing the three sections, Operative, Endodontics and CTP, within twelve (12) months. If any of the three core sections is failed, the WREB Exam is failed until the failed section(s) is/are passed within the required twelve (12) month period. If the failed sections(s) is/are not passed within twelve (12) months, all three core sections must be taken again. Many individual state licensing bodies also require passing performance on the Periodontal or Prosthodontics sections, in addition to the WREB Core Sections (Operative, Endodontics and Comprehensive Treatment Planning).
You should review the Dental Candidate Guide for detailed scoring information and requirements.
Additional details regarding performance are provided for your information. Please note that performance within each section is likely to vary more than overall clinical or written score across subsequent examination performances. Candidates retaking sections are encouraged to consider all content categories in preparation.

Important Document - Maintain for your records

Virginia Dental ASSOCIATION | 150 YEARS

March 4, 2021

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Mayland Dr., Suite 300
Henrico, VA 23233

Dear Ms. Reen and Members of the Board,

I'm writing on behalf of the Virginia Dental Association in sharing the priorities of VDA members in reforming dental licensure.

We applaud the board's consideration for permanently moving beyond the single encounter, procedure-based examinations on patients. This approach has been demonstrated to be subject to random error; is not reflective of the broad set of skills and knowledge expected of a dentist; and poses ethical challenges for test-takers, dental schools and the dental profession.

The VDA believes that replacing these single encounter exams on a permanent basis with clinical assessments that have stronger validity and reliability evidence is in the best interest of patients, students and the dental healthcare profession.

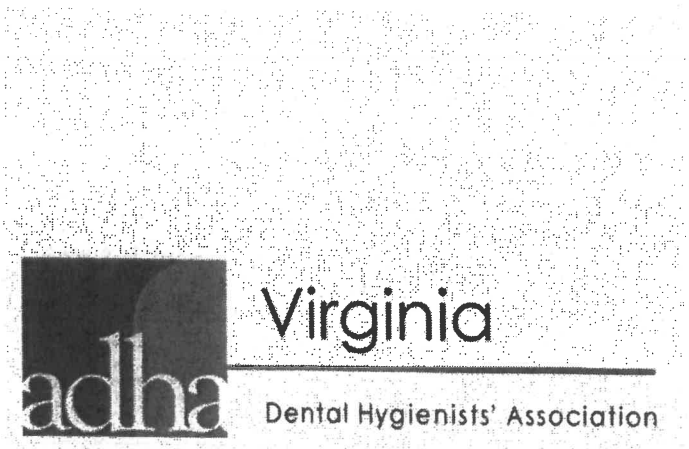
We also urge the Board to consider license portability in your deliberations. About half of VDA members went to dental school outside of Virginia. We also have a significant military presence, which includes a population of dentists and family members of those serving who frequently move. Having a straightforward process for becoming licensed in the Commonwealth that is consistent with the direction other states in the country are moving would help smooth those transitions and ease what can be a time consuming and costly barrier to dentists providing quality oral healthcare in Virginia.

Finally, as careful thought is given to dental licensure, parallel consideration should be given to licensure and portability of licensure for dental hygienists as they are an integral part of our oral healthcare system.

Thank you for your consideration.

Sincerely,

Dr. Frank Iuorno, Jr.
President
Virginia Dental Association



March 4, 2021

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Mayland Dr., Suite 300
Henrico, VA 23233

Dear Ms. Reen and Members of the Board,

The Virginia Dental Hygienists' Association strongly supports the board shifting from the single encounter, procedure-based examinations on patients as part of licensure for dental hygienists and dentists in Virginia. Our experience with last year's examination has shown that there are other options for clinical assessments that can reliably evaluate candidates for licensure, without the ethical challenges posed by single encounter, procedure-based examinations on patients.

This change could also put Virginia in line with the direction in which other states are moving, and lessen the burden faced by hygienists coming to Virginia through enhanced license portability

Thank you for your consideration.

Sincerely,

Tracey C Martin

Tracey Martin, BSDH, RDH

VDHA President

Exam Committee Report

Dentists Recommendations

Recommendation: Only Accept ADEX Dental Exam for licensure by examination

- **Rationale:**
  - Portability is not an issue because the ADEX exam is accepted for initial licensure in 48 of 50 states (not NY or DE).
  - The ADEX exam is administered by CITA and CDCA and the Board is a member of ADEX and CITA. Therefore, will know of any changes in the exam ahead of time and will also be a part of the discussion of any changes.
  - The ADEX exam covers the required components which the Board wants in an exam (Diagnostic Skills Examination, Endodontics, Fixed prosthodontics, Periodontics, and Restorative)
  - Utilizes Conjunctive Scoring methods only
  - for how Board Staff reviews applications.

Recommendation: For the Board to only accept the following exam components and scoring for Dental Applicants by Examination written in a guidance document and application:

- Every candidate must pass **each** individual component with only conjunctive scoring and no compensatory scoring with a **minimum passing score of 75%** for each of the following required components:
  - **Diagnostic Skills Examination**
  - **Endodontics**, including access opening of a posterior tooth and access, canal instrumentation, and obturation of an anterior tooth;
  - **Fixed prosthodontics**, including an anterior crown preparation and two posterior crown preparations involving a fixed partial denture factor;
  - **Periodontics**, including scaling and root planing;
  - **Restorative**, including a class II amalgam or composite preparation and restoration, and a class III composite preparation and restoration.

Recommendation: For the Board to continue accepting the passage of exams by all 5 testing agencies for Dental Applicants by Endorsement with the following requirements written in regulation, guidance document, and/or application:

- Every candidate must pass **each** individual component with a **minimum passing score of 75%** for each of the following required components:
  - **Diagnostic Skills Examination** (ADEX = CDCA and CITA) or **Comprehensive Treatment Planning** (WREB). **SRTA and CRDTS** do not have an exam component that is equivalent to the Diagnostic Skills Examination or the Comprehensive Treatment Planning.
  - **Endodontics**, including access opening of a posterior tooth and access, canal instrumentation, and obturation of an anterior tooth;

- **Fixed prosthodontics**, including an anterior crown preparation and two posterior crown preparations involving a fixed partial denture factor;
- **Periodontics**, including scaling and root planing;
- **Restorative**, including a class II amalgam or composite preparation and restoration, and a class III composite preparation and restoration.

AND

- Have been in continuous clinical practice in another jurisdiction of the United States or in federal civil or military service for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in another jurisdiction of the United States (i) as a volunteer in a public health clinic, (ii) as an intern, or (iii) in a residency program may be accepted by the board to satisfy this requirement. One year of clinical practice shall consist of a minimum of 600 hours of practice in a calendar year as attested by the applicant

Recommendation: If the Board accepts the acceptance of only the ADEX exam for Dental Applicants by examination to create a date in the future when this will be in effect.

- Dr. Archer, Consultant to the Board, recommends January 2023 for implementation.

Rationale: Would give applicants enough time to inform applicants of the change and letting them have enough time to adjust to the new requirements.

Dental Hygienists Recommendations

Recommendation: Only Accept ADEX for Dental Hygiene for licensure by examination.

- **Rationale:**
  - ADEX is administered by CITA and CDCA and the Board is a member of CITA and ADEX. Therefore, will know of any changes in the exam ahead of time and will also be a part of the discussion of any changes.
  - The ADEX is accepted in 45 of 50 states as initial licensure (not in CA,DE, GA, ND, or NE)
  - ADEX exam cover the required components which the Board wants in an exam (Treatment Clinical Examination, including calculus detection and removal, periodontal pocket depth measurements, and tissue management and a Computer Simulated Clinical Examination, including assessing various levels of diagnosis and treatment planning knowledge, skills, and abilities)
  - Utilizes Conjunctive Scoring methods only
- **Note**: The Dental Hygiene Exams across all 5 testing agencies seems to be equivalent in exam components and scoring.

Recommendation: For the Board to only accept the following exam components and scoring for Dental Hygiene Applicants by Examination written in regulation, guidance document, and/or application:

Every candidate must pass each individual component with only conjunctive scoring and no compensatory scoring and a minimum passing score of 75% for each of the following required components:

- **Treatment Clinical Examination,** including calculus detection and removal, periodontal pocket depth measurements, and tissue management.
- **Computer Simulated Clinical Examination,** including assessing various levels of diagnosis and treatment planning knowledge, skills, and abilities.

Rationale: These are the components and scoring methodology the Board agreed upon in March of 2020.

Recommendation: For the Board to continue accepting the passage of exams by all 5 testing agencies for Dental Hygiene Applicants by Endorsement with the following requirements written in regulation, guidance document, and/or application:

Every candidate must pass each individual component with a minimum passing score of 75% for each of the following required components:

- **Treatment Clinical Examination**, including calculus detection and removal, periodontal pocket depth measurements, and tissue management.
- **Computer Simulated Clinical Examination,** including assessing various levels of diagnosis and treatment planning knowledge, skills, and abilities.

AND

- Be currently licensed to practice dental hygiene in another jurisdiction of the United States and have clinical, ethical, and active practice for 24 of the past 48 months immediately preceding application for licensure.

Rationale: Experience is what is most important in regards to Applicants by Endorsement.

Recommendation: If the Board accepts the acceptance of only the ADEX exam for Dental Hygiene Applicants by examination to create a date in the future when this will be in effect.

- Dr. Archer, Consultant to the Board, recommends January 2023 for implementation.

Rationale: Would give applicants enough time to inform applicants of the change and letting them have enough time to adjust to the new requirements.

General Recommendations

Recommendation: To accept the following definitions to be adopted in a guidance document, application, and/or regulations.

- "**Clinical Competency Exam**" means a formal test of knowledge and competence in the evaluation, diagnosis, and treatment of dental conditions and the prevention of dental diseases which includes live patient and/or manikin based testing methods to demonstrate the skills needed to safely provide care and treatment of patients.

- **"Compensatory Scoring"** is a scoring methodology which allows for strong performance in one content area to compensate for poor performance in another content area as long as the overall score meets the performance standard.
- **"Conjunctive Scoring"** is a scoring methodology which requires that performance standards be met for each specified content area.
- **"Substantially Equivalent"** means any examination taken for another jurisdiction which is equivalent in content and degree of difficulty, respectively, to those requirements for licensure by examination.

Rationale:

  - This will make the expectations of applicants much clearer and will prevent confusion **Rationale**: Experience is what is most important in regards to Applicants by Endorsement.

Recommendation: For the Board to only the accepting the following requirements, in regards to score cards, in regulation, guidance document, and/or application:

- An original and detailed score card or report from the testing agency documenting passage of a clinical competency examination. Candidate's score cards are not acceptable. All score cards or reports must be requested by the applicant. (Canadian exams are not accepted.) Certificates are not accepted. (Must be mailed to the Board or if applicable, you must contact the testing agency to request that your test results be made available to the Virginia Board of Dentistry via online access portal.) For WREB (Western Regional Examining Board) you must request an IPR detailed report.
- **For Dental Licensure by Examination**: Score cards must show conjunctive scoring of the required clinical competency exam components. The score cards must show a pass (equivalent to at least 75%) or a fail.

- If an applicant has not passed the clinical competency exam, a score card is still required to be submitted. The applicant must notify the Board of all previously failed attempts of the clinical competency exam. Applicants must submit score cards for each attempt of the clinical competency exam.
- Applicants who successfully completed a clinical competency examination five or more years prior to the date of receipt of their applications for licensure by this board may be required to retake an examination or take continuing education that meets the requirements of 18VAC60-21-250 unless they demonstrate that they have maintained clinical, ethical, and legal practice in another jurisdiction of the United States or in federal civil or military service for 48 of the past 60 months immediately prior to submission of an application for licensure.

Rationale: Scoring methodology is not evident on a score cards provided. It is impossible for Board Staff to determine if a score card is conjunctive or compensatory scoring. Also, information from the testing agencies are proprietary and they are not required to give us the information. For a Board Staff to also try to make the determination based upon the year they took the test and compare the information, would be impossible. Also, in the past, applicants have taken the exam several times and have not passed and the Board has no way of knowing this without the applicant submitting all score cards for all exam taken.

Virginia Department of Health Professions
Board of Health Professions

Board of Health Professions
***VIRTUAL* - Full Board Meeting**
January 21, 2021 at 10:00 a.m.

DRAFT

An audio file of this meeting may be found here
https://www.dhp.virginia.gov/audio/BHP/FullBoardMeeting01212021.mp3

CALL TO ORDER - Dr. Jones, Jr.

Dr. Jones, Jr. called the virtual meeting to order at 10:00 a.m. Quorum was established with 17 members in attendance.

EMERGENCY EGRESS - Dr. Carter

Dr. Carter provided evacuation procedures for members in physical attendance.

ROLL CALL

VIRTUAL ATTENDEES: BOARD OF HEALTH PROFESSIONS

Dr. Alison King, Board of Audiology & Speech-Language Pathology
Dr. Kevin Doyle, Board of Counseling
Dr. Sandra Catchings, Board of Dentistry
Derrick Kendall, Board of Long-Term Care Administrators
Dr. Brenda Stokes, Board of Medicine
Louise Hershkowitz, Board of Nursing
Dr. Helene Clayton-Jeter, Board of Optometry
Ryan Logan, Board of Pharmacy
Dr. Herb Stewart, Board of Psychology
John Salay, Board of Social Work
Dr. Steve Karras, Board of Veterinary Medicine
Sheila Battle, Citizen Member
Sahil Chaudhary, Citizen Member
Dr. Martha Rackets, Citizen Member
Carmina Bautista, Citizen Member
James Wells, Citizen Member

BOARD MEMBERS ABSENT:

Louis Jones, Board of Funeral Directors and Embalmers

VIRTUAL ATTENDANCE: DHP STAFF & GUESTS

Dr. Allison-Bryan, Agency Chief Deputy Director
Elaine Yeatts, Agency Senior Policy Analyst
Dr. Yetty Shobo, Deputy Executive Director for the Board
Rajana Siva, Research Analyst for the Board
Dr. William Harp, Executive Director for the Board of Medicine
Kim Small, VisualResearch, Inc.
Neal Kauder, Visual Research, Inc.
Sandra Reen, Executive Director for the Board of Dentistry

VIRTUAL ATTENDANCE: DHP STAFF & GUESTS cont'd

Corie Tillman-Wolf, Executive Director for the Boards of Funeral Directors & Embalmers, Long-Term Care Administrators and Physical Therapy

PHYSICAL ATTENDANCE AT PERIMETER CENTER:

Dr. Elizabeth Carter, Executive Director for the Board
Dr. Allen Jones, Jr., Board of Physical Therapy
Laura Jackson, Operations Manager for the Board
Matt Treacy, Media Production Specialist

VIRTUAL ATTENDANCE: PUBLIC

Christina Barrille
Jetty Gentile
Karen Winslow

WELCOME NEW BOARD MEMBERS - Dr. Jones, Jr.

Dr. Jones, Jr., welcomed Dr. Catchings, Dr. Stokes and Carmina Bautista to the Board.

THANK YOU TO OUTGOING BOARD MEMBERS - Dr. Jones, Jr.

Dr. Jones, Jr., thanked outing going board members Dr. Watkins Dr. O'Connor and Maribel Ramos.

MEETING AGENDA - JANUARY 21, 2021

The Meeting agenda was approved as presented. A motion was made and properly seconded with all member in favor, none opposed.

PUBLIC COMMENT - Dr. Jones, Jr.

Ms. Cindy Warriner provided comment on her concern of potential Board of Pharmacy censure.

APPROVAL OF AUGUST 2O, 2020 FULL BOARD MEETING MINUTES - Dr. Jones, Jr.

The meeting minutes from the August 20, 2020 Full board meeting were approved as presented. A motion was made and properly seconded with all members in favor, none opposed.

DIRECTOR'S REPORT- Dr. Allison-Bryan

Dr. Allison-Bryan provided Dr. Brown's remarks as he was at a General Assembly committee meeting. The Board of Health Professions prepared two major studies in 2020, Diagnostic Medical Sonographers and Naturopathic Doctors. As of today, the naturopathic doctor House bills presenty have been "passed by" at the General Assembly. Two Senate bills are pending. Dr. Allison-Bryan provided an update on the research she gathered for the follow-up on "keepsake" sonography. She advised that the research reflects that fetal ultrasounds, performed by non-sonography licensed individual poses little harm to the fetus. The practice of "keepsake" sonography is discourage by the FDA and several professioal medical organizations.

LEGISLATIVE & REGULATORY REPORT - Ms. Yeatts

Assembly that directly impact DHP. This information is provided in the agenda meeting documents. (Attachment 1)

SANCTION REFERENCE POINTS UPDATE - Mr. Kauder

Mr. Kauder provide a presentation on the Sanctioning Reference Point system updates. The presentation is included in the agenda meeting documents.

BREAK 11:20 -11:30 a.m.

BOARD CHAIR REPORT - Dr. Jones, Jr.

Dr. Jones, Jr. stated how much of an honor it was to serve as Chair for two consecutive years. He thanked those who attended in person and those who attended virtually for being such a wonderful team. He thanked the Board for their vote of confidence in his leadership and is looking forward to new leadership and how the next Chair will lead the Board through this pandemic.

NOMINATING COMMITTEE REPORT - Ms. Hershkowitz

Ms. Hershkowitz, Chair of the Nominating Committee, provided the Board with the slate of officers that was adopted at the 9:00 a.m. Nominating Committee meeting.

Chair: James Wells, RPh, Citizen Member
Dr. Steve Karras, Board of Veterinary Medicine
1st Vice Chair: Sahil Chaudhary, Citizen Member
2nd Vice Chair: Dr. Brenda Stokes, Board of Medicine

ELECTION OF OFFICERS - Dr. Jones, Jr.

The Board approved the slate of officers as presented and the vote was opened for Mr. Wells as Board Chair. Roll call voting provided 16 members in favor of Mr. Wells, with one member voting for Dr. Karras. With the majority vote, Mr. Wells was announced as Chair.

The Board agreed with the slate of officers provided by the Nominating Committee for Mr. Chaudhary to serve as 1st Vice Chair and Dr. Stokes to serve as 2nd Vice Chair.

Dr. Jones, Jr. congratulated the newly appointed officers of the Board.

EXECUTIVE DIRECTOR'S REPORT - Dr. Carter

Dr. Carter provided an overview of the Board's budget, along with the agencies statistics and performance measures. A link was provided in the meeting agenda for board members to review the agencies 2019-2020 Biennial Report.

HEALTHCARE WORKFORCE DATA CENTER - Dr. Shobo

Dr. Shobo provided an update of the workforce profession reports that were finalized in 2020, as well as ways that the Center is assisting various entities with workforce data.

INDIVIDUAL BOARD REPORTS

Board of Audiology & Speech-Language Pathology (Attachment 2)

Board of Counseling - Dr. Doyle

The Board will be considering the conversion therapy regulations at the next meeting, which is scheduled for February 15, 2021. A compact is emerging for counseling that is in the roll out phase. The Board is working on a guidance document for telehealth as many have moved their services online during the pandemic. Current regulations will need additional language to guide safe and ethical practice.

Board of Dentistry - Dr. Catchings

Due to COVID-19 dental students preparing for graduation and licensure by the Board of Dentistry were unable to perform a live patient exam. The Board came up with a way to allow students to perform an exam involving artificial teeth that would qualify them for licensure. The Board also arranged for graduating students to be trained on giving COVID-19 injections.

Formal hearings have been held virtually, while informal meetings are still in person. The Board is now in the beginning phase of developing emergency plans that will address how to function in a state of emergency. Such as the COVID-19 pandemic.

Board of Medicine - Dr. Stokes

Requests for waivers for electronic transmission of opioid prescriptions: As of July 1st, 2020, the regulations stated that all opiate prescriptions had to be transmitted electronically, with a stipulation that people could apply for a waiver for up to 1 year. There were 2,000 requests for waivers with some needing additional information. The statute does not allow the waiver to go past July 1, 2021.

A new licensed profession for the Board is surgical assistants. A surgical assistant advisory board has been created to develop regulations.

Every three years, the Board of Medicine is required to provide a list of professionals to the Supreme Court for malpractice panels. A big thank you to the executive directors and their staff that helped provided the names of professionals to be added to the list.

Reciprocity with continuous jurisdictions is currently under review. State boards were contacted by the executive directors with North Carolina, Tennessee, Kentucky and West Virginia showing no interest, while Maryland and D.C. we're open to tthe idea. Ongoing discussions continue.

Dr. Kevin O'Connor has been nominated for a leadership award that is given by the Federation of State Medical Boards.

The Board has held virtual board meetings, but the informal and formal hearings are still in person.

Board of Nursing - Ms. Hershkowitz

Ms. Hershkowitz provided an overview of the Board of Nursing's activities. (Attachment 3)

Board of Optometry - Dr. Clayton-Jeter

Dr. Clayton-Jeter provided an overview of the Board of Optometry activities. (Attachment 4)

Board of Pharmacy - Mr. Logan

Mr. Logan stated that the Board of Pharmacy voted to adopt language on the cultivation and production of cannabis oil to prohibit the production of an oil intended to be inhaled from containing vitamin E. acetate. The board also voted to adopt final regulations of cannabidiol scheduled 5 that by default places into schedule 6 for consistency. He stated that the next board meeting is scheduled on February 22, 2021.

Board of Physical Therapy - Dr. Jones, Jr.

The Board of Physical Therapy met virtually on November 7, 2020. The board updated its telehealth guidance document based upon some questions and concerns identified during the pandemic. Physical therapy licensure compact implementation has been smooth for the board and the compact became effective January 1, 2021.

Board of Psychology - Dr. Stewart

The Board of Psychology board brief is available on the agencies website. Following are a few highlights: Psychology licensee total is roughly 5,700, of which three quarters are clinical psychologist, with the remaining spread among school psychology, sex offender treatment providers, applied psychologists and trainees.

Dr. Stewart provided an update on PsyPact, noting that 15 states are participating with another nine on board. He stated that about half of the states, including most of the surrounding states around Virginia, will be on board.

There has also been a periodic review of regulations governing the practice of psychology. These regulations are in the final stage and under review by the Office of the Governor. Similarly, the Board is updating the certification of sex offender treatment provider regulations which are on the fast track for authorization.

Board of Veterinary Medicine (Attachment 5)

NEW BUSINESS - Dr. Jones, Jr.

There was no new board business brought forward.

NEXT FULL BOARD MEETING

The next Full Board meeting will be held March 4, 2021 at 10:00 a.m.

ADJOURNMENT

The meeting adjourned at 12:36 p.m.

CHAIR

SIGNATURE _____ ____/____/____

James Wells, RPh

BHP EXECUTIVE DIRECTOR

SIGNATURE _____ ____/____/____

Elizabeth A. Carter, PhD

TIME & PLACE: This virtual Regulatory-Legislative Committee meeting was called to order at 9:44 AM, on October 23, 2020 at the Perimeter Center, 9960 Mayland Drive, Henrico, Virginia 23233.

COMMITTEE MEMBERS PRESENT BY TELEPHONE:
Sandra Catchings, D.D.S., Chairing, Board Vice President
Augustus A. Petticolas, Jr., D.D.S, Board President
Patricia B. Bonwell, R.D.H., PhD
Sultan E. Chaudhry, D.D.S
Margaret F. Lemaster, R.D.H
J. Michael Martinez de Andino, J.D.

OTHER BOARD MEMBERS PRESENT BY TELEPHONE:
Nathaniel C. Bryant, D.D.S., Board Secretary
Jamiah Dawson, D.D.S.
Perry E. Jones, D.D.S.

STAFF PRESENT AT THE PERIMETER CENTER:
Sandra K. Reen, Executive Director
Jamie C. Sacksteder, Deputy Executive Director
Kathryn E. Brooks, Executive Assistant

STAFF PRESENT BY TELEPHONE:
Elaine J. Yeatts, Senior Policy Analyst
James E. Rutkowski, Assistant Attorney General

ESTABLISHMENT OF A QUORUM: With all Committee members participating, a quorum was established.

PUBLIC COMMENT: Dr. Catchings explained the parameters for public comment then opened the public comment period by calling on the registered commenters as follows:

Thomas Glazier, DDS (VCU Associate Professor) stated the concerns about the proposal to require a third person on the treatment team for moderate sedation. He said there is a 99% success rate with a two-person team. He explained that a two-person team is the standard of care set by the American Society of Anesthesiologist and American Dental Association in guidelines which are available online. He also said adding a third person is unnecessary and would be an additional cost for treating children with dental disease.

Barrett Peters, DDS (President VAPD) addressed the concerns of the American and Virginia Academies of Pediatric Dentistry about developing

regulations by an age range for pediatric patients to dental treatment under sedation to be performed in a hospital setting. He said there are not enough services for children now and that treatment in a hospital would increase costs and add another barrier to access to care for children in need of treatment. He asked the Board to move forward based on science. Dr. Peters responded when Dr. Tran was called on to comment. He said he commented in lieu of Dr. Tran.

Ryan Dunn (Executive Director, Virginia Dental Association) addressed the VDA's concerns about developing sedation regulations for a specific age range for dental procedures to be performed in a hospital setting because it will create barriers for access to care. The current ADA guidelines provides thorough guidelines and provide an evidence-based foundation for treatment under sedation.

Jonathan L. Wong, DMD (Virginia Dentist Anesthesiologist) addressed his appreciation for the professional dental organizations coming together to address the proposal to limit treatment of young children under sedation to a hospital setting would be disastrous and would delay or prevent treatment of young children. He said pediatric dentists are not getting the OR time they once did. He added that access to ambulatory surgery centers is also an issue because dental treatment is not profitable and creates an access to care. He urged at looking at science to keep patients safer.

Shravan Renapurkar (President, Virginia Society of Oral Maxillofacial Surgeons) addressed VSOMS's concerns about developing regulations younger children to have sedation procedures to be performed in a hospital setting because it will create huge access to care issues. Medical complexity is a significant factor in determining who can be treated in a hospital. He said the Board should rely on the professional guidelines in setting policy.

Dr. Catchings said the written comments received were provided to Board members and will be included in the meeting minutes for today's meeting. Dr. Catchings asked if there were corrections to the posted draft minutes. Hearing none, Dr. Petticolas moved to accept the minutes for February 28, 2020 as presented. The motion was seconded by Dr. Bonwell and passed unanimously.

COMMITTEE DISCUSSION/ACTION:

REGULATORY ACTION ON PEDIATRIC SEDATION

Dr. Catchings called for discussion on developing separate regulations for treating pediatric patients under sedation to include setting an age range in which sedation and treatment would be performed in a hospital setting.

Each member of the Board was called on to speak to this proposal. All members opposed developing separate pediatric regulations based on the comments received. Discussion moved to addressing the concerns for safety, access to care and the information needed for future discussions. This discussion led to action on the following motions recommended by Ms. Yeatts.

Dr. Catchings asked for a motion for the Committee to recommend that the Board not proceed further with regulatory action on pediatric sedation at this time. Dr. Bonwell so moved and the motion was seconded. A roll call vote was taken and the motion passed with all in favor.

Dr. Petticolas - Aye
Dr. Bonwell - Aye
Dr. Chaudhry - Aye
Ms. Lemaster - Aye
Mr. Martinez - Aye
Dr. Catchings - Aye

Dr. Catchings asked for a motion to recommend that the Board direct staff to develop a methodology to gather statistics and aggregate data on past disciplinary cases addressing pediatric morbidity/mortality in dental offices in Virginia so the findings could be used to track specific information on sedation records to assist the Board in making policy decisions. Mr. Martinez so moved and the motion was seconded.

Discussion followed on if the information is currently available, how this information would be used and on whether the staff could collect the information or if a dental expert is needed. Dr. Catchings explained that information on the drugs used, the quantity administered and other information in case records are not being tracked. She said having that information in aggregate form would assist in future cases and in developing policies. Ms. Reen explained that a dental expert is needed for consistency in the information collected and for explaining the findings. Dr. Catchings Asked for a vote on the motion. The motion passed with all in favor.

Dr. Petticolas - Aye
Dr. Bonwell - Aye

Dr. Chaudhry - Aye
Ms. Lemaster - Aye
Mr. Martinez - Aye
Dr. Catchings - Aye

PULP CAPPING BY DA II'S

Dr. Catchings asked for discussion on removing pulp capping from the scope of practice of DAs II as requested by the Board.

The Committee and other Board members unanimously agreed that this procedure should only be done by dentists because it a delicate procedure and the risks far outweigh the benefits. Ms. Yeatts stated this is a long-standing regulation. The change could be addressed in the standard regulatory action which is a long process. She suggested considering a fast track action. She asked if staff could determine how many DA II's are currently performing this procedure. Ms. Reen said she could look at the procedures each DA II is registered to perform for the December Board meeting.

Dr. Catchings asked for a motion. Dr. Petticolas moved that the Board remove, from the scope of practice, pulp capping for DAs II as a fast track action. The motion was seconded. After a comprehensive discussion, a roll call vote was taken, and the motion passed with a unanimous vote.

Dr. Petticolas - Aye
Dr. Bonwell - Aye
Dr. Chaudhry - Aye
Ms. Lemaster - Aye
Mr. Martinez - Aye
Dr. Catchings - Aye

ADJOURNMENT: With all business concluded, Dr. Catchings adjourned the meeting at 11:00AM.

Sandra Catchings D.D.S., Chair

Date

Sandra K. Reen, Executive Director

Date

VIRGINIA BOARD OF DENTISTRY
EXECUTIVE COMMITTEE MEETING MINUTES
March 5, 2021

TIME AND PLACE: The virtual Executive Committee Meeting ("Committee") of the Virginia Board of Dentistry was called to order at 11:31 a.m., on March 5, 2021, at the Perimeter Center, 9960 Mayland Drive, Henrico, Virginia 23233.

CALL TO ORDER: Dr. Petticolas called the meeting to order.

Consistent with Amendment 28 to HB29 (the Budget Bill for 2018-2020) and the applicable provisions of § 2.2-3708.2 in the Freedom of Information Act, the Board is convening today's meeting virtually to consider such regulatory and business matters as are presented on the agenda necessary for the board to discharge its lawful purposes, duties, and responsibilities.

Dr. Petticolas provided the Board members, staff, and the public with contact information should the electronic meeting be interrupted.

COMMITTEE MEMBERS PRESENT VIRTUALLY:
Augustus A. Petticolas, Jr., D.D.S., Chair
Sandra J. Catchings, D.D.S.
Nathaniel C. Bryant, D.D.S.

STAFF PRESENT AT THE PERIMETER CENTER:
Sandra K. Reen, Executive Director, Board of Dentistry
Donna M. Lee, Discipline Case Manager, Board of Dentistry

OTHERS PRESENT VIRTUALLY:
Jamie C. Sacksteder, Deputy Executive Director, Board of Dentistry
Margaret F. Lemaster, R.D.H., Board Member

ESTABLISHMENT OF A QUORUM: A roll call of the Board members and staff was completed. With three members of the Committee present, a quorum was established.

PUBLIC COMMENT: No public comment.

APPROVAL OF MINUTES: Dr. Catchings moved to accept the minutes of March 8, 2018. Following a second, a roll call vote was taken. The motion passed.

REVIEW OF BYLAWS: Ms. Reen stated that at the December 11, 2020 Board meeting it was requested that the Bylaws be updated to add a provision for emergency action by the Executive Committee.

After review and discussion, the Committee made the following changes:
Article V. Committees, #1-Executive Committee – add letter "f" to read "Address urgent matters which adversely affect either the timely licensing of applicants or the continuity of board operations while a State of Emergency is in effect and documented efforts to convene a quorum of the Board have failed due to disruption of electronic communications and/or the ability to safely travel in the Commonwealth."

Article VI. Executive Director, #2 Duties, modify subsection "e" to add "Keep a record of efforts to convene a meeting of the Board during a State of Emergency to include methods of contact; a summary of the information provided; a summary of the responses of each member; and an explanation of why efforts to contact a member were unsuccessful."

Dr. Bryant moved to accept the proposed changes as noted in the draft Bylaws and make a recommendation to the Board that the Bylaws be revised. Following a second, a roll call vote was taken. The motion passed.

Dr. Petticolas stated that the Committee's recommendation will be presented to the Board at its March 19, 2021 meeting.

ADJOURNMENT: With all business concluded, the Committee adjourned at 11:55 a.m.

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

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY

BYLAWS

Article I. Officers
Election, Terms of Office, Vacancies

1. **Officers**

   The officers of the Virginia Board of Dentistry (Board) shall be President, Vice-President, and Secretary.

2. **Election.**

   The President shall appoint a nominating committee to meet and submit a slate of officers to be included in the September/Fall meeting agenda package. The election of each officer shall be held during the September/Fall meeting. Prior to the election of officers, nominations from the floor may be entered.

3. **Terms of Office.**

   The terms of office of the President, Vice-President, and Secretary shall be for twelve months, until succeeded, or their successor(s) are elected. The term of each office shall begin at the conclusion of the Fall meeting and end at the conclusion of the subsequent Fall meeting. No officer shall be eligible to serve for more than two consecutive terms in the same office unless serving an unexpired term.

4. **Vacancies.**

   In the event of a vacancy in the office of president, the vice-president shall assume the office of president for the remainder of the term. In the event of a vacancy in the office of vice-president, the secretary shall assume the office of vice-president for the remainder of the term. In the event of a vacancy in the office of secretary, the president shall appoint a board member to fill the vacancy for the remainder of the term.

   In the event that all of the offices are vacated and succession is not possible, the Board shall be convened to appoint a Nominating Committee which will develop a slate of candidates for the Board's consideration at its next meeting. Pending the election of new officers, the member of the Board with the longest length of continuous service shall serve as acting president.

Article II. Duties of Officers

1. **President.**

   The *President* shall preside at all meetings and conduct all business according to the Virginia Administrative Process Act and the American Institute of Parliamentarians Standard Code of Parliamentary Procedure. The President shall appoint all committees and designate committee chairs and all representatives, except where specifically

provided by law. The President shall sign certificates and documents authorized to be signed by the President, and may serve as an ex-officio member of all committees (at which times possessing all the rights, responsibilities, and duties as any other member of the committee; including the right to vote). The President also may serve as a substitute for an absent committee member and, in this role, he shall participate in voting.

2. **Vice-President.**

The *Vice-President* shall perform all duties of the President in either the absence of, or the inability of the President to serve.

3. **Secretary.**

The *Secretary* shall authorize issuance of the draft unapproved minutes of meetings of the Board.

Article III. Duties of Members

1. **Qualifications.**

After appointment by the Governor, each member of the Board shall forthwith take the oath of office to qualify for service as provided by law.

2. **Attendance at meetings.**

Members of the Board shall attend all regular and special meetings of the full Board, meetings of committees to which they are assigned, and all hearings conducted by the Board at which their attendance is requested by the President or Board Executive Director; unless prevented by illness or other unavoidable cause. In the case of unavoidable absence of any member from any meeting, the President shall reassign the duties of such absent member when necessary to achieve a quorum for the conduct of business.

3. **Examinations.**

Each member of the Board who is currently licensed as a dentist or as a dental hygienist may participate in conducting clinical examinations for testing agencies in which the Board holds membership.

4. **Code of Conduct.**

Via incorporation by reference, members of the Board shall abide by the adopted Virginia Board of Dentistry Code of Conduct for Members (Guidance Document 60-9, Adopted: June 12, 2009).

Article IV. Meeting

1. **Number.**

The Board shall hold at least three regular meetings in each year. The President shall call meetings at any time to conduct the business of the Board, and shall convene conference calls when needed to consider summary suspensions and settlements. Additional

meetings shall be called by the President at the written request of any two members of the Board.

2. **Quorum.**

   A majority of the members of the Board shall constitute a quorum at any meeting.

3. **Voting.**

   All matters shall be determined by a majority vote of the members present.

Article V. Committees

Standing committees of the Board shall be the following:

Executive Committee
Regulatory-Legislative Committee
Examination Committee
Special Conference Committees

Committee Duties.

1. **Executive Committee.**

   The Executive Committee shall consist of the current officers of the Board and the Past President of the Board, with the President serving as Chair. The Executive Committee shall:

   a) Order a biennial review of these Bylaws for review by the Board at its December/Winter meeting in odd-numbered years;

   b) Be knowledgeable about the budget of the Board;

   c) Review financial reports and may make recommendations to the Board regarding financial matters;

   d) Select current or former board members and knowledgeable professionals to be invited to serve as agency subordinates; and

   e) Conduct all other matters delegated to it by the Board.

   f) Address urgent matters which adversely affect either the timely licensing of applicants or the continuity of board operations while a State of Emergency is in effect and documented efforts to convene a quorum of the Board have failed due to disruption of electronic communications and/or the ability to safely travel in the Commonwealth.

2. **Regulatory-Legislative Committee.**

   The Regulatory-Legislative Committee shall consist of two or more members, appointed by the President. This Committee shall consider matters bearing upon state and federal regulations and legislation, and make recommendations to the Board regarding policy matters. The Board may direct the Committee to review the law for possible changes.

Proposed changes in State laws, or in the Rules and Regulations of the Board, shall be distributed to all Board members prior to scheduled meetings of the Board.

3. **Examination Committee.**

The Examination Committee shall develop and oversee the administration of all Board examinations. This shall include, but not be limited to, jurisprudence and licensure examinations.

4. **Special Conference Committees.**

Special Conference Committees shall:

a) Review investigation reports to determine if a violation of law or regulation has occurred;

b) Hold informal fact-finding conferences;

c) Direct the disposition of disciplinary cases at the informal fact-finding stages. The committee chairs shall provide guidance to Board staff on implementation of their committee's decisions;

a) Review and decide any action to be taken regarding applications for licensure when the application includes information about criminal activity, practice history, medical conditions, or other content issues;

b) Consider applicant or licensee requests for approval of credit for programs when the content or the sponsorship of courses are in question; and

c) Hold informal fact-finding conferences at the request of the applicant or licensee to determine if Board requirements have been met.

Article VI. Executive Director

1. **Designation.**

The Administrative Officer of the Board shall be designated the Executive Director of the Board.

2. **Duties.**

The Executive Director shall:

a) Supervise the operation of the Board office and be responsible for both the conduct and performance of the staff, and the assignment of cases to agency subordinates;

b) Execute the policies and services established by the Board;

c) Provide and disburse all forms as required by law to include, but not be limited to, new and renewal application forms;

d) Keep accurate record of all applications for licensure, maintain a file of all applications, and notify each applicant regarding the actions of the Board in response to their application. Prepare and deliver licenses to all successful applicants. Keep and maintain a current record of all dental and dental hygiene licenses issued by the Board;

e) Notify all members of the Board of regular and special meetings of the Board. Notify all Committee members of regular and special meetings of Committees. Keep a record of efforts to convene a meeting of the Board during a State of Emergency to include: methods of contact; a summary of the information provided; a summary of the responses of each member; and an explanation of why efforts to contact a member were unsuccessful. Keep true and accurate minutes of all meetings and distribute approved draft minutes to the Board members within ten days following such meetings;

f) Issue all notices and orders, render all reports, keep all records, and notify all individuals as required by these Bylaws or applicable law. Affix and attach the seal of the Board to such documents, papers, records, certificates and other instruments as may be directed by law;

g) Keep accurate records of all disciplinary proceedings. Receive and certify all exhibits presented. Certify a complete record of all documents whenever and wherever required by law; and

h) Provide the Board's financial statements and biennial budget, along with any revisions, to the Executive Committee for review.

i) Assign the determination of probable cause for disciplinary action to a board member or the staff dental review coordinator, who may offer a confidential consent agreement, offer a pre-hearing consent order, cause the scheduling of an informal conference, request additional information, or close the case.

DEFINITIONS OF TYPES OF COMMITTEE MEMBERS

1. Advisory Member - Specialized, non-voting member of a committee. Cannot make or second motions, but may participate fully in debate and discussions.
2. Ex-Officio Member - A member of a committee who serves by virtue of holding a specific office. Has all the rights, responsibilities and duties as any other member of the committee, including the right to vote.

Agenda Item: Regulatory Actions - Chart of Regulatory Actions
As of March 8, 2021

		Action / Stage Information
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Training and supervision of digital scan technicians [Action 5600] NOIRA - *Register Date: 3/1/21* *Comment period ends: 3/31/21*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Amendment to restriction on advertising dental specialties [Action 4920] Proposed - *At Governor's Office for 540 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Waiver for e-prescribing [Action 5382] Proposed - *At Governor's Office for 63 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Technical correction [Action 5198] Fast-Track - *At Governor's Office for 477 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Administration of sedation and anesthesia [Action 5056] Final - *Register Date: 2/15/21* *Effective: 3/17/21*
[18 VAC 60 - 25]	Regulations Governing the Practice of Dental Hygiene	Protocols for remote supervision of VDH and DBHDS dental hygienists [Action 5323] Final - *At Governor's Office for 56 days*
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	Training in infection control [Action 5505] NOIRA - *Register Date: 3/1/21* *Comment ends: 3/31/21*
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	Education and training for dental assistants II [Action 4916] Final - *Register Date: 3/1/21* *Effective: 3/31/21*

Final Text – Effective 3/17/21

Board Of Dentistry

Administration of sedation and anesthesia

18VAC60-21-10. Definitions.

Part I

General Provisions

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

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"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.

"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 a certified registered nurse anesthetist or the level of supervision 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.

"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.

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

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

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

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

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

Part VI

Controlled Substances, Sedation, and Anesthesia

A. ~~Application of~~ Part VI~~.~~ of this chapter:

~~This part applies~~ 1. 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.

2. Addresses the minimum requirements for administration to patients of any age. Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures, issued by the American Academy of Pediatrics and American Academy of Pediatric Dentistry, should be consulted when practicing pediatric dentistry.

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

C. Patient evaluation required.

1. An appropriate medical history and patient evaluation, including medication use and a focused physical exam, shall be performed before the decision to administer controlled substances for dental treatment is made. The decision to administer controlled ~~drugs~~ substances 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

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

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

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

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

4. Preoperative vital signs;

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

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

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

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

K. Patient monitoring.

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

2. An anesthesiologist;

3. A certified registered nurse anesthetist under ~~his medical~~ the dentist's direction and indirect supervision;

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

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

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

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

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

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

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

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

C. Delegation of administration.

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

5. Oxygen saturation with pulse oximeter, unless extenuating circumstances exist and are documented in the patient's record.

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

F. Monitoring requirements.

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

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

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

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

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

G. Discharge requirements.

a. A dentist;

b. An anesthesiologist;

c. A certified registered nurse anesthetist under ~~his medical~~ the dentist's direction and indirect supervision;

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

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

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

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

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

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

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

1. Blood pressure monitoring equipment;

~~qualified licensed health professional identified in subsection C of this section may turn the nitrous oxide/oxygen machines on or off~~ in the recommended dosage for minimal sedation. If deeper levels of sedation are produced, the regulations for the induced level shall be followed. The administration of one drug in excess of the maximum recommended dose or of two or more drugs, with or without nitrous oxide, exceeds minimal sedation and requires compliance with the regulations for the level of sedation induced.

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

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

G. Discharge requirements.

1. The dentist shall not discharge a patient until he exhibits baseline responses in a post-operative evaluation of the level of consciousness. Vital signs, to include blood pressure, respiratory rate, ~~and~~ heart rate, and oxygen saturation shall be taken and recorded prior to discharge unless extenuating circumstances exist and are documented in the patient's record.

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

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

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

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

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

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 moderate sedation.

A. Delegation of administration.

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

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

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

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

B. Equipment requirements. A dentist who provides or administers or who utilizes a qualified anesthesia provider to administer 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;

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

E. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, and ~~circulation~~ blood pressure and heart rate 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.

4. If a separate recovery area is utilized, oxygen and suction equipment shall be immediately available in that area.

5. Since re-sedation may occur once the effects of the reversal agent have waned, the patient shall be monitored for a longer period than usual when a pharmacological reversal agent has been administered before discharge criteria have been met.

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.

and related clinical medical subjects (i.e., medical evaluation and management of patients) comparable to those set forth in the ADA's Guidelines for Graduate and Postgraduate Training in Anesthesia in effect at the time the training occurred; and

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

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

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

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

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

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

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

B. Delegation of administration.

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

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

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

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

6. Mechanical (hand) respiratory bag;

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

8. Blood pressure monitoring equipment;

9. Appropriate emergency drugs for patient resuscitation;

~~9.~~ 10. EKG monitoring equipment;

~~10.~~ 11. Temperature measuring devices;

~~11.~~ 12. Pharmacologic antagonist agents;

~~12.~~ 13. External defibrillator (manual or automatic);

~~13.~~ 14. An end-tidal carbon dioxide monitor (capnograph);

~~14.~~ 15. Suction apparatus;

~~15. Throat pack~~ 16. Airway protective device; ~~and~~

~~16.~~ 17. Precordial or pretracheal stethoscope; and

18. Equipment necessary to establish intravenous or intraosseous access.

D. Required staffing. At a minimum, there shall be a three-person treatment team for deep sedation or general anesthesia. The team shall include the operating dentist, a second person to monitor the patient as provided in 18VAC60-21-260 K, and a third person to assist the operating

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

G. Discharge requirements.

1. If a separate recovery area is utilized, oxygen and suction equipment shall be immediately available in that area.

2. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation, ~~and circulation~~ blood pressure, and heart rate are satisfactory ~~for discharge~~ and vital signs have been ~~taken~~ assessed and recorded, unless extenuating circumstances exist and are documented in the patient's record.

~~2.~~ 3. Since re-sedation may occur once the effects of the reversal agent have waned, the patient shall be monitored for a longer period than usual before discharge if a pharmacological reversal agent has been administered before discharge criteria have been met.

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

~~3.~~ 5. The patient shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

Agenda Item: Petition for rulemaking

Included in your agenda package are:

A copy of a petition from Carmen Chilton

Copy of comments on the petition

Copies of applicable sections of the Code of Virginia

Board action:

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

Request for comment on Petition for Rulemaking

Promulgating Board: **Board of Dentistry**

Regulatory Coordinator: Elaine J. Yeatts
(804)367-4688
elaine.yeatts@dhp.virginia.gov

Agency Contact: Sandra Reen
Executive Director
(804)367-4437
sandra.reen@dhp.virginia.gov

Contact Address: Department of Health Professions
9960 Mayland Drive
Suite 300
Richmond, VA 23233

Chapter Affected:
18 vac 60 - 30: **Regulations Governing the Practice of Dental Assistants**

Statutory Authority: State: Chapter 24 and 27 of Title 54.1

Date Petition Received 11/06/2020

Petitioner Carmen Chilton

Petitioner's Request
To amend regulations to create a pathway for dental assistants with 5-10 years of experience to take the Certified Restorative Functions Dental Assistant exam and have the employing dentist observe and approve of their capabilities to be a dental assistant II.

Agency Plan
The petition will be published on December 7, 2020 in the Register of Regulations and also posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov to receive public comment ending December 31, 2020. The request to amend regulations and any comments for or against the petition will be considered by the Board at the first scheduled meeting in 2021. The petitioner will receive information on the Board's decision after that date.

Publication Date 12/07/2020 *(comment period will also begin on this date)*

Comment End Date 12/31/2020

COMMONWEALTH OF VIRGINIA
Board of Dentistry

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

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

Petition for Rule-making

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

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

Petitioner's full name (Last, First, Middle Initial, Suffix,)		
Chilton, Carmen M.		
Street Address	**Area Code and Telephone Number**	
1907 Red Marshall Rd.	(434) 483-7559	
City	**State**	**Zip Code**
Pelham	NC	27311
Email Address (optional)	**Fax (optional)**	
carmenchilton1975@yahoo.com	(434) 797 3596	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending. 18 VAC 60-30-115 General Application Requirements
18 VA C 60-30-120 Educational Requirements for dental assistants II
18 VA C 60-30-140 Registration by endorsement as a dental assistant II

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.
Pathway for CDAs with 5-10 years experience to PASS DANB's Certified Restorative Functions Dental Assistant exams and have the Virginia Dentist they are employed by willing to sign that they have observed and approve of their capabilities hands on. The dentists are the ones who take on liability and many would like a way to get their more talented assistants moved to DA II status easier than expensive far away co

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.
54.1-2401

Signature: [signature] **Date:** 11/3/2020

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Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter

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

36 comments

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: A. Wilson 12/7/20 7:15 am

Certified Dental Assistant II

In order to make the pathway more direct and attainable to qualified CDA's in Virginia we ask for review to amend regulations to create a pathway for dental assistants with 5-10 years of experience to take the Certified Restorative Functions Dental Assistant (DANB) exam and have the employing dentist observe and approve of their capabilities to become a Certified Dental Assistant II.

CommentID: **87684**

Commenter: Jason W Dulac, DDS, PLLC 12/7/20 7:36 am

in favor of modification

I'm in favor of approving this modification.

If the assistant has the ability, and can pass out of an exam, I don't see the need for a one year training program.

I believe this modification will keep Virginia more in line with other states with requirements for tiered assistants.

Thank you for your consideration of this issue.

CommentID: **87685**

Commenter: Tammy Swecker 12/7/20 9:24 am

Against DAII on the job training

Dear Board of Dentistry members,

I am against the Petition for Rule-Making to allow DAIIs to have on the job training. On the job training is spotty at best. Just because you have assisted for several years does not negate the fact that formal training is required to perform chairside duties. The VA BOD has training regulations set forth for DAIIs to obtain certification. DAIIs in Virginia are allowed to perform more invasive procedures than any other state in the country that allows expanded function. For this reason, all DAIIs should graduate from a CODA accredited program where educational standards

are set and maintained. While other health professions like physical therapy, occupational therapy, pharmacy and nursing have increased educational requirements for their professions; dentistry consistently requests for less training and education for DAIs and DAIIs. The public deserves a qualified, college-educated practitioner. Our profession needs to work with integrity to address very real issues our profession faces without compromising our duty to first, do no harm to patients, coworkers and the public depending on us.

All the best,

Tammy

CommentID: **87687**

Commenter: Lawrence A. Hayes DDS PLLC

12/7/20 2:30 pm

In favor of Petition

I believe this would be great for both Dentists and Assistants. From my understanding, Certified Dental Assistants have been through one to two years of school already and I feel if they are able to pass a National Board test the I would be capable and qualified enough to observe and decide if an assistant is up to par. Ultimately, as a dentist, I would be liable for any work an assistant performed wile working under my license.

CommentID: **87692**

Commenter: Melissa Wray, RDH

12/7/20 9:35 pm

In favor for petition

This would be a great opportunity to dental assistants with 5-10 years experience. If they are able to pass their boards and work under supervision of employing dentist that should be all that is needed for the said person to be a DAII.

CommentID: **87699**

Commenter: Anonymous

12/8/20 1:43 pm

DAII

I am in favor of this. Well qualified DA II's can improved much needed access to care.

CommentID: **87706**

Commenter: Arnela Hodzic / ECPI

12/9/20 3:22 pm

My Thoughts

I believe this is the next level for dental assistant. Not only will it save time and money for us but we will get more of a hands on learning with the dentist himself. What i'm trying to say is if we are assisting as a DA I we can see for ourselves how a certain procedure is done and have the dentist explain the steps and why. I can see why some others may disagree with this because they may believe this is just an easy way out from taking a test or class. It may be because of the dentist themselves. But this is just my opinion. Whichever one is chosen I know myself that I will like to be a DA II.

CommentID: **87736**

Commenter: VNJ

12/9/20 3:25 pm

Approve But Have Concerns.

I believe this could be an amazing opportunity for Dental Assistants interested in becoming a DA II although, this could be a risky petition to approve. The competency, skill, and ability of each DA II would greatly depend on the dentist that trained that individual. This brings to thought that in order for this to be beneficial to both the dental assistants and the general public there would need to be a baseline that each assistant would need to meet, as well as guidelines for both the assistant and dentist to follow. Not every dentist works the same or has the same views or preferences and because of this, if one assistant completes all training and meets requirements under one dentist and then that assistant tries to become employed elsewhere; the new dentist may not agree with how that assistant was trained and may not feel comfortable hiring that individual as a DA II at their practice. At this point the assistant would have to make the decision to go through this process all over again or settle being hired as a DA I.

CommentID: **87737**

Commenter: Aaliyah Jones / ECPI University

12/9/20 3:30 pm

In Favor of Petition

I feel as if the licensed Dentist has authorized and approved a DA I's capability to become a DA II there should be no problem. Colleges teach basics and if a DA I has the opportunity to do on the job training, seeing and learning in the real world; I say go for it! The licensed Dentist should be the ones imputing more because they will be the ones allowing and training. Its a great opportunity and if the licensed dentist entrusts that person they know they will be liable, so they know who to and who not to entrust with this certification.

CommentID: **87738**

Commenter: Dental Assistant

12/10/20 7:54 pm

In Favor

I have been a dental assistant for 9 years. I took a dental assistant class and became a certified dental assistant right out of high school. While the class taught me the book side of things it did not teach my the hands on portion of the job very well. Every doctor is different from the materials they use to the techniques they prefer. I learned more by working than reading a textbook.

I worked as an assistant as I earned my associates degree and completed my prerequisites for dental hygiene. Unfortunately while I have a passion for dentistry hygiene is not for me. I love being an assistant and I want to become a DA II. After looking into it there is no possible way for me to become a DAII without quitting my job. The closest class is 2.5 hours away. I have a family to provide for and can not afford to quit my job to take a DA II course. If a certified dental assistant with significant experience has a doctor sign off on clinical hours and they can pass the exam why not allow them?

CommentID: **87773**

Commenter: Carmen Chilton

12/11/20 9:07 am

More Explanation In Favor

I started this petition because I could see a need.

I think it is great that Virginia expanded it's functions as there are so many things a dental assistant could proficiently do to help dentists more. I live in a border town (NC) where I packed cord for 10 years only to come to VA and it be prohibited.

I have noticed a lot of dental assistants in VA are not Certified Dental Assistants. I am however Certified through DANB (Dental Assistant National Board). I also teach dental assisting at our local community college. I teach Dental Materials, Radiology, and Clinical Assisting I and II. Our program is a one year program that only prepares the assistant for the NELDA exam which is the entry level Dental Assistant Exam. Usually it is a two year program that prepares assistants for the CDA portion. Even though we teach only for NELDA the students learn and test on everything a DAII would do also. We place fillings in dexter teeth, pack cord, take all types of impressions among many other things. In addition to the classes our students take they have to work for a dentist for two years before they can take the exam to become a CDA.

That said, a CDA has two years or equivalent of Dental Assisting School. To become a DAII currently we would need another year of school. A dentist only spends 4 years in dental school. A hygienist only spends 2 years in school. But a CDA is asked for 3 years to be a DAII? When the hygienist were able to provide local anesthetic they weren't asked to reenter school for another year to do so.

I do not think this is a step back in education at all. I think this will push more of Virginia's Dental Assistants to seek their CDA Certification so they can later obtain their DAII license. Taking these exams is neither easy nor cheap. For a CDA to pass these exams they would need to study to brush up and update their skills and knowledge to pass them. These tests would cost a CDA I believe at least $500 to take. These are the SAME tests the DAII in the year long program are asked to take. If a CDA can study pass these and have a dentist willing to let them do the work under their license then why shouldn't they be able to?

You can argue that each dentist would have to gauge a newly hired DAII's abilities because of what some people consider office training. I can argue that ALL dentists should be gauging ALL new hires abilities anyway. If it were my dental license, I would. Any dentist or corporate office who cares would.

Furthermore, I said with 5 or 10 years experience as I don't feel any student straight out of school and with no experience has learned enough. There is a lot to be said for learning in the field. That is why there are externships and internships in the health fields. Not everything can be taught in a a classroom.

Thank you for your consideration. I hope this passes, or at least opens talks for new avenues toward improving the obtainability of the DAII licensure.

CommentID: **87786**

Commenter: jesse r wall dds

12/11/20 10:34 am

Regulationg Governing the Practice of Dental Assistants

I am in favor of granting this petition . As a practicing Dentist of over 4 decades and as a former dental educator I have had the opportunity to evaluate many dental assistants , Those who love the practice of dentistry and work to improve their knowledge and skills for decades are very special people. Often family needs and rural or small town areas limit formal education in a traditional environment , With my experience it is my belief that those dedicated to our profession need and deserve this pathway to certification as dental assistant II , Jesse R Wall DDS

CommentID: **87788**

Commenter: Anonymous 12/12/20 7:59 pm

ammend requirements for DAII

In Virginia, the opportunity for a CDA to advance to the DAII status is very difficult. The CDA that has the passion and desire to perform expanded duties and has the years of experience in the dental office, has no where to go to get the DAII licensure or the opportunity is very limited. By allowing direct training and supervision by the dentist, duties can be delegated to the assistant thus increasing their passion for dentistry. A CDA that is allowed to contribute to the quality care of their patients becomes a vital team member of the practice and develops the confidence to do more. The more qualified assistants available the less stress the dentist experiences. Even if a dentist hires a licensed DAII in Virginia, he or she must prove they are qualified to perform the duties delegated them to the satisfaction of the dentist. Usually training is still required by the dentist even if the DAII is licensed, in order to meet that particular dentist's standard of care. A CDA that has dedicated years to a career in dentistry, and has a personal desire to do the work should , in my opinion, be given the opportunity. I have been a CDA for 40 years and have dedicated my life's work to dentistry. I feel fully qualified to be given the legal opportunity to perform duties I have assisted with for 40 years. A well qualified assistant is someone that most dentist would like to utilize more, so why not let them take that responsibility to properly train them to their advantage. I think if young DA's had a dentist to mentor and train them every one would win!

Donna T. Smith, CDA

CommentID: **87800**

Commenter: Brian 12/14/20 2:27 pm

In Favor

It would be great if this passed and it is long overdue. Last time my assistants and I checked into it, there was not even a program available to produce a DAII. I have two assistants who have been in dentistry over 20 years who would love to extend their skills. It would be a great help to the office and I have all confidence that they would do an excellent job. If these assistants with experience can pass the needed test I see no reason they could not do the job.

CommentID: **87809**

Commenter: Jeannie Lipscomb 12/21/20 8:32 pm

DAII training requirements

The value of the expanded function dental assistant (DAII) has already been acknowledged by the creation of the title several years ago. No one is suggesting that training be diluted - just more accessible for those individuals who aspire to an elevated level of training. As a past President of the American Dental Assistants Association, I traveled the country testifying before dental boards and interacting with educational facilities. I observed first hand the diversity and benefits of expanded functions. I am also a member of the Fortis Advisory Committee where the DAII was first taught and is not currently available thus further limiting access to this accomplishment. As part of a national Task Force that studied credentialing for dental assistants over a period of two years,

we observed the diversity in training and delegable duties of all states. In instances where there was some form of preceptorship, there was a strict curriculum and individual competency examinations. It is a doable process; however, specific details must be evaluated.

CommentID: **87873**

Commenter: Germanna Community College 12/22/20 2:50 pm

Amending DA II regulations

Dear Honorable Members of the Board of Dentistry,

I write to oppose the petition to create a pathway for dental assistants with 5-10 years of experience to take the Certified Restorative Functions Dental Assistant exam and have the employing dentist observe and approve of their capabilities to be a dental assistant II.

The duties delegated to the DA II in Virginia are those that are a part of the art and science of dentistry. It would be a disservice to the patients in the Commonwealth to allow the proposed kind of practice. Those who want to practice as a Dental Assistant II need to be educated in an accredited institution and supervised by unbiased practitioners before being allowed to perform such services on a patient. Dentists do not have time to pay attention to the detail needed to teach such art and science while trying to run a practice/business. Nor do all practicing dentists have knowledge of pedagogically or andragogically sound teaching principles.

As a program director for a Dental Assistant II program, I have looked at the requirements of the Certified Restorative Functions Dental Assistant Exam offered by the Dental Assisting National Board. This exam does not address the expanded functions of a dental assistant II as defined by the Virginia Board of Dentistry. We must be quite careful to know the varying definitions and uses of the words "expanded functions." For example, Tennessee views coronal polishing as an expanded function and one reserved for a certified dental assistant. This is not the case in Virginia.

While I fully support the maximum utilization of allied dental professionals, this needs to be done in a way that is going to ensure the highest quality of care for our patients. The Board of Dentistry has a duty to protect the citizens of the Commonwealth. Reducing the educational requirements of a DA II would be a dereliction of duty.

Respectfully submitted,

Misty L. Mesimer, RDH, MSCH, CDA

CommentID: **87875**

Commenter: Marlana Thomas 12/22/20 7:13 pm

Against Petition for on the job training

As an RDH with DAII training, I am strongly against allowing on the job training. The duties delegated to the DA II in Virginia are those that are a part of the art and science of dentistry. I had completed hygiene school and was practicing dental hygiene for 6 years prior to starting the DAII training and realized that there was still a lot that I needed to learn when it came to the duties of a DA II. It would be a disservice to the patients to allow the proposed kind of practice. While I support allowing auxiliaries to practice at the maximum potential to increase access to care, on the job training is not the solution. Those who want to practice as a DA II should be educated in an accredited institution and supervised by unbiased practitioners, giving them a solid foundation before being allowed to perform such services on a patient. Not all practicing dentists have sound

teaching principles and are able to devote the time and attention to the detail needed to teach such art and science while trying to manage their practice.

CommentID: **87878**

Commenter: Michelle Fisher

12/22/20 8:36 pm

Opposed to OJT DAIIs in VA

To My esteemed members of the Virginia Board of Dentistry,

I am writing to you today to humbly ask that the petition for the OJT pathway for dental assistants to become DAIIs in Virginia be denied. I am in favor of having more dental auxillaries in the work force so that quality care can be more assessible to patients, but we need to make sure the quality of care provided is not jeopardized over quantity. I have been saying for quite some time now, that the lack of uniform training among dental assistants in Virginia is a problem, but at least with DAIIs, thanks to the regulations that have been in place, requiring CODA accredited schooling, by unbiased professionals with proven teaching skills, the quality of care has been standard. Patients deserve to know that no matter who they see in the dental office, they are being cared for by the most highly trained individual. A dental assistant who wishes to become expanded functions should also be willing to take the courses necessary to learn not only the how's but the whys and science behind what they are doing. Doctors just do not have the time, and some do not have the teaching ability, to dive that deep into the science. When I went though the courses I needed for my license, the textbooks used were the same textbooks several of my doctors used when they were in dental school. We studied the science behind the practice, and learned not just that A, B, and C were done, but why it was important to do A, B, and C, and even the techniques behind it. The science taught in the formal school setting, from the head and neck anatomy to tooth histology, to the biochemistry behind how the bonding of resin composite to teeth works, just can't be taught OJT, but is necessary for the dental assistant to be competent in what he or she does. In the nursing field, licensure is necessary from CNA to LPN to RN to BSN and higher. They take standardized, uniform classes and exams. As patients we can be cared for by those professionals with confidence that a certain level of education was earned. As Dental professionals, we are healthcare providers too.

Thank you for your time,

Michelle Fisher, CDA, CPFDA, CRFDA, RDAII

CommentID: **87879**

Commenter: Frank Fisher

12/22/20 8:46 pm

DAIIs should have higher education training

I'm a mechanic that got wind of the proposal for dental assistants to beable to be trained on the job to place fillings and what not. I'm against this. Just as you wouldn't want someone who was taught on the job to be working on your car, over an ASE trained and licensed mechanic, I want to know that the person fixing my teeth has has as much training as possible. It's hard to find a dentist that you can trust anyway, but then to wonder if my filling is going to come out or if my crown is going to fail because I wasn't sure if the person doing the work was properly trained, no thank you. We both work in fields, me automotive mechanics and you dentistry, where the trust of the public has been decreased. I think as the board of dentistry, you'd want to do everything you could to build confidence of the people, and you do that by making sure those you license are properly educated and trained using uniform standards, which you can only regulate through some sort of accredited teaching program.

Yours truly,

Frank Fisher

CommentID: **87880**

Commenter: Bernice Huttanus 12/22/20 9:22 pm

Against

I think we should be striving to improve the quality of education and training our dental professionals, well all healthcare providers, obtain in order to work on a patient. If lack of opportunities is the problem, then add the opportunities, don't lower the bar for everyone. That's not far to those who have gone through the schooling, and it certainly isn't fair to the patients who trust that the dental professional placing their fillings is highly trained. We make dentists, people who have been practicing for years, from other countries go through our dental schools. We do this so we know that they are fully trained because the training isn't uniform overseas. Why view the dental assistants, especially the expanded functions ones, any different? If they are placing fillings or cementing crowns--work that licensed dentists (who have not only earned a four year undergraduate degree but also spend four plus years in dental school) do--shouldn't there be some standard, uniform training from accredited sources for those assistants too? I think so.

CommentID: **87881**

Commenter: Charles Herman 12/22/20 9:36 pm

Opposed

As a patient, I want to know that the person working in my mouth has had a certain level of training. I can usually tell when an assistant has been formally educated or not. I've been to dentists where the dentist did everything and the assistant basically handed him things. And I've been to dentists where not only did the assistant do most of the work, she was so knowledgeable, and explained things to me so completely, that honestly, I thought she was at least a dental student intern if not the doctor, until the doctor came in the room and I saw that my assumptions were incorrect. The assistants that can explain things to me, tell me what they are doing step by step and why, they make me more comfortable in the chair, that I am otherwise a little nervous to sit in. If I have to worry whether the assistant who is placing my filling was trained in an accredited school or was taught on the whim by a doctor, maybe not even a doctor I know or trust, then that is going to hurt my confidence and trust in the profession, a profession that sometimes gets a bad name anyway.

CommentID: **87882**

Commenter: Pam Blankenship 12/23/20 4:30 pm

Oppose

I am writing to oppose the petition to create a pathway for dental assistants with 5-10 years of experience to take the Certified Restorative Functions Dental Assistant exam and have the employing dentist observe and approve of their capabilities to be a Dental Assistant II.

Having worked as a dental office manager, dental assistant and dental hygienist in Virginia for over 30 years, I can attest that the necessary skills and science needed for the duties delegated to the DA II in Virginia can not be gained through on the job training. A practicing dentist does not have the time or resources available to provide quality dental care for patients, while also providing on the job training to staff members.

To pass this petition would be a disservice to both the patients and the prospective DA II, who deserves an education from an accredited program. Reducing the educational requirements would be moving the profession in the wrong direction.

Respectfully Submitted,

Pam Blankenship

CommentID: **87887**

Commenter: Bryan Richards 12/23/20 5:13 pm

Opposed

I am opposed to this proposition for on the job training for DAIIs in Virginia. My mom is a DAII in Virginia, and she rocks. I've watched her go through all the classes and helped her study. She put in hours of studying and the stuff she had to learn, I don't see a doctor having the time to teach all of that in the dental office. If the dentists have to go through school and learn the theory behind what they do, then a dental assistant that is doing what the dentist does, should also know the theory. On the flip side, as a patient, I feel like the profession should move in the direction of having more education and formal training, not less. Patients deserve no less. Going forward with this proposition would be a disservice to the profession, current DAIIs, prospective DAIIs and the patients.

CommentID: **87888**

Commenter: Bonnie Blankenship 12/23/20 7:28 pm

Opposed to petition.

I am opposed to amending the existing law. I believe that DA II applicants need the education and the practice involved with the schooling aspect, and the benefits of the extra education vs taking an exam, are immense.

i have been a DA II for 4 years, an assistant for a total of 9 years and personally, I would not have been adequately prepared or knowledgeable enough to place fillings as well as I can now, without the school, the clinical s, the studying, the dentists and school staff reviewing my work closely.

Remembering the patients that I first started placing my first fillings on, they were nervous as it was, after 1.5 years of school, so if i were to go back and have no school, I can only imagine the feelings of those patients. Public perception is important

i think also the petition will dissuade more dentists from allowing DAII to practice in their offices. It is slim the number of offices that have da II anyway right now.

we need to keep the education requirements there. A simple exam and OJT years under our belt is not enough.

CommentID: **87891**

Commenter: Karim Gutierrez 12/27/20 10:22 pm

Against petition

I am writing in opposition to the petition for "on-job training" for dental assistants to become a DAII. I have 14 years of experience as a dental assistant of which the last three years were as a DAII. I have seen both on the job trained dental assistants and formally trained dental assistants and I can tell the difference in the quality of work between the two. Those who have formal training do a much better job. In my experience, the patients also notice the difference in terms of the quality of service provided, with those that have had formal training giving higher quality work as compared to those that have not. I see this petition as a step back in terms of the safety of the patients and the quality of care; especially, when compared to the requirements in other states. I believe the loosening of the qualification requirements would be a detriment to the profession and the patients and would open the state up to legal liability when on the job trained DAII's malpractice on patients. Please do not deny the importance of formal education and maintaining high qualifications for the profession. Dentists have years of formal education in addition to on the job training and standardized examinations in order to be allowed to provide dental care for patients. If it is not acceptable for people to become dentists through on the job training and formal examination alone without the formal education, then it should also not be allowed for DAII's. We as dental auxiliaries should have our profession protected and the same logic applied in requiring formal, accredited education as with dentists in order to ensure the integrity of the profession and protect the patients from harm. Patients deserve qualified knowledgeable dental care providers whether they be dentists or DAII's. Formal training as a DAII at school is an essential part of ensuring the integrity of the profession and to protect the patients from harm. At school an instructor is dedicated to teaching and supervising their trainees without the pressure of working in their private practice where the doctor's primary focus is on running their business and not training staff to perform complicated procedures on their own. If anything, the solution to the shortage of DAII's to encourage more educational institutions in the state to become accredited to training DAII's. The requirements to work as a dental assistant in Virginia are already less stringent than other states compromising the quality of care and safety of the patients. Therefore, I ask that the requirements to become a DAII are not lessened, as it would prove detrimental to the patients health and allow for legal liability, but instead continue to allow those assistants that have taken the time and effort to be properly trained to give patients the excellent standard of care that is to be expected of a DAII. Thank you for your consideration of my comments and perspective.

CommentID: **87897**

Commenter: Ivan Rakela

12/27/20 10:45 pm

Against petition

I am writing against the petition to allow dental assistants to practice as DAIIs without any formal training. As a patient I would not feel safe having an assistant perfom any procedure on me that was not properly trained by an accredited university. Having someone who might have been trained in a rush or not given the proper training do anything makes me uneasy as in the end it is me that would suffer from their lack of proper care. I would definitely prefer having someone that knows what they are doing and who have been trained at a school be the ones who work on my teeth. As such I am against dental assistants becoming DAIIs without having the proper training as I feel that it would lower my standard of care.

CommentID: **87898**

Commenter: Summer M Woodard, CDA/Team Leader at Powell Valley Dental

12/28/20 12:26 pm

Strongly Opposed

Dear Board Members,

I strongly disagree with this petition. I feel that this petition will be detrimental to the field of dental assisting, dentistry and the rights of patients to be in competent hands. This would discredit the art

and science of dentistry and the education that it requires to effectively perform the procedures. It takes dentists years of education at a School of Dentistry to learn the science and art of proper restorations. It takes dental assistants that strive for higher education, years of training and additional education to be competent to effectively do the same tasks that are licensed to dentists. I recently completed Oral Anatomy and Operative Dentistry through a CODA certified DA II program at Germanna Community College. This was a pre-requisite to be able to even apply and be accepted for my lab and clinical skills to attain my DA II in Virginia. I have been an OTJ trained dental assistant for 20 years, a CDA of my own decision for 12 years, and was an EFDA in Kentucky, through U of K School of Dentistry. Virginia did not allow me to reciprocate my EFDA skills to this state due to the program that I had completed not being CODA certified. I felt this unfair until I recently completed the Oral Anatomy and Operative Dentistry course. Now, I realize the education that I was missing from my previous training. Virginia was right to require my training to be through a CODA certified program. Even with my 20 years in the field and additional training I did not have the education needed to effectively be restoring teeth. I don't feel as if any dentist could appropriate the time to give an assistant the proper training in their office to be a DA II, while they are trying to treat patients and run a practice. This is not to discredit the abilities of any dentist, as I have worked for and currently work with two exceptional dentists. The office setting is just not the place for thorough DA II training. To allow this petition through will be taking a step that will be allowing severely under trained assistants to be treating patients. From experience, I can say that patients will notice this. We have a Virginia licensed EFDA in our office and patients inquire daily about her education and training. They are only appeased and comforted by the discussion that she has been trained in an educational institution and licensed by the Commonwealth of Virginia to be providing their care. Patients will lose their faith and trust in their dental providers if this petition goes through and becomes a new law. As an elected Board, you have a duty and responsibility to be an advocate for the people and protect their rights and health, and assure that they get the best possible dental care.

Summer Woodard, CDA and Team Leader at Powell Valley Dental in Big Stone Gap, VA

CommentID: **87900**

Commenter: Raul Mollinedo Vargas

12/28/20 10:22 pm

Against Petition

I am writing against the petition to allow dental assistants without formal training to become DAII's. Being a dental assistant working in the field for more than 13 years as well as a formally trained DAII for the last 3, I have seen both people with skills and people with knowledge. From experience I know that having an assistant with skills is very useful but having someone with the knowledge that comes from formal training really makes the difference, not only for the doctor and the team but most importantly for the patient. Providing the best care and service for the patient's health and wellbeing means not only having a certain number of years on the field, but having the training, practice and nuanced knowledge of the anatomy of the mouth as well as the different dental materials necessary for each procedure that only comes through formal learning; that is what quality standard of care is all about. This is a professional health field and it must be kept that way in order to provide the best of our knowledge and skills to the patients. Although I was forced to drive an hour each way to get my accreditation, I am absolutely sure that it was the right decision and I know that it provided me with the right training to excel in my field. Most doctors will not have the time to supply their staff with the proper knowledge and training in order to make them fully functional DAIIs,and that makes it unfair for a patient to be subjected to a lower standard of care. Therefore, I feel that approving the petition to allow dental assistants without formal training to become DAIIs would be detrimental to the profession, subjecting patients to a lower standard of care that comes with not giving the assistants the proper training that can only come from formal learning. We must keep the standard of care to its highest potential, and this can only

be reached by ensuring that those who have the drive to become DAIIs do it through the proper pathways. Thank you for taking the time to consider my petition.

CommentID: **87902**

Commenter: Marlene Rhodes CDA, BSDH, RDH 12/30/20 11:27 pm

Opposed to DAII OJT

There are multiple reasons this petition should not be considered, the top two for me are training and liability.

As adjunct faculty at a CODA accredited dental assisting program the training and clinical aspects of expanded function education is of upmost importance. Educators are well trained, faculty/staff undergo a calibration of sorts to produce graduates who can all pass the same extensive testing and board examinations. This is true of all dental schools, hygiene programs and assisting programs who are accredited. When you think back on your education, remember all of the different clinical faculty and the vast differences between them and expectations they each placed on you as a student. Also remember the multiple patients and learned techniques used to become the efficient practitioners you are now. Once graduating you each found your own preferred way to practice. Each doctor has their own way of completing treatment. Once completing a program where they learn the basic skills, assistants are on the job trained by whom they work for the specifics of that doctor's four handed technique. This is standard because the assistant is doing just that, assisting. Restorative general dentistry takes years to become proficient in even with the benefit of faculty/staff who can truly take the time to "teach" skills. I cannot imagine there are many practicing dentists who have the time, calibrated education training or willing patient base to accomplish proficiency for expanded function criteria. To have an assistant be on the job trained for expanded function assisting is simply not a beneficial way to achieve the required quality clinical skills set by CODA accredited programs.

On to liability. Once an assistant has completed an accredited program for expanded function and has passed the clinical exam as well a written exam he/she is responsible for his/her own liability and treatment outcomes. If on the job trained, who will ultimately be liable for subpar treatment? This alone should deter this moving forward. I fear the assistant could deflect liability based on training if there is not a clear standard set forth such as in a CODA accredited program.

As a former assistant who would have met the years criteria in the petition I can promise, based on the multiple practitioners with whom I have worked, there is no way this type of on the job training would come close to meeting the necessary training for an assistant to be as proficient as required by the state of Virginia and it's licensing board.

Thank you for your consideration of my opposing this petition,

Marlene Rhodes CDA, BSDH, RDH

Adjunct Faculty J Sargeant Reynolds Community College

VDHA 02 Component Chair, VHyPAC Director, Legislative Chair

CommentID: **87904**

Commenter: Sarah Holland, Virginia Health Catalyst 12/31/20 8:52 am

Opposed

Dear Honorable Members of the Board of Dentistry,

I write to you on behalf of Virginia Health Catalyst (Catalyst) staff, board, and partners. Catalyst is a statewide advocacy nonprofit committed to ensuring all Virginians have equitable access to affordable, comprehensive health care that includes oral health.

Thank you for the opportunity to provide comment on the Virginia Board of Dentistry's public petition for rulemaking to amend requirements for Dental Assistant IIs (DAIIs). Catalyst does not support the petition as written.

Catalyst staff and partners are committed to promoting programs and initiatives to increase the number of DAIIs in the commonwealth; we understand the immense value they bring to oral health care teams by supporting dentists

and expanding patient capacity. Standardized training and certification is vital to develop both a robust network of DAIIs and an appropriate workforce pipeline in the commonwealth.

Catalyst is currently convening a taskforce (Future of Public Oral Health) comprised of oral health stakeholders from across the commonwealth to develop recommendations to improve public oral health systems and care in the wake of COVID and the inequities it amplified. While the recommendations are not final, the taskforce members recognize the tremendous value DAIIs bring to oral health teams and are considering opportunities to increase access to education and certification to ensure more DAIIs are practicing in the commonwealth. This will include a practical and standardized DAII pipeline of education-to-certification-to-employment. We welcome new partners to join us in this important work.

If you have any questions, please do not hesitate to contact me at sholland@vahealthcatalyst.org.

Thank you,

Sarah Holland
Chief Executive Officer, Virginia Health Catalyst

CommentID: **87905**

Commenter: Anonymous 12/31/20 9:04 am

Opposed

Dear Members of the Virginia Board of Dentistry

I write to oppose the petition to create a pathway for dental assistants with 5-10 years of experience to take the Certified Restorative Functions Dental Assistant exam and have the employing dentist observe and approve of their capabilities to be a dental assistant II.

It would be a disservice to the patients in the Commonwealth to allow the proposed kind of practice. Those who want to practice as a Dental Assistant II need to be educated in an accredited institution and supervised by unbiased practitioners before being allowed to perform such services on a patient.

Additionally, the requirements of the Certified Restorative Functions Dental Assistant Exam offered by the Dental Assisting National Board does not address the expanded functions of a dental assistant II as defined by the Virginia Board of Dentistry.

While I fully support the maximum utilization of allied dental professionals, utilization needs to be done in a way that will ensure the highest quality of care for our patients. The Board of Dentistry has a duty to protect the citizens of the Commonwealth. Reducing the educational requirements of a DA II would be a dereliction of duty.

Respectfully submitted,

Kelly Tanner, Ph.D., RDH, CDA

CommentID: **87906**

Commenter: Katherine Landsberg, Dental Assisting National Board, Inc. 12/31/20 12:15 pm

Information About DANB's CRFDA Certification

Dear Distinguished Members of the Virginia Board of Dentistry:

I am writing on behalf of the Dental Assisting National Board, Inc. (DANB) in connection with the petition for rulemaking to amend requirements for a Dental Assistant II that is currently the subject of a public comment period ending December 31, 2020.

As you may know, DANB is the ADA-recognized national certification board for dental assistants and administers the nationally recognized Certified Dental Assistant™ (CDA®) certification program and four other certification programs for oral healthcare workers, including the Certified Restorative Functions Dental Assistant (CRFDA®) certification. DANB's CDA certification is required for registration as a Dental Assistant II in Virginia. DANB's mission is to promote the public good by providing credentialing services to the dental community; as part of that mission, DANB collects and compiles information about dental assisting laws and regulations across the country and serves as a resource to stakeholders seeking information about dental assisting practice in any of the states.

About DANB Certification Eligibility Requirements

The petitioner has asked the Virginia Board of Dentistry "to amend regulations to create a pathway for dental assistants with 5-10 years of experience to take the Certified Restorative Functions Dental Assistant exam and have the employing dentist observe and approve of their capabilities to be a dental assistant II."

The wording of the petition seems to indicate that the petitioner believes the Virginia Board of Dentistry has the authority to alter or amend the DANB CRFDA certification eligibility requirements. Although we know the Board is aware it does not have such authority, for the benefit of all stakeholders participating in this discussion, we would like to explain that CRFDA certification is a private certification program developed and administered by DANB, and only DANB's Board of Directors may make changes to certification eligibility requirements. Individual states may recognize or require one or more component exams that make up CRFDA certification to earn a state-specific license, registration or certificate, or states may require that an applicant for a state credential earn CRFDA certification, but states do not determine the content of the exams or the certification eligibility requirements.

Having said that, however, we would also like the Board and stakeholders to be aware that DANB does consider input from stakeholders about certification eligibility requirements when those requirements are periodically reviewed, and that any feedback about DANB certification may be submitted via email to Dr. Johnna Gueorguieva, DANB's Chief Credentialing and Research Officer, at jgueorguieva@danb.org.

About CRFDA Certification

If the Board is interested in establishing a pathway to the Virginia Dental Assistant II credential that includes successful performance on the CRFDA certification exam as one of the requirements, allow me to provide the following summary of CRFDA certification eligibility pathways:

Pathway I
1. Current or former DANB CDA certificant whose certification lapsed for no more than two years.
2. Current hands-on CPR, BLS or ACLS from a DANB-accepted provider.

Pathway II
1. Graduation from a Commission on Dental Accreditation (CODA)-accredited dental assisting or hygiene program, or Registered Dental Hygienist (RDH) status (from any state except Alabama).
2. Current hands-on CPR, BLS or ACLS from a DANB-accepted provider

Pathway III
1. Completion of an Expanded Functions Dental Auxiliary (EFDA) or restorative course/program offered by an institution with a CODA-accredited dental assisting, dental hygiene or dental program. Each function does not have to be listed separately, but the documentation must indicate that expanded functions/duties or restorative functions/duties were included in the course curriculum.
2. Minimum of 3,500 hours work experience as a dental assistant, accrued during the previous two to four years; employment must be verified by a licensed dentist.
3. Current hands-on CPR, BLS or ACLS from a DANB-accepted provider

I have also sent a copy of this letter to the Board via email. That email message includes an attachment (Attachment 1) containing exam outlines for each of the four component exams that make up the CRFDA certification.

As the Board considers the petitioner's proposal, we direct your attention to Pathway I above, which is the only pathway that would allow an individual who has not completed formal education to qualify for CRFDA certification. Candidates for DANB's CDA certification must either graduate from a CODA-accredited dental assisting program or complete 3,500 hours of work experience over a two- to four-year period to meet CDA eligibility requirements. (There is also a third CDA eligibility pathway for dentists trained outside the U.S. or Canada who wish to earn the CDA certification.) The only way an individual who has not completed formal education could qualify for CRFDA certification would be to first earn the CDA certification through the work-experience pathway, and then qualify for CRFDA through Pathway I above.

Restorative Functions Requirements in Other States

The scope of practice for Virginia Dental Assistants II includes functions that are considered expanded functions in those states where they may be performed by some level of dental assistant. Although the scopes of practice for Expanded Functions Dental Assistants (EFDAs) and equivalent levels of dental assistant roles vary from state to state, performance of restorative functions – that is, placing and finishing amalgam and composite restorations – is the cornerstone and common denominator of EFDA practice.

For your reference, we have provided, via email, a chart (Attachment 2) that shows the states where some level of dental assistant may perform placement and finishing of direct restorations, the level of dental assistant permitted to perform the

function, and the requirements to attain that level in each state. We hope these data will aid you in your consideration of the current rule petition.

DANB thanks the Board for the opportunity to comment on this petition for rulemaking. If there are any questions about the foregoing or any of the attachments, please don't hesitate to contact me at klandsberg@danb.org.
CommentID: **87907**

Commenter: Anonymous — 12/31/20 2:38 pm

Reservations of Suggested Pathway for DAII

Dear Members of Board of Dentistry,

It is a great opportunity to have different pathways for a certified dental assistant who is motivated to expand the knowledge and skills to move in their career forward in dentistry to provide standard of care necessary for dental patients.

I am an assistant professor of an accredited dental assisting program, while I fully support expanding duties of trained dental assistants with the knowledge skills of science and art of dentistry, I have reservation with the pathway provided as it is.

I am in support of provision for more pathways to obtain title dental assistant II (DAII), which include proficiency of all state allowable duties as a DAII. However, the pathway that was suggested may not suffice, as it is. It is beneficial to have other options of education such as DANB certifications to include all skilled dental professionals and also it is important to establish a board approved standard performance clinical examination to test clinical skill competencies, which is conducted by an approved educational institute approved by state regulatory board to maintain highest standards of our profession.

Respectfully,

Piumini Wanigasundera BDS, MEd, CDA

CommentID: **87908**

Commenter: Bonnie Turnage BA CDA, Reynolds Community College Dental Assisting program — 12/31/20 6:05 pm

Opposed to DAII OJT

Opposed to amendment

CommentID: **87909**

Commenter: Neil Turnage DDS — 12/31/20 6:06 pm

opposed to Amendment

Opposed -

CommentID: **87910**

Commenter: David Minoza Jr, Reynolds Community College — 12/31/20 6:57 pm

Opposed DA II

A lot of jobs will be lost and proper didactic training is gone. Therefore, I opposed to this petition.

David Minoza Jr. DDS, CDA
DNA Program Director
Reynolds Community College | School of Health Professions

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Reynolds
COMMUNITY COLLEGE
Where outstanding Health Careers get started!

CommentID: **87911**

Final Text
Regulations for DAII – effective 3/31/21

18VAC60-30-60 Delegation to dental assistants II

~~The following duties~~ Duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-30-120~~:~~.

~~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.~~

18VAC60-30-116 Requirements for educational programs

In order to train persons for registration as a dental assistant II, an educational program shall meet the following requirements:

1. The program shall be provided by an educational institution that maintains a program 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 is 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 is a licensed dentist in Virginia and who may also serve as the program coordinator. The clinical practice advisor shall assist in the laboratory training component of the program and conduct the program's calibration exercise for dentists who supervise the student's clinical experience.

4. A dental assistant II, registered in Virginia, who assists in teaching the laboratory training component of the program shall have a minimum of two years of clinical experience in performing duties delegable to a dental assistant II.

5. The program shall enter into a participation agreement with any dentist who agrees to supervise clinical experience. The dentist shall successfully complete the program's 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, a nonprofit dental clinic, or an educational institution clinic.

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

18VAC60-30-120 Educational requirements for dental assistants II

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

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 course work~~ Didactic coursework 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 coursework 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.

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, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than six class I and six 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, placement of a non-epinephrine retraction cord, and pulp capping procedures, and no less than 12 class I, 12 class II, five class III, five class IV, and five class V restorations completed on a manikin simulator to competency; and

c. At least ~~20~~ 10 hours of ~~taking~~ making final impressions ~~and use~~, placement of a non-epinephrine retraction cord~~; and~~, final cementation of crowns and bridges after preparation, and adjustment and fitting by the dentist, and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two 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, placement of a non-epinephrine retraction cord, and no less than six class I and six class II restorations completed on a live patient to competency;

b. At least ~~120~~ 60 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and no less than six class I, six class II, five class III, three class IV, and five class V restorations completed on a live patient to competency; and

c. At least ~~40~~ 30 hours of ~~taking~~ making final impressions ~~and use~~; placement of ~~a~~ non-epinephrine retraction cord; ~~and~~ final cementation of crowns and bridges after preparation, adjustment, and fitting by the dentist; and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two 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~~ 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.~~ An applicant may be registered as a dental assistant II with specified competencies set forth in subdivision a, b, or c of subdivisions B 3 and B 4 of this section.

Virginia Department of
Health Professions
Board of Dentistry

Disciplinary Board Report

Today's report reviews the 2020 Calendar year case activity.

Calendar Year 2020

The table below includes all cases that have received Board action since January 1, 2020 through December 31, 2020

Year 2020	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	40	26	4	30
Feb	45	35	6	41
March	34	27	10	37
April	49	30	1	31
May	36	34	0	34
June	28	48	0	48
July	26	43	2	45
Aug	51	45	12	57
Sept	35	27	5	32
Oct	37	26	6	32
Nov	28	47	5	52
Dec	32	55	3	58
TOTALS	441	443	54	497

Closed Case with Violations consisted of the following:

Patient Care Related:

- **34 Standard of Care: Diagnosis/Treatment:** Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also, include failure to diagnose/treat& other diagnosis/treatment issues.
- **3 Standard of Care: Surgery** : Improper/Unnecessary performance of surgery, improper patient management, and other surgery related issues.
- **4 Inability to Safely Practice:** Impairment due to use of alcohol, illegal substances, or prescription drugs or incapacitation due to mental, physical or medical conditions.
- **2 Cases of Drug Related-Patient Care:** Dispensing in violation of DCA (to include dispensing for non-medicinal purposes, excessive prescribing, not in accordance with dosage, filling an invalid prescription, or dispensing without a relationship), prescription forgery, drug adulteration, patient deprivation, stealing drugs from patients, or personal use.
- **2 Abuse/Abandonment/Neglect**: Any sexual assault, mistreatment of a patient, inappropriate termination of provider/patient relationship, leaving a patient unattended in a health-care environment, failure to do what a reasonable person would do in a similar situation.

- **1 Unlicensed Activity**: Practicing a profession or occupation without holding a valid license as required by statute or regulation to include: practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity.

Non-Patient Care Related:

- **6 Business Practice Issues**: Advertising, default on guaranteed student loan, solicitation, records, inspections, audits, self-referral of patients, required report not filed, prescription blanks, or disclosure.
- **2 Criminal Activity:** Felony or misdemeanor arrest, charges pending, or conviction.

CCA's

There were **6** CCA's issued so far in 2020. The CCA's issued consisted of the following violations:

- **4 had Business Practice Issues**
- **2 had Standard of Care: Diagnosis/Treatment**

Summary Suspensions/Suspensions/Revocations

There were **2** Summary Suspension and **1** Revocation issued so far in 2020. The Summary Suspensions, Suspensions, and Revocations consisted of the following violations:

- **2 Mandatory Suspension for Criminal Activity**: Felony Conviction
- **1 Revocation for Drug Related-Patient Care**

Calendar Year 2019

The table below includes all cases that have received Board action since January 1, 2019 through November 30, 2019

Year 2019	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	33	20	1	21
Feb	36	33	1	34
Mar	34	39	4	43
Apr	48	30	3	33
May	46	71	2	73
Jun	33	46	4	50
Jul	37	19	3	22
Aug	30	37	2	39
Sept	43	31	6	37
Oct	46	25	2	27
Nov	40	49	1	50
Dec	24	14	4	18
TOTALS	450	414	33	447

Virginia Department of
Health Professions
Board of Dentistry

Disciplinary Board Report

Today's report reviews the 2021 January and February case activity.

January/February 2021

The table below includes all cases that have received Board action since January 1, 2021 through February 28, 2021

Year 2021	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	40	20	10	30
Feb	29	28	4	32
TOTALS	69	48	14	62

Closed Case with Violations consisted of the following:

Patient Care Related:

- **14 Standard of Care: Diagnosis/Treatment:** Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also, include failure to diagnose/treat& other diagnosis/treatment issues.
- **1 Abuse/Abandonment/Neglect:** Any sexual assault, mistreatment of a patient, inappropriate termination of provider/patient relationship, leaving a patient unattended in a health-care environment, failure to do what a reasonable person would do in a similar situation.
- **1 Unlicensed Activity:** Practicing a profession or occupation without holding a valid license as required by statute or regulation to include: practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity.

MEETING AGENDA

***Please note the times listed below are in Eastern Standard Time ***

Friday, Feb. 26 - Welcome Reception

6:00 p.m. Virtual Check-in & Preview Sponsor Exhibits

7:00 p.m. Welcome Toast with President Zena

7:20 p.m. Comedy Set with Paul Morrissey

Paul was raised as a sports fanatic in the tiny town of Oswego, in upstate New York. After four years of playing college basketball, somehow he graduated. Aside from playing in the NBA, his dream job was to talk about sports for a living. Paul then moved to California after landing a television sports anchor job but found out quickly that he was "too much of a comedian" for TV news. After he was fired, Paul took his unique sense of humor to comedy club and college stages all over the country.

Paul was selected to perform at the HBO Comedy Festival in Las Vegas. Morrissey has also been a finalist in several national comedy competitions including Wendy's Comedy Challenge, Comedy Central's Open Mic Fight and Maxim's Real Men of Comedy. Morrissey's big break came when he made his network television debut on "The Late, Late Show" on CBS. He was so well received that Paul has been asked back 5 times!

Morrissey also released his debut CD, "Good Seats Still Available," which gets regular airplay on SiriusXM Satellite Radio. He has appeared twice on The Late Show with David Letterman on CBS and on Comedy Central.

8:00 p.m. Preview Sponsor Exhibits Cont.

Saturday, Feb. 27- General Assembly I

12:00 - 12:15 p.m. **President's Opening Remarks**
Robert B. Zena, DMD, President, AADB

12:15 - 12:20 p.m. **Executive Director's Report**
Tonia Socha-Mower, MBA, EdD (c), Executive Director

12:20 - 1:00 p.m. **U.S. Public Health Service**
Rear Admiral Timothy Ricks, DMD, MPH, FICD, Chief Dental Officer

1:00 - 1:10 p.m. **DentaQuest Partnership for Oral Health Advancement**
Michael Monopoli, DMD, MPH, MS, Vice President of Grant Strategy

1:10 - 1:35 p.m. **Sponsorship Recognition**

1:35 - 2:00 p.m. **Break**
Virtual Exhibit Hall Open for Networking

2:00 - 2:20 p.m.	**Centers for Disease Control and Prevention** Casey Hannan, MPH, Director of the Division of Oral Health
2:20 - 2:40 p.m.	**Update from Dental Educators in Response to COVID-19** Denice Stewart, DDS, MHSA, Chief Policy Officer, ADEA
2:40 – 3:00 p.m.	**Interprofessional Collaboration to Confront the Opioid Epidemic** Humayun 'Hank' Chaudry, DO, MS, MACP, FRCP, MACOI, President & CEO of the Federation of State Medical Boards Aisha Salman, Acting Director of the National Academy of Medicine Action Collaborative on Countering the US Opioid Epidemic
3:00 - 3:10 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**
3:10 – 3:40 p.m.	**Attorney Round Table** Lori Lindley, Senior Assistant Attorney General, Oregon Grant Gerber, Assistant Attorney General, Maryland
3:40 - 4:00 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**
4:00 - 5:00 p.m.	**Medical and Dental Parameters of Sleep Apnea** David Schwartz, DDS, President, American Academy of Dental Sleep Medicine Alejandra Lastra, MD, Director, Sleep Medicine Fellowship & Assistant Professor, Division of Pulmonary, Critical Care and Sleep Medicine, Rush University Hospital & President-Elect, Illinois Sleep Society

Sunday, Feb. 28 - General Assembly II

12:00 - 12:20 p.m.	**Diamond Sponsor Welcome** Susan Greenspon Rammelt, Chief Legal Officer, EVP Business Affairs, SmileDirectClub
12:20 - 1:00 p.m.	**Increasing Access to Care through Telehealth** Brant Herman, Co-Founder and CEO, MouthWatch, LLC Vincente Calderón, OD, CEO, Aspire Health Solutions ©
1:00 - 1:20 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**

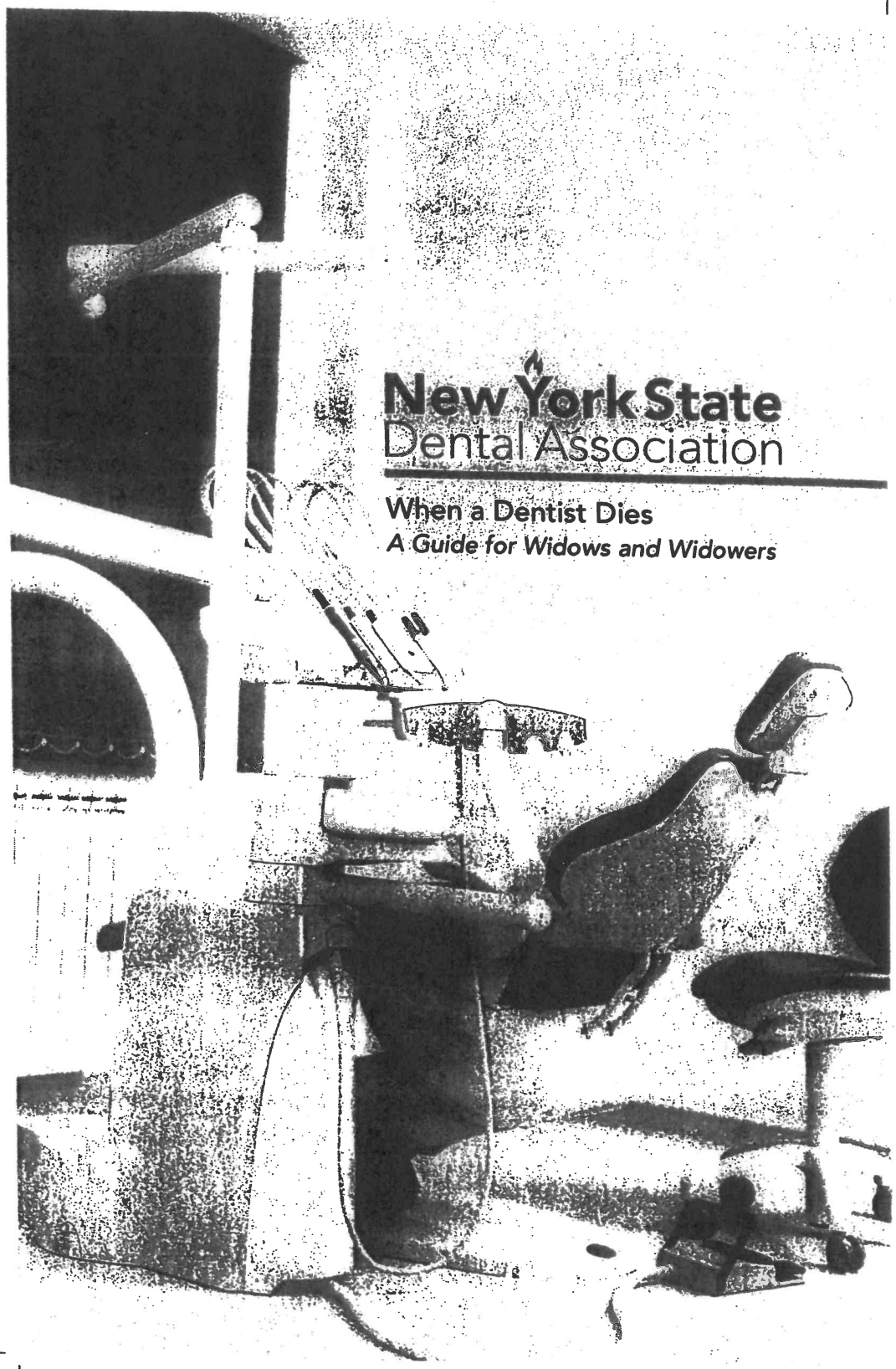
1:20 - 2:20 p.m.	**Anesthesia in the Dental Office** Jade Miller, DDS, Chair of the Safety Committee, American Academy of Pediatric Dentistry Michael Almeida, MSN, CRNA, President, Illinois Association of Nurse Anesthetists Eugene Vayman, DNAP, CRNA, Quantum Anesthesia Services
2:20 - 2:40 p.m.	**Break** **Virtual Exhibit Hall Open for Networking**
2:40 - 3:00 p.m.	**AADB Open Forum: State Board Issues** Frank Maggio, DDS, AADB Member and Moderator
3:00 p.m.	**Adjournment**

Thank you for participating in our first virtual meeting!

Board of Dentistry Licensees and Registrants

There are 15,181 Dentistry licensees as of February 1, 2021. The number of current licenses are broken down by profession in the following chart.

Current Licenses	
Cosmetic Procedure Certification	41
Deep Sedation/General Anesthesia	67
Dental Assistant II	38
Dental Faculty	13
Dental Hygienist	6,067
Dental Hygienist Restricted Volunteer	3
Dental Restricted Volunteer	13
Dentist	7,694
Enteral Moderate Sedation	134
Mobile Dental Facility	11
Moderate Sedation	255
Oral/Maxillofacial Surgeon Registration	252
Sedation Permit Holder Location	525
Temporary Resident	68
Total for Dentistry	**15,181**


New York State
Dental Association
When a Dentist Dies
A Guide for Widows and Widowers

When the owner and operator of a going dental practice dies, his or her spouse faces many questions about what to do with the practice and how.

Who owns the practice?

Can the practice continue to operate and generate income?

What should be done with patient records?

Are there special considerations if the practice was a partnership, professional corporation or limited liability company?

Often, the surviving spouse has no answers to these questions. Many family lawyers who handle estate matters are not well versed in the unique requirements surrounding professional dental practices.

This brochure sets forth some simple guidelines for surviving spouses to follow upon the death of a spouse who was operating a dental practice. The information found in this guide was prepared by the Legal Department of the New York State Dental Association.

Who Owns the Practice When the Dentist Dies?

Sole Proprietorships

As with any other property or business, a dental practice is an asset that becomes part of the owner's estate when the owner dies. The real property on which the office sits; the equipment, supplies and other personal property in the office; the patient records, and the goodwill of the practice are all assets whose ownership will pass to the deceased's estate.

If the dental office space was leased, the rights under the lease may also pass to the estate depending upon the terms of the lease. The surviving spouse needs to know what property was part of the dental practice and then make certain that all appropriate property is included in the estate.

The executor of the estate, if there is a will, or the administrator, if there is not, is legally responsible for marshaling all the assets of the estate. Although the deceased's estate takes ownership of the tangible and intangible property making up the former practice, the estate cannot own or operate a dental practice. Only a licensed person or entity can own a going dental practice, and an estate cannot obtain a dental license. Therefore, the estate's ownership is limited to the purpose of liquidating and selling the practice. The one exception is that the estate can ask permission from the New York State Surrogate's Court to operate the deceased dentist's practice for a maximum period of eight months.

Partnerships and Limited Liability Partnerships

A dentist who was a partner in a dental practice will usually have his/her share of the assets pass to his/her estate upon death. The estate will generally not have any specific interest in partnership property, so the assets that pass to the estate are usually governed by the written partnership agreement.

The surviving spouse needs to obtain a copy of the partnership agreement and be familiar with the rights and requirements spelled

out in that document. The situation is the same for a partnership that is structured as a limited liability partnership.

Professional Corporations

A dentist who was the sole shareholder of a professional corporation will have his/her assets treated exactly the same as a sole proprietorship, except that the shares of stock in the professional corporation are additional items that become part of the dentist's estate.

A dentist who was one of several shareholders in a professional corporation has very different considerations. The professional corporation is obligated by law to redeem the outstanding shares of the deceased within six moths after the appointment of an executor or administrator of the estate. The shares must be redeemed at their book value as of the end of the month immediately preceding the shareholder's death. However, the certificate of incorporation, the corporate bylaws, or an agreement among the corporation and all shareholders may shorten the time period for redemption or set a different method for determining the price of the shares to be redeemed.

Also, the corporation's obligation to redeem the shares does not prohibit the estate from selling the shares to another dentist prior to the corporation's redeeming the shares.

Professional Limited Liability Companies

A dentist who was the sole member of a professional limited liability company will have his/her assets treated exactly as if he/she had been a sole proprietor.

A dentist who was one of several members in a professional limited liability company will have his/her assets treated in the same way as a shareholder in a multi-shareholder professional corporation.

The deceased's membership interest must be redeemed by the company in the same way that shares in a professional corporation are redeemed when a shareholder dies. Also, the written operating agreement of the company will need to be consulted to determine if there are any special rights under the agreement. The surviving spouse needs to obtain a copy of the operating agreement and be familiar with the rights and requirements spelled out in that document.

Can the Practice Operate After the Owner Dies?

Sole Proprietorships

Although the dentist's estate has technical ownership over the assets comprising the practice, in New York State only a dentist licensed in the state can practice dentistry and, pursuant to Section 6512 of the New York State Education Law, no unlicensed person or entity can own or operate a dental practice.

Because an estate is not capable of obtaining a license to practice dentistry, it lacks the legal authority to continue to operate a dental practice for the benefit of the estate, unless the estate petitions the New York State Surrogate's Court to operate the deceased dentist's practice for a maximum period of eight months.

Partnerships and Limited Liability Partnerships

The death of a partner ordinarily will dissolve a partnership, unless the written partnership agreement provides otherwise. Most partnership agreements do provide otherwise by allowing the remaining partners to vote to continue the partnership.

The major issue that arises with the death of a partner is whether the partnership can continue to use the deceased partner's name in the practice. Unless the partnership agreement allows for such use, the deceased partner's name cannot be used unless his/her estate gives permission for such use.

Professional Corporations

The death of a dentist who was the sole shareholder in a professional corporation is treated essentially the same as if the deceased had been a sole proprietor. The dental practice cannot continue to be operated by the estate, unless the estate petitions the New York State Surrogate's Court to operate the deceased dentist's practice for a maximum period of eight months. The death of a dentist who was one shareholder in a multi shareholder professional corporation does not affect the right of the professional corporation to continue to operate. The corporation simply carries on with the remaining shareholders.

The name of the deceased shareholder cannot be used in the name of the professional corporation unless the name was used previously by the corporation. This continued use of the deceased dentist's name is not dependent upon permission from his/her estate.

Professional Limited Liability Companies

The death of a dentist who was the sole member in a professional limited liability company is treated essentially the same as if the deceased had been a sole proprietor. The dental practice cannot continue to be operated by the estate, unless the estate petitions the New York State Surrogate's Court to operate the deceased dentist's practice for a maximum period of eight months.

The death of a dentist who was one member in a multi-member professional limited liability company generally results in the dissolution of the company, unless the written operating agreement provides otherwise. In any event, the estate cannot substitute for the deceased as a member of the company.

If the written operating agreement does provide that the company survives a member's death, the company can continue to operate the dental practice. It can also continue to use the deceased dentist's name in the practice and it does not need to seek permission from the dentist's estate to do so.

What Should Be Done with Patient Records?

Sole Proprietorships

If a dentist dies, his/her patient records become part of the estate, and the estate obtains the same ownership rights that the dentist previously held.

As already stated, an estate cannot practice dentistry or carry on a dental practice for its own benefit, unless the estate petitions the New York State Surrogate's Court to operate the deceased dentist's practice for a maximum period of eight months. Therefore, the estate will have to sell the patient records as part of the sale of the practice if it wishes to obtain anything of value for the records. The eight month rule is designed to allow time to make a sale of the practice without the records and other assets losing their value.

The estate does not have to sell the patient records and, because it is not bound by the professional conduct rule that requires licensees to keep dental records for six years, it could destroy the records. However, despite being freed from the record-retention rule, the dentist's estate should not rush to destroy the patient records. It can still be sued for malpractice committed by the dentist before his/her death. This potential liability will not run out until the two-and-one-half-year dental malpractice statute of limitations runs out against all patients.

Therefore, in order to defend such suits, the dentist's estate should keep copies of the patient records for at least two-and-one-half years from the date of the dentist's death. In some instances, such as discovery of a foreign object in the patient's body, the statute of limitations can run for a longer period; and the dentist's estate should obtain advice from a qualified attorney about how to handle such a contingency.

A dentist's estate will also need to bear in mind that Section 4504 of the New York State Civil Practice Law and Rules (the dentist/patient privilege law) will still apply to any records held by the dentist's estate.

That law created confidentiality rights that were held by the patients rather than by the deceased dentist. The dentist's estate must take care not to breach the privilege of confidentiality held by the

patient. Thus, in selling any patient records, the estate should obtain the patient's consent through use of the same standard consent letter employed when a living dentist sells his/her patient records to another dentist.

(Copies of that letter can be obtained through NYSDA.)

Partnerships and Limited Liability Partnerships

In a partnership, the patient records are owned by the partnership and not by its individual members. Thus, when a partner dies, the partnership handles the disposition of the patient records. It is unlikely that the dentist's estate will have any specific right of ownership in any of the patient records. However, the estate may still want to obtain copies of the deceased's records in order to protect it from possible malpractice suits.

It should be kept in mind that the partnership has no legal obligation to provide copies of records to the deceased's estate, which is why it is a good idea for every dentist to maintain his/her own personal set of patient records.

Professional Corporations

The patient records of a deceased dentist who was the sole shareholder in a professional corporation should be treated essentially as if the deceased had been a sole proprietor.

The patient records of a deceased dentist who was one shareholder in a multi-shareholder professional corporation are owned by the professional corporation and not by the deceased's estate. Thus, the professional corporation will handle the disposition of the patient records. In this respect, the professional corporation is much like a partnership.

Again, the estate may still want to obtain copies of the deceased's records in order to protect it from possible malpractice suits. However, like a partnership, the professional corporation has no legal obligation to provide patient records to the estate.

Professional Limited Liability Companies

The patient records of a deceased dentist who was the sole member in a professional limited liability company should be treated exactly as if he/she had been a sole proprietor.

The patient records of a deceased dentist who was one member in a multi-member professional limited liability company are owned by the company and not the deceased's estate. Thus, the company will handle the disposition of the patient records. In this respect, the limited liability company is like the partnership and the professional corporation.

Again, the estate may still want to obtain copies of the deceased dentist's records in order to protect it from possible malpractice suits. However, like the partnership and the professional corporation, the limited liability company has no legal obligation to provide patient records to the estate.

Be Prepared

The emotional and economic upheaval caused by the death of a spouse can become even more devastating when that spouse was a dentist with a thriving practice. But there are steps you can take now to avoid the potentially tangled web of estate issues likely to follow the death of a dentist spouse.

1. Make sure the estate has an accurate list of the assets of the deceased dentist's practice, both tangible and intangible.

2. Make sure legal paperwork, such as partnership agreements, professional corporation bylaws, limited liability company agreements, leases, contracts and other similar documents, is available to the estate and understood by the estate.

3. Check to see if there are any pending or potential malpractice claims against the deceased so that the estate can be alerted to their existence.

4. Remember to maintain patient records until the estate is free and clear of any potential malpractice liability.

5. Make sure patient confidentiality is not breached by actions of the estate.

6. Make sure that the attorney handling the estate is familiar with and capable of handling the special considerations that the liquidation and sale of a dental practice pose.

With regard to choosing an attorney, NYSDA can help the dentist's survivors through the NYSDA Legal Services Panel. If you do not have an attorney or wish to obtain a new attorney, call NYSDA at 1-800-255-2100 to obtain assistance and a referral to the Legal Services Panel.