AGENDA
June 11, 2021

Virginia Department of Health Professions

MEETING OF THE VIRGINIA BOARD OF DENTISTRY
JUNE 11, 2021 BOARD BUSINESS MEETING

Perimeter Center, 9960 Mayland Drive, Board Room 4, Henrico, Virginia

Instructions for Accessing the Board Meeting and Providing Public Comment

The Board meeting is being held **in-person** at the Perimeter Center, 9960 Mayland Drive, Board Room 4, Henrico, Virginia. To observe this meeting, use one of the options below.

TO PARTICIPATE IN-PERSON:

Perimeter Center, 9960 Mayland Drive, Board Room 4, Henrico, VA 23233
Public attendance in Board Room 4 is limited due to the COVID-19 pandemic, and presence in the room will be on a first-come, first-seated basis; room capacity for the public is 8.

ONLY PERSONS ATTENDING THIS MEETING IN-PERSON WILL HAVE THE OPPORTUNITY TO ADDRESS THE BOARD DURING THE PUBLIC COMMENT PERIOD BEING HELD AT THE BEGINNING OF THE MEETING.

WRITTEN COMMENTS MAY BE SENT TO SANDRA.REEN@DHP.VIRGINIA.GOV BY 3PM ON THURSDAY JUNE 10, 2021. WRITTEN COMMENTS RECEIVED BY THIS DEADLINE WILL BE PROVIDED TO BOARD MEMBERS AND WILL BE NOTED IN THE MINUTES OF THIS MEETING.

TO LISTEN BY PHONE, CALL: 1-866-692-4530
Meeting number (access code): **161 431 2663**
Meeting password: **BODBM061121**

TO OBSERVE AND LISTEN TO THE MEETING CLICK THE LINK BELOW:

https://covaconf.webex.com/covaconf/j.php?MTID=m90c7fa5ef4ed2dfb5d1765c3a2a6f352

DIAL 804-912-0334 to report problems accessing the meeting and/or an interruption during the broadcast.

NOTE: Should the Board enter into a closed session, public participants will be asked to leave the room and those attending virtually will be blocked from seeing and hearing the discussion. When the Board re-enters into open session, public participation connections to see and hear the discussions will be restored.

Virginia Department of Health Professions

AGENDA
June 11, 2021
Board Room 4

VIRGINIA BOARD OF DENTISTRY

BOARD BUSINESS MEETING

PERIMETER CENTER, 9960 MAYLAND DRIVE, SECOND FLOOR CONFERENCE CENTER, HENRICO, VA 23233

Board Discussion Topics

Deputy Executive Director's Report – Ms. Sacksteder

Executive Director's Report – Ms. Reen

Board Counsel Report – Mr. Rutkowski

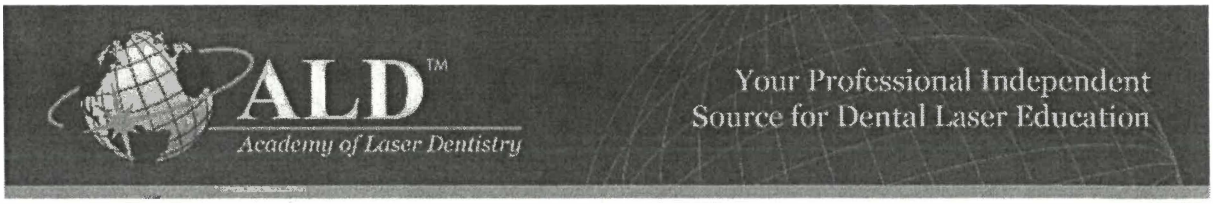
Commonwealth of Virginia

Reen, Sandra <sandra.reen@dhp.virginia.gov>

Aerosols in the Dental Office

2 messages

Gail Siminovsky, CAE - Academy of Laser Dentistry <memberservices@laserdentistry.org> Mon, May 3, 2021 at 4:05 PM
Reply-To: memberservices@laserdentistry.org
To: sandra.reen@dhp.virginia.gov



To: State Boards of Dentistry Office of the Executive Director and
Occupational Safety and Hazard Administration (OSHA) Agencies

From: Academy of Laser Dentistry

Re: Public Safety Information During COVID-19 Pandemic

Dear Sir or Madame,

The Academy of Laser Dentistry is the primary organization for dental lasers. Our mission is to provide education of dental practitioners to practice safe and effective use of laser technology that ensures both patients' and practice's well-being.

We are communicating with you to provide solutions to aerosol production that can occur in the dental environment.

Current devices utilized in dental operatories can create aerosols, with ultrasonics and high- speed handpieces producing more airborne contamination than other commonly utilized devices. Because of this, CDC guidelines for prevention of transmission of the novel Coronavirus SARS –CoV-2 includes recommendations to decrease high speed handpiece activity with particular attention to limiting the use of ultrasonic devices in the dental hygiene operatory. Public health benefits associated with adjunctive use of the diode laser for bacterial reduction in the sulcular epithelium are well documented with no aerosol production.

Similarly, co-morbidities associated with oral bacteria load become greater risk factors during public health emergencies, including the current pandemic. Consequently, clarity by public health experts about the safety and efficacy of the diode laser in the hygiene operatory may be key to optimizing the public health benefits of good oral health during the present, and possibly future pandemics.

We believe that dental diode lasers can serve as a safe and beneficial adjunct to manual cleaning devices, and we seek this clarification for three reasons:

1. To assure patients receiving dental or periodontal cleaning via dental diode lasers – and the hygienists who perform such procedures – that aerosol is not being generated.
2. To assure practicing dentists that the use of dental diode lasers for specific procedures and at their intended settings will not, in and of themselves, subject their practices to the various control measures.
3. To further individual and public health. The accompanying document, *Rationale for Consideration of a Diode Laser for Adjunctive Non-Aerosol Management, and references* explain how dental diode lasers can eliminate bacteria from the periodontal pocket which, if left alone, can cause diseases and conditions that make patients more vulnerable to COVID-19. The use of manual instruments, the primary alternative to ultrasonic devices, provides no such benefit.
4. In October 2020, an article in the Journal of the American Dental Association reported that COVID-19 prevalence among dentists, as of June 2020, during the initial acceleration phase of the pandemic was less than 1%. An estimated 3.1% of U.S. dental hygienist had contracted COVID-19 as of October 2020, according to research from the ADA and American Dental Hygienists' Association.

We can speak to you directly on the topic of laser dentistry. Feel free to ask us for any additional information you might need. You may contact me directly or through the Academy of Laser Dentistry Executive Director, Gail Siminovsky, CAE at siminovsky@laserdentistry.org.

Thank you for this consideration to recognize the rationale of the diode laser as non-aerosol-generating and beneficial for adjunctive dental hygiene management.

Respectfully yours,

Edward R. Kusek, DDS, MAGD, MALD, DABOI, FAAID
ALD President 2020-2021
Email: edkusek@me.com
Cell: 605 310-1965
www.laserdentistry.org

Tag @academyoflaserdentistry on social media so we can share your post!
#ALDlasers

The Academy of Laser Dentistry (ALD) is an international professional association of dental practitioners and supporting organizations dedicated to improving the health and well-being of patients through the proper use of laser technology.

ALD®
Academy of Laser Dentistry

Sandra Reen

From: Pace, Jacqueline <jacqueline.pace@vadoc.virginia.gov> on behalf of Pace, Jacqueline
Sent: Tuesday, June 1, 2021 8:59 AM
To: Donna Lee; Sandra Reen
Subject: Letter to the Board
Attachments: Board2021 (1).docx

Good morning ladies,
I hope this email finds you well. Please include the attached letter in the next Board meeting package/agenda. I understand I did not meet the deadline last time.

Have a great week!!

Thank you,
Jacki

March 15, 2021

Virginia Board of Dentistry
Attn: President Augustus Petticolas, Jr. DDS
Members of the Board

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Dear Dr. Petticolas, Members of the Board;

On March 5, 2021, the Examination Committee of the Virginia Board of Dentistry met to determine several items one of which was the acceptance of a dental exam for the Virginia dental and dental hygiene graduates.

There are several points of concern during this meeting and they are as follows:

First, is the validity of the consultant, Dr. Archer, who was selected to consult the exam committee on the various regional tests that were available, represents a conflict of interest. He is currently participating as an examiner for the exam (Adex) which he has recommended to the exam committee to be the exclusive exam for the state of Virginia (refer to March 5th minutes). According to Virginia Board of Dentistry Regulation 18 VAC-60-21-120 "...pass a compensatory clinical exam that is accepted by the board" and 18 VAC 60-25-140 "....successfully completed a board approved clinical competency examination in dental hygiene"; currently there are several exams that meet this criteria and only one was recommended to the committee. The selection of a neutral consultant would have given the committee a transparent view of all the information for the members to make a qualified informed decision.

The second concern is having one exam for the state lends itself to a monopoly, not to fair trade. We as a society are afforded choices in our daily lives such as subscribing to one of the many cable providers, which airline to book a flight, what type a car to purchase, which bank will provide me the best rates and which college should I attend. It would be a good fair trade decision to offer the students more than one exam to choose from and not restrict their path to licensure.

Another point of note, would be the absence of competition. Competition keep entities transparent, progressing and fees in check; this is where the

graduates benefit (airlines are one of the best examples of this). By the Board accepting more than one exam for their graduates, this gives the students more versatility for dates and sites to select from. Mobility has been a buzz word for the graduates taking the exam. Most states accept more than one exam, which lends itself to mobility by having a varied accepting criteria. Kentucky, Tennessee, and West Virginia are border states which accept multiple exams and this varied accepting criteria extends to the states on the West Coast.

In closing, members of the board, I ask that you consider the above concerns in your decision and the regulatory language you decide to choose in making choices for the dental and dental hygiene graduates.

Respectfully,

Ms. Jacqueline Pace, RDH, BS, MS
Past President 2010
Virginia Board of Dentistry

APPROVAL OF MINUTES

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING MINUTES
March 18, 2021

TIME AND PLACE: The virtual formal hearing of the Virginia Board of Dentistry was called to order at 1:00 p.m., on March 18, 2021.

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.
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.

BOARD MEMBERS ABSENT:
Sandra J. Catchings, D.D.S.
Jamiah Dawson, D.D.S.
Dag Zapatero, D.D.S.

STAFF PRESENT VIRTUALLY:
Sandra K. Reen, Executive Director, Board of Dentistry
Jamie C. Sacksteder, Deputy 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:
Lori Pound, Adjudication Consultant, Administrative Proceedings Div.
Camron Jordan, Court Reporter, Veteran Reporters, Inc.
Darlene Nicoletti, D.D.S., Respondent
Corey M. Tisdale, Esquire, Counsel for Respondent

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

Darlene Nicoletti, D.D.S. Case No.: 204109 Dr. Nicoletti was present with legal counsel in accordance with the Notice of the Board dated November 5, 2020.

Dr. Petticolas swore in the witnesses.

Dr. Petticolas stated there was an editorial correction in Allegation #2(h) in the Notice which should read as follows: "Dr. Nicoletti's history of substance abuse, positive screenings, and noncompliance with HPMP's requirement for ongoing treatment and monitoring."

There were no objections to the amended language.

Upon a request by Ms. Pound and no objections by Mr. Tisdale, the witnesses were sequestered.

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

Mr. Tisdale made an opening statement; however, he did not have any exhibits to present on behalf of the Respondent.

Testifying on behalf of the Commonwealth was David Robinson, DHP Adjudication Specialist and Amy Ressler, Program Administrator Director for the Health Practitioners' Monitoring Program (HPMP).

Testifying on behalf of the Respondent was Dr. Kevin Doyle, Dr. Bruce Clemons, Kate Basco, R.N., and Dr. Nicoletti.

Ms. Pound and Mr. Tisdale provided closing statements.

Closed Meeting:

Dr. Bryant 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 Darlene Nicoletti, D.D.S. Additionally, he moved that Board staff, Ms. Reen, Ms. Sacksteder, 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. Bryant 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. Bryant 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. Nicoletti's license to practice dentistry is reinstated; stayed pending proof of entry into a substance abuse monitoring program at HPMP or another program approved by the Board and successful completion of the program. Dr. Nicoletti also has to document completion of 15 hours of continuing education for the period ending March 2019, March 2020 and March 2021.

Dr. Bryant 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 5:40 p.m.

Augustus A. Petticolas, Jr., D.D.S., President	Sandra K. Reen, Executive Director
Date	Date

VIRGINIA BOARD OF DENTISTRY
BUSINESS MEETING MINUTES
March 19, 2021

TIME AND PLACE: The virtual meeting of the Virginia Board of Dentistry was called to order at 10:00 a.m., on March 19, 2021.

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.
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.

BOARD MEMBERS ABSENT: Sandra J. Catchings, D.D.S.

STAFF PRESENT VIRTUALLY:
Sandra K. Reen, Executive Director of the Board
Jamie C. Sacksteder, Deputy Executive Director
Donna Lee, Discipline Case Manager
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
Richard Archer, D.D.S., M.S. Board Consultant

COUNSEL PRESENT VIRTUALLY: James E. Rutkowski, Assistant Attorney General

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

Dr. Petticolas welcomed the new Board member, Dr. Zapatero.

PUBLIC COMMENT:

Dr. Petticolas explained the parameters for public comment and opened the public comment period. He stated that written comments were received from Mr. Trey Lawrence, Kannan Ramar, M.D., and Ms. Jessica Bui, which were included in the agenda package. He further stated that written comments received from Mr. Brett Seigel, Dr. James Watkins, Ms. Jessica Bui, Dr. Dag Zapatero, Dr. Erika Mason, Dr. David Schwartz, and Dr. Alexander Vaughan were sent by email to Board members and the Public Participation list and will be posted with the draft minutes.

Jessica L. Bui, Executive Director, Southern Regional Testing Agency, Inc. (SRTA) – Ms. Bui stated that SRTA has a long standing history with Virginia and it does fulfill the requirements that Virginia has for licensure. She stated that competition is good for students and it allows them to choose which examination they would like to take. Ms. Bui also stated that by only allowing one testing agency, it could hinder the acceptance of applicants to Virginia and she hoped that Virginia would remain inclusive and accept SRTA as a testing exam.

Brett Seigel, VCU ASDA Chapter President Elect - Mr. Seigel said the ASDA chapter at VCU takes the position of moving dental licensure from live patient board exams to non-live patient exams due to the negative impact of using human subjects in clinical licensing examinations. Mr. Seigel stated that ASDA 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; and is universally accepted.

Dr. Gerry Walker, SRTA President – Dr. Walker stated that competition is good across any endeavor. He also stated that using only one agency to test would make a monopoly; and students should be allowed to choose what testing examination they want to take.

Bruce D. Horn, D.D.S., WREB Dental Examination Director – Dr. Horn commented that WREB has been accepted in Virginia for more than 20 years. He stated that the current WREB exam meets and in some areas exceeds the requirements for Virginia licensure. He emphasized that portability for candidates is not equivalent to accepting just one examination and that the ADEX exam is not given everywhere. He said WREB would like to continue to be accepted in Virginia for initial licensure candidates offered to make a presentation to the Board to answer any questions or concerns.

Jason R. Bierig, General Counsel for WREB - Mr. Bierig said the Board is considering withdrawal of acceptance of the WREB exam because of concerns about WREB's system for scoring the exam; and the proposition that if one licensure exam is accepted in all states there is no reason to accept other exams in Virginia. He stated he believed the Board did not consider the correct score reports WREB sent to the

Board. He explained that accepting only one exam is contrary to the goal of portability and would also eliminate competition. He asked the Board to continue accepting their exam and requested a discussion between WREB and the Board to address their concerns.

Erika Mason, D.D.S. – Dr. Mason addressed her concerns about the letter from the American Academy of Sleep Medicine (AASM) which asks the Board to change or incorporate some rules to not allow dentists to use a home sleep test for the treatment of patients with obstructive sleep apnea. She said the AASM had misrepresented the article the American Academy of Dental Sleep Medicine (AADSM) provided. Dr. Mason said that dentists do not want to use the home sleep test for diagnostic purposes, but as something that would benefit the patient to make sure they receive proper treatment and is good for their health. Dr. Mason encouraged having further discussion about this issue before making any determinations about changing laws or regulations.

Alexander T. Vaughan, D.D.S., Dental Director of Virginia Total Sleep – Dr. Vaughan stated that the AASM letter was sent to all state Boards. The AADSM found that only ordering the home sleep test was within the scope of dentistry. The AASM is focused on testing and the interpretation of that test; however, the AADSM is focused on ordering the administration of testing, which is within the scope of the practice of dentistry. Dr. Vaughan encouraged the Board to either take no action with respect to the letter received from AASM or consider appointing a regulatory advisory panel composed of the stakeholders and specialties so that information could be provided from both sides to address the regulatory issue. Dr. Vaughan offered to assist the Board in discussion of this subject.

APPROVAL OF MINUTES:

Dr. Petticolas asked if there were any edits or corrections to any of the four sets of draft minutes included in the agenda package. Dr. Jones moved to approve the four sets of minutes. Following a second, a roll call vote was taken. The motion passed.

DHP DIRECTORS' REPORTS:

Dr. Brown reported that the General Assembly passed legislation to allow pharmaceutical processors, which are regulated by the Board of Pharmacy, to distribute cannabis flower or botanical cannabis. This bill is anticipated to be signed into law, which will increase the demand for the product. Legislation was also introduced to legalize possession of marijuana in Virginia.

Dr. Brown said the Governor is relaxing some of the COVID restrictions and added that in the near future the Boards may be able to hold in-person meetings and hearings.

Dr. Allison-Bryan reported that communities in Virginia are now open to the 1C category for vaccination and that the goal of the President and the Governor is to allow any adult who wants to get the vaccine to do so by May 1, 2021.

Dr. Allison-Bryan reviewed legislation which increased the type of eligible vaccinators in the Commonwealth. She explained that dentists are not able to give the vaccine in their dental office, and she encouraged anyone interested in participating as a volunteer vaccinator to go to the Virginia Department of Health's website to read about the qualifications and guidelines.

CONSIDERATON OF PUBLIC COMMENT:

Dr. Petticolas deferred discussion of the written comments received regarding the **American Association of Dental Boards (AADB)** to Ms. Reen's report on the AADB mid-year meeting later on the agenda.

Dr. Petticolas called for discussion of the comments received from **AASM** and **AADSM** regarding ordering home sleep tests. Mr. Rutkowski advised the Board to consider the definition of the practice of dentistry in the Code of Virginia. Ms. Reen said the Board's position has been that a dentist can refer patients for a sleep study, but only a medical doctor can make a diagnosis; then the medical doctor can refer a patient for dental treatment to address sleep apnea. Ms. Yeatts confirmed that sleep studies fall within the scope of the practice of medicine and dentists are allowed to make referrals, but not a diagnosis. After discussion, Dr. Bonwell moved to refer this matter to the Regulatory-Legislative Committee for discussion. Following a second, a roll call vote was taken. The motion passed.

Dr. Petticolas deferred discussion of the written and verbal comments regarding licensure examinations received from representatives of **ASDA**, **SRTA** and **WREB** to the Exam Committee report later on the agenda.

LIAISON & COMMITTEE REPORTS:

Update on ADEX - Dr. Bryant stated he had no updates to present.

Exam Committee Report – Dr. Bryant provided an overview of the Committee's work on exam acceptance including the difference between conjunctive and compensatory scoring then addressed each motion advanced by the Committee for Board action.

Dr. Bryant moved that the Board only accept examination results which meet the scoring content, passing score and the listed required components for licensure by examination as stated in the second recommendation on page 46 of the agenda. Following a second, Dr. Petticolas called for discussion. Discussion followed on delaying action on the motion to follow up on the comments received from testing agencies on compensatory scoring. Then a roll call vote on the Committee's motion was taken. The motion passed.

Dr. Bryant moved that the Board only accept the ADEX Dental Exam for licensure by examination as address in the recommendation on page 46 of the agenda. Following a second, Dr. Bryant asked Ms. Sacksteder and Dr. Archer to address this motion. Ms. Sacksteder explained that

the testing agencies' testing booklets were the source of the information she provided to the Committee for discussion. Dr. Archer stated there would be enough lead time for dental students to be aware of the change in Virginia and that dental students will have access nationwide with most being able to take the exam at their respective dental schools. Discussion followed about accepting all exams that meet the content requirements adopted in the first motion then a roll call vote on the Committee's motion was taken. The motion passed.

Dr. Bryant introduced the next motion by reading the requirements for a passing score, exam content and practice experience for licensure by endorsement as specified in the third recommendation on page 46 and continued on page 47 of the agenda. He then moved that the Board continue to accept, for dental licensure by endorsement, passage of the exams given by the 5 testing agencies which meet the specified requirements. Following a second, the floor was opened for discussion. Hearing none, a roll call vote was taken. The motion passed.

Dr. Bryant stated the Committee is recommending a grace period then moved that the Board adopt January 1, 2023 as the effective date for acceptance of only ADEX exam results for dental applicants by examination. Following a second, the floor was opened for discussion. Hearing none, a roll call vote was taken. The motion passed.

Dr. Bryant reviewed the information considered by the Committee on the equivalency of the dental hygiene exams administered by the 5 testing agencies which he said should be considered before addressing the motion on accepting only the ADEX exam. He went on to address the scoring and content requirements addressed on page 47 and 48 of the agenda. Then Dr. Bryant moved that the Board only accept the ADEX exam as recommended. The motion was seconded and the floor was opened for discussion. Questions about limiting acceptance to one exam were raised and addressed. Ms. Sacksteder said the motion to be addressed is the recommendation on required components and scoring. Dr. Petticolas agreed and the motion on the ADEX exam was withdrawn.

Dr. Bryant moved that the Board only accept the exam results for dental hygiene licensure by exam which include the required components and scoring requirements addressed at the bottom of page 47 and on page 48 of the agenda. The motion was seconded and the floor was opened for discussion. A question about the possibility of licensing challenges was addressed, then a roll call vote was taken. The motion passed.

Dr. Bryant moved to only accept the ADEX examination for dental hygiene licensure by examination as addressed in the recommendation on page 47. The motion was seconded. Discussion followed regarding accepting tests from all five testing agencies since they are currently equivalent, being restricted by law to being a member of only one testing agency and about having a voice in exam development. The discussion

included Mr. Rutkowski's explanation that the testing agencies are all corporations and there would be a conflict in being a member of two organizations delivering the same product. A roll call vote was taken. The motion passed.

Dr. Bryant moved that the Board continue to accept for dental hygiene licensure by endorsement passage of the exams given by the 5 testing agencies which meet all the requirements specified in the first full recommendation on page 48, including the practice requirement. Following a second, the floor was opened for discussion. Hearing none, a roll call vote was taken. The motion passed.

Dr. Bryant moved that the Board adopt January 1, 2023 as the effective date for acceptance of only ADEX exam results for dental hygienists applying by examination. Following a second, the floor was opened for discussion. Hearing none, a roll call vote was taken. The motion passed.

Dr. Bryant read the proposed definitions advanced by the Committee for "Clinical Competency Exam", "Compensatory Scoring", "Conjunctive Scoring" and "Substantially Equivalent" as addressed at the bottom of page 48 and the top of page 49 to be addressed in a guidance document for applicants. Dr. Bryant moved adoption of the definition of each of these terms. Following a second, the floor was opened for discussion. Hearing none, a roll call vote was taken. The motion passed.

Dr. Bryant asked if the terms needed to be addressed in regulations. Ms. Yeatts said that definitions in regulations can only define terms that are actually used in the regulations. Since these terms are not in the regulations, she recommended that a comprehensive guidance document be completed to include these definitions and presented to the Board for review at its next meeting. Dr. Petticolas requested that Ms. Yeatts, Ms. Reen and Ms. Sacksteder create a guidance document with the definitions to present to the Board at its next meeting.

Dr. Bryant read the recommendation on page 49 which addresses the proposed requirements for score cards then asked Ms. Yeatts if this information should be provided in a guidance document. Ms. Yeatts confirmed that would be appropriate. Dr. Bryant then moved that the Board adopt the recommendations for acceptable score cards as addressed on page 48 of the agenda for dental and dental hygiene applications. Following a second, the floor was opened for discussion. Hearing none, a roll call vote was taken. The motion passed.

Ms. Yeatts recommended that a guidance pertaining to the acceptable score cards be addressed in a guidance document and presented to the Board at its next meeting. Mr. Rutkowski agreed, explaining that the Board has the authority to address the exams it will accept.

Dr. Bryant stated that the Exam Committee wanted to ask Board Counsel and Ms. Yeatts if the changes in requirements adopted by the Board for clinical exam acceptance need to be addressed in regulations or in a guidance document and application instructions. Ms. Yeatts clarified the difference between a guidance document and a regulation and advised that it is not necessary to take regulatory action because the Board has the authority to determine which clinical exams are acceptable for licensure. Mr. Rutkowski concurred with Ms. Yeatts and added there is a statute that requires a candidate to pass a clinical examination acceptable to the Board. He stated that the Board can approve the examination and it does not have to go through regulations. Dr. Bryant moved that the changes in examination requirements adopted by the Board for clinical exam acceptance be addressed in a guidance document and application instructions. Following a second, the floor was opened for discussion. Dr. Bryant clarified for new members that guidance documents can be changed. A roll call vote was taken. The motion passed.

Dr. Petticolas asked if the motions adopted on dental hygiene exam content and on only accepting ADEX for licensure by examination were in conflict. Ms Yeatts responded that she sees them as complimentary.

Board of Health Professions – Ms. Reen reported that Dr. Catchings attended her first meeting and the draft minutes are provided for review.

Regulatory-Legislative Committee – Ms. Reen said the Committee recommended initiating a fast-track action to remove pulp capping from the scope of practice for DAs II. She added that there are 32 DAs II with approval to perform pulp capping who will need to be addressed. Ms. Yeatts pointed out that a fast track action would not be appropriate in this situation and the standard process will take about 2 years. Mr. Rutkowski agreed. After discussion, Dr. Chaudhry moved that a NOIRA be initiated to remove pulp capping from the scope of practice and training requirements of DAs II. The motion was seconded and the floor was opened for further discussion. Ms. Yeatts said that she was concerned about removing the ability to do pulp capping from people already authorized to do this function. She said the process can be started. Opposition to grandfathering and a question about increasing the education requirements were discussed. Ms. Yeatts said the process could be started now and added that new regulations for DAs II will go into effect March 31, 2021. A roll call vote was taken. The motion passed.

Update on CITA – The annual meeting will be in October in Florida. Dr. Petticolas suggested that a Board member should attend who intends to administer this exam. Ms. Lemaster indicated she would be interested in attending the CITA meeting.

Executive Committee Report - Dr. Petticolas referred to the draft minutes of the March 5, 2021 Committee meeting then moved to adopt

the following 2 amendments to the Bylaws on pages 61 and 65 which address conducting Board business during an emergency:

- **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."

Following a second, the floor was opened for discussion. Dr. Bonwell asked about the duplicate lettering on page 64 in number 4. Special Conference Committees which should read "a, b, c, d, e, and f". There was consensus to include this change in the motion. A roll call vote was taken. The motion passed.

LEGISLATION AND REGULATION:

Status Report on Regulatory Actions Chart. Ms. Yeatts reviewed the status of Regulatory Actions, noting that the sedation and anesthesia regulations went into effect on February 17, 2021 and the comment period for the 2 NOIRAs - on training and supervision of digital scan technicians and on training of DAs in infection control - ends on March 31, 2021. She gave an overview of the standard 3-stage process for the adoption and promulgation of regulations. She also described the steps in the approval process and stated that sometimes it can take up to 2 years before a regulation is final.

Petition for Rulemaking – Regulations Governing the Practice of Dental Assistants. - Ms. Yeatts reviewed the petition 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 their capabilities to practice as a Dental Assistant II. She explained the possible actions and responded to questions. Mr. Martinez moved to deny the petitioner's request for rulemaking at this time. Following a second, the floor was opened for further discussion. Hearing none, a roll call vote was taken. The motion passed.

BOARD COUNSEL REPORT:

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

DEPUTY EXECUTIVE DIRECTOR'S REPORT:

Ms. Sacksteder reviewed her disciplinary report on case activity for January 1, 2020 to December 31, 2020 and for January and February of 2021, giving an overview of the actions taken and a breakdown of the cases closed with violations.

EXECUTIVE DIRECTOR'S REPORT:

AADB Mid-Year Meeting – Ms. Reen stated the meeting was held virtually and was well organized with a focus on continuing education, adding that there was no business conducted. She noted the public comments received from three organizations expressing concerns regarding the new for-profit corporation sponsorships instituted by the AADB and the potential conflicts of interest these appear to have created. Dr. Bryant expressed concerns about maintaining the relationship. Dr. Brown commented that all DHP boards have national associations where each state has a representative except dentistry because AADB is not organized to represent the boards. He said that there needs to be a meeting of boards to create a national association for boards. Dr. Petticolas said the letter raised a significant issue. Discussion followed on actions the Board could take. The consensus of the Board was to send a letter to every state and a copy to the 3 organizations, AADB and the ADA expressing concerns about AADB serving the interests of companies rather than the Boards. Ms. Reen was directed to draft a letter outlining the Board's concerns, share it with the Board members for review, and then provide the final letter for signature by Dr. Petticolas.

CODA Accreditation Site Visit Scheduled in Virginia – Ms. Reen informed the Board that when CODA does an accreditation in Virginia, they like to have a Board representative present. She reported that Dr. Dawson was selected by CODA to be the Board representative for the site visit in Abingdon which will be conducted in April.

Dentistry's Licensees and Registrants – Ms. Reen reviewed the number of licensees and license types that make up the total number of 15,181 licensees.

When a Dentist Dies Guide – Ms. Reen asked if the Board would be interested in creating a guidance document to explain what to do with patient records and other factors to consider if a dentist dies. Mr. Rutkowski confirmed there is no statutory provisions on how to handle the records when a licensee passes away. By consensus the Board asked Ms. Reen, along with Mr. Rutkowski and Mr. Martinez, to prepare a guidance document to present to the Board at its next meeting.

Board Member Training - Ms. Reen invited recommendations on possible training topics of interest to the Board members that could be addressed in future board meetings.

Board, but not Boring:

Dr. Allison-Bryan was unable to make her presentation due to technical difficulties. Dr. Allison-Bryan agreed to provide the presentation at the Board's next meeting.

ADJOURNMENT: With all business concluded, the Board adjourned at 2:09 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

PUBLIC COMMENTS RECEIVED FOR MARCH 19, 2021 BOARD MEETING

Sandra Reen

From: Brett Siegel <siegelb2@mymail.vcu.edu> on behalf of Brett Siegel
Sent: Tuesday, March 16, 2021 12:41 PM
To: Sandra.reen@dhp.virginia.gov
Subject: Public comment for BOD
Attachments: Letter to the Board of Dentistry .pdf

Hey Sandra,
I would like to make a public comment on 3/19 at 10am. Below is the attached comment I will be making.
The Best,
Brett Siegel

Dear Board of Dentistry and Exam Committee,

My name is Brett Siegel I am the current President Elect of the American Student Dental Association Chapter at VCU. I am a 2nd year and I am speaking on behalf of my peers at the SOD that this committee recommendation will affect. The ASDA chapter at VCU takes the position of pro of moving dental licensure from live patient board exams to non live patient exams.

I am going to be reading state from ASDAs white paper regarding licensure reform

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

Adex is used for last 5 years

- Relate exams to what they teach at school
- Mannequin exams have evolved - research is valid it has the same tates of failure and criteria without all the ethical problems and logistical problems.
- Support!!! - adex - tooth only uses adex very realistic

Terrao

- What are the costs
- Expense -
- Month of clinical education → 30% ahead of experience due to non live patient exam
- Enamel dentin and pulp
- Gingiva
- Biggest opposition is the other companies →
-

Commonwealth of Virginia

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

Letter to the Board President for meeting on Friday

1 message

James Watkins <ddsjdw@aol.com> Tue, Mar 16, 2021 at 4:00 PM
Reply-To: James Watkins <ddsjdw@aol.com>
To: sandra.reen@dhp.virginia.go
Cc: donna.lee@dhp.virginia.gov

Please add this letter to the package for the next Board meeting under the topic that addresses the Report of the Board Exam committee.

Thanks & Hello!

Jim Watkins

Board ltr-3-19-21.docx
15K

March 19, 2021

From: James D. Watkins, DDS
Hampton, Virginia 23666

To: Dr. Augustus Petticolas
President, Va Board of Dentistry

Dear Dr. Petticolas:

I have been made aware that at the most recent Exam Committee meeting, a motion was made to recommend to the Board that ONLY the ADEX examination be accepted for licensure of dentists and dental hygienists in our state. I would like to speak in opposition of taking that approach to licensure in Virginia.

As we are aware, at one time SRTA was the only licensure exam accepted by Virginia and after years of looming promises of a NATIONAL licensing exam, this Board decided to accept ALL regional boards for licensure; thus creating for Virginia its own version of a National exam.

I applaud the Board in its decision to establish criteria that it has deemed necessary to obtain licensure in our state, but a decision to return to the ONE AGENCY EXAM creates less opportunity to again pursue the goal that has always been present for all jurisdictions which is having a true National exam. If you leave the window open to other agencies to meet the criteria of your Board, you provide competition within the regional board community which may continue to lead to that goal of National licensure. Also, when there is "one Virginia Board-selected agency" the goals or positions over time seem to be less state desired as agency desired; leaving the door open for other agencies to possibly provide those services because you have selected CRITERIA for acceptance and NOT a particular agency. Remember: all licensees are not graduates of my alma mater, VCU-MCV and the Board should desire those licensees that other agencies may provide.

As it stands right now, there are still at least TWO agencies that provide the Selected Criteria our Board seeks. They are the SRTA and the ADEX Exam agencies. SRTA provides licensure exams in Tennessee and West Virginia and is accepted by 35 jurisdictions. Those candidates should NOT lose their ability to obtain licensure in Virginia when they are taking the same exam based on the criteria as requested by our Board. THE RESPONSE OF OUR BOARD SHOULD NOT BE TO RETURN TO THOSE DAYS OF THE PAST which was to say: *if you want a license here, then go take the "XYZ" exam*! If you return to that mentality, the day will come when you will DENY licensure to a dental professional from another agency who presents credentials that EACH OF YOU will agree is "more challenging" than the "XYZ" exam that you have chosen. Then you will look around the table at each other and wonder how this happened. The answer is simple. YOU CHOSE AN AGENCY OVER THE CREDENTIALS!

Lastly, before the Board considers such a vote based on a particular agency representative's request (as I am sure the thoughts around the room are that I am the "SRTA guy" who is making a request for SRTA); I will say to you that I am NOT requesting that you accept ANY PARTICULAR AGENCY. I am requesting that you only accept those agencies that meet the criteria that you have set and to remember that it should not matter to the Virginia Board how many jurisdictions that accept an agency. It should only matter to our Board that you are protecting the citizens of Virginia by making sure the agency examines the CRITERIA that YOU desire for practice in the Commonwealth!

Sandra Reen

From: Dr. Dag Zapatero <dag@starfishdental.com> on behalf of Dr. Dag Zapatero
Sent: Tuesday, March 16, 2021 7:46 PM
To: Sandra Reen
Cc: Sacksteder, Jamie; Lee, Donna
Subject: Request to include additional material about sleep medicine and the AADSM
Attachments: State Dental Board Home Sleep Apnea Testing Regulations Table.pdf; HSAT By State Map.pdf; HSAT_Special_Article_Proof.pdf; Policy_statement_on_role_of_dentists_2017.pdf; Blue Starfish Logo copy.jpeg

Greeting Sandy,

In reading the letter from Dr. Kannan Ramar and colleagues, I found it to misrepresent the American Academy of Dental Sleep Medicine (AADSM) own policy statement. Virginia is one of 8 states that restricts dentists from ordering at-home sleep apnea tests (HSAT). Most other states do not specifically address dentists prescribing of HSAT by dentists, and the lack of restriction deems the practice as "within the scope of practice for dentists to order and administer HSATs in states where it is not specifically prohibited."

The AADSM advocates that only "qualified dentists" be allowed to order and administer HSAT, while only a physician can interpret, diagnose, and determine treatment efficacy. Dr. Ramar comments are in stark contrast to policies. The AADSM discourages non-qualified dentists from practicing sleep dentistry and encourages education to identify patients suffering from obstructive sleep apnea (OSA).

The ADA's policy states, "In 2017, the ADA recognized that dentists should play an essential role in addressing the public burden of OSA.4. n their policy, the ADA suggests that all dentists screen patients for OSA as part of a comprehensive medical and dental history and refer as needed to the appropriate physicians for diagnosis. The policy indicates that dentists may use HSATs to define the optimal target position of the mandible." The AADSM position is to further restrict the treatment of OSA to "qualified dentists", who have received specific education or have been board certified by the AADSM. *American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests David Schwartz, DDS1; Michael Adame, DDS2; Nancy Addy, DDS3; Michelle Cantwell, DMD4; James Hogg, DDS5; Nelly Huynh, PhD6; PaulJacobs,DDS7; MitchellLevine,DMD8;KevinPostol,DDS9; RosemarieRohatgi,DMD10

I have attached several papers that best articulated the position of the AADSM and the legislative landscape of HSAT in the United States for the consideration of the Board.

Sincerely,
Dr. Dag Zapatero

Starfish Dental
Dag Zapatero, DDS | 3020 Shore Drive | Virginia Beach, VA 23451
office. 757.481.3893 | fax 757.481.3898 | www.starfishdental.com
Master in the Academy of General Dentistry
Fellow of the American College of Dentists
Adjunct Professor UNC Adams School of Dentistry
Scholar and Visiting Faculty at L.D.Pankey Institute

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

Disclaimer: This material reflects responses provided by state dental boards to the AADSM and is offered as information only and not as practice, legal or other professional advice. Dentists must contact their own professional advisors for such advice.

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
[redacted]	Alabama Dental Practice Act	Dental Scope of Practice Citation: Section §34-9-6	Board of Dental Examiners of Alabama 5346 Stadium Trace Pkwy, Suite 112 Hoover, AL 35244 1-205-985-7267	[redacted]	Statement from Board of Dental Examiners: "The Board opines that it is outside the scope of practice for a dentist to order a sleep study or prescribe a CPAP as a result of interpreting a sleep study."
AK	Statutes and Regulations Dentists and Dental Hygienists	Dental Scope of Practice Citation: Sec.08.36 .360	Alaska Board of Dental Examiners 550 West Seventh Avenue, Suite 1500 Anchorage, AK 99501-3567 1-907-269-8160	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Board of Dental Examiners: "We have always allowed dentists to make sleep appliances as long as their patient has had a sleep study from an MD or other reputable source and been diagnosed with sleep apnea. We haven't felt the need to regulate it at this point."
AZ	Arizona Statutes affecting Dental Board Licensees	Dental Scope of Practice Citation: ARS – 32- 1202	Arizona State Board of Dental Examiners 4205 North 7th Avenue, Suite 300 Phoenix, AZ 85013 1-602-242-1492	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Board of Dental Examiners: "The Arizona Board does not have any specific statutes or rules regarding sleep apnea." "The Board's statutes and rules would still apply to licensees who engage in unprofessional conduct."

***Dentists are prohibited from ordering home sleep apnea test in only 8 states**
AL, GA, HI, NJ, NY, NC, OH, VA

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
AR	Arkansas Dental Practice Act	Dental Scope of Practice Citation: A.C.A. § 17-82-102	Arkansas State Board of Dental Examiners 101 East Capitol Avenue, Suite 111 Little Rock, AR 72201 1-501-682-2085	Dentists are not prohibited from ordering home sleep apnea tests.	In response to AADSM inquiry, the Board of Dental Examiners referred to the law stated in ACA 17-82-102: "(i) The evaluation, diagnosis, prevention, and treatment by nonsurgical, surgical, or related procedures of diseases, disorders, and conditions of the oral cavity, maxillofacial area, and the adjacent and associated structures and their impact on the human body, but not for the purpose of treating diseases, disorders, and conditions unrelated to the oral cavity, maxillofacial area, and the adjacent and associated structures"
CA	Dental Practice Act - California Business & Professions Code	Dental Scope of Practice Citation: Section 1625-1636.6	Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 1-877-729-7789	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Dental Board: "The scope of practice for dentists in California is defined in Business & Professions Code Section 1625. It has been understood that the Medical Board of California views the diagnosis and treatment of sleep apnea to be the practice of medicine; but that a physician may refer a patient with sleep apnea to a dentist for treatment if the physician determined that the sleep apnea was the result of a problem with the teeth, gums, jaws, and associated structures."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
CO	Colorado Revised Statutes - Dentists and Dental Hygienists Practice Act	Dental Scope of Practice Citation: § 12-35-103	Colorado Dental Board 1560 Broadway, Suite 1360 Denver, CO 80202 1-303-894-7690	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Dental Board: The response referred providers to board website here. "We don't have any further information on the topic."
CT	Connecticut Statutes - Chapter 379 Dentistry	Dental Scope of Practice Citation: Chapter 379: Sec. 20-123	Connecticut State Dental Commission 410 Capitol Avenue, MS #13PHO P.O. Box 340308 Hartford, CT 06134-0308 1-860-509-7603 (Menu Option 4)	Dentists are not prohibited from ordering home sleep apnea tests.	AADSM is currently working with the State Dental Commission which is considering whether to clarify its guidance on the ordering of HSATs.
DE	Delaware Code, Title 24, Chapter 11 Dentistry and Dental Hygiene	Dental Scope of Practice Citation: Title 24: §1101	Board of Dentistry and Dental Hygiene 861 Silver Lake Blvd. Dover, DE 19904 1-302-744-4500	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Board of Dentistry and Dental Hygiene: The response referred to website here. "Currently, the Delaware Board of Dentistry and Dental Hygiene does not have any law or regulations regarding sleep medicine."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
DC	DC Municipal Regulations for Dentistry	Dental Scope of Practice Citation: Chapter 12 Section 3-1201.02	District of Columbia State Board of Dentistry 899 North Capitol Street, NE Washington, DC 20002 1-202-442-5955	Dentists are not prohibited from ordering home sleep apnea tests.	The DC Board of Dentistry has not provided the AADSM with any comments about HSAT use by dentists.
FL	Florida Statutes, Title XXXII, Chapter 466 Dentistry, Dental Hygiene, and Dental Laboratories	Dental Scope of Practice Citation: 466.003	Florida Board of Dentistry 4052 Bald Cypress Way Bin C-08 Tallahassee, FL 32399-3258 1-850-488-0595	Dentists are not prohibited from ordering home sleep apnea tests.	The Florida Board of Dentistry has not provided the AADSM with any comments about HSAT use by dentists.

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
[redacted]	Georgia Dental Law (Title 43, Chapter 11) Georgia Board of Dentistry Policy Manual	Dental Scope of Practice Citation: § 43-11-1	Georgia Board of Dentistry 2 Peachtree Street, NW Atlanta, GA 30303 1-404-651-8000	[redacted]	Comment from the Board of Dentistry: The response referred providers to this text in the Dentistry Policy Manual: 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 does not fall within the scope of dentistry.

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
[redacted]	Hawaii Revised Statutes, Title 25, Chapter 448 – Dentistry	Dental Scope of Practice Citation: 448-1	Hawaii State Board of Dental Examiners King Kalakaua Building 335 Merchant Street, Rm. 301 Honolulu, Hawaii 96813 1-808-586-3000	[redacted]	Comment from the Board of Dental Examiners: "The Board of Dentistry ("Board") currently does not have any statutes or rules that govern sleep apnea devices/oral appliances. However, the Board has policies which state that a licensed dentist would perform a complete dental examination, take the necessary oral x-rays, take impressions of the teeth, fittings, and a bite record and send this information to a dental laboratory to be constructed. Furthermore, it is the Board's understanding that the procedures performed in the fitting of the oral appliances are considered within the scope of practice of dentistry. The construction of the oral appliances when sent to a dental laboratory would be exempt from the practice of dentistry.
ID	Idaho Statutes, Title 54, Chapter 9 Professions, Vocations, and Businesses: Dentists	Dental Scope of Practice Citation: Title 54-901	Idaho State Board of Dentistry 350 N. 9th Street, Suite M-100 Boise, Idaho 83720 1-208-334-2369	Dentists can order home sleep apnea tests.	Comment from the Board of Dentistry, responding to AADSM questions on HSAT: "There is nothing in the statutes or the administrative rule which directly addresses the issue. Of course, dentists can provide patients with OAT [Oral Appliance Therapy] but my understanding is it takes a physician to make the diagnosis."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
IL	Illinois Compiled Statutes: Illinois Dental Practice Act	Dental Scope of Practice Citation: 225 ILCS 25/1 –. Section 17	Illinois Department of Financial and Professional Regulation – Dental Professions 320 West Washington Street, 3rd Floor Springfield, IL 62786 1-217-785-0800	Dentists are not prohibited from ordering home sleep apnea tests.	The Illinois Department of Financial and Professional Regulation has not provided the AADSM with any comments about HSAT use by dentists.
IN	Indiana Code Title 25. Professions and Occupations § 25-14-1-23	Dental Scope of Practice Citation: IC 25-14-1-23	Indiana State Board of Dentistry 402 W. Washington Street, W072 Indianapolis, Indiana 46204 1-317-234-2054	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "The State Board of Dentistry does not have any statute or rules regarding on treating sleep apnea."
IA	Code of Iowa, Title IV, Chapter 153 Dentistry	Dental Scope of Practice Citation: 153.13	Iowa Dental Board 400 SW 8th Street, Suite C Des Moines, IA 50309-4686 1-515-281-5157	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Dental Board: "The Iowa Dental Board does not specifically have rules addressing dental sleep medicine. Services provided within the scope of practice of dentistry must fall within the definition of the practice of dentistry as established in Iowa Code Section 153."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
KS	Kansas Dental Practices Act - Statutes, Regulations, and Related Laws Pertaining to Dentists And Dental Hygienists	Dental Scope of Practice Citation: 65-1422	Kansas Dental Board 900 SW Jackson, Room 509 Topeka, KS 66612 1-785-296-6400	Dentists are not prohibited from ordering home sleep apnea tests.	AADSM is currently working with the State Dental Board which is considering how to clarify its guidance on the ordering of HSATs.
KY	Kentucky Revised Statutes, Chapter 313 Dentists and Dental Specialists	Dental Scope of Practice Citation: 313.010	Kentucky Board of Dentistry 312 Whittington Parkway, Suite 101 Louisville, Kentucky 40222 1-502-429-7280	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "Kentucky's rules are pretty silent on the issue of sleep apnea." Refer to Chapter 313 of the Revised Statues for more information.

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
LA	Louisiana Laws Governing the Practice of Dentistry as Authorized Under Chapter 9, Title 37, Dental Practice Act	Dental Scope of Practice Citation: §751	Louisiana State Board of Dentistry 365 Canal Street, Suite 2680 New Orleans, LA 70130 1-504-568-8574	Dentists can order home sleep apnea tests.	Comment from the Board of Dentistry: "The Louisiana State Board of Dentistry met on July 10, 2020 and addressed the four questions you posed in your January 10, 2020 letter. The Board answered all four questions in the affirmative." ▪ Dispense portable monitors when ordered by physicians for patients at risk for sleep apnea? ▪ Order portable monitors for patients identified by the dentist as being at risk for sleep apnea? ▪ Use a portable monitor to help determine the optimal effective position of a patient's oral appliance? ▪ To order a portable monitor to verify the effectiveness of an oral appliance?

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
ME	Maine Revised Statutes, Title 32, Chapter 143: Dental Professions	Dental Scope of Practice Citation: §18371	Maine Board of Dental Practice 143 State House Station 161 Capitol Street Augusta, Maine 04333-0143 1-207-287-3333	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dental Practice: "At its March 13, 2020 meeting, the Maine Board of Dental Practice ("the Board") reviewed and discussed correspondence received by Dr. Nancy Addy, President of the American Academy of Dental Sleep Medicine, dated January 10, 2020, requesting clarification regarding a dentist's scope of practice to treat sleep apnea with oral appliance therapy. It may be helpful to note that the Board does not provide practice or legal advice; however, it does attempt to highlight and clarify its existing statutes and rules when appropriate. To that end, the Board considered in detail your questions related to a dentist ordering and dispensing portable monitors to treat patients for sleep-related breathing disorders in consultation/coordination with physician care. A dentist's scope of practice is identified in statute and licensees are required to provide services in a competent and ethical manner (see: 32 M.R.S. §18371). There are a variety of dentally-related products on the market, but it is up to the individual licensee to make sure that the use of the product is within their scope of practice and that they are competent to utilize the product in the delivery of care."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
MD	Dental Practice Act	Dental Scope of Practice Citation: § 4-101	Maryland State Board of Dental Examiners 55 Wade Avenue/Tulip Drive Catonsville, MD 21228 1-410-402-8501	Dentists can order home sleep apnea tests.	Comment from Board of Dental Examiners: "DDS/DMD may order screening tests including sleep study. The diagnosis of sleep apnea must be done by a physician. Appliances constructed for sleep apnea treatment must be under physician order."
MA	Dental Practice Act	Dental Scope of Practice Citation: 2.03	Massachusetts Board of Registration in Dentistry 239 Causeway St., Suite 500, 5th Floor Boston, MA 02114 1-800-414-0168	Dentists are not currently prohibited from ordering home sleep apnea tests.	Comment from Board of Registration in Dentistry: "The Board's governing statutes and regulations do not address the use of oral appliances to treat dental sleep apnea as it is more a standard of care question than regulatory. However, to my knowledge the Board has not been asked to address this issue during my seven-year tenure as ED nor has it considered a complaint filed against a dentist for inappropriately prescribing or fabricating a defective oral appliance, etc."
MI	Michigan Public Health Code, Part 166 Dentistry	Dental Scope of Practice Citation: 333.16601	Michigan Board of Dentistry P.O. Box 30004 Lansing, MI 48909 517-373-1820	Dentists are not prohibited from ordering home sleep apnea tests.	The Michigan Board of Dentistry has not provided the AADSM with any comments about HSAT use by dentists.

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
MN	Minnesota Statutes, Chapter 150A. Dentistry	Dental Scope of Practice Citation: 150A.05	Minnesota Board of Dentistry 2829 University Ave SE, Suite 450 Minneapolis MN 55414-3249 1-612-617-2250	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "Minnesota allows dentists to make and monitor appliances and treatments, but we require a MD diagnosis of the sleep apnea."
MS	Mississippi Dental Practice Act	Dental Scope of Practice Citation: § 73-9-3	Mississippi State Board of Dental Examiners 600 East Amite Street, Suite 100 Jackson, MS 39201-2801 1-601-944-9622	Dentists can order home sleep apnea tests.	Comment from Board of Dental Examiners: "Is it within the scope of practice for dentists to order and overnight pulse oximetry to determine the presence of sleep apnea? Yes. At its 07/31/2015 meeting, the Board determined that it is within the scope of practice for dentists to order an overnight pulse oximetry to determine the potential presence of sleep apnea."
MO	Missouri Revised Statutes, Chapter 332, title XXII, Occupations and Professions	Dental Scope of Practice Citation: 332.071	Missouri Dental Board 3605 Missouri Boulevard P.O. Box 1335 Jefferson City, MO 65102-1335 1-573-751-0293	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Missouri Dental Board: "I have attached a link to the Missouri Dental Board's statute regarding the practice of dentistry. A dentist cannot diagnose sleep apnea, but they can create appliances used to treat sleep apnea. Regarding the equipment used by dentists, the Board does not regulate equipment."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
MT	Montana Code Annotated, Title 37 Chapter 4 Dentistry and Dental Hygiene	Dental Scope of Practice Citation: 37-4-101	Montana Board of Dentistry P.O. Box 1728 Helena, MT 59624-1728 1-406-444-5711	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Board of Dentistry: The Board of Dentistry indicated that they have no additional clarification to the rules and statutes already published and refer to the Definitions -- Practice of Dentistry.
NE	Nebraska Statutes Relating to Dentistry Practice Act	Dental Scope of Practice Citation: 38-1115	Nebraska Board of Dentistry 301 Centennial Mall South Lincoln, Nebraska 68509 -5026 1-402-471-2118	Dentists are not prohibited from ordering home sleep apnea tests.	The Nebraska Board of Dentistry has not provided the AADSM with any comments about HSAT use by dentists.
NV	Nevada Revised Statute Chapter 631 - Dentistry, Dental Hygiene, and Dental Therapy	Dental Scope of Practice Citation: 631.215	Nevada State Board of Dental Examiners 6010 S. Rainbow Blvd., Suite A-1 Las Vegas, NV 89118 1-702-486-7044	Dentists are not prohibited from ordering home sleep apnea tests.	The Nevada State Board of Dental Examiners has not provided the AADSM with any comments about HSAT use by dentists.
NH	New Hampshire Statutes, Chapter 317-A – Dentistry	Dental Scope of Practice Citation: 317-A:20	New Hampshire Board of Dental Examiners 121 South Fruit Street Concord, NH 03301 1-603-271-2152	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from Board of Dental Examiners: "Our rules do not currently address dental appliances for sleep apnea. It may have been discussed briefly, but currently nothing to warrant any rule changes."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
[redacted]	New Jersey State Board of Dentistry Laws	Dental Scope of Practice Citation: 45:6-19	New Jersey State Board of Dentistry P.O. Box 45005 Newark, New Jersey 07101 1-973-504-6405	[redacted]	From the Board of Dentistry: "The Board reviewed correspondence from Sara R. Gallagher, Vice-Chair, Board of Polysomnography, questioning whether the dental scope of practice allows the performance of home sleep testing. The Board repeated its prior determination that a dentist cannot order or interpret the home sleep test, or screen, treatment plan or diagnose sleep apnea patients. The Board noted that the sleep apnea issue has been referred to a committee of the Board to draft a regulatory proposal."
[redacted]	New York Education Law, Article 133, Dentistry and Dental Hygiene [and Registered Dental Assisting]	Dental Scope of Practice Citation: § 6601	New York State Board of Dentistry 89 Washington Avenue, 2nd Floor West Wing Albany, NY 12234 518-474-3817	[redacted]	Comment from the Board of Dentistry: "The physician can request or write orders for the dentist to fabricate an oral appliance for sleep apnea, but the physician would have to order the portable monitor and verify the effectiveness of the oral appliance."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
NC	North Carolina General Statutes, Chapter 90, Article 2, Dentistry	Dental Scope of Practice Citation: § 90-29	North Carolina State Board of Dental Examiners 2000 Perimeter Park Dr., Suite 160 Morrisville, NC 27560 1-919-678-8223	[redacted]	From NC Dental Board Newsletter: In the Dental Board's opinion, being involved in diagnosing OSA, including dispensing home sleep tests, would fall outside the scope of the practice of dentistry and would violate the Board's statutes and regulations. However, a dentist can perform initial or preliminary screening for OSA, including identifying certain risk factors, and make referrals to other appropriate medical providers to diagnose and treat this potential medical condition. Determining whether to utilize home sleep tests as part of a potential diagnosis should be done by appropriate medical provider to whom the patient is referred. If a physician diagnoses a patient with OSA, a properly trained dentist may work with the physician to fabricate a dental appliance for the patient to treat the condition.

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
ND	North Dakota Century Code, Title 43, Chapter 28 - Dentists	Dental Scope of Practice Citation: 43-28-01	North Dakota Board of Dental Examiners P.O. Box 7246 Bismarck, ND 58507 1-701-258-8600	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dental Examiners: ND laws regarding scope of practice for dentists may be found in the NDCC 43-28-01(7). "7. "Practice of dentistry" means examination, diagnosis, treatment, repair, administration of local or general anesthetics, prescriptions, or surgery of or for any disease, disorder, deficiency, deformity, discoloration, condition, lesion, injury, or pain of the human oral cavity, teeth, gingivae, and soft tissues, and the diagnosis, surgical, and adjunctive treatment of the diseases, injuries, and defects of the upper and lower human jaw and associated structures. Further guidance may be found in NDCC 43-28-18(22). "22. Failed to practice within the scope of that dentist's education or advanced training as recognized by the board, the American dental association, or other professional entity recognized by the board."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
[redacted]	Ohio Dental Practice Act	Dental Scope of Practice Citation: 4715.01	Ohio State Dental Board 77 S. High Street, 17th Floor Columbus, Ohio 43215-6135 1-614-466-2580	[redacted]	Comment from the Dental Board "If you are a dentist can you order a take home sleep test? (NO) Can you use a home sleep test to decide if your device is working? (NO)" Position Statement: Role of the Dentist in the Treatment of Sleep-related Breathing Disorders
OK	Oklahoma Statutes, Title 59, Chapter 7 - Dentistry, The State Dental Act	Dental Scope of Practice Citation: Title 59. Chapter 7	Oklahoma State Board of Dentistry 2920 N. Lincoln Blvd., Suite B OKC, OK 73105 1-405-522-4844	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "We do not have any specific rules or statutes that specifically refer to "sleep dentistry". A licensed dentist in the State of Oklahoma may treat an individual that has been previously diagnosed with sleep apnea, with appliances as long as they are acting with the general standard of care within dentistry."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
OR	Oregon Dental Practice Act - Compilation of Statutes and Administrative Rules	Dental Scope of Practice Citation: 679.010	Oregon Board of Dentistry 1500 SW 1st Ave., Suite 770 Portland, OR 97201 1-971-673-3200	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "It is the Board's position that the diagnosis of Sleep Related Disordered Breathing (SRDB) or Obstructive Sleep Apnea (OSA) is outside the scope of the practice of dentistry, and the diagnosis must be made by a physician prior to oral appliance therapy by a dentist. ...dentists legally are not in a position to diagnose sleep disordered breathing and sleep apnea; a physician must make the diagnosis and then prescribe oral appliance therapy before the dentist can treat it."
PA	Pennsylvania Dental Law	Dental Scope of Practice Citation: 63 P.S. §120	Pennsylvania State Board of Dentistry One Penn Center 2601 N. 3rd Street Harrisburg, PA 17110 1-717-783-7162	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the State Board of Dentistry: "The Board's Laws and Regulations are available on our website at www.dos.pa.gov/dent. The Board has no specific regulations addressing sleep apnea."
RI	Rhode Island General Laws, Chapter 5-31.1 - Dentists and Dental Hygienists	Dental Scope of Practice Citation: § 5-31.1-1	Rhode Island Board of Dentistry 3 Capitol Hill Providence, RI 0 2908 1-401-222-5960	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "Rhode Island Dental Rules and Regulations are silent on sleep apnea and oral appliances."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
SC	South Carolina Code of Laws, Title 40, Chapter 15, Dentists, Dental Hygienists, and Dental Technicians	Dental Scope of Practice Citation: 40-15-70§ 5-31.1-1	South Carolina Board of Dentistry 110 Centerview Dr. Columbia, SC 29210 1-803-896-4300	Dentists are not prohibited from ordering home sleep apnea tests.	The South Carolina Board of Dentistry has not provided the AADSM with any comments about HSAT use by dentists.
SD	South Dakota Laws, Title 36, Chapter 6A - Dentists, Dental Hygienists and Dental Auxiliaries	Dental Scope of Practice Citation: 36-6A-32	South Dakota State Board of Dentistry 1351 N. Harrison Ave. Pierre, SD 57501 1-605-224-1282	It is within the scope of a dentist's practice to order a sleep apnea study.	Comment from the Board of Dentistry: "Pursuant to a diagnosis of sleep apnea by a medical doctor, a dentist may provide dental services in addressing a diagnosis of sleep apnea if it is within the scope of the dentist's relevant education, training, and experience. SDCL § 36-6A-32.4. This advisory opinion was rendered by the Board upon submission of a written request. Although advisory opinions are not judicially reviewable and do not have the force and effect of law, they do serve as a guideline for dentists who wish to engage in safe dental practices. This advisory opinion was adopted at the meeting of the South Dakota Board of Dentistry on June 17, 2016."

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
TN	Tennessee Code Title 63 Professions of the Healing Arts, Chapter 5 Dentists	Dental Scope of Practice Citation: 63-5-108	Tennessee Board of Dentistry 710 James Robertson Parkway Nashville, TN 37243 1-615-532-5073	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "This [oral appliance therapy and dental sleep medicine] is not specifically addressed by the statutes and rules of the Board of Dentistry."
TX	Texas Dental Practice Act - Chapter 251. General Provisions Relating to Practice of Dentistry	Dental Scope of Practice Citation: 251.003	Texas State Board of Dental Examiners 333 Guadalupe, Tower 3, Suite 800 Austin, TX 78701-3942 1-512-463-6400	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dental Examiners: Referred to Texas Admin. Code Rule §108.12, Dental Treatment of Obstructive Sleep Apnea
UT	Utah Code Title 58, Chapter 69 - Dentist and Dental Hygienist Practice Act	Dental Scope of Practice Citation: 58-69-102	Utah Dental Board 160 East 300 South Salt Lake City, Utah 84111 1-801-530-6628	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Dental Board: "Utah law and rule does not specifically address specific health conditions. The scope of practice for licensees is defined within the practice acts and the definitions of the practice. I would refer you to 58-67-102 and the definition of the practice of medicine and 58-69-102 for the definition of the practice of dentistry. Licensees must practice within their respective scope of practice and meet the standard of care."

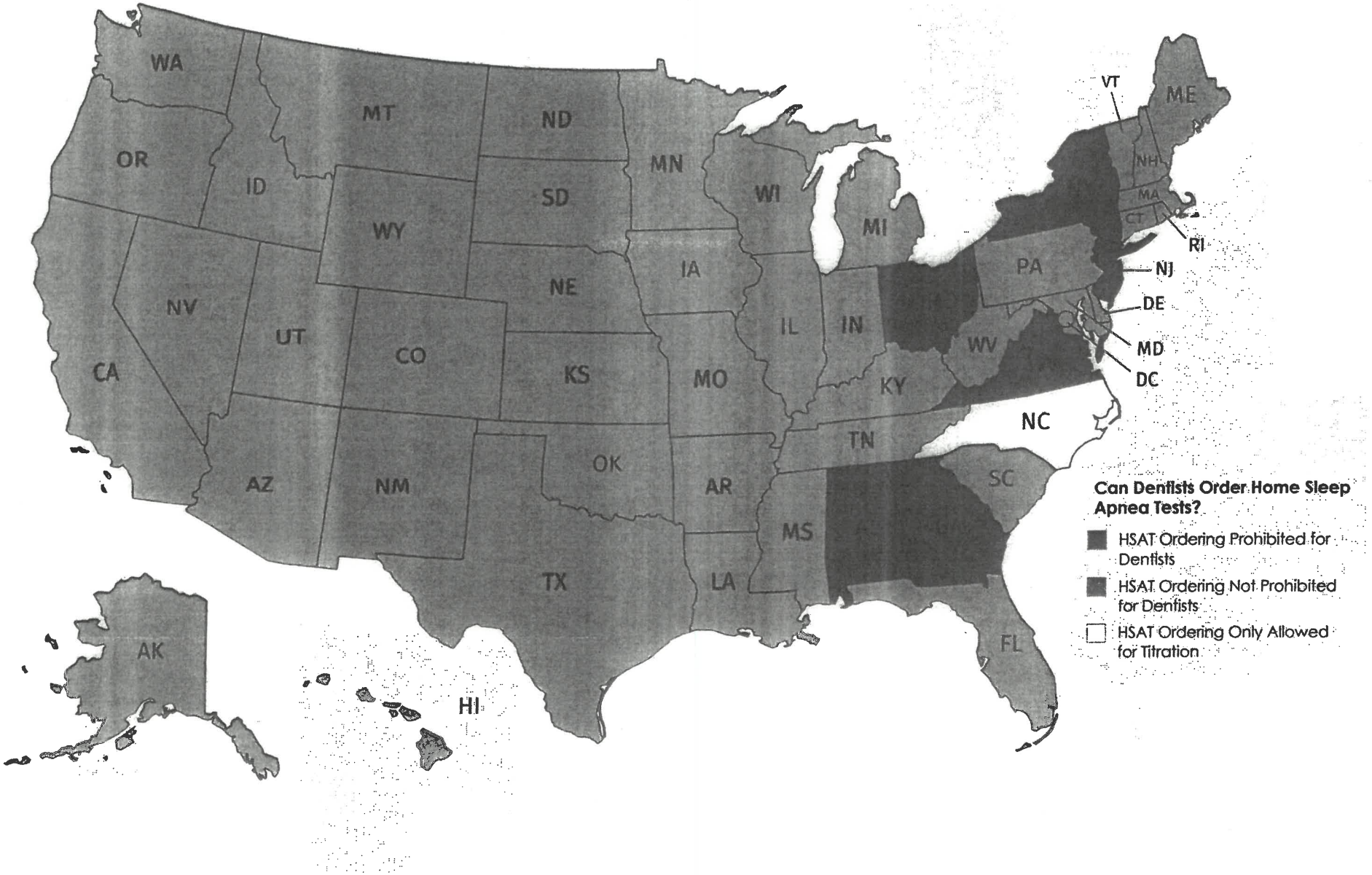
State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
VT	Vermont Statutes, Title 26, Chapter 12 - Dentists, Dental Hygienists, and Dental Assistants	Dental Scope of Practice Citation: § 561	Vermont State Board Dental Examiners 89 Main Street, 3rd Floor Montpelier VT 05620-3402 1-802-828-2363	Dentists are not prohibited from ordering home sleep apnea tests.	The Vermont Board of Dental Examiners has not provided the AADSM with any comments about HSAT use by dentists.
[redacted]	Code of Virginia, Title 54.1, Chapter 27 – Dentistry	Dental Scope of Practice Citation: § 54.1-2711	Virginia Board of Dentistry Perimeter Center 9960 Mayland Drive, Suite 300 Henrico, VA 23233-1463 (804) 367-4538	[redacted]	Comment from the Board of Dentistry: "The advice given to me by the Board's attorney, in response to previous inquiries from dentists about testing patients for sleep apnea, is that a Virginia dentist may refer a patient to a polysomnographic technologist for a sleep study but a Virginia dentist cannot conduct sleep studies. The technologist is required to report sleep study results to the supervising physician who could refer the patient to a dentist for dental treatment."
WA	Revised Code of Washington, Chapter 18.32 – Dentistry	Dental Scope of Practice Citation: 18.32.020	Washington State Board of Dentistry P.O. Box 1099 Olympia, WA 98507-1099 1-360-236-4700	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the State Board of Dentistry: "Washington State laws do not call out specific procedures or modalities that dentists may use to practice dentistry. We do have a definition of dentistry in RCW 18.32.020, link below." https://app.leg.wa.gov/RCW/default.aspx?cite=18.32.020

State Dental Board Information and Status of Home Sleep Apnea Testing Regulations

State	Dental Sleep Rules and Regulatory Links	Law Citation	Dental Board Contact Information	Home Sleep Apnea Test Status	State Dental Board Comments
WV	West Virginia Code, Chapter 30, Article 4 - West Virginia Dental Practice Act	Dental Scope of Practice Citation: §30-4-9	West Virginia Board of Dentistry 1319 Robert C. Byrd Drive Crab Orchard, WV 25827 1-877-914-8266	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dentistry: "The Standard of Care in WV is the dentist requires a diagnosis from a sleep study made by an MD. Once there is a diagnosis an appliance can be made by the dentist and any adjustments necessary to the appliance. The Dentist must work in conjunction with the MD for the patient's sleep apnea."
WI	Wisconsin Statutes and Annotations - Chapter 447 - Dentistry Examining Board	Dental Scope of Practice Citation: 447.01	Wisconsin Dental Board 1400 East Washington Avenue, Room 112 Madison, WI 53703 1-608-266-2112	Dentists are not prohibited from ordering home sleep apnea tests.	Position Statement from the Wisconsin Dental Board Website: Sleep Related Breathing Disorders Dentistry Examining Board Position Statements
WY	Dental Practice Act	Dental Scope of Practice Citation: 33-15-114	Wyoming Board of Dental Examiners 2001 Capitol Ave, Room 103 Cheyenne, WY 82002 1-307-777-7387	Dentists are not prohibited from ordering home sleep apnea tests.	Comment from the Board of Dental Examiners: "The Board had determined in 2018 that the treatment of sleep apnea without a medical consultation and diagnosis is outside the scope of practice of dentistry in Wyoming."

***Dentists are prohibited from ordering home sleep apnea test in only 8 states**
AL, GA, HI, NJ, NY, NC, OH, VA



SPECIAL ARTICLES

http://dx.doi.org/10.15331/jdsm.7156

American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests

David Schwartz, DDS[1]; Michael Adame, DDS[2]; Nancy Addy, DDS[3]; Michelle Cantwell, DMD[4]; James Hogg, DDS[5]; Nelly Huynh, PhD[6]; Paul Jacobs, DDS[7]; Mitchell Levine, DMD[8]; Kevin Postol, DDS[9]; Rosemarie Rohatgi, DMD[10]

[1]North Shore Family Dentistry, Skokie, IL; [2]Adame Dental Sleep Medicine; [3]Snoring and Sleep Apnea Dental Treatment Center, Leawood, KS; [4]Wellspan Pulmonary and Sleep Medicine, Lancaster, PA; [5]Carolina Smiles Family Dentistry, Brevard, NC; [6]Faculty of Dentistry, Universite de Montreal, Montreal, Canada; [7]Upper Peninsula Sleep Dentistry, Escabana, MI; [8]Department of Orthodontics, University of Tennessee Health Science Center, Memphis, Tennessee; [9]Sleep Disordered Dentistry, Ballwin, Missouri; [10]San Diego Sleep Therapy, San Diego, CA

It is the position of the American Academy of Dental Sleep Medicine (AADSM) that it is within the scope of practice for a qualified dentist, defined by the American Dental Association (ADA), as a dentist treating sleep-related breathing disorders who continually updates his or her knowledge and training of dental sleep medicine with related continuing education, to order or administer home sleep apnea tests (HSATs). Data from HSATs should be interpreted by a licensed medical provider for initial diagnosis and verification of treatment efficacy.

Historically, state dental practice acts have not addressed the dentist's role in using HSATs. It is commonly understood that practice acts are intentionally broad in nature. They tend to be more specific only when prohibiting a practice or use of equipment. Based on this, it is the AADSM's interpretation that it is within the scope of practice for dentists to order and administer HSATs in states where it is not specifically prohibited. For the few states where the use of HSATs is prohibited, dentists should abide by state guidance. The AADSM maintains a list of these states on its website and will be actively encouraging them to reconsider their policies.[1]

There are other medical conditions for which dentists order and dispense medical tests. Dentists screen and perform biopsies for oral cancer. Dentists routinely administer oxygen and anesthesia and prescribe drugs, including controlled substances. In some states, dentists with training provide flu vaccinations. Dentists also routinely take blood pressure and some test hemoglobin A1C levels. Given the public burden of obstructive sleep apnea (OSA), dentists must embrace that it is within their scope of practice to order and administer HSATs.

In 2016, the American Academy of Sleep Medicine commissioned a report from Frost & Sullivan.[2] This report indicates that there were 29.4 million adults with obstructive sleep apnea, and in 80% of that group the condition was undiagnosed - costing the United States approximately $149.6 billion per year. The same report indicated that OSA is also linked to comorbidities, mental health, productivity, and accidents. It goes on to further explain that the most significant barrier to treatment of OSA is patients' disregard of symptoms and their failure to report them to primary care physicians and that once an individual is screened or informed about OSA, a significant financial and personal time investment is often necessary to address the problem. New studies published in 2019 indicate that approximately 54 million adults in the United States have sleep apnea.[3] If 80% of these adults also have undiagnosed OSA, there could be as many as 43 million adults with undiagnosed OSA.

In 2017, the ADA recognized that dentists should play an essential role in addressing the public burden of OSA.[4] In their policy, the ADA suggests that all dentists screen patients for OSA as part of a comprehensive medical and dental history and refer as needed to the appropriate physicians for diagnosis. The policy indicates that dentists may use HSATs to define the optimal target position of the mandible.

By building on the ADA policy and recognizing that qualified dentists have the training and education necessary to order or administer HSATs, qualified dentists can provide a more streamlined and cost-effective model of care. A short algorithm outlining this model of care is shown in Figure 1. Communication and collaboration with physicians are key in this process. In this model of care, qualified dentists screen patients for sleep apnea. If patients are at risk and appropriate candidates for HSAT, the qualified dentist orders or administers the HSAT directly from his or her practice. Patients complete the HSAT. Pertinent patient information and HSAT data are provided to a physician for diagnosis, and, if appropriate, the physician prescribes an oral appliance. The qualified dentist then determines whether the patient is a suitable candidate, and then fabricates and delivers the appliance. After the appliance is at the appropriate therapeutic position, the qualified dentist once again orders or

administers the HSAT. [redacted]

This model of care achieves several outcomes:

1. Dentists identify patients at risk for sleep apnea.
2. The process of obtaining a diagnosis for sleep apnea requires fewer appointments, reducing expenses and patient inconvenience while increasing the likelihood of treatment if sleep apnea is diagnosed in a patient.
3. The workload of primary care physicians and board-certified sleep medicine physicians related to ordering and dispensing HSATs is reduced, allowing them to better allocate their resources to the diagnosis and treatment of sleep disorders.
4. The diagnosis of medical diseases and verification of treatment efficacy remains the responsibility of the medical provider.

With the public burden of OSA and technologic advances, new models of care are being implemented at a rapid pace. Patients can now purchase HSATs directly from online sources. It is hard to find an argument against allowing a qualified dentist who will collaborate directly with patients' physicians when patients can order the test directly from the Internet, entirely bypassing their health care providers.

As health care providers who live by the ethical code of "do no harm" and understand the harmful consequences of OSA, we owe it to the public to implement models of care that reduce barriers to diagnosis and treatment, ensure that sleep apnea is diagnosed and treatment efficacy is verified by physicians, and maximize the training and skills of qualified dentists.

CITATION

Schwartz D, Levine M, Adame M, Addy N, Cantwell M, Hogg J, Huynh N, Jacobs P, Postol K, Rohatgi R. American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests. *J Dent Sleep Med.* 2020;7(4).

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2. Frost & Sullivan. Darien, IL: American Academy of Sleep Medicine; 2016. Hidden health crisis costing America billions. Underdiagnosing and undertreating obstructive sleep apnea draining healthcare system. https://aasm.org/advocacy/initiatives/economic-impact-obstructive-sleep-apnea/. Accessed August 18, 2020.
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4. Policy on Dentistry's Role in Treating Obstructive Sleep Apnea, Similar Disorders. American Dental Association. ada.org/sleepapnea. Accessed August 18, 2020.

SUBMISSION AND CORRESPONDENCE INFORMATION

Submitted in final revised form August 28, 2020.

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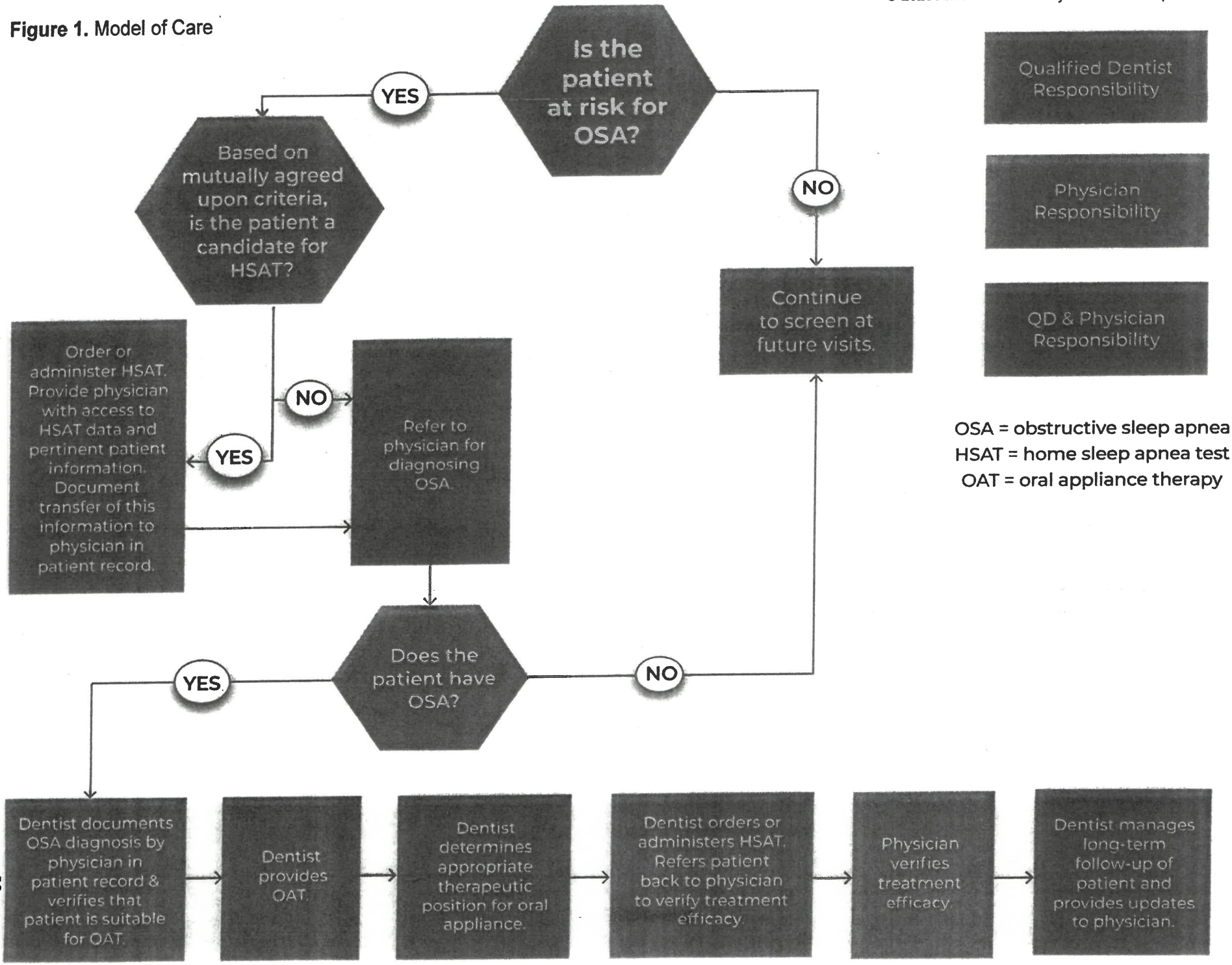
DISCLOSURE STATEMENT

All authors are members of the AADSM Board of Directors. Dr. Schwartz declares investments in Prosomnus Sleep.

Figure 1. Model of Care



OSA = obstructive sleep apnea
HSAT = home sleep apnea test
OAT = oral appliance therapy

SPECIAL ARTICLES

http://dx.doi.org/10.15331/jdsm.6920

Policy Statement on a Dentist's Role in Treating Sleep-Related Breathing Disorders

Nancy Addy, DDS[1]; Kathleen Bennett, DDS[2]; Alan Blanton, DDS[3]; Leslie Dort, DDS[4]; Mitchell Levine, DMD[5]; Kevin Postol, DDS[6]; Thomas Schell, DMD[7]; David Schwartz, DDS[8]; Rose Sheats, DMD[9]; Harold Smith, DDS[10]; for the American Academy of Dental Sleep Medicine Board of Directors

[1]Snoring and Sleep Apnea Dental Treatment Center, Leawood, Kansas; [2]Associated with UC Health Sleep Medicine Fellowship Program, Cincinnati, Ohio; [3]Center for Dental Sleep Medicine and Orofacial Pain, University of Tennessee Health Science Center, Memphis, Tennessee; [4]University of Calgary, Calgary, Alberta, Canada; [5]Jacksonville Center for Snoring and Sleep Apnea, Jacksonville, Florida; [6]Family and Cosmetic Dentistry, Ballwin, Missouri; [7]Schellnoble Dentistry, Lebanon, New Hampshire; [8]The Center for Sleep Medicine, Skokie, Illinois; [9]Chapel Hill, North Carolina; [10]Dental Sleep Medicine of Indiana, Indianapolis, Indiana

The American Academy of Dental Sleep Medicine (AADSM) is the only non-profit national professional society dedicated exclusively to the practice of dental sleep medicine and firmly believes that by screening and providing oral appliance therapy, dentists, with appropriate training and in collaboration with physicians, help reduce the number of undiagnosed and untreated patients with sleep-disordered breathing, which includes snoring and obstructive sleep apnea.

It is the position of the AADSM that:

- Dentists play an integral role in reducing the public health burden of undiagnosed and untreated sleep-related breathing disorders.
- Dentists should screen patients for sleep-disordered breathing with questionnaires and by evaluating the airway.
- Physicians are responsible for diagnosing sleep-disordered breathing and primary snoring, as well as prescribing the most appropriate or acceptable treatment options.
- Education in dental sleep medicine is required in order for dentists to provide safe, quality care to patients using oral appliance therapy for sleep-related breathing disorders. At minimum, dentists should meet the educational requirements defined by the AADSM to be a "Qualified Dentist" in dental sleep medicine.
- Dentists should verify oral appliance treatment efficacy using objective data only as permitted within their scope of practice and as defined by their state dental practice acts.
- Following the fitting and initial titration of an oral appliance by a "Qualified Dentist" the patient should always be referred back to the physician. Physicians should confirm the treatment efficacy of oral appliance therapy in a timely manner.
- Dentists need to provide timely, appropriate and ongoing follow-up care to manage dental-related side effects of oral appliance therapy.
- Dentists, in close collaboration with physicians, are an integral component to successfully managing sleep-related breathing disorders with oral appliance therapy.

Sleep-related breathing disorders impact a significant portion of the population. It is estimated that 23.5 million of United States adults have undiagnosed or untreated obstructive sleep apnea—costing billions[2]; increasing the risk of health complications such as hypertension, congestive heart failure, atrial fibrillation, coronary artery disease, stroke and type 2 diabetes[3]; in addition to reducing the quality of life for a significant portion of the population.

It is imperative that dentists receive postgraduate training to be able to provide and manage oral appliance therapy and its side effects. Inappropriately chosen and monitored oral appliance therapy by an inadequately trained dentist exposes patients to potentially life-threatening outcomes and dentists to potentially serious medicolegal liability. The AADSM recommends that dentists have at minimum: a valid state dental license, proof of liability coverage, and at least 25 hours of recognized continuing education in dental sleep medicine provided by a non-profit organization focused on dental sleep medicine or accredited dental school within the last two years in order to provide oral appliance therapy to patients with sleep-disordered breathing.[1] The AADSM encourages all dentists providing oral appliance therapy to become "Qualified Dentists" and subsequently Diplomates of the American Board of Dental Sleep Medicine.

When oral appliance therapy is prescribed by a physician, qualified dentists provide custom-made, adjustable oral appliances, in addition to providing diligent ongoing follow-up. Dentists who are not properly trained in oral appliance therapy may provide ineffective treatment and follow-up care, potentially reducing referrals from physicians to dentists and the potential role that dentistry plays in lessening the burden of snoring and sleep apnea on public health.

CITATION

Addy N, Bennett K, Blanton A, Dort L, Levine M, Postol K, Schell T, Schwartz D, Sheats R, Smith H. Policy statement on a dentist's role in treating sleep-related breathing disorders. *Journal of Dental Sleep Medicine*. 2018;5(1):25–26.

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3. Punjabi NM. The epidemiology of adult obstructive sleep apnea. *Proc Am Thorac Soc.* 2008;5(2):136–143.

SUBMISSION & CORRESPONDENCE INFORMATION

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Address correspondence to: American Academy of Dental Sleep Medicine National Office, 2510 North Frontage Road, Darien, IL 60561; Tel: (630) 737-9705; Email: info@aadsm.org

DISCLOSURE STATEMENT

Dr. Schwartz reports serving in an advisory capacity as part of Resmed's dental panel, owning public stock in Resmed, serving as part of an advisory group for Prosomnus, and having a financial stake in Prosomnus. The other authors report no conflicts of interest.

From: Jessica Bui <jbui@srta.org>
Sent: Wednesday, March 17, 2021 8:49 PM
To: Sandra Reen <sandra.reen@dhp.virginia.gov>; Sacksteder, Jamie <jamie.sacksteder@dhp.virginia.gov>; donna.lee@dhp.virginia.gov
Cc: Gerry Walker <efudd777@aol.com>
Subject: Additional Documents for Public Comment
Importance: High

Sandy,

Please see the attached additional letter for the board to review for the meeting this Friday, March 19th.

Also included are our dental and dental hygiene webinars regarding information on the SRTA examination:

SRTA Dental Nonpatient Webinar

SRTA DH Nonpatient Webinar

Thank you,

Jessica L. Bui

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 17, 2021

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

Dear Dr. Petticolas and the Members of the Virginia Board of Dentistry,

After listening to the Virginia Exam Committee meeting held on March 5, 2021, we thought it would be beneficial to clarify to the board that Southern Regional Testing Agency, Inc. has acceptance in 76% of the United States. Most recently gaining additional state acceptance within Idaho, Oklahoma, and Washington for the SRTA dental examination results. The number of states accepting SRTA are increasing, and with our ability to offer a respected and acceptable examination it allows students the greater chance of portability.

Limiting acceptance to only ADEX examination results hinders the opportunity of portability for many students across the country. We hope that Virginia will remain inclusive and progressive along with the many other states that accept the SRTA results.

We would like to extend an invitation to the board members to observe a SRTA examination to see how ours is comparable to the ADEX exam. An awareness of how the examination process is conducted allows the board members the opportunity to see that SRTA is evaluating at the same level as ADEX and to the state's highest standards.

Sincerely,

Thomas G. Walker, DMD
President

Jessica Bui
Executive Director

Commonwealth of Virginia

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

FW: Board Meeting / Public Comment

1 message

Sandra Reen <Sandra.Reen@dhp.virginia.gov>
To: "Lee, Donna" <donna.lee@dhp.virginia.gov>

Wed, Mar 17, 2021 at 6:00 PM

Here is another commenter, Donna, with an attachment to print and send out, if it hasn't already been received. If we received this attachment from Dr. Zapatero or another commenter there is no need to print multiple copies.

From: Dr. Erika Mason, DDS <dremason@gmail.com>
Sent: Wednesday, March 17, 2021 10:30 AM
To: sandra.reen@dhp.virginia.gov
Subject: Board Meeting / Public Comment

Good morning Sandy, I briefly spoke to Dr. Perry Jones this morning and he said I needed to contact YOU directly.

I needed to contact you anyway to see if I could get on the docket for the 3-5 min comment time in regards to the AASM letter sent to the board.

I wanted to make sure (and I have attached it to this email) that the Board of Dentistry has read the paper that was referenced by the AASM. I am disappointed that they did not include that with their letter (maybe they did but my guess was that they did not!). If the Board is going to have any discussion about what the AASM is proposing- I feel it is imperative for the Board to read and understand the position paper by the AADSM. Once they read it they should fully understand that the AADSM is NOT asking to diagnose OSA ... that is a blatant claim that is not correct. The AADSM is wanting to be collaborative in working with Sleep Physicians and the medical community for the betterment of our patients.

If you would place me on the docket but if there is any way that the Board members could be able to be familiar with the paper written by the AADSM it would be so helpful in what some of the dentists that is on the docket to speak can make the point they are trying to make within that 3-5 minute time frame more meaningful.

Thank you for your assistance with this matter. If you need to contact me - my information is below. I look forward to addressing the Board on Friday.

Best Regards, Dr. Erika Mason

Erika C Mason DDS,

Diplomate-ABDSM

Diplomate-ACSDD
www.sleepbetterva.com
804-745-0624 fax 804-410-4611

AADSM Position Paper on HSAT.pdf
811K

JDSM
Journal of Dental Sleep Medicine
(https://aadsm.org/journal/current_issue.php)
(http://www.facebook.com/AADSM.org) (https://twitter.com/AADSMorg)
(https://www.linkedin.com/company/american-academy-of-dental-sleep-medicine) (mailto:info@aadsm.org)

Special Article 1, Issue 7.4

American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests

http://dx.doi.org/10.15331/jdsm.7156

David Schwartz, DDS[1]; Michael Adame, DDS[2]; Nancy Addy, DDS[3]; Michelle Cantwell, DMD[4]; James Hogg, DDS[5]; Nelly Huynh, PhD[6]; Paul Jacobs, DDS[7]; Mitchell Levine, DMD[8]; Kevin Postol, DDS[9]; Rosemarie Rohatgi, DMD[10]

[1]North Shore Family Dentistry, Skokie, IL; [2]Adame Dental Sleep Medicine; [3]Snoring and Sleep Apnea Dental Treatment Center, Leawood, KS; [4]Wellspan Pulmonary and Sleep Medicine, Lancaster, PA; [5]Carolina Smiles Family Dentistry, Brevard, NC; [6]Faculty of Dentistry, Universite de Montreal, Montreal, Canada; [7]Upper Peninsula Sleep Dentistry, Escabana, MI; [8]Department of Orthodontics, University of Tennessee Health Science Center, Memphis, Tennessee; [9]Sleep Disordered Dentistry, Ballwin, Missouri; [10]San Diego Sleep Therapy, San Diego, CA

It is the position of the American Academy of Dental Sleep Medicine (AADSM) that it is within the scope of practice for a qualified dentist, defined by the American Dental Association (ADA) as a dentist treating sleep-related breathing disorders who continually updates his or her knowledge and training of dental sleep medicine with related continuing education, to order or administer home sleep apnea tests (HSATs). Data from HSATs should be interpreted by a licensed medical provider for initial diagnosis and verification of treatment efficacy.

Historically, state dental practice acts have not addressed the dentist's role in using HSATs. (https://www.aadsm.org/home_sleep_apnea_tests.php) It is commonly understood that practice acts are intentionally broad in nature. They tend to be more specific only when prohibiting a practice or use of equipment. Based on this, it is the AADSM's interpretation that it is within the scope of practice for dentists to order and administer HSATs in states where it is not specifically prohibited. For the few states where the use of HSATs is prohibited, dentists should abide by state guidance. The AADSM maintains a list of these states on its website and will be actively encouraging them to reconsider their policies.[1]

There are other medical conditions for which dentists order and dispense medical tests. Dentists screen and perform biopsies for oral cancer. Dentists routinely administer oxygen and anesthesia and prescribe drugs, including controlled substances. In some states, dentists with training provide flu vaccinations. Dentists also routinely take blood pressure and some test hemoglobin A1C levels. Given the public burden of obstructive sleep apnea (OSA), dentists must embrace that it is within their scope of practice to order and administer HSATs.

In 2016, the American Academy of Sleep Medicine commissioned a report from Frost & Sullivan.[2] This report indicates that there were 29.4 million adults with obstructive sleep apnea, and in 80% of that group the condition was undiagnosed - costing the United States approximately $149.6 billion per year. The same report indicated that OSA is also linked to comorbidities, mental

health, productivity, and accidents. It goes on to further explain that the most significant barrier to treatment of OSA is patients' disregard of symptoms and their failure to report them to primary care physicians and that once an individual is screened or informed about OSA, a significant financial and personal time investment is often necessary to address the problem. New studies published in 2019 indicate that approximately 54 million adults in the United States have sleep apnea.[3] If 80% of these adults also have undiagnosed OSA, there could be as many as 43 million adults with undiagnosed OSA.

In 2017, the ADA recognized that dentists should play an essential role in addressing the public burden of OSA.[4] In their policy, the ADA suggests that all dentists screen patients for OSA as part of a comprehensive medical and dental history and refer as needed to the appropriate physicians for diagnosis. The policy indicates that dentists may use HSATs to define the optimal target position of the mandible.

By building on the ADA policy and recognizing that qualified dentists have the training and education necessary to order or administer HSATs, qualified dentists can provide a more streamlined and cost-effective model of care. A short algorithm outlining this model of care is shown in Figure 1. Communication and collaboration with physicians are key in this process. In this model of care, qualified dentists screen patients for sleep apnea. If patients are at risk and appropriate candidates for HSAT, the qualified dentist orders or administers the HSAT directly from his or her practice. Patients complete the HSAT. Pertinent patient information and HSAT data are provided to a physician for diagnosis, and, if appropriate, the physician prescribes an oral appliance. The qualified dentist then determines whether the patient is a suitable candidate, and then fabricates and delivers the appliance. After the appliance is at the appropriate therapeutic position, the qualified dentist once again orders or administers the HSAT. Pertinent patient information and HSAT data are shared with the physician who verifies treatment efficacy.

Figure 1

Model of Care
(more ...) (https://www.aadsm.org/docs/Schwartz_Issue_7.4_Figure_1.pdf)

This model of care achieves several outcomes:

1. Dentists identify patients at risk for sleep apnea.
2. The process of obtaining a diagnosis for sleep apnea requires fewer appointments, reducing expenses and patient inconvenience while increasing the likelihood of treatment if sleep apnea is diagnosed in a patient.
3. The workload of primary care physicians and board-certified sleep medicine physicians related to ordering and dispensing HSATs is reduced, allowing them to better allocate their resources to the diagnosis and treatment of sleep disorders.
4. The diagnosis of medical diseases and verification of treatment efficacy remains the responsibility of the medical provider.

With the public burden of OSA and technologic advances, new models of care are being implemented at a rapid pace. Patients can now purchase HSATs directly from online sources. It is hard to find an argument against allowing a qualified dentist who will collaborate directly with patients' physicians when patients can order the test directly from the Internet, entirely bypassing their health care providers.

As health care providers who live by the ethical code of "do no harm" and understand the harmful consequences of OSA, we owe it to the public to implement models of care that reduce barriers to diagnosis and treatment, ensure that sleep apnea is diagnosed and treatment efficacy is verified by physicians, and maximize the training and skills of qualified dentists.

CITATION

Schwartz D, Levine M, Adame M, Addy N, Cantwell M, Hogg J, Huynh N, Jacobs P, Postol K, Rohatgi R. American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests. *J Dent Sleep Med.* 2020;7(4).

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1. Home sleep apnea tests. American Academy of Dental Sleep Medicine. https://www.aadsm.org/home_sleep_apnea_tests.php. Accessed August 18, 2020.
2. Frost & Sullivan. Darien, IL: American Academy of Sleep Medicine; 2016. Hidden health crisis costing America billions. Underdiagnosing and undertreating obstructive sleep apnea draining healthcare system. https://aasm.org/advocacy/initiatives/economic-impact-obstructive-sleep-apnea/. Accessed August 18, 2020.

3. Benjafield AV, Ayas NT, Eastwood PR, et al. Estimation of the global prevalence and burden of obstructive sleep apnoea: a literature-based analysis. *Lancet Respir Med.* 2019;7(8):687-698. doi:10.1016/S2213-2600(19)30198-5
4. Policy on Dentistry's Role in Treating Obstructive Sleep Apnea, Similar Disorders. American Dental Association. ada.org/sleepapnea. Accessed August 18, 2020.

SUBMISSION & CORRESPONDENCE INFORMATION

Submitted in final revised form August 28, 2020.

Address correspondence to: David Schwartz, DDS; Email: dschwartz@aadsm.org (mailto:dschwartz@aadsm.org)

DISCLOSURE STATEMENT

All authors are members of the AADSM Board of Directors. Dr. Schwartz declares investments in Prosomnus Sleep.

PDF (https://www.aadsm.org/docs/HSAT_Special_Article_Proof.pdf)

Contact Us:

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Email: info@aadsm.org
Phone: (630) 686-9875
Fax: (630) 686-9876

Commonwealth of Virginia

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

Fwd: FW: Public Comments for March 19 Meeting

1 message

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

Thu, Mar 18, 2021 at 11:38 AM

From: David Schwartz <dschwartz@aadsm.org>
Sent: Thursday, March 18, 2021 11:15 AM
To: sandra.reen@dhp.virginia.gov
Cc: Becky Roberts <broberts@aadsm.org>; Coreen Vick <cvick@aadsm.org>; Matthew Glans <mglans@aadsm.org>
Subject: Public Comments for March 19 Meeting

Good morning,

Please find attached written comments regarding the letter from Dr. Kannan Ramar that is on the agenda for the March 19 meeting of the Virginia Board of Dentistry. We believe our attached letter summarizes our comments, so we will not need 3-5 minutes to present during the meeting. We do plan on having representatives from the AADSM attend the public comment portion of the meeting, so should you need us to clarify any information or if you think it would be valuable for us to present this letter verbally, please let me know.

Kind regards,

David

David Schwartz, DDS

President

American Academy of Dental Sleep Medicine

www.aadsm.org

Phone: (630) 686-9875 | Email: dschwartz@aadsm.org

AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE®

March 18, 2021

Augustus A. Petticolas, DDS
President
Virginia Board of Dentistry
SENT VIA EMAIL: sandra.reen@dhp.virginia.gov

1001 Warrenville Road,
Suite 175
Lisle, IL 60532
Phone: 630-686-9875
Fax: 630-686-9876
Web: AADSM.org

Dear Dr. Petticolas:

Recently you received a letter from the American Academy of Sleep Medicine, American Academy of Neurology, American Academy of Otolaryngology - Head and Neck Surgery, and the American Thoracic Society urging you to declare that ordering and administering home sleep apnea tests (HSATs) is outside the scope of practice for dentists in your state.

The claim in the letter is that the American Academy of Dental Sleep Medicine (AADSM) position statement encourages the use of HSATs by dentists for the diagnosis of obstructive sleep apnea (OSA). Our position (Attachment A) contains no such claim. Rather, our position affirms a collaborative care model in which:

- Dentists must be trained in dental sleep medicine to order or administer HSATs.
- Licensed medical providers are responsible for initial diagnosis and verification of treatment efficacy.
- Trained dentists must communicate and collaborate with physicians to determine a mutually agreed criteria for identifying patients who are candidates for HSATs.

Our position statement outlines a model of care in which trained dentists utilize their knowledge and developed patient relationships to work in concert with physicians to help the 43 million Americans suffering from undiagnosed OSA navigate a pathway to diagnosis and treatment. Rather than encouraging dentists to diagnose OSA, our position is in fact intended to dissuade dentists from using HSATs if they are not trained or working in collaboration with physicians.

While the definition of ordering a test is universal across medicine and dentistry, the definition of administering a test can vary considerably. Administering a HSAT involves providing the test to the patient along with instructions for use; the patient is responsible for attaching sensors at home prior to bedtime.

It is important to clarify that both the American Dental Association's policy statement (Attachment B) and the American Association of Orthodontics' white paper (Attachment C) support dentists using a comprehensive medical and dental history and clinical examination to screen for OSA and state that trained dentists may use HSATs (commonly referred to as portable monitors) for the titration of oral appliances.

These papers were established prior to the publication of our position statement and offer a foundation for our collaborative care model. We have shared our position statement with both organizations, as well as with the American Association of Dental Boards.

The AADSM believes that every patient is entitled to effective treatment for OSA. We also believe that dentists and physicians need to have the ability to develop a practice model that works best for the patients in their community. In many communities, the agreed upon practice model involves the trained dentist ordering or administering HSATs for appropriate patients during certain points of the care continuum.

Dentistry provides a valuable resource for so many aspects of our health care system, and dentists are an essential resource in helping to get more patients access to treatment for OSA.

Should you have any questions about our position, please do not hesitate to reach out via email to dschwartz@aadsm.org.

Sincerely,
David Schwartz, DDS
President

SPECIAL ARTICLES

http://dx.doi.org/10.15331/jdsm.7156

American Academy of Dental Sleep Medicine Position on the Scope of Practice for Dentists Ordering or Administering Home Sleep Apnea Tests

David Schwartz, DDS[1]; Michael Adame, DDS[2]; Nancy Addy, DDS[3]; Michelle Cantwell, DMD[4]; James Hogg, DDS[5]; Nelly Huynh, PhD[6]; Paul Jacobs, DDS[7]; Mitchell Levine, DMD[8]; Kevin Postol, DDS[9]; Rosemarie Rohatgi, DMD[10]

[1]North Shore Family Dentistry, Skokie, IL; [2]Adame Dental Sleep Medicine; [3]Snoring and Sleep Apnea Dental Treatment Center, Leawood, KS; [4]Wellspan Pulmonary and Sleep Medicine, Lancaster, PA; [5]Carolina Smiles Family Dentistry, Brevard, NC; [6]Faculty of Dentistry, Universite de Montreal, Montreal, Canada; [7]Upper Peninsula Sleep Dentistry, Escabana, MI; [8]Department of Orthodontics, University of Tennessee Health Science Center, Memphis, Tennessee; [9]Sleep Disordered Dentistry, Ballwin, Missouri; [10]San Diego Sleep Therapy, San Diego, CA

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There are other medical conditions for which dentists order and dispense medical tests. Dentists screen and perform biopsies for oral cancer. Dentists routinely administer oxygen and anesthesia and prescribe drugs, including controlled substances. In some states, dentists with training provide flu vaccinations. Dentists also routinely take blood pressure and some test hemoglobin A1C levels. Given the public burden of obstructive sleep apnea (OSA), dentists must embrace that it is within their scope of practice to order and administer HSATs.

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In 2017, the ADA recognized that dentists should play an essential role in addressing the public burden of OSA.[4] In their policy, the ADA suggests that all dentists screen patients for OSA as part of a comprehensive medical and dental history and refer as needed to the appropriate physicians for diagnosis. The policy indicates that dentists may use HSATs to define the optimal target position of the mandible.

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administers the HSAT. Pertinent patient information and HSAT data are shared with the physician who verifies treatment efficacy.

This model of care achieves several outcomes:

1. Dentists identify patients at risk for sleep apnea.
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SUBMISSION AND CORRESPONDENCE INFORMATION

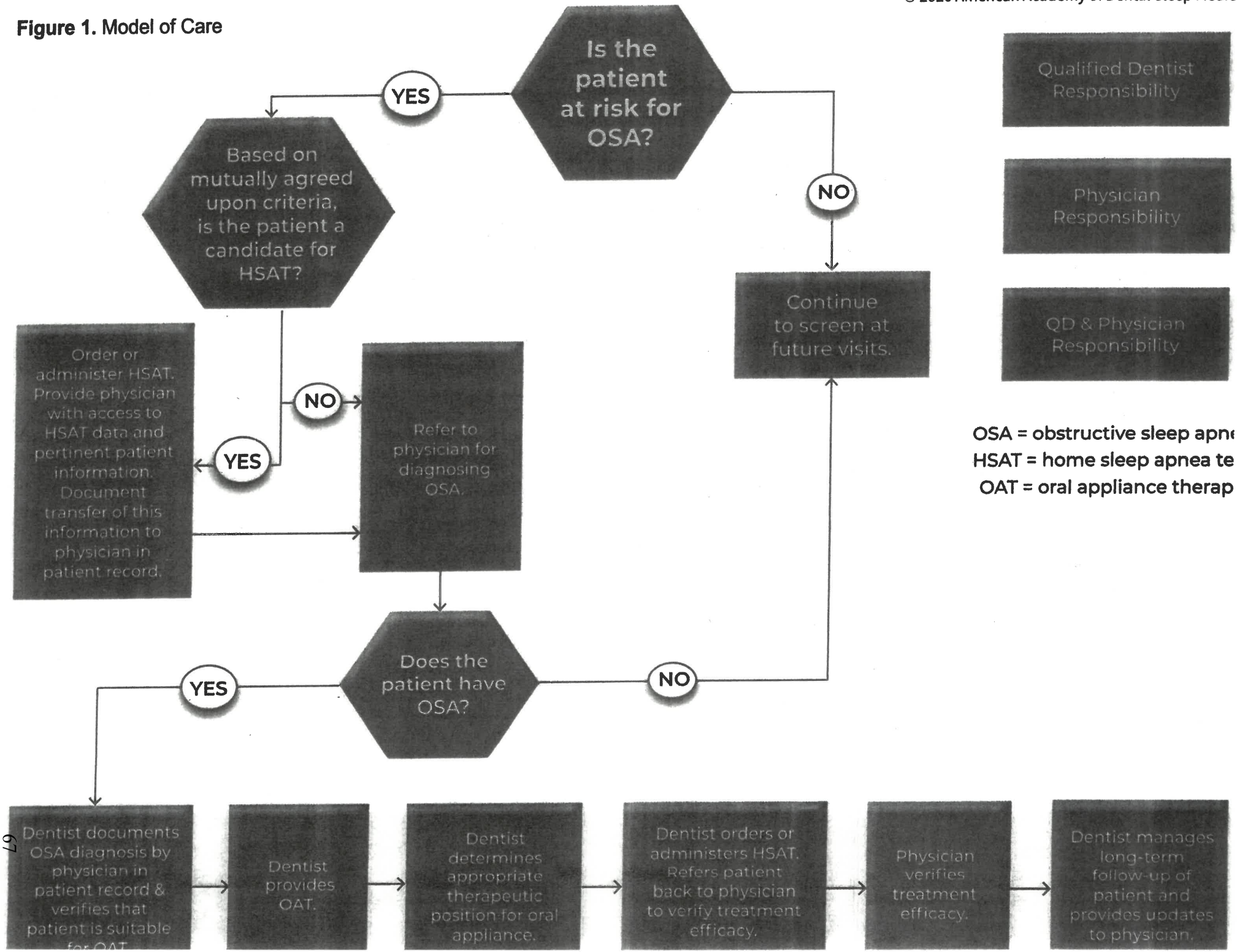
Submitted in final revised form August 28, 2020.

Address correspondence to: David Schwartz, DDS; Email: dschwartz@aadsm.org

DISCLOSURE STATEMENT

All authors are members of the AADSM Board of Directors. Dr. Schwartz declares investments in Prosomnus Sleep.

Figure 1. Model of Care



OSA = obstructive sleep apn
HSAT = home sleep apnea te
OAT = oral appliance therap

The Role of Dentistry in the Treatment of Sleep Related Breathing Disorders

Adopted by ADA's 2017 House of Delegates

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBDs are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBDs include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various surgical modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients compared to no therapy or placebo devices. Oral appliance therapy (OAT) can improve OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. If risk for SRBD is determined, these patients should be referred, as needed, to the appropriate physicians for proper diagnosis.

- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

- Oral appliance therapy is an appropriate treatment for mild and moderate sleep apnea, and for severe sleep apnea when a CPAP is not tolerated by the patient.

- When oral appliance therapy is prescribed by a physician through written or electronic order for an adult patient with obstructive sleep apnea, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance.

- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.

- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.

- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, the use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of these portable monitoring devices may assess the objective interim results for the purposes of OA titration.

- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.
- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.

- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers to the patient's treatment progress and any recommended follow-up treatment.

- Follow-up sleep testing by a physician should be conducted to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

Obstructive sleep apnea and orthodontics: An American Association of Orthodontists White Paper

Rolf G. Behrents,[a,b] Anita Valanju Shelgikar,[c] R. Scott Conley,[d] Carlos Flores-Mir,[e] Mark Hans,[f,g] Mitchell Levine,[h] James A. McNamara,[i,j] Juan Martin Palomo,[k] Benjamin Pliska,[l,m] John W. Stockstill,[n] John Wise,[o] Sean Murphy,[p] Norman J. Nagel,[q] and Jackie Hittner[r]

St. Louis, Mo, Ann Arbor, Mich, Orchard Park, NY, Edmonton, Alberta, and Vancouver, BC, Canada, Cleveland and Berea, Ohio, Memphis, Tenn, Atlanta, Ga, Frisco and McKinney, Tex, and Simi Valley, Calif

The Board of Trustees of the American Association of Orthodontists asked a panel of medical and dental experts in sleep medicine and dental sleep medicine to create a document designed to offer guidance to practicing orthodontists on the suggested role of the specialty of orthodontics in the management of obstructive sleep apnea. This White Paper presents a summary of the Task Force's findings and recommendations. (Am J Orthod Dentofacial Orthop 2019;156:13-28)

The specialty of orthodontics involves much more than just moving teeth, and the management of sleep apnea bears witness to this. As such, there is increasing interest in the role of the orthodontist both in screening for obstructive sleep apnea (OSA) and as a practitioner who may be valuable in the multidisciplinary management of OSA in both children and adults. As experts in the science of facial growth and development, combined with our knowledge of oral devices, orthodontists are well suited to collaborate with physicians and other allied health providers in the treatment of OSA.

Although OSA can be definitively diagnosed only by a physician, the orthodontist may be called on to screen for OSA, contribute to the identification of underlying dentofacial components, and assist the physician in managing the disease. As such, the orthodontist is not able to manage this care alone, and a cooperative shared effort between the orthodontist and other medical professionals is preferred to optimize care of patients with OSA.

Patients with suspected OSA may come to the orthodontist in several different ways. A patient who has been medically diagnosed with OSA may be referred to the orthodontist by a physician who prescribes an oral appliance or suggests orthodontic or orthopedic therapy to assist in the management of the OSA. Other patients or caregivers may present to the orthodontist with concerns about breathing during sleep. In addition, patients may present to the orthodontist unaware of their OSA, and orthodontic screening may reveal the need for further evaluation by a physician.

In November 2017, the Board of Trustees of the American Association of Orthodontists (AAO) tasked a panel of medical and dental experts in sleep medicine and dental sleep medicine to create a document

[a]American Journal of Orthodontics and Dentofacial Orthopedics, St. Louis, Mo.
[b]Graduate Orthodontic Program, Saint Louis University, St. Louis, Mo.
[c]Neurology, University of Michigan, Ann Arbor, Mich.
[d]Department of Orthodontics, University of Buffalo, Orchard Park, NY.
[e]Orthodontics Division, University of Alberta, Edmonton, Alberta, Canada.
[f]Department of Orthodontics, Case Western Reserve University, Cleveland, Ohio.
[g]Private practice, Berea, Ohio.
[h]Department of Orthodontics, Department of Oral Medicine, Division of Orofacial Pain, University of Tennessee Health Science Center, Memphis, Tenn.
[i]Department of Orthodontics and Pediatric Dentistry and Center for Human Growth and Development, University of Michigan, Ann Arbor, Mich.
[j]Private practice, Ann Arbor, Mich.
[k]School of Dental Medicine, Case Western Reserve University, Cleveland, Ohio.
[l]Division of Orthodontics, University of British Columbia, Vancouver, BC, Canada.
[m]Private practice, Vancouver, BC, Canada.
[n]Georgia School of Orthodontics. Atlanta, Ga.
[o]Private practice, Frisco and McKinney, Tex.
[p]Advocacy and General Counsel, American Association of Orthodontists, St. Louis, Mo.
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designed to offer guidance to practicing orthodontists on the suggested role of the specialty of orthodontics in the management of OSA. The panel completed an exhaustive review of the available literature as well as contributed their own personal expertise gleaned from managing these patients in both academic centers and within private practice settings. In considering the literature, it was obvious that there is broad interest in OSA, as evidenced by the development of guidelines for the consideration and treatment of OSA around the world and involving many different communities. The topic has been covered by physicians, dentists, and scientists from a variety of organizations, including the American Dental Association, American Academy of Dental Sleep Medicine, American Academy of Sleep Medicine, European Respiratory Society, Australian Dental Association, American Association of Oral and Maxillofacial Surgeons, American College of Prosthodontists, American Academy of Pediatric Dentistry, Canadian Dental Sleep Medicine, Canadian Thoracic Society, American Academy of Pediatrics, and U.S. Preventative Respiratory Society, among others.

However, the Task Force could not identify any formal OSA guidance for orthodontists. This was surprising because orthodontists have specialized knowledge, skill, and experience that would be beneficial in the management and care of patients with OSA. In addition, orthodontists typically have a broad patient population (children, adolescents, and adults), with contact maintained over a long period of time. Moreover, orthodontists have a long and productive history of working with others in medicine and dentistry to provide collaborative care for patients with special needs (eg, cleft lip and palate, craniofacial syndromes, complex restorative cases, orthognathic surgery).

Given that OSA can be a serious, even life-threatening, disorder and the quality of patient management and care that can be provided by orthodontists, the Task Force determined that it was very important to develop specific recommendations that would be useful to an orthodontist in practice. The following represents a summary of their findings and recommendations.

ADULT OSA

Sleep-related breathing disorders (SRBDs) constitute a diagnostic category of disease that encompasses obstructive phenomena, including primary snoring, upper airway resistance syndrome, and OSA, along with the related entities of central sleep apnea and sleep-related hypoventilation. This document focuses on OSA, beginning with this section on the adult patient (ie, 18 years of age or older). Clinical concerns for other forms of SRBD and additional types of sleep disorders (eg, insomnia, central disorders of hypersomnolence, circadian rhythm sleep-wake disorders, sleep-related movement disorders, and parasomnias), if identified, should be referred to a physician for evaluation and treatment; a sleep medicine physician is preferred.

Etiology

Obstructive sleep apnea occurs as a function of increased collapsibility of the upper airway. The pharyngeal critical closing pressure (Pcrit) is the pressure at which the upper airway collapses. This collapsibility is influenced further by impaired neuromuscular tone. Respiratory effort increases to maintain airflow through a constricted airway, accompanied by relative increase in serum carbon dioxide (hypercarbia) and decrease in serum oxygen (hypoxemia). The increased work of breathing causes a cortical arousal from sleep, which in turn raises sympathetic neural activity, leading to increased heart rate and blood pressure and a tendency for cardiac arrhythmia. With the cortical arousal from sleep comes an increase in airway patency and resumption of normal airflow, with subsequent return to sleep and recurrence of sleep-related upper airway collapsibility. This disruption in breathing may occur multiple times per hour for the entire duration of the patient's sleep.

The complexity of OSA is exemplified by its multifactorial etiology. Such etiologies involve the craniofacial structures, neuromuscular tone, and other related factors. Collapsibility of the upper airway is influenced further by hormonal fluctuation (eg, pregnancy or menopause), obesity, rostral fluid shifts, and genetic predisposition that influences craniofacial anatomy. OSA severity is heterogeneous among patients with the disorder. This wide range of presentation leads to variations in management approach and differences in treatment response.

Prevalence

Estimates of the prevalence of OSA in adults vary in the literature; OSA is commonly thought to involve 14% of men and 5% of women. Prevalence rates are higher in certain populations, such as obese patients considered for bariatric surgery and post-stroke patients. Underrecognition of OSA likely leads to underdiagnosis and a false reduction of the true prevalence of disease.

Risk factors

Individuals with certain characteristics appear to be predisposed to OSA. Conditions that may be risk factors for the development of OSA in adults include obesity (body mass index [BMI] $\geq$30 kg/m^2), menopause, male

sex, and increasing age. Genetic influences on craniofacial structure leads to higher OSA prevalence in certain ethnic groups that have been studied. Some genetic syndromes, particularly those with associated craniofacial anomalies, also are associated with an increased risk of OSA.

Craniofacial morphologies that may predispose to OSA include retrognathia, long and narrow faces, dolichocephalic facial type, narrow and deep palate, steep mandibular plane angle, anterior open bite, midface deficiency, and lower hyoid position. It should be noted, however, that the strength of the relationship between these craniofacial morphologies and the development of OSA is not well established.

Symptoms

Patients with OSA often have a history of snoring, gasping respiration or choking, and witnessed pauses in breathing (apneas) during sleep. Common clinical symptoms of untreated OSA include frequent nocturnal awakenings, nonrestorative sleep, morning headaches, and excessive daytime sleepiness. Patients with OSA often describe difficulty with attention and concentration, mood disturbance, and difficulty controlling other medical comorbidities such as diabetes mellitus, hypertension, and obesity.

Diagnosis

Diagnostic confirmation of OSA is performed by a sleep medicine specialist with the use of the gold standard of an in-center overnight sleep study (polysomnography [PSG]) or out-of-center sleep testing (OCST) for appropriately selected patients. Home sleep apnea testing (HSAT) is a type of OCST. Attended PSG includes at least 7 channels of recording, including electroencephalography (EEG), electrocardiography, and monitoring of sleep, airflow through the nose and mouth, pulse oximetry, respiratory effort, and leg movement. HSAT includes 4-7 channels. It is important to note that HSAT typically does not include EEG monitoring of sleep.

According to the International Classification of Sleep Disorders,[1] OSA can be diagnosed by either of 2 sets of criteria. The first set of diagnostic criteria for OSA includes the presence of at least 1 of the following: (1) the patient has sleepiness, nonrestorative sleep, fatigue, or insomnia symptoms, (2) the patient wakes with breath holding, gasping, or choking, (3) a bed partner or other observer reports habitual snoring, breathing interruptions, or both during the patient's sleep, and (4) the patient has been diagnosed with hypertension, a mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation, or type 2 diabetes mellitus; and polysomnography or OCST shows at least 5 predominantly obstructive events (obstructive or mixed apneas, hypopneas, or respiratory effort–related arousals (RERAs) per hour of sleep during a PSG or per hour of monitoring on OCST.

In the second criteria, OSA can be diagnosed if PSG or OCST shows 15 or more predominantly obstructive events (obstructive or mixed apneas, hypopneas, or RERAs per hour of sleep during a PSG or per hour of monitoring on OCST). Examples of apnea and hypopnea are presented in Appendix 1.

A few different terms are used in the classification of OSA. The respiratory disturbance index (RDI) includes the number of apneas, hypopneas, and RERAs per hour of sleep. The apnea-hypopnea index (AHI) includes the number of apneas and hypopneas per hour of sleep. Thus, a patient's RDI may be higher than the AHI. Some publications refer to AHI and others RDI, so it is important for clinicians and researchers to understand the difference between these 2 measurements. Compared with PSG, OCST often underestimates the frequency of obstructive events per hour because OCST typically does not measure total sleep time as determined by EEG. The respiratory event index can be used to indicate the frequency of respiratory events based on total recording time (rather than total sleep time).

Severity

Severity of obstructive sleep apnea is classified based on the AHI or RDI per hour; categories are mild (AHI or RDI $\geq$5 and $<$15), moderate (AHI or RDI $\geq$15 and $<$30), and severe (AHI or RDI $\geq$30). The minimum oxygen saturation also should be considered when making clinical assessment of the magnitude of OSA, although there are no consensus classifications for the severity of oxygen desaturation.

Significance

Untreated OSA can lead to many serious consequences. Excessive daytime sleepiness increases the risk of motor vehicle accidents and diminishes quality of life. Neurocognitive impairment leads to decreased scholastic and occupational performance. Chronic intermittent hypoxemia and heightened sympathetic neural activity, endothelial damage, and heightened inflammation are related to metabolic dysfunction and end-organ

sequelae. Untreated OSA increases risk of insulin resistance, coronary artery disease, congestive heart failure, myocardial infarction, hypertension, stroke, cardiac arrhythmia, and sudden cardiac death.

ROLE OF ORTHODONTICS IN ADULT OSA

The orthodontist is well positioned to perform an OSA screening assessment and refer at-risk patients for diagnostic evaluation. Once the diagnosis of OSA is confirmed, physicians (and advanced practice providers supervised by physicians) may prescribe orthodontic appliances or procedures in appropriately selected adult patients as part of OSA management.

Medical and dental history

Orthodontists should be familiar with the signs and symptoms of OSA in adult patients. Thorough history taking is critically important to establish the presence of preexisting conditions, a basis for a diagnosis, the need for referral, and a baseline for evaluating the effects of treatment. Orthodontists also should include assessment of a patient's height, weight, and neck size to screen adult patients for OSA.

The following items should be considered when constructing a health history that is sensitive to OSA: a previous diagnosis of OSA, excessive daytime sleepiness,* a previous diagnosis of other forms of SRBDs, fatigue during the day, height,* choking or gasping respirations during sleep, weight,* habitual or loud snoring,* sex,* observed episodes of pauses in breathing,* age,* abrupt awakening and shortness of breath, high blood pressure,* awakening with dry mouth or sore throat, mouth breathing, morning headaches, menopause, difficulty staying asleep, alterations in performance, enuresis or unexplained nocturia, disordered mood, attention, or memory problems, restlessness during sleep, sweating, nasal obstruction, bruxism, type 2 diabetes, and neck circumference (*component of the STOP-Bang questionnaire; see next section).

Screening tools

In adults, a validated tool for OSA risk assessment is the STOP-Bang questionnaire (Appendix II),[2,3] which asks yes or no questions based on its acronym: snoring (S), tiredness (T), observed pauses in breathing (O), high blood pressure (P), BMI >35 kg/m^2 (B), age >50 years (A), neck circumference of ≥17 inches in men, or ≥16 inches in women (N), and male gender (G). A patient is considered to be at low risk for OSA if the questionnaire has no more than 2 "yes" answers, at intermediate risk if here are 3 or 4 "yes" answers, and at high risk if there are 5 or more "yes" answers.

The patient is considered at high risk also if there are 2 "yes" answers from the STOP section, combined with either male gender, high BMI, or large neck size. Using a cutoff score of ≥3 to detect any OSA (AHI >5), moderate to severe OSA (AHI >15), and severe OSA (AHI >30), the sensitivities were 84%, 93%, and 100% and specificities 56%, 43%, and 37%, respectively.[4] The STOP-Bang questionnaire has a high sensitivity for identifying patients with moderate to severe OSA. This sensitivity gives the practitioner an excellent tool for identifying patients who have the condition. This questionnaire can be completed in a few minutes as part of an orthodontist's workflow.

Clinical examination

The clinical examination is an important part of the screening process. In addition to regular orthodontic screening, the orthodontist can use the modified Mallampati (MM) classification to describe the patency of the oral airway (Appendix III).[5-11] Three steps are followed to determine the MM class: step 1, patients are asked to take a seated or supine position; step 2, patients are asked to protrude their tongue as far forward as they can without emitting a sound; and step 3. The examiner observes the relationship between the palate, tongue base, and other soft tissue structures to determine the MM classification defined as class I, soft palate, fauces (the arched opening at the back of the mouth leading to the pharynx), uvula, and tonsillar pillars are visible; class II, soft palate, fauces, and uvula are visible; class III, soft palate and base of uvula are visible; and class IV, soft palate is not visible.

This clinical assessment framework can help orthodontists identify patients who may be at risk for upper airway obstruction during sleep. It should be noted that the MM class may vary over the course of a pregnancy, so the MM class may need to be reassessed at various times during pregnancy. The MM classification is a helpful part of the OSA screening process; it should not, however, be used in isolation to predict OSA presence or severity.

Many other OSA screening questionnaires have been developed and studied in various populations, with wide-ranging specificities and sensitivities. The Epworth Sleepiness Scale (Appendix IV)[12] asks patients to self-rate their level of sleepiness in 8 different sedentary situations. The Epworth Sleepiness Scale may be used to gauge or track symptomatic impairment (or response to treatment). However, it is not a screening tool for OSA, because it detects abnormalities in level of daytime sleepiness regardless of the cause of sleepiness.

Practitioners also may find the Friedman tongue classification system (Appendix V),[13] the Kushida index,[14] and the Berlin Questionnaire for Sleep Apnea[15] useful.

Orthodontic radiographs

The use of imaging in the assessment of OSA is often limited in a typical orthodontic setting. Conventional cephalometric images are dimensionally limited. Therefore, airway imaging with the use of a lateral cephalogram does not portray mediolateral information in the oropharyngeal airway and may give misleading information as to the volume and minimal cross-sectional area.

Cone-beam computed tomographic (CBCT) images have been shown to be useful in diagnostic and morphometric analysis of the hard and soft tissues in routine orthodontic treatment, but they have certain limitations regarding the diagnosis of OSA. CBCT provides no information on neuromuscular tone, susceptibility to collapse, or actual function of the airway. There are significant positional and functional differences when the patient is asleep versus awake. It is a snapshot of a specific moment of the breathing cycle. In addition, there is currently no minimal cross-sectional area or volume of the airway that has been validated as a minimal threshold level at which an individual is at higher risk of having OSA. Thus, orthodontic records may be taken by the orthodontist, but currently no radiographic methods have been reported to have high enough sensitivity or specificity to serve as a risk assessment tool for OSA.

Three-dimensional imaging of the airway should not be used to diagnose sleep apnea or any other SRBDs, because such imaging currently does not represent a proper risk assessment technique or screening method. On the other hand, 3-dimensional imaging of the airway, when available, may be used for monitoring or treatment considerations. If radiographic records are taken as part of orthodontic diagnosis and treatment planning, the airway and surrounding structure should be analyzed comprehensively.

DIAGNOSIS AND TREATMENT PLANNING IN ADULT OSA

Obstructive sleep apnea and other SRBDs can be definitively diagnosed only by a physician. It is not in the scope of the orthodontist or any other dentist to definitively diagnose OSA or any other SRBD. If the patient is found to have OSA, the physician will prescribe the appropriate course of action; the orthodontist should consider working in a collaborative way with the physician, providing related orthodontic treatment when necessary and when it does not interfere with medical treatment.

The OSA treatment plan should be based on careful consideration of the patient's individual needs and treatment goals. If the treatment plan involves orthodontics, a plan for treatment, monitoring, and long-term follow-up care should be developed by all practitioners involved. Care should be coordinated via communication between the orthodontist and any other practitioners participating in the treatment of the patient. It is recommended that treatment and management of OSA not take place without a referral from a physician (or provider supervised by a physician).

TREATMENT OF OSA IN ADULTS BY PHYSICIANS AND SURGEONS

Positive airway pressure (PAP) therapy is the gold standard treatment for OSA in adults. PAP acts as a pneumatic splint that maintains patency of the upper airway. PAP is delivered through a mask interface as either continuous positive airway pressure (CPAP), bilevel positive airway pressure (BPAP), or autotitrating positive airway pressure (APAP). Of note, CPAP and BPAP devices are available in conventional and autotitrating modes. CPAP use can decrease OSA-related cognitive impairment along with improving objective and subjective measures of sleepiness, particularly in patients with severe OSA (AHI $\geq$30/h).[16] BPAP may be used for patients with OSA who are intolerant of CPAP or those who have other forms of SRBDs (eg, sleep-related hypoventilation). APAP may be considered for patients with OSA who do not have contraindications to APAP use (eg, congestive heart failure, lung disease such as chronic obstructive pulmonary disease, obesity hypoventilation syndrome, or central sleep apnea).

Studies on PAP nonadherence report wide-ranging results. Although definitions of nonadherence vary across studies, a common definition of PAP nonadherence is mean use $\leq$4 hours per night. Estimates of PAP nonadherence range from 29% to 83%.[17,18] Early adherence to PAP use predicts longer-term PAP use; a study of 100 patients started on CPAP showed that CPAP use for at least 4 hours per night 3 days after starting therapy was predictive of CPAP adherence 30 days after treatment initiation.[19] Factors that affect PAP adherence include OSA severity, ability to tolerate the prescribed pressure setting, mask fit, spousal support, and other psychologic and social influences.[17]

Other treatment options include positional therapy (avoidance of sleeping on back) and long-term weight reduction as indicated. Nasal congestion and allergic rhinitis may be managed with the use of nasal steroids and other oral medications as indicated. For some patients, nasal surgery may be performed as adjunctive

therapy to decrease intranasal resistance and facilitate better adherence to PAP therapy. For selected patients, multilevel surgery including nasal and palatal surgery with or without mandibular surgery, genioglossus advancement, and hyoid suspension may be considered. Other soft tissue surgeries might be indicated that involve the tonsils, adenoids, frena, and tongue. Hypoglossal nerve stimulation addresses the impaired neuromuscular tone in OSA and may be considered in certain patients with OSA.

ORTHODONTIC MANAGEMENT IN ADULT OSA

After diagnosis of OSA by a physician, a patient may be referred to (or back to) an orthodontist for one or more types of care.

Informed consent

Before initiating care, informed consent appropriate to OSA must be obtained before any treatment is provided. The proposed treatment plan should be described in detail, and treatment alternatives also should be discussed. The orthodontist should describe the benefits, risks, short- and long-term side-effects, and complications that might arise. The need for compliance, long-term monitoring, and follow-up care should be discussed. An estimate of the nightly duration of oral appliance (OA) therapy use should be provided, and a realistic estimate of the probability of success with the treatment protocol should be presented. Given the serious nature of untreated OSA, it is recommended that the orthodontist carefully document the informed consent process.

Oral appliance therapy

Oral appliances, which include both mandibular advancing oral appliances (OAms) and tongue-retaining devices, are usually effective options for OSA management in appropriately selected patients. OAms are intended to hold the mandible or the associated soft tissues forward, resulting in an increased caliber of the upper airway at the oropharyngeal level. A substantial body of research supports the use of OAs for patients with OSA. Specifically, OAs may be used for treatment of mild to moderate OSA and for treatment of patients with severe OSA who are unwilling or unable to use PAP therapy. Published guidelines (American Academy of Sleep Medicine/American Academy of Dental Sleep Medicine) describe how OAs fit into the OSA management paradigm.[20,21]

Functional appliances and OAms are considered to be the first line of treatment for patients with OSA that prefer OAs over PAP and for those patients that do not respond to PAP therapy. Although typically well tolerated, it should also be noted that not all patients with OSA respond to OAm treatment; this form of therapy is reported to be completely effective in 36%-70% of OSA cases.

Many types of OAs are used in the treatment of OSA in adults. The appliances vary based on the coupling design, mode of fabrication and activation, titration capability, degree of vertical opening, lateral jaw movement, and whether they are custom made or prefabricated. Proper indications for each design should be considered.

Oral appliance titration

Oral appliances initially are delivered with the mandible advanced to a position approximating two-thirds of maximum protrusion. After a period of accommodation, based on subjective feedback from the patient regarding their OSA symptoms and sleep quality, the amount of protrusion can be titrated or increased until optimum symptom relief is obtained. Unattended (type 3 or 4) portable monitors may be used by the orthodontist to help define the optimal target position of the mandible. Then typically the physician involved will request a sleep study with the OAm in place. Should the physician deem the calibrated position to be subtherapeutic, the physician and orthodontist should discuss the possibility of further titration or alternate treatment.

Monitoring

During treatment for OSA, the patient should be monitored, which may involve subjective reports as well as objective observations. Reports on usage of the OA may be obtained from the patient and bed partner or caregiver. Compliance should be evaluated, and the appliance should be checked for fit and comfort, the need for titration, and the development of undesirable side-effects. At present, most data on adherence to OA therapy rely on subjective reports. Use of a thermal sensor[22] has been studied in an effort to have objective measurement of OA adherence, although such measures currently are not part of routine clinical care.

It has been suggested that monitoring be conducted at least once every 6 months during the first year and then annually. Routine monitoring should result in regular communications between the physician and

orthodontist. If the patient has worsening of OSA-related symptoms, or changes to overall health, a consultation with the physician is strongly recommended.

Goals of treatment

The end points of treatment include reduced or eliminated snoring, resolution of the patient's initial symptoms of OSA, normalization of the AHI, and normalization of oxyhemoglobin saturation. No pretreatment risk factors have been consistently shown to predict success for OAs in reaching treatment goals.

Change in occlusion

Oral appliances used in sleep apnea treatment move teeth. In the field of dentistry, orthodontists are generally considered to be the experts in the management of malocclusion owing to their education and clinical experience. Improved awareness of both OSA and the effectiveness of OAs has resulted in increased numbers of OSA patients being treated with the use of OAs by nonorthodontists. Although successful OSA treatment may be evident over the short term in many of these patients, nonorthodontic providers may be unaware of the unwanted effects that OAs can have on their patient's occlusion over the long term. Orthodontists can be helpful in providing our medical and dental colleagues valued oversight, and sometimes treatment, of unexpected and unwanted occlusal changes occurring with long-term OA wear.

Changes are progressive with ongoing OA use. Because many patients will be treated for a protracted period, OA-generated malocclusions often become significant over the long term and may require treatment to reverse the dentoskeletal adaptations that may occur. Typical changes include a reduction in overjet and overbite, changes in facial height, development of anterior crossbites, and posterior open bite.

Orthodontists may be asked to assess and treat OA-related malocclusions, a condition that has become a more frequent occurrence in recent years. When considering treatment of these malocclusions, orthodontists need to be aware that the patient will not be able to wear the OA during treatment; therefore, the patient may need to use PAP therapy during the period of orthodontic care. Communication with the physician helps to ensure that the patient's OSA is still being managed appropriately.

Should the patient return to using an OA for OSA after orthodontic treatment, then the malocclusion may also return. Consequently, such patients often switch to PAP therapy or may be evaluated for surgical treatment options.

Maxillomandibular advancement and surgically assisted rapid maxillary expansion

Patients who are unable to tolerate or adhere to PAP or OA therapy with an underlying sagittal skeletal discrepancy may be candidates for maxillomandibular advancement (MMA) or telegnathic (>10 mm) jaw advancement surgery. MMA is generally reserved for patients with severe OSA who are unable to tolerate PAP therapy and patients who also have an orthodontic indication for the procedure. The severity of OSA is not the only determinant of candidacy for MMA; these patients often require detailed evaluation and counseling before MMA is selected as a treatment option.

Such patients typically should proceed with routine orthodontic diagnosis and treatment planning, including comprehensive soft tissue facial evaluation to assure optimal presurgical preparation and that the surgery performed will not adversely affect facial esthetics. Orthodontic care is usually a beneficial adjunct for patients to facilitate obtaining optimal occlusion while simultaneously reducing the risk of postoperative malocclusion. Patients with ideal or minimal Class I malocclusion may not require extensive presurgical orthodontics in that the 2 jaws may have a similar interdigitation after symmetric maxillary and mandibular advancement. Telegnathic surgery is not recommended for patients who are already bimaxillary protrusive; such patients should usually be reevaluated by the team to explore alternate treatment options. One of the concerns of telegnathic surgery in this situation involves esthetics. As such, each practitioner and patient should decide for themselves if the benefits of the surgery outweigh the risks involved.

Significantly less data exist for surgically assisted rapid maxillary expansion (SARME), which aims to correct a maxillary transverse deficiency. In OSA patients with maxillary transverse deficiency, normalizing the width of the maxilla with the use of SARME and developing a functional and esthetic occlusion with comprehensive orthodontic treatment afterward has been suggested to improve PSG parameters.[23]

Possible treatments on the horizon

New treatment modalities, such as mini-implant (miniscrew or temporary anchorage device)–supported rapid maxillary expansion, are appearing as possible alternatives for SARME. However, to date there is very limited PSG evidence for its use in the management of OSA patients. Future studies are needed, and with time

mini-implant–supported expansion may become a viable adjunctive form of treatment for OSA management in adult patients.

PEDIATRIC OSA (UNDER 18 YEARS OF AGE)

Etiology

As with adult OSA, impaired neuromuscular tone underlies upper airway collapsibility in children. In addition to etiologic factors similar to those in adults, exacerbating factors for pediatric OSA often include lymphoid hyperplasia and growth-related changes in the size of the upper airway.

As the upper airway is narrowed or completely occluded, the patient's effort during breathing progressively increases. Owing to the airflow restriction, there is a relative increase in serum carbon dioxide (CO_2; hypercarbia) and decrease in serum oxygen (hypoxemia). The escalating respiratory effort causes a cortical arousal from sleep, which results in the upper airway opening so that normal airflow is reestablished. Once the patient falls back to sleep, the upper airway may collapse again with recurrence of the above-noted process. This breathing sequence may have significant consequences for the child.

Risk factors

Because the obesity epidemic also affects children, obesity is becoming a greater factor for childhood OSA. However, because untreated OSA may contribute to growth restriction, some children with OSA paradoxically may be underweight. Therefore, it is recommended that a clinical risk assessment for OSA be performed even in normal-weight and underweight children.

In addition, it is thought that certain craniofacial morphologies can increase a child's risk for having OSA. For example, mandibular retrognathia, long and narrow faces, narrow and deep palate, steep mandibular plane angle, anterior open bite, and midface deficiency may predispose a child to developing OSA. However, the presence of OSA cannot be determined by craniofacial morphology alone; these physical findings should be interpreted in the context of the clinical history.

Genetic syndromes that are associated with craniofacial anomalies can confer an increased risk of OSA. For example, patients with Pierre Robin sequence[24] and syndromic craniosynostosis[25] have a high prevalence of OSA. Children with Down syndrome[26] also have an increased OSA prevalence. Orthodontists who care for children with these and other genetic syndromes that affect craniofacial morphology should pay attention to clinical features that may suggest the presence of untreated OSA.

Symptoms

Children with OSA may present with snoring, witnessed apneas, and choking or gasping during sleep. Parents or caregivers may describe that the child sleeps in unusual positions, such as having the neck hyperextended or with the head hanging off the side of the bed, as well as appearing very restless with frequent position changes during sleep.

Some children with OSA may present with sleepiness; those who previously had discontinued daytime napping may resume daily or near-daily naps. In other children, untreated OSA may manifest as hyperactivity rather than excessive sleepiness. Whereas obesity may be a contributor to the pathogenesis of OSA in some children, others may present with failure to thrive. As such, it is recommended that the evaluation for OSA in every child should be part of an orthodontist's comprehensive clinical assessment.

Diagnosis

Diagnosis of OSA in children is confirmed only by the gold standard PSG. Diagnostic evaluation of childhood OSA has evolved in recent years. In addition to standard recording channels, all pediatric PSG is now conducted with CO_2 monitoring. Measurement with either end-tidal CO_2 (the partial pressure of CO_2 present at the end of exhalation) or transcutaneous CO_2 monitoring is acceptable.

According to the International Classification of Sleep Disorders,[1] OSA can be diagnosed by either of 2 sets of diagnostic criteria. The first set of criteria for OSA includes the presence of at least 1 of the following: (1) snoring, (2) labored, paradoxic, or obstructed breathing during the child's sleep, or (3) sleepiness, hyperactivity, behavioral problems, or learning problems; and polysomnography shows one or more obstructive apneas, mixed apneas, or hypopneas per hour of sleep.

Alternatively, OSA can be diagnosed if the PSG shows a pattern of obstructive hypoventilation, which is defined as at least 25% of total sleep time with hypercapnia ($PaCO_2$ >50 mm Hg) associated with at least 1 of the following: (1) snoring, (2) flattening of the inspiratory nasal pressure waveform, or (3) paradoxic thoracoabdominal motion. These OSA diagnostic criteria are for children under the age of 18 years, although adult OSA diagnostic criteria may be used for children of ages 13-18 years, according to the American Academy of Sleep Medicine Manual for the Scoring of Sleep and

Associated Events.[27] HSAT is not indicated in patients under 18 years of age.[28,29]

Severity

Published studies on childhood OSA have included various diagnostic criteria; some studies use the adult criteria of AHI ≥5/h. Other studies define childhood OSA as mild (AHI or RDI ≥1 and <5/h), moderate (AHI ≥5 <10/h) and severe (AHI ≥10/h). Of note, scoring of obstructive apneas and hypopneas on PSG differs slightly for children than for adults. For adults event duration is defined as is at least 10 seconds, whereas for children obstructive event duration is defined as at least 2 breaths.

Prevalence

Prevalence of childhood OSA is obscured by different diagnostic criteria used in published studies. Epidemiologic data from 2008 indicate prevalence of parent-reported "always" snoring to be 1.5%-6%, prevalence of parent-reported apneic events during sleep to be 0.2%-4%, and OSA diagnosed by varying criteria to be 1%-4%. Multiple studies have shown that during certain phases of growth, childhood OSA remits without any intervention. These data indicate that prevalence of childhood OSA changes across periods of growth and development. Specific populations, such as children with certain craniofacial or other genetic syndromes and those who are obese, have a higher prevalence of OSA compared with the general population.

Significance

Consequences of OSA in children include impaired growth and cardiovascular dysfunction. The impaired neurocognitive function seen in children with untreated OSA can have an effect on academic performance. Behavioral problems also can result. Persistent snoring and nocturnal enuresis (bedwetting), which can result from untreated OSA, can be embarrassing for children in social settings and thus affect interpersonal interactions.

PEDIATRIC OSA: SKELETAL AND SOFT TISSUE GROWTH

Orthodontists are aware of the impact that facial growth has on orthodontic treatment outcome. Facial growth also influences the size and shape of the upper airway in the pediatric population. One approach to understanding the interaction of hard and soft tissue growth on upper airway morphology can be described as follows. The hard tissue boundaries of the upper airway include the upper and lower incisors and the piriform rim in the anterior, the cranial base superiorly, the cervical vertebrae posteriorly, and the hyoid bone inferiorly. Laterally, the size of the airway is related to the width of the palate, the middle cranial fossa, and the distance between the ascending rami. Together these structures define the bony skeletal boundaries of the airway. Soft tissues then line this hard tissue framework. These tissues include the pharyngeal muscles, tongue, soft palate, turbinates, and the pharyngeal tonsils, adenoids, and nares.

Importantly, growth of the bony components effectively increases the size of the skeletal boundaries in the following ways. The anterior cranial base increases in length via growth at the sphenoethmoidal synchondrosis up to the age of 7 years. Increases in posterior cranial base length are similarly related to growth at the sphenooccipital synchondrosis up to the age of 13 years. The anterior cranial base carries the nasomaxillary complex forward at the same time that the individual bones of the midface are displaced in an anterior and inferior direction. Simultaneously, the mandible elongates and is displaced downward and forward with deposition of bone on the posterior and superior borders of the ramus, increasing the height of the rami (bony pharyngeal height) and increasing the distance between the ascending rami (bony pharyngeal width). Concurrently, resorption on the anterior border of the ramus increases corpus length (oropharyngeal length). While all these bony changes are occurring, the hyoid bone is displaced anteriorly and inferiorly. Thus, the normal facial growth process results in dramatic increases in all 3 dimensions of the skeletal framework.[30]

While the skeletal boundaries of the airway are increasing, the major lymphatic tissues of the upper airway (tonsils and adenoids) are shrinking. This combination of increases in skeletal dimensions along with decreases in soft tissue mass results in enormous increases in the size of the upper airway over infancy, childhood, and adolescence. These changes in airway due to growth far exceed any orthodontic or orthopedic effects on airway shape or size. Knowledge of these changes is important to understanding the dynamics of OSA in children.[31]

ROLE OF ORTHODONTICS IN PEDIATRIC OSA

It is strongly recommended that the orthodontist perform a clinical risk assessment for OSA and refer at-risk patients to the appropriate physician for definitive diagnosis of OSA. Subsequently, orthodontists may be involved in treatment of pediatric OSA if the treating physician refers the patient back to the orthodontist to address an underlying skeletal discrepancy thought to contribute to the child's OSA.

Medical and dental history

Orthodontists should be familiar with the signs and symptoms of OSA in pediatric patients. Questions concerning the health history of a pediatric patient should solicit information on snoring, sleep-related behaviors, daytime sleepiness, difficulty concentrating, and formal diagnosis of attention deficit–hyperactivity disorder. The American Academy of Pediatric Sleep Physicians recommends that if a patient reports snoring, more thorough questioning is warranted; the guidelines state, "If they snore, you must do more."[32]

Thorough history and examination are critically important in that they establish the presence of preexisting conditions, a basis for a diagnosis, the need for referral, and a baseline for evaluating the effects of treatment. Orthodontists also should include assessment of a patient's height, weight, and neck size to screen pediatric patients for OSA.

The following items should be considered when performing a pediatric evaluation that is sensitive to OSA: previous diagnosis of OSA, loud snoring, previous diagnosis of other forms of SRBDs, mouth breathing during sleep, height, poor school performance, weight, aggressive behavior, medications, developmental delays, age, bed wetting that is not age appropriate, attention problems, hard to wake up in the morning, trouble breathing during sleep, morning headaches, pauses in breathing during sleep, fall asleep quickly, nasal obstruction, and attention deficit–hyperactivity disorder.

Screening tools

One potential screening tool that has been validated and used in orthodontic offices is the Pediatric Sleep Questionnaire (PSQ; Appendix VI).[33-35] This questionnaire has a positive predictive value of 0.4 (ie, 40% of patients with a positive PSQ score will be diagnosed with OSA) and a negative predictive value of 0.99, (ie, only 1% of patients with a negative PSQ score will be diagnosed with OSA). The PSQ often is a valuable first step in screening patients presenting to the orthodontic office without a history of OSA. The Epworth Sleepiness Scale for Children and Adolescents (Appendix VII)[36] may be helpful to assess for problematic sleepiness, but it cannot identify a specific cause of daytime sleepiness. The Epworth scale has been validated only for children 12-18 years of age.[12]

Clinical examination

In addition to the usual orthodontic clinical examination that evaluates dental occlusion, range of mandibular motion, soft tissue frenum attachments, gingival health, and temporomandibular disorder, the orthodontist should also note the degree to which the tonsils impinge on the pharyngeal airway. A commonly accepted tonsil classification system, the Brodsky scale, grades the clinical manifestation of tonsil hypertrophy from 1 to 5 based on the percentage of the oropharyngeal airway taken up by the 2 tonsils (Appendix VIII).[37] The Friedman tonsil grading system (Appendix IX)[38] may also be a useful tool to evaluate the size of the tonsils. Because tonsil size does not correlate with OSA severity, there is no set cutoff point for tonsillar hypertrophy necessitating a referral to an otolaryngologist for further evaluation[39]; therefore, this decision is best made in the patient-specific context of symptoms and physical examination findings. The clinical evaluation of OSA in children should include evaluation of tongue size and position, the presence of obesity, and the patient's overall growth and development.

Orthodontic records

The typical orthodontic record set captures some important information that can be useful for further evaluation of the upper airway. For example, the adenoid mass and the hyoid bone can be seen on both the lateral cephalogram and the CBCT image. A low position of the hyoid bone when measured from the inferior border of the mandible has been shown to be an indicator of low muscle tonicity and has been linked with OSA.

Three-dimensional imaging is more accurate than 2-dimensional imaging for assessment of airway volume and area of maximum constriction. Airway imaging with the use of a cephalogram does not portray mediolateral changes in the oropharyngeal airway and may give misleading information as to the volume and minimal cross-sectional area. As in adult patients, although CBCT images have been shown to be useful in diagnostic and morphometric analysis of the hard and soft tissues in routine orthodontic treatment, there are limitations regarding the screening of OSA. CBCT provides no information on neuromuscular tone, susceptibility to collapse, or actual function of the airway. Although both 2-dimensional and 3-dimensional imaging of the airway are helpful, they cannot be used to diagnose sleep apnea or any other SRBDs alone, and they do not provide a proper risk assessment technique or screening method.

Importantly, there is no direct link between any radiographic measures of airway size or shape and PSG results. Therefore, imaging values should be interpreted cautiously and in conjunction with other clinical signs and symptoms. Three-dimensional imaging of the airway, when available, may also be used for monitoring

or treatment planning. If radiographic records are taken for orthodontic purposes, the airway and surrounding structures, specifically the adenoids in children, should be evaluated.

DIAGNOSIS AND TREATMENT PLANNING IN PEDIATRIC OSA

As mentioned previously, orthodontists should not assume the responsibility for the definitive diagnosis of OSA. The definitive diagnosis is appropriately made by a physician. If the patient is found to have OSA, the physician should decide on an appropriate course of action for the treatment of OSA. The orthodontist may choose to work in a collaborative way with the physician, providing orthodontic treatment when necessary and when it does not interfere with ongoing medical treatment.

The plan for treating pediatric OSA should be based on consideration of the patient's individual needs and treatment goals. If the OSA treatment regimen involves orthodontics, a plan for treatment, monitoring, and long-term follow up care should be considered by all medical and dental practitioners involved. Care should be coordinated via communication between the orthodontist and all other practitioners who are working to treat the patient's OSA.

The orthodontic treatment plan for patients with OSA should follow the same orthodontic principles for correction of dental and skeletal deformities. Two orthodontic procedures that may change upper airway physiology are rapid maxillary expansion (RME) and mandibular advancement appliances for Class II correction. With both types of interventions, the primary objective of the orthodontic appliance should be to improve the occlusion and address the underlying skeletal discrepancy.

It would be appropriate, for example, to recommend rapid maxillary expansion (RME) for patients diagnosed with maxillary transverse deficiency. In this situation, the primary treatment goals would be to normalize the transverse width of the maxilla and establish a normal occlusion. Secondary effects of this treatment may result in reduction of nasal airway resistance and increase in the volume of the nasopharynx and nasal cavity. Both secondary effects of RME have the potential to improve OSA.

In the case of mandibular advancement devices for mandibular retrognathia, the primary goals should be to correct the skeletal discrepancy and the Class II molar relationship. A secondary effect of mandibular advancement devices may be the increase in the caliber of the oropharyngeal airway. The same applies to maxillary advancement appliances used in the treatment of Class III malocclusions.

It is possible that an OSA patient might be referred for expansion but does not have a transverse discrepancy. Likewise, it is possible a patient with OSA might be referred for mandibular advancement (or maxillary advancement) where no sagittal discrepancy exists. In such situations, the treatment alternatives should be considered on a case-by-case basis by the medical and dental practitioners involved. In such situations, it is appropriate to prioritize the treatments to serve the best interests of the patient.

TREATMENT OF PEDIATRIC OSA

In the growing child, OSA management is dramatically different than for the adult. It is recommended that orthodontists become aware of the vast array of potential treatment modalities that are available and that they work in unison with medical and dental practitioners when managing pediatric OSA. Hypertrophic tonsils and adenoids are the most common risk factors for OSA in the pediatric population, with tonsillectomy and adenoidectomy typically considered as the first line of treatment.

Various forms of pharmacologic agents may be prescribed by the attending physician to reduce the size of the nasal soft tissues if there is suspicion of these tissues being a potential cause of OSA. Nasal surgery, including turbinate reduction and deviated septum correction, also may be considered in selected cases. For the obese child, weight reduction management should be considered as part of the treatment plan. PAP may be used in severe cases. Possible negative craniofacial consequences of longitudinal usage of PAP on the developing facial structures should be considered.

Dentofacial orthopedic management, which is within the scope of the orthodontic specialist, also may be considered. For example, RME is a well known orthodontic treatment option for patients with a narrow maxilla. There is growing evidence, though low level, that in mixed-dentition patients who are properly diagnosed with OSA, RME can decrease AHI in the short and long terms.[40] Unfortunately, untreated control groups generally were not used in the studies considered. Regardless of the presence of OSA, it is recommended that the orthodontist use these devices only when there is an appropriate underlying skeletal condition. There is no indication in the literature that prophylactic application of maxillary expansion prevents the future development of OSA.

Based on a few studies that were performed on mixed dentition samples, mandibular anterior repositioning appliances can produce a decrease in AHI. Long-term stability of these changes has not been studied; untreated control groups generally were not used in those studies as well. Regardless of the presence of OSA, it is recommended that the orthodontist use these devices only when there is an indication that a related retrognathic condition exists. As with RME, there is no clear indication in the literature, however, that prophylactic use of mandibular anterior repositioning appliances prevents later development of OSA.

In addition, the orthodontist should be aware that some children who remain PAP intolerant may require airway support while sleeping. The use of mandibular advancing devices may be prescribed by the physician, and this prescription is not predicated solely on the Angle classification of occlusion. In this case, treatment with the use of an oral device is directed primarily toward airway maintenance and less toward dentofacial orthopedic management. Careful monitoring of facial growth and development is important during this time.

For Class III patients, there are no studies that have assessed the impact of maxillary protraction on AHI. Only an assessment of pharyngeal dimensions has been published so far. It appears inappropriate for the clinician to make the jump from enlarged airway dimensions to improvement in airway function or sleep-related breathing parameters. Again, regardless of the presence of OSA, it is recommended that the orthodontist use these devices when there is an underlying skeletal issue.

Orthognathic surgery usually is not indicated until craniofacial growth is completed. As a result, the pediatric patient that presents with clear skeletal issues should typically be managed to adulthood in the normal fashion with corrective jaw surgery planned later when the timing of the surgery is appropriate. An exception might be considered in a case where the patient has OSA and a severe skeletal discrepancy. After considering the potential benefits and risks involved (including the need for later surgical revision), orthognathic or telegnathic surgery could be considered.

In summary, much is known regarding treatment for OSA in adults, whereas information on the treatment of OSA in pediatric patients is much more limited. Therefore, care should be taken regarding the indications for orthodontic and orthopedic treatment intended to treat OSA in the young patient. Clearly defined treatment goals, focusing on the orthodontic and orthopedic components, should be articulated to the responsible parties involved. Improvement of the OSA should be highlighted as a "possible," or some studies say "anticipated," outcome of treatment. But, no guarantees of OSA resolution can be implied or stated emphatically by the treating orthodontist.

FALLACIES ABOUT ORTHODONTICS IN RELATION TO OSA

Conventional orthodontic treatment has never been proven to be an etiologic factor in the development of OSA. When one considers the complex multifactorial nature of the disease, assigning cause to any one minor change in dentofacial morphology is not possible. However, misinformation exists regarding the potential airway-related sequelae of orthodontic treatment performed with the use of dental extractions or orthopedic headgear (HG).

The specific effects on the dental arches and the muscles and soft tissues of the oral cavity after orthodontic extractions can differ significantly, depending on the severity of dental crowding, the amount of protrusion of the anterior teeth and the specific mechanics used to close the extraction spaces. The indication for extractions varies from patient to patient, as does the resulting change to the width, length, and arch perimeter of the dentition—all may increase, decrease, or stay the same after treatment. The impact that orthodontic treatment with or without dental extractions may have on the dimensions of the upper airway also has been examined directly, first with the use of 2-dimensional cephalography and more recently with 3-dimensional CBCT imaging.[41]

In certain instances, namely, in patients with significant protrusion of both upper and lower anterior teeth where skeletal anchorage or extractions are used to retract the anterior teeth as much as possible to reduce lip protrusion in profile, reductions in the cross-sectional area of the oropharynx have been reported. More frequently, as in patients where extractions are performed to help address dental crowding or improve the occlusion, there is no discernible change in airway dimensions when extractions are used.[42,43] The studies examining these effects in children and adolescents have reported increases in airway volumes and cross-sectional areas in patients both with and without extractions performed as part of their orthodontic treatment.[44–46] These effects may likely be related to normal growth changes.

In discussing orthodontic treatment and changes in the dimensions of the upper airway, it is helpful also to understand that an initial small or subsequently reduced or increased size does not necessarily result in a change in airway function. Reflecting the higher significance of neuromuscular control on airway function during sleep, it has been demonstrated that a narrow airway does not result in OSA, but rather it is an inability for a patient's

airway muscles to compensate adequately that leads to obstruction and sleep-disordered breathing.[47]

As such, future investigations should aim to place greater emphasis on the effects of airway function after orthodontic treatment, instead of focusing solely on quantifying airway dimensions. One such study assessed dental extractions as a cause of OSA later in life by means of a large retrospective examination of dental and medical records.[48] Researchers reviewed the health records of more than 2700 adults with 4 missing premolars and evaluated whether this group had a higher prevalence of OSA compared with an equal-size group of patients with no missing teeth who were matched for the most significant confounding variables of OSA in adults, namely age, BMI, and sex. The study concluded that the prevalence of OSA was essentially the same in both groups, and that dental extractions were not a causative factor in OSA.

Overall, it can be stated that existing evidence in the literature does not support the notion that arch constriction or retraction of the anterior teeth facilitated by dental extractions, and which may (or may not) be the objective of orthodontic treatment, has a detrimental effect on respiratory function.

Headgear therapy

Growth modification, including orthopedic HG, which alters the direction of growth of the maxilla, has long been a staple of certain orthodontic treatments. Although dentoalveolar movement can be significant, the absolute skeletal change to the position of the maxilla elicited by HG is relatively small. Consequently, meaningful effects on volume or morphology of the upper airway should not be expected. A few studies with small sample sizes or methodologic limitations have examined this relationship directly. The best evidence available at this time indicates that HG does not pose an increased risk to the airway in that the airway remains the same or increases over the study periods reported.

Anecdotal concern exists about whether HG used during adolescence could contribute to the future development of OSA as an adult. To date, no studies have been performed using objective PSG to demonstrate an elevated risk of OSA in HG patients. Studies have investigated this concern indirectly by evaluating the radiographic airway in 2 dimensions with the use of lateral cephalograms of HG patients. One study concluded that the absolute value of the airway dimension was smaller in HG patients than in activator patients, but the differences were both small and not statistically significant.[49] A longitudinal study examined patients over a 12-year period and reported that the radiographic dimension of the airway decreased during the treatment phase but increased to the level of control subjects during follow-up.[50] A prospective, randomized, blinded study demonstrated an increase in the airway during the 6-year study period.[51] In summary, the best evidence available at this time indicates that HG does not pose an increased risk to the airway in that the airway dimension remains the same or increases over the study periods reported.

Frenectomy

Functional deficits regarding suction, swallowing, masticatory, and speech difficulties are known consequences of ankyloglossia or tongue-tie. However, uncertainty remains as to what degree of frenum attachment would contribute to a deviation of normal form or function in all but the most severe forms of ankyloglossia. More recently a 4-point severity scale of tongue mobility was reported, with the most severely restricted tongues graded as 4.[52] The investigators reported a reduced maxillary intercanine width and a longer soft palate in patients with more severe levels of tongue restriction compared with patients with no such restriction. However, the relationship between tongue mobility and function of the airway is complex. Future research efforts should aim to assess airway function during sleep as it relates to tongue mobility. At this time, frenectomy remains an appropriate treatment for speech and mastication deficiencies, but such procedures are not supported as a treatment to prevent future development of OSA.

LEGAL ISSUES

Obstructive sleep apnea is a medical disorder that can have serious consequences on overall health. Given some of the possible medical conditions associated with OSA, it is strongly recommended that orthodontists work with qualified and appropriately trained physicians in addressing OSA.

With that in mind, it is strongly recommended that orthodontists screen orthodontic patients for known OSA risk factors. Should the screening indicate an elevated risk for having OSA, it is strongly recommended that the patient be referred to an appropriate physician for definitive OSA diagnosis and treatment. Depending on the physician's diagnosis and plan for treatment, the orthodontist may be involved in the treatment after proper referral by the physician.

Any orthodontist involved in the treatment of adult or pediatric OSA should confirm that they are legally permitted to do so under the dental laws and standards of care in their jurisdiction. That is, orthodontists must not perform out of their scope of practice or involve

themselves in any treatment that would be noncompliant with applicable laws or outside the standards of care.

An orthodontist who provides prescribed treatment of OSA needs to have the appropriate training and qualifications and must operate within the laws and standards of care. Failure to do so may subject the orthodontist to civil and criminal penalties. In situations in which a qualified and appropriately trained orthodontist has confirmed their ability to treat OSA, they should also consult with their insurance carrier to confirm coverage in this domain.

EXECUTIVE SUMMARY

Obstructive sleep apnea is a medical disorder that can have many serious consequences if left untreated. OSA can affect adults and children and can present at any point in the lifespan. All orthodontists should consider incorporating OSA screening into their history-taking and examination of patients. When an orthodontist has a clinical suspicion that a patient may have OSA, it is strongly recommended that referral to a physician be made; a sleep medicine physician is preferred. The definitive diagnosis of OSA should be made by a physician. Individual orthodontists may elect to participate in the treatment and monitoring of OSA patients as appropriate and permissible under applicable laws, standards of care, and insurance coverages.

1. It is strongly recommended that orthodontists be familiar with the signs and symptoms of OSA.
2. It is strongly recommended that orthodontists screen patients with regard to the signs and symptoms of OSA. A thorough history and clinical examination are critically important in that they establish the presence of preexisting conditions, a basis for diagnosis, the need for referral, and a baseline for evaluating the effects of treatment.
3. It is strongly recommended that the orthodontist refer patients with risk factors for OSA to a physician for further evaluation and a definitive diagnosis. A sleep medicine physician is preferred.
4. It is recommended that the orthodontist refer pediatric patients with nasal obstruction or adenotonsillar hypertrophy to an otolaryngologist.
5. It is recommended that the orthodontist refer adult patients to an otolaryngologist when nasal obstruction or adenotonsillar hypertrophy is present.
6. The decision for an orthodontist to participate in the treatment of OSA is a choice that should be made based on interest as well as training, skills, experience, laws, standards of care, and insurance coverage applicable to the orthodontist.
7. If involved in the treatment of OSA, an orthodontist should monitor OA treatment efficacy.
8. An orthodontist may elect to manage adverse side effects of OA therapy.
9. No orthodontic treatments have been shown to cause or increase the likelihood of OSA. Rather, some forms of orthodontic treatment have been shown to be important in the treatment of OSA.
10. Interdisciplinary treatment of OSA helps to serve the best interests of patients with OSA.

ACTION PLAN

Future research

Meaningful research concerning OSA can be enhanced dramatically with the use of the PSG, which objectively assesses airway function, to measure outcomes of the long list of treatment possibilities, especially in growing children. There is a substantial leap of faith when researchers make the jump from "enlarged airway" to "OSA cure" or even "OSA improvement."

Areas of study worthwhile of future research include the following. Which craniofacial variables contribute to the pathogenesis of OSA? How is airway function affected by various orthodontic treatments? At what age can OSA be detected? Does OSA progress from childhood into adulthood? Does OSA treatment in childhood prevent OSA in adulthood? What are the end points expected for OSA therapy?

Education

At this time, the subject of OSA in pediatric and adult populations is not included in the curricula of most dental school predoctoral and postdoctoral programs. Before the introduction of OSA as a curriculum subject, it is paramount for the American Dental Education Association (along with the American Dental Association and Commission on Dental Accreditation) to adopt educational standards for this subject, so that OSA subject matter is taught with the proper endorsements and qualifications. A standardized curriculum should be developed and incorporated into all predoctoral and postdoctoral programs.

Additional recommendations

It is recommended that the AAO consider developing a health history form for OSA for children and adults or include OSA questions in current health history forms. When screening for possible OSA in their patients, practitioners should consider recording their patient's height, weight, and neck size. They should also consider

calculating the patient's BMI (Appendix X). An informed consent document for OSA might also be useful. The use of validated tools for risk assessment of OSA is recommended to develop more efficient and standardized screening methods. The AAO might also consider whether the definition of orthodontics needs modification relative to OSA.

LITERATURE RESOURCE FOR AAO MEMBERS

A Literature Resource for Orthodontics and OSA is being developed by Jackie Hittner, AAO librarian. It will be available via the AAO Library Web page.

The Literature Resource now contains more than 4,000 article citations. It is estimated that eventually it will contain around 5,000 article citations. If AAO members want to access the collection, they may access the searchable file and select articles. Initially, they will see only the abstract. If they want to view the entire article, they may then request the article from the AAO Library by means of the journal request form. It is intended that this resource will be updated periodically.

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APPENDICES

Appendix material will be available on the AAO Library Web site. They include the following:
Appendix I: Examples of apnea and hypopnea
Appendix II: STOP-Bang questionnaire
Appendix III: Modified Mallampati score
Appendix IV: Epworth Sleepiness Scale
Appendix V: Friedman tongue position
Appendix VI: Pediatric Sleep Questionnaire
Appendix VII: Epworth Sleepiness Scale for Children and Adolescents
Appendix VIII: Brodsky tonsil grades
Appendix IX: Friedman tonsil grading system
Appendix X: Body mass index tables 1 and 2

VS VIRGINIA TOTAL SLEEP

March 18, 2021

Dr. Augustus Petticolas
President
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dr. Petticolas and Members of the Virginia Board of Dentistry,

As one of Virginia's orofacial pain specialists, I'd like to take a brief moment to respond to a letter sent by the American Academy of Sleep Medicine (AASM) to all state boards of dentistry. In their letter, the AASM highlights their concerns regarding the recently published position statement of the American Academy of Dental Sleep Medicine. In that position, the American Academy of Dental Sleep Medicine finds that ordering of home sleep tests is within the scope of dentistry. Importantly, this position statement does not state that interpretation of these tests is within the scope of dentistry.

According to a report commissioned by the American Academy of Sleep Medicine and published in 2016, an estimated 29.4 million adults in the United States at that time had sleep apnea and of those, 80% were undiagnosed. In 2019, studies estimated an increase to 54 million adults with sleep apnea. Assuming 80% remained undiagnosed, that may leave as many as 43 million undiagnosed.

Of concern to me, my patients, and my colleagues is that this straw man argument regarding interpreting sleep tests will continue to harm the 80% of patients with sleep apnea that remain undiagnosed due to reduced access to care currently available.

In their letter, our physician colleagues consistently refer to home sleep studies as "medical" testing, inferring that there is somehow a different patient between the two fields. We would never say a pediatrician examining a patient's mouth for tooth development or a physician managing oral candidiasis is providing "dental" treatment. After all, we should be allies fighting this fight together as we are both treating our patient's overall health.

To provide context, a home sleep test typically measures respiratory volume, respiratory effort, pulse rate, and blood oxygenation while a patient sleeps. If we consider these metrics as something only a physician is qualified to measure, would that not imply that dentists should no longer perform sedation? Afterall, the standards for sedation require monitoring of those exact same values.

Again, I wish to highlight where I feel our physician colleagues may have erred. The American Academy of Dental Sleep Medicine's position statement clearly states that ordering and administering testing is within the scope of dentistry but that "data from [Home Sleep Apnea Tests] should be interpreted by a licensed medical provider for initial diagnosis and verification of treatment efficacy."

10120 W Broad St Suite I, Glen Allen, VA 23060 | P: (804) 625-4064 | F: (804) 625-4066

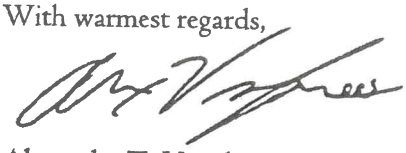
This is a similar situation to that of hypertension. Dentists have played an extremely key role in the early detection and treatment of hypertension through monitoring our patients with appropriate referral to physicians for interpretation of these test values. As we know, many of our healthy patients see their dentists more often than their physicians and we are a key component of the early detection of many diseases.

Fortunately, both medicine and dentistry practice self-governance. Just as it would be inappropriate for a dentist to attempt to restrict the practice of medicine, so too is it inappropriate for medical associations to attempt to restrict the practice of dentistry, chiropractic, pharmacy, or the practice of any of our other colleagues in the health professions.

I strongly urge the board to either consider the aforementioned letter as received with no action or, should there be a desire to take these concerns under further review, to appoint a Regulatory Advisory Panel composed of the various stakeholders and specialties to provide the professional specialization and expertise necessary to address this specific regulatory issue.

As one of the now 4 orofacial pain specialists that are licensed in Virginia, I am happy to provide any guidance, support, background, and help that the board deems necessary and appropriate as it relates to this matter or any other orofacial pain matter in the future. Thank you very much for your time and careful consideration of these issues.

With warmest regards,



Alexander T. Vaughan, DDS, MS
Dental Director, Orofacial Pain
Virginia Total Sleep

Diplomate, American Board of Orofacial Pain
Fellow, American Academy of Orofacial Pain

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 April 21, 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.
Jamiah Dawson, D.D.S.
Margaret F. Lemaster, R.D.H.
J. Michael Martinez de Andino, J.D.
Dagoberto Zapatero, D.D.S.

MEMBERS ABSENT:
Patricia B. Bonwell, R.D.H., PhD
Perry E. Jones, D.D.S.

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

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

OTHERS PRESENT:
James E. Rutkowski, Assistant Attorney General, Board Counsel
James E. Schliessmann, Senior Assistant Attorney General
Lori L. Pound, J.D., Adjudication Consultant

Nguyen Thao Thi Nguyen, D.D.S. Case No.: 203154

The Board received information from Mr. Schliessmann in order to determine if Dr. Nguyen's impairment from mental or physical incompetence constitutes a substantial danger to public health and safety. Mr. Schliessmann 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. 203154. 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: Mr. Martinez de Andino moved that the Board summarily suspend Dr. Nguyen's right to renew her license to practice dentistry in the Commonwealth of Virginia in that she is unable to practice dentistry safely due to impairment, resulting from mental or physical incompetence. The motion was seconded and passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:38 p.m.

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

_____
Date

_____
Sandra K. Reen, Executive Director

_____
Date

Virginia Department of Health Professions

WHO, WHAT, WHERE, WHEN, and WHY of the HPMP

Health Practitioners' Monitoring Program

for the Board of Dentistry
June 11, 2021

Virginia Department of Health Professions

HPMP: WHAT

- A DHP Program (along with PMP and HWDC)
- HPMP offers an alternative to disciplinary action for qualified healthcare practitioners with a substance use diagnosis, a mental health diagnosis, or a physical diagnosis that *may* alter their ability to practice their profession safely.
- HPMP refers healthcare professionals for appropriate treatment and provides ongoing monitoring of treatment progress.

2

Virginia Department of Health Professions

HPMP: WHAT

- Over 20 years old: An alternative to disciplinary action
- DHP contracts with the VCU Department of Psychiatry, Division of Addiction Psychiatry
- Most often a five-year program
- A benefit of health professional licensure in Virginia
  Licensed/ registered or even an active application on file
- DHP's HPMP coordinator: Chris Buisset

3

Virginia Department of Health Professions

HPMP: WHY

- Recovery support
- Safe return to productive work
- Disciplinary action may be avoided
- In the absence of criminal behavioral or Board action, public records may not be generated
- If Board ordered, HPMP team provides support including participant preparation for hearings, documentation of participation and progress

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Virginia Department of Health Professions

HPMP: WHO

Participation

- 62% Nursing
- 24% Medicine
- 4% each Dentistry and Pharmacy
- 1% each Audiology/Speech Language, Counseling, LTC, Optometry, PT, Social Work, Veterinary Medicine
- Lower than one would expect; < 450 participants (10-15% HCP have misused, 5.5% do misuse)

5

Virginia Department of Health Professions

HPMP: WHO

Most frequent diagnoses

- Substance use disorder (86.5%)
  - Alcohol 40.35%
  - Opioids 30.7%
- Mental Health Diagnosis (10.5%)

6

Virginia Department of Health Professions

HPMP: Medically Assisted Treatment

- At this time, naltrexone is the preferred drug for health professionals in recovery.
- Some clients come into HPMP stable on buprenorphine. Alternatively, there are reasons buprenorphine may be preferred to naltrexone in certain cases.
- Buprenorphine continuance is assessed on an individual basis. (history, treatment history, level of licensure)
- If client must wean buprenorphine, referred for inpatient detoxification.
- If remaining on buprenorphine, extended release preparations are preferred.
- A client remaining on buprenorphine undergoes yearly cognitive testing and must complete cognitive testing before approved for return to practice.
- A client on medically assisted treatment must also be compliant with recommended therapies.

7

Virginia Department of Health Professions

HPMP: WHEN

Before a DHP complaint:

- Voluntary
- Employer
- Treatment Provider

Upon receipt of a complaint:

- DHP Enforcement Division
- Board Order

8

Virginia Department of Health Professions

HPMP: WHAT

- VCU refers for treatment; treatment costs are the responsibility of the participant
- VCU provides ongoing monitoring of compliance with Program requirements (no expense) through
  - A dedicated case manager
  - Ongoing monitoring/ toxicology monitoring (lab expenses are the responsibility of the participant)
  - Daily call in to the test line
  - Approval to return to work
  - Work site monitoring

9

Virginia Department of Health Professions

RecoveryTrek

- In use about 4 years
- RecoveryTrek is an EMR that also
  - allows participants to enter information
  - allows treatment providers to enter information
  - allows work site monitors to enter information
  - provides the data base for reports
  - allows access to client information to DHP coordinator

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Virginia Department of Health Professions

Contacts

- Christina Buisset (DHP HPMP Coordinator)
  Christina.buisset@dhp.Virginia.gov
- Barbara Allison-Bryan
  Barbara.Allison-Bryan@dhp.Virginia.gov
- Amy Stewart (VCU HPMP Administration)
  Amy.Stewart@VCUHealth.org

11

REGULATORY LEGISLATIVE COMMITTEE REPORT

April 23, 2021 Meeting

- Public comment was received from Dr. Vaughan on the American Academy of Sleep Medicine's concern position on who can make a diagnosis following home sleep apnea tests. The commenter suggested forming an advisory panel to address the Board's position on dentists diagnosing sleep apnea.
- Public comment was received from a representative of the American Association of Orthodontists requesting that the AAO and the VAO not be referenced in the proposed regulations as continuing education sponsors as resources for training digital scan technicians. In addition, adding language in the digital scan technician regulations to require that the supervising dentist to inspect appliances to see if it was taken correctly and to make sure it fits.
- Revisions to several guidance documents were recommended to the Board and will be addressed in Ms. Yeatts report later on the agenda.
- Public comment on the NOIRA on the proposal to require infection control training for dental assistants was reviewed and an example of the desired regulatory language was discussed and adopted with the understanding that staff would edit the language as needed to amend the regulations.
- When it was explained that the Board is not authorized to license or register dental scan technicians, the Committee agreed to send questions and concerns about regulating these technicians to staff and reconvene for further discussion.
- Concerns about dental assistants II performing pulp capping were discussed and the Committee decided to recommend that the Board initiate rulemaking.
- Staff was directed to research home sleep studies, how home studies are conducted and other state boards' policies on this subject.

May 17, 2021 Meeting

- Public comment by a representative of the American Association of Orthodontists stated that the AAO and VAO should not be included as sponsors for digital scan technicians training.
- Following discussion, the Committee decided to have a workgroup draft a legislative proposal to require that patients who receive an appliance through teledentistry be examined in person by a dentist.
- Following discussion, the Committee decided to recommend adoption of the proposed regulatory provisions as amended to define the term remote supervision and address the practice of digital scan technicians.
- A proposed template for scans and laboratory work orders was reviewed and advanced to the Board with a recommendation for adoption.
- Staff reported the guidance received from the Executive Director of the Board of Medicine is that reading polysomnography results and diagnosing sleep apnea is the practice of medicine. He also advised that patients benefit from dentists doing screening and recommending sleep studies. The Committee decided by consensus to direct staff to gather more information on sleep apnea testing, home sleep studies, polysomnography tests and regulations in other states.

Sandra Reen

From: Jamiah Dawson (02244 Newport News VA) <Jamiah.Dawson@affordabledentures.com>
Subject: Coda Visit

Today, April 23, 2021, was the site visit for a CODA Accredation AEGD (advanced education in general dentistry) Program. This visit was held virtually by two CODA committee members and myself. The members and I visited three different clinical education sites which included two Virginia sites and one Alabama site. We interviewed the Program director, corresponding administrators, the faculty and the residents. The program goals and objectives were discussed along with budget, partnerships and curriculum.

Due to covid 19, a virtual visit protocol was implemented. Computer requirements and policies during the meeting was established and compliance was mandatory. I had to purchase a new computer with adequate video and microphone because use of cell phones was prohibited.

The CODA committee and participating program directors, faculty and residents expressed their sincere gratitude for the board's participation in today's site visit. They said it was the first time they had a member of the board on a site visit and that my input and discussion was very valuable.

The visit was very well organized and the transparency of the program was exemplary. CODA conducted very thorough interviews and was deeply engaged in the responses from the program team, faculty and the residents. Overall there was a mutual respect for the accreditation process, the time spent and efforts made to complete this task.

I would like to take this opportunity to thank the VA of board of Dentistry , Mr President Dr Peticolas, and Executive Director Ms Reen for submitting my name to attend this site visit. I am humbled and enlightened for the experience.

If I may, I would like to share with you some of the highlights from today. What the faculty and staff are most proud of about the program is the service of teaching and the service of treating the community in need. Here's why that touched me. Sometimes we robotcally start our day-to-day work load to get through it. We take for granted what impact we have on the lives of the people we care for. We spend thousands of hours, dollars and miles to accomplish higher learning in treating different levels of dental disease. But the full circle of learning, applying our skills to the community in need, then teaching what we've learned to the next generation so they can care for the community in need is monumental. This cycle was realized when residents consider returning to the program as faculty and hopefully inspire their flock of students with the same pride.

Finally, I have a great respect for my profession and I am blessed for this privilege to serve people in whatever capacity I can. But what I've learned today about some of my colleagues and what they do to help people blew my mind just a little. For example when my colleagues are able to treat patients with disabilities under sedation are they able to do more than Dentistry. At the request of caregivers they are able to help people who have no insurance, lack finances, who have multiple and severe disabilities while in the chair with dental work, but they don't stop there. They will do haircuts, clip toenails, fingernails, shave, blood draws medical exams etc... This is truly remarkable when they have 600 people on a waiting list for dentures.

I, again, enjoyed the experience and I am looking forward to advocate for installing more programs like this and funding to make sure programs like this continue and get recognized for what they do.

Sincerely,

Dr Jamiah Dawson, DDS

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
As of May 21, 2021

Board of Dentistry

Chapter		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 closed 3/31/21* *Board to adopt proposed regulations:* 6/11/21
[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 614 days*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Waiver for e-prescribing [Action 5382]
		Proposed - *Register Date: 5/10/21* *Comment closes: 7/9/21* *Public hearing: 6/11/21*
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Technical correction [Action 5198]
		Fast-Track - *At Governor's Office for 551 days*
[18 VAC 60 - 25]	Regulations Governing the Practice of Dental Hygiene	Protocols for remote supervision of VDH and DBHDS dental hygienists [Action 5323]
		Final - *Register Date: 4/26/21* *Effective: 5/25/21*
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	Training in infection control [Action 5505]
		NOIRA - *Register Date: 3/1/21* *Comment closed: 3/31/21* *Board to adopt proposed regulations: 6/11/21*

VIRGINIA
REGULATORY TOWN HALL

townhall.virginia.gov

Notice of Intended Regulatory Action (NOIRA)
Agency Background Document

Agency name	Board of Dentistry, Department of Health Professions
Virginia Administrative Code (VAC) Chapter citation(s)	18VAC60-30
VAC Chapter title(s)	Regulations Governing the Practice of Dental Assistants
Action title	Elimination of practice of pulp-capping
Date this document prepared	5/19/21

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation.

The Board has determined that 18VAC60-30-120 should be amended the eliminate the practice of pulp capping from the practices for which a dental assistant II can be trained and delegated to perform in a dental office.

Acronyms and Definitions

Define all acronyms or technical definitions used in this form.

N/A

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

The impetus for this regulatory change is a concern expressed by some members of the Board that the practice of pulp capping is inherently risky for practice by a dental assistant II.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400, which provides the Board of Dentistry the authority to promulgate regulations to administer the regulatory system:

> ***§ 54.1-2400 -General powers and duties of health regulatory boards***
> *The general powers and duties of health regulatory boards shall be:*
>
> *1. To establish the qualifications for registration, certification or licensure in accordance with the applicable law which are necessary to ensure competence and integrity to engage in the regulated professions.*
>
> *2. To examine or cause to be examined applicants for certification or licensure. Unless otherwise required by law, examinations shall be administered in writing or shall be a demonstration of manual skills.*
>
> *3. To register, certify or license qualified applicants as practitioners of the particular profession or professions regulated by such board.*
>
> *...*
> *6. To promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title. ...*

Specific authority for regulation of the profession of dental assisting is found in Chapter 27 of Title 54.1:

§ 54.1-2729.01. Practice of dental assistants.
A. A person who is employed to assist a licensed dentist or dental hygienist by performing duties not otherwise restricted to the practice of a dentist, dental hygienist, or dental assistant II, as prescribed in regulations promulgated by the Board may practice as a dental assistant I.
B. A person who (i) has met the educational and training requirements prescribed by the Board; (ii) holds a certification from a credentialing organization recognized by the American Dental Association; and (iii) has met any other qualifications for registration as prescribed in regulations promulgated by the Board may practice as a dental assistant II. A dental assistant II may perform duties not otherwise restricted to the practice of a dentist or dental hygienist under the direction of a licensed dentist that are reversible, intraoral procedures specified in regulations promulgated by the Board.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of the action is to protect patients in dental offices who receive services from a dental assistant II. While dental assistants receive laboratory and clinical training in pulp capping, board members believe the procedure should only be performed by a dentist because it represents some risk of harm to patients.

Substance

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

Pulp capping is the covering of an exposed dental pulp with some material to provide protection against external influences and to encourage healing. The Board's intent is to delete pulp capping from the procedures for which a dental assistant II can be trained and certified to perform.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

Since pulp capping is currently included in section 120 among the procedures for which a dental assistant II can be trained and evaluated, an amendment to the regulation is the only alternative to its elimination.

Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Board of Dentistry is seeking comments on this regulation, including but not limited to: ideas to be considered in the development of this regulation, the costs and benefits of the alternatives stated in this background document or other alternatives, and the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at https://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. Comments may also be submitted by mail, email or fax to Elaine Yeatts, Agency Regulatory Coordinator, 9960 Mayland Drive, Henrico, VA 23233 or **elaine.yeatts@dhp.virginia.gov** or by fax to (804) 527-4434. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of the proposed stage of this regulatory action and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (**http://www.townhall.virginia.gov**) and on the Commonwealth Calendar website (https://www.virginia.gov/connect/commonwealth-calendar). Both oral and written comments may be submitted at that time.

Agenda Item: Board Action on Requirements for Infection Control

Included in agenda package:

Copy of original petition requesting amendment to regulation

Copy of NOIRA notice on Townhall

Copy of comments on the NOIRA

Copy DRAFT regulations as recommended by the Regulatory/Legislative Comm.

Board action:

Adoption of proposed regulations for infection control

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,) Mesimer, Misty, L on behalf of the Virginia Dental Hygiene Program Directors' Consortium		
Street Address 2130 Germanna Hwy, P.O. Box 1430	**Area Code and Telephone Number** 540-423-9823	
City Locust Grove	**State** Virginia	**Zip Code** 22508
Email Address (optional) mmesimer@germanna.edu	**Fax (optional)** 540-423-9827	

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.
2. 18 VAC 60-30-10. Definitions.

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

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

The Virginia Dental Hygiene Program Directors' Consortium who also includes program directors for American Dental Association Commission on Dental Accreditation approved dental assisting programs recommends the amending 18 VAC 60-30-10. Definitions. Dental

"Dental assistant I" means any ~~unlicensed~~ person certified in infection control procedures and radiation health and safety recognized by the Dental Assisting National Board (DANB) or the National Entry Level Dental Assistant (NELDA) under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.

The primary purpose of the Virginia Board of Dentistry is to protect the public. Dental practices must have strict infection control practices in order to protect patients and employees. Breaches in infection control techniques jeopardize the safety of patients and the community. In Oklahoma, an aseptic breach by an oral surgeons office resulted in exposure to more than 7000 patients. In New Jersey, there is documentation of a patient death. In both California and Georgia, there are cases of pediatric patients developing infections in the bone as a result of pulpotomy procedures where instruments were not correctly processed. All dental professionals have a responsibility to societal trust, nonmaleficence, and beneficence.

Historically, dental assistants have received on the job training, putting the responsibility of infection control training on the dentist. Establishing a requirement for calibrated training and certification would ensure that all assistants have received the same information. In reality, dental practitioners are not the people in the office responsible for infection control processes and procedures. The CDC reports that majority of dental offices have no written protocol, exposure control plans, or a designated infection control coordinator.

Frequent breaches in asepsis is a result from not following transportation requirements, not wearing correct personal protective equipment, incorrect instrument packaging and reprocessing practices, inadequate sterilization testing procedures, and incorrect waterline maintenance.

We urge the Board to require minimum credentials for the safety of the citizens in the Commonwealth. The recommended credentials are successful completion of the Infection Control Examination and Radiation Health and Safety portions of the Dental Assisting National Board Examination or the National Entry Level Dental Assistant examination. This will not only benefit patients by improving safety. It will improve the quality of oral health care delivered in Virginia. Dentists will be able to focus on the art and science of dentistry, treating their patients, and growing their practices. They will be able to delegate with confidence the most important task related to patient care – SAFETY. There is absolutely no reason why Virginia should wait for one case of morbidity or mortality to occur before taking action. We urge you be proactive, not reactive.

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.

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

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

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

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

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

Signature: Misty L. Mesimer, RDH, CDA

Date: 11/5/19

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency Department of Health Professions

Board Board of Dentistry

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

Action: Training in infection control

Notice of Intended Regulatory Action (NOIRA)

Action 5505 / Stage 8932

Edit Stage | Withdraw Stage | Go to RIS Project

Documents		
Preliminary Draft Text	None submitted	Sync Text with RIS
Agency Background Document	4/13/2020 (modified 1/30/2021)	Upload / Replace
Governor's Review Memo	1/30/2021	
Registrar Transmittal	1/30/2021	

Status	
Public Hearing	Will be held at the **proposed** stage
Exempt from APA	No, this stage/action is subject to Article 2 of the *Administrative Process Act*
DPB Review	Submitted on 4/13/2020 Policy Analyst: Jeannine Rose Review Completed: 4/27/2020
Secretary Review	Secretary of Health and Human Resources Review Completed: 10/29/2020
Governor's Review	Review Completed: 1/30/2021 Result: Approved
Virginia Registrar	Submitted on 1/30/2021 **The Virginia Register of Regulations** Publication Date: 3/1/2021 **Volume: 37 Issue: 14**
Comment Period	**Ended 3/31/2021** **75 comments**

Contact Information	
Name / Title:	Sandra Reen / *Executive Director*
Address:	9960 Mayland Drive Suite 300 Richmond, VA 23233
Email Address:	**sandra.reen@dhp.virginia.gov**

Virginia
Dental Hygienists' Association

Virginia Department of Health Professionals
Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233

March 31, 2021

Dear Board of Dentistry members,

The Virginia Dental Hygienists' Association (VDHA) supports the Board of Dentistry's efforts to ensure the protection of the citizens of the Commonwealth by requiring Dental Assistants (I) to have training and education on the principles of Infection Prevention and Control as outlined by the Centers for Disease Control in their Guidance on Dental Settings.

VDHA has the following policies supporting CDC guidelines:

R 4-97 INFECTIOUS DISEASE TRANSMISSION GUIDELINES

The Virginia Dental Hygienists Association supports the Centers for Disease Control and Prevention's (CDC) guidelines for preventing the transmission of infectious disease.

R 4-05 STANDARD PRECAUTIONS

The Virginia Dental Hygienists' Association advocates the utilization of universal infection and exposure control precautions, and maximum work site safety and training to protect the health and safety of both practitioner and patient.

Successful completion of a CE course in Infection Prevention and Control offered by sponsors recognized by the BOD would provide a **MINIMAL** standard for these important clinical team members to uphold so that they can help protect both dental patients AND dental team members. This has become especially evident and important to maintain as we continue to navigate through a global pandemic.

We offer the following suggestions to include in the proposed language:

1. (i) Satisfactory completion of an infection control course and examination given by any approved continuing education **sponsor** specified in Virginia Regulations for dentists and dental hygienists; or

2. (ii) Satisfactory completion of the OSAP-DALE Foundation Dental Infection Prevention and Control Certificate Program; or
3. (iii) Satisfactory completion of the Infection Control Examination provided by the Dental Assisting National Board.

On behalf of the licensed dental hygienists and the student dental hygienists represented by the Virginia Dental Hygienists' Association (VDHA), we thank you for your public service.

Sincerely,

Tracey C Martin

Tracey C Martin, BSDH, RDH
VDHA President 2020-2021

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Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Mayland Drive
Suite 300
Richmond, VA 23233

Dear Ms. Reen and Members of the Virginia Board of Dentistry:

I write to you on behalf of the American Association of Orthodontists (AAO) in response to the Notice of Intended Regulatory Action (NOIRA) published in the Virginia Register on March 1, 2021 to take regulatory action regarding infection control for dental assistants I. We appreciate the opportunity to submit public comment at this time.

The AAO is the nation's largest dental specialty organization and represents more than 19,000 orthodontists in the United States and abroad. We have 396 members who are residents of, or licensed to practice dentistry in, the Commonwealth of Virginia.

Currently, the Virginia Board of Dentistry's ("Board") Guidance Document 60-15 (updated December 15th, 2018) titled, "Standards for Professional Conduct in The Practice of Dentistry," indicates that it is the practitioner's responsibility to, "Follow the applicable CDC infection control guidelines and recommendations. See https://www.cdc.gov/oralhealth/infectioncontrol/index.html."

Furthermore, the Centers for Disease Control and Prevention (CDC) states that:

> "Education on the basic principles and practices for preventing the spread of infections should be provided to all dental health care personnel (DHCP). DHCP include dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel). Training should include both DHCP safety (e.g., Occupational Safety and Health Administration bloodborne pathogen and patient safety, emphasizing job- or task-specific needs."

See, "Education and Training." Centers for Disease Control and Prevention: Oral Health, https://www.cdc.gov/oralhealth/infectioncontrol/faqs/education-training.html

If the Board's current Guidance is to follow the CDC guidelines, the AAO believes that necessary regulations should defer to the CDC or replicate CDC guidelines. The CDC also offers "Key Recommendations for Education and Training in Dental Settings". Those recommends are as follows:

1. Provide job- or task-specific infection prevention education and training to all DHCP.
2. Provide training on principles of both DHCP safety and patient safety.
3. Provide training during orientation and at regular intervals (e.g., annually).
4. Maintain training records according to state and federal requirements.

See," Administrative Measures and Infection Prevention Education Training." Centers for Disease Control and Prevention: Oral Health, https://www.cdc.gov/oralhealth/infectioncontrol/summary-infection-prevention-practices/administrative-measures.html

The CDC guidance supports the notion of job-or task- specific education that can be done annually. Therefore, we feel that any infection control education and training required for dental assistants I should not create unnecessary burdens for dental offices given the limited scope of practice of a dental assistant I and the existing annual required Occupational Safety and Health Administration (OSHA) training. Requiring additional training would seemingly only be beneficial if the training includes some specific element related to the tasks of a dental assistant I that are not covered by OSHA training and CDC guidelines. Due to the limited scope of a dental assistant I, there does not seem to be any other task-specific infection control training that is not covered in guidance and training modules offered by OSHA or the CDC.

In summary, any DHCP in Virginia is already required to follow CDC and OSHA requirements, that additional regulation on infection control education and training required for dental assistants I should not create unnecessary burdens for dental offices given the limited scope of practice of a dental assistant I and the existing annual required OSHA training. Thus, the AAO advises against creating this additional regulation.

Thank you in advance for your consideration of these comments. Please do not hesitate to contact the AAO if we can be of any further assistance to the Board in its consideration of these issues.

Sincerely,

Trey Lawrence
Vice President, Advocacy and General Counsel
American Association of Orthodontists

Virginia Dental ASSOCIATION | 150 YEARS

March 22, 2021

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

Dear Ms. Reen,
On behalf of the Virginia Dental Association (VDA), I would like to express opposition to the Board of Dentistry's (BOD) consideration for specific requirements for dental assistants in infection control in dental practices indicated in NOIRA Action 5505.

The BOD currently requires dentists to adhere to OSHA and CDC Guidelines. Both OSHA and the CDC include infection control training for dental assistants in their training guidelines for dental offices. The VDA has included those OSHA and CDC guidelines in educational materials we have shared with members to ensure their offices are in compliance. An additional requirement for infection control training by the BOD would be redundant and potentially confusing, considering that these Guidelines are already required on an annual basis.

We are unaware of a plethora of reported cases of infection contraction due to pathogen exposure in a dental office that prompt a need for additional regulation. We believe that the appropriate mechanisms for enforcement already exist through the BOD's current requirements with regards to OSHA and CDC Guidelines.

I appreciate your consideration of the VDA's request to not impose a redundant requirement for dental assistants in Virginia. Patient safety is ALWAYS our first priority, however; we do not believe that this intended regulatory action has a basis for implementation. Thank you in advance for your consideration of our comments.

Sincerely,

Dr. Frank Iuorno, DDS
President
Virginia Dental Association

American Dental Assistants Association
140 N. Bloomingdale Road
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Memo to: State Boards of Dentistry

From: Betty Fox, AS, CDA, RDA, FADAA
President, ADAA

Date: February 2, 2021

Subject: Mandatory Infection Control Education at the State Level

As the regulatory agency ultimately in charge of the protection of the public through licensing requirements for oral healthcare practitioners in the state, we are contacting you today to ask for your support in adopting the following important infection control guideline for the oral healthcare team practicing in your state. Of course, it is the state's prerogative to identify what is best for its citizens. The materials referred to in this correspondence are designed to provide guidance and assistance to the states in that endeavor.

The American Dental Assistants Association (ADAA) is the professional association in the United States whose mission is to advance the careers of dental assistants and to advocate for the dental assisting profession in matters of education, professional activities, credentialing and legislation. We promote the ideals and growth of the association which aid in the accessibility and delivery of quality oral health care to the public. ADAA works for the safety, health, and protection for all dental patients as well as the oral health care team and advocates that infection control laws, regulations, guidelines and best practices be mandated through government regulations.

The ADAA recognizes that mandatory education standards in infection control do not exist nationally for dental assistants. This means that someone with no background and knowledge in dentistry and infection control could be working in the dental office, participating in patient treatment and all facets of infection control. The coronavirus pandemic has magnified the importance of this issue and the need for education prior to being responsible for infection control in a dental setting.

Infection control education is at the forefront of the fight against coronavirus. The Centers for Disease Control emphasizes that "Ongoing education and training of DHCP are critical." See https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care2.pdf.

According to the World Dental Federation (FDI), "Although the principles of infection prevention and control remain unchanged, new technologies, materials, equipment and updated data require continuous evaluation of current infection control practices and continuous education for the oral health team." See https://www.fdiworlddental.org/resources/policy-statements/infection-prevention-and-control-in-dental-practice.

In light of this, ADAA believes that mandatory infection control education for the oral healthcare team should be implemented to include a requirement that ALL dental assistants have a minimum of 12 hours of CODA, ADA CERP, or AGD PACE-approved didactic and 4 hours of clinical education in infection control, including performance evaluation.

ADAA has a series of AGD PACE approved courses that would qualify for this education. ADAA has also created a clinical component made up of performance evaluations to provide guidance for the content to be included in the didactic portion of the mandated education.

The ADAA would be happy to provide any assistance in your deliberations regarding infection control education for dental assistants.

Please let us know how else we may help.

BF/jek
S:\ADAA\Legislation\sbod_template_infection_control.pdf

Julie F Simms, RDH, BSDH
4811 Walney Knoll Ct.
Chantilly, VA 20151

December 30, 2019

Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463

Dear Honorable Board Members,

My name is Julie Simms and have been a licensed dental hygienist in Virginia since 1983. I have worked as a clinical hygienist all these years. Recently, accepted an adjunct staff position at Hagerstown Community College.

I write in support of regulation of Dental Assistant I and II's to have educational requirements to comply with the standards of Infection Control as defined by the Centers for Disease Control and Prevention guidelines for preventing the transmission of infectious disease.).

The following is VDHA Policy regarding our standards.
R 4-05
STANDARD PRECAUTIONS
The Virginia Dental Hygienists' Association advocates the utilization of universal infection and exposure control precautions, and maximum work site safety and training to protect the health and safety of both practitioner and patient.

R 6-80
RADIATION STANDARDS
The Virginia Dental Hygienists' Association supports educational standards and proven minimal competency in radiation, physics, safety, and technique for all dental office personnel responsible for exposing radiographic films in the dental environment.

R 7-80
RADIATION SAETY STANDARDS
The Virginia Dental Hygienists' Association supports the active involvement of the dental profession: dentists, dental hygienists, and dental assistants, in reviewing, revising, maintaining and monitoring quality standards for radiation safety and health of the public.

R 4-97
INFECTIOUS DISEASE TRANMISSION GUIDELINES
The Virginia Dental Hygienists' Association supports the Centers for Disease Control and Prevention's (CDC) guidelines for preventing the transmission of infectious disease.

18VAC60-21-170. Radiation certification.

No dentist or dental hygienist shall permit a person not otherwise licensed by this board to place or expose dental x-ray film unless he has one of the following: (i) satisfactory completion of a radiation safety course and examination given by an institution that maintains a program in dental assisting, dental hygiene, or dentistry accredited by CODA; (ii) certification by the American Registry of Radiologic Technologists; or (iii) satisfactory completion of the Radiation Health and Safety Review Course provided by the Dental Assisting National Board or its affiliate and passage of the Radiation Health and Safety Exam given by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

I have been an active member of the Virginia Dental Hygienists' Association since graduating from Old Dominion University in 1983. My interest in a dental hygiene career started as a high school senior in which a dentist hired me to perform dental assistant duties. I was trained in the office. I took radiographs, gave fluoride treatments and performed "prophylaxis" on children not realizing the potential risks and hazards to the patients and me. I worked while going to college to become a hygienist. I became very aware of the need for dental assistants to become trained, certified and licensed. Not only do these regulations protect the community we are serving, but raises the standards of the dental assistants and gives this profession the recognition it deserves. In my experience, dental assistants are given numerous responsibilities regardless of their professional training. I refer to professional training, as a certification from a dental assistant program. I have considerable respect for dental assistants. They play a major role in the dental team. But they should have educational requirements to safely continue their role.

Again, I support regulations of Dental Assistant I and II's to have educational requirements to comply with the standards of Infection Control as defined by the Centers for Disease Control and Prevention guidelines for preventing the transmission of infectious disease.).

Respectfully,

Julie F Simms, RDH, BSDH
VDHA Trustee

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter

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

Action	**Training in infection control**
Stage	**NOIRA**
Comment Period	Ends 3/31/2021

75 comments

All comments for this forum

Back to List of Comments

Commenter: Heather Fonda

3/1/21 11:50 am

DA's need to be Infection Control Certified

I am writing in support of the proposed regulation change requiring dental assistants to be Infection Control Certified (ICE) through DANB or NELDA before they are permitted to practice in the Commonwealth of Virginia. Having graduated from an accredited dental assisting program as a CDA in December of 2018, I am well aware that dentistry, like other medical fields, has its potential for health-altering hazards. My education and subsequent DANB certifications have provided me with the knowledge and credentials I need to protect my patients, myself, my team, and my community from injury and communicable disease. An on-the-job trained dental assistant without certifications, however, will likely have no idea what airborne or bloodborne pathogens are, what standard precautions are, or even that there is a difference between disinfection and sterilization; all of which are paramount knowledge in the avoidance of cross-contamination and subsequent maleficence. Patients and people, in general, have immense societal trust in their healthcare providers. That trust should be honored. The allowance of substandard practice is therefore unacceptable. I ask you to please see the validity and criticality of this proposal. The patients and dentists of the Commonwealth of Virginia deserve competent certified dental assistants. With COVID an ever-present threat these days, I can't think of a more opportune moment to instate this change.

Thank you for reading my testimony and for your consideration of this very important issue.
CommentID: **97268**

Commenter: Austin Westover

3/6/21 8:11 am

Against Certification

This proposed certification requirement will not benefit the public or dental offices. Any new dental assistant is trained under the dentist who has already received extensive training and is entirely capable of training a new assistant. COVID has shown that dental offices around the country are routinely doing an adequate job with sterilization as there hasn't been a single COVID outbreak traced back to a dental office anywhere in the country. Requiring a certificate that an assistant went to an assistant school will especially hurt dental assistants in rural areas that do not have access to an accredited assisting school.

We already have OSHA training every other year to refresh the staff and doctors about proper sterilization protocols. Many assistants will be forced to pay for this certification themselves which will put an undue hardship on those who have the lowest income in a dental practice.

If various infections disease outbreaks have been traced to improper sanitation of dental offices, I would support this bill. However, I feel the only group of people this will help are those who run dental assisting accreditation programs.

CommentID: **97288**

Commenter: Misty Mesimer, Germanna Community College 3/11/21 11:31 am

Infection Control for DA I's

Misty L. Mesimer, RDH, MSCH, CDA
14 Little Street
Fredericksburg, VA 22405

March 11, 2021

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

Dear Honorable Members of the Board,

Thank you so very much for advancing the petition requiring dental assistants to have certification in infection control procedures. It is such a very important topic that needs to be addressed. As we learn to live in a post-pandemic world being more mindful of aerosolized transmissions, you are demonstrating progressive thinking and action. The importance of needing education and certification in infection control is evident in your decision last March to advance this petition. I am writing now to discuss how we can operationalize this request.

The easiest and most simple solution would be to say that all dental assistants must hold Certified Dental Assistant certification from the Dental Assisting National Board. It would take all the work of certification and recertification off of your plate. It would allow safe practice of dental assistants to be credentialed by a well-recognized and reputable organization that the Board can trust. The Board would be assured of currency in infection control knowledge as well because maintaining the CDA credential requires annual education in infection prevention. I strongly advocate for dental assistants to be Certified Dental Assistants. This truly is a first step in assuring quality oral health care in our great Commonwealth.

But I also recognize that we must navigate a regulatory system that has not always recognized the importance of formal education and credentials. Those that have served in the role of a dental assistant without formal education and credentialling must be respected and honored. The good news is that there are options for these professionals as well.

As a first step, I recommend that we mirror regulations that are already in place. The requirements for x-ray certification. The language reads:" A dental assistant I or II shall not place or expose dental x-ray film unless he has one of the following: (i) satisfactory completion of a radiation safety course and examination given by an institution that maintains a program in dental assisting, dental hygiene, or dentistry accredited by CODA; (ii) certification by the American Registry of Radiologic Technologists; or (iii) satisfactory completion of the Radiation Health and Safety Review Course provided by the Dental Assisting National Board or its affiliate and passage of the Radiation Health

and Safety Exam given by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient."

I propose that you create language for infection control certification that reads: "A dental assistant I shall not participate in clinical dental procedures until (i) satisfactory completion of an infection control course and examination given by an institution that maintains a program in dental assisting, dental hygiene, or dentistry accredited by CODA; (ii) satisfactory completion of the OSAP-DALE Foundation Dental Infection Prevention and Control Certificate Program; or (iii) satisfactory completion of the Infection Control Examination provided by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient." Dental assistants who certify through any of these methods and do not maintain the CDA credential must have annual continuing education in infection prevention and control. It is further recommended that dental assistants have until the next license renewal cycle to become compliant once the final language is approved.

There have been so many stories of allied dental professionals not returning to their roles as they feared the unknown. Requiring this level of entry-level credentials will help to grow the dental profession. Dental assistants will be able to face the next pandemic with a strong base of knowledge. They can proudly and safely serve because they understand disease transmission and prevention principles. They will not need to rely on the media and political rhetoric to try and decipher best practices. Doctors will have a well-informed assistant to help them navigate stressful and uncertain times. This will help to better serve the dental team and the patients.

Dental assistants will be able to use this credential as a stepping-stone to a long career in dentistry. There won't be a temptation to go work at Starbucks where there the only aerosol is coffee grounds and steamed milk. This will encourage relationship building with the patients of the Commonwealth and help promote the highest standards of care.

Again, thank you for your attention to this important issue. Your decisions have the potential for positive impact both immediately and long term.

Respectfully,

Misty L. Mesimer, RDH, MSCH, CDA
CommentID: **97296**

Commenter: Matthew Stephens

3/14/21 8:16 am

Against Certification Requirement

The responsibility for proper infection control policies and training lies with the dentist or practice owner solely. A certification for dental assistants will be an extraneous requirement. Further, the targeting of the dental assistant community by the hygiene community is condescending and misplaced: if it is important for one portion of the profession it is important for everyone. This certification will duplicate the annual OSHA training, CDC guidelines, and place an undue burden on the dentist or practice owner.

CommentID: **97299**

Commenter: Betty Fox

3/15/21 2:28 pm

Practice of Dental Assisting (18 VA 60-30) - Training in Infection Control

The American Dental Assistants Association (ADAA) is in support of proposed Chapter Regulations governing the Practice of Dental Assisting (18 VA 60-30) Training in Infection Control.

In October 2020, the ADAA called on all states to recognize the importance of educating dental assistants in infection control.

Our position recommends a minimum of 12 hours of didactic instruction in infection control and 4 hours of hands-on instruction to include skill evaluations that are signed off on by a licensed dentist for all dental assistants. We believe that each individual State Board will know how best to serve the citizens of their state to keep them safe while in a dental office.

The ADAA believes that an educated dental assistant is an asset first and foremost to the public, then to the dental practice. The ADAA offers course work for all dental assistants that covers several different areas of infection control, including waterline biofilm, handwashing techniques, placement of barriers in the treatment room and placement of personal protective equipment.

Please contact ADAA should you need additional information. We would be pleased to discuss this issue further with you.
CommentID: **97310**

Commenter: Richard F Roadcap DDS

3/16/21 9:12 pm

Opposed to this new requirement

This proposed certification places an undue burden on rural practices, where employees may have to travel long distances to receive training. Dental office employees are already required to receive annual training in OSHA and infection control. Also, dental assistants entering the workforce will feel compelled to seek training at their own expense, to be considered for employment.

CommentID: **97345**

Commenter: Angela Smith

3/17/21 1:11 pm

Support for IC Certification

As a career dental assistant and now a dental assistant educator, I cannot express how important it is to have infection control training and certification. I have had both on-the-job and formal dental assisting training. My OTJ training was sufficient for the time (1980s), but the current environment warrants more strict/stringent training in infection control. Certification in Infection Control would go far in winning the trust of the public. Understanding the whys, as well as the hows, of IC makes a dental assistant very valuable and formal training and certification takes the burden off the doctor to do so. Relying solely on annual OSHA training isn't enough to protect the public since OSHA protects the employee. Thank you for your time and attention in this matter.

CommentID: **97371**

Commenter: Summer Marquette Woodard

3/23/21 2:11 pm

In strong favor of Certification for Dental Assistants

As a career dental assistant of 20+ years, who started as an OTJ trained assistant, I fully support this petition for certification in infection control procedures. I was trained very well at a community health clinic who was accredited through JCAHO. Unfortunately, I found that after leaving the organization, the infection control training and annual OSHA training were not regulated and maintained the same in offices that were not accredited through an organization. I am from the poorest and most rural area in Virginia, the most southwest area of the state, and the education is available if you are willing to look for it. The ADAA offers courses that train dental offices in infection control and meet DANB requirements. I am now a CDA, the team leader at my wonderful dental home, a member of the Advisory Board of the MECC Dental Assisting Program, and a current DAII student at GCC. I have always believed that furthering education and attaining certifications are the best way to provide the best care for my patients. My personal opinion is that all dental assistants should be certified through the DANB and maintain their certifications yearly by completion of CE credits. This would allow the great State of Virginia to offer the best quality of oral healthcare to our patients. Patients would recognize that their safety, and the safety of their practitioners has become of the utmost importance to us. In this post pandemic world, patients are highly aware and inquire of the measures being taken to keep them healthy and safe. I would hope that dental assistants that are currently practicing without a certification could easily complete such a course and sit for the DANB Infection Control Exam. I would also hope that they would be willing to do this to further their knowledge and provide the safest oral healthcare they can to their families and communities. I understand that this is only a first step and that there will need to be special circumstances that allow already practicing non-certified dental assistants a smooth and easy transition into attaining the certifications needed. I am confident that the Board will handle this matter with respect and fairness to those assistants. I am excited for what this petition could mean for the growth of the practice of dental assisting. Thank you for your attention and consideration to this petition.

Summer Woodard, CDA

Big Stone Gap, VA 24219

CommentID: **97413**

Commenter: Roger A. Palmer, DDS

3/23/21 10:06 pm

Against another regulation

The Board of Dentistry has already required that Dental Offices abide by the regulations of both the CDC and OSHA.

I practice in a rural community where trained dental assistants are a rarity. We must train our own assistants and formal training is not readily available.

Over the past 45 years I have had a number of high school students who have worked in my office. Several have gone on to be Dental Hygienists, RN's and one is now a dentist.

Having a requirement, as some have suggested, that no one could work as a dental assistant before having approximately 16 hours of infection control training at a formal setting is not reasonable. We lose and must rehire staff quickly in a rural practice.

Our Component (3) of the Virginia Dental Association has an annual meeting where we do OSHA, Infection Control and CPR Training.

I do not think that requiring dental assistants to be certified once a year will protect the health of the citizens of the Commonwealth of Virginia and instead lose employment opportunities to young Virginians.

CommentID: **97414**

Commenter: William G. Horbaly, D.D.S., M.S., M.D.S.

3/25/21 2:11 pm

Oppose additional Regulations

March 25, 2021

Dear Members of the Virginia Board of Dentistry,

The Virginia Board of Dentistry does not need to regulate infection control training for DAs. First, the Virginia Dental Hygiene Director's Consortium should not be initiating a petition for rule making that affects the Dental Profession as a whole. They should certainly make that recommendation for their own membership should they feel the need. As dental professionals with advanced education and training, Dentists are more than qualified to ensure that their DAs are effectively and competently trained in infection control procedures. This is in fact the case as evidenced by the Board's finding that there have been no reports of infection spread in the state of Virginia by an untrained dental assistant. This finding alone should negate the need for an added regulation...case closed. Otherwise, we are now subjected to proposed regulations based on a perceived issue, rather than on the scientific data. In addition, the Board makes the case for relieving the owner/doctor from all infection control accountability with the following statement: "Since dental assistants I are not regulated by the Board, the dentist is accountable for infection control practice, but it is often the dental assistant who is responsible for infection control processes and procedures." So, by regulating DA infection control training, one can only assume that the Board now feels that it wants to take on the added responsibility for monitoring dental assistant training and disciplining them when standard infection control procedures are not followed. This would also seem to have the negative effect of releasing the overseeing Doctor from having any accountability for the infection control procedures implemented in his/her office possibly increasing the number of infectious diseases spread by poorly supervised infection control procedures.

In summary, I think the Board's decision to consider regulating infection control training for DAs is shortsighted and an overreach by the Board. The mere fact that this proposal was not even put forth by the community of professional dentists shows the lack of need for this type of regulation.

I respectfully request that the Board reconsider implementing such a regulation.

Sincerely,

Unsupported image type.

CommentID: **97419**

Commenter: Walter E Saxon Jr

3/27/21 10:11 am

Against Unneeded Regulation

I am against the Board of Dentistry requiring dental assistants to be certified by another agency for infection control, etc. The dental assistant (DA) works under our license. We are already required to provide training in Blood Borne Pathogens, HIPAA, etc. This includes infection control. I doubt that any standardized test would be specific enough to cover each individual office. In essence the proposed regulation would still result in the individual office being sure that the DA is trained for that office. We've been doing this for all employees for many years, not just DAs. Infection control, etc. is an office endeavor. There have not been any instances that I'm aware of infection control causing a problem in dental offices, even though we are in a pandemic, that is different from previous ones (avian and swine flu).

This also poses a hardship for dental offices who need to hire a dental assistant. The majority that I've hired through the years don't have experience and we train them. Requiring them to pass a test by another entity first is a hinderance to allowing us to provide safe, quality dentistry in an efficient manner. The first item on their first day is about the risks of bloodborne, etc. as we want them to remain healthy, which is connected to infection control (part of OSHA requirements). A

required state test would not relieve dentists of their responsibilities and if a new assistant was to be regulated by the Board of Dentistry, it would probably mean that we would have a harder time filling the position. This could potentially result in our insurance premiums going up.

Years ago, at a statewide meeting of regional planning district commissions, the director of the BIGS Center of John Tyler CC was talking about their ability to increase revenue due to state regulations. The first example was the "Radiation Safety Course". This proposal seems to me to be in the same category. I don't see any benefit in either one and would welcome the Board of Dentistry declining to require DA to get any other training other than what is already required by state and federal regulations. It would be even better is they would study and see if there are any advantages in the "Radiation Safety Course". It was implemented over 40 years ago and x-rays have undergone many improvements through the years. One teaching institution has a sign saying that the machine is low radiation and shielding is not required, but will be used if requested. It seems that this requirement has outlined it's usefulness, but not been deleted. That's the problem with regulations and laws, their relevance isn't reviewed and updated as needed. Don't add another.

CommentID: **97437**

Commenter: Denise Nguyen, DDS

3/27/21 6:50 pm

Notices of Intended Regulatory Action

I am a member of the American Association of Orthodontists, and I agree with the comments my association has submitted.

Denise Nguyen

CommentID: **97444**

Commenter: George Sabol

3/28/21 9:31 am

NOIRA regarding additional training for infection control

I am opposed to the proposed regulations to require additional infection control for dental assistants. The current state laws already require dentist to provide and be responsible for proper infection control training of our staff. In our offices, we provide both CDC and OSHA training on an annual basis. We also have members of our team that are "compliance monitors" to make sure proper procedures and protocols are being followed at all times.
Additional training beyond what is already required would be a burden to our practice and be redundant.

CommentID: **97445**

Commenter: American Association of Orthodontists

3/28/21 11:35 am

Infection Control for Dental Assistants I

Dear Ms. Reen and Members of the Virginia Board of Dentistry:

I write to you on behalf of the American Association of Orthodontists (AAO) in response to the Notice of Intended Regulatory Action (NOIRA) published in the Virginia Register on March 1, 2021 to take regulatory action regarding infection control for dental assistants I. We appreciate the opportunity to submit public comment at this time.

The AAO is the nation's largest dental specialty organization and represents more than 19,000 orthodontists in the United States and abroad. We have 396 members who are residents of, or licensed to practice

dentistry in, the Commonwealth of Virginia.

Currently, the Virginia Board of Dentistry's ("Board") Guidance Document 60-15 (updated December 15th, 2018) titled, "Standards for Professional Conduct in The Practice of Dentistry," indicates that it is the practitioner's responsibility to, "Follow the applicable CDC infection control guidelines and recommendations. See https://www.cdc.gov/oralhealth/infectioncontrol/index.html."

Furthermore, the Centers for Disease Control and Prevention (CDC) states that:

> "Education on the basic principles and practices for preventing the spread of infections should be provided to all dental health care personnel (DHCP). DHCP include dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel). Training should include both DHCP safety (e.g., Occupational Safety and Health Administration bloodborne pathogen and patient safety, emphasizing job- or task-specific needs."

See, "Education and Training." Centers for Disease Control and Prevention: Oral Health, https://www.cdc.gov/oralhealth/infectioncontrol/faqs/education-training.html

If the Board's current Guidance is to follow the CDC guidelines, the AAO believes that necessary regulations should defer to the CDC or replicate CDC guidelines. The CDC also offers "Key Recommendations for Education and Training in Dental Settings". Those recommends are as follows:

1. Provide job- or task-specific infection prevention education and training to all DHCP.
2. Provide training on principles of both DHCP safety and patient safety.
3. Provide training during orientation and at regular intervals (e.g., annually).
4. Maintain training records according to state and federal requirements.

See," Administrative Measures and Infection Prevention Education Training." Centers for Disease Control and Prevention: Oral Health, https://www.cdc.gov/oralhealth/infectioncontrol/summary-infection-prevention-practices/administrative-measures.html

The CDC guidance supports the notion of job-or task- specific education that can be done annually. Therefore, we feel that any infection control education and training required for dental assistants I should not create unnecessary burdens for dental offices given the limited scope of practice of a dental assistant I and the existing annual required Occupational Safety and Health Administration (OSHA) training. Requiring additional training would seemingly only be beneficial if the training includes some specific element related to the tasks of a dental assistant I that are not covered by OSHA training and CDC guidelines. Due to the limited scope of a dental assistant I, there does not seem to be any other task-specific infection control training that is not covered in guidance and training modules offered by OSHA or the CDC.

In summary, any DHCP in Virginia is already required to follow CDC and OSHA requirements, that additional regulation on infection control education and training required for dental assistants I should not create unnecessary burdens for dental offices given the limited scope of practice of a dental assistant I and the existing annual required OSHA training. Thus, the AAO advises against creating this additional regulation.

Thank you in advance for your consideration of these comments. Please do not hesitate to contact the AAO if we can be of any further assistance to the Board in its consideration of these issues.

Sincerely,

Trey Lawrence

Vice President, Advocacy and General Counsel
American Association of Orthodontists
CommentID: **97447**

Commenter: Michael Morgan, DDS

3/29/21 11:10 am

Oppose new regulation

As a member of the Va. Dental Association, I support the position expressed by VDA President, Dr. Frank Iuorno, which opposes a new regulation and certification process requiring dental assistants to receive additional training for infection control.

CommentID: **97461**

Commenter: Ronald C Fuhrmann DDS

3/29/21 11:44 am

Oppose new and redundant certification

This new requirement is already addressed and in place with everything we already are doing. It is just an unneeded new regulation. Dr Fuhrmann

CommentID: **97464**

Commenter: Mollie Gioffre, DDS

3/29/21 11:48 am

oppose this regulation

I strongly oppose adding yet another training to the list of requirements. At the bare minimum dental assistants are trained by their dentist employers who have been extensively trained in infection control. That should be enough, but assistants are also trained in their dental assisting educational programs and in yearly OSHA trainings. What is the science behind needing more regulation regarding infection control? Have there been a large number of infections due to inadequate infection control? Unnecessary regulations drive the good people away.

CommentID: **97465**

Commenter: Weisberg

3/29/21 12:15 pm

Notice of Intended Regulatory Action (NOIRA) 5505

There are currently extensive guidelines from both the CDC and OSHA related to infection control in dental offices. As of currently, I am unaware of cases originating in dental offices and therefore recommend against increased documentation of training for dental assistants which would lead to an unnecessary increase in costs to the patients.

CommentID: **97467**

Commenter: K. Vaughan, DDS

3/29/21 12:40 pm

New regulatory requirement issue

I tried to find statistics that support the need for this additional training but was not successful. This is already an annual requirement. All new assistants are trained in this when they get their certification and annually thereafter. If they are unaware of the infection control protocols and are having measurable issues with infection control, it is not due to a lack of training. Adding another redundant training requirement will not solve this perceived problem.

CommentID: **97468**

Commenter: Ralph L Howell, Jr., DDS, MAGD

3/29/21 1:28 pm

Against new regulation

As a dentist that has practiced in the Commonwealth for over 30 years, I find this additional regulation to redundant in nature and it could have an adverse effect on access to care in a profession that currently has a shortage of providers in underserved communities. Current regulations and requirements on the practice of dentistry in the Commonwealth require adherence to OSHA and CDC guidelines. Any additional regulation is unnecessary.

CommentID: **97472**

Commenter: Ryan Simone, DDS

3/29/21 1:36 pm

Opposition to Proposal

The newly proposed regulation for additional training is redundant and has no purpose. Infection control training is already accounted for extensively with the current CDC and OSHA guidelines which require such training on an annual basis; furthermore, these existing guidelines have proven to be successful as demonstrated by the fact that the State of Virginia has, as I currently understand it, reported no cases of infection contraction due to pathogen exposure in a dental office.

CommentID: **97473**

Commenter: Ellis Family Dentistry - Jonathan Ellis DDS

3/29/21 2:37 pm

Against new regulation regarding dental assistants

The proposed new regulations requiring additional infection control training for dental assistants creates an unnecessary hurdle to becoming a dental assistant, especially in a COVID-19 world. Dental employers have always been responsible for this training and adhering to OSHA and CDC guidelines. We have done an exceptional job at this type of training and have had no issues with transmission. We do not need additional regulation with red tape making it more difficult to hire and maintain employees.

CommentID: **97474**

Commenter: Carmen Cote

3/29/21 2:53 pm

Opposing to new regulations for Dental Assistants

I think we have enough training to do already for us an our staff. We made it through this Covid-19 year without any patient or staff member getting contaminated. We do not need more unnecessary training of something we are already doing.

CommentID: **97475**

Commenter: Gregory Kontopanos, DDS

3/29/21 3:05 pm

Opposition to new proposal due to it's redundant nature with current training

I am opposed to the BOD current proposal for redundant training in infection control for dental assistants in NOIRA Action 505. I believe the current Virginia regulations for infection control

training thru CDC and OSHA guidelines are sufficient and further requirements by the BOD would be unnecessary due to the redundant nature.

CommentID: **97476**

Commenter: Peter Murchie DDS

3/29/21 3:18 pm

Opposition to requirements for Dental Assistants

Board of Dentistry,

I am writing in opposition to requirements that dental assistants receive separeate training and certification regarding infection control. The additional training would be redundant and unnecessary as it is already included in OSHA and CDC guidelines.

In addition to my knowledge the state of Virginia has not had any reported cases of infection contraction due to exposure in a dental office.

Thank you for your consideration.

Peter Murchie dds

CommentID: **97477**

Commenter: Dr Don Cherry

3/29/21 3:29 pm

Oppose the additional requirement for dental assistants !

Additional requirements are redundant and not needed !

CommentID: **97478**

Commenter: Scott H Francis DDS

3/29/21 3:54 pm

Opposition to additional training

Dentists, dental hygienists, and dental assistants have already "stepped up to the plate" to deliver safe, quality dental care to the citizens of the Commonwealth by using OSHA and CDC guidelines to add to dentistry's already robust infection control procedures. Acquisition or spread of Coronavirus in the dental setting has not been shown to be a problem. Requiring "training" of dental assistants would be a redundant and unnecessary burden and have the unintended consequence of adding to the cost of dental care in the midst of a pandemic which is sapping the financial resources of both dental practices and patients.

CommentID: **97480**

Commenter: David Circeo

3/29/21 5:20 pm

Oppose the additional requirements for dental assistants

Due to the redundant nature of this type training from our annual OSHA classes and routine office discussions about infection control , I feel this is redundant and unnecessary.

Thank you for your consideration

CommentID: **97481**

Commenter: William Munn DDS

3/29/21 5:32 pm

Opposing to new regulations for Dental Assistants

Additional requirements for Dental Assistants would be a waste of time since everyone in the dental office should get this information through our required yearly OSHA and CDC training. Current laws already require dental offices to maintain exceptionally high standards for infection control. Additional training isn't needed.

CommentID: **97482**

Commenter: Milan Bhagat

3/29/21 5:38 pm

Opposition to New Regulations for Training for Dental Assistants

Hello,

I strongly oppose to the new requirements for dental assistants requiring additional training, as it would be reduntant and further more confusing. As Dentist, we are already adhere by CDC and OSHA guidelines for compliance, which include yearly training.

I appreciate you to reconsider imposing such redundant requirements for dental assistants.

Thank you,

-

Milan Bhagat, DMD

CommentID: **97483**

Commenter: Michael Hutchings, DDS, Hampton Family Dentistry

3/29/21 7:04 pm

Oppose Additional Dental Assistant Training Requirements

As a dental practice owner and full-time clinician, I am very concerned all my staff maintain high infection control standards. New staff receive initial training and all staff receive periodic and annual refresher training based on OSHA and CDC Guidelines. I agree with the position of the VDA that implementing an additional layer of requirements would be redundant and hence, I am in opposition.

Respectfully,

Michael L. Hutchings, DDS

CommentID: **97484**

Commenter: Thomas Olivero

3/29/21 7:26 pm

Infection control training and certification for assistants

To require additional training and certification for dental assistants would be unnecessary and redundant. The Infection control protocols are dictated by OSHA and CDC requirements and guidelines. This additional requirement would place a unneeded and additional burden on dental practices which have demonstrated exceptional compliance with current standards. This is another layer of regulation which is already covered in current standards. I do not feel this is necessary.

Respectfully,

Tom Olivero DDS

CommentID: **97485**

Commenter: McKenzie Woodard

3/29/21 7:32 pm

Additional infection control training

This seems very much a redundancy of the training already mandated through OHSA regulatory protocols. I do not see the benefit to this and places an additional burden on offices.

CommentID: **97486**

Commenter: Robert Feild , Feild Dentistry

3/29/21 7:56 pm

Infection control regulation

I support the VDA presidents position and think that dentistry is doing a great job in infection control and is following OSHA and CDC to name a few.

CommentID: **97493**

Commenter: Michael Newman DMD

3/29/21 7:57 pm

Opposition to proposal.

I oppose the proposal for additional training requirement.

CommentID: **97494**

Commenter: Richard W Bates DDS

3/30/21 7:51 am

opposition to proposed additional training for dental assistants

I support the VDA President's letter opposing the proposed legislation for additional training for dental assistants. It has been covered by the CDC and OSHA guidlines and dentistry has done a fantastic job following these guidelines. More legislation would be redundant and an additional cost to dental offices when costs have gone up already during this COVID crises.

Richard W Bates DDS

CommentID: **97510**

Commenter: GERALD Q FREEMAN JR DDS LLC

3/30/21 10:59 am

In complete agreement with Dr. Vaughn in opposing more layers of legislation redundancy

After reading over the comments I feel Dr. Keith Vaughn's position is of merit. The training is there and available. Mandating more training will not solve a perceived problem and only add more burden to all providers without benefit to the public. I do not support this measure.

CommentID: **97532**

Commenter: Ursula Klostermyer 3/30/21 11:00 am

Opposing

I oppose this proposal, as this is an unnecessary burden for dental assistants. The regular OSHA training performed gives the dental assistant a good fresh up of their knowledge annually. An extra course would be -especially for dental assistants who live and work in more rural areas- unnecessary for an experienced dental assistant.

CommentID: **97533**

Commenter: Steven A Carroll DDS 3/30/21 12:56 pm

opposition to proposed additional training for dental assistants

opposition to proposed additional training for dental assistants

CommentID: **97545**

Commenter: Heath Cash 3/30/21 4:05 pm

Strongly opposed to additional infection control requirements for assistants

I am strongly opposed to the newly considered requirements for dental assistants.

CommentID: **97561**

Commenter: Dr A B Hammond III 3/30/21 6:31 pm

I DO NOT Support additional regulation on infection control education & training dental assistants

I DO NOT support additional regulation on infection control education and training for dental assistants. This creates unnecessary burdens on our practices when we already have extensive training required for our assistants to meet existing OSHA and other infection control requirements.

Respectfully,

A B Hammond III DDS

Orthodontist

Lexington VA

CommentID: **97569**

Commenter: Edward Joseph Weisberg 3/30/21 9:44 pm

I am Opposed to Additional Certification in Infection Control for Dental Assistants.

I am opposed to additional certification in infection control for Dental Assistants. Dental offices adhering to OSHA and CDC guidelines train all of their staff (hygienists, dental assistants and administrative staff) on a regular basis how to protect themselves and their patients. This certification process would be a costly and unnecessary. I have not heard of any problems in dental offices with the current training requirements.

CommentID: **97572**

Commenter: Tiffany F Kessler DDS London Bridge Smiles A Division of Atlantic Dental Ca 3/30/21 9:49 pm

Opposition to required addirional infection control training for dental assistants

I oppose additional separate certification and training of dental assistants in infection control practices. I find it redundant in the fact we are required to train according to CDC and OSHA standards and spend many hours training annually to comply.

To date there are no reported cases in the state of infection due to pathogen exposure in a dental office.

CommentID: **97573**

Commenter: Charles Jewett DDS 3/31/21 12:33 am

Opposition to unneeded, redundant IC training for DA

I have read comments in support of this regulatory proposal, which goes back a few years. The comments do not include specific cases, or research, that demonstrate problems with the existing requirements or support this redundant regulation. The support is from organizations, educators, and individuals that would benefit financially from the regulation. The result of the regulation would further reduce the already small number of applicants for DA positions, and complicate the already expensive and time consuming process of on the job training for new employees, and employment of part time DAs. The result would reduce clinical time, and raise the overhead cost for dental offices, and probably reduce the total number of DA in the workforce.

My clinical team have all been with me for 12 to 20 years. They are already frustrated with our repetitive quarterly retraining in Infection Control, OSHA, HIPAA, Emergency management, CPR, etc. I have benefited from several DAs with DANB certification in my practice. Other excellent DAs have considered DANB, with my support, and ruled it out for a variety of personal and financial reasons. Many DAs do not have the patience or interest to take a lot of classroom courses, and to force repetition of overlapping training yearly is frustrating and a waste of their time. I do not see how patients would benefit from this addition of redundant training requirements. It would certainly reduce the time we have to provide their dental care.

CommentID: **97576**

Commenter: Margaret Capocelli 3/31/21 8:27 am

Infection control and DA 1

I strongly favor the infection control requirements for DA 1 in Va. During this time of covid and any future outbreaks, it is essential that proper training is given to help stop the spread of viruses and diseases to our staff and patients.

CommentID: **97584**

Commenter: Heather Bowling 3/31/21 8:35 am

DAI infection Control

As a CDA I believe dental assistants should have infection control training. Without this proper training we leave room for cross contamination this is even more important with COVID-19 and many other viruses. Operatories need to be properly cleaned before the next patient arrives as well as the instruments and waterlines being properly maintained and cleaned. We are putting our community and families more at risk by not having dental assistants trained in infection control.

CommentID: **97585**

Commenter: John Sellers DDS 3/31/21 8:50 am

In favor of DA to have infection certificate

It is important for the assistant to have the infection control certificate as they are with the oatients more, and should have the updated information. Thank you

CommentID: **97586**

Commenter: Jeffrey Randall Bek 3/31/21 9:03 am

Opposed to proposed redundant regulation

As a licensed dentist in Virginia for more than 33 years I have seen a significant increase in regulatory requirements imposed by the Board of Dentistry, many of which have had my support. The proposed requirement for additional specific training for dental assistants in the area of infection control is unnecessary and redundant in my opinion because regulatory requirements for the entire staff are already in place. Initial training for dental assistants is regulated and required, and annual re-training requirements have existed for years in order to satisfy OSHA and CDC policies and procedures. The dental industry, in general, provides one of the least hazardous workplaces in the health care sector and there are few if any instances of illness transmission documented from a dental healthcare setting. Additional regulatory burden on dental practitioners is not necessary in this regard, and serves to contribute to the consumer cost of dentistry in Virginia.

CommentID: **97587**

Commenter: Taylor Fairfax, CDA 3/31/21 9:37 am

I agree

I support the act to require Infection Control certification among DAs. As a current certified dental assistant, I have met many DAs that have been assisting in the office for many years, yet have

never taken any accredited education courses relevant to the dental field. As a result, many new DAs that have been hired without certification are limited to understanding what they are taught in that office. I've noticed this creates assistants that do what they're told, without a full understanding of the why's and how's. The DA spends a lot of time with the patients and is expected to be fully knowledgeable. The patients are trusting our knowledge.

The current pandemic has complicated and strained many. Why not move on with professionals that are strengthened in how to handle infectious diseases for the future?

CommentID: **97595**

Commenter: Danielle Robb

3/31/21 1:28 pm

Opposition to Additional Regulation

I oppose this NOIRA to regulate additional training needed for dental assistant I's. These employees are already required to go through extensive training to meet OSHA and CDC requirements. Additional training needed would create an unnecessary burden for practices in Virginia. In addition, it could pose difficulty for practices in more remote areas of the state to meet these requirements.

CommentID: **97620**

Commenter: Tiina Hobbs

3/31/21 1:31 pm

Agree with infection control certification

I agree on the need for all DA's to have infection control certificate for safer work practices.

CommentID: **97622**

Commenter: Stephanie Bettis, RDH/DA

3/31/21 2:06 pm

I STRONGLY AGREE

As a Dental Hygienist and a former Dental Assistant, I strongly agree that infection control should be number one priority. This is a portion required for CDAs to get their certificate anyways. Also, in these times where we are more highly focused on infection control because of COVID these healthcare personnel should have the highest standard of infection control. In regards to OHSA, infection control falls under that which by law should be follow at every office. I know I have heard from several offices that I have temped in that say they wish their Dental Assistants had the same infection control concerns and regulations that are taught to dentist and hygienist. Do we really want these DAs to come out not having the slightest idea that a dirty instrument doesn't go into a person mouth or not being able to check if the autoclave is working right? Which dental assistants are paid very good money to make sure they are running sterilization for dentist and sometimes even for hygienist. On that matter, I strongly agree that DAs should and always should have infection control in their course work. Thank you for reading my response and hopefully the right decision happens.

CommentID: **97630**

Commenter: John Monacell, DDS

3/31/21 2:31 pm

Infection control training for Dental Assistants

Since any DHCP in Virginia is already required to follow CDC and OSHA requirements, additional regulation on infection control education and training required for dental assistants creates unnecessary burdens for dental offices. I advise against creating this additional regulation at this time.

CommentID: **97633**

Commenter: Natalie Baxter 3/31/21 2:56 pm

Support and encourage Infection Control training for supporting Dental Assistants

I am in support of having all Dental Assistants be trained in Infection Control. I am new to the field of dentistry but have a background as a CNA. I have always wondered why the standards of care including protecting patients, health care providers and staff are not the same, as both medical fields involve exposure and/or potential exposure to all of the bodily fluids and can be passed from one to another in a variety of ways. Since beginning the Dental Assisting program, I have thought a lot about where we go for dental care and wondered whether or not they have training in infection control etc... I would not knowingly place my children or myself in the hands of someone who is not knowledgeable in infection control because it presents a great risk that does not outweigh the benefit. Until now, I have assumed and trusted that all medical professionals have medical training. As a future Dental Assistant, I will seek out a practice who supports infection control training in their other Dental Assistants. That will be a sign of encouragement to me that they have their patients' and staff members' well being and good health as a priority in their offering of safe medical-professional oral health care.

CommentID: **97640**

Commenter: Smile By Design, A Division of Atlantic Dental Association, PLC 3/31/21 2:56 pm

Strongly Disagree with NOIRA Action 5505

I feel strongly the the current regulations and training that Dental Assistants are required to become employed in the field are sufficiently adequate to meet the needs of our patients and staff. The additional requirements are unnecessary and burdensome. Thank you.

CommentID: **97641**

Commenter: Debbie Thomas, CDA, RDH, BSDH 3/31/21 3:21 pm

All DA must be trained in Infection Control

I agree 110%!

CommentID: **97643**

Commenter: Griselda Lopez 3/31/21 4:07 pm

Support

As a previously on-the-job trained dental assistant and orthodontic assistant, and now an RDH who chose to take my CDA exam recently. I am well aware of the education required. I, without a doubt, support this. Every dental assistant (and personnel) is the responsibility of the dentist that hired them, yes. However, most DA's are usually trained by other dental assistants, and unfortunately, the ones providing the training for day-to-day tasks and infection control are not

always qualified to do so. Telling someone "how" to do a task is much different than someone understanding "why" they are doing the said task. Infection control is of the utmost importance for safety. You can never be over-educated so this will not harm anyone. It will provide consistency for offices and dental assistants. It will not only protect the public but also the dental assistants themselves.

CommentID: **97646**

Commenter: Glenna Gagnon

3/31/21 4:22 pm

infection control

Dental Assistants should be infection control certified.

CommentID: **97652**

Commenter: Heather Tuthill, MPH, BSDH, RDH

3/31/21 7:58 pm

For ALL DA personnel to have control over their education!

I have been inside an office recently where there was not OSPA training provided within the last two years. There were other temp. personnel in the office and we noticed there were OSAP problems within the office and their employees said they had not had training and they OSAP person was out of the office for a personal matter. We need to give DA's more control over their education and not only rely on their employers. I can see that is is varying from employer to employer. We need to keep the public safe!

CommentID: **97663**

Commenter: James F Londrey, DDS

3/31/21 7:59 pm

New Regulatory action

Dr Londrey votes NO To the new regulatory action.

Thank you

CommentID: **97664**

Commenter: Susan Pharr, RDH, BSDH

3/31/21 9:06 pm

Infection Control for DAIs

I strongly support protecting the public by requiring DAs to complete Infection Control training, which is offered free from the CDC.

CommentID: **97672**

Commenter: Sherry Basham, RDH, MSDH

3/31/21 9:07 pm

Dental Assistants

It is important for **all** of the dental team to be trained in infection control. The dental assistant plays a huge role in all aspects of routine care in dental office. Infection control protects not only the

members of the team but all of our patients. Please pass this bill.

CommentID: **97673**

Commenter: Maureen P. McCann Sawin,RDH,BSDH

3/31/21 9:15 pm

Infection Control for the DAI

I am in favor of having all members of the dental team be required to take a course in infection control, but especially dental assistants(DAI) who are often on-the-job trained and have not been given the opportunity through a school environment to learn infection control in a structured and standard format. The CDC offers a course on their website and there are an abundance of courses available. This benefits both dental assistants and the patients that they serve.

CommentID: **97676**

Commenter: Savannah Thomas

3/31/21 9:50 pm

Infection Control for DAs is Essential

It is essential to require infection control training for dental assistants. They are responsible for much of the cleaning, disinfecting, and sterilizing in the dental setting. Dental offices are also often fast paced, which leaves no room for error when it comes to proper sanitization for patients' health, as well as the staff's health especially given the current pandemic. I've walked into an operatory "cleaned" by an untrained assistant only to find smeared blood remaining on high touch surfaces. Situations like this will most likely make patients think the office is dirty, that the office may take shortcuts, and they are likely to wonder what else in the office is not properly disinfected. Offices are likely to lose patients if patients believe the office staff does not take sanitization seriously. It's important for dental assistants to have infection control training in order to understand what blood borne pathogens are and how they are transmitted, and what "Universal/Standard Precautions" means and how to take all necessary precautions. This will protect staff and patients and help keep business flowing well; time is money in dentistry, and time gets wasted if a properly trained assistant has to check over tasks an uninformed assistant preforms in order to ensure safety.

CommentID: **97679**

Commenter: Kendal Wagner, CDA

3/31/21 10:06 pm

Required Infection Control (ICE) Support

As a newly graduated certified dental assistant (CDA), I can attest to the vitality of infection control education for the dental assistant. Prior to my education, I had no concept of what goes into having a dental operatory "clean" for the next patient. In all honesty, I did not know that instruments were used on other patients (sterilized afterward, of course). This is one of the main reasons why I believe that dental assistants in Virginia should be infection control certified- because our patients simply do not know. When someone sits in the dental chair, they have no idea whether or not the operator had been properly cleaned, if the instruments are sterile, or if the care they are about to receive is, most importantly, sanitary. The dental assistant is the person who is generally responsible for the cleanliness aspect of a patient's dental visit. We make sure that instruments are clean, rooms are clean, and that there is no cross-contamination between patients, the dental team, or the community. Therefore, I believe that education and training in this vital aspect of infection control should be apart of the standard Virginia has for dental assistants.

There has not been a more concerning time in recent history than right now to be cautious and educated on infection control. Every single person in the whole world has been affected by the

COVID pandemic in one way or another. It seems like every patient I see has something to say about the pandemic and what the dental profession is doing to keep them safe and healthy. Having my infection control training, I have the education and knowledge to assure my patient that the guidelines we are following, in reference to the pandemic and ICE training, are at the highest level of sterility.

In addition to these reasons, I believe that dental assistants in Virginia should be ICE certified to protect themselves. As the saying goes, "you don't know what you don't know". However, in the dental setting, I do not believe that is a good excuse for any behavior, whether intentional or unintentional, should be excused. If you think about healthcare, in a nutshell, no other field of practice (I.E nursing, physical therapy, pharmacology, Physician assistant, EMT) is legally allowed to practice without some sort of certification or formal education. Even nursing assistants (CNA's) have to be certified before they are allowed to help an elderly person use the restroom. So, my question is, why is it still ok that dental assistants are allowed to practice in Virginia without any form of education with the (possible) exception of RHS?

I believe that this requirement would benefit the patient, practitioner, and community through the enhancement of knowledge and awareness in a key member of the dental team. Dental Assistants do so much for the practice of dentistry. They are the quintessential glue that holds the dental team together and I cannot think of one downfall of requiring dental assistants to have a little knowledge on controlling infection.

Thanks,
Kendal Wagner, CDA

CommentID: **97681**

Commenter: Sheila B. Sheats, RDH

3/31/21 10:23 pm

DA certification

I am in favor of infection control certification of dental assistants, They are on the fore front of keeping patients as well as staff safe. Many assistants have on the job training and, therefore, not getting enough instruction. One DDS I worked for hired a person that was soliciting for advertising! The rest of the staff doesn't really have time to do extra training. It is hard enough moving from office to office to incorporate procedures without some standardization. Thank you.

CommentID: **97683**

Commenter: Gloria Langmeyer. VDAA

3/31/21 10:26 pm

Dental Assistant and infectious control

As a dental assistant for 30 years, this is something that is badly

needed.

People who are hired straight off the street have no

idea of what to do.

Things change from year to year, and infectious

control needs to be required and classes done every year
please take this in serious consideration.

Gloria Langmeyer CDA CDPMA

PAST PRESIDENT VADD

CommentID: **97684**

Commenter: Kristin Barnes

3/31/21 10:26 pm

Strongly Agree

I think this is very important for all DAs to be properly trained in ICE to ensure we are protecting our patients and staff members especially now during the covid-19 pandemic.

CommentID: **97685**

Commenter: Rashmi Bhatt

3/31/21 11:00 pm

Opposition to additional required infection control training for dental assistants

Dental offices already have required annual OSHA training and CDC guidelines being implemented in the office. This proposed regulation is therefore redundant and adds an extra burden on an already stretched dental practice .No infection has been shown to have been transmitted from a dental office in this state.

CommentID: **97687**

Commenter: Cassie Sissom

3/31/21 11:06 pm

Required infection control for DA

As a healthcare worker, infection protocol changes frequently. It is important for us to give the upmost care to patients safely and effectively. It is used to keep the patients and us safe from the risk of infection and contamination.

CommentID: **97688**

Commenter: Cathy Berard

3/31/21 11:20 pm

Support Infection Prevention and Control for Dental Assistants I

I **strongly** encourage the Board of Dentistry to require training in Infection Prevention and Control for Dental Assistant I. This training is vital for their own personal health and protection as well as that of the patients we serve. Our patients place their trust in us to maintain our offices as a safe place for them to receive dental care. That can only happen when each dental team member cares about and has knowledge of how to break the Chain of Infection.

Successful completion of a CE course in Infection Prevention and Control offered by the sponsors recognized by the BOD would provide a **MINIMAL** standard for these important clinical team members to uphold so that they can help protect both dental patients AND dental team members. This has become especially evident and important to maintain as we continue to navigate through a global pandemic.

Thank you for your thoughtful deliberation on this very important subject.

CommentID: **97689**

Commenter: Michael Berard

3/31/21 11:23 pm

Support Infection Prevention and Control for Dental Assistants I

As a patient, I trust that the dental office where I receive care is maintained in a clean and safe manner. It is shocking to me that there is discussion against training Dental Assistants in the basic principles of Infection Prevention and Control.

I support and encourage the Board of Dentistry to require training in Infection Prevention and Control for Dental Assistant I.

Successful completion of a CE course in Infection Prevention and Control offered by the sponsors recognized by the BOD would provide a **MINIMAL** standard for these important clinical team members to uphold so that they can help protect both dental patients AND dental team members.

Thank you.

CommentID: **97690**

Commenter: MARGARET L GREEN

3/31/21 11:29 pm

DA I infection Prevention and Control Training

Dear Members of the Virginia Board of Dentistry,

As a former member of the Virginia Board of Dentistry, former Chair of Old Dominion University, School of Dental Hygiene, member of the VDHA and a semi retired clinician with over 40 years of practice, I support the requirement of the DA I to complete training in Infection Prevention and Control. This training is readily accessible as a continuing education course provided by any of the many educational sponsors listed in the Regulations.

This is the very least that can be required for the Board to ensure the public and entire dental team are protected.

Thank you for the opportunity to be heard as a supporter of training regulations for the DA I.

Margaret L. Green, RDH, MS

CommentID: **97691**

Commenter: Barry Lee Green, DMD, MS

3/31/21 11:37 pm

DAI Training in Infection Control

This testimony is to document my support of requiring the DA I to be trained in Infection Control as a minimal standard of practice. Continuing education courses are readily available and cost effective for obtaining this training. This training will enable enhanced protection of the public we serve and the team I supervise.

Yours for better oral health,

Barry Lee Green, DMD, MS

CommentID: **97692**

Commenter: Kelly Tanner, PhD, RDH

4/1/21 12:00 am

Support Training and Infection Control for DA I

Dear Members of the Virginia Board of Dentistry,

As an educator and member of the VDHA and a clinician with over 25 years of practice, I support the requirement of the DA I to complete training in Infection Prevention and Control. This training is readily accessible as a continuing education course provided by any of the many educational sponsors listed in the Regulations.

This is the very least that can be required for the Board to ensure the public and entire dental team are protected.

Thank you for the opportunity to be heard as a supporter of training regulations for the DA I.

Kelly Tanner, PhD, RDH

CommentID: **97693**

Draft Proposed Regulations for Training of dental assistants in infection control

18VAC60-21-175. Infection control training.

A dentist shall be responsible for assuring that dental assistants complete annual training in infection control standards required by the Occupational Safety and Health Administration and as recommended by the Centers for Disease Control. Newly employed dental assistants shall receive training as soon as possible, but no later than 60 days from employment.

Documentation records shall show the dates of completion of initial and annual training, including the date of employment for new dental assistants. All documentation of training in infection control shall be maintained by the dentist for three years.

Agenda Item: Board Action on Digital Scan Technician

Included in agenda package:

Copy of HB165 (SB122 was identical) passed by the 2020 General Assembly – it is Chapter 37 of the 2020 Acts of the Assembly.

Copy of NOIRA notice on Townhall

Copy of comments on the NOIRA

Copy DRAFT regulations as recommended by the Regulatory/Legislative Committee

Board action:

Adoption of proposed regulations

CHAPTER 37

An Act to amend and reenact §§ 54.1-2700, 54.1-2711, and 54.1-2719 of the Code of Virginia and to amend the Code of Virginia by adding in Article 2 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.5, relating to teledentistry.

[H 165]

Approved March 2, 2020

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2700, 54.1-2711, and 54.1-2719 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 2 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.5 as follows:

§ 54.1-2700. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Appliance" means a permanent or removable device used in a plan of dental care, including crowns, fillings, bridges, braces, dentures, orthodontic aligners, and sleep apnea devices.

"Board" means the Board of Dentistry.

"Dental hygiene" means duties related to patient assessment and the rendering of educational, preventive, and therapeutic dental services specified in regulations of the Board and not otherwise restricted to the practice of dentistry.

"Dental hygienist" means a person who is licensed by the Board to practice dental hygiene.

"Dentist" means a person who has been awarded a degree in and is licensed *by the Board* to practice dentistry.

"Dentistry" means the evaluation, diagnosis, prevention, and treatment, through surgical, nonsurgical, or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent, and associated structures and their impact on the human body.

"Digital scan" means digital technology that creates a computer-generated replica of the hard and soft tissues of the oral cavity using enhanced digital photography.

"Digital scan technician" means a person who has completed a training program approved by the Board to take digital scans of intraoral and extraoral hard and soft tissues for use in teledentistry.

"Digital work order" means the digital equivalent of a written dental laboratory work order used in the construction or repair of an appliance.

"License" means the document issued to an applicant upon completion of requirements for admission to practice dentistry or dental hygiene in the Commonwealth or upon registration for renewal of license to continue the practice of dentistry or dental hygiene in the Commonwealth.

"License to practice dentistry" means any license to practice dentistry issued by the Board.

"Maxillofacial" means pertaining to the jaws and face, particularly with reference to specialized surgery of this region.

"Oral and maxillofacial surgeon" means a person who has successfully completed an oral and maxillofacial residency program, approved by the Commission on Dental Accreditation of the American Dental Association, and who holds a valid license from the Board.

"Store-and-forward technologies" means the technologies that allow for the electronic transmission of dental and health information, including images, photographs, documents, and health histories, through a secure communication system.

"Teledentistry" means the delivery of dentistry between a patient and a dentist who holds a license to practice dentistry issued by the Board through the use of telehealth systems and electronic technologies or media, including interactive, two-way audio or video.

§ 54.1-2708.5. Digital scans for use in the practice of dentistry; practice of digital scan technicians.

A. No person other than a dentist, dental hygienist, dental assistant I, dental assistant II, digital scan technician, or other person under the direction of a dentist shall obtain dental scans for use in the practice of dentistry.

B. A digital scan technician who obtains dental scans for use in the practice of teledentistry shall work under the direction of a dentist who is (i) licensed by the Board to practice dentistry in the Commonwealth, (ii) accessible and available for communication and consultation with the digital scan technician at all times during the patient interaction, and (iii) responsible for ensuring that the digital scan technician has a program of training approved by the Board for such purpose. All protocols and procedures for the performance of digital scans by digital scan technicians and evidence that a digital scan technician has complied with the training requirements of the Board shall be made available to the Board upon request.

§ 54.1-2711. Practice of dentistry.

A. Any person shall be deemed to be practicing dentistry who (i) uses the words dentist, or dental surgeon, the letters D.D.S., D.M.D., or any letters or title in connection with his name, which in any way represents him as engaged in the practice of dentistry; (ii) holds himself out, advertises, or permits to be advertised that he can or will perform dental operations of any kind; (iii) diagnoses, treats, or professes to diagnose or treat any of the diseases or lesions of the oral cavity, its contents, or contiguous structures~~,~~; or (iv) extracts teeth, corrects malpositions of the teeth or jaws, takes *or causes to be taken digital scans or* impressions for the fabrication of appliances or dental prosthesis, supplies or repairs artificial teeth as substitutes for natural teeth, or places in the mouth and adjusts such substitutes. *Taking impressions for mouth guards that may be self-fabricated or obtained over-the-counter does not constitute the practice of dentistry.*

B. No person shall practice dentistry unless a bona fide dentist-patient relationship is established in person or through teledentistry. A bona fide dentist-patient relationship shall exist if the dentist has (i) obtained or caused to be obtained a health and dental history of the patient; (ii) performed or caused to be performed an appropriate examination of the patient, either physically, through use of instrumentation and diagnostic equipment through which digital scans, photographs, images, and dental records are able to be transmitted electronically, or through use of face-to-face interactive two-way real-time communications services or store-and-forward technologies; (iii) provided information to the patient about the services to be performed; and (iv) initiated additional diagnostic tests or referrals as needed. In cases in which a dentist is providing teledentistry, the examination required by clause (ii) shall not be required if the patient has been examined in person by a dentist licensed by the Board within the six months prior to the initiation of teledentistry and the patient's dental records of such examination have been reviewed by the dentist providing teledentistry.

C. No person shall deliver dental services through teledentistry unless he holds a license to practice dentistry in the Commonwealth issued by the Board and has established written or electronic protocols for the practice of teledentistry that include (i) methods to ensure that patients are fully informed about services provided through the use of teledentistry, including obtaining informed consent; (ii) safeguards to ensure compliance with all state and federal laws and regulations related to the privacy of health information; (iii) documentation of all dental services provided to a patient through teledentistry, including the full name, address, telephone number, and Virginia license number of the dentist providing such dental services; (iv) procedures for providing in-person services or for the referral of patients requiring dental services that cannot be provided by teledentistry to another dentist licensed to practice dentistry in the Commonwealth who actually practices dentistry in an area of the Commonwealth the patient can readily access; (v) provisions for the use of appropriate encryption when transmitting patient health information via teledentistry; and (vi) any other provisions required by the Board. A dentist who delivers dental services using teledentistry shall, upon request of the patient, provide health records to the patient or a dentist of record in a timely manner in accordance with § 32.1-127.1:03 and any other applicable federal or state laws or regulations. All patients receiving dental services through teledentistry shall have the right to speak or communicate with the dentist providing such services upon request.

D. Dental services delivered through use of teledentistry shall (i) be consistent with the standard of care as set forth in § 8.01-581.20, including when the standard of care requires the use of diagnostic testing or performance of a physical examination, and (ii) comply with the requirements of this chapter and the regulations of the Board.

E. In cases in which teledentistry is provided to a patient who has a dentist of record but has not had a dental wellness examination in the six months prior to the initiation of teledentistry, the dentist providing teledentistry shall recommend that the patient schedule a dental wellness examination. If a patient to whom teledentistry is provided does not have a dentist of record, the dentist shall provide or cause to be provided to the patient options for referrals for obtaining a dental wellness examination.

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

§ 54.1-2719. Persons engaged in construction and repair of appliances.

A. Licensed dentists may employ or engage the services of any person, firm, or corporation to construct or repair *an appliance*, extraorally, ~~prosthetic dentures, bridges, or other replacements for a part of a tooth, a tooth, or teeth~~ *in accordance with a written or digital work order. Any appliance constructed or repaired by a person, firm, or corporation pursuant to this section shall be evaluated and reviewed by the licensed dentist who submitted the written or digital work order, or a licensed dentist in the same dental practice.* A person, firm, or corporation so employed or engaged shall not be considered to be practicing dentistry. No such person, firm, or corporation shall perform any direct dental service for a patient, but they may assist a dentist in the selection of shades for the matching of prosthetic devices when the dentist sends the patient to them with a written *or digital* work order.

B. Any licensed dentist who employs the services of any person, firm, or corporation not working in a dental office under ~~his~~ *the dentist's* direct supervision to construct or repair~~,~~ *an appliance* extraorally~~,~~ ~~prosthetic dentures, bridges, replacements, or orthodontic appliances for a part of a tooth, a tooth, or teeth,~~ shall furnish such person, firm, or corporation with a written *or digital* work order on forms

prescribed by the Board, which shall, at minimum, contain: (i) the name and address of the person, firm, or corporation; (ii) the patient's name or initials or an identification number; (iii) the date the work order was written; (iv) a description of the work to be done, including diagrams, if necessary; (v) specification of the type and quality of materials to be used; and (vi) the signature and address of the dentist.

The person, firm, or corporation shall retain the original *written* work order *or an electronic copy of a digital work order,* and the dentist shall retain a duplicate *of the written work order or an electronic copy of a digital work order,* for three years.

C. If the person, firm, or corporation ~~receiving~~ *receives* a written *or digital* work order from a licensed dentist ~~engages a subcontractor to perform services relative to the work order,~~ a written *disclosure and* subwork order shall be furnished *to the dentist* on forms prescribed by the Board, which shall, at minimum, contain: (i) the name and address of the *person, firm, or corporation and* subcontractor; (ii) a number identifying the subwork order with the original work order; (iii) the date ~~the~~ *any* subwork order was written; (iv) a description of the work to be done *and the work to be done* by the subcontractor, including diagrams *or digital files,* if necessary; (v) a specification of the type and quality of materials to be used; and (vi) the signature of the person issuing the *disclosure and* subwork order.

The subcontractor shall retain the subwork order, and the issuer shall retain a duplicate *of the subwork order, which shall be* attached to the work order received from the licensed dentist, for three years.

D. No person, firm, or corporation engaged in the construction or repair of appliances shall refuse to allow the Board or its agents to inspect the files of work orders or subwork orders during ordinary business hours.

~~The provisions of this section shall not apply to a work order for the construction, reproduction, or repair, extraorally, of prosthetic dentures, bridges, or other replacements for a part of a tooth, a tooth, or teeth, done by a person, firm or corporation pursuant to a written work order received from a licensed dentist who is residing and practicing in another state.~~

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VIRGINIA REGULATORY TOWN HALL

Agency **Department of Health Professions**

Board **Board of Dentistry**

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

Action: Training and supervision of digital scan technicians

Notice of Intended Regulatory Action (NOIRA)

Action 5600 / Stage 9069

Edit Stage | Withdraw Stage | Go to RIS Project

Documents		
Preliminary Draft Text	None submitted	Sync Text with RIS
Agency Background Document	9/16/2020	Upload / Replace
Governor's Review Memo	1/30/2021	
Registrar Transmittal	1/30/2021	

Status	
Public Hearing	Will be held at the **proposed** stage
Exempt from APA	No, this stage/action is subject to Article 2 of the *Administrative Process Act*
DPB Review	Submitted on 9/16/2020 Policy Analyst: Jerry Gentile Review Completed: 9/24/2020
Governor's Review	Review Completed: 1/30/2021 Result: Approved
Virginia Registrar	Submitted on 1/30/2021 The Virginia Register of Regulations Publication Date: 3/1/2021 Volume: 37 Issue: 14
Comment Period	Ended 3/31/2021 10 comments

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Dear Ms. Reen and Members of the Virginia Board of Dentistry:

I write to you on behalf of the American Association of Orthodontists (AAO) in response to the Notice of Intended Regulatory Action (NOIRA) published in the Virginia Register on March 1, 2021 to take regulatory action regarding the training and supervision of digital scan technicians. We appreciate the opportunity to submit public comment at this time.

The AAO is the nation's largest dental specialty organization and represents more than 19,000 orthodontists in the United States and abroad. We have 396 members who are residents of, or licensed to practice dentistry in, the Commonwealth of Virginia.

As you know, HB 165 and SB122 of the 2020 General Assembly defined a digital scan technician, as used in teledentistry, and required the Board to promulgate regulations for the training for technicians to practice under the supervision of a dentist licensed in Virginia. The AAO opposed HB 165/SB 122 unless amended, as we believed the bills, as eventually passed, have several provisions that could have unintended consequences and seemingly do not best protect patient health and safety. One proposed amendment, which was not accepted by the legislature, is included below in red font.

[As proposed in section 54.1-2719. Persons engaged in construction and repair of appliances. A.]: Licensed dentists may employ or engage the services of any person, firm, or corporation to construct or repair an appliance, extraorally, in accordance with a written or digital work order. Any appliance constructed or repaired by a person, firm, or corporation pursuant to this section shall be evaluated and reviewed in-person by the licensed dentist who submitted the written or digital work order, or a licensed dentist in the same dental practice. A person, firm, or corporation so employed or engaged shall not be considered to be practicing dentistry. No such person, firm, or corporation shall perform any direct dental service for a patient, but they may assist a dentist in

the selection of shades for the matching of prosthetic devices when the dentist sends the patient to them with a written or digital work order.

The AAO suggested amending this section so that the treating dentist, or a licensed dentist in the same dental practice, who orders any appliance, reviews that appliance in person to confirm its accuracy and fit. In the case of another dental appliance, dentures, laws regularly require that a lab creating the appliance send the appliance back to the prescribing dentist prior to receipt by the patient, so the dentist can inspect and confirm that the appliance conforms with the prescription and impressions that were provided. The same reasoning should apply to orthodontic appliances; the dentist should be required to inspect the appliances for conformity to the prescription and impressions (digital or physical) before being sent to the patient to begin treatment. Improperly fitting orthodontic appliances can cause significant harm—certainly physical harm from the appliance (such as cut or bleeding gums), but also significant harm from the unintended or improper movement of teeth caused by an inaccurate appliance. Dental boards regularly direct that treatment administered through teledentistry should maintain the same standard of care as in-person treatment. This principle applies in requiring the inspection and fitting of the appliance in-person by the treating dentist.

As the Board works to fulfill its task to promulgate regulations that specify the responsibility of the dentist for the practice of teledentistry and training and supervision of a digital scan technician, the AAO respectfully asks that you consider language that ensures that an appliance, such as a clear aligner, that is fabricated as a result of a scan taken by a digital scan technician, is verified in-person by the treating dentist to prevent patients from receiving clear aligners that were fabricated based on inaccurate images.

The AAO also emphasizes the importance of establishing a doctor/patient relationship via a face-to-face encounter, specifically before beginning orthodontic treatment, because there are certain diagnoses and evaluations that can only be performed in-person or are best performed in-person (x-rays, etc.). There are a number of categories of problems/conditions that a dentist usually looks for as part of a physical examination at the outset of traditional in-person treatment. These can include conditions or problems that may be quite serious, such as oral cancer, periodontal problems, advanced decay, gum disease, etc. If an in-person examination of the patient by a dentist does not occur, there may be no examination of the patient by a dentist to detect such problems. With that in mind, the AAO believes dental and orthodontic treatment should not occur before a physical, in-person examination/evaluation of the patient and before the treating dentist has inspected and approved any orthodontic appliance created using images taken by a digital scan technician, has occurred by a Virginia licensed dentist. To that end, the AAO proposes inclusion of the following requirement in any dental scan technician regulations:

No person, other than a dentist, shall obtain digital scans for use during the practice of dentistry unless the patient has or will be seen in person by a dentist within six months of the scan.

Thank you in advance for your consideration of these comments. Please do not hesitate to contact the AAO if we can be of any further assistance to the Board in its consideration of these issues.

Sincerely,

Trey Lawrence

Vice President, Advocacy and General Counsel

American Association of Orthodontists

Virginia Dental ASSOCIATION | 150 YEARS

March 31, 2021

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

Dear Ms. Reen,

On behalf of the Virginia Dental Association, I am submitting comments and suggestions in response to the current Board of Dentistry NOIRA: Training and supervision of digital scan technicians.

Attached with this letter are our recommendations for digital scan technician requirements. Thank you in advance for your consideration.

Sincerely,

Dr. Frank Iuorno, DDS
President
Virginia Dental Association

18VAC60-21-10. Definitions.

E. The following words and terms relating to teledentistry or digital scan technicians as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Appliance" means a permanent or removable device used in a plan of dental care, including crowns, fillings, bridges, braces, dentures, orthodontic aligners, and sleep apnea devices.

"Digital work order" means the digital equivalent of a written dental laboratory work order used in the construction or repair of an appliance.

"Teledentistry" means the delivery of dentistry through the use of telehealth systems and technologies, including live, two-way interactions between a patient and a dentist holding an active license to practice dentistry in the Commonwealth using audiovisual telecommunications technology or the secure transmission of electronic health records, digital files, or medical data to a dentist holding an active unrestricted license to practice dentistry in the Commonwealth to facilitate evaluation of a patient other than as part of a real-time live interaction.

New Chapter 35: Regulations Governing the Practice of Digital Scan Technicians

Part I. General Provisions

Section 10: Definitions

"Digital scan" means digital technology that creates a computer-generated replica of the hard and soft tissues of the oral cavity using enhanced digital photography.

"Digital scan technician" means a person who has completed a training program approved by the Board to take digital scans of intraoral and extraoral hard and soft tissues of the oral cavity for use in the practice of teledentistry.

"Remote direction" means that a dentist is accessible and available at all times ~~generally accessible~~ for communication and consultation with a digital scan technician during the delivery of digital scan services but such dentist may not have conducted an initial examination of the patients who are to be seen by the digital scan technician and may not be present with the digital scan technician when digital scan services are being provided.

Section 20: Training

A. Any digital scan technician taking intraoral digital scans for any appliance, prothesis, crown, or any other permanent or removable dental device for which a digital work order is required must complete a training program approved by the Board and, upon the request of the Board, make available evidence that they have complied with the training requirements.

B. Training certification may be earned by verifiable participation in any course that is relevant to digital scanning which includes programs provided by any of the following sponsors:

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

Commented [A1]: Correct, "accessible and available at all times," and regulation should reflect that.

2. The American Association of Orthodontists and their constituent and component/branch associations, including the Virginia Association of Orthodontists;

~~2~~3. The American Dental Hygienists' Association and the National Dental Hygienists Association and their constituent and component/branch associations;

~~3~~4. The American Dental Assisting Association and its constituent and component/branch associations;

~~4~~5. The American Dental Association specialty organizations and their constituent and component/branch associations;

~~5~~6. A provider accredited by the Accreditation Council for Continuing Medical Education for Category 1 credits;

~~6~~7. The Academy of General Dentistry and its constituent and component/branch associations;

~~7~~8. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;

~~8~~9. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Healthcare Organizations;

~~9~~10. A medical school accredited by the American Medical Association's Liaison Committee for Medical Education or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association;

~~10~~11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

~~11~~12. The Commonwealth Dental Hygienists' Society;

13. The Virginia~~MCV~~ Orthodontic Education and Research Foundation;

~~12~~14. The Dental Assisting National Board and its affiliate, the Dental Auxiliary Learning and Education Foundation;

~~13~~15. The American Academy of Dental Hygiene, its constituent and component/branch associations;

~~14~~16. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, Council of Interstate Testing Agencies, or Western Regional Examining Board) when serving as an examiner

~~15~~17. A training program certified by the manufacturer of the digital scanner; or

~~16~~18. A written training program provided by the directing dentist that includes policies, procedures, and protocols for a digital scan and is sufficiently similar in information and training as another program found in this Section.

C. Verification of compliance with training requirements includes:

1. A certificate of completion from any of the training sponsors found in Section 20 subsection B of this Part; or

2. A written certification made by the directing dentist verifying that the digital scan technician has completed on-the-job training sufficient to meet all protocols and procedures for the performance of digital scans. The written certification shall be made at the time of training completion and shall be kept on record with the directing dentist.

D. A Board registered Dental Hygienist, Dental Assistant I, or Dental Assistant II with an active license in good standing who has been trained in digital scanning or educated in digital scanning as a part of their education curriculum shall be deemed to have training sufficient to comply with this Chapter.

Part II: Practice of Digital Scan Technicians

Section 30: Practice of digital scan technicians under direction

In all instances and on the basis of his ~~or her~~ diagnosis, a licensed dentist assumes ultimate responsibility for determining with the patient or his representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with the Regulations Governing the Practice of Dentistry, and the Code.

Section 40: Nondelegable duties

A digital scan technician may not perform any other duties other than taking a digital scan unless authorized elsewhere in this Chapter or in another Chapter of these Rules.

Section 50: Delegation to a digital scan technician

A. Under the direction of a Board-licensed dentist, a digital scan technician may take a digital scan and use remote technology to transmit the digital scan to the directing dentist.

B. Nothing in this chapter shall be construed to allow a dentist to delegate duties to a digital scan technician that are ~~not~~ beyond the ability to take a digital scan.

Commented [A2]: The "not" here creates a double negative. We don't want the dentist delegating duties beyond the ability to take a digital scan.

C. Notwithstanding Subsection B of this Section, nothing in this Chapter shall be construed to limit the scope of practice for a dentist, a dental hygienist, or a dental assistant I or II.

Section 60: What does not constitute practice.

The following are not considered the practice of a digital scan technician:

1. General oral health education.

2. Taking of non-invasive photographs.

3. Using a digital scanner for a purpose other than for the construction of any appliance, prothesis, crown, or any other permanent or removable dental device for which a digital work order is required.

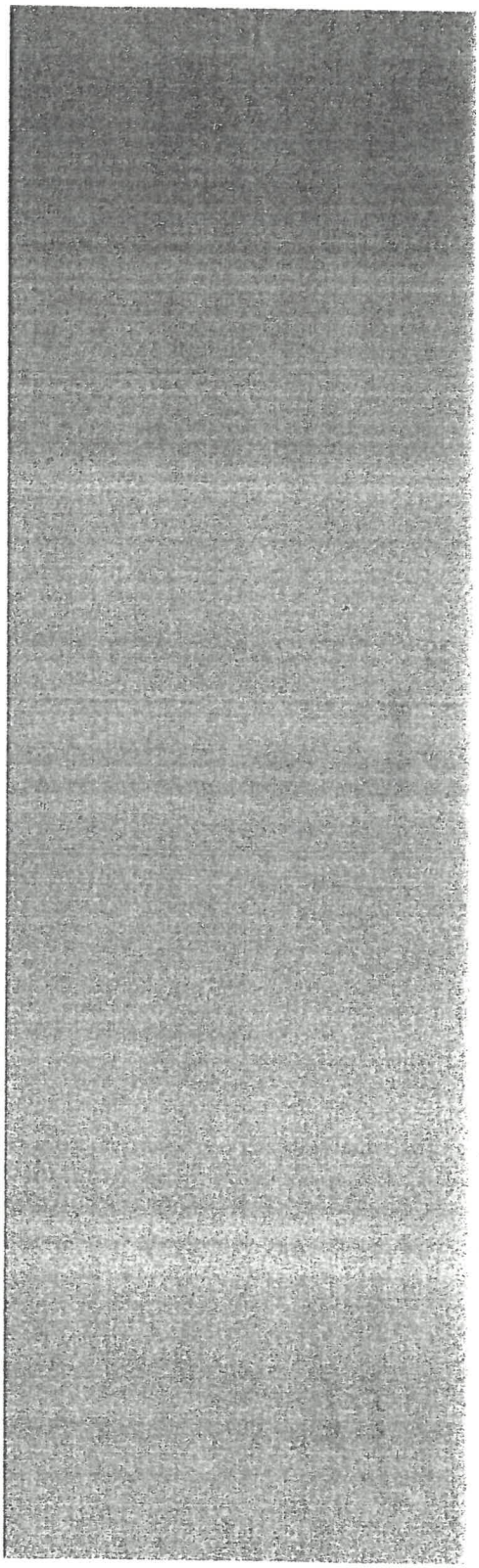
4. Collection of general patient information.

Part III: Standards of Conduct

Section 70: Patient records; confidentiality

A. A digital scan technician shall be responsible for accurate and complete information in patient records for those services provided by the digital scan technician, to include clearly labeling any digital images, digital scans, and photographs with the patient name and date taken.

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



March 24, 2021

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

Re: Comments on the Proposed Regulation for Digital Scan Technicians

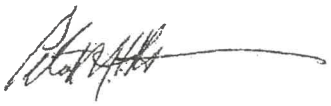
Dear Executive Director Reen,

SmileDirectClub ("SDC") submits the following comment on the proposed action to regulate digital scan technicians for consideration. SDC has an interest in this proposed regulatory action because our contractually-affiliated, Virginia-licensed dentists and orthodontists who provide oral healthcare services to Virginia patients often utilize digital scanners – and "digital scan technicians" to operate those scanners – in the delivery of remote clear aligner therapy.

During the 2020 Virginia General Assembly session, SDC worked collaboratively with stakeholders to find compromise legislation regarding the regulation digital scan technicians and teledentistry – the same legislation that gives rise to the regulatory process the Board is now undertaking. We have drafted proposed regulations for the Board's consideration that we believe are reflections of the Legislature's intent and are protective of public health. We look forward to participating in the formal rulemaking process in the months ahead.

If you have any questions or would like to talk further on this issue or on teledentistry more broadly, please do not hesitate to contact me at 615-647-8656 or Peter.Horkan@smiledirectclub.com.

Respectfully,



Peter Horkan
Vice President, Government Affairs
SmileDirectClub

18VAC60-21-10. Definitions.

E. The following words and terms relating to teledentistry or digital scan technicians as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Appliance" means a permanent or removable device used in a plan of dental care, including crowns, fillings, bridges, braces, dentures, orthodontic aligners, and sleep apnea devices.

"Digital work order" means the digital equivalent of a written dental laboratory work order used in the construction or repair of an appliance.

"Teledentistry" means the delivery of dentistry through the use of telehealth systems and technologies, including live, two-way interactions between a patient and a dentist holding an active license to practice dentistry in the Commonwealth using audiovisual telecommunications technology or the secure transmission of electronic health records, digital files, or medical data to a dentist holding an active unrestricted license to practice dentistry in the Commonwealth to facilitate evaluation of a patient other than as part of a real-time live interaction.

New Chapter 35: Regulations Governing the Practice of Digital Scan Technicians

Part I. General Provisions

Section 10: Definitions

"Digital scan" means digital technology that creates a computer-generated replica of the hard and soft tissues of the oral cavity using enhanced digital photography.

"Digital scan technician" means a person who has completed a training program approved by the Board to take digital scans of intraoral and extraoral hard and soft tissues of the oral cavity for use in the practice of teledentistry.

"Remote direction" means that a dentist is accessible and available at all times for communication and consultation with a digital scan technician during the delivery of digital scan services but such dentist may not have conducted an initial examination of the patients who are to be seen by the digital scan technician and may not be present with the digital scan technician when digital scan services are being provided.

Section 20: Training

A. Any digital scan technician taking intraoral digital scans for any appliance, prothesis, crown, or any other permanent or removable dental device for which a digital work order is required must complete a training program approved by the Board and, upon the request of the Board, make available evidence that they have complied with the training requirements.

B. Training certification may be earned by verifiable participation in any course that is relevant to digital scanning which includes programs provided by any of the following sponsors:

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

2. The American Association of Orthodontists and their constituent and component/branch associations, including the Virginia Association of Orthodontists;

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

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

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

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

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

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

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

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

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

12. The Commonwealth Dental Hygienists' Society;

13. The Virginia Orthodontic Education and Research Foundation;

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

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

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

17. A training program certified by the manufacturer of the digital scanner; or

18. A written training program provided by the directing dentist that includes policies, procedures, and protocols for a digital scan and is sufficiently similar in information and training as another program found in this Section.

C. Verification of compliance with training requirements includes:

1. A certificate of completion from any of the training sponsors found in Section 20 subsection B of this Part; or

2. A written certification made by the directing dentist verifying that the digital scan technician has completed on-the-job training sufficient to meet all protocols and procedures for the performance of digital scans. The written certification shall be made at the time of training completion and shall be kept on record with the directing dentist.

D. A Board registered Dental Hygienist, Dental Assistant I, or Dental Assistant II with an active license in good standing who has been trained in digital scanning or educated in digital scanning as a part of their education curriculum shall be deemed to have training sufficient to comply with this Chapter.

Part II: Practice of Digital Scan Technicians

Section 30: Practice of digital scan technicians under direction

In all instances and on the basis of his diagnosis, a licensed dentist assumes ultimate responsibility for determining with the patient or his representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with the Regulations Governing the Practice of Dentistry, and the Code.

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A digital scan technician may not perform any other duties other than taking a digital scan unless authorized elsewhere in this Chapter or in another Chapter of these Rules.

Section 50: Delegation to a digital scan technician

A. Under the direction of a Board-licensed dentist, a digital scan technician may take a digital scan and use remote technology to transmit the digital scan to the directing dentist.

B. Nothing in this chapter shall be construed to allow a dentist to delegate duties to a digital scan technician that are beyond the ability to take a digital scan.

C. Notwithstanding Subsection B of this Section, nothing in this Chapter shall be construed to limit the scope of practice for a dentist, a dental hygienist, or a dental assistant I or II.

Section 60: What does not constitute practice.

The following are not considered the practice of a digital scan technician:

1. General oral health education.

2. Taking of non-invasive photographs.

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Section 70: Patient records; confidentiality

A. A digital scan technician shall be responsible for accurate and complete information in patient records for those services provided by the digital scan technician, to include clearly labeling any digital images, digital scans, and photographs with the patient name and date taken.

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

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Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter

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

Action	**Training and supervision of digital scan technicians**
Stage	**NOIRA**
Comment Period	Ends 3/31/2021

10 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: William G. Horbaly, D.D.S., M.S., M.D.S., LTD. 3/24/21 11:12 am

Stop with over-regulating!

First of all, the Hygiene Board has no business making regulation recommendations that encroach on Dentistry as a whole. Secondly, the need for infection control training for DA's is obviously not an issue in Virginia as it was stated that their have been no significant cases of infection spread in a dental office in Virginia. Stop looking for things to regulate that do not require regulation. As professionals with advanced degrees we are all responsible and capable of training our DAs with regards to infection control in our individual practices. If you have found egregious issues with sterilization procedures in some offices then that is a reflection of the doctor in charge and they should be held accountable. Whether the DAs are trained or not will not matter if the particular office does not hold a high standard of infection control. An added regulation will incur costs that will simply be passed on to the public, who in the end, really pay for all of these regulations thereby impacting the affordability of care for those in need. I respectfully request that you reconsider establishing this needless regulation.

William G. Horbaly, DDS, MS, MDS

CommentID: 97415

Commenter: American Association of Orthodontists 3/28/21 11:31 am

Digital Scan Technicians and Patient Health and Safety

Dear Ms. Reen and Members of the Virginia Board of Dentistry:

I write to you on behalf of the American Association of Orthodontists (AAO) in response to the Notice of Intended Regulatory Action (NOIRA) published in the Virginia Register on March 1, 2021 to take regulatory action regarding the training and supervision of digital scan technicians. We appreciate the opportunity to submit public comment at this time.

The AAO is the nation's largest dental specialty organization and represents more than 19,000 orthodontists in the United States and abroad. We have 396 members who are residents of, or licensed to practice dentistry in, the Commonwealth of Virginia.

As you know, HB 165 and SB122 of the 2020 General Assembly defined a digital scan technician, as used in teledentistry, and required the Board to promulgate regulations for the training for technicians to practice under the supervision of a dentist licensed in Virginia. The AAO opposed HB 165/SB 122 unless amended, as we believed the bills, as eventually passed, have several provisions that could have unintended consequences and seemingly do not best protect patient health and safety. One proposed amendment, which was not accepted by the legislature, is included below in italicized and bold font.

[As proposed in section 54.1-2719. Persons engaged in construction and repair of appliances. A.]: Licensed dentists may employ or engage the services of any person, firm, or corporation to construct or repair an appliance, extraorally, in accordance with a written or digital work order. Any appliance constructed or repaired by a person, firm, or corporation pursuant to this section shall be evaluated and reviewed ***in-person*** by the licensed dentist who submitted the written or digital work order, or a licensed dentist in the same dental practice. A person, firm, or corporation so employed or engaged shall not be considered to be practicing dentistry. No such person, firm, or corporation shall perform any direct dental service for a patient, but they may assist a dentist in the selection of shades for the matching of prosthetic devices when the dentist sends the patient to them with a written or digital work order.

The AAO suggested amending this section so that the treating dentist, or a licensed dentist in the same dental practice, who orders any appliance, reviews that appliance in person to confirm its accuracy and fit. In the case of another dental appliance, dentures, laws regularly require that a lab creating the appliance send the appliance back to the prescribing dentist prior to receipt by the patient, so the dentist can inspect and confirm that the appliance conforms with the prescription and impressions that were provided. The same reasoning should apply to orthodontic appliances; the dentist should be required to inspect the appliances for conformity to the prescription and impressions (digital or physical) before being sent to the patient to begin treatment. Improperly fitting orthodontic appliances can cause significant harm—certainly physical harm from the appliance (such as cut or bleeding gums), but also significant harm from the unintended or improper movement of teeth caused by an inaccurate appliance. Dental boards regularly direct that treatment administered through teledentistry should maintain the same standard of care as in-person treatment. This principle applies in requiring the inspection and fitting of the appliance in-person by the treating dentist.

As the Board works to fulfill its task to promulgate regulations that specify the responsibility of the dentist for the practice of teledentistry and training and supervision of a digital scan technician, the AAO respectfully asks that you consider language that ensures that an appliance, such as a clear aligner, that is fabricated as a result of a scan taken by a digital scan technician, is verified in-person by the treating dentist to prevent patients from receiving clear aligners that were fabricated based on inaccurate images.

The AAO also emphasizes the importance of establishing a doctor/patient relationship via a face-to-face encounter, specifically before beginning orthodontic treatment, because there are certain diagnoses and evaluations that can only be performed in-person or are best performed in-person (x-rays, etc.). There are a number of categories of problems/conditions that a dentist usually looks for as part of a physical examination at the outset of traditional in-person treatment. These can include conditions or problems that may be quite serious, such as oral cancer, periodontal problems, advanced decay, gum disease, etc. If an in-person examination of the patient by a dentist does not occur, there may be no examination of the patient by a dentist to detect such

problems. With that in mind, the AAO believes dental and orthodontic treatment should not occur before a physical, in-person examination/evaluation of the patient and before the treating dentist has inspected and approved any orthodontic appliance created using images taken by a digital scan technician, has occurred by a Virginia licensed dentist. To that end, the AAO proposes inclusion of the following requirement in any dental scan technician regulations:

No person, other than a dentist, shall obtain digital scans for use during the practice of dentistry unless the patient has or will be seen in person by a dentist within six months of the scan.

Thank you in advance for your consideration of these comments. Please do not hesitate to contact the AAO if we can be of any further assistance to the Board in its consideration of these issues.

Sincerely,

Trey Lawrence

Vice President, Advocacy and General Counsel

American Association of Orthodontists

CommentID: **97446**

Commenter: Julie Staggers

3/29/21 10:19 am

Scanning Technician

Allow someone to scan teeth outside of a dental office is opening the door to facilitate online do it yourself dentistry. The Board's primary function is to protect the public from unlicensed and/or poor dentistry. The public does not know the quality of unregulated online/direct to consumer dentistry, they are only focused on convenience and price. The Board should be protecting patients from online, do it yourself dentistry. Scanning teeth or selling aligners directly to patients should be illegal. Pretending that online care is the same as in person care delivered by a licensed, qualified is ridiculous. Disallowing scanning by unlicensed, unsupervised personnel is one step in the process of combating do it yourself dentistry.

CommentID: **97458**

Commenter: Dr A B Hammond III

3/30/21 6:27 pm

I Support VDA proposed definition for Dental Scan Technician

I support the Virginia Dental Association proposal for the definition of Dental Scan Technician

A B Hammond

Orthodontist

Lexington VA

CommentID: **97568**

3/31/21 1:39 pm

Commenter: Danielle Robb

Support for the definition of dental scan technician proposed

Good afternoon,

I strongly support the comments made by the AAO in regards to this NOIRA. I also additionally support the definitions and training protocols that the VDA has proposed to the board. I think it is incredibly important for a dentist or orthodontist who has initiated treatment or fabrication of a dental appliance via teledentistry (where the patient was scanned by specifically a dental scan technician) to be verified for accuracy and appropriate fit prior to delivery. It is disservice to our patients and standards of care to require anything but.

Thank you for your consideration.

CommentID: **97623**

Commenter: Bao Vu

3/31/21 2:05 pm

Support VDA proposed definition for Dental Scan Technician

I support the Virginia Dental Association proposal for the definition of Dental Scan Technician

Bao Vu

Orthdontist

McLean, VA

CommentID: **97627**

Commenter: Michael Holbert

3/31/21 2:06 pm

Support of Dental Scanning Technician

Good afternoon,

I strongly support the comments made by the AAO, as well as the definitions and training protocols that the VDA has proposed to the board. It is important for a dentist or orthodontist who has initiated treatment or fabrication of a dental appliance via teledentistry (where the patient was scanned by specifically a dental scan technician) to verify the scan for accuracy and the appropriate fit of the appliance prior to delivery.

CommentID: **97629**

Commenter: Herb Hughes

3/31/21 6:22 pm

Support the VDA Proposal for Dental Scan Technican

I support the VDA proposal for dental scan technican.

I have had several grossly negligent orthodontic cases that were misdiagnosed and mistreated by a DIY aligner company. In one case, it was so bad that the patient had numerous teeth that were decayed to the gum line, moderate periodontial disease, and rampant caries only to be accepted and trays delivered to the patient. Thank heavens the trays didn't fit and the patient came to our

office to see what could be done. There were no in-person exams or x-rays reviewed. The general dentist who recently graduated from dental school lives in Phoenix, Arizona and doesn't even see patients in-person. She generates her income from her home working on a computer to approve as many aligner cases as possible. There is a financial incentive for dentists to approve cases because they get paid for patients that start treatment. At the present time they aren't accountable for their actions. Unless we fix this broken system more innocent people will be taken advantage! It's bad enough to take their money but to cause irreversible harm is totally unacceptable. Let's put the patients first and make laws that protect them not the DIY companies that are focused on how much money they can generated.

CommentID: **97660**

Commenter: Paul Supan

3/31/21 9:23 pm

Comments - Notice of Intended Regulatory Action Re: Digital Scan Technician Training & Supervision

Dear Distinguished Members of the Board,

I am writing regarding the pending NOIRA for Training and Supervision Requirements for Digital Scan Technicians. I would like to comment from the perspective of a dental specialist in dental public health and orthodontics. I fully support a prior comment made by another clinician, Dr. Julie Staggers, namely that:

" The Board's primary function is to protect the public from unlicensed and/or poor dentistry. The public does not know the quality of unregulated online/direct to consumer dentistry, they are only focused on convenience and price. The Board should be protecting patients from online, do it yourself dentistry. "

I support a dentist being a necessary part of the training and supervision process, but in what exact manner is the question that needs clarification. Quality care also needs to be reasonably accessible and affordable for the public.

In order to help ensure reasonable treatment costs and availability, I hope the Board will also permit dentists to have maximum flexibility in terms of delegating teledentistry related procedures. This would include scanning as well as the final seating of appliances, as long as some form of final check for quality of care, either directly or remotely, is available from a licensed dentist.

As teledentistry continue to expand in fields other than orthodontics, many traditionally under served populations, including Medicaid patients, will benefit from regulations that offer wide freedom to delegate procedures. As has been already dramatically demonstrated in Alaska, remote dentist supervision of dental auxiliaries has been shown to be a safe and clinically successful means of providing often complex dental services.

To summarize, as the Board promulgates regulations for the training and supervision of digital scan technicians, I believe it is quite reasonable that **the role of the dentist could be integrated in either a remote or direct** manner. In this way the public will benefit from both quality assurance of services rendered, **and** increased availability and affordability.

Paul Supan, DDS, MA, MPH

Diplomate, American Board of Orthodontics

CommentID: **97677**

Commenter: Albert L. Kelling DDS

3/31/21 10:05 pm

Intra-oral Scans Do Not Stand Alone

An intra-oral scan can not learn the patients's chief complaint, can not get a medical and dental history, can not examine the whole mouth, most of which is soft tissue and can not assemble a comprehensive problem list and discover any and all oral pathology. While an intra-oral scan can lend to gathering this information, it does not stand alone and can not be verified as accurate without expert analysis.

Any intra-oral scan must be performed within the context of gathering all the necessary information to provide the patient options for treatment, implications of doing nothing, and the expert professional recommendation on what the dentist believes is in the patient's best interest. These are the requirements for practicing dentistry. Accordingly, the gathering of an intra-oral scan must be performed under the direct supervision of a practicing dentist who can assure the accuracy of the scan through direct intra-oral examination and then bring together all the necessary information, as noted above, to form the full context in which the intra-oral scans may be made relevant. Any intra-oral scan, without this full context, is, at best, meaningless and could provide a basis to bring economic and/or physical harm to the patient. An intra-oral scan, by itself, does not serve the best interests of the patient.

CommentID: 97680

18VAC60-21-10. Definitions.

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

"Appliance"

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"Digital scan"

"Digital scan technician"

"Digital work order"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

"Teledentistry"

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

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

"ADA" means the American Dental Association.

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

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

"Code" means the Code of Virginia.

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

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

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

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

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

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

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

"Direct supervision" means that the dentist examines the patient and records diagnostic findings prior to delegating restorative or prosthetic treatment and related services to a dental assistant II for completion the same day or at a later date. The dentist prepares the tooth or teeth to be

restored and remains immediately available in the office to the dental assistant II for guidance or assistance during the delivery of treatment and related services. The dentist examines the patient to evaluate the treatment and services before the patient is dismissed.

"Direction" means the level of supervision (i.e., immediate, direct, indirect, or general) that a dentist is required to exercise with a dental hygienist, a dental assistant I, 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. For a digital scan technician, "direction" means the written or electronic instructions provided by a dentist to a digital scan technician in the form of a work order for a digital scan of a patient and the dentist's specified availability to consult with a digital scan technician while the scan is taken.

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

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

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist , a dental assistant, or a certified registered nurse anesthetist who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, (iii) preparing the patient for dismissal following treatment, or (iv) administering topical local anesthetic, sedation, or anesthesia as authorized by law or regulation.

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

hygiene services are being provided. For the purpose of supervision of a digital scan technician, remote supervision means that a supervising dentist is accessible and available for communication and consultation in the practice of teledentistry.

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

"Analgesia" means the diminution or elimination of pain.

"Continual" or "continually" means repeated regularly and frequently in a steady succession.

"Continuous" or "continuously" means prolonged without any interruption at any time.

"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

the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness and includes "inhalation analgesia" when used in combination with any such sedating agent administered prior to or during a procedure.

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

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

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

"Provide" means, in the context of regulations for moderate sedation or deep sedation/general anesthesia, to supply, give, or issue sedating medications. A dentist who does not hold the applicable permit cannot be the provider of moderate sedation or deep sedation/general anesthesia.

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

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

18VAC60-21-165. Delegation to digital scan technicians for use in teledentistry.

A. A dentist who delegates the taking of a digital scan by a digital scan technician shall ensure that the technician has a certificate of completion from a training program approved by the board that includes:

1. Training in prepping the patient, taking and evaluating the quality of a digital scan, safety protocols, and dental terminology given by a sponsor approved for continuing education as set forth in subsection C of 18VAC60-21-250; and

2. In-office training by the manufacturer on the proper operation of the digital scanner that includes orientation to the process and protocols for taking and evaluating digital scans for fabrication of a restoration or an appliance.

B. The dentist who directs a digital scan technician to take digital scans shall establish:

1. Written or electronic protocols for the practice of teledentistry in compliance with subsections B and C of § 54.1-2711 of the Code of Virginia;

2. Written or electronic protocols and procedures for the performance of digital scans by digital scan technicians in compliance with subsection B of §54.1-2708.5 of the Code of Virginia; and

3. A written or electronic work order for a digital scan that includes required components of a dental work order.

C. The dentist who directs a digital scan technician to take digital scans shall be:

1. Licensed by the board to practice dentistry in the Commonwealth;

2. Accessible and available for communication and consultation with the digital scan technician at all times during the patient interaction; and

3. Ultimately responsible for communicating with the patient or his representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with the Regulations Governing the Practice of Dentistry and the Code of Virginia and for documenting such communication in the patient record.

D. The directing dentist shall make available to the board any requested:

1. Protocols and procedures as specified in subsection B of this section;

2. Evidence that the digital scan technician has complied with the training requirements of subsection A of this section; and

3. Written or electronic work orders used in reliance on digital scans.

Virginia Board of Dentistry

Policy on Auditing Continuing Education and Sanctioning for Failure to Meet the Requirements

Excerpts of Applicable Law and ~~,~~ Regulation ~~and Guidance~~

- The Board shall promulgate regulations requiring continuing education (CE) for any dental license or reinstatement and may grant extensions or exemptions, §54.1-2709.E.
- The Board shall promulgate regulations requiring continuing education for any dental hygiene license or reinstatement and may grant extensions or exemptions, §54.1-2729.
- Dentists and dental hygienists are required to:
  - complete a minimum of 15 hours of approved continuing education18VAC60-21-250.A and 18VAC60-25-190.A and
  - maintain the required documentation of completion for a minimum of four years following each renewal. 18VAC60-21-250.G and 18VAC60-25-190.D.4.
- The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters. A written request with supporting documents must be submitted prior to renewal of the license. 18VAC60-21-250.D and 18VAC60-25-190.E.2.
- Failure to comply with continuing education requirements may subject the licensee to disciplinary action, 18VAC60~~18 VAC 60-20~~-21-250.J~~I~~ and 18VAC60-25-190.D.5.
- ~~Confidential Consent Agreements may be used to address continuing education, Guidance Document: 60-1~~

Extension and Exemption Requests

- The ~~President of the Board~~Executive Director or designee may grant an extension request for up to one year for completion of continuing education upon receipt of a written request with an explanation which is submitted prior to the renewal date.
- The Executive Director or designee ~~President of the Board~~ may grant an exemption request for up to one year for all or part of the required 15 hours upon receipt of a written request with supporting documents which is submitted prior to the renewal date.

~~Initiation of a CE Audit~~

~~After the completion of the April 1st to March 31st renewal cycle in an odd numbered year, the Executive Director shall report to the Board the current operational issues, staffing, and disciplinary caseload for consideration by the Board in deciding the scope of the audit to be conducted that year.~~

Scope of Audits

The Board may ~~shall~~ biennially conduct an audit of compliance with CE requirements on a random sample of licensees selected from MLO by the DHP IT Department. The sample size shall be~~-~~ 1% of the total number of licensees~~determined using both the online Sample Size Calculator by Raosoft (or equivalent algorithm) and the total number of licensees~~. The Board may also audit the following:

- Active licensees who have completed the terms of a CCA or a Board Order which required completion of CE in addition to the 15 hours requirement per year;
- Active licensees who failed to respond, or responded "no", to the CE renewal question on the annual renewal form, and/or requested an exemption after license renewal;
- Active licensees who were granted an extension to meet their CE requirement.

Auditing CE

- Selected licensees will be notified by email to submit the necessary documentation to verify CE completion. A second notice will be sent by USPS if there is no response.
- Documentation submitted to verify CE completion will be reviewed by Board staff for compliance with the regulations.
- ~~Licensees who have met the CE requirements will be sent a thank you letter.~~
- Licensees who have not complied with the audit notification or CE requirements will be referred for possible disciplinary action.

A. Guideline for Offering a Confidential Consent Agreement (CCA)

1. The reviewing Board member or designated staff ~~The Executive Director or designee shall~~may review the documentation received for probable cause and ~~shall~~ may only offer a CCA for a first offense when:
    - there is only one finding of probable cause and that finding is that the licensee is unable to document completion of from 1 to 5 hours of acceptable continuing education (CE).
    - there are findings of probable cause for violations in addition to missing CE consistent with Guidance Document 60-1, Policy on CCAs/Confidential Consent Agreements.
2. The offered CCA ~~shall~~ may include a finding that a violation occurred and ~~shall~~ may request the licensee's agreement to obtain the missing hours within 45 days and to henceforth comply with the CE requirements. The CCA ~~shall~~ may state that the hours obtained pursuant to the CCA ~~shall~~ shall not count toward the next license renewal.

B. Guidelines for Imposing Disciplinary Sanctions

1. In addition to a notice of an informal conference, a licensee ~~shall~~ may be offered a Pre-Hearing Consent Order (PHCO) when the licensee:
    - falsely certified completion of the required CE for license renewal.
    - is unable to document completion of from 1 to 5 hours of acceptable CE in a subsequent audit.
    - is unable to document completion of from 6 to 15 hours of acceptable CE.
2. In cases where there are findings of probable cause for violations in addition to missing CE, a PHCO may be offered with a notice of an informal conference.
3. The following sanctioning guidelines ~~shall~~ may be included in the PHCO:
    a. For falsely certifying completion for renewal – Reprimand and $1000 monetary penalty.
    b. For missing 1 to 5 hours – Subsequent Offenses – Reprimand, obtain the missing hours within 30 days and a $250 monetary penalty for each missing hour.

c. For missing 6 to 15 hours – First offense - Reprimand and obtain the missing hours within 45 days.
d. For missing 6 to 15 hours – Subsequent offenses – Reprimand, obtain the missing hours within 45 days and a $500 monetary penalty for each missing hour.

Virginia Board of Dentistry

Policy on Sanctioning for Failure to Comply with Advertising Guidelines

Excerpts of Applicable Law, Regulation and Guidance on 18VAC60-2120-180 et seq.

- The Board may sanction any licensee for advertisements that are false, deceptive or misleading; contain a claim of superiority or violate regulations, §54.1-2706(7).
- A general dentist who limits his practice shall advertise that he is a general dentist providing only certain services, 18VAC60-21-80.A.
- Any statement specifying a fee for a dental service which does not include the cost of all related procedures, services, and products shall be deemed to be deceptive or misleading, 18VAC60-21-80.B.
- Discount offers for dental services shall include the nondiscounted fee, the discounted fee and the time period for the discount, 18VAC60-20-21.80.C.
- A prerecorded or archived copy of all advertisements shall be retained for two years following the final appearance of the advertisement, 18VAC60-21-80.D.
- Advertising of fees is limited to only routine dental services as set forth in the American Dental Association's "Dental Procedures Codes," ~~"Code on Dental Procedures and Nomenclature."~~ 18VAC60-21-80.E.
- Advertisements, including but not limited to signage, containing descriptions of the type of dentistry practiced or a specific geographic locator are permissible so long as the requirements of §§54.1-2718 and 54.1-2720 of the Code of Virginia are met 18VAC60-21-80.F.

- The following practices shall constitute false, deceptive, or misleading advertising: §54.1-2706(7) and 18VAC60-21-80.G:
  - Publishing an advertisement which contains a material misrepresentation or omission of facts that is likely to cause an ordinarily prudent person to be deceived, 18VAC60-21-80-G.1.
  - Publishing an advertisement which fails to include the information and disclaimers required by this section, 18VAC60-21-80.G.2.
  - Publishing an advertisement which contains a false claim of professional superiority, or uses any term to designate a dental specialty to which he is not entitled, 18VAC60-21-80.G.3.~~4.~~
  - A dentist not entitled to a specialty designation shall not represent that his practice is limited to providing services in a specialty area without disclosing that he is a general dentist, 18VAC60-21-80. G.4~~5~~.
- ~~Advertisements, including but not limited to signage, containing descriptions of the type of dentistry practiced or a specific geographic locator are permissible so long as the requirements of §§54.1-2718 and 54.1-2720 of the Code of Virginia are met.~~
- ~~Confidential Consent Agreements may be used to address advertising guidelines, Guidance Document 60-1.~~

Making a Probable Cause Decision

1. In regards to allegations of false, deceptive and misleading advertisements, the reviewing Board member or ~~staff (the reviewer)~~designated staff ~~shall~~ may consider whether evidence exists that the source of the complaint was actually deceived, misled, etc.
2. In regards to allegations of claims of superiority and the failure to disclose required information, the reviewer ~~shall~~ may not only consider the content of the advertisement but the evidence collected about the development and publication of the advertisement in deciding if there is clear and convincing evidence that the licensee is the responsible party and there is probable cause to believe a violation occurred.

A. Guidelines for sending an Advisory Letter

1. The reviewing Board member or designated staff ~~The reviewer~~ may ~~shall~~ only request an Advisory Letter when there is not clear and convincing evidence to support a finding that a violation of law or regulation has occurred.
2. Advisory letters may be used to close cases when the reviewer decides ~~is concerned~~ that the presenting information indicates that the licensee may be acting in ignorance of the applicable law and regulations.

B. Guidelines for Offering a Confidential Consent Agreement

1. The reviewing Board member or designated staff ~~The reviewer~~ may ~~shall~~ offer a CCA for a first advertising offense and may offer a CCA for subsequent advertising violations, if no other violations exist.
2. In cases where there are findings of probable cause for violations in addition to advertising, the reviewer may offer a CCA consistent with Guidance Document 60-1.
3. The offered CCA ~~shall~~ may include a finding that a violation occurred and ~~shall~~ may request the licensee's agreement to cease and desist advertising in violation of law and regulations.
4. The offered CCA may also include ~~a requirement for passage of the Virginia Dental Law Exam or~~ completion of a continuing education course in ethics.

C. Guidelines for Imposing Disciplinary Sanctions

a. The reviewing Board member or designated staff ~~The reviewer~~ may offer a Pre-Hearing Consent Order (PHCO) or request an informal fact finding conference when probable cause is found that the licensee has subsequent advertising violations.
b. The following sanctioning guidelines may be included in the PHCO~~The reviewer shall consider the following sanctioning guidelines~~:
   a. A $1,000 monetary penalty per violation, a reprimand and successful completion of the Virginia Dental Law Exam for a second offense.
   b. A $5,000 monetary penalty per violation, a reprimand and continuing education in ethics for a third and subsequent offenses.
c. In cases where there are findings of probable cause for violations in addition to advertising the reviewer may offer a PHCO or request an informal fact finding conference.

Guidance document: 60-18 Approved: ~~December 11, 2015~~

VIRGINIA BOARD OF DENTISTRY
APPROVED TEMPLATE FOR DENTAL ~~LABORATORY~~ APPLIANCE WORK ORDER FORMS

This form is provided by the Board to guide dentists on meeting the legal requirements for written or digital work order forms as addressed in §54.1-2719 of the **Code of Virginia**. Dentists have the option of using this form or another form to meet the requirements of the law. Regardless of the form and the format the dentist chooses to use, the information requested below must be included as part of the patient's treatment records and maintained as required by 18VAC60-21-90 of the **Regulations Governing the Practice of Dentistry**.

PATIENT NAME, INITIALS or ID#: _____

Laboratory Owner's or Business Name: _____

Physical Address: _____

_____

E-mail Address ~~(optional)~~: _____

Phone Number: _____

Contact Person: _____

RETURN BY: _____

INSTRUCTIONS FOR WORK TO BE DONE (include diagrams if needed):

_____

_____

_____

_____

_____

_____

TYPE AND QUALITY OF RESTORATION MATERIALS:
(include diagrams if needed)

_____

_____

_____

_____

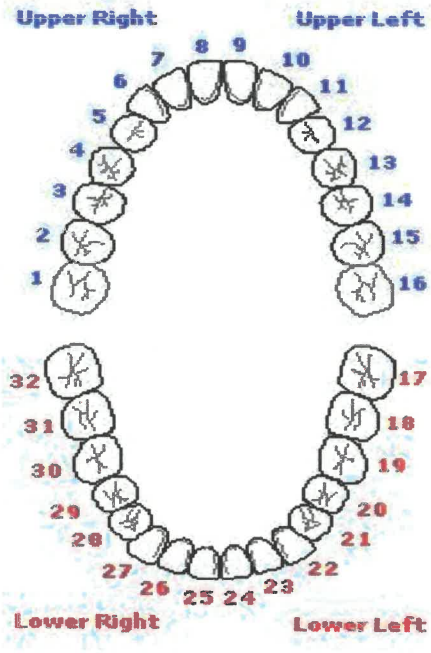
INSTRUCTIONS FOR SHADING:
(include diagrams if needed)

_____

_____

_____

_____



INSTRUCTIONS FOR RETURNING THE RESTORATION:

- Provide the sanitized restoration in a sealed container.
- Provide the name and physical address of the location where the restoration was fabricated.
- Provide a copy of the information the lab received from a manufacturer on the composition of the casting and ceramic materials used in fabrication, such as an Identalloy sticker.

Guidance document: 60-18 Approved: ~~December 11, 2015~~

INSTRUCTIONS ~~FOR~~ REGARDING SUBCONTRACTING THIS ORDER OR PORTIONS OF THIS ORDER

_____ I do not authorize subcontracting this order or any part of this order. Return the order to me if you are unable to complete this order.

_____ Contact me before subcontracting any work for this order.

_____ I authorize subcontracting to a domestic lab.

_____ I authorize subcontracting to an overseas/international lab.

_____ I authorize subcontracting to either a domestic or overseas lab.

NOTICE OF ACTIONS YOU ARE REQUIRED BY LAW TO TAKE WHEN SUBCONTRACTING THIS ORDER OR PORTIONS OF THIS ORDER - §54.1-2719.C of the Code of Virginia

- You must send me, the ordering dentist, a written disclosure of subcontracting this order with the subwork order you issued to the subcontractor.
- The written disclosure must include:
  - The name and address of the person, firm or corporation and subcontractor;
  - A number identifying the subwork order with the original order;
  - The date any subwork order was written;
  - A description of the work to be done and the work to be done by the subcontractor, including diagrams and digital files, if necessary;
  - Specification of the type and quality of material to be used; and
  - The signature of the person issuing the disclosure and subwork order.

Dentist's Signature: _____ Date: _____

Dentist's Name Printed: _____ Dental License # _____

Dentist's Address: _____ Telephone: _____

Dentist's Email Address ~~(optional)~~: _____

Guidance document: 60-19 Approved: ~~December 7, 2012~~
~~Re-adopted: June 8, 2018~~

VIRGINIA BOARD OF DENTISTRY
APPROVED TEMPLATE
DENTAL ~~LABORATORY~~ APPLIANCE SUBCONTRACTOR DISCLOSURE and SUBWORK ORDER FORM

This form is provided by the Board to guide owners of dental laboratories (owners) on meeting the legal requirements for subwork orders ~~forms~~ to be issued to subcontractors as addressed in §54.1-2719 of the **Code of Virginia.** The ~~O~~owners ~~have~~ has the option of using this form or another form to subcontract all or part of a dentist's work order ~~is being subcontracted~~ to another dental laboratory (subcontractor). Regardless of the form and the format the owner chooses to use, the information ~~requested~~ addressed below must be included in the subwork order sent to the subcontractor. The owner is required to retain a copy of the subwork order; to attach the copy of the subwork order to the order received from the dentist; and to maintain both orders for not less than three years.

PATIENT NAME, INITIALS or ID#: _____

Subcontractor Name: _____

Physical Address: _____

_____

E-mail Address ~~(optional)~~: _____

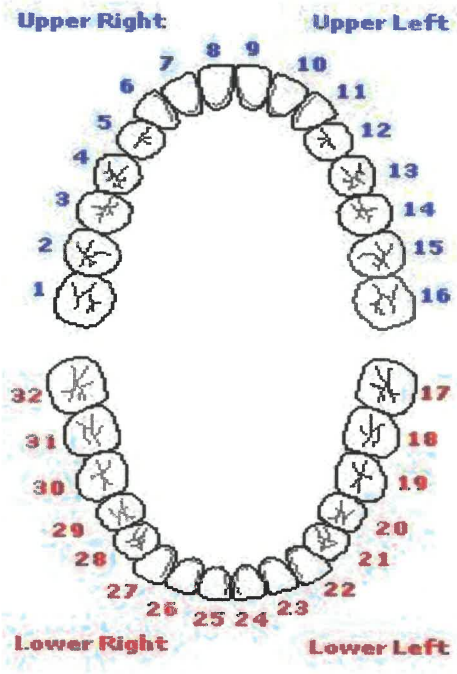
Phone Number: _____

Contact Person: _____

RETURN BY DATE: _____

INSTRUCTIONS FOR WORK TO BE DONE (include diagrams if needed):

_____
_____
_____
_____



_____
TYPE AND QUALITY OF RESTORATION MATERIALS:
(include diagrams if needed)

_____
_____
_____
_____

INSTRUCTIONS FOR SHADING:
(include diagrams if needed)

_____
_____
_____
_____

INSTRUCTIONS FOR RETURNING THE RESTORATION:

- Provide the sanitized restoration in a sealed container.
- Provide the name and physical address of the location where the restoration was fabricated.
- Provide a copy of the information the lab received from a manufacturer on the composition of the casting and ceramic materials used in fabrication, such as an Identalloy sticker.

Signature: _____ Date: _____
Name Printed: _____ Telephone: _____
Address: _____
Email Address ~~(optional)~~: _____

Virginia Board of Dentistry

Policy on Sanctioning for Failure to Comply with Insurance and Billing Practices

Excerpts of Applicable Law and ~~,~~ Regulation ~~and Guidance~~

- The Board may sanction any licensee for any unprofessional conduct likely to defraud or to deceive the public or patients, §54.1-2706(4)
- The Board may sanction any licensee for intentional or negligent conduct in the practice of dentistry or dental hygiene which causes or is likely to cause injury to a patient or patients, §54.1-2706(5)
- The Board may sanction any licensee for conducting his practice in a manner contrary to the standards of ethics of dentistry or dental hygiene, §54.1-2706(10)
- A dentist shall not obtain, attempt to obtain or cooperate with others in obtaining payment for services by misrepresenting procedures performed, dates of service, or status of treatment, 18VAC60-21-60.B.3
- ~~If a disciplinary proceeding will not be instituted, a board may send an Advisory Letter to the subject of a complaint or report, §54.1-2400.2(F)~~
- ~~Confidential Consent Agreements ("CCA's") may be used to address minor or technical violations, Guidance Document 60-1~~

~~—~~Guidelines for Sending an Advisory Letter

1. If a disciplinary proceeding will not be instituted, a board may send an Advisory Letter to the subject of a complaint or report, §54.1-2400.2(F)

1. The reviewing Board member or ~~staff (the "Reviewer") should~~designated staff may only request an Advisory Letter when there is not clear and convincing evidence to support a finding that a violation of law or regulation has occurred.
2. Advisory letters may be used to close cases when the r~~R~~eviewer ~~is~~ determines ~~concerned~~ that the presenting information indicates that the licensee may be acting in ignorance of the applicable law and regulations.

~~—~~Guidelines for Offering a Confidential Consent Agreement

1. The reviewing Board member or designated staff ~~The Reviewer shall~~may offer a CCA for a first offense where there is only one finding of probable cause for fraudulent insurance and/or billing practices.
2. In cases where there are findings of probable cause for violations in addition to a single first offense of fraudulent insurance/billing practice violation, the r~~R~~eviewer may offer a CCA consistent with Guidance Document 60-1.

~~2.~~ 3. The offered CCA ~~shall~~ may include a finding that a violation occurred, ~~shall~~ may request that the licensee cease and desist the fraudulent insurance and/or billing practices, and ~~shall~~ may require continuing education in recordkeeping.

A. Guidelines for Imposing Disciplinary Sanctions

1. The reviewing Board member or designated staff ~~The Reviewer~~ may offer a Pre-Hearing Consent Order ("PHCO") or request an informal fact finding conference when probable cause is found that the licensee has prior insurance and/or billing practice violations:
   a. ~~has prior insurance and/or billing practice violations~~
   b. there were multiple patients affected by the licensee's fraudulent insurance and/or billing practice violations
   ~~1.~~c. there were fraudulent insurance and/or billing practice violations

~~2. The Reviewer may offer a PHCO or request an informal fact finding conference when probable cause is found that there were multiple patients affected by the licensee's fraudulent insurance and/or billing practice violations.~~

~~3. The Reviewer shall offer a PHCO or request an informal fact finding conference when probable cause is found that there were fraudulent insurance and/or billing practice violations.~~

2. The following sanctioning guidelines may be included in the PHCO:

~~4. The Reviewer shall consider the following sanctioning guidelines:~~

   a. A $1,000.00 monetary penalty per violation, and continuing education in recordkeeping and risk management for a second single offense of fraudulent insurance and/or billing practices; or a first offense where there were multiple patients affected by the fraudulent insurance and/or billing practices
   b. A $5,000.00 monetary penalty per violation, a reprimand and continuing education in ethics for a third offense of fraudulent insurance and/or billing practices.

~~a. A $1,000.00 monetary penalty per violation, and continuing education in recordkeeping and risk management for a second single offense of fraudulent insurance and/or billing practices; or a first offense where there were multiple patients affected by the fraudulent insurance and/or billing practices~~

~~b. A $5,000.00 monetary penalty per violation, a reprimand and continuing education in ethics for a third offense of fraudulent insurance and/or billing practices.~~

~~5.~~3. In cases where there are findings of probable cause for violations in addition to fraudulent insurance and/or billing violations, the Reviewer may offer a PHCO or request an informal fact finding conference.

Virginia Board of Dentistry
Policy on
DENTAL CLINICAL COMPETENCY EXAMINATION
REQUIREMENTS FOR LICENSURE

Notice of Policies on Acceptable Clinical Examinations Effective January 1, 2023

Effective January 1, 2023, the Board will only accept from applicants who apply for licensure by examination, the **ADEX Exam**, for dental applicants. This policy applies to all examinations completed in calendar year 2023 and thereafter, regardless of the dates portions of the examination were taken.

Effective January 1, 2023, the Board will only accept from dental applicants who apply for licensure by credentials, a Clinical Competency Exam that is substantially equivalent to the required clinical exam components. This policy applies to all examinations completed regardless of the date or dates an examination was taken.

Acceptable Clinical Examinations Effective March 19, 2021

Definitions to Applied Terms

- "**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.

Dental Applications by Examination

Every candidate who examines with CDCA, CITA, CRDTS, SRTA, or WREB shall pass **each** individual component listed below with only conjunctive scoring (not compensatory scoring) with a **minimum passing score of 75%** for each of the following required components ~~of the ADEX~~ for an exam to be accepted by the Board:

- **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.

Dental Applications by Credentials

The Board will only accept from dental applicants who apply for licensure by credentials, a Clinical Competency Exam that is substantially equivalent to the required clinical exam components for licensure by examination (includes CDCA, CITA, CRDTS, SRTA, and WREB). Every candidate shall pass **each** individual component with only conjunctive scoring (not compensatory scoring) with a **minimum passing score of 75%** for each of the following required components for an exam to be accepted by the Board:

- **Diagnostic Skills Examination** (ADEX = CDCA and CITA) or **Comprehensive Treatment Planning** (WREB). Based on review of the respective 2021 Candidate Examination Guides, **SRTA and CRDTS** do not have an exam component that is substantially 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.
- Every candidate shall 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. 18VAC60-21-210.B.4

*~~***Based on review of the 2021 Candidate Examination Guides***~~

Acceptable Score Cards and Reports for Dental Licensure

- An original and detailed score card or report is required 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. The original and detailed score card or report must be mailed to the Board. Or, the applicant must contact the testing agency to request that the test results be made available to the Virginia Board of Dentistry via online access portal. For WREB you must request an IPR detailed report. The Board does not accept certificates or Canadian exams.

- Score cards shall show conjunctive scoring of the required clinical competency exam components. The score cards must show a pass (equivalent to at least a score of 75%) or a fail.

- Applicants shall submit score cards for each attempt of a clinical competency exam. If an applicant has failed any clinical competency exam, a score card is still required to be submitted. The applicant shall notify the Board of all previously failed attempts of any 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 clinical continuing education as evidence of continuing competence 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. 18VAC60-21-210 (B) (4)

Excerpts of Applicable Laws and Regulations Addressing Clinical Examinations

- **Dental Applicants**
  - "An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant . . . has successfully completed a clinical examination acceptable to the Board." Va. Code §54.1-2709(B)(iv).

  - "The Board may grant a license to practice dentistry to an applicant licensed to practice in another jurisdiction if he . . . meets the requirements of subsection B." Va. Code §54.1-2709(C)(i).

  - Dental licensure by examination. All applicants for licensure by examination shall have:
    Passed a dental clinical competency examination that is accepted by the board. 18VAC60-21-210(A)(1)(b).

  - Dental licensure by credentials. All applicants for licensure by credentials shall: have successfully completed a clinical competency examination acceptable to the board. 18VAC60-21-210(B)(2).

Virginia Board of Dentistry
Policy on
DENTAL HYGIENE CLINICAL COMPETENCY EXAMINATION
REQUIREMENTS FOR LICENSURE

Notice of Policies on Acceptable Clinical Examinations Effective January 1, 2023

Effective January 1, 2023, the Board will only accept from applicants who apply for licensure by examination, the **ADEX** Exam, for dental hygiene applicants. This policy applies to all examinations completed in calendar year 2023 and thereafter, regardless of the dates portions of the examination were taken.

Effective January 1, 2023, the Board will only accept from dental hygiene applicants who apply for licensure by credentials, a Clinical Competency Exam that is substantially equivalent to the required clinical exam components. This policy applies to all examinations completed regardless of the date or dates an examination was taken.

Acceptable Clinical Examinations Effective March 19, 2021

Definitions to Applied Terms

- "**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.

Dental Hygiene Applications by Examination

Every candidate who examines with CDCA, CITA, CRDTS, SRTA, or WREB shall pass each individual component listed below with only conjunctive scoring (not compensatory scoring) and a minimum passing score of 75% for each of the following required components ~~of the ADEX~~ for an exam to be accepted by the Board:

- **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.

Dental Hygiene Applications by Credentials

The Board will only accept from dental hygiene applicants who apply for licensure by credentials, a Clinical Competency Exam that is substantially equivalent to the required clinical exam components for licensure by examination (includes CDCA, CITA, CRDTS, SRTA and WREB). Every candidate shall pass each individual component with only conjunctive scoring (not compensatory scoring) and a minimum passing score of 75% for each of the following required components for an exam to be accepted by the Board:

- **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.
- 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. 18VAC60-25-150.2

Acceptable Score Cards and Reports for Dental and Dental Hygiene Licensure

- An original and detailed score card or report is required 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. The original and detailed score card or report must be mailed to the Board. Or, the applicant must contact the testing agency to request that the test results be made available to the Virginia Board of Dentistry via online access portal. For WREB you must request an IPR detailed report. The Board does not accept certificates or Canadian exams.

- Score cards shall show conjunctive scoring of the required clinical competency exam components. The score cards must show a pass (equivalent to at least a score of 75%) or a fail.

- Applicants shall submit score cards for each attempt of a clinical competency exam. If an applicant has failed any clinical competency exam, a score card is still required to be submitted. The applicant shall notify the Board of all previously failed attempts of any 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 clinical continuing education as evidence of continuing competence that meets the requirements of 18VAC60-25-190 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. 18VAC60-25-140.C.

Excerpts of Applicable Laws and Regulations Addressing Clinical Examinations

- **Dental Hygiene Applicants**
  - An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant has successfully completed a clinical examination acceptable to the Board. §54.1-2722.B (iv)
  - The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he meets other qualifications as determined in regulations promulgated by the Board. §54.1-2722. C (iv)
  - An applicant for dental hygiene licensure by credentials shall~~: 4.~~ have successfully completed a clinical competency examination substantially equivalent to that required for licensure by examination. 18VAC60-25-150.4

CONSIDERATION OF PUBLIC COMMENT

Virginia Department of Health Professions

2022 BOARD OF DENTISTRY CALENDAR

FORMAL HEARINGS:

MARCH 17
JUNE 9
SEPTEMBER 8
DECEMBER 1

BOARD BUSINESS MEETINGS:

MARCH 18
JUNE 10
SEPTEMBER 9
DECEMBER 2

TENTATIVE DATES TO HOLD:

FEB 18
MAY 20
OCTOBER 14

SCC - A JAN 31; MAR 7; APRIL 11; MAY 16; JUNE 27; AUGUST 1; SEP 19; OCT 24; DEC 12

SCC - B JAN 7; FEB 4; MAR 25; APR 22; MAY 27; JULY 8; AUG 12; SEPT 23; NOV 4; DEC 16

SCC - C JAN 21; FEB 25; APR 1; MAY 13; JUNE 17; JUL 22; AUG 26; OCT 7; NOV 18

JANUARY

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DECEMBER

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DISCUSSION TOPIC

May a dentist allow a dental assistant I or II to use a scaler to remove cement from the coronal surface of teeth?

EXCERPTS FROM THE REGULATIONS GOVERNING THE PRACTICE OF DENTISTRY

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

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

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

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

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

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

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

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

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

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

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

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

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

2. Performing an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets, or other abnormal conditions for assisting the dentist in the diagnosis.

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

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

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

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

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

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

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

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

18VAC60-21-150. Delegation to dental assistants II.

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

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.

18VAC60-21-160. Delegation to dental assistants I and II.

A. Duties appropriate to the training and experience of the dental assistant and the practice of the supervising dentist may be delegated to a dental assistant I or II under indirect supervision, with the exception of those listed as nondelegable in 18VAC60-21-130, those which may only be delegated to dental hygienists as listed in 18VAC60-21-140, and those which may only be delegated to a dental assistant II as listed in 18VAC60-21-150.

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

VIRGINIA BOARD OF DENTISTRY
DELEGATION TO DENTAL ASSISTANTS

DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS I AND II UNDER INDIRECT SUPERVISION OF A DENTIST
GENERAL SERVICES
Prepare patients for treatment/seating/positioning chair/placing napkin
Perform health assessment
Preventive education and oral hygiene instruction
Perform mouth mirror inspection of the oral cavity
Chart existing restorations and conditions as instructed by the dentist
Take, record and monitor vital signs
Transfer dental instruments
Prepare procedural trays/armamentaria set-ups
Maintain emergency kit
Sterilization and disinfection procedures
Compliance with OSHA Regulations and Centers for Disease Control Guidelines
Prep lab forms for signature by the dentist
Maintenance of dental equipment
Select and manipulate gypsums and waxes
RADIOLOGY and IMAGING
Mount and label images
Place x-ray film and expose radiographs **ONLY WITH REQUIRED TRAINING**
Use intraoral camera or scanner to take images for tooth preparation and CAD CAM restorations
RESTORATIVE SERVICES
Provide pre- and post operative instructions
Place and remove dental dam
Maintain field of operation through use of retraction, suction, irrigation, drying
Acid Etch - Apply/wash/dry remove only when reversible
Amalgam: Place only
Amalgam: Polish only with slow-speed handpiece and prophy cup
Apply pit and fissure sealants
Apply and cure primer and bonding agents
Fabricate, cement, and remove temporary crowns/restorations
Make impressions and pour and trim study/diagnostic models and opposing models
Make impressions for athletic/night/occlusal/snore mouthguards and fluoride/bleaching trays
Matrices - place and remove
Measure instrument length
Remove excess cement from coronal surfaces of teeth
Remove sutures
Dry canals with paper points
Mix dental materials
Place and remove post-extraction dressings/monitor bleeding
Rubber Dams: Place and remove
Sterilization and disinfection procedures
Take bite and occlusal registrations
HYGIENE
Apply dentin desensitizing solutions
Apply fluoride varnish, gels, foams and agents
Apply pit and fissure sealant
Address risks of tobacco use
Give oral hygiene instruction
Polish coronal portion of teeth with rotary hand piece and rubber prophy cup or brush
Place and remove periodontal dressings
Clean and polish removable appliances and prostheses

VIRGINIA BOARD OF DENTISTRY
DELEGATION TO DENTAL ASSISTANTS

DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS I AND II UNDER INDIRECT SUPERVISION OF A DENTIST CONTINUED
ORTHODONTICS
Place and remove elastic separators
Check for loose bands and brackets
Remove arch wires and ligature ties
Place ligatures to tie in archwire
Select and fit bands and brackets for cementation by dentist
Instruct patients in placement and removal of retainers and appliances after dentist has fitted and made adjustments in the mouth
Take impressions and make study models for orthodontic treatment and retainers
BLEACHING
Take impressions and fabricate bleaching trays
Apply bleach/whitener
Bleach with light but not laser
Instruct pt on bleaching procedures
SEDATION AND ANESTHESIA SERVICES
Apply topical Schedule VI anesthetic
Monitor patient under nitrous oxide
Monitor patient under minimal sedation/anxiolysis
Monitor patient under moderate/conscious sedation ONLY WITH REQUIRED TRAINING
Monitor patient under deep sedation/general anesthesia ONLY WITH REQUIRED TRAINING
Take blood pressure, pulse and temperature
DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS I AND II UNDER INDIRECT SUPERVISION OF A DENTAL HYGIENIST
Prepare patients for treatment/seating/positioning chair/placing napkin
Perform health assessment
Preventive education and oral hygiene instruction
Transfer dental instruments
Prepare procedural trays/armamentaria set-ups
Maintain emergency kit
Sterilization and disinfection procedures
Compliance with OSHA Regulations and Centers for Disease Control Guidelines
Maintenance of dental equipment
Polish coronal portion of teeth with rotary hand piece and rubber prophy cup or brush
Place and remove periodontal dressings
Clean and polish removable appliances and prostheses
Mount and label images
Place x-ray film and expose radiographs ONLY WITH REQUIRED TRAINING
DUTIES THAT MAY ONLY BE DELEGATED TO DENTAL ASSISTANTS II UNDER DIRECT SUPERVISION OF A DENTIST
Condense/pack and carve amalgam
Place, cure and finish composite resin restorations only with slow-speed handpiece
Apply base and cavity liners/perform pulp capping procedures
Final cementation of crowns and bridges after adjustment and fitting by the dentist
Make final impressions and fabricate master casts
Place and remove non-epinephrine retraction cord

Sandra Reen

Subject: New dental school opening 2023 at High Point University

From: Dag Zapatero <dag.zapatero@verizon.net>
Sent: Monday, May 10, 2021 3:40 PM
To: Sandra Reen <sandra.reen@dhp.virginia.gov>
Cc: Sacksteder, Jamie <jamie.sacksteder@dhp.virginia.gov>; " cmspatafore@vcu.edu " <cmspatafore@vcu.edu>
Subject: New dental school opening 2023 at High Point University

Greeting Sandy,

A new $150 million private dental school is coming to High Point University in North Carolina. It will probably cater to international and more affluent students who can afford the higher cost of a private education. The new Dean is Scott De Rossi, who stepped down as Dean from UNC last fall. Thirty-six students in year one ramping up to forty-five student at full capacity.
https://www.highpoint.edu/blog/2021/05/hpu-announces-new-dentistry-school-dean-facility-and-hundreds-of-new-jobs/

It is already a challenge finding and retaining qualified dental instructors at any SOD in the country. The addition of a new school in our region will only put pressure upwards on a frail system. VCU is already having difficulty attracting and retaining qualified faculty because of Virginia's current regulatory codes, which require instructors to only come from a pool of CODA-accredited programs. That means that potential faculty who graduated from US SOD with degrees in operative dentistry, implantology, or sleep medicine would not be an acceptable instructor candidate under our current licensing requirements.

My NC instructor's license allows me to teach and treat patients under the auspices of UNC SOD while my Dean's appointment remains in place. At any time, the Dean could rescind my appointment and disclose that information to the NC BOD, thus voiding my instructor's license. This power would apply the Deans from any dental schools in North Carolina, including UNC, ECU, and now HPU.

I feel we must give VCU's interim Dean Spatafore the same powers to hire and retain faculty to remain competitive and provide the necessary education for our dental students. The current regulations are antiquated and immediate action is required to address the deficiency as a matter of public safety concerns to the citizenry that we serve.

I hope this email will foster some dialog between the BOD and VCU SOD and foster. I'd appreciate it if my comments were shared with all fellow board members to see if others share my concerns.

Respectfully,
Dag Zapatero

Best,
Dag Zapatero

Thanks Dag for initiating this discussion
We are now at a crisis level in dental education. One source of faculty are foreign trained dentists that would be closely vetted by the teaching institution.
VA licensing requirements currently restrict these applicants from applying for faculty positions, in fact it further narrows an already slim pool of qualified applicants.

I would love to have a dialogue with the Board, or propose a slight change to the faculty license requirement, removing the "CODA approved" dental school language.
That would open the door to qualified applicants that would be vetted by the search committees, and screened by the Dean prior to approval.

Let me know how you would like to proceed

Clara M. Spatafore DDS MS
Diplomate American Board of Endodontics
Interim Dean VCU School of Dentistry
Chair Department of Endodontics and Oral Diagnostic Sciences

Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 27. Dentistry
Article 2. Licensure of Dentists

§ 54.1-2713. Licenses to teach dentistry; renewals

A. Upon payment of the prescribed fee and provided that no grounds exist to deny licensure pursuant to § 54.1-2706, the Board may grant, without examination, a faculty license to teach dentistry in a dental program accredited by the Commission on Dental Accreditation of the American Dental Association to any applicant who meets one of the following qualifications:

1. Is a graduate of a dental school or college or the dental department of an institution of higher education, has a current unrestricted license to practice dentistry in at least one other United States jurisdiction, and has never been licensed to practice dentistry in the Commonwealth; or

2. Is a graduate of a dental school or college or the dental department of an institution of higher education, has completed an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association, and has never been licensed to practice dentistry in the Commonwealth.

B. The dean or program director of the accredited dental program shall provide to the Board verification that the applicant is being hired by the program and shall include an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.

C. The holder of a license issued pursuant to this section shall be entitled to perform all activities that a person licensed to practice dentistry would be entitled to perform and that are part of his faculty duties, including all patient care activities associated with teaching, research, and the delivery of patient care, which take place only within educational facilities owned or operated by or affiliated with the dental school or program. A licensee who is qualified based on educational requirements for a specialty board certification shall only practice in the specialty for which he is qualified. A license issued pursuant to this section shall not authorize the holder to practice dentistry in nonaffiliated clinics or in private practice settings.

D. Any license issued under this section shall expire on June 30 of the second year after its issuance or shall terminate when the licensee leaves employment at the accredited dental program. Such license may be renewed annually thereafter as long as the accredited program certifies to the licensee's continuing employment.

1975, c. 479, § 54-175.1; 1976, c. 327; 1988, c. 765; 2005, cc. 505, 587;2012, cc. 20, 116.

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

Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 27. Dentistry
Article 2. Licensure of Dentists

§ 54.1-2714. Restricted licenses to teach dentistry for foreign dentists

A. The Board may grant, without examination, a restricted license for a temporary appointment to teach dentistry at a dental school in this Commonwealth to any person who:

1. Is a resident of a foreign country;

2. Is licensed to practice dentistry in a foreign country;

3. Holds a faculty appointment in a dental school in a foreign country;

4. Is a graduate of a foreign dental school or college or the dental department of a foreign institution of higher education;

5. Is not licensed to practice dentistry in Virginia;

6. Has not failed an examination for a license to practice dentistry in this Commonwealth;

7. Has received a temporary appointment to the faculty of a dental school in this Commonwealth to teach dentistry;

8. Is, in the opinion of the Board, qualified to teach dentistry; and

9. Submits a completed application, the supporting documents the Board deems necessary to determine his qualifications, and the prescribed fee.

B. A restricted license shall entitle the licensee to perform all operations which a person licensed to practice dentistry may perform but only for the purpose of teaching. No person granted a restricted license shall practice dentistry intramurally or privately or receive fees for his services.

C. A restricted license granted pursuant to this section shall expire 24 months from the date of issuance and may not be renewed or reissued.

1977, c. 349, § 54-175.2; 1988, c. 765; 2012, cc. 20, 116.

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

Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 27. Dentistry
Article 2. Licensure of Dentists

§ 54.1-2715. Temporary permits for certain clinicians

A. The Board may issue a temporary permit to a graduate of a dental school or college or the dental department of an institution of higher education, who (i) has a D.D.S. or D.M.D. degree and is otherwise qualified, (ii) is not licensed to practice dentistry in Virginia, and (iii) has not failed an examination for a license to practice dentistry in the Commonwealth. Such temporary permits may be issued only to those eligible graduates who serve as clinicians in dental clinics operated by (a) the Virginia Department of Corrections, (b) the Virginia Department of Health, (c) the Virginia Department of Behavioral Health and Developmental Services, or (d) a Virginia charitable corporation granted tax-exempt status under § 501(c)(3) of the Internal Revenue Code and operating as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services: (i) as a federal qualified health center designated by the Centers for Medicare and Medicaid Services or (ii) at a reduced or sliding fee scale or without charge.

B. Applicants for temporary permits shall be certified to the executive director of the Board by the Director of the Department of Corrections, the Commissioner of Health, the Commissioner of Behavioral Health and Developmental Services, or the chief executive officer of a Virginia charitable corporation identified in subsection A. The holder of such a temporary permit shall not be entitled to receive any fee or other compensation other than salary. Such permits shall be valid for no more than two years and shall expire on the June 30 of the second year after their issuance, or shall terminate when the holder ceases to serve as a clinician with the certifying agency or charitable corporation. Such permits may be reissued annually or may be revoked at any time for cause. Reissuance or revocation of a temporary permit is in the discretion of the Board.

C. Dentists licensed pursuant to this chapter may practice as employees of the dental clinics operated as specified in subsection A.

Code 1950, § 54-152; 1968, c. 604; 1970, c. 639; 1972, c. 805; 1975, c. 479; 1976, c. 327; 1985, c. 373; 1988, c. 765; 2002, c. 549;2004, c. 48;2005, cc. 505, 587;2006, c. 176;2009, cc. 813, 840.

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

Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 27. Dentistry
Article 3. Licensure of Dental Hygienists

§ 54.1-2725. Faculty licenses to teach dental hygiene; renewals

A. Upon payment of the prescribed fee, the Board shall grant, without examination, a license to teach dental hygiene to any applicant who (i) is a graduate of a dental hygiene school or college or the dental hygiene department of an institution of higher education accredited by the Commission of Dental Accreditation of the American Dental Association; (ii) has a B.S., B.A., A.B., or M.S. degree and is otherwise qualified; (iii) is not licensed to practice dental hygiene; and (iv) has a license to practice dental hygiene in at least one other United States jurisdiction.

B. The dean or program director of the accredited dental hygiene program shall provide to the Board verification that the applicant is being hired by the program and shall include an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.

C. The holder of a license issued pursuant to this section shall be entitled to perform all activities that a person licensed to practice dental hygiene would be entitled to perform that are part of his faculty duties, including all patient care activities associated with teaching, research, and the delivery of patient care that take place only within educational facilities owned or operated by or affiliated with the dental school or program. A license issued pursuant to this section does not entitle the holder to practice dental hygiene in nonaffiliated clinics or other private practice settings.

D. Any license issued under this section shall expire on June 30 of the second year after its issuance or shall terminate when the licensee leaves employment at the accredited dental program. Such license may be renewed annually thereafter as long as the accredited program certifies to the licensee's continuing employment.

1975, c. 479, § 54-175.1; 1976, c. 327; 1988, c. 765; 2012, cc. 20, 116.

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

Virginia Department of
Health Professions
Board of Dentistry

Disciplinary Board Report

Today's report reviews the January –May 2021 case activity.

The table below includes all cases that have received Board action since January 1, 2021 through May 31, 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
March	31	45	4	49
April	52	24	6	30
May	30	37	3	40
TOTALS	**182**	**154**	**27**	**181**

Closed Case with Violations consisted of the following:

Patient Care Related:

- **24 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.

Non-Patient Care Related:

- **1 Fraud Non-Patient Care Related**: improper patient billing, mishandling of pre-need funds, fee splitting, and falsification of licensing/renewal documents

CCA's

There were **3** CCA's issued from January 1, 2021 to May 31, 2021. The CCA's issued consisted of the following violations:

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

Virginia Department of
Health Professions
Board of Dentistry

Disciplinary Board Report

Suspensions/Revocations

There have been **2** Suspensions and **1** Summary Suspension issued from January 1, 2021 to May 31, 2021.

- **2 Suspensions for Inability to Safely Practice**
- **1 Summary Suspension for Inability to Safely Practice**

Response to Regulatory-Legislative Committee Motion on October 23, 2020

Motion: 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 it 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. Catching explained that information on drugs used, the quantity administered, and other information in case records are not being tracked. She said having the information in aggregate form would assist in future cases and in developing policies. Ms. Reen explained that 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.

Board Findings: Currently deaths associated with sedation and anesthesia are tracked in MLO since 3/2/2016. Since there has been 2 deaths association with sedation since 2016, it is easy for staff to look up the individual cases. However, the information on what drugs that were used and quantity administered is not tracked but can be found easily within the case information. Also, it would seem that type of drugs used and the quantity used would be on an individual basis depending on height, weight, and BMI of the patient. Therefore, it would not be useful to inform the Board on future policy decisions, since it would be individualized and not universal.

IMMEDIATE RELEASE

DOD Receives Approval for Grants to Develop Interstate Compacts for Licensure Portability

MARCH 15, 2021

The Department of Defense announced Friday the approval of a series of grants that will help military spouses with the issue of professional license portability.

Through a cooperative agreement with the Council of State Governments, grants will allow selected professions to work with CSG's National Center for Interstate Compacts to develop model interstate occupational licensure compact legislation, addressing license portability affecting transitioning military spouses, along with other practitioners in the profession.

The five selected professions are teaching, social work, cosmetology, massage therapy, and dentistry/dental hygiene.

This is the first time the department has provided this kind of grant.

"The department views the selection of these professions as a significant milestone in achieving the long-term goal of providing license portability for military spouses," Lernes J. Hebert, performing the duties of the assistant secretary of defense for manpower and reserve affairs, said Friday to the Senate Armed Services Committee staff at their staffer day presentation. "We look forward to working with the National Center for Interstate Compacts and the selected professions on the completion of compacts for these professions."

Today's announcement is the first installment of the cooperative agreement authorized by10 U.S.C. 1784, a bill that addresses the burden associated with relicensing by assisting professions interested in developing interstate licensing compacts except that the organizations overseeing these professions lack the resources necessary to engage in the process. Medicine, nursing, physical therapy, psychology, emergency medical services,

audiology/speech-language pathology, licensed professional counseling and occupational therapy are professions that have successfully developed interstate licensing compact prior to the cooperative agreement grant process.

Reducing the burden associated with the occupational relicensing of military spouses is a priority for the department. The annual percent of the military spouse population that moves across state lines is 14.5% — compared to 1.1% for civilian spouses. As much as 34% of military spouses in the labor force are required to be fully licensed; and of those spouses, 19% experience challenges maintaining their licenses.

Military spouses can call Military OneSource at 800-342-9647 to speak with a Spouse Education and Career Opportunities career coach to learn about free tools and resources to help them achieve their education and career goals.

About the Department of Defense-State Liaison Office

The Department of Defense-State Liaison Office engages state policymakers on the needs of military members and their families. Currently, efforts focus on 10 key issues (as approved by the assistant secretary of defense for Manpower and Reserve Affairs), which promote the well-being of service members and their families. The DSLO is the department's point of contact for the cooperative agreement with Council of State Governments.

About Spouse Education and Career Opportunities

The Defense Department established the Spouse Education and Career Opportunities program to provide education and career guidance to military spouses worldwide, offering free comprehensive resources and tools related to career exploration, education, training and licensing, employment readiness and career connections. This program also offers free career coaching services six days a week.

About Military OneSource

Military OneSource is a DOD-funded program that is both a call center and a website providing comprehensive information, resources and assistance on every aspect of military life. Service members and the families of active duty, National Guard, and reserve

(regardless of activation status), Coast Guard members when activated for the Navy, DOD expeditionary civilians, and survivors are eligible for Military OneSource services, which are available worldwide 24 hours a day, seven days a week, at no cost to the user.

WREB
A National Dental and Dental Hygiene Testing Agency

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May 5, 2021

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
Perimeter Center
9960 Mayland Dr. #300
Richmond, VA 23233-1463

Dear Ms. Reen,

I am writing in follow up to a recent conversation between WREB's counsel, Jack Bierig, and James Rutkowski, counsel for the Board of Dentistry.

In their conversation Mr. Bierig explained that WREB will be moving for reconsideration of the decision by the Board to cease accepting WREB examinations for the licensure of dentists and dental hygienists in the Commonwealth effective January 1, 2023. He noted that the decision of the Board seems to have been based on two considerations: (1) A perception that the WREB exam and scoring system for dental licensure are not to the satisfaction of the Board; and (2) A feeling that, although the WREB dental hygiene licensure exam is currently acceptable to the Board, as a non-member of WREB, the Board will have no say over any changes in the dental or dental hygiene exams and will not even know about those changes until after they are made.

With respect to the first of these concerns, WREB respectfully submits that the Board's current evaluation of our dental licensure exam is based on a misperception of that exam. In that connection, we would point out that the consultant whom the Board selected to evaluate the WREB exam is compensated by ADEX, our principal competitor, and therefore had a clear conflict of interest. But even apart from that conflict, we believe that the Board does not have an accurate picture of our exam and scoring system. We respectfully submit that it would be in the interests of dentists and patients in the Commonwealth if the Board were to make its decision based on a correct understanding, both licensure exam and the scoring system.

Therefore, I am requesting on behalf of WREB a meeting between appropriate representatives of the Board and representatives of WREB. In that meeting, WREB can explain our exam and scoring system, listen to the concerns that the Board has about the exam, and work with the Board to accommodate any concerns that the Board may have. Such a meeting might take two or three hours. It could be in Richmond, by electronic means, or any other location of the Board's choosing. We hope that, at this time, the Board will see fit to hold a substantive meeting with us to discuss our exam and explore how we can provide what the Board wants.

With respect to the concern about non-membership in WREB, I am hereby extending an invitation to the Board to become a member of WREB. In extending this invitation, I understand that Mr. Rutkowski has advised that it would create a conflict of interest if the Board were to belong to more than one testing agency. We must respectfully question that advice. Indeed, WREB has several State Board members that are members of more than one testing agency. Apparently, those Boards do not see membership in more than one testing agency as a conflict of interest.

In our experience, membership by a Board in more than one testing agency has never created a problem either for the Board or any agency. Please see the attached chart indicating what states are currently members of the various testing agencies. We would welcome Virginia Dental Board members to join WREB and participate in test construction and administration. And our legal counsel, Mr. Bierig, would be pleased to discuss the conflict-of-interest issue with Mr. Rutkowski.

WREB would very much like to resolve these issues amicably. Please feel free to reach out to me at bcole@wreb.org or 623-209-5411 if you would like to discuss these matters. Thanks for the Board's consideration of our request for a meet and invitation to become a member of WREB.

Sincerely,

Beth Cole
Chief Executive Officer

Cc: James Rutkowski, Jack Bierig

Member States of Testing Agencies

	CDCA	CITA	CRDTS	SRTA	WREB
Alabama		x	x	x	
Alaska					x
Arizona	x				x
Arkansas	x	x	x	x	x
California			x		x*
Colorado					x
Commonwealth of Jamaica	x				
Connecticut	x				
Delaware					
District of Columbia	x				
Florida	x				
Georgia			x		
Hawaii	x		x		x**
Idaho					x
Illinios	x		x		x
Indiana	x				x
Iowa			x		x
Kansas	x		x		x
Kentucky	x				
Louisiana		x			
Maine	x				
Maryland	x				
Massachusetts	x				
Michigan	x				
Minnesota	x		x		x
Mississippi	x				
Missouri	x		x		x
Montana					x
Nebraska			x		
Nevada	x				x
New Hampshire	x				
New Jersey	x				
New Mexico	x		x		x
New York	x				
North Carolina		x			
North Dakota			x		x
Ohio	x				
Oklahoma	x		x		x
Oregon	x				x
Pennsylvania	x				
Puerto Rico		x			
Rhode Island	x				
South Carolina		x	x	x	
South Dakota			x		
Tennessee		x		x	
Texas			x		x
US Virgin Islands		x			
Utah	x	x			x
Vermont	x				
Virginia		x			
Washington	x		x		x
West Virginia	x	x	x	x	
Wisconsin	x		x		
Wyoming	x		x		x
* Dental Only					
** Dental Hygiene Only					

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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Virginia Board of Dentistry

May 12, 2021

Ms. Beth Cole, Chief Executive Officer
Western Regional Examining Board
23460 North 19th Avenue, Suite 210
Phoenix, Arizona 85027

Dear Ms. Cole:

I am writing to acknowledge receipt of your May 5, 2021 letter in which you requested a meeting with representatives of the Virginia Board of Dentistry (the Board) and extended an invitation for the Board to become a member of the Western Regional Examining Board. Your request and invitation will be considered by the Board at its June 11, 2021 meeting.

Sincerely,

Sandra K. Reen
Executive Director

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

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character; (ii) is a graduate of an accredited dental school or college, or dental department of a university or college; (iii) has passed all parts of the examination given by the Joint Commission on National Dental Examinations; (iv) has successfully completed a clinical examination acceptable to the Board; and (v) has met other qualifications as determined in regulations promulgated by the Board.