

VIRGINIA BOARD OF DENTISTRY

AGENDA

December 3 and 4, 2009

Department of Health Professions

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

PAGE

December 3, 2009

10:00 a.m. Formal Hearings

December 4, 2009

9:00 a.m. Board Meeting

Call to Order – Dr. Levin, President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

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| • September 10, 2009 Formal Hearing | 1-4 |
| • September 11, 2009 Board Meeting | 5-14 |

DHP Director's Report – Ms. Ryals

Health Practitioners' Monitoring Program – Ms. Wood

Liaison/Committee Reports

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| • BHP – Dr. Zimmet | |
| • AADB Report – Dr. Levin | |
| • SRTA – Dr. Gokli | |
| o Exam Committee Report from Dr. Watkins | 15 |
| • Regulatory/Legislative Committee – Ms. Howard | |

Legislation and Regulation – Ms. Yeatts

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| o Mobile Dental Clinics | |
| o Disciplinary Action Cost Recovery | |
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Board Discussion/Action

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Report on Case Activity – Mr. Heaberlin

50-51

Executive Director's Report/Business – Ms. Reen

- Report on OMS Audits
- Law Exam

Board Counsel Report – Mr. Casway

Service Award – Dr. Levin

Adjourn

**VIRGINIA BOARD OF DENTISTRY
FORMAL HEARINGS
SEPTEMBER 10, 2009**

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:42 a.m. on September 10, 2009 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Meera A. Gokli, D.D.S.

MEMBERS PRESENT: Jacqueline G. Pace, R.D.H.
Paul N. Zimmet, D.D.S.
Myra Howard, Citizen Member
Robert B. Hall, Jr., D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Herbert R. Boyd, III, D.D.S.
Martha C. Cutright, D.D.S.

MEMBERS ABSENT: Misty Mesimer, R.D.H.
Jeffrey Levin, D.D.S.

STAFF PRESENT: Sandra K. Reen., Executive Director
Huong Vu, Administrative Assistant

COUNSEL PRESENT: Howard M. Casway, Senior Assistant Attorney General

OTHERS PRESENT: James E. Schliessmann, Assistant Attorney General
Leigh C. Kiczales, Adjudication Specialist
Melissa H. Custis, Court Reporter, Capitol Reporting, Inc.

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

**Brandi L. Gunter,
R.D.H.
Case No. 125724**

Ms. Gunter appeared without counsel in accordance with a Notice of the Board dated August 7, 2009.

Dr. Gokli admitted into evidence Commonwealth's exhibits 1 through 3.

Dr. Gokli admitted into evidence Respondent's exhibits A and B.

Dr. Gokli swore in the witnesses.

Testifying on behalf of the Commonwealth were Lisa Oliphant, Senior Investigator and Sarah William Jones, Office Manager of Hunting Hills Family Dentistry.

Testifying on behalf of the respondent was her husband, Stephen Gunter.

Ms. Gunter testified on her own behalf.

Closed Meeting:

Ms. Pace moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Ms. Gunter. Additionally, it was moved that Board staff, Sandra Reen, Huong Vu and Board counsel, Howard Casway attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Pace moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

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

Decision:

Dr. Gokli asked Mr. Casway to report the Findings of Fact, Conclusions of Law and Sanctions adopted by the Board.

Dr. Petticolas moved to adopt the Findings of Fact and Conclusions of Law as reported by Mr. Casway and to issue an order stating that Ms. Gunter's license is continued on suspension indefinitely with said suspension stayed contingent upon her continued compliance with the terms of her HPMP Recovery Monitoring Contract. The motion was seconded and passed.

**SECOND FORMAL
HEARING:**

Convened at 11:40 am.

PRESIDING:

Meera A. Gokli, D.D.S.

MEMBERS PRESENT:

Jacqueline G. Pace, R.D.H.
Paul N. Zimmet, D.D.S.
Myra Howard, Citizen Member
Robert B. Hall, Jr., D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Herbert R. Boyd, III, D.D.S.
Martha C. Cutright, D.D.S.

MEMBERS ABSENT:

Misty Mesimer, R.D.H.
Jeffrey Levin, D.D.S.

STAFF PRESENT:

Sandra K. Reen., Executive Director
Huong Vu, Administrative Assistant

COUNSEL PRESENT: Howard M. Casway, Senior Assistant Attorney General

OTHERS PRESENT: James E. Schliessmann, Assistant Attorney General
Gail E. Ross, Adjudication Specialist
Melissa H. Custis, Court Reporter, Capitol Reporting, Inc.

**ESTABLISHMENT OF
A QUORUM:**

With eight members present, a quorum was established.

**Peter Francisco,
D.D.S.
Case No. 125616**

Dr. Francisco appeared with counsel, Robert M. Gallumbeck, in accordance with a Notice of the Board dated August 6, 2009.

Dr. Gokli admitted into evidence Commonwealth's exhibits 1 and 2.

Dr. Gokli admitted into evidence Respondent's exhibits A, B and C.

Dr. Gokli swore in the witnesses.

Testifying on behalf of the Commonwealth were Donald M. Jackson, Department of Health Professions Inspector, Christopher Gilley, Special Agent of Virginia State Police – Wytheville Office, and Marsha Nash, Dental Assistant of Lutz Family Dentistry.

Testifying on behalf of the Respondent was his wife, Elaine Francisco.

Dr. Francisco testified on his on behalf.

Closed Meeting:

Ms. Pace moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Dr. Francisco. Additionally, it was moved that Board staff, Sandra Reen, Huong Vu, and Board counsel, Howard Casway attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Pace moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

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

Decision:

Dr. Gokli asked Mr. Casway to report the Findings of Fact, Conclusions of Law and Sanctions adopted by the Board.

Dr. Zimmet moved to adopt the Findings of Fact and Conclusions of Law as reported by Mr. Casway and to issue an order that Dr. Francisco's

license is continued on suspension indefinitely with said suspension stayed contingent upon his continued compliance with the terms of his HPMP Recovery Monitoring Contract. Further, during the period of stayed suspension, he shall be prohibited from prescribing, administering or dispensing any schedule II through V controlled substances. Upon completion of his Recovery Monitoring Contract, he may petition the Board for modification of this order. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 3:45 p.m.

Jeffrey Levin, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
MINUTES
September 11, 2009**

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:10 A.M. on September 11, 2009 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Meera A. Gokli, D.D.S., President

**BOARD MEMBERS
PRESENT:** Jacqueline G. Pace, R.D.H., Secretary-Treasurer
Herbert R. Boyd, III, D.D.S.
Martha C. Cutright, D.D.S.
Robert B. Hall, Jr. D.D.S.
Myra Howard, Citizen Member
Misty Mesimer, R.D.H.
Augustus A. Petticolas, Jr. D.D.S.
Paul N. Zimmet, D.D.S.

**BOARD MEMBERS
ABSENT:** Jeffrey Levin, D.D.S., Vice President

STAFF PRESENT: Sandra K. Reen, Executive Director for the Board
Emily Wingfield, Deputy Director for the Agency
Alan Heaberlin, Deputy Executive Director for the Board
Huong Vu, Administrative Assistant

OTHERS PRESENT: Howard M. Casway, Senior Assistant Attorney General

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

Dr. Gokli welcomed and introduced two new Board members, Dr. Boyd and Dr. Cutright.

PUBLIC COMMENT: **Ralph L. Howell, D.D.S.**, president of the Virginia Dental Association (VDA), noted that the members of the VDA Board of Directors attended the meeting to see how the Board works. He thanked the board members for the hard work they are doing and stated that the VDA is here to support the Board.

Michele Satterlund of the Virginia Association of Nurse Anesthetists asked the Board to be aware that 65% of all

anesthesias administered in Virginia are administered by nurse anesthetists.

APPROVAL OF MINUTES:

Dr. Gokli asked if the Board members had reviewed the minutes in the agenda package. Dr. Petticolas asked that the minutes for June 11, 2009 be amended to show that he was recused from participation in the first formal hearing. He then moved to accept the minutes of the June 11, 2009 meeting as amended and the June 12, 2009 meeting as presented. The motion was seconded and carried.

DHP DIRECTOR'S REPORT:

DHP Performs. Ms. Wingfield reported that the Board is doing very well in regard to performance measures and thanked the Board members for their continued efforts. She then noted that the number of complaints being received is down so DHP will be taking steps to increase public awareness. She invited any suggestions for improving the disciplinary process.

Ms. Wingfield advised that effective July 1, 2009 the impairment program for practitioners was renamed and restructured. She stated that one significant change in the new Health Practitioner Monitoring Program (HPMP) is that respondents need to have a current license to be in the program. In response to a question she indicated that summary action taken by a board would not result in dismissal but that a final order of suspension or revocation would.

Ms. Reen noted that the Board has asked about having a presentation by HPMP at its December meeting. Ms. Wingfield suggested contacting Peggy Wood, Monitoring Program Manager, to schedule the presentation.

Ms. Wingfield said that DHP is not experiencing the effects of the budget shortfalls such as layoffs like many state agencies and acknowledged that Board members were directly affected by the decision to withhold per diems.

VCU SCHOOL OF DENTISTRY :

Ron Hunt, D.D.S., Dean – R. Hunt thanked the Board for the opportunity to provide an update on the school and gave a presentation on "Change & Innovation in Dental Education at VCU." The topics addressed were:

- Clinical Simulation
- Student-friendly Culture
- Assessment Methods – competency based

- Clinical Curriculum Enhancement – buddy system
- VCU' s Preceptorships in Public Health Clinic – students will be sent out to public clinics for 30 days
- Preceptorship Program – for 4th year dental & dental hygiene students
- Electronic Dental Record – will comes in November 2009
- Digital Radiography
- Continuing Education Offices – ADA Cerp – AGD PACE

Dr. Hunt thanked the Board for their continuing support of the school. Dr. Gokli commented that the program is very impressive and thanked Dr. Hunt for the presentation.

REPORTS:

Board of Health Professions (BHP), Dr. Zimmet said that Ms. Wingfield covered most of the topics addressed by BHP and added that the BHP is studying the practice of polysomnographers for possible licensure. Ms. Wingfield added that a legislative proposal is not being advanced at this time.

AADE. Dr. Gokli reported that the travel request for attendance at the annual meeting in Hawaii was denied so the Board will not be sending anyone. In response to questions, she added that she had sent an appeal to Ms. Ryals, DHP Director, and that the reasons for the denial were the Board's projected deficit and the Governor's directive on curtailing travel.

SRTA. Dr. Gokli reported that she attended the 34th SRTA annual meeting with Ms. Pace in Biloxi, Mississippi. She stated that SRTA continues to operate in the black and has elected a new President, Dr. Tommy Dixon from South Carolina. She indicated that a uniform national exam will be the topic of a meeting to be held in Hawaii. She went on to say that the testing agencies are aligning in competing groups to address this issue. She asked Ms. Pace to talk about the work on the dental hygiene exam.

Ms. Pace reported that "Mobility" was the theme for efforts underway to align the dental hygiene exams given by SRTA and NERB. She went on to note that major changes to both exams were proposed and that SRTA's Board of Directors approved the changes for the 2010 exam cycle and that NERB is expected to act on the proposals at its next meeting.

Executive Committee Meeting. Dr. Gokli reported that the Executive Committee met yesterday and addressed the following issues:

- Amendment of Article III of the Bylaws to reference the Code of Conduct adopted at the June meeting - She requested a motion to amend the Bylaws as proposed. Dr. Hall moved to adopt the amendment. The motion was seconded and passed.
- Recovery of Disciplinary Costs (House Bill No. 2058) - She reported that the NOIRA for these regulations was still under administrative review.
- Standards for Professional Code of Conduct - Dr. Gokli stated that a proposed guidance document will be presented to the Board in December.
- Revenue and Expenditures - Dr. Gokli commented that given the FY09 positive cash balance the Board does not need to work on fee increases at this time and that the Committee will be monitoring budget reports in preparation for addressing the need in the future.

Regulatory/Legislative Committee. Ms. Howard reported that Dr. Levin could not attend this meeting so she would go over the following issues that the Committee addressed in August 2009:

- Dental Assistant Regulations – She reported the proposed regulations are still in administrative review.
- Registration of Mobile Clinics – She stated these regs are also still in administrative review in the Secretary's office. Ms. Yeatts noted they had just moved to the Governor's office.
- Chart on permissible Delegation of Duties – Ms. Howard reported the Committee is developing this chart for release with Dental Assistant II regulations and will be sent out for public comment before it is presented to the Board.
- Draft Guidance Document on Administering and Monitoring – She advised that the Board is recommending the document for adoption as an action item later on the agenda.
- Periodic Review Regulations – She reported the Committee's internal review for identification of possible changes is in progress with a markup of changes to be considered in Parts I, II and III completed and review of Part IV now underway.

Nominating Committee. Ms. Pace reported that the Nominating Committee met yesterday and proposes the

following slate of officers for election as an action item later in the agenda:

Jeffrey Levin, DDS – President

Jacqueline G. Pace, RDH – Vice President, and

Robert B. Hall, Jr., DDS – Secretary/Treasurer.

LEGISLATIVE AND REGULATION:

Petition for Rule-making – Robert J. Haddad. Ms. Yeatts reported that the Board received several public comments. She went on to note that there are 3 requests in the petition that the Board needs to look at individually. She asked the Board to give the rationale for the responses to be given. Dr. Gokli agreed to going over each request and to vote.

- Request # 1 (Eliminate the distinction currently in regulation between conscious sedation & deep sedation) – Dr. Gokli commented that there is no scientific basis for the assumption that even if conscious sedation is the goal deep sedation is likely to result. Ms. Yeatts noted that the anesthesia regulations are currently in review and that addressing all substantive changes at one time would be advisable. Dr. Zimmet moved to deny this request. The motion was seconded and passed.
- Request # 2 (Institute a sedation/anesthesia permit and office inspection process) – Dr. Gokli noted that Oral and Maxillofacial Surgeons (OMS) already have this in place. Ms. Reen added that the Virginia Society of Oral and Maxillofacial Surgeons (VSOM) does peer reviews for its members but that not all OMS are members of the VSOM. Ms. Yeatts stated that the Board would need statutory authority to issue permit. Ms. Yeatts went on to say that most states do require registration. Ms. Howard moved to deny this request because the Board does not have statutory authority. The motion was seconded and passed.
- Request # 3 (establish an Anesthesia Review Committee to evaluate cases) – Mr. Casway stated that the Board uses special conference committees to review cases and further stated that a public forum on cases would likely violate confidentiality requirements. Ms. Howard moved to deny this request because the Board has a process in place for case reviews. The motion was seconded and passed.

Review of Regulatory Actions Chart. Ms. Yeatts reported that the regulations for:

- Registration of Dental Assistants II is still in the administrative review stage of the process.

- Mobile Dental Clinics is at the Governor's office, the stage before issuance for public comment.
- Disciplinary Action Cost Recovery is being reviewed at the Secretary's Office.

Dr. Lynch's Recommendation. Ms. Yeatts stated that Dr. Lynch has requested an amendment to our current law to allow dental hygienists to administer local anesthetic in the presence of a medical doctor if a dentist is not available. She commented that legislation would be needed and that the Board could not advance this request until work on the 2011 Session begins next year. Ms. Reen added that if the Board chooses not to pursue this issue, Dr. Lynch might work with his legislators. Dr. Zimmet moved to deny the request. The motion was seconded and passed.

Proposed Guidance Document on Administering and Monitoring. Ms. Reen reported that this document was requested by licensees following disciplinary action taken by the Board and it has gone through extensive drafting as well as discussions with Board of Nursing, Board of Pharmacy, Board of Medicine, the DHP Chief Deputy and Mr. Casway. Ms. Reen stated that this document reflects the current legal parameters for administration and is advanced by the Regulatory-Legislative Committee for adoption by the Board. Following discussion with members of the audience regarding the practice of nurses, Dr. Zimmet moved to adopt the Guidance Document. The motion was seconded and passed.

Amendment of the Proposed Dental Assistant II Regulation. Ms. Reen reported that she is requesting Board action to amend these regulations before they are released for public comment to comport with the decisions made by the Regulatory-Legislative Committee regarding the duties that might be delegated to DASII as listed in 18VAC60-20-230. She requested that:

- Performing pulp capping procedures be added to this section to limit performance of this duty to DASII, and
- The use of non-epinephrine retraction cord be stricken from the provision for taking final impressions and listed as a separate duty.

Dr. Hall moved to adopt the amendments. The motion was seconded and passed.

BOARD

DISCUSSION/ACTION:

Status of Public Comment. Dr. Gokli stated that this is a new item being added to the agenda so that the Board would have the opportunity to discuss any comment received at the

beginning of the meeting to determine if action is needed or if action is already underway. She then asked for any discussion of the public comment received at the beginning of the meeting. It was agreed by consensus that no action was needed.

ADA Letter on Clinical Licensing Examinations. Ms. Reen advised that this information was provided to assist the board members who are participating in testing to follow the ongoing discussions of clinical examinations.

Summary Action. Mr. Casway discussed the legal considerations and the circumstances that must be addressed when summary action is considered. He cautioned that the decision to take summary action cannot be made based solely on prior bad acts, that present circumstances must be considered, and that the respondent, must at the time the decision is considered, pose a danger to the public health and safety which is supported by clear and convincing evidence. Ms. Reen went over the process for advancing a case for summary action and explained that the decision regarding the action to be taken rests solely with the Board. The respondent's participation in the Health Practitioner's Monitoring Program was also discussed as an important consideration of present danger. Mr. Casway concluded by saying that when a respondent is not in practice it would be difficult to prove substantial danger in most cases.

Auditing CE for Compliance. Ms. Pace proposed that the Board begin periodic auditing of licensees using random samples for checking compliance with continuing education requirements. Ms. Wingfield commented that Dr. Carter with the Board of Health Professions could assist in identifying a statistically relevant sample and further that several boards have programs that could be used to develop a process. Ms. Reen noted that presently the Board only checks CE when licensees appear before a special conference committee. Following discussion, no action was taken.

VDH Inquiry about General Supervision. Ms. Reen requested guidance on the response to be given regarding the Virginia Department of Health's (VDH) inquiry about dental hygiene practice under general supervision. The inquiry was, when a dentist has ordered placement of sealants under general supervision, is a dental hygienist permitted, in the ten month period following the order, to see the patient and place the sealants and then to see the

patient subsequently to assess sealant loss and reapply sealants based on the dental hygienist's assessment. The Board was advised that under current law dental hygienists are not permitted to make a final diagnosis or treatment plan; and further, that one of the requirements for general supervision is that the time frame for performance of treatment is to be specified in the order. She then read a proposed response which explained that the dentist would need to expressly authorize multiple treatments and to establish the time period for each of the treatments to authorize the dental hygienist to see and treat the patient. Discussion of known practices regarding general supervision and concern over the risk of sealing over emergent decay followed.

Ms. Reen read her proposed response again.

Dr. Petticolas moved to adopt the response proposed by Ms. Reen. The motion was seconded and passed by voice vote. A roll call vote was requested. The motion passed with six members voting in favor – Dr. Cutright, Dr. Gokli, Dr. Hall, Ms. Howard, Dr. Petticolas and Dr. Zimmet and three members voting against – Dr. Boyd, Ms. Mesimer and Ms. Pace.

Election of Officers. Dr. Gokli called for the election of officers. Dr. Zimmet moved to elect the nominees as reported by Ms. Pace -

Dr. Levin as president, Ms. Pace as vice president, and Dr. Hall as secretary/treasurer.

The motion was seconded and passed. Dr. Gokli congratulated the new officers and expressed her appreciation for the opportunity to lead the Board as president.

REPORT ON CASE ACTIVITY:

Mr. Heaberlin reviewed his report on the status of the 171 open cases as of September 9, 2009. He noted that only 3% of the pending caseload is older than 250 business days. He went on to say that from July 1, 2009 to September 9, 2009, the Board received 65 cases from Enforcement and has closed 85 cases for a 130% closure rate. He thanked the Board for all their hard work. He added information on the changes in the HPMP to that noted earlier by Ms. Wingfield, saying that respondents who are revoked or suspended while enrolled in HPMP will be reviewed on a case by case basis and most likely decided following the Board's formal hearing.

**EXECUTIVE
DIRECTOR'S
REPORT/BUSINESS:**

New Member Orientation. Ms. Reen reported that the orientation for Dr. Cutright and Dr. Boyd was held in August.

Dental Hygiene Practice in Virginia Department of Health. Ms. Reen reported on the implementation of the pilot program and the protocol for dental hygienists to provide preventative dental care under the "remote supervision" of a public health dentist in three health districts.

ADEA Statement on Professionalism in Dental Education. Ms. Reen showed the Board the pamphlet from ADEA and noted the six values-based statements defining professionalism in dental education - competence, fairness, integrity, responsibility, respect and service-mindedness. She made copies available for pick up.

**BOARD COUNSEL
REPORT:**

Jeffrey R. Leidy, D.M.D. v. Virginia Board of Dentistry. Mr. Casway stated the only court case pending against the Board is the one in which Dr. Jeffrey Leidy seeks to vacate a Consent Order. Mr. Casway advised that he has requested an agreement to non-suit the matter.

**CONSIDERATION
OF SUMMARY
RESTRICTION:**

Gordon J. Miniclier, DDS, case no. 126388. The Board received information from William Clay Garrett, Assistant Attorney General regarding the evidence and the allegations in Dr. Miniclier's case. Mr. Garrett concluded by asking the Board to summarily restrict Dr. Mimiclier's prescribing authority to make it unlawful for him to prescribe, administer, or dispense Schedule II, III, IV, and V controlled substances.

Closed Meeting:

Ms. Pace moved that the Board enter into a closed meeting pursuant to §2.2-3711(A) (27) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Dr. Miniclier. Additionally, it was moved that Board staff, Sandy Reen, Huong Vu, Alan Heaberlin and Board counsel, Howard Casway attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Ms. Pace moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public

business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

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

Decision:

Dr. Zimmet moved that the Board find that Dr. Miniclier's practice of dentistry does constitute a substantial danger to the public health and safety and to summarily restrict him from prescribing schedule II through V controlled substances. The motion was seconded and passed.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 1:00 p.m.

Jeffrey Levin, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

October 19, 2009

Report of the SRTA Exam committee (Oct. 16-17, 2009 in Atlanta,Ga.)

-----Dr. James D. Watkins

-----Review of existing calibration/standardization exercises for use in 2010.

-----Reviewed all aspects of the Examiner Manual to have it updated for 2010.

-----Reviewed 180 questions to establish a data bank of questions to provide for the 100-question exam that all examiners will have to pass (@85%) to be able to examine in 2010. This on-line test will be taken once by each SRTA examiner prior to examining in 2010. This test is meant to be available some time in December. It does NOT replace the calibration exercise at each exam; but it will replace the brief written test given before each exam. More questions are requested to be supplied by committee members at a later date.

-----Each CFC/SAC will have MANDATORY training on the Friday before the January, 2010, SCDDE's meeting in Crystal City. That training date is Friday, January 22, 2010.

-----SRTA plans to do a study as soon as possible using senior dental students to evaluate the use of plastic endodontic teeth vs natural teeth for the endodontic portion of the SRTA exam.

-----Dr. Tom Willis of the Alabama Board of Dentistry was an observer at this meeting and he reported that the Alabama dental board just voted to accept all regional boards for licensure for dentists and dental hygienists in their state.

Board of Dentistry Regulatory Actions

Chapter	Action / Stage Information
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	<u>Action:</u> Registration of mobile clinics <u>Stage:</u> Emergency/NOIRA - Register Date: 11/23/09 Effective date of emergency regulations: 1/7/10 Comment on NOIRA to replace emergency regulations 11/23/09 to 12/23/09
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	<u>Action:</u> Recovery of disciplinary costs <u>Stage:</u> NOIRA - Register Date: 10/26/09 Comment on NOIRA – 10/26/09 to 11/25/09 Board to adopt proposed regulations – 12/4/09
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	<u>Action:</u> Registration and practice of dental assistants <u>Stage:</u> Proposed - At Governor's Office

Information and Draft Proposed Regulations

Recovery of Disciplinary Costs

VIRGINIA ACTS OF ASSEMBLY -- 2009 SESSION

CHAPTER 89

An Act to amend the Code of Virginia by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.2, relating to recovering costs of disciplinary action by the Board of Dentistry.

[H 2058]

Approved February 25, 2009

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.2 as follows:

§ 54.1-2708.2. Recovery of monitoring costs.

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

Recovery of Disciplinary Costs in Other States

Washington

Law passed in 2009 - RCW 18.32.775

Disciplinary proceedings — Cost and fee recovery.

<http://apps.leg.wa.gov/RCW/default.aspx?cite=18.32.775>

RCW 18.32.775

Disciplinary proceedings — Cost and fee recovery.

(1) In any disciplinary case pertaining to a dentist where there is a contested hearing, if the commission or its hearing panel makes the finding requisite for, and imposes upon the dentist, a disciplinary sanction or fine under RCW 18.130.160, unless it determines to waive the assessment of a hearing fee, it shall assess against the licensee a partial recovery of the state's hearing expenses as follows:

(a) The partial recovery hearing fee must be:

(i) An amount equal to six thousand dollars for each full hearing day in the proceeding and one-half of that amount for any partial hearing day; and

(ii) A partial recovery of investigative and hearing preparation expenses in an amount as found to be reasonable reimbursement under the circumstances but no more than ten thousand dollars;

(b) Substantiation of investigative and hearing preparation expenses for purposes of (a) of this subsection may be by affidavit or declaration descriptive of efforts expended, which are reviewable in the hearing as would be a cost bill;

(c) The commission or its hearing panel may waive the partial recovery hearing fee if it determines the assessment of the fee (i) would create substantial undue hardship for the dentist, or (ii) in all the circumstances of the case, including the nature of the charges alleged, it would be manifestly unjust to assess the fee. Consideration of the waiver must be applied for and considered during the hearing itself. This may be in advance of the decision related to RCW 18.130.160.

(2) If the dentist seeks judicial review of the disciplinary action and there was a partial recovery hearing fee assessed, then unless the license holder achieves a substantial element of relief, the reviewing trial court or appellate court shall further impose a partial cost recovery fee in the amount of twenty-five thousand dollars at the superior court level, twenty-five thousand dollars at the court of appeals level, and twenty-five thousand dollars at the supreme court level. Application for waiver may be made to the court at each level and must be considered by the court under the standards stated in subsection (1)(c) of this section.

(3) In any disciplinary case pertaining to a dentist where the case is resolved by agreement prior to completion of a contested hearing, the commission shall assess against the dentist a partial recovery of investigative and hearing preparation expenses in an amount as found to be reasonable reimbursement in the circumstances but no more than ten thousand dollars, unless it determines to waive this fee under the standards stated in subsection (1)(c) of this section.

(4) In any stipulated informal disposition of allegations pertaining to a dentist as contemplated under RCW 18.130.172, the potential dollar limit of reimbursement of investigative and processing costs may not exceed two thousand dollars per allegation.

(5) Should the dentist fail to pay any agreed reimbursement or ordered cost recovery under the statute, the commission may seek collection of the amount in the same manner as enforcement of a fine under RCW 18.130.165.

(6) All fee recoveries and reimbursements under this statute must be deposited to the health professions account for the portion of it allocated to the commission. The fee recoveries shall be fully credited in reduction of actual or projected expenditures used to determine dentist license renewal fees.

(7) The authority of the commission under this section is in addition to all of its authorities under RCW 18.130.160, elsewhere in chapter 18.130 RCW, or in this chapter.

Tennessee

Tennessee has a statute that allows the collection of costs. The Board order must state that the respondent must pay the costs for them to be collected. The Board's attorneys send an Affidavit of Costs to the respondent to collect the costs, so the amount of the costs due are not put in the order. Below is the statute.

63-1-144. Payment of costs of investigation and prosecution. —

(a) In addition to any existing authority regarding the requirement to pay costs in disciplinary proceedings, when the division or any board, council, or committee created pursuant to this title and/or title 68, chapters 24 and 29 and regulated under the authority of the department of health imposes sanctions on a license or certificate holder in any disciplinary contested case proceeding, the license or certificate holder may, at the discretion of the division, board, council or committee before which the contested case proceeding was held be required to pay the actual and reasonable costs of the investigation and prosecution of the case, which shall include, but not be limited to, the following:

- (1) All costs absorbed by the division or attributed to and assessed against the board, council, or committee by the division's bureau of investigations in connection with the prosecution of the matter including all investigator time, travel and lodging incurred during the prosecution;
 - (2) All costs absorbed by the division or assessed against the board, council, or committee by the division for the use of the division facilities and personnel for prosecution of the matter;
 - (3) All costs assessed against the division, board, council, or committee for the appearance fees, transcripts, time, travel and lodging of administrative law judges and court reporters and witnesses required in the prosecution of the matter; and
 - (4) All costs attributed to and assessed against the division, board, council, or committee by the department's office of general counsel in connection with the prosecution of the matter including all attorney and paralegal time, travel and lodging incurred during the prosecution of the matter.
- (b) The division, board or committee shall include in any order in which the payment of costs has been assessed an amount that is the maximum amount owed by the license or certificate holder at the time the order is entered. Prior to the expiration of sixty (60) days from the effective date of the order, the division, council, board or committee shall send to the license or certificate holder, by certified mail, return receipt requested, and by regular United States mail, a final costs assessment that does not exceed the maximum amount in the order.

Kentucky

Kentucky does not have a regulatory citation but does recover cost through settlement agreement language. For example, we charged \$500.00 administrative cost to all the hygienists who failed our CE audit this last spring.

West Virginia

West Virginia Code §30-1-8. Denial, suspension or revocation of a license or registration; probation; proceedings; effect of suspension or revocation; transcript; report; judicial review.

(a) Every board referred to in this chapter may suspend or revoke the license of any person who has been convicted of a felony or who has been found to have engaged in conduct, practices or acts constituting professional negligence or a willful departure from accepted standards of professional conduct. Where any person has been convicted of a felony or has been found to have engaged in such conduct, practices or acts, every board referred to in this chapter may enter into consent decrees, to reprimand, to enter into probation orders, to levy fines not to exceed one thousand dollars per day per violation, or any of these, singly or in combination. *Each*

board may also assess administrative costs. Any costs which are assessed shall be placed in the special account of the board and any fine which is levied shall be deposited in the state treasury's general revenue fund.

Iowa

The Board is authorized to recover costs associated with a hearing: transcript, witness fees and expenses, depositions, medical examination fees. May impose a civil penalty not to exceed \$10,000. For those under board ordered probation in settlement agreements: The Board may charge a fee to cover actual costs including mileage, meals, travel expenses, hourly investigative time, and all incidental expenses associated with monitoring compliance OR the Respondent is required to remit a fee of \$300 to be paid quarterly to cover the boards expenses associated with monitoring a licensee's or registrant's compliance with the settlement agreement. These rules are found in 650-51 of the Board's rules.

New Jersey

We collect costs of investigation in NJ. The NJ Uniform Enforcement Act provides the grounds at NJSA 45:1-25(d):

d. In any action brought pursuant to this act, a board or the court may order the payment of costs for the use of the State, including, but not limited to, costs of investigation, expert witness fees and costs, attorney fees and costs, and transcript costs. You can find that online at: <http://www.njconsumeraffairs.gov/laws/uniformact.pdf>

Minnesota

Has a provision in place statutorily to recover costs or to assess civil penalties, under MS 150a.08, subd 3b, which states:

Subd. 3a. Costs; additional penalties. (a) The board may impose a civil penalty not exceeding \$10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including, but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.

(b) In addition to costs and penalties imposed under paragraph (a), the board may also:

- (1) order the dentist, dental hygienist, or dental assistant to provide unremunerated service;
- (2) censure or reprimand the dentist, dental hygienist, or dental assistant; or
- (3) any other action as allowed by law and justified by the facts of the case.

Rarely do we pursue full fee recovery, or decide to assess a civil penalty up to the maximum of \$10,000 per violation.

Massachusetts

No cost recovery.

Louisiana

Collects costs including attorney fees, investigative costs, expenses and per diem of board members and stenographers.

Nevada

Does include investigation cost recovery in stipulation agreements. NRS 622.400---see link:

<http://www.leg.state.nv.us/NRS/NRS-622.html#NRS622Sec400>

NRS 622.400 Recovery of attorney's fees and costs incurred by regulatory body in certain regulatory proceedings.

1. A regulatory body may recover from a person reasonable attorney's fees and costs that are incurred by the regulatory body as part of its investigative, administrative and disciplinary proceedings against the person if the regulatory body:

(a) Enters a final order in which it finds that the person has violated any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body; or

(b) Enters into a consent or settlement agreement in which the regulatory body finds or the person admits or does not contest that the person has violated any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body.

2. As used in this section, "costs" means:

(a) Costs of an investigation.

(b) Costs for photocopies, facsimiles, long distance telephone calls and postage and delivery.

(c) Fees for court reporters at any depositions or hearings.

(d) Fees for expert witnesses and other witnesses at any depositions or hearings.

(e) Fees for necessary interpreters at any depositions or hearings.

(f) Fees for service and delivery of process and subpoenas.

(g) Expenses for research, including, without limitation, reasonable and necessary expenses for computerized services for legal research.

DRAFT proposed regulations

BOARD OF DENTISTRY

Recovery of disciplinary costs

18VAC60-20-181. Recovery of disciplinary costs.

A. Assessment of cost for investigation of a disciplinary case.

1. In any disciplinary case in which there is a finding of a violation against a licensee or registrant, the board may assess the hourly costs relating to investigation of the case by the Enforcement Division of the Department of Health Professions and, if applicable, the costs for hiring an expert witness and reports generated by such witness.

2. The imposition of recovery costs relating to an investigation shall be included in the order from an informal or formal proceeding or part of a consent order agreed to by the parties. The schedule for payment of investigative costs imposed shall be set forth in the order.

3. At the end of each fiscal year, the board shall calculate the average hourly cost for enforcement that is chargeable to investigation of complaints filed against its regulants and shall state those costs in a guidance document to be used in imposition of recovery costs. The average hourly cost multiplied times the number of hours spent in investigating the specific case of a respondent shall be used in the imposition of recovery costs.

B. Assessment of cost for monitoring a licensee or registrant.

1. In any disciplinary case in which there is a finding of a violation against a licensee or registrant and in which terms and conditions have been imposed, the costs for monitoring of a licensee or registrant may be charged and shall be calculated based on the specific terms and conditions and the length of time the licensee or registrant is to be monitored.

2. The imposition of recovery costs relating to monitoring for compliance shall be included in the board order from an informal or formal proceeding or part of a consent order agreed to by the parties. The schedule for payment of monitoring costs imposed shall be set forth in the order.

3. At the end of each fiscal year, the board shall calculate the average costs for monitoring of certain terms and conditions, such as acquisition of continuing education, and shall set forth those costs in a guidance document to be used in the imposition of recovery costs.

C. Total of assessment.

In accordance with § 54.1-2708.2 of the Code of Virginia, the total of recovery costs for investigating and monitoring a licensee or registrant shall not exceed \$5,000, but shall not include the fee for inspection of dental offices and returned checks as set forth in 18VAC60-20-30 or collection costs incurred for delinquent fines and fees.

D. Waiver of recovery of disciplinary costs. (Subsection D was not recommended by Regulatory/Legislative Committee)

1. The board may provide a total or partial waiver for recovery of investigative or monitoring costs if the imposition of costs would create a substantial undue

hardship on the licensee or registrant, or if it would be unjust to the public to assess fees, or if the collection of such fees does not appear to be feasible.

2. The board shall set out in the findings of fact in the disciplinary order the specific reasons for such a waiver.

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Ronald L. Tankersley, D.D.S.
President

Date: November 6, 2009

To: Presidents and Executive Directors, State Boards of Dentistry

R. L. Tankersley DDS

From: Dr. Ronald L. Tankersley, president

Subject: CRDTS Termination of Agreement with ADEX

As you are all aware, the Central Regional Dental Testing Service (CRDTS) is no longer administering the American Dental Licensing Examination (ADLEX) developed by the American Board of Dental Examiners (ADEX). As of June 30, CRDTS terminated its agreement with ADEX and will be administering its own examination once again.

Those most affected by this change are recent dental school graduates who are unsure of their ability to be licensed in their state of choice. For example, a student could have already taken the CRDTS examination expecting that the results would be accepted in a particular state only to have that state now change its rules regarding acceptance of the examination due to CRDTS withdrawal from ADEX.

Out of concern for the effect this decision may have on recent graduates, the Board of Trustees adopted the following resolution at its June 2009 meeting.

Resolved, that all state dental boards that currently accept the ADLEX dental examination results continue to accept results of the ADEX/NERB/CRDTS/Nevada examinations taken prior to June 30, 2009 for their established standard acceptance period.

The ADA Board of Trustees urges state boards to consider the impact of this recent event on new graduates and consider continuing to accept the results of the ADEX/NERB/CRDTS/Nevada examinations as described in the Board's resolution.

Thank you for your consideration of this matter.

RLT:ljh

cc: President and Executive Director, American Association of Dental Boards
President and Executive Director, American Student Dental Association
President and Executive Director, American Dental Education Association
ADA Officers and Members of the Board of Trustees
Presidents and Executive Directors, Constituent Dental Societies
Members, Council on Dental Education and Licensure

Reen, Sandra

Subject: FW: Anesthesia Guidelines

From: Dr. Thomas Padgett [mailto:drpadgett@rocs.net]

Sent: Wednesday, November 04, 2009 2:53 PM

To: Board of Dentistry

Subject: Anesthesia Guidelines

BOD Members

Sandra Reen

The Virginia Society of Oral and Maxillofacial Surgeons is still concerned with the restrictions placed on nurses as stated in the recently adopted Anesthesia Guidelines. After reviewing the Virginia Code and discussions with the Board of Nursing and members of the Board of Dentistry and our national organization (AAOMS) we feel these restrictions limit Nurses from providing services they are trained to do. The guidelines contradict Va. Code 54.1-3408(B) allowing a nurse to administer drugs and devices. It also contradicts the Board of Nursing Guidelines 90-5 authorizing nurses to administer drugs prescribed by a licensed provider. The Board of Nursing has shown support for administration of sedative drugs as seen in Gastroenterology Clinics and other Medical offices. Also by dismissing the case of the Nurse giving Propofol in the Oral Surgeons office under direct supervision they have indirectly given approval for administration of anesthetic drugs. That being said, those decisions should be left to the Board of Nursing. We realize the BOD feels they need to make a statement with regard to the duties of a Nurse in the Dental setting. Since Oral Surgeons are predominantly the sole employer of Nurses we would like to offer our assistance in this matter. Unfortunately, there is no longer an Oral Surgeon on the BOD which I feel may hinder the Boards ability to make informed decisions with regard regulations involving the practice of Oral Surgery and Anesthesia. We are only recommending the references to Nurses as presently stated in the Guidelines be removed and replaced with something more general such as " A Dentist may employ a Nurse to assist in their practice. Their duties would be directed by a licensed provider and limited by the rules and regulations as provided for in the Guidelines of the Board of Nursing and the Commonwealth of Virginia". We feel this would be in the best interest of both the Dentist who employs Nurses and the Nurses themselves.

We would appreciate your reconsideration of the Anesthesia Guidelines and make the suggested changes or allow us to petition the BOD so further discussion can be facilitated.

Respectfully,

Thomas B. Padgett D.M.D.

President, Virginia Society of Oral and Maxillofacial Surgeons

VIRGINIA BOARD OF DENTISTRY
**Policy on Administering Schedule II through VI Controlled Substances for Analgesia,
Sedation and Anesthesia in Dental Offices/Practices**

Administration

1. When used in the **Regulations Governing the Practice of Dentistry and Dental Hygiene**, the terms “administration”, “administer” and “administering” as defined in pertinent part in Va. Code § 54.1-3401 of the Virginia Drug Control Act, refers to the “direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient by (i) practitioner, or by his authorized agent and under his direction. . .”. The term “authorized agent”, as provided for in Va. Code § 54.1-3401, means “a nurse, physician assistant or intern” consistent with Va. Code § 54.1-3408(B) and more specifically, in the context of the practice of dentistry, a dental hygienist or dental assistant (I or II) as provided for in Va. Code 54.1-3408(J).
2. In the context of the administration of a controlled substance in a dental practice, the term “under his direction and supervision” as provided for in Va. Code §§54.1-3408.B and 54.1-3408.J respectively, means that the treating dentist has examined the patient prior to the administration of the controlled substance and is present for observation, advice and control of the administration consistent with the term “direction” as defined in 18 VAC60-20-10. A qualified dentist is responsible for providing the level of observation, advice and control:
 - a. appropriate to the planned level of administration (local anesthesia, inhalation analgesia, anxiolysis, conscious sedation or deep sedation/general anesthesia); and
 - b. appropriate to his education, training and experience and consistent with the scope of practice of the ancillary personnel (anesthesiologist, certified registered nurse anesthetist, nurse, dental hygienist or dental assistant).

The treating dentist may need to be physically present with the patient and the ancillary personnel to personally observe and direct actions in some instances and in others he may need to be in the office/facility and immediately available for oral communication with the ancillary personnel.

3. **LOCAL ANESTHESIA:**

A qualified dentist may administer or use the services of the following personnel to administer local anesthesia:

- A dentist;
- An anesthesiologist;
- A certified registered nurse anesthetist under his direction;
- A dental hygienist with the training required by 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older under his direction;
- A dental hygienist to administer Schedule VI topical oral anesthetics under his direction or under his order for such treatment under general supervision;

- A dental assistant to administer Schedule VI topical oral anesthetics under his direction; and
- A registered or licensed practical nurse to administer Schedule VI topical oral anesthetics under his direction.

4. ANXIOLYSIS:

- a. A qualified dentist may administer or use the services of the following personnel to administer anxiolysis:
 - A dentist;
 - An anesthesiologist; and
 - A certified registered nurse anesthetist under his direction.
- b. Preceding the administration of anxiolysis, a dentist may use the services of the following personnel to administer local anesthesia to numb an injection or treatment site:
 - A dental hygienist with the training required by 18VAC60-20-81 to administer Schedule VI local anesthesia to persons age 18 or older under his direction;
 - A dental hygienist to administer Schedule VI topical oral anesthetics under his direction;
 - A dental assistant to administer Schedule VI topical oral anesthetics under his direction; and
 - A registered or licensed practical nurse to administer Schedule VI topical oral anesthetics under his direction.
- c. If anxiolysis is self-administered by a patient before arrival at the dental office/facility, the dentist may only use the personnel listed in 4.a. to administer local anesthesia.

5. INHALATION ANALGESIA:

A qualified dentist may administer or use the services of the following personnel to administer inhalation analgesia:

- A dentist;
- An anesthesiologist;
- A certified registered nurse anesthetist under his direction; and
- A dental hygienist with the training required by 18VAC60-20-81 under his direction.

6. CONSCIOUS SEDATION:

- a. A dentist not qualified to administer conscious sedation shall only use the services of an anesthesiologist to administer conscious sedation in a dental office. In an outpatient surgery center or hospital, a dentist not qualified to administer conscious sedation shall use an anesthesiologist or a certified registered nurse anesthetist to administer conscious sedation.
- b. A qualified dentist may administer or use the services of the following personnel to administer conscious sedation:

- A dentist with the training required by 18VAC60-20-120(C) to administer by an enteral method;
 - A dentist with the training required by 18VAC60-20-120(B) to administer by any method;
 - An anesthesiologist; and
 - A certified registered nurse anesthetist under the direction of a dentist who meets the training requirements of 18VAC60-20-120(B).
- c. Preceding the administration of conscious sedation, a qualified dentist may use the services of the following personnel to administer local anesthesia to numb the injection or treatment site:
- A dental hygienist with the training required by 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older under his direction;
 - A dental hygienist to administer Schedule VI topical oral anesthetics under his direction;
 - A dental assistant to administer Schedule VI topical oral anesthetics under his direction; and
 - A registered or licensed practical nurse to administer Schedule VI topical oral anesthetics under his direction.

7. DEEP SEDATION/GENERAL ANESTHESIA:

- a. A dentist not qualified to administer deep sedation/general anesthesia shall only use the services of an anesthesiologist to administer deep sedation/general anesthesia in a dental office. In an outpatient surgery center or hospital, a dentist not qualified to administer conscious sedation shall use an anesthesiologist or a certified registered nurse anesthetist to administer deep sedation/general anesthesia.
- b. A qualified dentist may administer or use the services of the following personnel to administer deep sedation/general anesthesia:
- A dentist with the training required by 18VAC60-20-110;
 - An anesthesiologist; and
 - A certified registered nurse anesthetist under the direction of a dentist who meets the training requirements of 18VAC60-20-110.
- c. Preceding the administration of deep sedation/general anesthesia, a qualified dentist may use the services of the following personnel to administer local anesthesia to numb the injection or treatment site:
- A dental hygienist with the training required by 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older under his direction;
 - A dental hygienist to administer Schedule VI topical oral anesthetics under his direction;
 - A dental assistant to administer Schedule VI topical oral anesthetics under his direction; and
 - A registered or licensed practical nurse to administer Schedule VI topical oral anesthetics under his direction.

Assisting in Administration

1. When used in 18VAC60-20-135 of the **Regulations Governing the Practice of Dentistry and Dental Hygiene**, the phrase “to assist in the administration” means that a qualified treating dentist, consistent with the appropriate planned level of administration (local anesthesia, inhalation analgesia, anxiolysis, conscious sedation or deep sedation/general anesthesia) and appropriate to his education, training and experience, utilizes the services of a dentist, anesthesiologist, certified registered nurse anesthetist, dental hygienist, dental assistant and/or nurse to perform functions appropriate to such practitioner’s education, training and experience and consistent with that practitioner’s respective scope of practice.
2. The tasks that a dental hygienist, dental assistant or a nurse might perform under direction to assist in administration are:
 - Taking and recording vital signs
 - Preparing dosages as directed by and while in the presence of the treating dentist who will administer the drugs;
 - Positioning the container of the drugs to be administered by the treating dentist in proximity to the patient;
 - Placing a topical anesthetic at an injection or treatment site preceding the administration of sedative agents as follows:
 - A dental hygienist who meets the training requirements of 18VAC60-20-81 may parenterally administer Schedule VI local anesthesia to persons age 18 or older under direction;
 - A dental hygienist may administer Schedule VI topical local anesthetics under direction;
 - A dental assistant may administer Schedule VI topical oral anesthetics under direction; and
 - A registered or licensed practical nurse may administer Schedule VI topical oral anesthetics under direction.
 - Placing a face mask for inhalation analgesia on the patient;
 - Adjusting the flow of nitrous oxide machines as directed by and while in the presence of the treating dentist who initiated the flow of inhalation analgesia; and
 - Implementing assigned duties should an emergency arise.

Monitoring a Patient

1. When used in 18VAC60-20-135 of the **Regulations Governing the Practice of Dentistry and Dental Hygiene**, the term “to assist in monitoring” means that a dental hygienist, dental assistant or nurse who is under direction is continuously in the presence of the patient in the office, operatory and recovery area (a) before administration is initiated or immediately upon arrival if the patient self-administered a sedative agent; (b) throughout the administration of drugs; (c) throughout the treatment of the patient; and (d) throughout recovery until the patient is discharged by the dentist.
2. The person monitoring the patient:
 - has the patient’s entire body in sight,
 - is in close proximity so as to speak with the patient,
 - converses with the patient to assess the patient’s ability to respond in order to determine the patient’s level of sedation,
 - closely observes the patient for coloring, breathing, level of physical activity, facial expressions, eye movement and bodily gestures in order to immediately recognize and bring any changes in the patient’s condition to the attention of the treating dentist, and
 - reads, reports and records the patient’s vital signs.

Excerpts of Applicable Law, Regulations and Guidance

1. “Administer” means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient by (i) a practitioner or by his authorized agent and under his direction or (ii) the patient at the direction and in the presence of the practitioner. Va. Code §54.1-3401
 - A dentist may administer drugs and devices, or he may cause them to be administered by a nurse, physician assistant or intern under his direction and supervision. Va. Code §54.1-3408(B)
 - A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist. Va. Code §54.1-3408(J)
 - A dentist may authorize a dental hygienist under his general supervision to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions. Va. Code §54.1-3408(J)
 - Statutes regarding the practice of dentistry (Title 54.1, Chapter 27) shall not apply to a nurse practitioner licensed by the Committee of the Joint Boards of Nursing and Medicine except that intraoral procedures shall be performed only under the direct supervision of a dentist. Va. Code §54.1-2701(2)
 - A dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. Va. Code §54.1-2722(D) & §54.1-3408(J)
 - To administer anxiolysis, a dentist shall have training in and knowledge of the appropriate dosages and potential complications of the medications and of the

- physiological effects and potential complications of nitrous oxide. Board of Dentistry Regulation 18VAC60-20-108(A)
- To administer deep sedation/general anesthesia, a dentist shall have completed (1) one calendar year of advanced training in anesthesiology and related academic subjects or (2) an ADA approved residency in a dental specialty which includes one calendar year of full-time training in clinical anesthesia and related clinical medical subjects. Board of Dentistry Regulation 18VAC60-20-110(A)
 - A dentist not qualified to administer deep sedation/general anesthesia may use the services of a qualified anesthesiologist or a qualified dentist to administer deep sedation/general anesthesia. Board of Dentistry Regulation 18VAC60-20-110(B)(1)
 - A qualified dentist may use the services of a certified registered nurse anesthetist to administer deep sedation/general anesthesia. Board of Dentistry Regulation 18VAC60-20-110(B)(2)
 - A dentist is automatically qualified to administer conscious sedation if he meets the requirements to administer deep sedation/general anesthesia. Board of Dentistry Regulation 18VAC60-20-120(A)
 - To administer conscious sedation by any method, shall have completed (1) training in a CODA accredited program or (2) 60 hours of acceptable continuing education plus the management of at least 20 patients consistent with ADA Guidelines. Board of Dentistry Regulation 18VAC60-20-120(B)
 - A dentist who self-certified prior to January 1989 may continue to administer conscious sedation. Board of Dentistry Regulation 18VAC60-20-120(B)(2)
 - To administer conscious sedation only enterally, a dentist shall have completed 18 hours of acceptable continuing education plus 20 clinically-oriented experiences. Board of Dentistry Regulation 18VAC60-20-120(C)
 - A dentist must hold current certification in advanced resuscitative techniques to administer deep sedation/general anesthesia and conscious sedation. Board of Dentistry Regulation 18VAC60-20-110(A)(2) and 18VAC60-20-120(D)
2. "Anxiolysis" means the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness. Board of Dentistry Regulation 18VAC60-20-10
 3. "Conscious sedation" means a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal commands, produced by pharmacological or nonpharmacological methods, including inhalation, parenteral, transdermal or enteral, or a combination thereof. Board of Dentistry Regulation 18VAC60-20-10
 4. "Deep sedation/general anesthesia" means an induced state of depressed consciousness or unconsciousness accompanied by a complete or partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or respond purposefully to physical stimulation or verbal command and is produced by a pharmacological or nonpharmacological method, or a combination thereof. Board of Dentistry Regulation 18VAC60-20-10
 5. "Direction" means the dentist examines the patient and is present for observation, advice, and control over the performance of dental services. Board of Dentistry Regulation 18VAC60-20-10

6. "Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness. Board of Dentistry Regulation 18VAC60-20-10
7. "Local anesthesia" means the loss of sensation or pain in the oral cavity or the maxillofacial or adjacent and associated structures generally produced by a topically applied or injected agent without depressing the level of consciousness.
8. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. If inhalation analgesia is used, monitoring shall include observing the patient's vital signs and making the proper adjustments of nitrous oxide machines at the request of or by the dentist or by a qualified dental hygienist. Board of Dentistry Regulation 18VAC60-20-108.C
9. A dentist not qualified to administer deep sedation/general anesthesia may treat patients under deep sedation/general anesthesia if a qualified anesthesiologist or a qualified dentist is responsible for the administration, Board of Dentistry Regulation 18VAC60-20-110.B(1)
10. A qualified dentist may use the services of a certified registered nurse anesthetist to administer deep sedation/general anesthesia, Board of Dentistry Regulation 18VAC60-20-110.B(2)
11. Monitoring of the patient under deep sedation/general anesthesia, including direct, visual observation is to begin prior to induction and shall take place continuously during the procedure and recovery. Monitoring shall include: recording and reporting of blood pressure, pulse, respiration and other vital signs. Board of Dentistry Regulation 18VAC60-20-110.E
12. Monitoring of the patient under conscious sedation, including direct, visual observation of the patient is to begin prior to administration, or if self-administered, when the patient arrives and shall take place continuously during the procedure and recovery. Board of Dentistry Regulation 18VAC60-20-120.F
13. Dentists who employ ancillary personnel to assist in the administration and monitoring of any form of conscious sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have training in basic resuscitation techniques or responding to a clinical emergency or are an anesthesia assistant certified by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology. Board of Dentistry Regulation 18VAC60-20-135.
14. Only licensed dentists shall prescribe or parenterally administer drugs or medicaments with the exception that dental hygienists with appropriate training may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older. Board of Dentistry Regulation 18VAC60-20-190
15. "Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e. intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular). Board of Dentistry Regulation 18VAC60-20-10
16. A certified registered nurse anesthetist shall practice in accordance with the functions and standards defined by the American Association of Nurse Anesthetists andunder the medical direction and supervision of a dentist in accordance with rules and regulations promulgated by the Board of Dentistry. Board of Nursing Regulation 18VAC90-2-120(D)

Virginia Board of Dentistry

Guidance on Periodontal Diagnosis and Treatment

The Board has the following recommendations to assist the general dentist in the application of periodontal diagnosis and treatment:

Plaque Associated Gingivitis

Plaque associated gingivitis is defined as inflammation of the gingival in the absence of clinical attachment loss. Gingivitis may be characterized by presence of any of the following clinical signs:

- Redness and edema of the gingival tissue
- Bleeding upon provocation
- Changes in contour and consistency
- Presence of calculus and/or plaque
- No radiographic evidence of crestal bone loss

Adult Periodontitis

Adult periodontitis is defined as inflammation of the gingival and the adjacent attachment apparatus. The disease is characterized by loss of clinical attachment due to destruction of the periodontal ligament and loss of the adjacent supporting bone. Clinical features may include combinations of the following signs and symptoms:

- Edema
- Erythema
- Gingival bleeding upon probing and/or suppuration
- Slight or moderate destruction demonstrates a loss of up to 1/3 of the supporting periodontal tissues and is generally characterized by periodontal probing depths up to 6mm (with clinical attachment loss of up to 5mm)
- Radiographic evidence of bone loss
- Increased tooth mobility may be present

Treatment Considerations

Treatment plans for plaque associated gingivitis or adult periodontitis include patient education, customized oral hygiene instruction and debridement of tooth surfaces to remove supra/subgingival plaque and calculus.

Adult periodontitis may require additional treatment modalities including resective, regenerative procedures, occlusal therapies, selective extraction of teeth and various types of implant and prosthetic treatments.

Patients with mild inflammation of the marginal tissue, minimal calculus, little or no clinical evidence of attachment loss and insignificant probeable depths (3.0mm) are not candidates for multiple visits of root planing/scaling.

2007 CURRENT PROCEDURAL TERMINOLOGY FOR PERIODONTICS AND INSURANCE REPORTING MANUAL 11th EDITION

A glossary of terms and procedures designed as
a guide for interpreting and reporting periodontal
services to third party agencies

Published by
The American Academy of Periodontology

Section 1

Classification System for Periodontal Diseases and Conditions*

Classification systems are necessary in order to provide a framework in which to scientifically study the etiology, pathogenesis, and treatment of diseases in an orderly fashion. In addition, such systems give clinicians a way in which to organize the health care needs of their patients. In 1989, scientists and clinicians met at the World Workshop in Clinical Periodontics, and agreed upon a classification system for periodontal disease.¹ Subsequently, a simpler classification was agreed upon at the 1st European Workshop in Periodontology held in 1993.²

These classification systems have been widely used throughout the world. Unfortunately, the 1989 classification had many shortcomings including: 1) considerable overlap in disease categories; 2) absence of a gingival disease component; 3) inappropriate emphasis on age of onset of disease and rates of progression; and 4) inadequate or unclear classification criteria. The 1993 European classification lacked the detail necessary for adequate characterization of the broad spectrum of periodontal diseases encountered in clinical practice.

The need for a revised classification system was emphasized during the 1996 World Workshop in periodontics.³ In the fall of 1999, the American Academy of Periodontology hosted the International Workshop for a Classification of Periodontal Diseases and Conditions. As a result of this workshop, a new classification system was agreed upon, and is provided in Figure 1.

The highlights of this new classification system include:

1. **The addition of a section on "Gingival Diseases."** An important feature of the section on dental plaque-induced diseases is an acknowledgment that the clinical expression of gingivitis can be substantially modified by
 - 1) systemic factors such as disorders of the endocrine system, 2) medications, and 3) malnutrition. The section on non-plaque-induced gingival lesions includes a wide range of disorders that affect the gingiva. Many of these disorders are frequently encountered in clinical practice.
2. **The replacement of "Adult Periodontitis" with "Chronic Periodontitis."** From the outset, the term "Adult Periodontitis" has created a diagnostic dilemma for clinicians. Epidemiological data and clinical experience suggest that this form of periodontitis can also be seen in adolescents.⁴ If this is true, how can non-adults (e.g., adolescents) with this type of periodontal disease be said to have "adult periodontitis?" Clearly, the age-dependent nature of the adult periodontitis designation created problems. Therefore, the more generalized term "Chronic Periodontitis" is used to characterize this constellation of destructive periodontal diseases. Traditionally, this form of periodontitis has been characterized as a slowly progressive disease.⁵ However, there also are data indicating that some patients may experience short periods of rapid progression.^{6,7} Therefore, rates of progression should not be used to exclude patients from receiving the diagnosis of Chronic Periodontitis. It can, however, be further classified on the basis of extent (localized or generalized) and severity (slight, moderate, or severe).
3. **The replacement of "Early-Onset Periodontitis" with "Aggressive Periodontitis."** A diagnosis of "Early-Onset Periodontitis" (EOP) implies temporal knowledge of when the disease started, yet in clinical practice and most other situations that rarely is the case. Also, there is considerable

*Adapted from Armitage GC. Development of a classification system for periodontal diseases and conditions. *Ann Periodontol* 1999; 4:1-6.

uncertainty about an arbitrary upper age limit. Accordingly, the term "Aggressive Periodontitis" was adopted. It, too, may be further classified on the basis of extent and severity.

4. **The elimination of a separate disease category for "Refractory Periodontitis."** A small percentage of patients with all forms of periodontal disease experience a continuing progression of periodontitis in spite of excellent patient compliance and the provision of periodontal therapy that succeeds in most patients. Because of the diversity of clinical conditions and treatments under

which periodontal therapy fails to arrest the progression of periodontitis, it was determined that "Refractory Periodontitis" is not a single disease entity.

5. **The clarification of the designation "Periodontitis as a Manifestation of Systemic Diseases."** Since it is clear that destructive periodontal disease can be a manifestation of certain systemic diseases, the classification of "Periodontitis as a Manifestation of Systemic Diseases" has been retained. However, diabetes mellitus is not on that list. While it can alter the clinical course and expression of chronic and aggressive

I. Gingival Diseases

A. Dental plaque-induced gingival diseases*

1. Gingivitis associated with dental plaque only
 - a. without other local contributing factors
 - b. with local contributing factors (See VIII A)
2. Gingival diseases modified by systemic factors
 - a. associated with the endocrine system
 - 1) puberty-associated gingivitis
 - 2) menstrual cycle-associated gingivitis
 - 3) pregnancy-associated
 - a) gingivitis
 - b) pyogenic granuloma
 - 4) diabetes mellitus-associated gingivitis
 - b. associated with blood dyscrasias
 - 1) leukemia-associated gingivitis
 - 2) other
3. Gingival diseases modified by medications
 - a. drug-influenced gingival diseases
 - 1) drug-influenced gingival enlargements
 - 2) drug-influenced gingivitis
 - a) oral contraceptive-associated gingivitis
 - b) other
 4. Gingival diseases modified by malnutrition
 - a. ascorbic acid-deficiency gingivitis
 - b. other

B. Non-plaque-induced gingival lesions

1. Gingival diseases of specific bacterial origin
 - a. Neisseria gonorrhea-associated lesions
 - b. Treponema pallidum-associated lesions
 - c. streptococcal species-associated lesions
 - d. other

2. Gingival diseases of viral origin

- a. herpes virus infections
 - 1) primary herpetic gingivostomatitis
 - 2) recurrent oral herpes
 - 3) varicella-zoster infections
- b. other

3. Gingival diseases of fungal origin

- a. Candida-species infections
 - 1) generalized gingival candidosis
- b. linear gingival erythema
- c. histoplasmosis
- d. other

4. Gingival lesions of genetic origin

- a. hereditary gingival fibromatosis
- b. other

5. Gingival manifestations of systemic conditions

- a. mucocutaneous disorders
 - 1) lichen planus
 - 2) pemphigoid
 - 3) pemphigus vulgaris
 - 4) erythema multiforme
 - 5) lupus erythematosus
 - 6) drug-induced
 - 7) other
- b. allergic reactions
 - 1) dental restorative materials
 - a) mercury
 - b) nickel
 - c) acrylic
 - d) other

Figure 1.

Classification of periodontal diseases and conditions.

* Can occur on a periodontium with no attachment loss or on a periodontium with attachment loss that is not progressing.

forms of periodontitis, there are insufficient data to conclude that there is a specific diabetes mellitus-associated form of the disease.

6. Replacement of "Necrotizing Ulcerative Periodontitis" with "Necrotizing Periodontal Diseases." Periodontitis associated with ulcerative gingivitis (NUG)

and necrotizing ulcerative periodontitis (NUP) are clinically identifiable conditions, but the relationship between them is uncertain. It is not known whether they are a single disease process or truly separate diseases.

Accordingly, both clinical conditions were placed under the single category of "Necrotizing Periodontal Diseases."

- | | |
|--|---|
| <ul style="list-style-type: none"> 2) reactions attributable to <ul style="list-style-type: none"> a) toothpastes/dentifrices b) mouth rinses/mouth washes c) chewing gum additives d) foods and additives 3) other 6. Traumatic lesions (factitious, iatrogenic, accidental) <ul style="list-style-type: none"> a. chemical injury b. physical injury c. thermal injury 7. Foreign body reactions 8. Not otherwise specified (NOS) II. Chronic Periodontitis[†] <ul style="list-style-type: none"> A. Localized B. Generalized III. Aggressive Periodontitis[†] <ul style="list-style-type: none"> A. Localized B. Generalized IV. Periodontitis as a Manifestation of Systemic Diseases <ul style="list-style-type: none"> A. Associated with hematological disorders <ul style="list-style-type: none"> 1. Acquired neutropenia 2. Leukemias 3. Other B. Associated with genetic disorders <ul style="list-style-type: none"> 1. Familial and cyclic neutropenia 2. Down syndrome 3. Leukocyte adhesion deficiency syndromes 4. Papillon-Lefèvre syndrome 5. Chediak-Higashi syndrome 6. Histiocytosis syndromes 7. Glycogen storage disease 8. Infantile genetic agranulocytosis 9. Cohen syndrome 10. Ehlers-Danlos syndrome (Types IV and VIII) 11. Hypophosphatasia 12. Other C. Not otherwise specified (NOS) V. Necrotizing Periodontal Diseases | <ul style="list-style-type: none"> A. Necrotizing ulcerative gingivitis (NUG) B. Necrotizing ulcerative periodontitis (NUP) VI. Abscesses of the Periodontium <ul style="list-style-type: none"> A. Gingival abscess B. Periodontal abscess C. Pericoronal abscess VII. Periodontitis Associated With Endodontic Lesions <ul style="list-style-type: none"> A. Combined periodontic-endodontic lesions VIII. Developmental or Acquired Deformities and Conditions <ul style="list-style-type: none"> A. Localized tooth-related factors that modify or predispose to plaque-induced gingival diseases/periodontitis <ul style="list-style-type: none"> 1. Tooth anatomic factors 2. Dental restorations/appliances 3. Root fractures 4. Cervical root resorption and cemental tears B. Mucogingival deformities and conditions around teeth <ul style="list-style-type: none"> 1. Gingival/soft tissue recession <ul style="list-style-type: none"> a. facial or lingual surfaces b. interproximal (papillary) 2. Lack of keratinized gingiva 3. Decreased vestibular depth 4. Aberrant frenum/muscle position 5. Gingival excess <ul style="list-style-type: none"> a. pseudopocket b. inconsistent gingival margin c. excessive gingival display d. gingival enlargement (See I.A.3. and I.B.4.) 6. Abnormal color C. Mucogingival deformities and conditions on edentulous ridges <ul style="list-style-type: none"> 1. Vertical and/or horizontal ridge deficiency 2. Lack of gingiva/keratinized tissue 3. Gingival/soft tissue enlargement 4. Aberrant frenum/muscle position 5. Decreased vestibular depth 6. Abnormal color D. Occlusal trauma <ul style="list-style-type: none"> 1. Primary occlusal trauma 2. Secondary occlusal trauma |
|--|---|

Figure 1. (Continued)

[†]Can be further classified on the basis of extent and severity. As a general guide, extent can be characterized as Localized = <30% of sites involved and Generalized = >30% of sites involved. Severity can be characterized on the basis of the amount of clinical attachment loss (CAL) as follows: Slight = 1 or 2 mm CAL, Moderate = 3 or 4 mm CAL, and Severe = >5 mm CAL.

7. **The addition of a category on "Periodontal Abscess."** Since periodontal abscesses present special diagnostic and treatment challenges, a simple classification was adopted, based primarily on location (i.e., gingival, periodontal, pericoronal).
8. **The addition of a category on "Periodontic-Endodontic Lesions."** The 1989 classification did not include a section on the connection between periodontitis and endodontic lesions. Therefore, a simple classification based on this connection, not on initial etiology, has been added.
9. **The addition of a category on "Developmental or Acquired Deformities and Conditions."** Developmental and acquired deformities and conditions often are important modifiers of the susceptibility to periodontal diseases or can dramatically influence outcomes of treatment. Since periodontists are routinely called upon to treat many of these conditions, they have been given a place in the new classification.

As more is learned about the etiology and pathogenesis of periodontal diseases, future revisions to this classification will be needed. All classifications have inconsistencies or inaccuracies and the present system is no exception. Nevertheless, it represents the consensus of an international group of experts and is intended to be useful to the profession and the public it serves.

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The *Annals of Periodontology*, Volume 4 contains the complete proceedings of the 1999 International Workshop for a Classification of Periodontal Diseases and Conditions, including the literature reviews and consensus reports on each of the classifications. To order the *Annals of Periodontology*, Volume 4, contact the Publications and Marketing Department at the Academy's Central Office at 800/282-4867. Orders can also be placed on the Academy's Web site, www.perio.org/catalog.

Reen, Sandra

From: AGD Advocacy [advocacy@agd.org]
Sent: Friday, October 30, 2009 12:22 PM
To: Reen, Sandra
Subject: AGDtranscript - October 2009 Issue

To ensure you continue to receive e-mails from AGD, please add advocacy@agd.org to your address book.
 If you cannot view the e-mail version, please [click here](#) for the online version of the AGDTranscript e-newsletter.

AGDtranscript

a quarterly newsletter for state dental boards

The AGDTranscript is a quarterly e-newsletter sent to each state dental board in an effort to facilitate greater awareness of dental trends and issues across the nation. As the Academy of General Dentistry (AGD) worked with licensing dental boards toward acceptance of the AGD state transcript, it was noticed that happenings in one state were not always publicized to other states. Through this newsletter, the AGD hopes to build a lasting relationship with state licensing agencies while communicating information of interest.

Survey on Interest in Creation of a Universal CE Certificate

The Academy of General Dentistry (AGD) is seeking feedback from state dental boards about their interest in the creation of a universal continuing education (CE) certificate. If a universal CE certificate is created, ideally all providers of dental CE would be required to fill out the same template certificate for each course participant. The certificate would provide all of the information a state dental board requires for course approval while having it appear in the same place every time. To that end, the AGD would like to ask all state dental boards to respond to the following two questions:

1. *Would your state dental board be interested in seeing a universal CE certificate, approved by both the AGD's Program Approval for Continuing Education (PACE) and the American Dental Association's (ADA) Continuing Education Recognition Program (CERP)?*

_____ **Yes, we would be interested in seeing this happen.**

_____ **No, we would not be interested in seeing this happen.**

If no, please explain why: _____

2. *If yes, would you be willing to help the AGD work to achieve this?*

_____ **Yes**

_____ **No**

Please send your responses via e-mail to advocacy@agd.org or via fax to 312.335.3425 by Friday, Oct. 30, 2009. THANK YOU!

Notification of Credentials

A recent petition to the North Carolina Medical Board proposes to change the North Carolina General Statutes section 150B-20(a) requiring any non-physician health care provider who uses the designation "Doctor" to (a) identify the specific type of license under which he/she is authorized to practice by wearing an identification badge and (b) verbally disclose to patients the specific type of license or certification under which he/she is licensed to practice.

Teeth Whitening Update

In January 2008, the AGD *transcript* e-newsletter published an article about who is eligible to perform teeth whitening procedures. Since then, many state agencies, including both dental boards and legislatures, have undertaken this debate. Find out what's been happening during the past year and a half.

AGD Report on HRSA Workforce Summit

Through its Washington lobbyist firm, the AGD attended the Health Resources and Services Administration (HRSA) Health Care Workforce Summit held in Washington, D.C., Aug. 10-12, 2009. The summit assembled health care workforce experts from government, industry, and academia to explore the challenges facing the health delivery system.

Collaborative Health Care for Older Adults: A Symposium for Creating Dialogue between Medicine and Dentistry

On Oct. 16, 2009, the New York Academy of Sciences, in collaboration with Oral Health America, Columbia University, College of Dental Medicine (CUCDM) and Columbia University, College of Physicians and Surgeons, hosted a symposium that brought together geriatric care leaders from the medical and dental communities. This symposium focused on oral health and the significant role it plays in the overall health of the older population. Stanley Markovits, DDS, attended on behalf of the AGD.



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Reen, Sandra

From: annemarie connolly [annem256@yahoo.com]

Sent: Wednesday, October 14, 2009 1:14 PM

To: Reen, Sandra

Subject: Sargenti Paste in the News

Hello,

I am sending you the link to a news broadcast that aired on WCAU Philadelphia. It is about the harm that Sargenti Paste can cause to a patient.

State Dental Boards are mandated to protect the public. The FDA states that the public cannot be assured of the safety and effectiveness of Sargenti Paste, therefore it lies with you to take direction from their statement. We are asking that you put in place stronger policies to make sure that no patient will be injured by this toxic substance.

http://www.nbcphiladelphia.com/news/health/Investigaton_Is_Your_Root_Canal_Treatment_Safe_Philade

Thank you,

Annemarie Miczulski

www.worstrootcanalever.com

Standards for Professional Conduct In The Practice of Dentistry

Preamble

The Standards for Professional Conduct for licensees of the Virginia Board of Dentistry establishes a set of principles to govern the conduct of licensees in the profession of dentistry. Licensees must respect that the practice of dentistry is a privilege which requires a high position of trust within society. The Board maintains that adherence to these standards will safeguard patients, uphold the laws and regulations governing practice and maintain the public trust. The standards are an expression of types of conduct that are either required or encouraged and that are either prohibited or discouraged to provide further guidance on the requirements for practice set out in the Code of Virginia and the Regulations Governing the Practice of Dentistry and Dental Hygiene.

Scope of Practice

- Keep knowledge and skills current. The privilege, professional status, and a license to practice derive from the knowledge, skill, and experience needed to safely serve the public and patients.
- Seek consultation, if possible whenever the welfare of patients will be safeguarded or advanced by utilizing the knowledge and skills of those who have special skills, knowledge and experience, or advanced training.
- Do not prescribe treatment or use diagnostic techniques or diagnose, cure, or alleviate diseases, infections or other conditions that are not within the scope of the practice of dentistry or that are not based upon accepted scientific knowledge or research.
- Do not treat or prescribe for yourself.

Treating or Prescribing for Family

- Only treat and prescribe based on a bona-fide practitioner-patient relationship, and prescribe by criteria set forth in §54.1-3303 of the Code of Virginia.
- Do not prescribe to a family member a controlled substance or a medicine outside the scope of dentistry.
- When treating a family member or a patient maintain a patient record documenting a bona-fide practitioner-patient relationship.

Staff Supervision

- Protect the health of patients by only assigning to qualified auxiliaries those duties which can be legally delegated.
- Prescribe and supervise the patient care provided by all auxiliary personnel in accordance with the correct type of supervision.
- Maintain documentation that staff has current licenses, certificates for radiology, up-to-date vaccinations, CPR training, HIPPA training, and OSHA training in personnel files.

- Display documents that are required to be posted in the patient receiving area so that all patients might see and read them.
- Be responsible for the professional behavior of staff towards patients and the public at all times.
- Avoid unprofessional behavior with staff
- Provide staff with a safe environment at all times.
- Provide staff with opportunities for continuing education that will keep treatment and services up-to-date and allow staff to meet continuing education requirements
- Supervise staff in dispensing, mixing and following the instruction for materials to be used during treatment.
- Instruct the staff to inform the dentist of any event in the office concerning the welfare of the patient regarding exposures or blood borne pathogens

Practitioner-Patient Communications

- Before performing any dental procedure, accurately inform the patient or the guardian of a minor patient of the diagnoses, prognosis and the benefits, risks, and treatment alternatives to include the consequences of doing nothing.
- Inform the patient of proposed treatment and any reasonable alternatives, in understandable terms to allow the patient to become involved in treatment decisions.
- Acquire informed consent of a patient prior to performing any treatment.
- Refrain from harming the patient and from recommending and performing unnecessary dental services or procedures.
- Specialists must inform the patient that there is a need for continuing care when they complete their specialized care and refer patients to a general dentist or another specialist to continue their care.
- Immediately inform any patient who may have been exposed to blood or other infectious material in the dental office or during a procedure about the need for post exposure evaluation and follow up and to immediately refer the patient to a qualified health care professional
- Do not represent the care being provided in a false or misleading manner
- Inform the patient orally and note in the record any deviation in a procedure due to the dentist's discretion or a situation that arises during treatment that could delay completion of treatment or affect the prognosis for the condition being treated.
- Inform the patient about the materials used for any restoration or procedure such as crowns, bridges, restorative materials, ingestibles, and topicals as to risks, alternatives, benefits, and costs, as well as describing the materials, procedures, or special circumstances in the patient's notes.
- Refrain from removing amalgam restorations from a non-allergic patient for the alleged purpose of removing toxic substances from the body. The same applies to removing any other dental materials.

Patient of Record

- A patient becomes a patient of record when the patient is seated in the dental chair and examination and diagnosis of the oral cavity is initiated.
- In §54.1-2405(B) of the Code of Virginia, “current patient” means a patient who has had a patient encounter with the provider or his professional practice during the two-year period immediately preceding the date of the record transfer.

Patient Records

- Maintain treatment records that are timely, accurate, legible and complete.
- Note all procedures performed as well as substances and materials used.
- Note all drugs with strength and quantity administered and dispensed.
- Safeguard the confidentiality of patient records.
- Upon request of a patient or an authorized dental practitioner, provide any information that will be beneficial for the welfare and future treatment of that patient.
- On request of the patient or the patient’s new dentist timely furnish gratuitously or at a reasonable cost, legible copies of all dental and financial records and readable copies of x-rays. This obligation exists whether or not the patient’s account is paid in full.
- Comply with §32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.
- Post information concerning the time frame for record retention and destruction in the patient receiving area so that all patients might see and read it.
- Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.
- Maintain records for not less than three years from the last date of treatment as required by the Board of Dentistry and maintain records for longer periods of time to meet contractual obligations or requirements of federal law.
- When closing, selling or relocating a practice, meet the requirements of §54.1-2405 of the Code of Virginia for giving notice and providing records.

Financial Transactions

- Do not accept or tender “rebates” or split fees with other health professionals.
- Maintain a listing of customary fees and represent all fees being charged clearly and accurately.
- Do not use a different fee without providing the patient or third party payers a reasonable explanation which is recorded in the record.
- Return fees to the patient or third party payers in a timely manner if a procedure is not completed or the method of treatment is changed.
- Do not accept a third party payment in full without disclosing to the third party that the patient’s payment portion will not be collected.
- Do not increase fees charged to a patient who is covered by a dental benefit plan.

- Do not incorrectly describe a dental procedure in order to receive a greater payment or reimbursement or incorrectly make a non-covered procedure appear to be a covered procedure on a claim form.
- Do not certify in a patient's record or on a third party claim that a procedure is completed when it is not completed.
- Do not use inaccurate dates that are to benefit the patient; false or misleading codes; change the procedure code to justify a false procedure; falsify a claim not having done the procedure, or expand the claim.
- Avoid exploiting the trust a patient has in the professional relationship when promoting or selling a product by: advising the patient or buyer if there is a financial incentive for the dentist to recommend the product; providing the patient with written information about the product's contents and intended use as well as any directions and cautions that apply to its use; and, informing the patient if the product is available elsewhere.
- Do not misrepresent a product's value or necessity or the dentist's professional expertise in recommending products or procedures.

Relationships with Practitioners

- Upon completion of their care, specialists or consulting dentists are to refer back to the referring dentist, or if none, to the dentist of record for future care unless the patient expresses a different preference.
- A dentist who is rendering a second opinion regarding a diagnosis or treatment plan should not have a vested interest in the patient's case and should not seek to secure the patient for treatment unless selected by the patient for care.

Practitioner Responsibility

- Once a course of treatment is undertaken, the dentist shall not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Emergency care must be provided during the notice period to make sure that the patient's oral health is not jeopardized or to stabilize the patient's condition.
- Only prescribe, dispense, and utilize those devices, drugs, dental materials and other agents accepted for dental treatment.
- Make reasonable arrangements for the emergency care of patients of record.
- Exercise reasonable discretion in the selection of patients. Dentists may not refuse patients because of the patient's race, creed, color, sex, or national origin.
- Do not refuse to treat a patient because the individual has AIDS, is HIV positive, or has had hepatitis. Use a proper protocol in the office to protect the public and staff.
- Follow the rules and regulations of HIPPA, OSHA, FDA, and the laws governing health practitioners in the Code of Virginia.
- Be knowledgeable in providing emergency care and have an acceptable emergency plan with delegated duties to the staff in written form, maintain accurate records and be current in basic CPR.

- Avoid interpersonal relationships with patients and staff that could impair professional judgment or risk the possibility of exploiting the veracity and confidence placed in the doctor-patient relationship.

Advertising Ethics

- Do not hold out as exclusive any device agent, method, or technique if that representation would be false or misleading in any material respect to the public or patients.
- When you advertise, fees must be included stating the cost of all related procedures, services and products which to a substantial likelihood are necessary for the completion of the service as it would be understood by an ordinarily prudent person.
- Disclose the complete name of a specialty board or other organization which conferred certification or another form of credential.
- Do not claim to be a specialist or claim to be superior in any dental specialty or procedure unless you have attained proper credentials from an advanced postgraduate education program accredited by the Commission on Dental Accreditation of the American Dental Association.

Reports and Investigations

- Cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board and timely provide information and records as requested.
- Allow staff to cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board.
- Report the adverse reaction of a drug or dental device to the appropriate medical and dental community and in the case of a serious event to the Food and Drug Administration or Board of Dentistry.
- Provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.
- Become familiar with the special signs of child abuse and report suspected cases to the proper authorities.
- Report to the Board of Dentistry instances of gross or continually faulty treatment by other dentists.

Notice

This guidance document does not address every law and regulation which governs the practice of dentistry. To fully understand your legal responsibilities you should periodically review the laws, regulations, notices and guidance documents provided on the Board of Dentistry webpage, www.dhp.virginia.gov/dentistry.

Disciplinary Caseload Report for December 4, 2009

This report addresses the three key performance measures for discipline for the first quarter of fiscal year 2010 as well as provides some highlights for where the disciplinary cases stand now and what to expect as we move into the third quarter of fiscal year 2010.

The agency's three key performance measures for disciplinary case processing are as follows:

1. We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
(Dentistry's Clearance rate is 106%.)
2. We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
(Dentistry case load of over 250 business days is 8%.)
3. We will investigate and process 90% of patient care cases within 250 work days.
(Dentistry closed 94% of its patient care cases within 250 work days.)

Of the three largest boards in the agency, Nursing, Medicine and Dentistry, we are the only board that met all three performance measures for the first quarter.

One year ago, the Board had 80 cases over 250 business days. At the beginning of this quarter (Q2 2010) we had 5 cases over 250 business days and currently there are 5 cases over 250 business days.

With 182 open cases this makes our pending caseload older than 250 business days at 3%. This is well within the agency goal of reducing the percentage of open patient care caseload older than 250 business days to no more than 25% by the end of FY 2010.

Of these 5 cases that are over 250 days, four of these cases are in Probable Cause and have Notices of Informal Conference drafts pending and one has a CCA offered. One case is in Investigation.

From July 1, 2009 to September 9, 2009 the Board has received 91 cases from Enforcement in all categories and has closed 105 cases for a 115% case closure rate.

The 108 cases were closed as follows:

- No Violation/Undetermined – 77 cases
- No Violation / Advisory Letter 13 cases
- Violation / IFC, PHCO, Formal – 10 cases
- Violation / CCA – 5 cases

A Look Ahead At the Cases Over 240 Calendar Days

Barring any continuances, the 5 cases that are currently greater than 365 calendar days should be closed by the next Board meeting. We have about 6 more cases that may creep into the greater than 250 calendar days between now and the next board meeting, but these cases are either at APD, already scheduled for Informal Conferences or have Notices of Informal Conferences drafted and need final reviews. Therefore, these cases will likely be closed by the next full Board meeting. Dentistry has about 9 cases that are moving quickly towards being scheduled for informal conferences in January and February. Four cases are in Investigation and 5 are being reviewed by Board members. Therefore, there is a good possibility that at the next Board meeting I will be able to report that the Board of Dentistry has zero cases over 365 calendar days.

The following tables show cases moving through the adjudication procedure. You can compare where we were at this time last year as well as see how cases have moved this quarter.

11/12/08	Number	Inv	P/C	APD	IFC	Formal
A	3	2	1	0	0	0
B	14	2	3	2	5	2
C	169	55	73	9	19	4
D	22	4	11	1	3	0
Total	208 (80>250)	64	88	12	27	6

9/9/09	Number	Inv	P/C	APD	IFC	Formal
A	5	0	0	1	1	2 (1@OAG)
B	16	6	5	4	0	0
C	110	66	33 (24)	4	5	1
D	43	16	21 (14)	4	1	0
Total	171 (5>250)	88	59	13	7	3

11/3/09	Number	Inv	P/C	APD	IFC	Formal
A	5	4	0	0	1	0
B	16	9	7	0	0	0
C	114	70	40(20)*	2	2	2
D	47	19	26(7)*	1	1	0
Total	182 (5>250)	102	73	4	4	2

*(Cases w/Board review)