VIRGINIA BOARD OF DENTISTRY

AGENDA

March 11, 2011

Department of Health Professions

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

PAGE

March 11, 2011

9:00 a.m. **Board Meeting**

Call to Order – Ms. Pace, President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- December 2, 2010 Formal Hearing P.1–P.3
- December 3, 2010 Board Meeting P.4–P.12
- January 5, 2011 Telephone Conference P.13
- January 28, 2011 Formal Hearing P.14-P.15

DHP Director's Report – Dr. Reynolds-Cane

Evaluating the Need to Regulate a Heath Profession and Healthcare Workforce Data Center's Dentistry Advisory Committee – Elizabeth Carter, Ph.D., Executive Director, Board of Health Professions and Director, Healthcare Workforce Data Center P.16-P.31

President's Plaque Presentation to Dr. Levin – Ms. Pace

Liaison/Committee Reports

- BHP – Dr. Zimmet
- AADB Report – Dr. Levin
- SRTA – Dr. Gokli and Ms. Pace
- SCDDE – Dr. Boyd
- Regulatory/Legislative Committee – Dr. Boyd

Legislation and Regulation – Ms. Reen

- Report on Legislation Related to Dentistry P.32-P.36
- Review of Regulatory Actions P.37
- Amend Radiation Certification Regulations P.38-P.42

Board Discussion/Action

- Public Comment Topics
- FAQ from the Committee for an Integrated Examination P.43-P.51
- Amendment of Educational Requirements for DasII P.52-P.54
- University of Florida Request for Teleradiology Consults P.55-P.56

Report on Case Activity – Mr. Heaberlin P.57-P.58

PAGE

Executive Director's Report/Business – Ms. Reen

Recommedation of Credentials Committee

- **Case # 135116**

Board Counsel Report – Mr. Casway

Adjourn

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARINGS
December 2, 2010

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 11:06 a.m. on December 2, 2010 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Robert B. Hall, Jr., D.D.S.

MEMBERS PRESENT:
Jeffrey Levin, D.D.S.
Paul N. Zimmet, D.D.S.
Herbert R. Boyd, III, D.D.S.
Myra Howard, Citizen Member
Martha C. Cutright. D.D.S.

MEMBERS EXCUSED:
Augustus A. Petticolas, Jr., D.D.S.
Meera Gokli, D.D.S.
Jacqueline G. Pace, R.D.H.

MEMBER ABSENT: Misty Mesimer, R.D.H.

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

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

OTHERS PRESENT:
Kelley Wynne, Adjudication Specialist
Lynn Taylor, Court Reporter, Farnsworth & Taylor Reporting

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

Robert E. Cruickshanks, D.D.S.
Case No. 131225: The initial hearing was convened at 11:06 am and adjourned at 12:15 pm. Dr. Cruickshanks was not present.

Following the arrival of Dr. Cruickshanks, the Board decided to vacate the previous hearing and to re-convene at 1:05 pm.

ADDITIONAL MEMBER ABSENT AT THIS HEARING: Jeffrey Levin, D.D.S.

ESTABLISHMENT OF A PANEL:

With five members present, a panel was established.

Dr. Cruickshanks appeared without counsel in accordance with a Notice of the Board dated September 20, 2010.

Dr. Hall swore in the witnesses.

Following Ms. Wynne's opening statement, Dr. Hall admitted into evidence Commonwealth's exhibit 1 through 5.

Dr. Cruickshanks had no evidence to submit after his opening statement.

Testifying on behalf of the Commonwealth was Rose DeMatteo, the Board of Dentistry Compliance Manager.

Dr. Cruickshanks testified on his own behalf.

Closed Meeting:

Dr. Boyd 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. Cruickshanks. 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:

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

Mr. Casway reviewed the findings and conclusions then reported that the Board decided to suspend Dr. Cruickshanks's license indefinitely for a period of not less than 60 days. At such time as Dr. Cruickshanks petitions the Board for reinstatement of his license, he shall be noticed to appear before a Special Conference Committee of the Board which shall have the

authority to determine whether to reinstate his license and upon such terms as it may deem necessary.

Dr. Zimmet moved to adopt the Findings of Fact, Conclusions of Law and Sanctions as read by Mr. Casway. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 3:40 p.m.

Robert B. Hall, Jr., DDS, Vice President

Date

Sandra K. Reen, Executive Director

Date

VIRGINIA BOARD OF DENTISTRY
MINUTES
December 3, 2010

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:02 a.m. on December 3, 2010 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jacqueline G. Pace, R.D.H., President

BOARD MEMBERS PRESENT:
Robert B. Hall, Jr. D.D.S., Vice President
Augustus A. Petticolas, Jr., . D.D.S., Secretary-Treasurer
Herbert R. Boyd, III, D.D.S.
Martha C. Cutright, D.D.S.
Jeffrey Levin, D.D.S.
Paul N. Zimmet, D.D.S.

BOARD MEMBERS ABSENT:
Meera A. Gokli, D.D.S.
Misty Mesimer, R.D.H.
Myra Howard, Citizen Member

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Arnie Owens, DHP Deputy Director
Elaine Yeatts, DHP Senior Policy Analyst
Alan Heaberlin, Deputy Executive Director for the Board
Huong Vu, Administrative Assistant for the Board

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

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

PUBLIC COMMENT: **Michelle Satterlund** with the Virginia Association of Nurse Anesthetists (VANA) spoke in favor of allowing CRNAs to practice in all dental settings regardless of the training of the dentist and in opposition to the contrary position taken by the Virginia Society of Oral Maxillofacial Surgeons (VSOMS). She stated that CRNAs are not required to be supervised in other practice settings and that the standards for CRNA practice should not be different in a dental office.

Dag Zapatero, D.D.S. from Virginia Beach passed out information he collected about dental laboratory services and asked the Board to consider:

- Including Dental Lab Technicians as a regulated profession
- Requiring laboratory registration with annual disclosure of the use of foreign labs
- Requiring each lab to have at least one certified dental technician (CDT)
- Requiring continuing education for lab technicians
- Requiring disclosure of point of origin and materials used
- Imposing penalties for non compliance

Ed Amrhen, D.D.S., President of the Virginia Society of Oral Maxillofacial Surgeons (VSOMS), expressed VSOMS opposition to VANA's proposal to allow CRNAs to work in dental offices without a qualified dentist supervising. He asked to Board to think about the outcome if an adverse reaction occurs and the dentist is not able to intervene. He then asked how many dentists have asked the Board to use CRNAs.

Ms. Reen stated that all public comment topics would be considered later under Board discussion/action.

APPROVAL OF MINUTES:

Ms. Pace asked if the Board members had reviewed the minutes in the agenda package. Dr. Zimmet moved to accept the minutes of the August 5, 2009 and July 10, 2010 Telephone Conference Calls. The motion was seconded and carried.

Dr. Levin moved to accept the minutes of the September 17, 2010 Business minutes and the October 9, 2010 Telephone Conference Call. The motion was seconded and carried.

DHP DIRECTOR'S REPORT:

Mr. Owens noted that Dr. Cane could not attend due to a prior commitment. He then reported that:

- The Board Member Orientation on October 27, 2010 was a great success which the Department plans to repeat annually.
- The Governor established six taskforces for the Virginia Health Reform Initiative (VHRI). The six taskforces are:
    1. Medicaid Reform
    2. Insurance Reform
    3. Service Delivery and Payment Reform
    4. Capacity
    5. Technology
    6. Purchasers

These taskforces are coordinating with the Virginia Health Reform Initiative Advisory Council to bring recommendations to the Governor for a comprehensive strategy for implementing health reform in Virginia. The Advisory Council's final meeting for this year will be on December 13-14, 2010.

- The Workforce Data Center has just organized the Dentistry Workforce Advisory Committee to develop the survey which will be conducted in concert with the 2012 license renewal process. He indicated that the data collected should be rolled out about one year from now.
- National Take Back Day by Drug Enforcement Administration (DEA), supported by DHP was very successful. Two and a half tons of controlled substances were collected. DEA plans to repeat this activity in the future.

TRAINING ON SANCTION REFERENCE POINTS (SRP):

Kim Langston, Research Associate for VisualResearch, Inc. provided a training seminar to the Board. She presented a PowerPoint presentation including the following topics:

- The purpose of SRP
- Three worksheets were developed through study sample
- Which worksheet is used when multiple case types exits
- Sanctioning ranges available after a score has been determined
- Departures Reasons
- Cases to exclude
- SRP Agreement Analysis

Dr. Zimmet asked if Pre-Hearing Hearing Consent Orders (PHCO) are included in the statistics. Ms. Langston responded no and Ms. Reen indicated that it would be good to complete the worksheets on PHCOs for inclusion in the data.

ENFORCEMENT UPDATE:

Faye Lemon, Director of Enforcement, introduced herself and Sammy Johnson, Deputy Director of Enforcement to the Board. She gave a PowerPoint presentation on the following:

- Role of Enforcement
- Sources of Complaints

- Complaint Priorities A-D
- Dentistry major case categories
- Typical Investigation

Mr. Johnson added that the Board has done two rounds of audits on the Oral and Maxillofacial Surgeons with cosmetic certification.

Dr. Zimmet thanked Ms. Lemon for improvements made in investigation reports and in obtaining readable x-rays. Ms. Lemon commented that tiering cases and early coordination with Board staff have really helped.

REPORTS:

Board of Health Professions (BHP). Dr. Zimmet indicated the board was scheduled to meet next week so he had no report.

AADB. Dr. Levin said that he, Ms. Pace, Ms. Reen and Mr. Casway attended the AADB annual meeting in Orlando in October 2010 then reported the following topics were addressed:

- The various strategies being developed by states to create and expand mid-level providers
- Live testing for dental licensure is a continuing issue and AADB has appointed a taskforce to look into this issue within the next two years
- Role of continuing education as in establishing continuing competence

He added that during the annual ADA meeting Dr. Terry D. Dickerson, Executive Director of the Virginia Dental Association and the VCU School of Dentistry were recognized.

Ms. Pace stated that the AADB Dental Hygiene Caucus met on October 7, 2010 where ten states were represented. She reported the following:

- the growing interest in the Advanced Dental Hygiene Practitioner model for mid-level providers with support for building upon an established profession rather than creating new ones
- Washington State Dental Association and Connecticut State Dental Association have passed resolutions to support establishing Dental Therapist practitioners in their states
- 29 states are considering legislative changes in the hygiene scope of practice to address access to care issues
- the Minnesota Oral Health Care Practitioner (MSOHCP) model was introduced and it was noted

that its first class is expected to graduate next year(2011).

SRTA. Ms. Pace read a report from Dr. Watkins on the changes made to the Dental Examination which included:

- In the endodontic section, requiring that "the restoration must not encroach upon the access opening."
- Deleting the penalty on one criteria error if stints are not submitted.
- Any form of patient sedation prior to approval will result in failure of and dismissal from the exam.
- Any patient who has received IV, IM or subcutaneous bisphosphonate is not eligible to sit for the exam.
- Penalty verbiage was changed from "may be grounds for dismissal" to "will be grounds for dismissal."
- Defined Class II Composite Slot, and
- The process for managing the general Evaluation Forms generated by the CFC was established.

Ms. Pace added that SRTA will address two items with the educators at a future meeting. The items are not allowing latex sensitive patients and allowing the use of mandibular first premolars. She also noted that the online calibration exam for examiners is now available.

Dentistry Workforce Advisory Committee. Dr. Petticolas reported that the Department of Health Professions Healthcare Workforce Data Center has established the advisory committee for developing surveys for dentistry licensees and that he is serving on the committee. He explained that the Center is collecting data to measure Virginia's healthcare workforce supply and demand. The committee will develop surveys to be completed online during licensure renewal. For the first time, dentists and dental hygienists will be surveyed directly on key issues related to workforce (practice types, locations, hours worked, anticipated retirement). The results will be analyzed and reported annually and will be available to policymakers, researchers, insurers, hospitals, and the general public. Information concerning individuals will remain confidential. The surveys will be developed during FY2011 and implemented during the license renewal process of 2012.

Regulatory/Legislative Committee. Dr. Hall reported that the Committee met yesterday and discussed the VCU School of Dentistry's legislative proposal. Ms. Reen noted that Dr. David C. Sarrett, Dean of the School, would like to address the Board then reported that she had identified some concerns with the proposed language regarding temporary licenses for continuing education, authorizing

licensure when an applicant has failed a clinical examination twice, permitting licensure of someone with no CODA accredited training and allowing the Board to license someone based on its opinion that the applicant is otherwise qualified. Dr. Sarrett then explained the problems with the current law which hinder the School in recruiting qualified foreign trained faculty members. He said the proposed legislation will permit issuance of faculty licenses to individuals who either hold a license in another state or have completed a CODA accredited advanced specialty program but have not completed a CODA accredited DDS or DMD program. Dr. Levin moved that Board staff work with the School to address the identified policy concerns and to offer technical assistance in re-drafting the bill. The motion was seconded and passed.

Dr. Hall stated that the Committee would reconvene its meeting following the Board business meeting.

LEGISLATION AND REGULATION:

Review of Regulatory Action. Ms. Reen reported that the:

- Public comment period on the NOIRA for Periodic Review and Reorganization of the regulations ended and the request for an extension for publication is still pending with the Governor's office.
- Recovery of Disciplinary Costs regs are still pending the Governor's approval for publication for public comment.
- Registration of Mobile Clinics – Ms. Reen reported that these final regulations are at the Governor's office for approval and will not be in place by January 7, 2011. She added that an extension of the emergency regulations has been requested but not yet granted by the Governor.
- Registration and Practice of Dental Assistants – Ms. Reen reported that these regulations are also at the Governor's office. She added that once approved these will be published for 30 days before becoming effective.

BOARD DISCUSSION/ACTION:

Public Comment Topics. Ms. Reen noted that all public comment topics are already on the agenda for discussion.

Letter from Dr. Zapatero, D.D.S. Ms. Reen stated that Dr. Zapatero's letter asks the Board to require dental labs to register to do business for Virginia dentist. Dr. Levin commented that dentists should be held liable for the

materials being used in dental appliances. Dr. Hall added that the Board is pursuing the dental lab form requirement. Ms. Reen noted that the Board currently does not have any statutory authority over the dental labs. The Board only has the authority to prescribe dental lab form. She added that the Board could ask the Board of Health Professions (BHP) to study the need to register dental labs and to certify dental lab technicians to protect patients. Dr. Boyd moved to ask Dr. Carter, the executive director of the BHP, to discuss how a study would be conducted at the next Board meeting. The motion was seconded and passed.

VSOM Letter. Ms. Reen stated that the Regulatory-Legislative Committee will consider the utilization of CRNAs when it addresses the regulations on administering controlled substances as part of the regulatory review process.

Guidance Document on Delegating to Dental Assistants. Ms. Reen stated that she and Dr. Zimmet met to edit the guidance document as requested at the last Board meeting and that it is presented for action. After much discussion the Board made the following changes:

- Expand the section on radiology to include operating an intraoral camera/scanner and taking images for CADCAM restorations.
- Expand the provisions for taking impressions to address opposing models, various guards and trays.
- Delete one of the items addressing placing bands and brackets
- Add taking impressions for orthodontic study models and retainers.

Dr. Hall moved to adopt the guidance document as amended for release when the Dental Assistant II regulations become effective. The motion was seconded and passed.

Volunteer Practice Application. Dr. Petticolas stated that he and Ms. Reen met on October 22, 2010 to review the application and agreed it is too lengthy. They also determined that some of the required documents may already be on file for applicants previously licensed in Virginia. He added that the other application requirements in 18VAC60-20-100 need to be changed before the application can be changed. He asked that the requirements for volunteer practice be reduced in the regulatory review process. All agreed.

He added that in the meantime, the executive director is acting to make the application process less burdensome by

waiving the requirement for original results from National Dental Board Exams for applicants who previously held Virginia dental licenses.

Dental Lab Forms. Dr. Hall presented samples of two dental lab forms, one for the dental lab and one for the dental lab subcontractor. He then referred to the letter from Saunders Dental Laboratory and noted that it was not the intention of the Board to mandate the form but rather to establish the minimum information requirements. Ms. Reen asked if the Board wants to proceed with issuing these forms as a guidance document. The consensus was to return the forms for additional work by the Regulatory-Legislative Committee.

REPORT ON CASE ACTIVITY:

Mr. Heaberlin reported that the Board continues to meet or exceed the key performance measures for discipline cases. He said for the period from June 1, 2010 to August 31, 2010 the Board received 109 cases excluding ones for late renewal. He added that 159 late renewal cases were closed with either a CCA or an advisory letter and that 94 other cases were closed as follow:

- 55 No Violation
- 7 Undetermined
- 15 Violations
- 17 Advisory letters

He also reported that from September 1, 2010 to November 11, 2011 (Q2 FY2011) the Board received 118 cases excluding late renewal cases. He added that 169 late renewal cases were closed with either a CCA or an advisory letter and 114 other cases were closed as follows:

- 82 No Violation
- 11 Undetermined
- 12 Violations
- 2 CCAs
- 7 Advisory letters

He closed by stating that as of November 19, 2010, the Board has 197 open cases and that 44 advertising cases were received from September 1, 2010 to November 19, 2010.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Ms. Reen reported the following:

- The AADA meeting included an excellent presentation on skills and strategies for negotiating to win. She added that a presentation on the importance of airway management during sedation and anesthesia given

during the AADB meeting was also very informative. She encouraged adding provisions for airway management training in the regulations being developed through regulatory review.

- The Board's financial position is still healthy then said that costs associated with data management by VITA are growing dramatically and may eventually lead to a fee increase. Mr. Owen stated this is an issue that all state agencies are facing and that Dr. Cane and he are acting to control costs and find solutions.
- The North East Regional Board of Dental Examiners (NERB) has notified her that they have misreported Florida examination results as NERB results for 200 candidates who took the Florida exam in 2009 and 2010. Out of these 200 candidates, four (4) were licensed in Virginia based on the erroneous NERB score reports. She added that NERB had yet to inform these candidates of the problem. She asked the Board for guidance for addressing this situation. Mr. Casway advised her to notice these individuals for an informal conference and offer a prehearing consent order for voluntary surrender of their licenses. It was agreed by consensus that Ms. Reen should collect any additional information needed before beginning the disciplinary process and she should work closely with Mr. Casway in developing the notices to be issued to the four licensees.

BOARD COUNSEL REPORT:

Mr. Casway thanked the Board for sending him to the AADB Attorney's Roundtable meeting in October. He noted that it was extremely beneficial to him as the Board's attorney and reported on the discussions that took place on the following subjects:

- Practitioner data banks
- Litigation in AL and NC on teeth whitening.
- Moral turpitude as grounds for initial denial or for imposing discipline.
- Post doctoral training programs.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 1:10 p.m.

Jacqueline G. Pace, R.D.H., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED DRAFT

VIRGINIA BOARD OF DENTISTRY

MINUTES
SPECIAL SESSION – TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 12:03 p.m., on January 5, 2011, in Hearing Room 2, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, VA 23233.

PRESIDING: Jacqueline G. Pace, RDH.

MEMBERS PRESENT:
Herbert R. Boyd, III, D.D.S.
Martha C. Cutright, D.D.S.
Robert B. Hall, Jr., D.D.S.
Myra Howard, Citizen
Jeffrey Levin, D.D.S.
Augustus A. Petticolas, D.D.S.
Paul N. Zimmet, D.D.S.

MEMBERS ABSENT:
Meera A. Gokli, D.D.S.
Misty Mesimer, R.D.H.

QUORUM: With 8 members present, a quorum was established.

STAFF PRESENT:
Sandra K. Reen, Executive Director
Alan Heaberlin, Deputy Executive Director
Gail W. Ross, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT:
Howard Casway, Senior Assistant Attorney General
Wayne Halbleib, Senior Assistant Attorney General

GREGORY T. HARVEY, D.D.S. Case No. 132169 The Board received information from Mr. Halbleib in order to determine if Dr. Harvey's practice of dentistry constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.

DECISION: Dr. Zimmet moved that the Board find Dr. Harvey practiced in a manner to cause patient harm and that his license to practice dentistry shall be summarily restricted so as to preclude him from using or authorizing others to use a laser in the treatment of patients. Following a second and discussion, a roll call vote was taken. The motion passed with a 7 to 1 vote. Dr. Levin voted against the motion.

ADJOURNMENT: With all business concluded, the Board adjourned at 12:43 p.m.

_____ _____
Jacqueline G. Pace RDH, President Sandra K. Reen, Executive Director

_____ _____
Date Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARINGS
January 28, 2011

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 11:00 a.m. on January 28, 2011 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jacqueline G. Pace, R.D.H.

MEMBERS PRESENT: Paul N. Zimmet, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Myra Howard, Citizen Member
Martha C. Cutright. D.D.S.

MEMBERS EXCUSED: Herbert R. Boyd, III, D.D.S.
Robert B. Hall, Jr., D.D.S.

MEMBER ABSENT: Jeffrey Levin, D.D.S.
Meera Gokli, D.D.S.
Misty Mesimer, R.D.H.

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

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

OTHERS PRESENT: James E. Schliessman, Assistant Attorney General
Gail Ross, Adjudication Specialist
Lynn Taylor, Court Reporter, Farnsworth & Taylor Reporting

ESTABLISHMENT OF A QUORUM: With five members present, a panel was established.

Kent Stevens, D.D.S. Case No. 126468: Dr. Stevens appeared with counsel, R. Glen Morgan, in accordance with a Notice of the Board dated December 6, 2010.

Ms. Pace swore in the witnesses.

Following Mr. Schliessman's opening statement, Ms. Pace admitted into evidence Commonwealth's exhibits 1 through 5.

Mr. Morgan had no evidence to submit after his opening statement.

Testifying on behalf of the Commonwealth were Lynne Austin, RN, DHP Senior Investigator, William Hawkins, Facility Director of Southside Virginia Training Center, and Dr. Paul Da Cunha, DDS.

Testifying on behalf of Dr. Stevens was Dr. Robert Campbell, DDS. Dr. Stevens testified on his own behalf.

Closed Meeting: Dr. Petticolas 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. Stevens. 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: Dr. Petticolas 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: Ms. Pace asked Mr. Casway to report the Findings of Fact, Conclusions of Law and Sanctions adopted by the Board.

Mr. Casway reviewed the findings and conclusions then reported that the Board decided to suspend Dr. Stevens' right to renew his dental license indefinitely.

Dr. Zimmet moved to adopt the Findings of Fact, Conclusions of Law and Sanctions as read by Mr. Casway. The motion was seconded and passed.

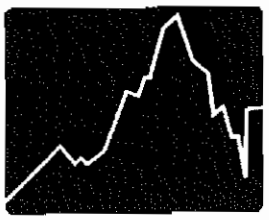
ADJOURNMENT: The Board adjourned at 7:05 p.m.

_____ _____

Jacqueline G. Pace, R.D.S., President Sandra K. Reen, Executive Director

_____ _____

Date Date



VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

VIRGINIA BOARD OF HEALTH PROFESSIONS

Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions

1998

TABLE OF CONTENTS

Introduction.....1

Authority.....2

Policies.....3

Statute.....3
The Criteria and Their Application.....5
Alternatives to Occupational and Professional Regulation..7

Procedures.....7

Who may request a study and how?.....7
How is a study conducted?.....8
What happens to the results?.....10

Appendix

Introduction

Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions: 1998 was developed to inform interested parties concerning the Virginia Board of Health Profession's authority to investigate the need for state regulation of health care providers and its approach in conducting such investigations. This report revises and supersedes a document of the same title published in 1992. This revision was prompted by the results of a study mandated by the 1996 Session of the General Assembly as set forth in forth in §54.1-2409.2 of the *Code of Virginia* (see insert).* The study required an examination of the appropriateness of the Board's evaluation standards.

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§54.1-2409.2. Board to set criteria for determining need for professional regulation. The Board of Health Professions shall study and prepare a report for submission to the Governor and the General Assembly by October 1, 1997, containing its findings and recommendations on the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession. Such criteria shall address at a minimum the following principles:

1. Promotion of effective health outcomes and protection of the public from harm.
2. Accountability of health regulatory bodies to the public.
3. Promotion of consumers' access to a competent health care provider workforce.
4. Encouragement of a flexible, rational, cost-effective heath care system that allows effective working relationships among health care providers.
5. Facilitation of professional and geographic mobility of competent providers.
6. Minimization of unreasonable or anti-competitive requirements that produce no demonstrable benefit.

The Board in its study shall analyze and frame its recommendations in the context of the total health care delivery system, considering the current and changing nature of the settings in which health care occupations and professions are practiced. It shall recognize in its recommendations the interaction of the regulation of health professionals with other areas of regulation, including, but not limited to, the following:

1. Regulation of facilities, organizations, and insurance plans;
2. Health delivery systems data;
3. Reimbursement issues;
4. Accreditation of education programs; and
5. Health workforce planning efforts.

The Board in its study shall review and analyze the work of publicly and privately sponsored studies of reform of health care workforce regulation in other states and nations. In conducting its study the Board shall cooperate with the state academic health science centers with accredited professional degree programs.

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* A copy of The *Study of the Appropriate Criteria to be Applied in Determining the Need for Regulation of Any Health Care Occupation or Profession* is available upon request.

Among the findings of this comprehensive study is that the Board's current seven criteria are appropriate: 1) risk of harm to the consumer, 2) specialized skills and training, 3) autonomous practice, 4) scope of practice, 5) economic impact, 6) alternatives to regulation, and 7) least restrictive regulation. A complete description of each is found on page 5. An accompanying finding, however, is that the application of the criteria could be strengthened by factoring in additional quantitative and qualitative evidence-based information.

In response to this finding, the Board now requires in its analysis consideration of a job analysis or role delineation study completed within the last two to three years as well as malpractice insurance coverage information. It is held that consistent review of these two sources of objective information should enable the Board to better apply Criteria One through Five.

Authority

The Virginia Board of Health Professions was established by the General Assembly in 1977 to advise the Governor and the General Assembly on matters related to the regulation of health occupations and professions and to provide policy coordination for the twelve health regulatory boards administered by the Virginia Department of Health Professions. It is comprised of seventeen members appointed by the Governor with five citizen members and a member from each of the twelve health regulatory boards.

The powers and duties of the Board are established in *Code of Virginia* § 54.1-2510. Among these duties is the following:

> **. . . [The Board shall] evaluate all health care professions and occupations in the Commonwealth, including those regulated and those not regulated by other provisions [of Title 54]** ***to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed*** **[emphasis added]. Whenever the Board determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Board shall recommend to the General Assembly a regulatory system to establish the appropriate degree of regulation.**

It must be made clear that the General Assembly, and not the Board, is the body empowered to make the final determination of the need for state regulation of a health care profession or occupation. The General Assembly has the authority to enact legislation specifying the profession to be regulated, the degree of regulation to be

imposed, and the organizational structure to be used to manage the regulatory program (e.g., board, advisory committee, registry).

The Board's role is purely advisory. It has the authority and responsibility to study and make recommendations concerning the need to regulate new (i.e., currently unregulated) occupations and professions (i.e., a "sunrise" review) as well as to routinely re-examine the appropriateness of the regulatory schemes for currently regulated professions and occupations.

Policies

The Board's evaluation policies are grounded in the Commonwealth's philosophy on occupational regulation as expressed in statute and in the Board's own *Criteria for Evaluating the Need for Regulation* (i.e., the Criteria). Alternatives to regulation are also always considered.

Statute

The following statement epitomizes the Commonwealth's philosophy on the regulation of professions and occupations: ***The occupational property rights of the individual may be abridged only to the degree necessary to protect the public.*** This tenet is clearly stipulated in statute and serves as the Board's over-arching philosophy in its approach to all its reviews of professions or occupations:

> **. . . the right of every person to engage in any lawful profession, trade or occupation of his choice is clearly protected by both the Constitution of the United States and the Constitution of the Commonwealth of Virginia. The Commonwealth cannot abridge such rights except as a reasonable exercise of its police powers when it is found that such abridgement is necessary for the preservation of the health, safety and welfare of the public. (*Code of Virginia* §54.1-100)**

Further statutory guidance is provided in this same *Code* section. The following conditions must be met before the state may impose regulation on a profession or occupation:

1. **The unregulated practice of a profession or occupation can endanger the health, safety or welfare of the public, and the potential for harm is recognizable and not remote or dependent upon tenuous argument;**

2. **The practice of the profession or occupation has inherent qualities peculiar to it that distinguish it from ordinary work or labor;**
3. **The practice of the profession or occupation requires specialized skill or training and the public needs, and will benefit by, assurances of initial and continuing professional and occupational ability; and**
4. **The public is not effectively protected by other means.**

In addition, although the General Assembly has established that the following factors be considered in evaluating the need for the regulation of *commercial* occupations and professions, the Board has determined that these factors should be considered in evaluating proposals for the regulation of *health* professions, as well.

1. **Whether the practitioner, if unregulated, performs a service for individuals involving a hazard to public health.**
2. **The opinion of a substantial portion of the people who do not practice the particular profession . . . on the need for regulation.**
3. **[Intentionally deleted]**
4. **Whether there is sufficient demand for the service for which there is no regulated substitute and this service is required by a substantial portion of the population.**
5. **Whether the profession or occupation requires high standards of public responsibility, character and performance of each individual engaged in the profession or occupation, evidence by established and published codes of ethics.**
6. **Whether the profession requires such skill that the public generally is not qualified to select a competent practitioner without some assurance that he has met minimum qualifications.**
7. **Whether the professional or occupational associations do not adequately protect the public from incompetent, unscrupulous or irresponsible members of the profession or occupation.**
8. **Whether current laws which pertain to public health, safety and welfare generally are ineffective or inadequate.**
9. **Whether the characteristics of the profession or occupation make it impractical or impossible to prohibit those practices of the profession or occupation which are detrimental to the public health, safety and welfare.**
10. **Whether the practitioner performs a service for others which may have a detrimental effect on third parties relying on the expert knowledge of the practitioner.**

(*Code of Virginia* §54.1-311(B)1-2, 4-10)

The Criteria and Their Application

Based on the principles of occupational and professional regulation established by the General Assembly, the Board has adopted the following criteria to guide evaluations of the need for regulation of health occupations and professions.

VIRGINIA BOARD OF HEALTH PROFESSIONS
CRITERIA FOR EVALUATING THE NEED FOR REGULATION
Initially Adopted October, 1991
Readopted February, 1998

Criterion One: Risk for Harm to the Consumer
The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

Criterion Two: Specialized Skills and Training
The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice
The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice
The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact
The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation
There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation
When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently, depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

Licensure. Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.

RISK: High potential, attributable to the nature of the practice.
SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.
SCOPE OF PRACTICE: Definable in enforceable legal terms.
COST: High
APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

Statutory Certification. Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
SCOPE OF PRACTICE: Definable, but not stipulated in law.
COST: Variable, depending upon level of restriction of supply of practitioners.
APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

Registration. Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.

RISK: Low potential, but consumers need to know that redress is possible.
SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.
AUTONOMY: Variable.
APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.

Professions currently practiced only with a license include medicine, nursing, dentistry, pharmacy, optometry, veterinary medicine, and psychology, among others. Rehabilitation

providers and massage therapists are certified by the state. Currently in Virginia, there are no health occupations or professions that are registered.

Alternatives to Occupational and Professional Regulation

When a risk or potential risk has been demonstrated but it is not substantiated that licensure, certification, or registration are appropriate remedies, other alternatives may be warranted. These alternatives should always be considered as less restrictive means of addressing the need to adequately protect the public health, safety, and welfare than restricting the occupational property rights of individuals.

Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods for protecting the public that do not require the regulation of specific occupations or professions.

Procedures

The Board has established general guidelines and procedures for the conduct of its evaluation studies. These procedures are intended to assist in the fair and equitable assessment of the need to regulate a profession or occupation or to determine the need for changing a current regulatory approach. These procedures are aimed at translating the Board's policies into operational terms. Three questions are addressed: Who may request a study and how? How is a study conducted? and What happens to the results?

Who may request a study and how? Requests for the Board to conduct an evaluation may come from a number of sources:

* the General Assembly
  - as a legislative resolution
  - as a request from an individual member,
- the Governor,
- the Director of the Department of Health Professions,
- Professional or Occupational Associations and Organizations,
- Concerned Members of the Public.

For requests from organizations or individuals, the review process commences with a formal letter of intent proposing the study. Because the time frame for such studies can require over a year (from request to recommendations), it is important that a contact person or persons be identified in this letter who will provide continuity to the review process. It should be noted that this time frame does not include consideration of the Board's recommendations by the Governor or General Assembly. Nor does it take into

account the extensive work that must be accomplished between the time the General Assembly may enact enabling legislation and the promulgation of regulations which would be required to implement such legislation.

Prior to filing a request, it is recommended that the responsible individual(s) meet with Director of the Department of Health Professions and the Executive Director for the Board. At this meeting, proposal preparation may be discussed in detail and a suggested timetable agreed upon.

How is a study conducted?

When a request for study is presented to the Board, the Board may agree to go forward or it may ask for additional information from the professional or organizational group in question. If the Board agrees to go forward with the study, the matter is referred to the Regulatory Research Committee, which conducts the study and prepares a report with recommendations for the full Board's review and final recommendations.

The Committee reviews and approves a staff prepared workplan, which details the background for the study, its scope, and the specific methodology to be employed. The specific questions to be addressed are detailed here and reflect those questions outlined in the Appendix. Traditional workplans include a comprehensive review of the relevant literature and provide opportunities for receipt of public comment. In some instances, further information is gathered through Board sponsored surveys of practitioners, other states, or other parties knowledgeable about the issues germane to the profession or occupation.

As discussed earlier, as a result of the recent review on the Criteria, it was determined that the evidentiary basis for application of the Criteria should be strengthened whenever possible. As such, the Board will now routinely refer to recent job analyses (or role delineation studies) and actuarial risk assessments of malpractice insurers.

Commonly used to develop credentialing examinations, a job analysis (or role delineation study) abstracts the knowledge, skills, and abilities that define a profession and help distinguish it from related professions. In its simplest terms, a job analysis provides a detailed job description. An occupation or profession is broken down into performance domains, which broadly define the profession being delineated. Then each performance domain is broken down further into tasks. The tasks are categorized further into knowledge, skills, and ability statements.

Malpractice insurance underwriters establish premium rates and the extent of coverage based upon their actuarial assessment of the risk posed by the insured group. Data on

civil suits, assessments of the type of work and work settings involved in practice, and evaluations of similar professions' claim histories, among other factors are considered.

Job analyses and data derived from malpractice insurance were selected to strengthen the Board's evidentiary basis for three reasons. First, they are generally readily available. Most health occupations and professions have professionally developed examinations based on job analyses, and most professions have malpractice insurance. Second, because they were designed for purposes other than to promote the regulation of the respective profession, these sources are viewed as relatively objective. Third, and most important, they are viewed as providing insight into better applying the most crucial criterion, Criterion One – Risk of Harm to the Consumer.

It has often been difficult or impossible to obtain objective information about actual harm to consumers gathered collectively by profession, precisely because the group is unregulated. The literature is usually unavailing, and evaluation of anecdotal evidence, alone, makes attributions to the profession (and not simply individuals) questionable. Thus, to make fair assessments about the *potential* risks to the public when actual data are lacking, the Board's evaluations of criticality based on recent job analyses and actuarial risk predictions found in the rationale for malpractice insurance coverage will be factored into the reasoning.

Job analyses and actuarial risk predictions are not only useful in applying Criterion One. To appropriately apply the entire Criteria, the Board must have a thorough understanding of what comprises the practice of the profession and the necessary educational and training background required for entry level competency.

To answer the questions posed by the Criteria, the Board will review the job analysis information garnered and apply its own measures of importance or *criticality*. Criticality "generally refers to the extent to which the ability to perform the task is essential to the performance on the job." (National Organization for Competency Assurance (1996) p.54).

To collect data on criticality, Likert-type scales will be used. The scales will vary depending upon specific issues being evaluated. For example, for Criterion One, information about potential harm that would result if the task were not performed competently would need to be evaluated. Scales such as those below would be appropriate. All major tasks will be reviewed, and the data tabulated to provide an overall score on each criterion for consideration by the Board.

Sample Criticality Scales for Rating Risk of Harm

Using the occupation as veterinary technician as an example, the following are sample scales for rating the risk of harm.

TASK 1: Scaling teeth above the gum line.

What is the effect of poor performance on public health & safety?

1. No risk
2. Little risk
3. Some risk
4. Significant risk
5. Severe risk

TASK 2: Preparing patient for surgery by shaving surgical area.

Could this activity be omitted on some occasions without having a major impact on client well-being?

1. Can sometimes omit – This activity could sometimes be omitted for some clients without a substantial risk of unnecessary complications, impairment of function or serious distress.

2. Can never omit – This activity could NEVER be omitted without a substantial risk of unnecessary complications, impairment of function, or serious distress.

Based on Correspondence with Kara Schmidt October 30, 1997 11:35 a.m.

These scores, along with the malpractice insurance risk assessment, literature review, public comment, and any other sources of information the Committee would like to explore will serve as the basis to answer the questions expressed in the workplan. Their responses form the basis for their report and recommendations.

What happens to the results?

Once completed, the Committee's study report including recommendations is forwarded to the full Board. Upon adoption or revision of the report, the Board prepares its report for the consideration of the Director of the Department, the Secretary of Health and Human Resources, the Governor, and the General Assembly.

Once the final draft is approved, the Board or the source of the study may disseminate the report as they deem appropriate.

Appendix

QUESTIONS TO BE CONSIDERED FOR THE EVALUATION OF THE NEED FOR REGULATION OF A HEALTH OCCUPATION OR PROFESSION

A. GENERAL INFORMATION

1. What occupational or professional group is seeking regulation?
2. What is the level or degree of regulation sought?
3. Identify by title the association, organization, or other group representing Virginia-based practitioners. (If more than one organization, provide the information requested below for each organization.)
4. Estimate the number of practitioners (members and nonmembers) in the Commonwealth.
5. How many of these practitioners are members of the group preparing the proposal? (If several levels or types of membership are relevant to this proposal, explain these level and provide the number of members, by type).
6. Do other organizations also represent practitioners of this occupation/profession in Virginia? If yes, provide contact information for these organizations.
7. Provide the name, title, organizational name, mailing address, and telephone number of the responsible contact person(s) for the organization preparing this proposal.
8. How was this organization and individual selected to prepare this proposal?
9. Are there other occupations/professions within the broad occupational grouping? What organization(s) represent these entities? (List those in existence and any that are emerging).
10. For each association or organization listed above, provide the name and contact information of the *national* organizations with which the state associations are affiliated.

B. QUESTIONS WHICH ADDRESS THE CRITERIA

Criterion One: Risk for Harm to the Consumer. *The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.*

1. Provide a description of the typical functions performed and services provided by members of this occupational group.
2. Has the public actually been harmed by unregulated providers or by providers who are regulated in other states? If so, how is the evidence of harm documented (i.e., court case or disciplinary or other administrative action)? Was is physical, emotional, mental, social, or financial?
3. If no evidence of actual harm is available, what aspects of the provider group's practice constitute a potential for harm?
4. To what can the harm be attributed? Elaborate as necessary.
    - lack of skills
    - lack of knowledge
    - lack of ethics
    - lack of supervision
    - practices inherent in the occupation
    - characteristics of the client/patients being served
    - characteristics of the practice setting
    - other (specify)

1. 5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a
2. competent practitioner?
3. 6. Does a potential for fraud exist because of the inability for third party payors to determine competency?

7. Is the **public** seeking regulation or greater accountability of this group?

Criterion Two: Specialized Skills and Training. The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

1. What are the educational or training requirements for entry into this occupation? Are these programs accredited? By whom?
    - Are sample curricula available?
    - Are there training programs in Virginia?
2. If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived?
3. Are there national, regional, and/or state examinations available to assess entry-level competency?
    - Who develops and administers the examination?
    - What content domains are tested?
    - Are the examinations psychometrically sound -- in keeping with *The Standards for Educational and Psychological Testing*?
4 Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?
5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?
6. Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so,
    - What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other organization)?
    - What are the various levels of specialties in terms of the functions or services performed by each?
    - How can the public differentiate among these levels or specialties for classification of practitioners?
    - Is a "generic" regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?

Criterion Three: The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

1. What is the nature of the judgments and decisions which the practitioner must make in practice?
    - Is the practitioner responsible for making diagnoses?
    - Does the practitioner design or approve treatment plans?
    - Does the practitioner direct or supervise patient care?
    - Does the practitioner use dangerous equipment or substance in performing his functions?

    If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?
2. Which functions typically performed by this practitioner group are **unsupervised**, i.e., neither directly monitored or routinely checked?
    - What proportion of the practitioner's time is spent in unsupervised activity?
    - Who is legally accountable/liable for acts performed with no supervision?
3. Which functions are performed **only under supervision**?
    - Is the supervision *direct* (i.e., the supervisor is on the premises and responsible) or *general* (i.e., supervisor is responsible but not necessarily on the premises)?
    - Who provides the supervision? How frequently? Where? For what purpose?
    - Who is legally accountable/liable for acts performed under supervision?
    - Is the supervisor a member of a regulated profession (please elaborate)?

- What is contained in a typical supervisory or collaborative arrangement protocol?

3. Does the practitioner of this occupation supervise others? Describe the nature of this supervision (as in #3 above).
4. What is a typical work setting like, including supervisory arrangements and interaction of the practitioner with other regulated/unregulated occupations and professions?
5. Does this occupational group treat or serve a specific consumer/client/patient population?
6. Are clients/consumers/patients **referred to** this occupational group for care or services? If so, by whom? Describe a typical referral mechanism.
7. Are clients/consumers/patients **referred from** this occupational group for care or services? If so, to what practitioners are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made?

Criterion Four: The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

1. Which functions of this occupation are **similar to** those performed by other health occupational groups?
   - Which group(s)?
   - Are the other groups regulated by the state?
   - If so, why might the applicant group be considered different?
2. Which functions of this occupation are **distinct from** other similar health occupational groups?
   - Which group(s)?
   - Are the other groups regulated by the state?
3. How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?

Criterion Five: The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

1. What are the range and average incomes of members of this occupational group in the Commonwealth? In adjoining states? Nationally?
2. What are the typical current fees for services provided by this group in the Commonwealth? In adjoining states? Nationally?
3. Is there any evidence that cost for services provided by this occupational group will increase if the group becomes state regulated? In other states, have there been any effects on fees/salaries attributable to state regulation?
4. Would state regulation of this occupation restrict other groups from providing care given by this group?
   - Are any of the other groups able to provide similar care at lower costs?
   - How is it that this lower cost is possible?
5. Are there current shortages/oversupplies of practitioners in Virginia? In the region? Nationally?
6. Are third-party payers in Virginia currently reimbursing services of the occupational group? By whom? For what?
   - If not in Virginia, elsewhere in the country?
   - Are similar services provided by another occupational group reimbursed by third-party payers in Virginia? Elsewhere? Elaborate.
7. If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation?

Criterion Six: There are no alternatives to State regulation of the occupation which adequately protect the public. [Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.]

1. What laws or regulations currently exist to govern:
    - Facilities in which practitioners practice or are employed?
    - Devices and substances used in the practice?
    - Standards or practice?

2. Does the institution or organization where the practitioners practice set and enforce standards of care? How?
3. Does the occupational group participate in a nongovernmental credentialing program, either thorough a national certifying agency or professional association (e.g., National Organization for Competency Assurance)?
    - How are the standards set and enforced in the program?
    - What is the extent of participation of practitioners in the program?
4. Does a Code of Ethics exist for this profession?
    - What is it?
    - Who established the Code?
    - How is it enforced?
    - Is adherence mandatory?
4. Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.
5. How is a practitioner disciplined and for what causes? Violation of standards of care? Unprofessional conduct? Other causes?
6. Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?
7. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)? How are challenges to a practitioner's competency handled?
9. What is the most appropriate level of regulation?

Board of Dentistry

Report of the 2011 Session of the General Assembly

HB 1459 Medical malpractice; increases cap on recovery in actions against health care providers.

Chief patron: Albo

Summary as passed:
Remedies; limitation on recovery in certain medical malpractice actions. Increases from $2 million to $2.05 million, on July 1, 2012, the cap on the recovery in actions against health care providers for medical malpractice. Thereafter, the cap is increased by $50,000 annually with the last increase on July 1, 2031. This bill is identical to SB 771.

02/16/11 House: VOTE: ADOPTION (89-Y 7-N)
02/17/11 House: Enrolled
02/17/11 House: Bill text as passed House and Senate (HB1459ER)
02/17/11 House: Signed by Speaker
02/20/11 Senate: Signed by President

HB 1642 Dental school faculty; licensure.

Chief patron: O'Bannon

Summary as passed House:
Dental school faculty; licensure. Provides that the Board of Dentistry may issue a faculty license to a faculty member of an accredited dental program who is (i) a graduate of a dental school or college or dental department of a college or university, is licensed to practice dentistry in another state and has never been licensed in Virginia, or (ii) a graduate of a dental school or college or dental department of a college or university, has completed an advanced dental education program, and has never been licensed in Virginia. This bill also provides that faculty licenses issued by the Board and temporary licenses issued by the Board for persons enrolled in advanced dental education programs, serving as dental interns or residents, or post-doctoral certificate or degree candidates shall be for patient care activities associated with the educational program and that take place within facilities owned or operated by or affiliated with the dental school or program.

01/21/11 House: VOTE: BLOCK VOTE PASSAGE (94-Y 0-N)
01/24/11 Senate: Constitutional reading dispensed
01/24/11 Senate: Referred to Committee on Education and Health
02/08/11 Senate: Assigned Education sub: Health Licensing
02/17/11 Senate: Stricken at request of patron in Education and Health (15-Y 0-N)

HB 1968 Physician assistants; signature to be included when law requires signature, etc., of a physician.

Chief patron: Robinson

Summary as introduced:
Physician assistants; when signature accepted. Provides that whenever any law or regulation requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit, or endorsement by a physician assistant.

02/17/11 House: Enrolled
02/17/11 House: Bill text as passed House and Senate (HB1968ER)
02/17/11 House: Impact statement from DPB (HB1968ER)
02/17/11 House: Signed by Speaker
02/20/11 Senate: Signed by President

HB 2216 Laboratory results; authority to provide directly to insurance carrier, etc.

Chief patron: Stolle

Summary as passed House:
Laboratory results; authority to receive directly. Allows a laboratory, with authorization from patient, to provide a copy of the report of the results directly to the insurance carrier, health maintenance organization, or self-insured plan that provides health insurance or similar coverage to the patient. This bill is identical to SB 1116.

02/22/11 House: Enrolled
02/22/11 House: Bill text as passed House and Senate (HB2216ER)
02/22/11 House: Signed by Speaker
02/23/11 House: Impact statement from DPB (HB2216ER)
02/23/11 Senate: Signed by President

HB 2255 Disclosure of health records; health care providers who dispense controlled substances.

Chief patron: Nutter

Summary as introduced:
Disclosure of health records; dispensing of controlled substances. Clarifies that nothing in the Health Records Privacy Act shall prohibit a health care provider who dispenses a controlled substance to a patient from disclosing information obtained from the Prescription Monitoring Program and contained in a patient's health care record to another health care provider when such disclosure is related to the care or treatment of the patient. This bill also provides that nothing shall prevent a person who prescribes or dispenses a controlled substance from redisclosing information obtained from the Prescription Monitoring Program to another prescriber or

dispenser who prescribes or dispenses a controlled substance to a recipient. This bill is identical to SB 1029 (Puckett).

02/17/11 House: Enrolled
02/17/11 House: Bill text as passed House and Senate (HB2255ER)
02/17/11 House: Impact statement from DPB (HB2255ER)
02/17/11 House: Signed by Speaker
02/20/11 Senate: Signed by President

HB 2373 Medical malpractice; privileged communications of certain committees.

Chief patron: Peace

Summary as passed House:
Medical malpractice; privileged communications of certain committees. Provides that nothing in the statute governing privileged communications of certain health committees shall be construed as providing any privilege to any health care provider, emergency medical services agency, community services board, or behavioral health authority with respect to any factual information regarding specific patient health care or treatment, including patient health care incidents, whether oral, electronic, or written. However, the analysis, findings, conclusions, recommendations, and the deliberative process of any medical staff committee, utilization review committee, or other committee, board, group, commission, or other entity, as well as the proceedings, minutes, records, and reports, including the opinions and reports of experts, of such entities shall be privileged in their entirety under the aforementioned statute. This bill is identical to SB 1469.

02/16/11 House: Bill text as passed House and Senate (HB2373ER)
02/16/11 House: Impact statement from DPB (HB2373ER)
02/16/11 House: Signed by Speaker
02/16/11 Senate: Signed by President
02/25/11 Governor: Approved by Governor-Chapter 15 (effective 7/1/11)

SB 1014 Dental hygienists; extension of educational and preventive care protocol.

Chief patron: Puckett

Summary as introduced:
Dental hygienists; extension of educational and preventive care protocol. Extends for one year the protocol allowing dental hygienists to provide educational and preventive dental care in the Lenowisco, Cumberland Plateau, and Southside Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Department of Health. The bill also delays the report required until January 1, 2012.

02/25/11 Senate: Enrolled
02/25/11 Senate: Bill text as passed Senate and House (SB1014ER)
02/25/11 Senate: Impact statement from DPB (SB1014ER)

02/25/11 House: Signed by Speaker
02/25/11 Senate: Signed by President

SB 1146 Dentists; sedation and anesthesia permits.

Chief patron: Quayle

Summary as passed Senate:
Dentists; sedation and anesthesia permits. Requires dentists, with certain exceptions, who use sedation or anesthesia in a dental office to obtain either a conscious/moderate sedation permit or a deep sedation/general anesthesia permit issued by the Board of Dentistry. Also requires the Board of Dentistry to promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

02/18/11 House: Read second time
02/21/11 House: Passed by for the day
02/22/11 House: Read third time
02/22/11 House: Passed House (93-Y 3-N)
02/22/11 House: VOTE: PASSAGE (93-Y 3-N)

SB 1147 Health professions; social security numbers for investigations.

Chief patron: Quayle

Summary as introduced:
Health professions; social security numbers for investigations. Allows the investigative personnel of the Department of Health Professions to request and receive social security numbers from practitioners or federal employee identification numbers from facilities.

02/16/11 Senate: Enrolled
02/16/11 Senate: Bill text as passed Senate and House (SB1147ER)
02/16/11 Senate: Impact statement from DPB (SB1147ER)
02/16/11 Senate: Signed by President
02/16/11 House: Signed by Speaker

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SENATE BILL NO. 1146

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Education and Health on February 3, 2011)

(Patron Prior to Substitute—Senator Quayle)

A BILL to amend the Code of Virginia by adding a section numbered 54.1-2709.5, relating to sedation and anesthesia in dental offices.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2709.5 as follows:

§ 54.1-2709.5. Permits for sedation and anesthesia required.

A. Except as provided in subsection C, the Board shall require any dentist who provides or administers sedation or anesthesia in a dental office to obtain either a conscious/moderate sedation permit or a deep sedation/general anesthesia permit issued by the Board. The Board shall establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of sedation and anesthesia to patients in a dental office.

B. A permit for conscious/moderate sedation shall not be required if a permit has been issued for the administration of deep sedation/general anesthesia.

C. This section shall not apply to:

1. An oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the Board with reports which result from the periodic office examinations required by AAOMS; or

2. Any dentist who administers or prescribes medication or administers nitrous oxide/oxygen or a combination of a medication and nitrous oxide/oxygen for the purpose of inducing anxiolysis or minimal sedation consistent with the Board's regulations.

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

Board of Dentistry

Report on Regulatory Actions

Chapter	Action / Stage Information
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	Action: Periodic review; reorganization of chapter Stage: NOIRA - *Register Date: 8/2/10* *Work on proposed regulations in progress*
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	Action: Recovery of disciplinary costs Stage: Proposed - *Register Date: 1/3/11* *Public hearing: 2/25/11* *Comment closed: 3/4/11* *Adoption of final regulations: 6/3/11*
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	Action: Registration of mobile clinics Stage: Proposed - *Register Date: 1/3/11* *Public hearing: 2/25/11* *Comment closed: 3/4/11* *Adoption of final regulations: 6/3/11*
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	Action: Registration and practice of dental assistants Stage: Final - *Register Date: 1/31/11* *Effective date: 3/2/11*

Virginia Board of Dentistry
March 11, 2011

Agenda Item: **Radiation Certification Regulation**

The Board action to resolve a long term problem with the regulation on radiation certification, 18VAC60-20-195, is requested. Essentially, the problem is that the Board has in regulations an educational option for an unlicensed person to qualify to take x-rays in a dental office by "(iii) completing a course and passing an examination in compliance with guidelines provided by the board, …" which the Board has no statutory authority to oversee or enforce.

The Board learned of this problem in 2007 when Ms. Reen received a student complaint about a radiation safety program approved by the Board. At that time, Ms. Reen discussed the complaint with Board Counsel and the Credentials Committee then reported the matter to the Board. In response to the guidance received, Ms. Reen suspended the Board's program review activities and has since then explained to interested parties that the Board lacks authority to approve radiation safety programs and that the Board's November 2001 guidelines were out of date and could not be relied on to start a program. She also directs callers to Part VI, 18VAC5-481-1580 of Department of Health's Virginia Radiation Protection Regulations and encourages consideration of the other three options available for a person to qualify to take x-rays.

The actions being implemented since 2007 fail to address the status of the courses that the Board had previously approved as evidenced in the attached January 5, 2011 letter which Mr. Fogarty, Interim Director of the State Council of Higher Education for Virginia (SCHEV), sent to Ms. Reen. In his letter, Mr. Fogarty requests clarification regarding the status of the dental assistant training programs which are certified by SCHEV and which received approval from the Board to provide radiation safety training.

Consistent with the advice of Board Counsel, the Board is asked to:

1. Adopt regulatory action to repeal 18VAC60-20-195(A)(iii) as follows:
   18VAC60-20-195. Radiation certification.
   No dentist or dental hygienist shall permit a person not otherwise licensed by this board to place or expose dental x-ray film unless he has (i) satisfactorily completed a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, (ii) been certified by the American Registry of Radiologic Technologists, ~~(iii) satisfactorily completed a course and passed an examination in compliance with guidelines provided by the board,~~ or ~~(iv)~~ (iii) satisfactorily completed a radiation course and passed an examination given by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

2. Authorize Ms. Reen to consult with the Department of Health then send a letter to the providers who received approval from the Board to offer a radiation course advising that Board approval is rescinded.

3. Provide guidance to staff on what to tell dental assistants who hold a certificate indicating that they successfully completed a Board approved radiation course.

Proposed Exempt Action

BOARD OF DENTISTRY

Radiation certification

18VAC60-20-195. Radiation certification.

No person not otherwise licensed by this board shall place or expose dental x-ray film unless he has (i) satisfactorily completed a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, (ii) been certified by the American Registry of Radiologic Technologists, or (iii) ~~satisfactorily completed a course and passed an examination in compliance with guidelines provided by the board, or (iv)~~ satisfactorily completed a radiation course and passed an examination given by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

RECEIVED
JAN 10 2011
Board of Dentistry

DHP JAN 10 2011

Andrew B. Fogarty
Interim Director

COMMONWEALTH of VIRGINIA

COUNCIL OF HIGHER EDUCATION

James Monroe Building, 101 North Fourteenth Street, Richmond, Va. 23219

(804) 225-2600
FAX (804) 225-2604
www.schev.edu

January 5, 2011

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

Dear Ms. Reen:

I am writing to ask your assistance on certain matters of compliance with Virginia regulations that relate to the training of Dental Assistants.

The State Council of Higher Education for Virginia (SCHEV) is seeking clarification regarding appropriate Radiation Certification training for students enrolled in Dental Assistant training programs certified to operate by the Council. We are concerned that without proper guidance from the Virginia Department of Health and Virginia Board of Dentistry, students enrolled at SCHEV certified schools may be awarded certificates to operate x-ray equipment without being properly trained in Radiation Safety techniques. Virginia Radiation Protection Regulations refer to the Board of Dentistry Regulations; therefore, SCHEV is requesting a meeting with representatives of both agencies to clarify how dental assisting schools certified to operate by SCHEV may be deemed to comply with your statutory and regulatory requirements.

I have enclosed a summary of SCHEV staff concerns for your review. Ms. Sylvia Rosa-Casanova, Compliance Manager for Private and Out-of-State Post Secondary Education will contact you shortly to arrange a meeting to discuss these issues. If you have any questions, you may reach her at 804-225-3399 or by email at sylviarosacasanova@schev.edu.

Thank you for your attention to this matter. We look forward to working with you to ensure the proper qualification of Virginia's Dental Assistant students and the safety of the patients they will be caring for.

Sincerely,

Andrew B. Fogarty

Enclosure

c: Jacob A. Belue, Assistant Attorney General, Education Division
Joseph DeFilippo, Director of Academic Affairs and Planning, SCHEV
Linda Woodley, Director, Private and Out-of-State Postsecondary Education, SCHEV

State Council of Higher Education for Virginia (SCHEV)

Radiation Safety Certification at Dental Assisting Schools

January 5, 2011

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1. Schools certified to operate by SCHEV must comply with all statutory and regulatory provisions governed by 8 VAC 40-31 et seq. of the Virginia Administrative Code.

2. 8 VAC 40-31-150 (c) (1) dictates that courses at career-technical schools conform to state, federal, trade, or manufacturing standards of training.

3. During routine audits SCHEV has found some schools in violation of regulations governing the proper use of X-Ray equipment and/or the radiation safety certification of X-Ray machine operators enrolled in dental assisting programs.

4. Virginia Radiation Protection Regulations 12 VAC 5-481-140 lists the following prohibited use:

> No person shall intentionally apply or allow to be applied, either directly or indirectly, radiation to human beings except by, or under the supervision of, a practitioner of the healing arts licensed by this state, except in the case of healing arts screening programs approved in advance by the commissioner. Supervision, as used in this subsection, means the responsibility for and control of quality, radiation safety and technical aspects of the application of radiation to human beings for diagnostic or therapeutic purposes.

5. SCHEV interprets 12 VAC 5-481-140 as meaning that students in dental assisting schools are prohibited from taking X-rays on <u>each other</u> to learn correct x-ray techniques.

6. During routine audits of dental assisting schools, SCHEV has found several schools that allow students to practice taking x-rays on each other.

7. SCHEV seeks confirmation from the Department of Health that schools currently employing this method to teach x-ray techniques either are or are not in compliance with the Department of Health Regulations and, thereby, 8 VAC 40-31-150 (c) (1).

8. Virginia Radiation Protection Regulations 12VAC5-481-1590 (A) (14) states the following general and administrative requirement (italics added for emphasis):

> Operators must be licensed by the Department of Health Professions where X-rays are used within the scope of practice or be certified by the ARRT, or an individual enrolled in an accredited program for radiologic technology and under the supervision of a licensed or certified radiological technologist, *and if a dental assistant, comply with the Board of Dentistry's radiation certification requirements in <u>18VAC60-20-195</u>.*

9. The Board of Dentistry Regulation 18VAC60-20-195 (regulations last revised as of August 14, 2010) states the following (italics added for emphasis):

> No person not otherwise licensed by this board shall place or expose dental x-ray film unless he has (i) satisfactorily completed a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, (ii) been certified by the American Registry of Radiologic Technologists, *(iii) satisfactorily completed a course and passed an examination in compliance with guidelines provided by the board,* or (iv) satisfactorily completed a radiation course and passed an examination given by the Dental Assisting National Board. *Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.*

10. In January 2010, SCHEV requested the guidelines described in item (iii) from the Board of Dentistry to ensure that dental assisting schools certified to operate by SCHEV are in compliance with the Board of Dentistry regulations.

11. At that time, Ms. Sandra Reen of the Board of Dentistry verbally informed SCHEV that option (iii) above was no longer valid, in that the Board of Dentistry did not have the authorization to offer or authorize courses, or to develop guidelines by which an examination can be provided. This change was NOT communicated to any schools that were previously informed that their eligibility was contingent upon this criteria.

12. SCHEV requested clarification on how dental assistant students in our schools could obtain proper radiation safety certification training and obtain the required certificate.

13. Ms. Reen informed SCHEV, verbally, that option (iv) above – completing a radiation course and passing an examination given by the Dental Assisting National Board – would meet the requirement.

14. Although Ms. Reen informed SCHEV that the Board of Dentistry has no authority to approve radiation safety courses, their regulations continue to indicate that the board has guidelines for these courses.

15. Currently SCHEV has 19 schools (at 22 locations) that provide Dental Assisting Training. In addition, in the last 6 months, at least three people have expressed interest in opening dental assisting schools.

16. Some schools certified to operate by SCHEV continue to use the Board of Dentistry "approved" courses to train, test and certify students in radiation safety.

17. SCHEV seeks advice from the Board of Dentistry as to whether that schools using previously approved courses to train, test and certify students in Radiation Safety are still in compliance with the Board of Dentistry regulations. (ie; whether they have been grandfathered.)

18. SCHEV seeks verification from the Board of Dentistry as to whether the programs in Dental Radiation Safety offered at Old Dominion University and J. Sergeant Reynolds Community College are in compliance with the Board of Dentistry regulations. These programs currently advertise on their websites that they "meet the Virginia Board of Dentistry's regulations for certification in dental radiation safety hygiene."

19. SCHEV seeks clarification and guidance from the Department of Health and the Board of Dentistry, so that we can confirm that dental assisting schools certified to operate by SCHEV are in compliance with all statutory and regulatory provisions.

JOINT COMMISSION
ON NATIONAL
DENTAL EXAMINATIONS

Date: February 10, 2011

To: National Board Dental Examination Stakeholders

From: Dr. Mark Christensen, Chair, Committee for an Integrated Examination
Joint Commission on National Dental Examinations

Subject: Update on the Progress of the Joint Commission on National Dental Examinations Committee for an Integrated Examination (CIE)

This is the second communiqué to update stakeholder groups on the progress of the Joint Commission on National Dental Examinations (JCNDE) CIE. The task of the CIE is to develop and validate a new integrated examination that will replace NBDE Part I and Part II. This is a long-term project that is expected to take a minimum of five years. The CIE recognizes that a change of this magnitude has implications for many stakeholder groups and intends to keep all stakeholders informed of the committee's progress and solicit comment and feedback from all stakeholder groups as the project progresses.

The new examination will integrate basic, behavioral, and clinical sciences to comprehensively assess the knowledge and cognitive skills and abilities needed for entry-level competency in dental practice. For the new examination to be truly integrated, a process for combining basic and clinical sciences into single examination must be developed and validated. A necessary first step in this process is identification of the domain of knowledge (basic science and clinical science) and cognitive skills and abilities needed for dental practice. Identification of this Domain of Dentistry is a priority because it becomes the foundation for subsequent steps in examination development.

Since the last update in July 2010 there have been two additional meetings of the CIE: a workgroup charged to identify the Domain of Dentistry met in July 2010 and the entire committee met in November 2010.

The Domain Workgroup initially reviewed the current 65 clinical competencies used in the 2005 practice analysis for NBDE Part II. It also considered the ADA *2005-06 Survey of Dental Services Rendered*, CODA's *Accreditation Standards for Dental Education Programs*, *Competences for the New General Dentist* (ADEA 2008), *Foundation Knowledge for the New General Dentist* (ADEA CCI in 2010), as well as information from other sources. The Workgroup then developed a revised list of clinical competencies which have been forwarded to the JCNDE's Research and Development Committee (R&D) for consideration. The R&D Committee is responsible for making recommendations to the JCNDE regarding the competencies that are used when a practice analysis is conducted for NBDE Part II. A new practice analysis for NBDE Part II is planned for 2011.

To address the identification of basic biomedical and behavioral science competencies, the Workgroup reviewed how other professional groups have defined the basic biomedical and

behavioral science competencies that underlie their professions. One document reviewed by the Workgroup was *Scientific Foundations for Future Physicians a Report of the AAMC-HHMI Committee* (available at http://www.hhmi.org/grants/sffp.html) which identifies basic biomedical and behavioral science competencies that underlie the practice of medicine. The document also provides examples of how these competencies can be broken down and related to clinical practice. The Workgroup decided to use a similar approach to identify the basic biomedical and behavioral sciences that support the clinical competencies identified as essential for dental practice. This work then culminated in the development of a draft Model of the Domain of Dentistry. The Model provides a way to demonstrate links between the clinical sciences and basic biomedical and behavioral sciences that inform the practice of dentistry.

At its November 2010 meeting, the CIE further refined the draft Model of the Domain of Dentistry and developed plans for initial validation of the Model. An outside panel of experts composed of clinically focused dentists who have expertise in the basic sciences will meet to review the science competencies and validate the Model in the spring of 2011. Eventually both clinical and basic science competencies will form the basis of the test specifications for the new integrated examination.

The CIE plans to meet twice in 2011. The first meeting will focus on work done to validate the draft Model of the Domain of Dentistry. Once the CIE is satisfied that the draft of the Model is sound, it will be made available to stakeholders for comment.

Communication remains a priority for the CIE. As work progresses and documents are developed, the CIE plans to post them on a dedicated web site for review and comment by all stakeholder groups. An initial FAQ document has been included with this update to address some questions that have arisen. The FAQ document will be updated as the project progresses and will be posted on the site as soon as the web site is functional. An update on committee activity will also be featured in each edition of the JCNDE newsletter which can be found on the JCNDE website at http://www.ada.org/2288.aspx.

The CIE welcomes comment and encourages recipients to share this communiqué with interested persons who are not on its mailing list. Comment and feedback can be sent to the CIE by email to jcndecie@ada.org. mailto:While individual responses are not possible, the committee reviews all comments and questions. Those who have received this memo indirectly and would like to be added to the CIE's mailing list can be added to the list by sending email to jcndecie@ada.org with "mailing list" as the subject line.

MC/JK/s

The Committee for an Integrated Examination (CIE)

FAQ

THE CIE

What is the Committee for an Integrated Examination (CIE)?
The Committee for an Integrated Examination (CIE) is a special subcommittee of the Joint Commission on National Dental Examinations (JCNDE).

What is the charge of the CIE?
The charge of the CIE is to develop and validate a new examination instrument for dentistry that integrates basic, behavioral, and clinical sciences to assess entry level competency in dental practice to assist state boards of dentistry in evaluating candidates for dental licensure. It is expected to be a long term project taking at least five years with implementation no sooner than 2015.

Who is on the CIE?
The committee is chaired by Dr. Mark Christensen. Other members of the committee are: Dr. Ellen B. Byrne, Dr. Bruce D. Horn, Dr. Ron J. Seeley, Dr. Stephen T. Radack III and Dr. Andrew Spielman. Consistency and continuity are important in any long term project both internally to ensure the work moves forward and externally to facilitate communication between the CIE and stakeholder groups; therefore committee members, who are current or former members of the JCNDE, will serve for the duration of the project.

In addition, three consultants are assisting the CIE to ensure the psychometric soundness of the new examination. These consultants are: Dr. Gregory J. Cizek, Professor of Educational Measurement and Evaluation at the School of Education at the University of North Carolina at Chapel Hill; Dr. Michael T. Kane, Holder of Messick Chair in Validity at the Educational Testing Service in Princeton, New Jersey and Dr. Steven M. Downing Associate Professor of Medical Education, Emeritus at the University of Illinois at Chicago.

Who appointed the CIE committee members?
The members of the CIE were appointed by the JCNDE. Two CIE members were American Dental Association (ADA) appointees to the JCNDE, two were American Dental Education Association (ADEA) appointees and two were American Association of Dental Boards (AABD) appointees.

I would like to be a member of the CIE, can I be appointed?
In order to assure consistency and continuity of the project, the membership will remain the same during the life of the committee. However, the CIE anticipated opportunities for additional individuals to participate on *ad hoc* committees, expert review panels and other activities.

The CIE welcomes comment and feedback from all stakeholder groups. Information can be sent to the committee by email using the following address jcndecie@ada.org. While individual responses are not possible, the committee reviews all comments, feedback and questions.

How long has the CIE been working on an integrated examination?
The work of the CIE began in 2010. The first meeting was in January 2010 with additional meetings in May and November 2010.

How often is the CIE going to meet?
The frequency of meetings will vary depending on the completion of interim tasks. Currently the CIE is planning to meet in summer and fall of 2011. In addition, sub committees and *ad hoc* committees will meet as needed.

THE NEW INTEGRATED EXAMINATION

Why did the JCNDE decide to create one integrated examination?
At it's the April 8, 2009 meeting, the JCNDE reviewed the report of the *ad-hoc* Committee on Strategic Planning. A Mission Statement and several goals were proposed by the *ad hoc* Committee and adopted to guide the work of the JCNDE over the next five years. The JCNDE established the CIE to carry out select pieces of the strategic plan, specifically a need to develop contemporary assessment formats and approaches to evaluate candidates for licensure. As the JCNDE has worked to implement a more clinically relevant approach to testing, many stakeholders have encouraged integration of the NBDE Part I and NBDE Part II examinations.

What is going to happen to all the science content that is currently on NBDE Part I?
The basic science foundation knowledge is very important and will continue to be tested, but the content will be integrated into a clinical context.

How will the examination change, will it just be a combination of the current NBDE Part I and NBDE Part II?
No, the integrated examination will not just combine the current NBDE Part I and NBDE Part II. It is being designed as a truly integrated examination. The basic science foundation knowledge will still be tested but in a clinical context.

How many days will it take to administer the new examination?
No final decision has been made regarding the length of the examination or the time required for administration. However, it is most likely the total examination time will be less than the combined total of the current NBDE Part I and NBDE Part II.

What will happen to the current NBDE Part I and NBDE Part II?
The JCNDE will continue to administer the current NBDE Part I and NBDE Part II until work on the new integrated examination is complete. Once the new integrated examination is launched, it will replace NBDE Part I and NBDE Part II. Sufficient transition time will be planned to allow students who have taken NBDE Part I time to complete NBDE Part II assuming the students stay on schedule to graduate within the normal time frame.

If a student has taken NBDE Part I but not NBDE Part II when the new examination is implemented, will he/she have to take the new examination?
No, a transition plan will be developed so that no students will be disadvantaged by the switch to an integrated examination. Sufficient transition time will be planned to allow students who have taken NBDE Part I time to complete NBDE Part II, assuming the students stay on schedule to graduate within the normal time frame.

Will the new integrated examination go back to having a numeric score?
No, the new integrated examination will be pass/fail.

Is the new examination going to focus on theoretical knowledge or will it have a practical "hands on" component?
The examination will serve the same purpose as the current NBDE Part I and NBDE Part II. There are no plans to add a practical component to the examination. The practical examination is the domain of the state boards and clinical testing agencies and it will remain their responsibility.

Where in the dental school curriculum will students take the new integrated examination?
The timing of the administration of the integrated examination will be determined by each school just like NBDE Part I and NBDE Part II are now. Each school's curriculum is unique and it will be up to the school to decide where in the curriculum the students will be sufficiently prepared to take the examination.

How will this new integrated examination impact the curriculum at my school?
The new examination will emphasize critical thinking, problem solving and application of knowledge. This approach should reinforce those aspects of the curriculum. Just like the current NBDE Part I and NBDE Part II, the examination will be designed to measure beginning level competency to practice dentistry. Dental curricula are varied and have many learning goals, including some that may not be directly relevant to the purpose of the NBDE. Each dental school will determine the extent to which its curriculum should relate to the NBDE.

We use NBDE Part I as an internal assessment tool at my school; will there be something to replace it?
The JCNDE does not have any plans to develop an examination to take the place of NBDE Part I. When pass/fail score reporting is implemented on January 1, 2012, numerical scores will no longer be reported for NBDE Part I or NBDE Part II. The JCNDE is mindful of dental schools need for feedback on their student's performance and is developing a means to provide this information.

Will the examination still be given at a computer center?
There are no plans to return to a print examination.

Will the new examination have the same kind of questions it has now or will there be new item types?
The JCNDE is continually evaluating the content and item types on all National Board examinations. As advertised in Volume 3, Number 2 of the Joint Commission newsletter, new items types will begin appearing on the current National Board examinations in 2012. As the new integrated examination is developed, additional item types may be considered but definitive decisions have not been made at this point in time.

If there are new item types, how will students prepare?
If new item types are introduced, sample items will be available for students just as examples of the new item types being implemented in 2012 were advertised in Volume 3, Number 2 of the Joint Commission newsletter. Other methods, such as sample tests may also be available.

Will the new integrated examination have any implications for the state boards and state dental practice acts?
The implication for state boards will vary depending on the language in the state dental practice act. If the state dental practice act specifically refers to NBDE Part I and/or NBDE Part II, the language may need to be updated.

In addition, with the implementation of pass/fail score reporting on January 1, 2012, numerical scores will no longer be reported for NBDE Part I or NBDE Part II. Any language referencing a particular passing score will need to be adjusted.

How will the new examination be validated?
The validation of a new examination involves a number of steps. The first task is to define the Domain of Dentistry using a model that is described by the core components: basic science foundation knowledge and clinical competencies. The clinical competencies that underlie NBDE Part II will continue to be validated through the use of a practice analysis. A new practice analysis is planned for 2011. Information on the last practice analysis, done in 2005, can be found in the NBDE Technical Report on the JCNDE web site at this link http://www.ada.org/2287.aspx. The basic science foundation knowledge will be validated by a group of experts who are dentists with a strong science background. This activity is planned for the spring of 2011.

Test items will be developed by content experts and pretested to ensure their validity and reliability before use. The new examination will be pilot tested and carefully evaluated before final implementation.

What will the new examination cost?
Decisions on the cost of the new examination will not be made until the JCNDE has information on the length of the examination and other factors that impact the cost of producing and administering the examination.

COMMUNICATION

How is information about the CIE communicated to stakeholders?
Updates on the CIE can be found in each edition of the JCNDE newsletter which is published twice a year. The newsletter is sent directly to a number of groups (dental deans, associate/academic deans, advanced education program directors, state boards, clinical testing agencies, associations, etc) and any individuals who request to be on the mailing list. The newsletter is also available on the JCNDE website and a link to the JCNDE website is included in the ASDA e-newsletter *Word of Mouth*.

Communiqués from the chair of the CIE are sent out periodically with more detailed information on the current activities of the CIE. There are plans to develop a web site devoted to the CIE to consolidate information and make it easier for all stakeholders to keep informed. As documents are developed and plans made, they will be made available to all stakeholder groups for review and comment.

As the project progresses, the need for other means of communication will be evaluated and additional communication methods will implemented as needed, for example, presentations at national meetings.

How can I provide input to the CIE?
The CIE values input from all stakeholders and encourages individuals and groups to provide comment and feedback. Comment and feedback can be provided by sending an email to the CIE mailbox at jcndecie@ada.org. mailto: While individual responses are not possible, the committee reviews all comments, feedback and questions.

Who can get on the mailing list for information?
The CIE encourages anyone (faculty, state board members, students, organizations, etc.) who is interested in being on the mailing list to send their contact information to the CIE mailbox at jcndecie@ada.org. Just use "mailing list" as the subject line. Your contact information will be added to the CIE mailing list and the JCNDE mailing list. If a large group (i.e., entire faculty or all members of a state board) would like to be added to the mailing list, all email addresses can be sent in one email.

How will students get information about the CIE?
Just like anyone else, students can request to be on the mailing list and they are encouraged to read the JCNDE newsletter. The newsletter is available on the JCNDE website at http://www.ada.org/2288.aspx and each time a JCNDE newsletter is published, there is a link to the newsletter in the ASDA e-newsletter *Word of Mouth*. When the CIE web site becomes active, the address and directions will be communicated via the JCNDE newsletter which will be linked to the ASDA e-newsletter *Word of Mouth.*

As time progresses and when the students currently in dental school are likely to be impacted by the switch to an integrated examination, information will be posted on the JCNDE web site (http://www.ada.org/JCNDE.aspx).

TIMELINE

When will the new integrated examination be implemented?
The creation of an integrated examination is not a project to be rushed. The JCNDE wants to make certain all stakeholder groups have an opportunity to comment on the examination during the development process and to have sufficient time to plan for the change. While no exact implementation date has been set, this is seen as a long term project that will take a minimum of five years to complete and most likely will not be implemented prior to 2015. All stakeholders will be given ample advance warning before implementation.

What is the timeline for CIE activities?
Overall it is anticipated that it will take a minimum of five years to develop and validate the new integrated examination. Students currently in dental school, as of January 2011, will not be impacted, assuming they complete dental school and NBDE Part I and NBDE Part II within four years of admission.

The CIE wants to ensure that all steps of the examination development process are given sufficient time and that all stakeholder groups have time to comment, therefore there is currently no set date for implementation. All final recommendations will be reviewed and approved by the JCNDE before implementation. The CIE is currently planning detailed work one year in advance. As the project progresses, activities further into the future will be assigned specific dates and an implementation date will be set that allows all stakeholders sufficient notice.

Year	Date	Activity
2009	April	JCNDE creates the CIE.
2010	January	First meeting of the CIE.
	May	CIE meets and begins work on developing a model of the Domain of Dentistry.
	July	Workgroup on the Domain of Dentistry develops draft model which identifies basic science foundation knowledge, including behavioral sciences, and reviews the current clinical competencies which form the basis for NBDE Part II. First communiqué sent out by CIE chair. CIE mailbox set up to receive comment and feedback at jcndecie@ada.org.
	November	CIE meets to refine the draft model of the Domain of Dentistry and makes plans for the validation of the model.
2011	Spring	Validation of the model of the Domain of Dentistry by a group of experts who are dentists with a strong science background.
	June	CIE will meet to consider the results of the validation of the model of the Domain of Dentistry.
	November	Planned CIE meeting.
2012 and Beyond: These activities will be addressed before the new examination is implemented. Items are grouped by topic not implementation order.		
Communication with stakeholder groups via • Communiqués • FAQ • Newsletters • Web site • Presentations • CIE mail box for feedback		
Domain of Dentistry model • Practice analysis to validate clinical competencies • Validation of the basic science foundation knowledge by a group of experts who are dentists with a strong science background • Development of proposed test specifications derived from the validation process		

Item types
- Evaluation of item types to meet the needs of an integrated examination
- Development of new items types as needed
- Pretesting of items
- Sample of transitional and new item types available.

Test construction committees
- Identify best structure for test construction committees
- Identify qualification for test constructors
- Recruit and train test constructors

Examination Issues
- Format
- Review and amendment of examination administrative policies and procedures

Scoring system
- Develop and validate scoring system

Transition plan
- Plan for students/candidates who have taken NBDE Part I but not NBDE Part II at time the new examination is implemented
- Plan for students/candidates who have taken NBDE Part I and/or NBDE Part II and have not passed at the time the new examination is implemented

Pilot study
- Develop pilot examination
- Administer pilot examination
- Analyze data

Implementation
- Review and address test publishing and test administration issues with the delivery vendor
- Format examination for vendor delivery

Live date
- Begin to advertise time frame for live date two years in advance
- Set live date for new examination (no sooner than 2015)

Virginia Board of Dentistry
March 11, 2011

Agenda Item: **Dental Assistant II Regulation**
Amendment for education in pulp capping procedures

At its September 2010 meeting, the Board agreed in principle to submitting a fast track regulatory amendment to specify the education requirements for pulp-capping in 18VAC60-20-61. The Board could not adopt the regulatory action until the regulations became effective so the Board delegated the authority to adopt the proposed amendment to the Executive Committee. Since the Dental Assistant II regulations did not go into effect until March 2, 2011, it was possible to bring this matter back to the Board for action at this meeting rather than convene the Executive Committee.

Proposed Fast-track action

Amendment for education in pulp capping procedures

18VAC60-20-61. Educational requirements for dental assistants II.

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

B. To be registered as a dental assistant II, a person shall complete the following requirements from an educational program accredited by the Commission on Dental Accreditation of the American Dental Association:

1. At least 50 hours of didactic course work in dental anatomy and operative dentistry that may be completed on-line.

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

a. At least 40 hours of placing, packing, carving, and polishing of amalgam restorations and pulp capping procedures;

b. At least 60 hours of placing and shaping composite resin restorations and pulp capping procedures;

c. At least 20 hours of taking final impressions and use of a non-epinephrine retraction cord; and

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

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

a. At least 80 hours of placing, packing, carving, and polishing of amalgam restorations;

b. At least 120 hours of placing and shaping composite resin restorations;

c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and

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

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

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

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

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

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

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UF UNIVERSITY of FLORIDA
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Health Science Center
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February 22, 2011

Dr. Sandra Green
Virginia Board of Dentistry
9960 Maryland Drive, Suite 300
Henrico, Virginia 23233

Re: Request for permission to provide teleradiology consults for Cone Beam Computed Tomography (CBCT) Studies

Dear Dr. Green,

This request is being submitted on behalf of the Division of Oral and Maxillofacial Radiology, Department of Diagnostic Sciences, University of Florida College of Dentistry. The Division is staffed by two American Board of Oral and Maxillofacial Radiology certified radiologists.

Occasionally, we receive requests for interpretation of Cone Beam Computed Tomography (CBCT) scans from dentists in the State of Virginia. Due to a national shortage of radiologists, we would like to be able to provide interpretative services for such studies sent to us to help the dentists diagnose any incidental pathology captured in these studies. A comprehensive interpretation of these three-dimensional studies assumes importance in light of the fact that some non-radiology dental specialists and general practitioners do not feel comfortable reading CTs. The responsibility is delegated to boarded radiologists in these instances. We have to date not entertained any such requests from the State of Virginia. We understand that a license is required to practice dentistry in the State of Virginia. Both radiologists at the University of Florida College of Dentistry hold unrestricted licenses in Pennsylvania and are US DMDs. Both have teaching licenses issued by the Florida State Board of Dentistry to practice dentistry within the University of Florida.

We would like to take this opportunity to request you to favorably consider our request for explicit permission to read CTs from the State of Virginia when requested by dentists from your state. This would enable us to provide much needed interpretative services to dentists, thus protecting the dentists from liability related to missed pathology on CT scans. The permission would be limited to reading radiographs taken on patients seen in the State of Virginia only. Our University requires permission from the State Board of Dentistry in writing to enable us to read these studies. We will provide this service only with your explicit permission.

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Our radiologists are nationally and internationally renowned. They are Dr. M. K. Nair DMD, MS, PhD, and Dr. J. C. Pettigrew Jr. DMD. Both are diplomates of the American Board of Oral and Maxillofacial Radiology. Both radiologists enjoy appointments in the Department of Radiology, Neuroradiology Division, College of Medicine, University of Florida as well. Consults with medical radiologists on complex cases is available at no additional cost to the referring practitioner therefore. Advise for appropriate further complex imaging will be provided on a case-by-case basis as well to the practitioner.

Thank you for your time. Please let us know if you have any questions.

Sincerely,

James Webb

James Webb
Assistant Director, Medical/Health Administration
Oral Maxillofacial Surgery & Oral Maxillofacial Diagnostic Sciences
PO Box 100414
Gainesville, FL 32610-0414
(352)-273-5122

Disciplinary Board Report for March 11, 2011

At the December 3, 2010, board meeting, the key performance measures for the first quarter of Fiscal year 2011 had not been officially released. Now that they have been released, they are reported here. In Quarter 1 for fiscal year 2011, the Board's case clearance rate was 122%. The pending caseload older than 250 days was 10% and the percent closed within 250 business days was 96%. These numbers exceed all three key performance measures adopted by the agency.*

The rest of today's report addresses the Board's disciplinary case activities for the time period November 1, 2010, to February 28, 2011. This period covers the second two months of the second quarter for fiscal year 2011 and the first two months for the third quarter for fiscal year 2011.

The table below includes all cases that have received Board action since November 1, 2010 through February 28, 2011.

2010-11	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Nov '10	57	94	6	100
Dec '10	23	30	7	37
Jan '11	43	21	8	29
Feb '11	31	16	12	28
Totals	154	161	33	194

The most important numbers are the cases received and cases closed for January and February. We have received seventy four cases and closed fifty-seven. This is well below where we need to be at the beginning of the last month of the quarter.

The Board currently has 217 open cases. Seventy-three of these cases are in probable cause with thirty of them for Board member review.

This time last year the Board had 190 open cases. Seventy-two cases were in probable cause and thirty-one were assigned to board members.

If you have cases for probable cause review, please complete them and return them back to us as soon as possible.

To finish out calendar year 2010 in November and December, the Board closed 137 cases. One hundred twenty-four cases were closed no violation, 64 of these no violation cases were closed with an advisory letter, mostly for late renewals. The board closed 3 cases with Confidential Consent Agreements and the remaining were closed with a Board Order.

Of the 217 open cases the Board currently has, 7% or 15 cases are over 250 business days.

Of the fifty-seven cases closed so far by the Board in calendar year 2011, 95% or fifty-four cases have been closed within 250 calendar days.

Of the fifty-seven cases closed, forty-two were closed without a violation. Of the remaining fifteen cases, 8 were closed with Confidential Consent Agreements, 1 was closed due to an application being withdrawn and the remaining 6 were closed with Board Orders.

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*The Agency's Key Performance Measures.

- 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.
- 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.
- We will investigate and process 90% of patient care cases within 250 work days.