

VIRGINIA BOARD OF DENTISTRY

AGENDA

September 10 and 11, 2009

Department of Health Professions

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

September 10, 2009

PAGE

9:00 a.m. Formal Hearings

2:00 p.m. Executive Committee – Dr. Gokli, Chair

- Approval of Minutes
 - June 12, 2009 Minutes EC1- EC2
- Bylaws Amendment – Ms. Reen EC3 – EC6
- Recovery of Disciplinary Costs – Ms. Yeatts EC7 – EC23
- Standards for Professional Code of Conduct – Mr. Casway EC24 – EC28
- Revenue and Expenditure Report – Ms. Reen EC29 – EC33
- FY2010 Budget – Ms. Reen EC34

4:00 p.m. Nominating Committee – Ms. Pace, Chair

6:30 p.m. Board Member Service Recognition Dinner
Capital Ale House - Innsbrook – 804-780-2537
4024-A Cox Road, Glen Allen, VA 23060
NO BUSINESS WILL BE CONDUCTED

September 11, 2009

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9:00 a.m. Board Meeting

Call to Order – Dr. Gokli, President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- June 11, 2009 Formal Hearing 1-4
- June 12, 2009 Board Meeting 5-13

DHP Director’s Report – Ms. Whitley-Ryals

VCU School of Dentistry – Dr. Hunt

Liaison/Committee Reports

- BHP – Dr. Gokli
- AADE Report – Dr. Gokli
- SRTA – Dr. Gokli and Ms. Pace
- Executive Committee – Dr. Gokli
- Regulatory/Legislative Committee – Dr. Levin
 - August 21, 2009 Regulatory-Legislative Minutes 14 - 17

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- Nominating Committee – Ms. Pace

Legislation and Regulation – Ms. Yeatts

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 - Mobile Dental Clinics
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Board Discussion/Action

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- Summary Action – Mr. Casway

Report on Case Activity – Mr. Heaberlin

Executive Director’s Report/Business – Ms. Reen

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- Dental Hygiene Practice in Virginia Department of Health
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 - Protocol for Dental Hygiene Practice 48 - 49
- ADEA Statement on Professionalism in Dental Education

Board Counsel Report – Mr. Casway

Adjourn

Executive Committee Meeting

UNAPPROVED - DRAFT
BOARD OF DENTISTRY
MINUTES OF EXECUTIVE COMMITTEE

Friday, June 12, 2009

Department of Health Professions
9960 Mayland Drive, 2nd Floor
Henrico, Virginia 23233
Training Room 2

CALL TO ORDER: The meeting was called to order at 8:05 a.m.

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

MEMBERS PRESENT: Jeffrey Levin, D.D.S.
Jacqueline Pace, R.D.H.
Paul N. Zimmet, D.D.S

OTHER BOARD MEMBERS PRESENT: James D. Watkins, D.D.S.
Darryl J. Pirok, D.D.S.

STAFF PRESENT: Sandra Reen, Executive Director

COUNSEL PRESENT: Howard Casway, Senior Assistant Attorney General

QUORUM: All members were present.

PUBLIC COMMENT: None

APPROVAL OF MINUTES: Dr. Gokli requested a motion for approval of the minutes of the March 13, 2009 meeting of the Committee. Ms. Pace moved the approval of the minutes. The motion was seconded and passed.

STANDARDS FOR PROFESSIONAL CONDUCT: Dr. Gokli asked Dr. Levin to review the standards he had prepared for discussion. He noted that Ms. Reen had helped organize and edit the draft. He said the standards were developed following a review of several codes of conduct in the dental community to help licensees understand the responsibilities of being a professional. Mr. Casway stated that the draft may exceed the Board's authority and suggested that a format of questions and answers might be a better approach. He asked the Committee to defer consideration of adopting standards so that he might do some research to better advise the Committee. Dr. Gokli agreed and tabled the discussion until the next meeting.

BUDGET REVIEW: Ms. Reen reported that the Board will be given preliminary

**Virginia Board of Dentistry
Executive Committee Meeting
June 12, 2009**

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information about increasing fees during its meeting later today and that she anticipates that there will be a proposal to increase fees presented at the September meeting. She asked the Committee members to review the monthly financial reports she has been providing before the September meeting to identify any questions they might want to address about the income and expenditures of the Board.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 9:00 a.m.

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

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY

BYLAWS

Article I. Officers Election, Terms of Office, Vacancies

1. Officers

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

2. Election.

The Board shall annually elect its slate of officers at its regularly scheduled Fall meeting.

3. Terms of Office.

The terms of office of the President, Vice-President and Secretary-Treasurer shall be for twelve months or until their successors shall be elected. No officer shall be eligible to serve for more than two consecutive terms in the same office unless serving an unexpired term.

4. Vacancies.

A vacancy occurring in any office shall be filled by a special election at the next meeting of the Board.

Article II. Duties of Officers

1. President.

The *President* shall preside at all meetings and conduct all business according to the Administrative Process Act and Robert's Rules. The President shall appoint all committees except where specifically provided by law. The President shall sign certificates and documents authorized to be signed by the President and may serve as an ex-officio member of all committees.

2. Vice-President.

The *Vice-President* shall perform all duties of the President in the absence of the President.

3. Secretary-Treasurer.

The *Secretary-Treasurer* shall authorize posting on the Internet the draft unapproved minutes of meetings of the Board and shall be knowledgeable about the budget of the Board.

Article III. Duties of Members

1. Qualifications.

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

2. Attendance at meetings.

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

3. Examinations.

Each member of the Board who is currently licensed as a dentist or as a dental hygienist may participate in conducting clinical examinations.

4. Code of Conduct.

Members of the Board shall abide by the adopted Code of Conduct.

Article IV. Meeting

1. Number.

The Board shall hold at least three regular meetings in each year. The President shall call meetings at any time to conduct the business of the Board and shall convene conference calls when needed to act on summary suspensions and settlement offers. Additional meetings shall be called by the President at the written request of any two members of the Board.

2. Quorum.

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

3. Voting.

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

Article V. Committees

As part of their responsibility to the Board, members appointed to a committee shall faithfully perform the duties assigned to the committee. The standing committees of the Board shall be the following:

Executive Committee
Regulatory-Legislative Committee
Credentials Committee
Examination Committee
Special Conference Committees

Committee Duties.

1. Executive Committee.

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

- a) order a biennial review of these Bylaws
- b) review the proposed budget presented by the Executive Director, and submit it and recommendations relating to the proposed budget to the Board for approval
- c) periodically review financial reports and may make recommendations to the Board regarding financial matters
- d) select former board members and knowledgeable professionals to be invited to serve as agency subordinates
- e) conduct all other matters delegated to it by the Board.

2. Regulatory-Legislative Committee.

The Regulatory-Legislative Committee shall consist of two or more members, appointed by the President. This Committee shall consider matters bearing upon state and federal regulations and legislation and make recommendations to the Board regarding policy matters. The Board may direct the Committee to review the law for possible changes. Proposed changes in State laws, or in the Rules and Regulations of the Board, shall be distributed to all Board members prior to scheduled meetings of the Board.

3. Credentials Committee.

The Credentials Committee shall review and provide guidance to staff on the action to be taken regarding:

- a) applications for licensure when the application includes information about criminal activity, practice history, medical conditions or other content issues.
- b) applicant or licensee requests for approval of credit for programs when the content or the sponsorship of the course is in question.
- c) hold informal fact-finding conferences at the request of the applicant or licensee to determine if the requirements established by the Board have been met.

4. Examination Committee.

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

5. Special Conference Committees.

Special Conference Committees shall:

- a) review investigation reports to determine if there is probable cause to conclude that a violation of law or regulation has occurred,
- b) hold informal fact-finding conferences, and

- c) direct the disposition of disciplinary cases at the probable cause review and informal fact-finding stages. The committee chair shall provide guidance to staff on implementation of the committee's decisions.

Each year, on a rotating basis, one of the Special Conference Committees shall be designated to receive all investigation reports alleging violations of the existing Board of Dentistry Rules and Regulations pertaining to advertising.

Article VI. Executive Director

1. Designation.

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

2. Duties.

The Executive Director shall:

- a) Supervise the operation of the Board office and be responsible for the conduct of the staff and the assignment of cases to agency subordinates,
- b) Carry out the policies and services established by the Board.
- c) Provide and disburse all forms as required by law to include, but not be limited to, new and renewal application forms.
- d) Keep accurate record of all applications for licensure, maintain a file of all applications and notify each applicant regarding the actions of the Board in response to their application. Prepare and deliver licenses to all successful applicants. Keep and maintain a current record of all dental and dental hygiene licenses issued by the Board.
- e) Notify all members of the Board of regular and special meetings of the Board. Notify all Committee members of regular and special meetings of Committees. Keep true and accurate minutes of all meetings and distribute such minutes to the Board members within ten days following such meetings.
- f) Issue all notices and orders, render all reports, keep all records and notify all individuals as required by these Bylaws or law. Affix and attach the seal of the Board to such documents, papers, records, certificates and other instruments as may be directed by law.
- g) Keep accurate records of all disciplinary proceedings. Receive and certify all exhibits presented. Certify a complete record of all documents whenever and wherever required by law.
- h) Present the biennial budget with any revisions to be reviewed by the Executive Committee prior to submission to the Board for approval.

Approved by the Board –

2009 SESSION

INTRODUCED

098066528

HOUSE BILL NO. 2058
Offered January 14, 2009
Prefiled January 13, 2009

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

Patron—Hamilton

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

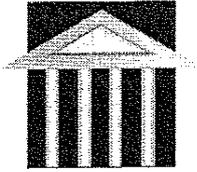
1. That the Code of Virginia is amended by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.2 as follows:

§ 54.1-2708.2. Recovery of monitoring costs.

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

INTRODUCED

HB2058



Virginia
Regulatory
Town Hall

townhall.virginia.gov

**Notice of Intended Regulatory Action (NOIRA)
Agency Background Document**

Agency name	Board of Dentistry, Department of Health Professions
Virginia Administrative Code (VAC) citation	18VAC60-20-10 et seq.
Regulation title	Regulations Governing the Practice of Dentistry and Dental Hygiene
Action title	Recovery of administrative costs in disciplinary actions
Date this document prepared	5/28/09

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual*.

Purpose

Please describe the subject matter and intent of the planned regulatory action. Also include a brief explanation of the need for and the goals of the new or amended regulation.

The purpose of this regulatory action is to initiate rules for recovery of administrative costs relating to the investigation and monitoring of a licensee disciplined by the Board of Dentistry. Legislation passed by the 2009 General Assembly (HB2058 – Delegate Hamilton) provides statutory authorization for imposition of such costs, and the goal of the amendments is to establish the regulatory framework for which costs may be assessed, how those costs may be determined, the process for assessment of costs and conditions under which the Board may choose to waive the imposition of costs.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

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

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

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

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

Specific regulatory authority for the Board of Dentistry is found in Chapter 89 of the 2009 Acts of the Assembly:

§ 54.1-2708.2. Recovery of monitoring costs.

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

Need

Please detail the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, delineate any potential issues that may need to be addressed as the regulation is developed.

Enforcement activities constitute the largest expenditure for the board, although only a small percentage of licensees undergo investigation, and an even smaller percentage are found to be in violation of statutes and regulations governing their professions. Therefore, it is equitable to

assess at least a portion of enforcement and monitoring costs to those who are the cause of the expenditure. By recovering a portion of its enforcement costs, the Board will be better able to meet its obligation to investigate every complaint it receives and to more efficiently and effectively resolve cases related to patient care. The Board will have the additional resources necessary to adequately investigate reports of misconduct to make the practice of dentistry and dental hygiene safer for patients in Virginia.

Substance

Please detail any changes that will be proposed. For new regulations, include a summary of the proposed regulatory action. Where provisions of an existing regulation are being amended, explain how the existing regulation will be changed.

The statute is specific about some aspects of the authority to recover "reasonable administrative costs associated with investigating and monitoring" a licensee. The recovery of costs will only be implemented if a licensee has had disciplinary action imposed. It will not affect those licensees: 1) who are investigated by the Department, but for whom no probable cause is found to indicate a violation may have occurred; 2) who have a disciplinary proceeding, but for whom no violation is found and no discipline imposed; or 3) who have matters resolved through a confidential consent agreement or an advisory letter.

Rather than setting specific fees or dollar amounts in regulation, the amendments will provide a process for determination of both the investigative and monitoring costs, as specified in the Code section. At the end of each fiscal year, regulations will require a calculation of the average hourly cost for enforcement that is chargeable to the work of the Board of Dentistry. The Enforcement Division of the Department tracks the number of hours an investigator spends on a case, so that number could be multiplied by the hourly cost to determine the specific costs relating to the investigation of the case against a specific respondent. In addition, the Board would assess any costs relating to hiring expert witnesses and the reports generated by such witnesses. While not inclusive of all related administrative costs, a fee based on the actual number of hours and the hourly cost of an investigation would be reasonable and not arbitrary or selectively punitive. The imposition of the recovery cost would become part of the order from an informal or formal proceeding or part of a consent order agreed to by the parties.

The monitoring costs would be calculated based on the terms and conditions imposed and the length of time the licensee is to be monitored. As with the enforcement costs, the Board would annually calculate the average costs of monitoring certain terms, such as the acquisition of continuing education in an area of practice. If the licensee is to be monitored beyond one year, the monitoring cost would be imposed for each of those years. A guidance document would be adopted annually setting out the average investigative and monitoring cost (for the various terms and conditions to be monitored), so the licensees (and their attorneys, if applicable) would have knowledge of the recovery of costs, if disciplinary action is imposed. Since the costs would be incorporated in the order, the respondent would have the option to accept the order, request a formal hearing following an informal, or appeal an order from a formal hearing to a circuit court.

As specified in statute, the total of the recovery of costs could not exceed \$5,000. However, the regulations will reference current fees for inspection of dental offices and returned checks as fees not subject to the recovery maximum. Additionally, the Board may seek to recover the collection costs for delinquent fines and fees.

Finally, the Board intends to set in regulation a limited number of reasons for which all or part of the costs may be waived. The Board would be required to set out in the findings of fact in the disciplinary order the specific reasons for such a waiver. Regulations may provide that a total or partial waiver could be granted if the imposition of costs would create a substantial undue hardship on the licensee, or if it would be unjust to the public to assess fees, or if the collection of such fees does not appear to be feasible.

Alternatives

Please describe all viable alternatives to the proposed regulatory action that have been or will be considered to meet the essential purpose of the action. Also, please describe the process by which the agency has considered or will consider other alternatives for achieving the need in the most cost-effective manner.

The only viable alternative for the Board of Dentistry is to continually increase application and renewal fees for all licensees to cover rising administrative costs for discipline and enforcement. The Board has already been notified that a significant deficit in the next biennia is projected and documented, and it will need to consider appropriate regulatory action as mandated by law. While the recovery of some of those costs from the licensees who generate the need for investigation and disciplinary action will not replace future need for increased fees, it may help to mitigate against large fee increases for all licensees in the future.

The statutory authority for recovery of disciplinary costs is already held by the boards at the Department of Professional and Occupational Regulation and the Board of Accountancy. Therefore, the Board will consult with its sister agencies to learn from their experience with a recovery program. Additionally, there are other states in which the Board of Dentistry has such authority, so those states' statutes and regulations will be reviewed. In the state of Washington, legislation recently passed that authorizes the Board to seek reasonable reimbursement of disciplinary proceedings up to \$10,000. If the licensee seeks judicial review of the disciplinary action and does not receive a "substantial element of relief," the law requires that the trial or appellate court shall impose \$25,000 at each level of judicial review. Such authorization is not included in the Virginia statute.

To the extent possible, the intent of the regulation would be to set out a process by which fees could be calculated, assessed, collected or waived in a manner that would be reasonable and equitable to all parties.

Public participation

Please indicate the agency is seeking comments on the intended regulatory action, to include ideas to assist the agency in the development of the proposal and the costs and benefits of the alternatives stated in this notice or other alternatives. Also, indicate whether a public hearing is to be held to receive comments on this notice.

The agency is seeking comments on the intended regulatory action, including but not limited to 1) ideas to assist in the development of a proposal, 2) the costs and benefits of the alternatives stated in this background document or other alternatives and 3) potential impacts of the regulation. The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments may do so by posting comment on the Regulatory Townhall at www.townhall.virginia.gov or by mail, email or fax to Elaine Yeatts, Agency Regulatory Coordinator, 9960 Mayland Drive, (804) 527-4434 (fax) or elaine.yeatts@dhp.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last day of the public comment period.

A public hearing will be held after the Board has adopted proposed regulations. Notice of the hearing may be found on the Virginia Regulatory Town Hall website at www.townhall.virginia.gov and can be found in the Calendar of Events section of the Virginia Register of Regulations. Both oral and written comments may be submitted at that time.

Family impact

Assess the potential impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

There is no impact on the family.

SUBSTITUTE SENATE BILL 5752

Passed Legislature - 2009 Regular Session

State of Washington 61st Legislature 2009 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators
Marr, Pflug, Hobbs, and Keiser)

READ FIRST TIME 02/10/09.

1 AN ACT Relating to cost recovery in disciplinary proceedings
2 involving dentists; and adding a new section to chapter 18.32 RCW.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** A new section is added to chapter 18.32 RCW
5 to read as follows:

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

12 (a) The partial recovery hearing fee must be:

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

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

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

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

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

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

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

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

1 (6) All fee recoveries and reimbursements under this statute must
2 be deposited to the health professions account for the portion of it
3 allocated to the commission. The fee recoveries shall be fully
4 credited in reduction of actual or projected expenditures used to
5 determine dentist license renewal fees.
6 (7) The authority of the commission under this section is in
7 addition to all of its authorities under RCW 18.130.160, elsewhere in
8 chapter 18.130 RCW, or in this chapter.

Passed by the Senate March 3, 2009.

Passed by the House April 13, 2009.

Approved by the Governor April 22, 2009.

Filed in Office of Secretary of State April 23, 2009.

FINAL BILL REPORT

SSB 5752

C 177 L 09
Synopsis as Enacted

Brief Description: Regarding cost recovery in disciplinary proceedings involving dentists.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Marr, Pflug, Hobbs and Keiser).

Senate Committee on Health & Long-Term Care
House Committee on Health Care & Wellness
House Committee on Health & Human Services Appropriations

Background: The Dental Quality Assurance Commission (DQAC) was established to regulate the competency and quality of professional dentist health care providers by establishing, monitoring, and enforcing qualification for licensure, continuing education, standards of practice, competency, and discipline. The administrative expenses of every health care profession, including dentists, are paid for by that profession's licensing fees. Disciplinary action accounts for approximately 85 percent of the administrative expenses of the commission. Expenses incurred for disciplinary activities include investigations and legal analysis, board member time, outside experts, Attorney General advice and prosecution, records collection and reproduction, staff attorneys, health law judges, and hearing room rentals. Licensing fees are determined by the number of members in the licensed profession and the level and complexity of disciplinary activity.

Summary: When DQAC sanctions or fines a dentist in a disciplinary hearing, the commission must assess a partial recovery hearing fee in the amount of \$6,000 for each full day hearing. It must also assess a partial recovery of investigative and hearing preparation expenses up to \$10,000. The commission can waive the hearing fee if its imposition would cause an undue hardship for the dentist or it would be manifestly unjust. In the event a dentist pursues judicial review at the superior court, appellate court, or Supreme Court level, a partial cost recovery fee of \$25,000 must be assessed at each level of review. The reviewing court is permitted to waive the hearing fee for undue hardship or manifest injustice. A partial recovery fee is limited to \$2,000 if the disciplinary action is resolved through a stipulated informal disposition.

All fees are to be deposited in that portion of the health professions account allocated to the commission.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Multiple Agency Fiscal Note Summary

Bill Number: 5752 SB	Title: Dentists
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Estimated Cash Receipts

Agency Name	2009-11		2011-13		2013-15	
	GF- State	Total	GF- State	Total	GF- State	Total
Department of Health	0	285,000	0	520,000	0	520,000
Total \$	0	285,000	0	520,000	0	520,000

Local Gov. Courts *						
Local Gov. Other **						
Local Gov. Total						

Estimated Expenditures

Agency Name	2009-11			2011-13			2013-15		
	FTEs	GF-State	Total	FTEs	GF-State	Total	FTEs	GF-State	Total
Administrative Office of the Courts	Non-zero but indeterminate cost and/or savings. Please see discussion.								
Department of Health	1.0	0	282,000	.9	0	190,000	.9	0	190,000
Total	1.0	\$0	\$282,000	0.9	\$0	\$190,000	0.9	\$0	\$190,000

Local Gov. Courts *	Non-zero but indeterminate cost. Please see discussion.								
Local Gov. Other **									
Local Gov. Total									

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Prepared by: Nick Lutes, OFM	Phone: 360-902-0570	Date Published: Final
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* See Office of the Administrator for the Courts judicial fiscal note

** See local government fiscal note

FNPID 24144

Judicial Impact Fiscal Note

Bill Number: 5752 SB	Title: Dentists	Agency: 055-Admin Office of the Courts
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Part I: Estimates

No Fiscal Impact

Estimated Cash Receipts to:

FUND	FY 2010	FY 2011	2009-11	2011-13	2013-15
Counties					
Cities					
Total \$					

Estimated Expenditures from:

Non-zero but indeterminate cost. Please see discussion.

The revenue and expenditure estimates on this page represent the most likely fiscal impact. Responsibility for expenditures may be subject to the provisions of RCW 43.135.060.

Check applicable boxes and follow corresponding instructions:

- If fiscal impact is greater than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.
- If fiscal impact is less than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).
- Capital budget impact, complete Part IV.

Legislative Contact: Dominic Kehoe	Phone: 360-786-7183	Date: 03/27/2009
Agency Preparation: Julia Appel	Phone: (360) 705-5229	Date: 03/31/2009
Agency Approval: Dirk Marler	Phone: 360-705-5211	Date: 03/31/2009
OFM Review: Cheri Keller	Phone: 360-902-0563	Date: 03/31/2009

Request # -1

Bill # 5752 SB

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact on the Courts

The amendment to the substitute bill has no impact on the following analysis.

This bill relates to costs for prosecuting disciplinary actions against dentists. If a dentist appeals the results of an administrative disciplinary hearing to the superior court, and after that to the court of appeals or supreme court, section 1 (2) specifies the amount of money the courts must impose on the dentist to reimburse the state for its additional litigation costs.

II. B - Cash Receipts Impact

II. C - Expenditures

According to DOH, dental hearing decisions are already appealed to superior court at a high rate, so additional filings are not expected. It is possible that more actions might be appealed to the appellate courts and possibly to the supreme court, but it is assumed that the fiscal impact will be less than \$50,000 annually.

Part III: Expenditure Detail

Part IV: Capital Budget Impact

Individual State Agency Fiscal Note

Bill Number: 5752 SB	Title: Dentists	Agency: 303-Department of Health
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Part I: Estimates

No Fiscal Impact

Estimated Cash Receipts to:

FUND	FY 2010	FY 2011	2009-11	2011-13	2013-15
Health Professions Account-State 02G-1	25,000	260,000	285,000	520,000	520,000
Total \$	25,000	260,000	285,000	520,000	520,000

Estimated Expenditures from:

	FY 2010	FY 2011	2009-11	2011-13	2013-15
FTE Staff Years	1.1	0.9	1.0	0.9	0.9
Fund					
Health Professions Account-State 02G-1	187,000	95,000	282,000	190,000	190,000
Total \$	187,000	95,000	282,000	190,000	190,000

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

- If fiscal impact is greater than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.
- If fiscal impact is less than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).
- Capital budget impact, complete Part IV.
- Requires new rule making, complete Part V.

Legislative Contact: Dominic Kehoe	Phone: 360-786-7183	Date: 03/27/2009
Agency Preparation: Danny Howard	Phone: (360) 236-4625	Date: 03/31/2009
Agency Approval: Patty Steele	Phone: 360-236-4530	Date: 03/31/2009
OFM Review: Nick Lutes	Phone: 360-902-0570	Date: 04/03/2009

Request # 09-174-1

Bill # 5752 SB

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

Section 1: This bill adds a new section to Chapter 18.32 RCW (Dentistry) to recover costs in disciplinary proceedings for dentists. The bill provides for the Dental Quality Assurance Commission to recover a hearing fee from the respondent in those instances when a sanction or fine is levied against the respondent as a result of the hearing. It also imposes recovery fees on appeals and agreed orders, and increases the maximum recovery fee for stipulation to informal dispositions (STIDS). The fees may be waived if they would cause substantial undue hardship for the dentist, or appear manifestly unjust based on the circumstances of the case.

In any disciplinary case pertaining to a dentist where there is a contested hearing and a disciplinary sanction or fine is imposed on the dentist, a partial recovery of the state's hearing expenses can be recovered. Up to \$6,000 for each full hearing day and \$3,000 for any partial hearing day may be recovered. The state will also recover partial expenses of investigative and hearing preparation in the amount found to be reasonable under the circumstances but no more \$10,000. The commission may waive the partial recovery hearing fee if it determines the assessment of the fee would create substantial undue hardship for the dentist or if in all circumstances of the case would be manifestly unjust to assess the fine.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

Assumptions: The Dental Quality Assurance Commission (DQAC) will use the full financial authority granted with this bill. Due to anticipated appellate litigation, the only revenue expected to be received in fiscal year (FY) 2010 will be for the STIDS. The Department of Health (DOH), Division of Health Systems Quality Assurance (HSQA) is estimating that one quarter of the number of cases (9), which in the past would have resulted in agreed orders (36), will instead go to hearing due to the respondents' reluctance to settle and pay the increased agreed order cost recovery. This will increase the number of hearings to 12 each year. It is assumed that the appellate courts will impose \$25,000 per level of appeal and will not grant more waivers than DQAC. It is also assumed that the addition of a \$25,000 cost recovery for an unsuccessful appeal will decrease the number of appeals taken by respondents, based on HSQA's experience with attorneys at the appellate level.

HSQA currently obtains fines on agreed orders and cost recovery on STIDS. No cost recovery is currently collected for hearings or appeals. For agreed orders, HSQA currently collects up to \$5,000 per violation. For STIDS, HSQA currently collects up to \$1,000 per allegation.

Section 1 - Increased cost recovery authority estimates:

Beginning in FY 2010, an additional \$25,000 will be collected each year as a result of STIDS, based on data from the 2008 UDA report (25 STIDS per year X \$1,000).

Beginning in FY 2011, an additional \$135,000 will be collected each year as a result of nine additional hearings, based

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Bill # 5752 SB

on data from the 2008 UDA report (9 hearings of 2.5 days each at \$6,000 per day, and \$3,000 for a half day). An additional \$100,000 will be collected each year as a result of four additional appeals and a 90 percent affirmation rate, based on data from the 2008 UDA report (33% of 12 total orders appealed X \$25,000 each).

This bill allows a practitioner to seek a reduction in the amount of the recovery, and because HSQA has not collected fees based on costs in cases other than STIDs, the impact is difficult to predict and is therefore not a part of this cost estimate.

Current law requires that this profession be fully self-supporting and sufficient revenue be collected through fee increases to fund 02G expenditures in the Health Professions Account. Nothing in this legislation creates a new fee. Nor does it authorize increasing fees for the programmatic changes contained in the bill. Depending on the impact of this and other new legislation that may also affect this profession, fee adjustments will be required in the future.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

Assumptions: DQAC will use the full financial authority granted to them under the bill. HSQA is estimating that some respondents who would have settled at the agreed order stage of the disciplinary process will instead go to hearing. For fiscal note purposes, HSQA is estimating one quarter of the number of past agreed orders from the 2008 UDA report will go to hearing due to respondents' reluctance to settle and pay the increased agreed order cost recovery. Estimates are based solely on data for the dental profession. Based on the 2008 UDA report, all DQAC cases that went to hearing were later appealed.

Section 1(1): For fiscal note purposes, HSQA is estimating nine additional cases per year will go to hearing due to respondents' reluctance to settle and pay the increased agreed order cost recovery. Hearing times will be extended due to increased testimony and argument about the amount of costs to be assessed to the respondent and hardship waivers. The number of post-hearing motions for reconsideration and/or motions to modify will increase because respondents will dispute the investigative and hearing preparation expenses and/or the determination by the commission on the hardship waiver and seek to strengthen their record for appeal.

HSQA is estimating at least an additional day for the hearing. Hearings require a panel of three members of the DQAC to be in attendance along with a court reporter. There will be staff time to substantiate costs of investigative and hearing preparation and to create a new billing and time tracking change in the HSQA Integrated Licensing and Regulatory System database. Costs in FY 2010 will include staff and associated costs, Commission member time, court reporter services, and travel. Costs are estimated to be 0.7 FTE and \$104,000. Starting in FY 2011, ongoing costs are estimated to be 0.6 FTE and \$94,000 each year.

Section 1(2): HSQA is estimating that nine additional cases per year will require judicial review of the disciplinary action by the superior court or appellate court. To be sent to the appellate court and the Attorney General's Office, the case file will need to be copied and indexed. Attorney General time will be needed to address new arguments which will be raised about the cost recovery requirements in this bill and the legal standards for waiving cost recovery. Costs in FY 2010 will include staff and associated costs, and Attorney General time. Costs are estimated to be \$83,000. Starting in FY 2011, ongoing costs are estimated to be \$1,000 each year.

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In FY 2010, expenditures also include salary, benefits and related staff costs for a 0.2 FTE Health Services Consultant (HSC) 1 and a 0.2 FTE Fiscal Analyst (FA) 2 to assist with the increased administrative workload. In FY 2011 and ongoing, these expenditures are expected to decrease to 0.1 FTE HSC and 0.1 FTE FA.

Part III: Expenditure Detail

III. A - Expenditures by Object Or Purpose

	FY 2010	FY 2011	2009-11	2011-13	2013-15
FTE Staff Years	1.1	0.9	1.0	0.9	0.9
A-Salaries and Wages	64,000	52,000	116,000	104,000	104,000
B-Employee Benefits	16,000	12,000	28,000	24,000	24,000
E-Goods and Services	97,000	26,000	123,000	52,000	52,000
G-Travel	4,000	4,000	8,000	8,000	8,000
J-Capital Outlays	5,000		5,000		
M-Inter Agency/Fund Transfers					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements	1,000	1,000	2,000	2,000	2,000
9-					
Total:	\$187,000	\$95,000	\$282,000	\$190,000	\$190,000

III. B - Detail: List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA

Job Classification	Salary	FY 2010	FY 2011	2009-11	2011-13	2013-15
Board Member FTE @ 250 per day		0.1	0.1	0.1	0.1	0.1
Board Member FTE @ 50 per day						
Fiscal Analyst 2	44,928	0.2	0.1	0.2	0.1	0.1
Health Services Consultant 1	43,836	0.2	0.1	0.2	0.1	0.1
HEALTH SERVICES CONSULTANT 3	61,632	0.0	0.0	0.0	0.0	0.0
HEARINGS EXAMINER 3	78,900	0.3	0.3	0.3	0.3	0.3
HEARINGS SCHEDULER	36,756	0.1	0.1	0.1	0.1	0.1
INFORMATION TECHNOLOGY	71,496	0.0		0.0		
SPECIALIST 4						
LEGAL SECRETARY 2	42,588	0.2	0.2	0.2	0.2	0.2
WMS03	87,096	0.0	0.0	0.0	0.0	0.0
Total FTE's	467,232	1.1	0.9	1.0	0.9	0.9

III. C - Expenditures By Program (optional)

Program	FY 2010	FY 2011	2009-11	2011-13	2013-15
Health Systems Quality Assurance (060)	166,000	84,000	250,000	168,000	168,000
Administration (090)	21,000	11,000	32,000	22,000	22,000
Total \$	187,000	95,000	282,000	190,000	190,000

Part IV: Capital Budget Impact

None.

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Bill # 5752 SB

DISCUSSION DRAFT

Standards for Professional Conduct In The Practice of Dentistry

Preamble

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

Scope of Practice

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

Treating or Prescribing for Family

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

Staff Supervision

- Protect the health of patients by only assigning to qualified auxiliaries those duties which can be legally delegated.
- Prescribe and supervise the patient care provided by all auxiliary personnel in accordance with the correct type of supervision.

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

Deleted: in order to maintain the esteem and integrity of the dental profession.

Practitioner-Patient Communications

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

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DISCUSSION DRAFT

- Refrain from removing amalgam restorations from a non-allergic patient for the alleged purpose of removing toxic substances from the body. The same applies to removing any other dental materials.

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Patient of Record

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

Patient Records

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

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Financial Transactions

- Do not accept or tender "rebates" or split fees with other health professionals.
- Maintain a listing of customary fees and represent all fees being charged clearly and accurately.
- Do not use a different fee without providing the patient or third party payers a reasonable explanation which is recorded in the record.
- Return fees to the patient or third party payers in a timely manner if a procedure is not completed or the method of treatment is changed.

DISCUSSION DRAFT

- Do not accept a third party payment in full without disclosing to the third party that the patient's payment portion will not be collected.
- Do not increase fees charged to a patient who is covered by a dental benefit plan.
- Do not incorrectly describe a dental procedure in order to receive a greater payment or reimbursement or incorrectly make a non-covered procedure appear to be a covered procedure on a claim form.
- Do not certify in a patient's record or on a third party claim that a procedure is completed when it is not completed.
- Do not use inaccurate dates that are to benefit the patient; false or misleading codes; change the procedure code to justify a false procedure; falsify a claim not having done the procedure, or expand the claim.
- Avoid exploiting the trust a patient has in the professional relationship when promoting or selling a product by: advising the patient or buyer if there is a financial incentive for the dentist to recommend the product; providing the patient with written information about the product's contents and intended use as well as any directions and cautions that apply to its use; and, informing the patient if the product is available elsewhere.
- Do not misrepresent a product's value or necessity or the dentist's professional expertise in recommending products or procedures.

Relationships with Practitioners

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

Practitioner Responsibility

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

DISCUSSION DRAFT

- Be knowledgeable in providing emergency care and have an acceptable emergency plan with delegated duties to the staff in written form, maintain accurate records and be current in basic CPR.
- Avoid interpersonal relationships with patients and staff that could impair professional judgment or risk the possibility of exploiting the veracity and confidence placed in the doctor-patient relationship.

Advertising Ethics

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

Reports and Investigations

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

Deleted: consistent with §63.2-1509 of the Code.

Notice

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

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
 July 1, 2008 through June 30, 2009

FY10 Budget

	Budget
Revenue	
2400 · Fee Revenue	
2401 · Application Fee	146,350
2402 · Examination Fee	
2406 · License & Renewal Fee	2,098,025
2407 · Dup. License Certificate Fee	4,100
2408 · Board Endorsement - In	53,750
2409 · Board Endorsement - Out	11,725
2421 · Monetary Penalty & Late Fees	13,025
2430 · Board Changes Fee	
2432 · Misc. Fee (Bad Check Fee)	-
Total 2400 · Fee Revenue	2,326,975
3000 · Sales of Prop. & Commodities	
3002 · Overpayments	
3020 · Miscellaneous Sale	
Total 3000 · Sales of Prop. & Commodities	
9000 · Other Revenue	
9060 · Inspection Fees	2,450
Total 9000 · Other Revenue	2,450
Total Revenue	2,329,425
Expenditures	
1100 · Personal Services	
Employee Suggestion Awards	
1110 · Employee Benefits	
1111 · Employer Retirement Contrib.	36,502
1112 · Fed Old-Age Ins- Sal St Emp	24,799
1113 · Fed Old-Age Ins- Wage Earners	2,599
1114 · Group Insurance	2,561
1115 · Medical/Hospitalization Ins.	44,888
1116 · Retiree Medical/Hospitalizatn	3,242
1117 · Long term Disability Ins	3,242
Total 1110 · Employee Benefits	117,833
1120 · Salaries	
1123 · Salaries, Classified	324,173
1125 · Salaries, Overtime	
Total 1120 · Salaries	324,173
1130 · Special Payments	
1131 · Bonuses and Incentives	
1134 · Specified Per Diem Payment	14,950
1138 · Deferred Compnstn Match Pmts	3,120
Total 1130 · Special Payments	18,070
1140 · Wages	

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
 July 1, 2008 through June 30, 2009

FY10 Budget

	<u>Budget</u>
1141 · Wages, General	33,641
1143 · Wages, Overtime	
Total 1140 · Wages	<u>33,641</u>
1150 · Disability Benefits	
1153 · Short-trm Disability Benefits	
Total 1150 · Disability Benefits	
1160 · Terminatn Personal Svce Costs	
1162 · Salaries, Annual Leave Balanc	
Total 1160 · Terminatn Personal Svce Costs	
Total 1100 · Personal Services	<u>493,717</u>
1200 · Contractual Services	
1210 · Communication Services	
1211 · Express Services	890
1212 · Outbound Freight Services	35
1213 · Messenger Services	25
1214 · Postal Services	18,000
1215 · Printing Services	1,487
1216 · Telecommunications Svcs (DIT)	1,926
1217 · Telecomm. Svcs (Non-State)	885
1219 · Inbound Freight Services	
Total 1210 · Communication Services	<u>23,248</u>
1220 · Employee Development Services	
1221 · Organization Memberships	5,980
1222 · Publication Subscriptions	2,603
1224 · Emp Trning Courses, Wkshp & Cnf	
1225 · Employee Tuition Reimbursement	
1227 · Emp Trning- Trns, Ldgng & Meals	
Total 1220 · Employee Development Services	<u>8,583</u>
1230 · Health Services	
1236 · X-ray and Laboratory Services	2,132
Total 1230 · Health Services	<u>2,132</u>
1240 · Mgmnt and Informational Svcs	
1242 · Fiscal Services	40,202
1244 · Management Services	561
1246 · Public Infrmtnl & Relation Svcs	
1247 · Legal Services	3,424
1248 · Media Services	3,082
1249 · Recruitment Services	
Total 1240 · Mgmnt and Informational Svcs	<u>47,269</u>
1250 · Repair and Maintenance Svcs	
1253 · Equip Repair & Maintenance	15

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
 July 1, 2008 through June 30, 2009

FY10 Budget

	Budget
1257 · Plant Rep & Maintenance Svcs	
Total 1250 · Repair and Maintenance Svcs	15
1260 · Support Services	
1263 · Clerical Services	7,595
1264 · Food & Dietary Services	2,587
1266 · Manual Labor Services	3,584
1267 · Production Services	23,961
1268 · Skilled Services	45,200
Total 1260 · Support Services	82,927
1280 · Transportation Services	
1282 · Travel, Personal Vehicle	16,871
1283 · Travel, Public Carriers	3,182
1284 · Travel, State Vehicles	
1285 · Travel, Subsistence & Lodging	15,695
1288 · Trvl, Meal Reimb- Not Rprtble	6,660
Total 1280 · Transportation Services	42,408
Total 1200 · Contractual Services	206,582
1300 · Supplies And Materials	
Personal Care Supplies	
1310 · Administrative Supplies	
1312 · Office Supplies	1,610
1313 · Stationery and Forms	2,220
Total 1310 · Administrative Supplies	3,830
1330 · Manufctrng and Merch Supplies	
1335 · Packaging and Shipping Suppl	
Total 1330 · Manufctrng and Merch Supplies	
1340 · Medical and Laboratory Supp.	
1342 · Medical and Dental Supplies	
Total 1340 · Medical and Laboratory Supp.	
1350 · Repair and Maint. Supplies	
1352 · Custodial Rep & Maint Mat'is	
Total 1350 · Repair and Maint. Supplies	
1360 · Residential Supplies	
1362 · Food and Dietary Supplies	288
1363 · Food Service Supplies	34
Total 1360 · Residential Supplies	322
Total 1300 · Supplies And Materials	4,152
1400 · Transfer Payments	
Incentives	

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
 July 1, 2008 through June 30, 2009

FY10 Budget

	Budget
1410 · Awards, Contrib., and Claims	
1413 · Premiums	70
1415 · Unemployment Compnsatn Reimb	1,178
Total 1410 · Awards, Contrib., and Claims	1,248
Total 1400 · Transfer Payments	1,248
1500 · Continuous Charges	
1510 · Insurance-Fixed Assets	
1516 · Property Insurance	-
1510 · Insurance-Fixed Assets - Other	640
Total 1510 · Insurance-Fixed Assets	640
1530 · Operating Lease Payments	
1534 · Equipment Rentals	10,345
1535 · Building Rentals	56,669
Total 1530 · Operating Lease Payments	67,014
1540 · Service Charges	
1541 · Agency Service Charges	
Total 1540 · Service Charges	
1550 · Insurance-Operations	
1551 · General Liability Insurance	
1554 · Surety Bonds	
Total 1550 · Insurance-Operations	
Total 1500 · Continuous Charges	67,654
2200 · Equipment Expenditures	
Electrnc & Phtgrphc Equip Imprv	
2210 · Computer Equipment	
2216 · Network Components	
2218 · Computer Software Purchases	
Total 2210 · Computer Equipment	
2220 · Educational & Cultural Equip	
2224 · Reference Equipment	113
Total 2220 · Educational & Cultural Equip	113
2230 · Electrnc & Photographic Equip	
2233 · Voice & Data Transmissn Equip	
Total 2230 · Electrnc & Photographic Equip	
2260 · Office Equipment	
2261 · Office Appurtenances	240
2262 · Office Furniture	2,749
2263 · Office Incidentals	29
2264 · Office Machines	

Virginia Dept. of Health Professions
Revenue and Expenditures Summary
 July 1, 2008 through June 30, 2009

FY10 Budget

	Budget
2268 · Office Equipment Improvements	
Total 2260 · Office Equipment	3,018

2270 · Specific Use Equipment	
2271 · Household Equipment	
Total 2270 · Specific Use Equipment	

Total 2200 · Equipment Expenditures	3,131
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Total Expenditures	776,484
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9001 · Allocated Expenditures	
9301 · DP Operations & Equipment	378,218
9302 · Human Resources	37,069
9303 · Finance	67,871
9304 · Director's Office	35,126
9305 · Enforcement	564,396
9306 · Administrative Proceedings	196,288
9307 · Impaired Practitioners	2,099
9308 · Attorney General	113,082
9309 · Board of Health Professions	17,740
9310 · SRTA	
9311 · Moving Costs	12,813
9313 · Emp. Recognition Program	2,697
9315 · Pgm Devlpmt & Implmentn	7,786
9316 Workforce	15,911
987900 · Cash Trsfr Out- Appr Act Pt. 3	4,495

Total 9001 · Allocated Expenditures	1,455,590
Total Direct and Allocated Expenditures	2,232,074

Net Cash Surplus\Shortfall	97,351
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**Board of Dentistry
Revenue Budget
FY10-FY14**

	Licensees	REVENUE	Fees
Renewal Fee:			
Cosmetic Procedure Certification, Current Active	25	2,500	\$ 100
Dental Full Time Faculty, Current Active	10	2,850	285
Dental Hygienist, Current Active	4,500	337,500	75
Dental Hygienist, Current Inactive	225	9,000	40
Dental Teacher, Current Active	4	1,140	285
Dentist, Current Active	5,800	1,653,000	285
Dentist, Current Inactive	350	50,750	145
Oral/Maxillofacial Surgeon Registration, Current Ac	220	38,500	175
Temp-Residents	20	700	35
Dental Assistant	TBD		
Application Fee:			
Dentists	245	98,000	400
Dental Restricted Volunteer	1	25	25
Dental Hygienists	250	43,750	175
Dental Teachers	1	400	400
Full Time Faculty	1	400	400
Oral/Maxillofacial Surgeon Registration	10	1,750	175
Cosmetic Procedure Certification	2	450	225
Dentist - Volunteer Registration	15	375	25
Temp-Residents	20	1,200	60
Endorsement - Out			
Dentists	225	7,875	35
Dental Hygienists	110	3,850	35
Endorsement - In			
Dentists (Credentialing)	80	40,000	500
Dental Hygienists	50	13,750	275
Inspection Fee	7	2,450	350
Late Fee - Dentist	70	7,000	100
Late Fee - Dental Hygienists	55	1,375	25
Duplicate Wall Certificates	10	600	60
Duplicate Licensee	175	3,500	20
Reinstatement (Dentist)	5	2,500	500
Reinstatement (Dental Hygienists)	7	1,400	200
Reinstatement after Discipline	1	750	750
Inactive to Active (Dentist)	6	1,710	285
Inactive to Active (Dental Hygienists)	5	375	75
Total		2,329,425	

Cash Balance as of June 30, 2008	(339,506)	Projected Cash Balance as of June 30, 2011	137,481
FY09 Budget Revenue	2,282,825	FY12 Budget Revenue	2,329,425
FY09 Direct and Allocated Budget Expenditures	1,875,958	Total FY12 Direct and Allocated Budget Expenditures	2,473,551
Cash Balance as of June 30, 2009	<u>67,361</u>	Projected Cash Balance as of June 30, 2012	<u>(6,645)</u>
Cash Balance as of June 30, 2009	67,361	Projected Cash Balance as of June 30, 2012	(6,645)
FY10 Budget Revenue	2,329,425	FY13 Budget Revenue	2,329,425
Total FY10 Direct and Allocated Budget Expenditures	2,232,074	Total FY13 Direct and Allocated Budget Expenditures	2,518,328
Projected Cash Balance as of June 30, 2010	<u>164,712</u>	Projected Cash Balance as of June 30, 2013	<u>(195,548)</u>
Projected Cash Balance as of June 30, 2010	164,712	Projected Cash Balance as of June 30, 2013	(195,548)
FY11 Budget Revenue	2,329,425	FY14 Budget Revenue	2,329,425
Total FY11 Direct and Allocated Budget Expenditures	2,356,656	Total FY14 Direct and Allocated Budget Expenditures	2,546,448
Projected Cash Balance as of June 30, 2011	<u>137,481</u>	Projected Cash Balance as of June 30, 2014	<u>(412,571)</u>
Projected Cash Balance as of June 30, 2011	137,481	Projected Cash Balance as of June 30, 2014	(412,571)

Board

Business

Meeting

**VIRGINIA BOARD OF DENTISTRY
FORMAL HEARINGS
JUNE 11, 2009**

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

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

MEMBERS PRESENT: Darryl J. Pirok, D.D.S.
James D. Watkins, D.D.S.
Jacqueline G. Pace, R.D.H.
Paul N. Zimmet, D.D.S.

MEMBERS EXCUSED: Jeffrey Levin, D.D.S.
Myra Howard, Citizen Member
Robert B. Hall, Jr., D.D.S.

MEMBERS ABSENT: Misty Mesimer, R.D.H.
Augustus A. Petticolas, Jr., D.D.S.

STAFF PRESENT: Alan Heaberlin, Deputy Executive Director

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

OTHERS PRESENT: Wayne Halblieb, Assistant Attorney General
Gail E. Ross, Adjudication Specialist
Sandra Spinner, Court Reporter, Capitol Reporting, Inc.

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

Bland Massie, Jr., D.D.S. Dr. Massie appeared with his counsel, Larry Pochucha in accordance with a Notice of the Board dated April 30, 2009.

Case No. 117021

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

The respondent advised that he had no additional exhibits.

Dr. Gokli swore in the witnesses.

Testifying on behalf of the Commonwealth was Jennifer Baker, Senior Investigator.

Dr. Massie testified on his own behalf.

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

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

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

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

Ms. Pace moved to adopt the Findings of Fact and Conclusions of Law as reported by Mr. Casway and to issue an order stating that Dr. Massie practiced without a current active and valid license from April 1, 2006 to April 27, 2008. Dr. Massie shall be issued a monetary penalty in the amount of \$7,000, shall successfully complete the Board's Dental Law Examination and complete 4 hours of continuing education in Risk Management. The motion was seconded and passed.

SECOND FORMAL HEARING:

Convened at 11:57 am.

PRESIDING:

Meera A. Gokli, D.D.S.

MEMBERS PRESENT:

Darryl J. Pirok, D.D.S.
James D. Watkins, D.D.S.
Jacqueline G. Pace, R.D.H.
Augustus A. Petticolas, Jr. D.D.S.
Paul N. Zimmet, D.D.S.
Robert B. Hall, Jr. D.D.S.

MEMBERS EXCUSED:

Jeffrey Levin, D.D.S.
Myra Howard, Citizen Member

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: William Clay Garrett, Assistant Attorney General
Gail E. Ross, Adjudication Specialist
Sandra Spinner, Court Reporter, Capitol Reporting, Inc.

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

**Evan S. Weiner,
D.D.S.
Case No. 117714** Dr. Weiner did not appear in accordance with a Notice of the Board dated May 8, 2009.

~~Dr. Gokli rules that adequate notice was provided to Dr. Weiner and the hearing proceed in his absence.~~

Dr. Gokli admitted into evidence Commonwealth's exhibits 1 and 5.

Dr. Gokli swore in the witnesses.

Testifying on behalf of the Commonwealth were Helene J. Kelly, R.N., M.S.N., Senior Investigator, Marta J. Ishmael, DHP Inspector, Paul M. Spector, D.O., and Charles L. Cuttino, D.D.S.

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

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

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

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

Ms. Pace moved to adopt the Findings of Fact and Conclusions of Law as reported by Mr. Casway and to issue an order that Dr. Weiner's privilege to renew his license is hereby indefinitely suspended. Dr. Weiner shall not petition the Board for reinstatement of his license for a period of at least twelve months from the date of entry of this Order. If Dr. Weiner decides to seek reinstatement of his license, he shall be noticed to appear before the Board, in accordance with the Administrative Process Act. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 1:57 p.m.

Meera A. Gokli, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
MINUTES
June 12, 2009**

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:10 A.M. on June 12, 2009 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

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

**BOARD MEMBERS
PRESENT:**

Jeffrey Levin, D.D.S., Vice-President
Jacqueline G. Pace, R.D.H., Secretary-Treasurer
Robert B. Hall, Jr. D.D.S.
Myra Howard
Misty Mesimer, R.D.H.
Augustus A. Petticolas, Jr. D.D.S.
Darryl J. Pirok, D.D.S.
James D. Watkins, D.D.S.
Paul N. Zimmet, D.D.S.

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

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

**ESTABLISHMENT OF
A QUORUM:** All members of the Board were present.

PUBLIC COMMENT: **Thomas B. Padgett, D.M.D.**, President of Virginia Society of Oral and Maxillofacial Surgeons (VSOM), expressed VSOM position on the following issues:

- Guidance Document 60 (the Policy of Administering Schedule II through VI Controlled Substances for analgesia Sedation and Anesthesia in Dental Practice) - VSOM requested the Board to allow RN's and LPN's to administer sedative or anesthesia drugs when under direct supervision of a practitioner who is licensed to give said drugs.
- Dr. Futerman's Petition for Rulemaking (amending 18VAC60-20-108, 18VAC60-20-120 and 18VAC60-110 and replaces the present guidelines for administering anesthesia with the ADA guidelines) – VSOM feel that the current Virginia Guidelines for this issue are more stringent than the ADA Guidelines and do not think a change is needed.
- Mr. Haddad's Petition for Rulemaking (amending sections 18VAC60-20-110 and 18VAC60-20-120 - regulating dental

providers who administer sedative and or anesthesia drugs) – VSOM feel that the current Virginia Guidelines for Administering Anesthesia are more than adequate but there is currently no office inspection or anesthesia permits required in the State of Virginia for general dentist who administers sedation and or anesthesia. Dr. Padgett went on to say if the Board decides to implement an inspection process, VSOM ask that Oral Surgeons who are evaluated through AAOMS be exempt.

Dr. Padgett commented that the safety of the patients is VSOM's utmost concern. Dr. Padgett thanked the Board for the opportunity to address these issues and stated that VSOM appreciates the Board's consideration on these important issues.

Ralph L. Howell, D.D.S., president of the Virginia Dental Association (VDA), asked on behalf of the VDA that the Board:

- Be proactive in addressing emerging dentistry delivery models.
- Hold everyone to same standards for practice.
- Corrects inconsistency in regulations such as permitting
 - prescribing antibiotics but not allowing treatment of symptoms known to result from antibiotics
 - administration of Botox for dental treatment but not for cosmetic purposes
- Post a PowerPoint presentation on advertising rules on its webpage similar to the one posted on recordkeeping.

Dr. Howell thanked the board members for the hard work they are doing.

APPROVAL OF MINUTES:

Dr. Gokli asked if the Board members had reviewed the minutes in the agenda package. Dr. Zimmet moved to accept the minutes of the March 12, 2009 meeting. The motion was seconded and carried.

Ms. Mesimer moved to accept the minutes of the March 13, 2009 meeting. The motion was seconded and carried. Dr. Watkins asked that on page 11 in Acupuncture the phrase "Mr. Casway advised that the Board decides if and when acupuncture can be used in dentistry" is correct. Ms. Reen stated that it is correct. Dr. Gokli agreed.

DHP DIRECTOR'S REPORT:

DHP Performs. Ms. Ryals reported to the Board on the following issues:

- DHP Performance – Ms. Ryals congratulated the Board members and staff for doing a great job with processing licensure applications, its feedback on customer satisfaction surveys, and for clearing cases in 250 days or less. Ms. Ryals asked Board members and staff to continue efforts to meet or exceed the performance measures.

- Health Practitioner Intervention Program (HPIP) – She noted that the name change of this program to Health Practitioner Monitoring Program (HPMP) will take effect on July 1, 2009.
- Healthcare Workforce Data Center– Ms. Ryals reported that the agency received \$250,000 for start up so the agency has not been using funds from the boards yet. She reported that the supply and demand issues for physicians and nurses were addressed first and that next on the list of professions to be addressed are dentists and dental hygienists. Ms. Ryals asked the Board to designate a representative to participate on the study of dental professions.
- Prescription Monitoring Program (PMP) data breach– Ms. Ryals reported that on April 30 ,2009, there was an unauthorized access to the PMP database so all DHP systems were shutdown immediately. She reported that most systems are back up and that the criminal investigation is still being aggressively pursued. Ms. Ryals stated that there are Questions and Answers handouts available if anyone would like to have a copy. These questions and answers are also available on DHP website. Ms. Ryals reported that the agency has developed scripts and contracted with a call center to answer questions in regard to this matter. Ms. Ryals assured the Board that the agency has been going above and beyond to be responsive to the public.

**REPORT ON REVENUE,
EXPENDITURES
AND CASH:**

Mark Monson, DHP Deputy Director of Administration – thanked the Board for the opportunity to discuss its revenue, expenditures and cash. He advised that the Board is responsible for assuring that its revenue covers the expenses incurred and that the Board may be asked to begin the regulatory process to increase fees at its September meeting. Mr. Monson then turned the discussion of the financial reports over to Mr. Giles.

Charles Giles, DHP Budget Manager – referred to the DHP Projected Board Revenue, Expenditures and Cash FY09 – FY14 report and stated that based on current information without any organizational changes the projection is that the Board will have over a million dollar deficit at the close of FY 2014. He reported that the reason for the projected shortfall is due to costs which resulted from the agency move to a new location, implementation of record management software – Documentum, increased office space, and the Board staff increase from 3.3 fulltime employees to 6 fulltime employees. Mr. Giles stated that currently 88% of the revenue comes from renewal fees and that the projections do not include the addition of dental assistants. He also commented on the need to anticipate increased costs in areas such as:

- Salaries
- Healthcare
- Lease

- Technology (VITA)

Mr. Monson stated that there will be a detailed presentation for the Board Meeting in September and he asked the Board to let him know what information is needed to help the Board make an informed decision about beginning the regulatory process.

Dr. Gokli commented that back in 2006, the Board was given 3 choices in regard to adjusting fees and asked if the Board will have options to look at in September. Mr. Monson replied that options would be available and Ms. Ryals assured the Board that the year end figures for FY09 will also be available.

Dr. Zimmet asked what the impact would be on the revenue and expenditures when the Board begins collecting disciplinary costs. Ms. Ryals said that the agency did do an impact statement and the impact would be minimal. Ms. Reen stated that the Board can not collect the fee until the regulatory process is completed so there will be no impact in the near future.

Dr. Hall asked if there are cost estimates available on each level of the investigative process. Ms. Reen responded that Enforcement tracks the number of hours spent on each case. She also commented that the Board has not been in the black since she has been with the Board.

DENTAL ASSISTANT APPRENTICESHIP PROGRAM:

Ms. Reen introduced Beverley Donati, Director Registered Apprenticeship of Department of Labor and Industry, and Ms. Westerman, Director of Apprenticeship Relation of Virginia Community College System (VCCS) who had contacted her about their apprenticeship program when they heard the Board is working on regulations for Dental Assistants II. Ms. Reen said she invited them to present their program for dental assistants to the Board.

Ms. Donati spoke about the value of registered apprenticeships and asked the Board for its support of this program. Ms. Donati reviewed the information package on apprenticeships, noting that the program provides a minimum training standard which is used throughout the U.S. and in some foreign countries. Ms. Westerman explained that this program provides a framework for training and offers a career pathway to take people as far as they want to go. Ms. Westerman went on to say that VCCS offers the courses required to complete apprenticeships, noting that the requirements are driven by the industries and employers who participate.

Dr. Gokli commented that it sounds very impressive. Dr. Zimmet asked if this program lasts for 2 years. Ms. Donati replies it is a 2000 hours or 1 year program. Ms. Ryals asked Ms. Donati and Ms. Westerman what they would like the Board to do. Ms. Donati asked the Board to support

the Apprenticeship concept. Ms. Pace move to support the concept. The motion was seconded and passed.

REPORTS:

Board of Health Professions (BHP), Dr. Gokli said she was not able to attend the last meeting and went on to say that Dr. Zimmet is now representing Dentistry on the BHP.

AADE – Dr. Gokli reported that she attended the AADE Mid-Year meeting in Chicago from April 5-6. She commented that interest in having a national exam was discussed then voted on as being a priority for action. She said it was adopted as a priority with a 65% vote in favor. She commented that it was a hand-raise vote, that some states had more representatives present than others, and that she wished that the voting was done by state role call. She went on to report on the discussion of the following issues:

- Leadership of the profession in serving the public and not ourselves.
- The effects of the economy on dental education which touched on subjects such as the need to reach out in the community, making the schools green, and utilizing basic science faculty.
- Communication between dental associations, schools, and state boards to figure out the needs in the community and ways to work together to address them.

Dr. Gokli recommended that at least 2 people should be going to these high level meetings due to the voting system. Dr. Zimmet added that at least one representative should attend the upcoming AADE annual meeting.

Dr. Gokli noted the information provided in the agenda materials on AADE's "Sexual Boundary Issues" continuing education course. She explained that it addresses the importance of respecting sexual boundaries in the practice of dentistry. Ms. Reen commented that it is a new resource that special conference committees might use.

Executive Committee Meeting. Dr. Gokli reported that the Executive Committee met this morning and addressed the Discussion Draft of Standards for Professional Conduct in the Practice of Dentistry. She commented that the draft is still under discussion and she hoped that it will be ready for the September meeting.

Regulatory/Legislative Committee. Dr. Watkins asked if there were any questions about the information in the April 22, 2009 Draft Minutes of the Committee meeting. He reported that the Committee is working on a guidance document of what Dental Assistants I can do and the next Committee meeting will be July 1, 2009.

SRTA. Dr. Watkins reported that he did not attend the SRTA meeting at MCV but there will be a conference call next week. He said that the fee will be slightly increased, it is not finalized yet. He went on to state that the SRTA annual meeting is coming up from August 6-9, 2009 in

Biloxi, Mississippi. Ms. Reen said she would clarify how many people SRTA will reimburse to go to the meeting and asked if any Board member is interested in going to please let her know.

LEGISLATIVE AND REGULATION:

Ms. Reen reported that Elaine Yeatts could not attend this meeting so she would introduce the agenda items.

Petition for Rule-making – Robert J. Haddad. Ms. Reen stated the petition has been published, public comment is open until July 22, 2009 and the Board will act on the petition at its September meeting.

Petition for Rule-making by Len Futerman, DDS. Ms. Reen asked the Board to either accept or reject the petitioner's request to amend regulations for anesthesia in dental office for consistency with the 2007 guidelines of the American Dental Association. Dr. Zimmet moved to deny the petition because the current regulations are adequate to protect the public. The motion was seconded and passed.

Registration of Dental Assistants II. Ms. Reen stated that the proposed regulations are presented for adoption to submit for administrative review and then for public comment. Dr. Watkins asked that section C on page 46 be changed because dental assistants are allowed to place amalgam now. Discussion of 18VAC60-20-230(C) followed and three changes were adopted by motion of Dr. Hall:

- the words "placing" and "polishing" were deleted from the provision on amalgam restorations in section C1
- In the first line of (C), after the phrase "The following duties may" the word "only" was added.

Dr. Zimmet moved adoption of the proposed regulations as amended. The motion was seconded and passed.

Mobile Dental Clinics. Ms. Reen reported the proposed emergency regulations are presented for adoption, noting that the regulations must be effective no later than January 12, 2010. Dr. Pirok commented that he is concerned for patients who have received partial treatment, where they will go next. Dr. Pirok asked if dentists are mandatory reporters for child abuse. Mr. Casway replied that dentists are not mandatory reporters and advised the Board to adopt the emergency regulations as presented then make any amendments in the final regulation. Staff was asked to research the provisions for reporting child abuse. Ms. Howard moved to adopt the Mobile Dental Clinics emergency regulations. The motion was seconded and passed. Dr. Hall moved to strike the word "emergency" from section B1 of 18VAC60-20-332. The motion was seconded and passed. Ms. Howard moved to adopt the regulations as amended and to issue a Notice of Intended Regulatory Action for final regulations. The motion was seconded and passed.

NOIRA for Disciplinary Action Cost Recovery – Ms. Reen reported that the Board needs to adopt the Notice of Intended Regulatory Action to address the assessment of costs related to investigating and

monitoring licensees disciplined by the Board as permitted by §54.1-2708.2 of the Code. The NOIRA addresses the costs to be assessed, how the costs will be determined, the process for assessment and the possible waiver of costs. Dr. Petticolas moved to approve the NOIRA. The motion was seconded and passed.

BOARD

DISCUSSION/ACTION:

Code of Conduct for Board Members. Dr. Levin stated that the Executive Committee approved the proposed guidance document for presentation to the Board. He explained that the Code is recommended to help new members understand their role and responsibilities. Discussion followed and three changes on page 55 were agreed to as follows:

- The word "rescuing" was changed to "recusing" in the third bullet
- The phrase "turning off electronic equipment" was changed to "silencing personal devices" in the seventh bullet, and
- The eleventh bullet on eating and drinking during meetings was deleted.

Dr. Hall moved to adopt the Code as amended. The motion was seconded and passed.

Disciplinary Case Consultant's Evaluation. Dr. Levin said he wanted the Board to consider having sources/patients in cases evaluated by dentists to assess the dental care provided, as is done in Georgia. He commented this is another way to determine if the allegations of mistreatment are true. Mr. Casway commented that the Board retains experts to review cases and he questioned establishing an expectation that patients should be examined as part of an investigation. Dr. Pirok asked how an "expert evaluator" is different from an Agency Subordinate. Ms. Reen responded that Agency Subordinates do not examine patients, they make case decisions instead of a Special Conference Committee. Dr. Zimmet suggested that Dr. Levin do more research and present it to the Board in September. Dr. Gokli tabled the matter.

CODA Letter about VCU Endodontics Program. Ms. Reen advised that this material was provided as information only.

Letter from Discus Dental. Dr. Gokli advised that this material was provided as information only.

Letter from White Smile. Dr. Gokli advised that this material was provided as information only.

Automatic Electronic Defibrillators (AED) – Dr. Levin stated that dental offices should be required to have AEDs device, it is like the second insurance policy, then moved to require an AED in a dental office within 5 years of enactment. Dr. Pirok commented that there needs to be information provided on the need for equipment before it is mandated. Ms. Mesimer agreed. Dr. Levin withdrew the motion and Dr. Gokli referred this subject to the Regulatory-Legislative Committee.

Antibiotic Pre-medication of Orthopaedic Patients. Dr. Pirok reviewed the materials he received about prosthetic joint infections and the risk factors for infections which includes consideration of pre-medication for dental procedures.

**DENTISTRY'S
ADMINISTRATIVE
PROCEEDINGS:**

James Banning, Director of the Administrative Proceedings Division (APD) of DHP commented that the Board has done a great job in clearing out old cases, screening cases, recognizing secondary issues and requesting more investigation before forwarding cases to APD, all of which gives APD a more complete picture of the issues to be addressed in notices. Mr. Banning thanked Board members for their hard work. Dr. Zimmet asked if APD would call the Board reviewer to discuss case issues. Mr. Banning replied that APD will contact Board staff if there are questions. Dr. Pirok commented that he often has to call staff for additional information. Dr. Levin suggested that APD try to frame allegations differently so that the Board is not boxed in during hearings. Mr. Banning expressed appreciation for the suggestions and encouraged reviewers to note relevant details in a case to facilitate development of accurate allegations.

**REPORT ON CASE
ACTIVITY:**

Mr. Heaberlin reviewed the report he distributed addressing the status of the 190 open cases as of June 1, 2009. He indicated that the Board currently has 12 cases older than 365 days and that several of these cases will be closed by June 30, 2009. He went on to say that in the current quarter, April 1 – June 30, 2009, the Board closed its last case that was over 2000. He said the closure of these old cases will cause a dip in the Board's performance on the 250 day measure for this quarter. He also indicated that as of June 1, 2009, the Board has 70 cases in the Probable Cause stage and noted that these cases include cases being reviewed, ones where more information has been requested from Enforcement, cases that have gone to a second reviewer, and cases that are being offered Confidential Consent Agreements. He thanked the Board for all their hard work.

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

Ms. Reen reported that the Department of Health (VDH) is working on the protocol for their dental hygienists to practice under remote supervision as authorized by new legislation. She noted that she has been included in the workgroup which is developing the policies that will guide the provision of dental hygiene treatment in this pilot program which will be implemented in three health districts. Ms. Reen stated that more information will be available for the September Board meeting.

Proposed 2010 Calendar – Ms. Reen stated that this calendar has been sent to all Board members for review and that changes were made in the September schedule. She asked that the calendar be

adopted. Dr. Levin move to adopt the 2010 calendar. The motion was seconded and passed.

BOARD COUNSEL REPORT:

Mr. Casway stated that Dr. Leidy's case is closed and he has nothing new to report.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 3:01 p.m.

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

Sandra K. Reen, Executive Director

Date

Date

**VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY/LEGISLATIVE COMMITTEE
August 21, 2009**

TIME AND PLACE: The meeting of the Regulatory/Legislative Committee of the Board of Dentistry was called to order at 9:00 A.M. on August 21, 2009 in Board Room 1, Department of Health Professions, 9960 Mayland Drive, Suite 201, Richmond, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., Chair

MEMBERS PRESENT: Jacqueline G. Pace, R.D.H.
Myra Howard
Robert B. Hall, Jr., D.D.S.

**OTHER BOARD
MEMBERS PRESENT:** None

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

OTHERS PRESENT: Howard M. Casway, Senior Assistant Attorney General
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

**ESTABLISHMENT OF
A QUORUM:** All members of the Committee were present.

PUBLIC COMMENT: **Michele Satterlund** of Virginia Associate Nurse Anesthetist commented that on page 7 of the Draft Guidance Document on Administering and Monitoring, item number 13, the term "certified anesthesia assistant" should be changed to "dental anesthesia assistant" because anesthesia assistant is not licensed in Virginia. Dr. Levin thanks Ms. Satterlund for her input and stated that the Committee will take it into consideration.

Nancy Daniel of J. Sargeant Reynolds Community College asked the Committee once again to require work experience in restorative dentistry for dental assistant II certification. She stated that it is critical to success. In regards to the Chart on Permissible Delegation of Duties, Ms. Daniel commented that it does not mention the placing of bonding for composite. She asked that the Committee may want to add bonding for composite. Dr. Levin thanked Ms. Daniel for her suggestion and stated that the Committee will take it into consideration.

MINUTES:

Dr. Levin asked if the Committee had reviewed the minutes of the April 22, 2009 meeting. Dr. Hall asked for clarification on top of page 3 of the minutes where it stated "Ms. Yeatts asked if the Committee would like to double the hours as the minimum requirement for clinical experience." Dr. Hall wanted to know if this meant doubling the hours of laboratory training. Ms. Yeatts stated that page 20 of the agenda is the listing of the doubling hours of laboratory training. Ms. Reen clarified that the wording should be "to double the number of laboratory hours as the minimum requirements for clinical experience. Dr. Hall moved to accept the amended April 22, 2009 minutes. The motion was seconded and passed.

STATUS REPORT ON REGULATORY ACTIONS:

Ms. Reen commented that the Regulatory-Legislative Committee is still in the process of reviewing the Regulations. Dr. Levin asked that Ms. Yeatts to walk the Committee through the status of regulatory actions.

Dental Assistant Regulations – Ms. Yeatts reported that the dental assistant regulation is at the proposed stage. Ms. Reen asked that the Committee likes to advance the Amendment to Dental Assistant Regulations and take it to the Board in September meeting. Dr. Hall moved to take the Amendment to Dental Assistant Regulations to the September Board meeting. The motion was seconded and passed.

Mobile Dental Clinics Regulations – Ms. Yeatts reported this regulation is in emergency status and at the Secretary's office for review.

Recovery of Disciplinary Costs – Ms. Yeatts reported that it is at the Governor's office.

CHART ON PERMISSIBLE DELEGATION OF DUTIES:

Dr. Levin commented that the Committee has read and has taken into consideration all of the Townhall public comments when developing this chart.

Ms. Reen added that what dental assistants are currently doing is not reflected on this chart. She advised the Committee to make sure that these duties are clear and accurate before making changes to this chart. She also advised the Committee to send this chart out to the public and interested parties for input. Dr. Levin agreed.

After discussion, the following changes were made to the chart:

- Restorative and Adjuction Services – adding apply primer and bonding
- Anesthesia Services – item #1 should state “Apply topical **Schedule VI** anesthetic”
- Hygiene – item #6 is stricken
- Bleaching – item # 4 is a **Yes** for Dental Assistants I and Dental Assistants II under Indirect Supervision

Dr. Hall moved to approve the amended chart. The motion was seconded and passed.

**DRAFT GUIDANCE
DOCUMENT ON
ADMINISTERING AND
MONITORING:**

Ms. Reen noted that this draft of the guidance document represents what the law currently permitted. She went on to say that this guidance document reflects the discussions held with the Executive Director of the Board of Nursing and Mr. Casway to explain what monitoring and administering meant, what dental assistant can do, and what nurses can do in dental offices. Ms. Reen stated that this is still a discussion draft.

Mr. Casway noted that currently the Regulations do not make clear distinction. He advised that the Committee needs to go over the guidance document paragraph by paragraph with the intention to make clear distinction.

After much discussion, the following amended changes were made:

Administration

6a – “a dentist not qualified to administer conscious sedation **shall only** use the services of an anesthesiologist in **dental office** to administer conscious sedation. **In an Outpatient Surgery Center or hospital, a dentist not qualified to administer conscious sedation shall use an anesthesiologist or certified registered nurse anesthetist to administer conscious sedation**”

7a – “A dentist not qualified to administer deep sedation/general anesthesia **shall only** use the services of an anesthesiologist **in a dental office** to administer deep sedation/general anesthesia. **In an Outpatient Surgery Center or hospital, a dentist not qualified to administer conscious sedation shall use an anesthesiologist or certified registered nurse anesthetist to administer deep sedation/general anesthesia**”

No other change was made. Ms. Pace moved to take the guidance document to the September Board meeting as amended. The motion was seconded and passed.

PERIODIC REVIEW OF REGULATIONS:

Mark-up of Parts I, II and III – Ms. Reen noted that this process is still internal with the Committee. She stated that she has taken comments from Committee members to assist with putting together this document. She stated that this document reflects what the Committee has done and where the Committee wants to go. She advised Committee members to review it thoroughly.

Chart on Part IV, Anesthesia, Sedation and Analgesia – Ms. Reen noted that this section needs to be retitled. She asked Committee members to think about any additional concerns or considerations that need to be added while reviewing this part. Dr. Levin said that he will start the process and then the rest of the Committee members will follow alphabetically.

NEXT MEETING:

Dr. Levin asked about dates for scheduling the next meeting. It was agreed the Committee would meet again at 9:00 am on Friday, October 23, 2009.

ADJOURNMENT:

Dr. Levin adjourned the meeting at 11:30 a.m.

Jeffrey Levin, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date



COMMONWEALTH OF VIRGINIA

MAY 21 2009

Board of Dentistry

DHP

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

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

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)		
Petitioner's full name (Last, First, Middle initial, Suffix.)		
Haddad, Robert J.		
Street Address	Area Code and Telephone Number	
4525 South Blvd., Suite 300	757-671-6000	
City	State	Zip Code
Virginia Beach	VA	23452
Email Address (optional)	Fax (optional)	
rhaddad@srgslaw.com		
Respond to the following questions:		
1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.		
We are seeking to amend Sections 18VAC60-20-110 and 18VAC60-20-120.		
2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.		
See attached.		
3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.		
I believe the Board has the legal authority to make the above changes pursuant to Section 54.1-2400 of the Code of Virginia.		
Signature:	Date: 5/19/09	

ATTACHMENT

2. I'm requesting that changes be made. Number one, because it is so easy for a patient to slip from conscious sedation to deep sedation, I'm requesting that the Board do away with the distinction in the regulations between the two types of sedation. The regulations should assume that even if conscious sedation is the goal that deep sedation is a likely result and the regulations should be consistent. There should be one regulation dealing with "sedation" and that regulation should be tailored after Section 18VAC60-20-110 with the heightened requirements for deep sedation.

Secondly, I'm requesting that the Board institute some sort of permitting process that would require an inspection of a dentist's office to ensure that the office is outfitted with the appropriate equipment to handle any sort of emergency that may arise with the use of sedation and that the dentist and the dentist's staff are proficient with handling an emergency situation that may arise. I'm requesting that the permit expire after a certain period of time and that the permitting process needs to be repeated periodically.

Third, that there be created a standing "Anesthesia Review Committee" to assist the profession and public in all areas pertaining to anxiety/pain control/sedation in dentistry. I'm requesting that this committee have the authority to evaluate cases with respect to how accidents/incidents occur and what could be done to ensure that they do not occur in the future.

Agency Decision

Title of Regulation: N/A - There are no present regulations on this subject.

Statutory Authority: §§ 37.2-203 and 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Adopt regulations to require mental health facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services to physically post up information about the Virginia Freedom of Information Act. This information layout is outlined in § 2.2-3704.1 of the Code of Virginia. It includes the rights of the requester for requesting public records; the obligations of public bodies to process requests for public records; contact information for making requests for public records from the given public body; most commonly used public record exemptions; and recourse to the courts for violations of the Virginia Freedom of Information Act.

Agency Decision: Request denied.

Statement of Reasons for Decision: The board has determined that this request may be appropriately addressed by policy rather than regulation. The Department of Mental Health, Mental Retardation and Substance Abuse Services has complied with the Virginia Freedom of Information Act (FOIA) which requires all state public bodies to post information on their websites informing the public about procedures for requesting public records and responding to those requests. The board understands that some individuals receiving services in state facilities do not have access to the Internet through which they may obtain information about FOIA. Therefore, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services has issued a policy directive to the state facility directors encouraging the posting of FOIA information on facility websites and throughout the facility and specifically on patient units. The board affirms the commissioner's policy and believes that this policy directive addresses the intent of this petition.

Agency Contact: Wendy V. Brown, Policy Analyst, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218, telephone (804) 225-2252, FAX (804) 371-0092, or email wendy.brown@co.dmhmrzas.virginia.gov.

VA.R. Doc. No. R09-20; Filed June 8, 2009, 11:02 a.m.



**TITLE 18. PROFESSIONAL AND
OCCUPATIONAL LICENSING**

BOARD OF DENTISTRY

Initial Agency Notice

Title of Regulation: 18VAC60-20. Regulations Governing the Practice of Dentistry and Dental Hygiene.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Name of Petitioner: Robert J. Haddad.

Nature of Petitioner's Request: To amend regulations to (i) eliminate the distinction between conscious sedation and deep sedation since deep sedation is a likely result; (ii) institute a permitting process with inspection of dental offices to ensure they are appropriately equipped to handle an emergency situation; and (iii) create an Anesthesia Review Committee to assist the profession and the public with issues relating to anxiety/pain control/sedation in dentistry.

Agency's Plan for Disposition of the Request: The board is requesting public comment on the petition to amend rules to amend regulations relating to sedation and anesthesia. Following a public comment period, the board will consider its action on the petition at its meeting on September 11, 2009.

Comments may be submitted until July 22, 2009.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, FAX (804) 527-4434, or email elaine.yeatts@dhp.virginia.gov.

VA.R. Doc. No. R09-27; Filed May 26, 2009, 9:44 a.m.

Virginia Society of Oral & Maxillofacial Surgeons

7525 Staples Mill Road / Richmond, VA 23228 / 804-261-1610 fax 804-261-1660

June 11, 2009

The Honorable Sandra Reen
Executive Director
Virginia Board of Dentistry
Perimeter Center, 9960 Mayland Drive
Richmond, VA 23233

Dear Ms. Reen,

On behalf of the Virginia Society of Oral and Maxillofacial Surgeons (VSOMS), I am expressing our position on three issues that have recently been brought to your attention by other individuals and organizations. These issues are as follows:

- Letter from VANA regarding Guidance Document 60, issued 2/24/09
- Dr. Futerman's Petition for Rulemaking, issued 2/9/09
- Mr. Haddad's Petition for Rulemaking, issued 5/19/09

After reviewing the VANA's petition and the Virginia Board of Nursing's guidance document #90-5, we feel RN's and LPN's are within their scope of practice when administering sedative or anesthesia drugs when done so under direct supervision by an individual who is licensed to prescribe and administer said drugs; direct supervision being defined as the licensed practitioner being in the room and visualizing the drugs being given. This practice is already performed in hospital ICU's, Emergency Rooms and surgical clinics. We do not support the use of RN's and LPN's as a substitute for an Anesthesiologist or a CRNA. In the discussion draft, we agree with the change in the definition of Anxiolysis to the elimination of pain instead of anxiety. At this time, we do not agree with removing any reference to

registered or licensed practical nurses. If in the future, if the Board of Nursing decides to change the Guidance Document 90-5 to prohibit RN's or LPN's from administering sedative or anesthesia drugs under any circumstances, we will be glad to readdress this issue. We request that the Board of Dentistry continue to allow RN's and LPN's to administer sedative and anesthesia drugs when under direct supervision of a practitioner who is licensed to give said drugs.

With regards to the Petition by Dr. Futerman to consider amending 18 VAC60-20-108, 18VAC60-20-120 and 18VAC60-110 and replace the present guidelines for administering anesthesia with the ADA guidelines, we feel the Virginia Guidelines for Administering Anesthesia are currently more stringent than the ADA Guidelines and do not think a change is needed. That being said, if the Virginia Board of Dentistry decides to change the Virginia Guidelines to the ADA Guidelines, we would not be philosophically opposed. It is the safety of the patients in the Commonwealth that is most important to the VSOMS and we as Oral and Maxillofacial Surgeons have exceeded the Virginia Guidelines as they currently stand.

In regards to Mr. Haddad's petition for rulemaking seeking to amend sections 18VAC60-20-110 and 18VAC60-20-120; Mr. Haddad has concerns about regulating dental providers who administer sedative and or anesthesia drugs. We feel the current Virginia Guidelines for Administering Anesthesia are more than adequate but there is currently no office inspection or anesthesia permits required in the State of Virginia for Dentists who perform sedation and or anesthesia, with the exception of the Oral and Maxillofacial Surgeons. Oral and Maxillofacial Surgeons are currently (and have been for several years now) mandated by the American Association of Oral and Maxillofacial Surgeons (AAOMS) to have intensive peer-review office anesthesia evaluations. This process examines both office and personnel preparedness for proper anesthesia delivery and emergency situations. In addition, as you know, Oral and Maxillofacial Surgeons already must have special registration in the State of Virginia. In addition, all Oral and Maxillofacial Surgeons are automatically credentialed to perform deep sedation and general anesthesia in The State of Virginia by their hospital-based residency training (which MUST include anesthesia training to meet or exceed Virginia's requirements).

When reviewing other states requirements for non-surgeons providing anesthesia and sedation, the State of Virginia lags behind. Should the Virginia Board of Dentistry decide to implement an inspection or permit process, we request that Oral and Maxillofacial Surgeons who already undergo AAOMS office evaluations be exempt from this permitting process (since this process and anesthesia credentialing is inherent in the Rules and Regulations via the Registration for OMSs). We would also recommend that any Rule change would state that office evaluations could be done by the "Board of Dentistry or another agency approved by the Board" (such as AAOMS).

In summary, the VSOMS feels the safety of the patients in the Commonwealth is of our utmost concern. Oral and Maxillofacial Surgeons have provided operator anesthesia for over 150 years. We continue to provide the safest care available and the VSOMS has been recognized by AAOMS to have exceeded their safety standards.

Thank you for the opportunity to provide comment on the above issues. We appreciate your consideration of our position on these important matters affecting the practice of dentistry and our specialty.

Sincerely,

Dr. Thomas B. Padgett

President, VSOMS



Virginia Regulatory Town Hall

Logged in: DHP

Agency

Department of Health Professions

Board

Board of Dentistry

Chapter

Virginia Board of Dentistry Regulations [18 VAC 60 - 20]

All comments for this forum

Commenter: Dr Robert Campbell Va Dental Soc of Anesthesiology *

6/30/09

9052

I support the 2nd and 3rd items presented

The entire country except So Carolina and Virginia have permits to practice sedation and/or general anesthesia. So Carolina is in the process of developing its permit which would leave Va the ONLY state that does not have a permitting system. If Virginia would at least talk with the other states and find out why they have decided to institute a permit, it would certainly be a plus for our state, and the public, in knowing what practitioner, has what training. The reasons to have a permit system have already been hashed out by the other 48 states and it probably would be best if the Board did the inquires rather than I go into the reasons in this short comment session.

Secondly, the use of a "blue ribbon" panel of anesthesia experts to help the Board sift through the difficulties of investigating a morbidity or mortality HELPS the Board and the public both. California does it and although not perfect, it does help the Board get an indepth insite into the intricacies of some of these cases. Va has had 17 deaths since 1972 about one every two to three years and who knows how many reported or unreported morbidities.

The costs of developing an ad hoc blue ribbon panel would more than be offset by the fees generated by the permits issued and would help defray the costs of "targeted" office inspections that might be needed and experts' fees to review cases for the Board.

Commenter: Rodney Mayberry / R. S. Mayberry DDS

7/2/09

9080

Sedation/Anesthesia Rule Changes Again? Who's Petitioning for Changes and Under What Motivation?

Several years ago the status and issue of anesthesia, sedation, licensing, permits, etc. was brought before the Board of Dentistry and settled. There were individuals at that time who were proponents of making changes similar to Mr. Haddad, the personal injury attorney who is currently petitioning for changes to the regulations. The previous evaluation of similarly proposed regulation changes proved such changes to be overly burdensome to dentists providing anesthesia/sedation services. It was also determined that the public interest was being served well by the status quo. Again, at that time there were self serving claims of numerous patient deaths at the hands of dentists using sedation/anesthesia, but like the current claims, there was no substantiating evidence, other than 2 or 3 cases over many decades and those cases were associated with oral surgeons, and one oral surgeon in particular. A request for governing agencies to provide for public perusal, statements of basis, purpose, and substance, to consider any issue of proposed changes of the current

regulations on sedation/anesthesia, would show the same results. No doubt such investigation would show little or no public benefit, and only again show that the cost benefit ratio for such rule changes would be onerous. Practicing dentists are struggling to pay ever increasing mandated taxes, fees, and financial levies mandated by state and local bureaucracies that are ever growing even in the current climate of recessionary depression. I propose we see proof demonstrating a verifiable public need for change, or leave well enough alone. We don't need to rehash this issue, and yoke small business with any additional burdens. R.S. Mayberry DDS

Commenter: Virginia Association of Nurse Anesthetists *

7/6/09

9161

Comments on Public Request for Rulemaking on Sedation and Anesthesia requirements.

DRAFT:

Comments from VANA to Virginia Board of Dentistry

Elaine J. Yeatts
Agency Regulatory Coordinator
9960 Mayland Drive
Suite 300
Richmond, VA 23233
elaine.yeatts@dhp.virginia.gov

Dear Ms. Yeatts,

On behalf of the Virginia Association of Nurse Anesthetists (VANA), I would like to submit comments regarding a proposal to Amend 18 VAC 60-20, Regulations Governing the Practice of Dentistry and Dental Hygiene submitted by Robert J. Haddad and open for public comment until July 22, 2009.

This proposal is "To amend regulations to: 1) eliminate the distinction between conscious sedation and deep sedation since deep sedation is a likely result; 2) institute a permitting process with inspection of dental offices to ensure they are appropriately equipped to handle an emergency situation; and 3) create an Anesthesia Review Committee to assist the profession and the public with issues relating to anxiety/pain control/sedation in dentistry."

VANA is the professional association representing Certified Registered Nurse Anesthetists (CRNAs) in Virginia. As you are aware, CRNAs provide more than 65% of anesthesia care in Virginia, and in the United States, in all patient care settings, from hospitals to ambulatory surgery centers to office based practices. The safety record of CRNAs and the importance of anesthesia care was recognized by the Board of Medicine in its regulations on Office Based Anesthesia (18 VAC85-20-310 through 390), in which personnel, equipment and procedural requirements were delineated for management of different levels of sedation and general anesthesia for procedures conducted in office settings. The foundation of the Virginia's legislature's requirement for these regulations was concern over patient safety in physician office practice in Virginia. These regulations required that sedation and/or general anesthesia in an office based practice could not be provided by the operating physician, and that the personnel providing this care had to be appropriately trained and licensed. In this, the Board of Medicine diverged directly from current practice in dental offices.

VANA believes that, as the Board of Dentistry considers the petition submitted by Mr. Haddad, it carefully consider not whether different requirements for administration of conscious sedation vs. deep sedation are appropriate, and that a "permitting process with inspection of dental offices to ensure they are appropriately equipped to handle an emergency situation", but, even more important, that regulations require that emergency situations can be avoided, whenever possible, by requiring appropriately trained and licensed

personnel are required to be responsible for the administration of sedation and anesthesia, specifically other than the operating dentist. Only when patients have the protection of knowledgeable, skilled and appropriately licensed anesthesia personnel solely dedicated to their anesthesia care when they are undergoing procedures, can they be assured of the safest possible care.

VANA agrees with the petitioner that the Board should "create an Anesthesia Review Committee to assist the profession and the public with issues relating to anxiety/pain control/sedation in dentistry." VANA stands ready to assist in elucidating the critical issues that will determine how to best assure the anesthesia safety of all patients in Virginia.

If we can be of assistance, please do not hesitate to contact me.
H.M. (Mike) Black, CRNA, President

Commenter: Brian Hoard, U. of Virginia Medical Center General Practice Dental Residenc *

7/20/09

9327

Mr. Haddad's petition with respect to conscious sedation oversight

I do not have a problem with the idea of development of an inspection and approval process for conscious sedation or creation of an anesthesia review committee. Assuming both are intelligent developed by individuals with a background in anesthesia and sedation, they are good ideas and probably inevitable anyway. Those who resist the notion might keep in mind that this will ultimately improve patient safety and possibly keep malpractice insurance rates and liability low. We might as well start working on this now while we have time, as opposed to resisting it until some sort of knee-jerk reactive policy becomes necessary. My one strenuous objection is the manner in which Mr. Haddad is presenting the petition to the Board, ie under the premise that conscious sedation is "likely" to lead to deep sedation. I know of no studies, literature articles, or consensus statements to support this. To preface the proposal with such a statement is irresponsibly inflammatory, and it makes me want to tell Mr. Haddad to go back, re-write the petition and resubmit it to the Board. At the very least, the Board should go on record as rejecting such a rationale for development of an inspection process and review committee.

Commenter: Jacqueline Carney, Children's Dentistry of Charlottesville *

7/20/09

9336

Burden of Petition

I'm reading the petition to consider changes of the current sedation regulations and would ask that the parties that will be deciding this important matter to consider the implications of this petition carefully. Thank you for reviewing my response.

First, Mr. Haddad's request to eliminate the distinction between conscious sedation and deep sedation "since deep sedation is a likely result" does not agree with the training I received, the research I have reviewed or the clinical experience of the dentists in my practice. I would ask that the Board of Dentistry do a thorough review of the research to verify the truth of this claim by Mr. Haddad. I am not sure it can be scientifically supported. Additionally, my training and my specialty board define deep sedation as a category of conscious sedation, not a separate form of sedation. Mr. Haddad appears to be comparing to a level of conscious sedation to conscious sedation, not a logical comparison. A truer comparison would consider relatable categories; these are not since deep sedation is indeed a distinct level within conscious sedation.

Second, I would be in favor of some sort of permit process as long as a large financial burden is n

placed on the practitioner and this inspection process can be completed in a timely fashion, neither of which I am certain a bureaucratic agency can guarantee. I would hate to have to give up my ability to perform mild and moderate sedation to benefit so many pediatric patients in my area because I couldn't afford the cost of yet another license or renewal fee. The costs associated with practicing dentistry already are high, particularly for a practice such as mine that accepts Medicaid. Adding an additional fee makes it extremely difficult to justify the service, even though conscious sedation is greatly needed.

Third, isn't the Board of Dentistry already tasked with assisting the profession and the public with issues relating to anxiety/pain control/sedation in dentistry? The Board has published guidelines and requirements, they review cases related to these subjects and have access to qualified expert witnesses as needed. What additional benefits would Mr. Haddad expect another committee to provide?

I would suggest that the Board rather than deleting the distinction between conscious sedation and deep sedation spend time more clearly defining the definitions of the varying levels of conscious sedation since conscious sedation has varying levels from mild to moderate to deep rather than eliminating the class of procedures currently defined as conscious sedation. Deep sedation is a level of conscious sedation and needs to be considered within the confines of conscious sedation. Deep sedation is currently placed alongside general anesthesia in the Virginia guidelines which is confusing to many people. Conscious sedation by the AAPD guidelines is broken into 3 levels (minimal: drug induced state in which patients respond normally to verbal commands, ventilatory and cardiovascular functions are unaffected; moderate: drug induced depression of consciousness with the ability to maintain a patent airway, maintain purposeful response to stimulation and spontaneous ventilation is adequate; deep: drug induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated verbal or painful stimulation, ability to maintain ventilatory function may be impaired and patient may require assistance in maintaining a patent airway). If Virginia is going to allow practitioners to perform conscious sedation, then all 3 levels of sedation should be listed and considered within the criteria/requirements for conscious sedation and general anesthesia should be considered separately with its criteria/requirements (even if they are the same as general anesthesia) to reduce the confusion. Something as simple as changing the title of section 18VAC60-20-120 from "Requirements to administer conscious sedation" to "Requirements to administer mild or moderate conscious sedation" along with the definitions that set a standard for this category would be most helpful. Change the title of 18VAC60-20-110 from "Requirements to administer deep sedation/general anesthesia" to "requirements to administer deep conscious sedation/general anesthesia" would keep these sections parallel in content and definition. It would hopefully help reduce confusion as well.

I appreciate the opportunity to comment.

Commenter: John Bitting, Regulatory Counsel, DOCS Education *

7/20/09

9337

DOCS comments on Haddad petition

DOCS Education supports reasonable oral sedation regulations that carefully and thoughtfully balance patient safety with access to care. Having a permit/inspection process and an anesthesia committee are certainly reasonable. Most state boards have anesthesia committees, and 39 of 50 states require conscious sedation permits (3 more will by next year). However, please keep in mind that the recession has stripped away the ability of most states to fund the manpower necessary to hold office inspections quickly AND the inspection process (in other states) was already slower than molasses in January anyway. We believe that a self-inspection by affidavit with the threat of random Board inspections is just as effective (CA, ID, WA, WI do this). However, if the board does adopt a inspection process, then we would recommend peer review by experienced oral sedation volunteer

dentists (MD, ME, WV will be doing this). These options will preserve a healthy balance between patient safety and access to care.

As for eliminating the distinction between conscious sedation and deep sedation because deep sedation is a likely result, this is asinine and should be denied outright. While my fellow commenters and I may disagree as to the training that should be required for oral conscious sedation, I doubt any of them believe that the level of sedation known as "conscious sedation" doesn't exist in the spectrum of sedation. Otherwise, there would be a gap between anxiolysis and deep sedation such that a patient went straight from wide awake to practically unconscious without exhibiting the oxymoron we call "conscious sedation" along the way. No state has such an onerous regulation and none are considering it.

Thank you for your time and consideration.

Commenter: James A Snyder, DDS, MS *

7/22/09

9369

Dental Anesthesia Permits, Inspection and Review Committee



Most states have implemented a 'permit' program and many also have a facility inspection requirement for anesthesia services provided to dental patients. It is noteworthy that most states have set requirements similar to those in place in Virginia right now (albeit without a permit process). It would seem prudent to determine to what degree patient safety is greater in those states versus Virginia, a state with similar requirements but without a certificate. It may, also, be of interest to find out if access is in some amount reduced versus our state. Safety trumps all else and if there is a measure of gain by having permits, or increasing the requirements needed to provide the various levels of service beyond what is now in place, we should all be in. Possibly, this is a place for the proposed "Anesthesia Review Committee" to start to work. If we believe our current requirements for providing anesthesia services to dental patients are prudent, the objective is reached already.

The same argument can be used for facility inspections. If gains in safety can be demonstrated, and without placing onerous barriers to the services, we should proceed. The proposed "Anesthesia Review Committee" will likely find from other state's experience, that implementation of state wide inspections by qualified persons, timely and fairly done is a real challenge. A challenge most states have not been able to meet. A committee of true experts, using the best data available, producing thoughtful recommendations makes sense. The citizens of the Commonwealth of Virginia deserve fact based public policy that is smart, effective, practical and sustainable.

[Back to List Comments](#)

* Nonregistered public user

JUL 22 2009

DHP

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

VADIVS, LLC
242 Butler Rd.
Suite 101
Fredericksburg, VA 22405
(540) 373-6557

Re: Petition from Robert J. Haddad concerning conscious sedation

Members of the Board,

The Virginia Association of Dentists for Intravenous Sedation, LLC, (VADIVS), has reviewed Mr. Haddad's proposal and would advise the Board of Dentistry to reject it due to its lack of merit. The proposal is both a waste of time and valuable State resources and the motives behind such a proposal are highly questionable.

Mr. Haddad has made an erroneous statement of fact in the first part of his proposal as a means to justify the other parts of his proposal. He states that deep sedation is the likely result of conscious sedation. Although I'm sure that Mr. Haddad is well-informed about anesthesia, since he specializes in personal injury and medical malpractice concerning anesthesia, he lacks any clinical experience relating to conscious sedation. It is clinical experience that gives one any real understanding of sedation dentistry. Deep sedation is not a likely result of conscious sedation in the hands of a competent practitioner. Eliminating the distinction between the two would be displaying a misunderstanding of conscious sedation in dentistry today. It would be manufacturing a danger that does not readily exist and be cause for fear and unnecessary new regulations on the practice of conscious sedation by the general dentist.

Conscious sedation, whether enteral or parenteral, is in fact part of a continuum that ends with general anesthesia and then death. These results are extremely unlikely when conscious sedation is performed by a properly trained dental professional. Although deep sedation can theoretically be achieved, it is not something that is normally clinically observed during conscious sedation. Training and clinical experience allow the dental professional to manage conscious sedation cases safely and maintain patients in a comfortable conscious, yet sedated, state where their reflexes remain intact. The techniques and drugs that have been used for well over half a century by thousands of dentists on millions of patients throughout the world have a very good track record for safety and efficacy.

Even among the dental profession there has been considerable ignorance on the subject which has led to false statements, like the one made by Mr. Haddad, and attempts at onerous regulation aimed at limiting access to or even eliminating sedation in dentistry altogether. It was just over five years ago that the regulations regarding sedation and anesthesia were completely overhauled by the Board of Dentistry. It was a three year process that finally resulted in very good and stringent regulations that we are still adjusting to. There is no need for another overhaul when the current regulations are working well.

RECEIVED

JUL 22 2009

Virginia Board of Dentistry

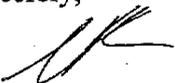
The creation of a permitting process is something that would increase costs with fees and use up needed State resources. We already have emergency training standards and regulations in place that require that certain protocols are followed and emergency equipment is in place. Dentists currently must post a certificate showing they have completed sedation and advanced life support training in their offices. A permit system would do the work for Mr. Haddad, and other malpractice lawyers, by making a short list of dentists that they can profile and research for potential lawsuits.

Random inspections would cost the State money and time and any infraction could be used as ammunition by malpractice lawyers to tarnish a good dentist's reputation in court. We have demonstrated in the past that medical emergencies are just as likely to occur in a dental office that does not practice sedation, so it would be unfair to require inspections of just the offices of those who do provide conscious sedation. All offices should have equipment to manage a patient's airway and have an automated external defibrillator with appropriate emergency drugs. Dental professionals who do sedation have all had training well beyond most dental school graduates, including multiple courses in ACLS, advanced life support and airway management, and they must keep current certificates. Inspections should be limited to responses to legitimate complaints or they will be a serious waste of resources.

We formed our organization, VADIVS, in part to fulfill an advisory role for the Virginia Board of Dentistry. We represent the interests of general dentists that perform conscious sedation in Virginia. We do not believe a committee for anesthesia is a practical idea. The makeup of this committee is of concern since so few members of the dental board have sedation training meeting ADA guidelines. Oral surgeons would certainly have knowledge of sedation, but they do not do operative dentistry with sedation. They tend to use deep sedation or even general anesthesia and have a different office setup from the general dentist. For a committee that advises the Virginia Dental Board and the public to be taken seriously it needs to consist of qualified general dentists who routinely use parenteral or enteral conscious sedation in their practices. This describes the dentists that we represent, not trial lawyers or laypersons that we fear could make up such a committee.

In summary, we believe the proposal by Mr. Haddad is fundamentally flawed. The proposal would be a waste of State funds and resources. The current regulations regarding anesthesia, recently overhauled, are more than adequate to satisfy any of Mr. Haddad's concerns. The motives behind the proposal are potentially contrary to the best interests of the dental profession and the public. We would ask that the Dental Board reject the proposal from Mr. Haddad.

Sincerely,


G. Preston Burns Jr., DDS, PC
President VADIVS, LLC
AGD PACE Provider

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JUL 22 2009

Virginia Board of Dentistry



DEPARTMENT of DENTISTRY

June 23, 2009

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

Dear Board of Dentistry;

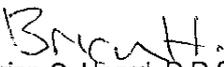
I am writing to you in response to the proposal by Mr. Robert J. Haddad. His request is to amend Regulations Governing the Practice of Dentistry and Dental Hygiene as follows: 1) Eliminate the distinction between conscious sedation and deep sedation, since deep sedation is a likely result; 2) Institute a permitting process with inspection of dental offices to ensure they are appropriately equipped to handle an emergency situation; and 3) create an Anesthesia Review Committee to assist the profession and the public with issues relating to anxiety/pain control/sedation in Dentistry.

The BOD is requesting public comment on this proposal prior to its meeting on Sept. 11. My suggestion is that the BOD strike down the proposal at the outset on the basis that I am not aware of any studies that support Mr. Haddad's rationale for 1) above. In fact, upon seeing the announcement, I e-mailed Mr. Haddad through his website to ask him, while I consider his proposal, to provide me with any literature references that I might be unaware of that support his contention that deep sedation is a likely result of conscious sedation. He did not even reply to me, and I think the reason is obvious: there are none. Deep sedation is NOT a LIKELY result of conscious (moderate) sedation. Those providing conscious sedation are doing so under definition of such by the American Society of Anesthesiologists: that the patient can make a purposeful response to verbal or tactile stimulation, has an intact airway (no intervention required), has adequate spontaneous ventilation, and has maintenance of cardiovascular function (ASD definition). Deep sedation is quite different: purposeful response following repeated or painful stimuli, airway intervention may be required, and spontaneous ventilation is inadequate (cardiovascular function is still usually maintained). I cannot imagine any dentist performing conscious sedation who would frequently or likely push a patient into a deep sedation situation, unless he actually intends deep sedation. In fact, the only dentists I know of who employ "deep" sedation are Oral Surgeons, who also sometimes perform general anesthesia in their offices. My point is, Mr. Haddad's 1) above is so fundamentally flawed in his assumption that deep sedation is a likely result of conscious sedation, I do not see how the BOD can even consider the approving any of the plan at all. To do so would automatically lend some sort of credibility to a false statement.

Frankly, regarding the rest of his proposal, I do not think I am opposed to a permitting process or creation of an Anesthesia Review Committee, but that depends on how these are staffed and structured. Who would make up the Anesthesia Review Committee and the inspection committee that inspects dental offices? How would they be selected? How would one decide on what criteria are used for the inspection process? As long as the representation includes GPs, not exclusively Oral Surgeons or Anesthesiologists, I am on board with this. But, bear in mind, the inspection process for Oral Surgery offices is considerably different when you take into account that these offices provide deep sedation or general anesthesia on a frequent basis. In addition, in my particular case, it would seem odd to me that I would have to get a permit when I am already subject to compliance from the Hospital Sedation Committee and Life Support Center at the U. of Virginia Health System, which are already quite specific and restrictive.

In any case, I hope that I have sufficiently made my case to the BOD that Mr. Haddad's proposal, while not without merit for consideration in 2) and 3), makes a flawed assumption in 1) that should result in outright rejection.

Sincerely


Brian C. Hoard, D.D.S.
Associate Professor
Director, General Practice Dental Residency
Dental Director, Children's Medical Center

RECEIVED
JUN 25 2009
VA Bd. of Dentistry

Yeatts, Elaine J.

From: Jim Jelinek [yjdds@cox.net]
Sent: Tuesday, July 21, 2009 8:35 PM
To: Yeatts, Elaine J.
Cc: yjdds@cox.net
Subject: Comment On Sedation Regulation Request

Virginia Board Of Dentistry
9960 Mayland Dr.
Suite 300
Richmond, Virginia 23233

Re: Petition from Robert J. Haddad concerning conscious sedation

Wow! Talk about something out of left field. Where's Mr. Haddad coming from, not to mention I thought we settled the conscious sedation issue about 5 years ago? Have there been any recent sedation issues in Virginia since the Board addressed this 5 years ago?

I don't have much exposure to this process, but is it normal to issue a petition without stating a basis or reason? If it is, then I petition that that be changed. Who is Mr. Haddad? What does he do that puts him in a position to reasonably submit this petition? What practical clinical dental experience does Mr. Haddad have? What is Mr. Haddad's agenda? Who does he represent? I did a Google search on him and found that he's a personal injury attorney. Is he somehow setting things up for what he sees as an easy dollar? I can't imagine how his request is honorable. Because he did not state any reasons for his request, I am assuming that he has none. I would welcome some substantiated reasons. I wish he had qualified his request. I have no choice now but to speculate.

I have been a dentist for 25 years and have been doing conscious sedation during that entire amount of time. I do know the difference between conscious sedation and deep sedation and have yet to put any of my patients into deep sedation. Deep sedation IS NOT a likely result during conscious sedation. While there is a continuum between consciousness, conscious sedation, deep sedation and then general anesthesia, there are very distinct clinical differences between each. This is dependent on the patient and which procedures are done under conscious sedation versus the procedures done under general anesthesia and what specific drugs are employed and their dosages. I am, and you should be more concerned about the surprise patient who goes into anaphylactic shock after one carpule of local anesthetic. That's the situation we really need to be prepared for. Mr. Haddad has revealed his ignorance of sedation.

And talk about access to care. If such a proposal passes, there will be thousands of anxious, dental phobic patients who just won't get dental treatment done. That's not right. They'll just go around with untreated dental disease and we know dental disease affects the whole body. Oral surgeons don't do restorative dentistry. The cost of care would definitely go up. Wait a minute...isn't our government trying to increase access to care and lower costs of care?

The Board Of Dentistry's time has been wasted in this matter. There isn't a basis for this petition. My time has been wasted to address this when I could be with my family. This petition is frivolous. It appears that if I wanted to, I could inundate the Board Of Dentistry with all kinds of petitions that could

be passed unless someone commented on them to the contrary. That would cause dentists across the state to have to drop what they are doing (serving patients) and spend valuable time defending what they normally do.

This would be like me petitioning the Board Of Law to require all law offices to have emergency medical crash carts and that everyone who works there have annual training in their use. You never know when someone might code in a law office.

I propose that the Board Of Dentistry not consider any petitions that do not have worthy backing or good reason, or no reason at all, for consideration and that they not see the light of day.

We don't need a permitting process or an anesthesia review committee. Dentists who are doing conscious sedation are already complying with adequate regulations. We don't need any more regulation other than regulation to wipe out frivolous petitions such as this proposed by Mr. Haddad. I request that the Board Of Dentistry refuse the requests made by Mr. Haddad.

Sincerely

James W. Jelinek, D.D.S.
60 Rock Pointe Ln
Warrenton, Virginia 20186

Yeatts, Elaine J.

From: Hoard, Brian C *HS [BCH3N@hscmail.mcc.virginia.edu]
Sent: Wednesday, May 27, 2009 11:39 AM
To: Yeatts, Elaine J.
Subject: Regulatory ammendment proposal

Regarding the proposed ammendment to "eliminate the distinction between conscious sedation and deep sedation since deep sedation is a likely result"--What individual or what study panel is claiming that deep sedation is a "likely result" of conscious (moderate) sedation? I don't really understand the basis of this claim, unless, unknown to me, the majority of Virginia dentists practicing conscious sedation are intentionally or frequently pushing patients to deep sedation levels as defined by the American Society of Anesthesiologists.... Is there some written information available anywhere to support the argument that is leading to this proposal in the first place?

Agenda Item: Regulatory Actions - Chart of Regulatory Actions

Staff Note: Status of regulations for the Board as of mailing of agenda

Action: None – provided for information only

Chapter	Action / Stage Information	
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	<u>Action:</u> -	Registration of mobile clinics
	<u>Stage:</u>	Emergency/NOIRA - <i>At Secretary's Office</i>
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	<u>Action:</u> -	Recovery of disciplinary costs
	<u>Stage:</u>	NOIRA - <i>At Secretary's Office</i>
Virginia Board of Dentistry Regulations [18 VAC 60 - 20]	<u>Action:</u> -	Registration and practice of dental assistants
	<u>Stage:</u>	Proposed - <i>DPB Review in progress</i>

Reen, Sandra

From: Yeatts, Elaine J.
Sent: Thursday, July 23, 2009 11:19 AM
To: Reen, Sandra
Subject: FW: Dr. Ronald D Lynch

Sandy - can you put Dr. Lynch's recommendation on the agenda for Sept.

From: Ahern, Judith (GOV)
Sent: Wednesday, July 22, 2009 2:14 PM
To: Yeatts, Elaine J.; Cunningham, Dwuana R.
Subject: Dr. Ronald D Lynch

due 8-3

From: "NoReplyBot@governor.virginia.gov" Date: 7/22/2009 8:36:50 AM To: IMA@governor.virginia.gov Subject: Access to Healthcare SCCMAIL Dr. Ronald D Lynch 369 Johnstown Road Chesapeake VA 23322 757-546-0301 rlynchdds@hotmail.com Access to Healthcare Professional

Recently Virginia law changed allowing Dental Hygienist, when properly trained, the ability to administer local anesthetic to patients if a "Dentist" is present. I am a volunteer dentist and a board member of Chesapeake Care Free Clinic. There are times in the clinic that a dentist is not in the facility but a physician is present. Because the law is written requiring a Dentist present the hygienist is unable to provide pain control for patients if needed. Physicians are able to treat the entire body. Why then cannot a medical doctor's presence be adequate for dental hygienist to give dental local anesthesia. Is there some way the law could be amended to allow physician supervision? This would allow greater access to care for patients by allowing our volunteer hygienist increases options of hours to be in the clinic. Respectfully, R. D. Lynch, DDS

DRAFT RECOMMENDED
by the REGULATORY-LEGISLATIVE COMMITTEE

September 11, 2009

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

Administration

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

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

3. **LOCAL ANESTHESIA:**

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

- A dentist;
- An anesthesiologist;
- A certified registered nurse anesthetist under his direction;
- A dental hygienist with the training required by 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older under his direction;

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- A dental hygienist to administer Schedule VI topical oral anesthetics under his direction or under his order for such treatment under general supervision;
- A dental assistant to administer Schedule VI topical oral anesthetics under his direction; and
- A registered or licensed practical nurse to administer Schedule VI topical oral anesthetics under his direction.

4. ANXIOLYSIS:

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

5. INHALATION ANALGESIA:

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

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

6. CONSCIOUS SEDATION:

- a. A dentist not qualified to administer conscious sedation shall only use the services of an anesthesiologist to administer conscious sedation in a dental office. In an outpatient surgery center or hospital, a dentist not qualified to administer conscious

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sedation shall use an anesthesiologist or a certified registered nurse anesthetist to administer conscious sedation.

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

7. DEEP SEDATION/GENERAL ANESTHESIA:

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

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

Assisting in Administration

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

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by the REGULATORY-LEGISLATIVE COMMITTEE

September 11, 2009

Monitoring a Patient

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

Excerpts of Applicable Law, Regulations and Guidance

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

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- A dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. Va. Code §54.1-2722(D) & §54.1-3408(J)
 - To administer anxiolysis, a dentist shall have training in and knowledge of the appropriate dosages and potential complications of the medications and of the physiological effects and potential complications of nitrous oxide. Board of Dentistry Regulation 18VAC60-20-108(A)
 - To administer deep sedation/general anesthesia, a dentist shall have completed (1) one calendar year of advanced training in anesthesiology and related academic subjects or (2) an ADA approved residency in a dental specialty which includes one calendar year of full-time training in clinical anesthesia and related clinical medical subjects. Board of Dentistry Regulation 18VAC60-20-110(A)
 - A dentist not qualified to administer deep sedation/general anesthesia may use the services of a qualified anesthesiologist or a qualified dentist to administer deep sedation/general anesthesia. Board of Dentistry Regulation 18VAC60-20-110(B)(1)
 - A qualified dentist may use the services of a certified registered nurse anesthetist to administer deep sedation/general anesthesia. Board of Dentistry Regulation 18VAC60-20-110(B)(2)
 - A dentist is automatically qualified to administer conscious sedation if he meets the requirements to administer deep sedation/general anesthesia. Board of Dentistry Regulation 18VAC60-20-120(A)
 - To administer conscious sedation by any method, shall have completed (1) training in a CODA accredited program or (2) 60 hours of acceptable continuing education plus the management of at least 20 patients consistent with ADA Guidelines. Board of Dentistry Regulation 18VAC60-20-120(B)
 - A dentist who self-certified prior to January 1989 may continue to administer conscious sedation. Board of Dentistry Regulation 18VAC60-20-120(B)(2)
 - To administer conscious sedation only enterally, a dentist shall have completed 18 hours of acceptable continuing education plus 20 clinically-oriented experiences. Board of Dentistry Regulation 18VAC60-20-120(C)
 - A dentist must hold current certification in advanced resuscitative techniques to administer deep sedation/general anesthesia and conscious sedation. Board of Dentistry Regulation 18VAC60-20-110(A)(2) and 18VAC60-20-120(D)
2. "Anxiolysis" means the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness. Board of Dentistry Regulation 18VAC60-20-10
 3. "Conscious sedation" means a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal commands, produced by pharmacological or nonpharmacological methods, including inhalation, parenteral, transdermal or enteral, or a combination thereof. Board of Dentistry Regulation 18VAC60-20-10

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4. "Deep sedation/general anesthesia" means an induced state of depressed consciousness or unconsciousness accompanied by a complete or partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or respond purposefully to physical stimulation or verbal command and is produced by a pharmacological or nonpharmacological method, or a combination thereof. Board of Dentistry Regulation 18VAC60-20-10
5. "Direction" means the dentist examines the patient and is present for observation, advice, and control over the performance of dental services. Board of Dentistry Regulation 18VAC60-20-10
6. "Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness. Board of Dentistry Regulation 18VAC60-20-10
7. "Local anesthesia" means the loss of sensation or pain in the oral cavity or the maxillofacial or adjacent and associated structures generally produced by a topically applied or injected agent without depressing the level of consciousness.
8. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. If inhalation analgesia is used, monitoring shall include observing the patient's vital signs and making the proper adjustments of nitrous oxide machines at the request of or by the dentist or by a qualified dental hygienist. Board of Dentistry Regulation 18VAC60-20-108.C
9. A dentist not qualified to administer deep sedation/general anesthesia may treat patients under deep sedation/general anesthesia if a qualified anesthesiologist or a qualified dentist is responsible for the administration, Board of Dentistry Regulation 18VAC60-20-110.B(1)
10. A qualified dentist may use the services of a certified registered nurse anesthetist to administer deep sedation/general anesthesia, Board of Dentistry Regulation 18VAC60-20-110.B(2)
11. Monitoring of the patient under deep sedation/general anesthesia, including direct, visual observation is to begin prior to induction and shall take place continuously during the procedure and recovery. Monitoring shall include: recording and reporting of blood pressure, pulse, respiration and other vital signs. Board of Dentistry Regulation 18VAC60-20-110.E
12. Monitoring of the patient under conscious sedation, including direct, visual observation of the patient is to begin prior to administration, or if self-administered, when the patient arrives and shall take place continuously during the procedure and recovery. Board of Dentistry Regulation 18VAC60-20-120.F
13. Dentists who employ ancillary personnel to assist in the administration and monitoring of any form of conscious sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have training in basic resuscitation techniques or responding to a clinical emergency or are an anesthesia assistant certified by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology. Board of Dentistry Regulation 18VAC60-20-135.
14. Only licensed dentists shall prescribe or parenterally administer drugs or medicaments with the exception that dental hygienists with appropriate training may parenterally

DRAFT RECOMMENDED
by the REGULATORY-LEGISLATIVE COMMITTEE
September 11, 2009

administer Schedule VI local anesthesia to patients 18 years of age or older . Board of Dentistry Regulation 18VAC60-20-190

15. "Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e. intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular). Board of Dentistry Regulation 18VAC60-20-10
16. A certified registered nurse anesthetist shall practice in accordance with the functions and standards defined by the American Association of Nurse Anesthetists andunder the medical direction and supervision of a dentist in accordance with rules and regulations promulgated by the Board of Dentistry. Board of Nursing Regulation 18VAC90-2-120(D)

Amendment to Proposed Dental Assistant Regulations
Recommended by the Regulatory-Legislative Committee

Following adoption of these proposed regulations by the Board, staff realized that the provision for performing pulp capping procedures, which the Regulatory-Legislative Committee had decided to make delegable to dental assistants II, had been omitted from the list of delegable duties and also realized that the use of retraction cord had been combined with taking final impressions. The Committee voted to recommend amendment of the proposed regulations to include pulp capping procedures and to separate the provision for retraction cord so that its use is not limited to taking impressions. The recommended amendment would read as follows:

18VAC60-20-230. Delegation to dental assistants.

C. The following duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience and examinations specified in 18VAC60-20-61:

1. Performing pulp capping procedures;
2. Packing and carving of amalgam restorations;
3. Placing and shaping composite resin restorations;
4. Taking final impressions ~~and use of non-epinephrine retraction cord;~~
5. Final cementation of crowns and bridges after adjustment and fitting by the dentist; and
6. Use of a non-epinephrine retraction cord.

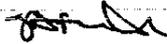
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John S. Findley, D.D.S.
President

Date: June 10, 2009
To: Presidents and Executive Directors, State Boards of Dentistry
From: Dr. John S. Findley, president 
Subject: Clinical Licensing Examinations

I am writing in follow-up to Dr. Mark Feldman's September 11, 2008 correspondence to state boards of dentistry about clinical licensing examinations. A copy of the letter is enclosed. In his letter, Dr. Feldman stated that the ADA Board of Trustees believes that the American Board of Dental Examiners (ADEX), Southern Regional Testing Agency (SRTA) and the Western Regional Examining Board (WREB) developed examinations with substantially similar content and methods. Dr. Feldman further stated that there are more similarities than differences in the examinations and that the examinations should be considered equivalent for assessing entry level clinical skills. He noted that information about the Council of Interstate Testing Agencies (CITA) was not evaluated at that time.

CITA recently contacted the ADA and provided information about the agency's status and testing programs that was not available at the time the ADA reviewed the other testing programs. The CITA was incorporated in July 2005. CITA's examination criteria began as a by-product of the efforts of the American Dental Licensure Examination (ADLEX) to develop a national uniform clinical licensure examination. From December 2005 through 2008, CITA developed and refined its own examination, criteria and process.

Since the time of Dr. Feldman's September 2008 letter, the ADA has had an opportunity to review materials submitted by the CITA about its clinical examination. Like the other agencies, CITA provided evidence to justify the use of its performance measure in making licensure decisions and demonstrated that it has mechanisms in place for internal and external review of its examination program. An analysis using the information provided by CITA and materials previously submitted by the other clinical testing agencies demonstrated similarities in content, format and administration among the examinations. While acknowledging the dynamic nature of testing programs and changes in the participation and governance of clinical testing agencies, the ADA believes it has sufficient information to encourage state boards of dentistry to consider any of these examinations in evaluating candidates for licensure.

The ADA Board of Trustees hopes that the state boards of dentistry find this information helpful. We continue to urge the states to work within their state statutes to accept results of all clinical examinations in accordance with ADA policy that promotes the recognition of multiple examinations and results in freedom of movement for qualified dental professionals. The ADA also encourages state boards that may be considering changes in their examination requirements to carefully consider the impact of sudden rules changes on students, who may already be in the process of taking examinations and applying for licensure. Thank you for your consideration of this important issue.

JSF:LJH:kb
Enclosure

cc: Presidents and Executive Directors, CITA, CRDTS, NERB, SRTA, WREB and AADE
ADA Officers and Board of Trustees
Presidents and Executive Directors, ADA Constituent Organizations
ADA, Department of State Government Affairs, Council on Government Affairs and Council on
Dental Education and Licensure



*Dental Hygiene Practice in
Virginia Department of Health*

SB 1202/HB 2180 of 2009 Section 54.1-2722

Notwithstanding any provision of law or regulation to the contrary, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the Cumberland Plateau, Southside, and Shenandoah Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Virginia Department of Health. A dental hygienist providing such services shall practice pursuant to a protocol developed jointly by the medical directors of each of the districts, dental hygienists employed by the Department of Health, the Director of the Dental Health Division of the Department of Health, one representative of the Virginia Dental Association, and one representative of the Virginia Dental Hygienists' Association. A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of these districts, shall be prepared and submitted by the medical directors of the three health districts to the Virginia Secretary of Health and Human Resources by November 1, 2010. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

Protocol for Virginia Department of Health (VDH) Dental Hygienists to Practice in an Expanded Capacity under Remote Supervision by Public Health Dentists

I approve the following protocol developed in response to the addition of Subsection E of § 54.1-2722. License; application; qualifications; practice of dental hygiene in Chapter 27 of Title 54.1 of the Code of Virginia.

As authorized by law, VDH is conducting a pilot program in three health districts, Cumberland Plateau, Lenowisco and Southside, to assess the use of dental hygienists employed by VDH in an expanded capacity as a viable means to increase access to dental health care for underserved populations. This protocol shall guide the pilot program.

Definitions:

- “*Expanded capacity*” means that a VDH dental hygienist provides education, assessment, prevention and clinical services as authorized in this protocol under the remote supervision of a VDH dentist.
- “*Remote supervision*” means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but has not done an initial examination of the patients who are to be seen and treated by the dental hygienist, and is not necessarily onsite with the dental hygienist when dental hygiene services are delivered.

Management:

- Program guidance and quality assurance shall be provided by the Division of Dental Health at VDH for the hygienists and dentists providing services under this protocol. Clinical oversight for the program will be provided by VDH public health dentist(s). The public health dentist(s) will be available to provide an appropriate level of contact, collaboration and consultation with the dental hygienist. At a minimum, communication will be maintained and documented by the hygienist reporting to the dentist at 14 day intervals.
- The protocol may be revised as necessary during the trial period through agreement of the committee composed of medical directors of the three health districts, staff from the Division of Dental Health and Office of Community Health Services, and representatives from the Virginia Dental Hygienists’ Association, Virginia Dental Association and Virginia Board of Dentistry. This committee shall meet and discuss program progress and any necessary revisions to the protocol at periodic intervals beginning July 1, 2009. The protocol and any revisions will be approved by the Commissioner of VDH.
- No limit shall be placed on the number of full or part time VDH dental hygienists that may practice under the *remote supervision* of a public health dentist(s) in the three targeted health districts.
- The dental hygienist may use and supervise assistants under this protocol but shall not permit assistants to provide direct clinical services to patients.

Remote Supervision Practice Requirements:

- The dental hygienist shall have graduated from an accredited dental hygiene school, be licensed in Virginia, employed by the Virginia Department of Health in a full or part time position, and have a minimum of two years of dental hygiene practice experience.
- The dental hygienist shall consent in writing to providing services under remote supervision.
- The patient or a responsible adult shall be informed prior to the appointment that no dentist will be present, that no anesthesia can be administered, and that only limited described services will be provided.
- Written basic emergency procedures shall be established and in place, and the hygienist shall be capable of implementing those procedures.

Expanded Capacity Scope of Services:

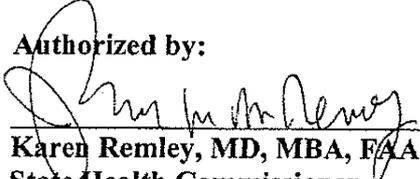
Public health dental hygienists may perform the following duties under *remote supervision*:

- An initial examination of teeth and surrounding tissues, including charting existing conditions including carious lesions, periodontal pockets or other abnormal conditions for further evaluation by a dentist, as required.
- Prophylaxis of natural and restored teeth.
- Scaling of natural and restored teeth using hand instruments, and ultrasonic devices.
- Assessing patients to determine the appropriateness of sealant placement according to VDH Division of Dental Health guidelines and applying sealants as indicated. Providing dental sealant, assessment, maintenance and repair.
- Application of topical fluorides.
- Providing educational services, assessment, screening or data collection for the preparation of preliminary written records for evaluation by a licensed dentist.

Required Referrals:

- Public health dental hygienists will refer patients without a dental provider to a public or private dentist with the goal to establish a dental home.
- When the dental hygienist determines at a subsequent appointment that there are conditions present which required evaluation for treatment, and the patient has not seen a dentist as referred, the dental hygienist will make every practical or reasonable effort to schedule the patient with a VDH dentist or local private dentist volunteer for an examination, treatment plan and follow up care.

Authorized by:



Karen Remley, MD, MBA, FAAP
State Health Commissioner



Date