VIRGINIA BOARD OF DENTISTRY

AGENDA

June 10-11, 2010

Department of Health Professions

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

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June 10, 2010

9:00 a.m. **Formal Hearing**

June 11, 2010

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

Call to Order – Dr. Levin, President

Evacuation Announcement – Ms. Reen

Public Comment

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Adjourn

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARINGS
MARCH 11, 2010

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 2:31 p.m. on March 11, 2010 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

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

MEMBERS PRESENT:
Meera A. Gokli, D.D.S.
Paul N. Zimmet, D.D.S.
Augustus A. Petticolas, Jr., D.D.S.
Herbert R. Boyd, III, D.D.S.
Martha C. Cutright. D.D.S.

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

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

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

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

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

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

Grover P. Burns, III, D.D.S.
Case No. 120577

Dr. Burns appeared with counsel, Kenneth C. Hirtz, in accordance with a Notice of the Board dated November 3, 2009.

Ms. Pace admitted into evidence Commonwealth's exhibits 1 through 3.

Ms. Pace denied admission of Respondent's exhibit A into evidence.

Ms. Pace swore in the witnesses.

Testifying on behalf of the Commonwealth were Helene J. Kelly, RN, MSN, Senior Investigator, Department of Health Professions, and Patient A.

Testifying on behalf of the respondent was his dental assistant, Elizabeth C. Taylor.

Dr. Burns testified on his own behalf.

Closed Meeting: Dr. Gokli 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. Burns. Additionally, it was moved that Board staff, Sandra Reen, Huong Vu and Board counsel, Howard Casway attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

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

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

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

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

Mr. Casway reported that the Board decided to impose the following sanctions:

- A monetary penalty of $1000,
- Seven hours of approved continuing education in risk management and record keeping, and
- A prospective audit of ten of Dr. Burns' patient records within one year of completion of the continuing education requirement.

Dr. Zimmet moved to adopt the Sanctions as read by Mr. Casway. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 9:15 p.m.

Jacqueline G. Pace, RDH, Vice-President

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
MINUTES
MARCH 12, 2010

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:05 A.M. on March 12, 2010 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

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

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

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Diane Powers, DHP Communications Director
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: **William J. Bennett, D.D.S.,** addressed his concerns regarding dentists advertising themselves as specialists when the specialty is not recognized and regarding superiority claims. He stated that despite having filed complaints, the Board has not corrected what he believes are clear violations of the regulations. He asked the Board to establish and enforce clear rules for advertising.

APPROVAL OF MINUTES: Dr. Levin asked if the Board members had reviewed the minutes in the agenda package. Dr. Petticolas moved to accept the minutes of the December 3, 2009 meeting. The motion was seconded and carried.

Dr. Hall moved to accept the minutes of the December 4, 2009 meeting. The motion was seconded and carried.

DHP DIRECTOR'S REPORT:

Dr. Levin stated that Ms. Ryals was not able to attend. Ms. Reen added that Mr. Heaberlin would address DHP Performs in his report and she will report on legislation later in the agenda.

HEALTH PRACTITIONERS' MONITORING PROGRAM (HPMP):

Dr. Ziegler, HPMP Medical Director – gave a Power Point presentation on the following topics:

- the new name of the program,
- monitoring as an alternative to discipline action,
- HPMP operation,
- stay procedure,
- current scope of the program,
- HPMP staff,
- how participants are referred,
- monitoring components,
- drug monitoring
- report to MPC/Board
- grounds for dismissal,
- readmission following dismissal, and
- current projects in development.

Dr. Ziegler introduced Ms. Grant, the case manager for dental participants and Peggy Wood, the DHP program manager and liaison, as she responded to questions about participation at proceedings, how to obtain program input when the Board is addressing return to practice, the role of case managers and the selection of practice monitors.

REPORTS:

Board of Health Professions (BHP). Dr. Zimmet reported he was not at the February 9 meeting and that there was not a quorum to conduct business due to the snow storm.

AADB. Dr. Levin reported that the Board was not represented at the last AADB meeting in Hawaii and that he and Ms. Reen would be attending the April meeting in Chicago.

SCDDE. Dr. Levin reported that he attended the Southern Conference of Dean and Dental Examiners meeting in Washington D.C. last month where the age of electronic technology was discussed.

VCU School of Dentistry. Dr. Levin then reported that Dean Hunt left his post on March 12, 2010 and that Dr. Sarrett, the associate vice president for health sciences, is serving as the interim dean pending the appointment of a new dean. He added that CODA conducted a site visit at the school which went well with no recommendations for changes being made.

SRTA. Dr. Gokli reported that she attended the board of directors meeting on January 22, 2010 in D.C. where:

- a budget report showing the agency to be in good financial shape was received,
- compensating observers at the same rate as examiners was approved,
- dismissing examiners who test below the calibration standard was approved, and
- allowing associate members from Georgia to continue to examine for SRTA was approved.

Dr. Gokli then asked Ms. Pace to report on the dental hygiene mock board conducted by the Dental Hygiene Committee. Ms. Pace stated that examiners participated in the mock board to learn how to apply changes that were made to the dental hygiene examination by SRTA's Board of Directors at the annual meeting in August 2009. The mock board was held on March 6, 2010 and the following aspects of the exam were reviewed and tested:

- standardization
- case entry
- check in
- final evaluation, and
- PDA software.

Ms. Pace added that the mock board may be conducted annually due to the evolving nature of the exam.

Regulatory/Legislative Committee. Ms. Howard reported the internal review of parts VI and VII of the regulations has been completed and is recommending that the Board adopt the NOIRA for regulatory review which will be addressed later in the agenda. She said the Committee is working to create clear and user friendly regulations for the professions and the public.

LEGISLATION AND REGULATION:

Ms. Reen noted that she is filling in for Ms. Yeatts who was unable to be at the meeting today.

Report on 2010 Legislative. Ms. Reen reported the following bills directly affect the work of the Board or the practice of dentistry:

- HB 308 (Regulation of mobile dental clinics) – was requested by the VDA to have this requirement from the 2009 Appropriations Act included in statute in order to continue the Board's oversight.
- HB 1263 (Payment for services by dentist and oral surgeon) – requires insurance companies to limit fee provisions in contracts to the services covered in their dental plan.
- HB 662 (General powers and duties of health regulatory boards) – adds provisions for acceptance of surrender of a license in lieu of disciplinary action.

Review of Regulatory Actions Chart. Ms. Reen reported that:

- the proposed draft for final regulations for the registration of mobile clinics is on the agenda for adoption.
- the proposed draft of the final regulations for the registration and practice of dental assistants is also on the agenda for adoption.
- the regulations for recovery of disciplinary costs are under administrative review at the Secretary's office then will go to the Governor's office before they can be published for public comment.

Adoption of Regulations for Dental Assistants II. Ms. Reen referred the Board's attention to the public hearing transcript, the letter and proposed language from the Virginia Dental Hygienist Association (VDHA), the summary of all public comment, and the draft of final regulations in the agenda package. She stated that the Board needs to respond to the public comment then adopt final regulations.

In response to the VDHA's comments, the Board decided:

- To keep the language permitting a dentist to employ up to 4 dental hygienists and dental assistants II in any combination because it does allow a dentist to increase the number of hygienists supervised above the current limitation to 2.
- Against adding a separate track for dental hygienists to qualify to perform the duties of DAsII because dental hygienists need to have the same training and experience.
- Against changing the requirement for certification from a credentialing organization recognized by the ADA because this language is consistent with the enabling statute.
- Against separating the provisions for DAsII in these regulations because the restructuring is being addressed in regulatory review.
- To revise the last sentence as "*the order may authorize the dental hygienist to supervise a dental assistant performing duties delegable to dental assistant I*" rather than delete it.
- Against amending the definition of "indirect supervision" because consistency between the definition and the body of the regulations is beneficial.
- Against reverting to current language for continuing education because "dental practice" is more inclusive of a range of courses than specifying "dentistry and dental hygiene".

The Board responded to Ms. Daniel's question about delegating etching and bonding saying that dental assistants are permitted to perform etching and bonding when the application is reversible so no change in the regulations is needed.

Ms. Reen then asked the Board to review the regulations and make any changes needed before adoption. The following changes were agreed to:

- Page 48, under the definition of "Direct supervision" – delete the phrase "*in the operatory or an area immediately adjacent to the operatory.*"
- Page 49, under the definition of "Direction" – amend to reference "*dental assistant I and dental assistant II.*"
- Page 49, under the definition of "General supervision" – amend the last sentence to read "The order may authorize the dental hygienist to supervise a dental assistant performing the duties delegable to dental assistants I."
- Page 54, under 18VAC60-20-61.B. – the language in brackets for dental hygienists was stricken.
- Page 58, under the new # 7 – "or dental hygienists" was stricken.
- Page 60, under 18VAC60-20-230.C. – "or a dental hygienist" was stricken.

Dr. Zimmet moved to adopt the proposed regulations as amended. The motion was seconded and passed.

Adoption of Regulations for Mobile Dental Clinics. Ms. Reen said the Board needs to respond to public comment then adopt final regulations. She noted that the comment made by Dr. Dickinson for the Virginia Dental Association supports the proposed regulations. She then referred to Dr. Mix's petition for rulemaking which requests amendment of 18VAC60-20-352 to exempt dentists whose primary focus is to deliver timely emergency dental care to adults in their home from registration. After much discussion, the Board's response was that the amendment Dr. Mix requested is not necessary for occasional emergency visits to patients of record so long as he has fixed office and does not have a "mobile facility" or "portable operation."

Ms. Reen then asked the Board to review the regulations and make any changes needed before adoption. The Board agreed to the following changes:

- On the third page, in 18VAC60-20-332 – section A2 and A3, deleting "*at least 10 days*" and replacing it with "*in writing*" and adding Section B to make the information required in this section available to the public.
- On the fourth page, under 18VAC60-20-352 – item number 2 to exempt emergency treatment was stricken.

Dr. Boyd moved to adopt the proposed regulation as amended. The motion was seconded and passed.

Adoption of NOIRA for Regulatory Review. Ms. Reen stated the proposed NOIRA is needed to begin the formal regulatory review process. She noted that the Regulatory/Legislative Committee is proposing to repeal the current regulations and replace them with four chapters (dentistry, dental hygiene, dental assistant and discipline) and to make changes throughout the regulations to make it easier to find and understand the rules. She also said the proposal would change the sequencing of the regulations to have those

applicable to everyday practice before the licensure provisions. Following comments in support of the proposal, Dr. Zimmet moved to adopt the NOIRA. The motion was seconded and passed.

BOARD DISCUSSION/ACTION:

Letter from Dr. Carter. Dr. Levin advised this letter was provided as information only.

Public Comment. Dr. Boyd said he shared Dr. Bennett's concerns about advertising and would like for the Board to address it. Mr. Casway noted that free speech protections have to be considered as well as the fact that complaints are coming from other dentists and not from the public. Ms. Reen stated that Dr. Bennett's complaints have been investigated and addressed. She said that advertising cases are usually addressed with an advisory letter or a confidential consent agreement so the cases rarely rise to the level for public information. Ms. Reen reminded the Board that regulatory review provides the opportunity to amend and develop policies in this area.

REPORT ON CASE ACTIVITY:

Mr. Heaberlin reported on the Board's FY2010 second quarter disciplinary performance on patient care cases noting that the:

- Clearance rate was 83%,
- Case load over 250 business was 8%, and
- Case closed within 250 work days was 97%.

He went on to report that:

- 164 cases were received from Enforcement in the second quarter and 172 were closed for a total clearance rate of 105%.
- the 172 cases were closed as follows:
  - No Violation/Undetermined – 88 cases
  - No Violation / Advisory Letter 66 cases (license was lapsed for 30 days or less)
  - Violation / IFC, PHCO, Formal – 16 cases
  - Violation / CCA – 2 cases
- Currently there are 8 cases over 250 days with four scheduled for informal conferences, two with pending CCAs, one was heard at a Formal Hearing on March 11 and the other is at the Administrative Proceedings Division.

He discussed billing and fraud cases, asking that the entire file be reviewed and that all documents be considered to determine if fraud has occurred. He advised that the Board does have the authority to sanction licensees for unprofessional conduct that is likely to defraud or to deceive the public or patients.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Ms. Reen reported that:

- applicants for general dental and dental hygiene licenses may now begin the application process on license.

- current estimates show that the Board should be about $400,000 in the black at the end of this fiscal year so a fee increase does not need to be undertaken at this time. She also noted that now month to month cash flow was being monitored.
- work is underway on BRIEFS, the periodic publication discussed by the Executive Committee. She noted that Dr. Hall and Ms. Powers were meeting after the Board to review the draft. She noted that the first edition recaps the actions taken in 2009 and that future editions should follow at six month intervals.

Dr. Boyd asked if the Board could provide risk management and record keeping courses and charge a fee to generate revenue. Mr. Casway stated there is no statute that allows the Board to do so.

BOARD COUNSEL REPORT: Mr. Casway stated that he had nothing to report.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 2:00 p.m.

Jeffrey Levin, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

Assessing the Effectiveness of Sanctioning Reference Points

Approved by the Virginia Board of Health Professions, May 4, 2010

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Introduction

The Virginia Board of Health Professions has recommended that the agency's Sanctioning Reference Points (SRP) be evaluated to determine whether the program has met the objectives set forth in 2001. In addition to measuring effectiveness, a study of this type should clearly identify potential improvements to the system, and recommend any additional changes related to future SRP operations. This document outlines specific methods for evaluating SRP effectiveness, and how any needed changes in SRP operations should be identified.

The original purpose of the SRP project was to positively impact the oversight and governance functions related to disciplining healthcare professionals. This presupposes an important question: how long should a new program be in place before a proper assessment can be made? The answer is not based only on a certain number of years, or even after a certain number of SRP worksheets have been collected. There are several reasons why now is an appropriate time to examine the overall SRP system:

1. Since the program was initially implemented by the Board of Medicine in 2004, the SRPs have been applied to a large number of cases (n=1,148 as of 1/1/2010).
2. Boards report a high agreement rate with recommended sanctions.
3. The majority of DHP health regulatory boards have adopted and implemented SRPs.
4. Boards have voiced some concerns relating to training needs, and there seems to be a misunderstanding of how to properly apply the SRP system in all cases (agreement rate monitoring shows worksheets not being filled out correctly in many cases).
5. Boards, because of their unique "cultures," have interpreted implementation of the system in different ways, and, from an agency-wide perspective, some unintended operational differences may be resulting.
6. Many other state and national organizations (other states, VA agencies, and professional groups) have expressed great interest in SRP effectiveness.[1]

For these reasons, BHP has asked VisualResearch, Inc. (VRI) to begin evaluating the SRP system. VRI was instrumental in developing the SRPs and has extensive experience evaluating programs similar in both nature and scope to the Virginia SRP system.

Goals of the Effectiveness Study

The purpose of this study is to evaluate the SRP system against its own unique set of objectives. The SRPs were designed to aid board members, staff and the public in a variety of ways. An effectiveness study would seek to examine whether or not the SRPs were successful, and if not, what areas require improvement. Currently, the goals of this effectiveness study include:

- Striving toward consistency, proportionality and neutrality in sanctions
- Constraining undesirable outcomes of SRPs (increased workload, etc.)

[1] Researchers have made formal presentations to health and occupational regulatory boards in Colorado and South Carolina, and have presented at the Federation of State Medical Boards (FSMB), Council on Licensure, Enforcement and Regulation (CLEAR), Citizen Advocacy Center (CAC), Council of State Governments (CSG), Association of State and Provincial Psychology Boards (ASPPB), and the Virginia Board of Accountancy.

- Examining whether or not SRP training has been adequately provided
- Examining current agreement monitoring and board feedback practices
- Re-examining/modifying SRP worksheet factors and scoring weights
- Re-examining/modifying SRP sanction recommendation thresholds
- Determining how board polices fit within SRPs (CCA's, PHCOs, Formal Hearings)
- Identifying unintended consequences and outcomes of SRPs

Historical Background

In April 2001, The Virginia Board of Health Professions (BHP) approved a work plan to conduct an analysis of health regulatory board sanctioning and to consider the appropriateness of developing historically-based sanctioning reference points for boards to use in disciplinary cases. Criticism had come from respondents, attorneys, public officials, the public, and others suggesting that sanctioning was too harsh, too lenient, or inconsistent over time. Some had indicated that sanctioning variation could be attributed to other undesirable influences, such as Board member ID or Board composition, respondent race or ethnicity, attorney presence, or geographical location of the Board hearing. The BHP decided that an analysis should be conducted to determine if these assertions were true, and what measures should be taken to rectify them.

Data collection and analysis began in 2002, and has continued in an effort to examine each individual health regulatory board. The results offer insight into the relative importance of each factor and show which respondent and case factors are influential in sanctioning. With this empirical information, eight SRP manuals have been developed for ten Boards (the three behavioral sciences Boards share one manual) with assistance and input from each Board and staff. The SRPs provide worksheets that score a respondent on a set of factors that can be tallied to arrive at a sanction recommendation that reflects past practice. Thus, the SRPs help ensure similarly situated respondents are handed down similar sanctions.

Recognizing the complexity and difficulty in sanction decision-making, Board members and staff have indicated that for any sanctioning reference system to be successful, it must be *"developed with complete Board oversight, be value neutral, be grounded in sound data analysis, and be totally voluntary"*—that is, the system is viewed strictly as a Board decision tool[2]. With this in mind, the Board of Health Professions cites the following purposes and goals for establishing Sanctioning Reference Points:

- Making sanctioning decisions more predictable
- Providing an education tool for new Board members
- Adding an empirical element to a process that is inherently subjective
- Providing a resource for Board staff and attorneys (both sides)
- "Neutralizing" sanctioning inconsistencies
- Validating Board member or staff recall of past cases
- Constraining the influence of undesirable factors—e.g., Board member ID, overall Board makeup, race or ethnic origin, etc.
- Helping predict future caseloads and need for probation services and terms
- Provide feedback to BHP and individual Boards

[2] Department of Health Professions Internal Committee & Staff, Fall 2001 organizational meeting.

SRP Implementation Timeline

The implementation of Sanctioning Reference Points for Health Regulatory Boards has taken approximately seven years. It should be noted that during this time, researchers were performing a variety of other agency tasks. Therefore, SRP implementation did not require a continuous seven years of full time work. Below is a brief timeline of activities that concluded with SRP development for eleven VA Boards. It is anticipated that the remaining two Boards will implement in early 2010.

Spring 2001	Board of Health Professions adopts work plan to conduct systematic analysis of board sanctions and to derive reference points for board members and an educational tool for respondents and the public.
January 2002	Interviews with current and past board members, counsel, staff and members of the Attorney General's office to qualitatively glean information about the boards' past sanctioning, future goals, and expectations about uses for Sanctions Reference Points.
April 2002	Analyze results of interviews and present for feedback from respective boards and Board of Health Professions. In conjunction with boards and staff, develop and obtain approval from the boards on objective scaling for subjective factors.
May 2002	Finalize data collection instrument for obtaining sanctioning information from case files, minutes, notices. Data collection and keying begins.
October 2002	Compile, merge, clean databases.
December 2002	Determine statistical significant factors through multivariate analyses, report the results of analysis showing the relative importance of each factor, determine which factors the board wishes to retain as *appropriate* and exclude as *inappropriate.*
January 2003	Introduce board feedback into the statistical model and revise statistical models, use analysis to predict sanctioning outcomes, present results back to board members.
February 2003	Begin sanction reference point worksheet development for Medicine Board.
May 2003	Finalize sanctioning worksheets with sanction decision grids which provide for simultaneous consideration of offense, respondent, and prior record factors deemed appropriate by the board.
June 2003	Pharmacy data collection and analysis begins.
January 2004	Repeated the same steps as detailed above (for Medicine) for other boards.
January 2005	Beginning of ongoing monitoring of sanctioning worksheets for all implemented boards.
August 2004	Virginia Board of Medicine's Sanctioning Reference Points Manual is adopted. Training sessions are held for board members, staff, enforcement and adjudicative staff, the press, and private Bar. (Manual posted on the Board of Medicine's Guidance Document website)
December 2004	Pharmacy manual and worksheet complete
July 2005	Board of Dentistry adopts and begins implementation
May 2006	Board of Nursing adopts and begins implementation.
July 2006	Adapt methodology for boards with much smaller case volumes Funeral Directors & Embalmers, and Optometry. The same approach of gleaning data from the computer database, interviews, case files, minutes, notices, is applied. Smaller boards also use larger board's analysis to help determine which offense and respondent factors guide worksheet development. Resultant systems are tailored to the needs of the individual boards.
November 2006	Board of Veterinary Medicine adopts and begins implementation
March 2007	Board of Funeral Directors and Embalmers adopt and begin implementation.
November 2007	Board of Pharmacy adopts and begins implementation
January 2008	Adapt methodology for boards with similar culture: Counseling, Psychology, and Social Work. The same approach of gleaning data from the computer database, interviews, case files, minutes, notices, is applied. These boards also use larger board's analysis to help determine which offense and respondent factors guide worksheet development.
December 2008	Board of Optometry adopts and begins implementation
June 2009	Board of Counseling adopts and begins implementation Board of Psychology adopts and begins implementation Board of Social Work adopts and begins implementation
November 2009	Board of Physical Therapy adopts SRPs

Methods for Measuring the Effectiveness of Sanctioning Reference Points

The focus of this study is to determine how well the SRPs have performed utilizing three objective criteria that provide a balanced conceptual framework for the study; consistency, proportionality, and neutrality.

Consistency

Are similarly situated respondents treated the same way in terms of sanctions handed down?
Consistency in sanctioning attempts to address the following question: "To what extent do similar respondents and offenses receive similar sanctions?" One of the goals of SRPs is to make concepts like "similarly situated" measurable. For example, given a combination of offense and respondent factors on the Board of Medicine's Patient Care worksheet, a respondent falls within a certain grid cell. Being in the same grid cell carries the implication that those respondents are comparable in terms of factors deemed relevant in sanctioning, and hence, should receive similar penalties.

What methods can be employed to evaluate consistency?
The first method involves examining how a broad range of factors related to respondent and case characteristics (independent variables) predict sanctioning outcomes (dependent variables). Examples of factors that can potentially influence sanctioning include, but are not limited to: prior board history, substance abuse, gender, region, corrective action, attorney involvement, and patient injury. Depending on the presence of these factors, respondents could be eligible to receive sanctions ranging from "no sanction" to "loss of license".

A second method for evaluating consistency relies on examining SRP agreement rates. Before initial implementation, large samples of previously disposed cases were scored on the newly developed worksheets in order to test the accuracy of SRP recommendations. Another way researchers will evaluate consistency is to determine the degree to which agreement rates fall within the worksheet recommended ranges. Monitoring agreement with SRPs and departure reasons is a separate component of this evaluation.

Proportionality

Are the most serious cases getting the most serious sanctions? Conversely, are less serious cases getting less serious sanctions?
Sanctioning Reference Points (SRP) provide an empirical point system that links offense and respondent characteristics to appropriate sanctions.[3] In order for rational sanctioning to occur, the proportionality of offense to sanction must be accurately represented by the point system. Inaccurate or unproven numerical proportions could lead to more serious offenders receiving less serious sanctions, and vice versa. Thus, the completed SRP worksheets must be evaluated to ensure that the point values are numerically sound.

[3] See *Sanctioning Reference Points Instruction Manual*, July 2004, Virginia Board of Medicine.

What methods can be employed to evaluate proportionality?
Using the prior history factors as an example, a methodology for determining proportionality can be explained. The worksheets have a point value assigned for a prior board order, with respondents receiving additional points if that prior order is similar to the current offense. A cumulative building of points for these factors ensures a more severe sanction for a respondent that not only has a prior record, but one that includes behaviors similar to the current case circumstances. The question becomes "Do the intended differences in sanctioning outcomes correspond to actual factors scored on a worksheet?" It is anticipated that higher scores on case type, respondent and prior record factors will be associated with an increased likelihood of receiving more severe sanctions (i.e. loss of license).

In order to answer the aforementioned question, data collection may be necessary to refine the terms that are part of a specific sanction in a specific case. Additionally, data on case circumstances may be needed to differentiate between the egregiousness of violations. Proportionality will rely mainly on those respondents who received sanctions at opposing ends of the continuum. "Middle ground" sanctioning thresholds, with their relatively wide ranges, will make it difficult to evaluate proportionality in any meaningful way.

Neutrality

Do "extra-legal" factors continue to affect sanctioning?
Neutrality addresses the issue that sanctions could differ based on specific "extra-legal" characteristics of the respondent or case. For example, older respondents or those with attorneys could receive different sanctions even when other worksheet factors remain constant. For this reason, researchers will attempt to delineate the effects of any unwarranted disparities that the SRPs are intended to prevent—those resulting from the respondent's gender, attorney involvement, or age.

What methods can be employed to evaluate neutrality?
Neutrality is traditionally the most difficult criteria to measure when differentiating among sanctioning decisions. For this phase of the efficacy study, researchers will employ an approach similar to what was used when SRPs were first developed. Beginning with cases that have already been closed using SRP worksheets, data will be collected on extra-legal factors such as gender, age, attorney representation and region. In order to gather these pieces of information, researchers will review case orders and minutes which show persons present at hearings and give information translatable to gender (referring to the respondent as "he" or "she"). Researchers will also obtain information from the department's data collection system, L2K, which will provide the respondent's date of birth (translatable to age) and region. Once data collection is complete, statistical analysis will be used in order to determine the presence of any "extra-legal" factors still influencing sanctioning. Data collection and analysis is expected to take six to eight weeks.

Examining SRP Agreement Monitoring

"Worksheets and coversheets are to be completed in all cases resolved by a Pre-Hearing Consent order or any informal conference including those conducted by special conference committees or agency subordinates. The resulting worksheets are collected and analyzed by VisualResearch, Inc. and quarterly reports are provided to the Board of Health Professions."

- Sanctioning Reference Points Manual, Board of Nursing

Each quarter, completed coversheets and worksheets should be obtained and logged into a database. These cases are to be analyzed based on overall agency agreement rate and by board. The database should include a variety of case factors: case number, board, case type, SRP recommendation, actual sanction handed down, whether the sanction handed down was a departure (high or low), and any cited departure rationale.

Currently, over one thousand worksheets have been submitted from various boards. The agency continues to have an overall agreement rate of approximately 80%. Each board with adequate cases for review should have an agreement rate comparable to the agency overall. For example, a board may have a low agreement rate due to the completion of very few worksheets and one departure.

The effectiveness study should incorporate the examination of the SRP worksheet collection process as well as other methods for reporting information back to BHP and individual boards. As stated above, the analysis of data from implemented boards was intended for report to BHP quarterly. Researchers would examine both the extent to which this is being done, and if individual boards are aware of their agreement rates.

Furthermore, the data used in the evaluation is only reliable and valid if the SRP worksheet data reported by boards is of high quality. Therefore, an assessment of the reliability and integrity of completed worksheets and coversheets should be included. This piece of the study would provide information regarding whether actual case files and worksheets and/or coversheets match up. Simultaneously, information regarding the accuracy and completeness of worksheets and coversheets could be gathered. This would entail a brief survey of the worksheets and coversheets returned for incorporation onto a board's reportable file of cases closed by violation using SRP worksheets.

Lastly, agreement rates for each board have been reported as an overall percentage of cases. This leaves many older "outlier" cases in the sample, giving a potentially biased average for those boards which implemented SRPs earlier in their program. Researchers encourage an examination of more valid methods of reporting. Other alternatives include:

> Rolling Average – The percent of cases in agreement for a standard time period. For instance, the percent of cases that agreed in the past year (6 months, 18 months, etc). This method may allow for a relatively large amount of cases and reduce the number of older cases in the sample.

Quarterly- The rate of agreement on completed worksheets for a given quarter. This method would eliminate older cases from the sample, however using this method may not report any cases for certain quarters.

Examining Agreement Monitoring - Departure Reasons

In the Sanctioning Reference Points system, compliance is completely voluntary. SRPs are fundamentally guidelines; thus, boards use them as reference tools and may choose to sanction respondents outside the recommendation. In instances where the board feels a departure is necessary, it is encouraged to depart and provide a brief explanation as to the reason. During training, board members were informed that the departure reason provided would supply researchers with critical information on SRP accuracy and information for future changes to the SRP system.

Therefore, another purpose of monitoring the progress of the SRP agreement rates lies in the departure results. The three boards with the largest volume of cases (Medicine, Dentistry, and Nursing) implemented SRPs more than three years ago. Since that time no evaluation of departure reasons has been carried out. Researchers will evaluate departure results so as to recommend modifications to worksheets so that they reflect the most current practices.

SRP Training Issues

Upon adoption of the SRP manual as a guidance document, each board's members, Executive Director, and administrative staff were trained on its use. In 2004, DHP's administrative proceedings division, attorneys from the AG's office and the private Bar were trained in the Board of Medicine's SRP manual. Since full board training, some boards have new Executive Directors, while other boards have new support staff. It is not known to what extent any new staff has been trained on SRP use and procedure. Discussions with current board staff indicate very little, if any, training has occurred.

There has been significant turnover of board members since training began. The extent to which new members were trained by existing members or staff is unknown. During the five year period since the first manual was implemented, no board members or staff have been formally trained or re-trained by VisualResearch, Inc (VRI) staff. However, VRI maintains contact with board staff, providing consultation and problem solving as needed. Informally, VRI has provided ad hoc training to staff and continues to make efforts to improve SRP procedure.

This lack of formal training fosters potential problems in correctly completing the worksheets, choosing the appropriate recommended sanction, and proper handling of the completed worksheets and coversheets. These issues are those which are most critical to properly administering a sound SRP system.

Additional Evaluation Issues

Formal Hearings
The SRP system, as applied today, relates only to newly generated cases ending in violation. It does not apply to those cases which deal with compliance issues, actions by other boards, or mandatory suspensions. Additionally, in 2004, it was the opinion of the Attorney General's office to exclude the use of SRPs at formal hearings.[4]

An evaluation will include the possibility of broadening the scope of SRP use to include formal hearings. This evaluation would examine issues such as the current appeal rate for cases which closed using the SRP worksheet or examining the potential for other negative consequences of using SRPs at the formal stage. Also, an updated opinion from the Attorney General's office will be solicited, as the original opinion was given before any board had started using the SRPs.

Confidential Consent Agreements
Legislation enacted in 2003 gave boards the ability to resolve certain allegations of practitioner misconduct by means of a Confidential Consent Agreement (CCA). CCAs could be used by any board in lieu of public discipline once certain criteria were met. For a case to be considered for a CCA, three conditions must be present:

- the case must involve minor misconduct and non-practice related infractions
- there can be little or no injury to a patient or the public
- there can be little likelihood of repetition by the practitioner

SRPs do not recommend sanctions for cases which end in a CCA. However, by statute, the existence of a past CCA may be considered in future disciplinary proceedings. The extent to which CCAs are scored as prior history when using an SRP worksheet should be evaluated as part of the effectiveness study.

The enactment of legislation regarding use of CCAs occurred while some boards were developing SRPs. Therefore, those boards do not have CCAs incorporated into each of their SRP systems. Consequently, it is possible that agreement rates are weighted by the worksheets' inclusion of cases that now have the potential for receiving a CCA. More specifically, when older boards were studied, all cases within a given time frame were analyzed. It is reasonable to expect that some of the cases analyzed and used to create the SRP worksheets would today receive a CCA, thus creating the potential for a biased worksheet. This effect of CCAs on sanctioning practice should be considered during this study with the goal of potentially updating older boards' worksheets.

The Boards of Medicine, Dentistry and Nursing were the first to implement SRPs, and researchers suggest that these boards be the first examined with regards to the effect of CCAs on worksheet performance.

Pre-Defined Sanctions
The Board of Optometry removed certain violations with pre-defined sanctions from use on SRP worksheets. The following information appears at the top of Optometry's worksheet:

[4] Inter-Office Memorandum, Office of the Attorney General. "APA Inquiry Involving the Board of Medicine and Sanctioning Reference Points." Sept. 9, 2003.

The following violations do not qualify for a CCA and are prescribed the following sanctions:

- CE 2nd offense: $300 fine first missing credit hour, $200 each remaining hour
- CE 3rd or more: higher fines, additional sanctions, and pay hourly fees at a rate commensurate with 2nd time CE offenders
- PD 2nd offense: $500 fine, pay renewal fees, reprimand
- PD 3rd offense: $1000 fine, pay renewal fees, reprimand
- PD 4th or more: higher fines, additional sanctions, and pay renewal fees

Researchers will examine the effectiveness of this level of transparency by determining whether or not the number of violations indicated with pre-defined sanctions has changed. Researchers will also attempt to determine if other boards have begun using pre-defined sanctions since the implementation of SRPs. One of the reasons for this in-depth examination is to test whether or not these sanctions should be incorporated onto each board's worksheet.

Dissemination of Materials

The dissemination of completed worksheets and coversheets is a point of confusion within the SRP system. Early in the implementation process, it was decided that completed worksheets and coversheets were to be sent to the respondent with the final order, with the worksheet and coversheet being confidential under §54.1-2400.2 of the Virginia Code. Since that time, the question of what to do with completed worksheets has been a source of debate among board members, staff and attorneys. Researchers are aware of inconsistent practices among boards regarding this matter (see Appendix A). Researchers will evaluate the need for a standardized policy and incorporate any more recent decisions into training in an attempt to have all boards practicing in the same manner.

Unintended Outcomes

Researchers have been asked whether or not the SRPs have contributed significantly to the variety of disposition methods employed by DHP: violation, no violation, undetermined, CCA, etc. Currently, it is unknown if the implementation of SRPs has had any effect on the method or speed with which a case is processed. Some board staff have suggested that the number of informal conferences were decreasing due to SRPs, but no formal evaluation has been done to substantiate this. During the evaluation, researchers will examine the effect of SRPs on disposition method.

Board Member and Staff Experiences

Evaluating board member and staff experiences with the worksheets provides qualitative data from those actually using the SRPs in everyday practice. Researchers would develop a survey to be answered anonymously or by face-to-face interview. Probative questions regarding use and perceived effectiveness of the SRPs will be asked. Some questions might include:

- Do you feel SRPs had a positive or negative impact on case processing?
- In your experience, have you seen new board members make the transition to sanctioning respondents more easily?
- Do you feel that SRPs have improved an inherently difficult process?

- Do you feel there has been a lack of training?
- In your opinion, are the sanctioning recommendations too harsh? Too lenient?
- Do you feel your board's worksheet reflects current practice?
- Are the case types available for scoring the same case types presented?
- What can be done to improve the system?
- Do you feel the system is worthwhile?

Answers to such questions are relevant because disciplinary hearings consume a large portion of agency resources and sanctioning decisions have such a profound impact on healthcare practitioners and on the public's safety.

Anticipated Evaluation Obstacles

As with any empirical evaluation, researchers should anticipate several obstacles. Should the boards be studied as separate entities, as they were when the SRPs were designed, small sample sizes may limit the availability of cases for study. However, many of DHP's smaller regulatory boards may provide useful input related to modifying SRP worksheets or procedures, even without being able to provide sufficient quantitative data.

The boards that have larger numbers of cases[5] (Medicine, Dentistry and Nursing) are defined by sanctioning cultures and practices that are different from smaller boards. This makes it difficult to add their data into the study without separating them from other boards. For instance, Nursing does not make use of monetary penalties as a general rule in sanctioning, whereas it is common in Dentistry. Likewise, certain factors appear on the Dentistry worksheet that do not appear on other boards' worksheets. For these reasons, it is advised to assess boards with larger sample sizes individually.

Additionally, the data collected by the agency does not always reflect the extra-legal factors that are ideal for examination. L2K, the agency's data management system, has no way to record certain features key to the concept of defining neutrality (for example, respondent gender or race). Additionally, more specificity on the types of terms given and the amounts of monetary penalties are not specified in a consistent and reliable format.

[5] See Appendix B.

Appendices

Appendix A: SRP Procedures Overview

(as of July 2008)

	Medicine	Nursing	Nurse Aide	Dentistry	Vet Med	Pharmacy	Funeral	Optometry
SRP posted to the web as Guidance Document	yes	yes	yes	yes	yes	yes	yes	yes
Use of SRP referenced in the notice	yes	yes	yes	yes	yes	yes		yes
Use of SRP referenced in the Cover Letter sent with Final Order	yes			yes		yes		
Completed Worksheet sent with Final Order	yes			yes		yes		
Completed Coversheet sent with Final Order	yes			yes		yes		

Appendix B: SRP Caseload and Agreement Rates for Implemented Boards (2004-2010)

Board	Total Number of Cases	Overall Agreement Rates
BHP Overall	1148	80%
Medicine	115	72%
Dentistry	91	82%
Nursing (Nurses and CNAs)	839	82%
Funeral	16	75%
Veterinary Medicine	52	85%
Pharmacy	30	67%
Optometry	3	33%
Psychology	2	100%
Counseling	0	n/a
Social Work	0	n/a
Physical Therapy	0	n/a

Agenda Item: Regulatory Action – Adoption of Exempt Final Amendments for Regulations for Disclosure of information obtained from the Prescription Monitoring Program (PMP)

Enclosed is:

A copy of § 54.1-2525 and § 54.1-2706

A draft of final amended regulations – will be exempt from the Administrative Process Act to adopt amendments to conform regulations to changes in the Code.

Action: Motion to adopt final amended regulations to provide grounds for disciplinary action for unauthorized use or disclosure of confidential information received from the PMP.

Law on Disclosure of PMP Information

§ 54.1-2525. Unlawful disclosure of information; disciplinary action authorized; penalties.

A. It shall be unlawful for any person having access to the confidential information in the possession of the Program or any data or reports produced by the program to disclose such confidential information except as provided in this chapter. Any person having access to the confidential information in the possession of the program or any data or reports produced by the program who discloses such confidential information in violation of this chapter shall be guilty of a Class 1 misdemeanor upon conviction.

B. It shall be unlawful for any person who lawfully receives confidential information from the Prescription Monitoring Program to redisclose or use such confidential information in any way other than the authorized purpose for which the request was made. Any person who lawfully receives information from the Prescription Monitoring Program and discloses such confidential information in violation of this chapter shall be guilty of a Class 1 misdemeanor upon conviction.

C. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall also be grounds for disciplinary action by the relevant health regulatory board.

Law on Unprofessional Conduct in Dentistry

§ 54.1-2706. Revocation or suspension; other sanctions.

The Board may refuse to admit a candidate to any examination, refuse to issue a license to any applicant, suspend for a stated period or indefinitely, or revoke any license or censure or reprimand any licensee or place him on probation for such time as it may designate for any of the following causes:

1. Fraud, deceit or misrepresentation in obtaining a license;

2. The conviction of any felony or the conviction of any crime involving moral turpitude;

3. Use of alcohol or drugs to the extent that such use renders him unsafe to practice dentistry or dental hygiene;

4. Any unprofessional conduct likely to defraud or to deceive the public or patients;

5. Intentional or negligent conduct in the practice of dentistry or dental hygiene which causes or is likely to cause injury to a patient or patients;

6. Employing or assisting persons whom he knew or had reason to believe were unlicensed to practice dentistry or dental hygiene;

7. Publishing or causing to be published in any manner an advertisement relating to his professional practice which (i) is false, deceptive or misleading, (ii) contains a claim of superiority, or (iii) violates regulations promulgated by the Board governing advertising;

8. Mental or physical incompetence to practice his profession with safety to his patients and the public;

9. Violating, assisting, or inducing others to violate any provision of this chapter or any Board regulation;

10. Conducting his practice in a manner contrary to the standards of ethics of dentistry or dental hygiene;

11. Practicing or causing others to practice in a manner as to be a danger to the health and welfare of his patients or to the public;

12. Practicing outside the scope of the dentist's or dental hygienist's education, training, and experience;

13. Performing a procedure subject to certification without such valid certification required by the Board pursuant to § 54.1-2709.1 and Board regulations; however, procedures performed pursuant to the provisions of subdivision 5 of § 54.1-2712 as part of an American Dental Association accredited residency program shall not require such certification;

14. The revocation, suspension or restriction of a license to practice dentistry or dental hygiene in another state, possession or territory of the United States or foreign country; or

15. The violation of any provision of a state or federal law or regulation relating to manufacturing, distributing, dispensing or administering drugs.

Project 2450 – final exempt

BOARD OF DENTISTRY

Unauthorized disclosure from PMP

Part V

Unprofessional Conduct

18VAC60-20-170. Acts constituting unprofessional conduct.

The following practices shall constitute unprofessional conduct within the meaning of § 54.1-2706 of the Code of Virginia:

1. Fraudulently obtaining, attempting to obtain or cooperating with others in obtaining payment for services;

2. Performing services for a patient under terms or conditions which are unconscionable. The board shall not consider terms unconscionable where there has been a full and fair disclosure of all terms and where the patient entered the agreement without fraud or duress;

3. Misrepresenting to a patient and the public the materials or methods and techniques the licensee uses or intends to use;

4. Committing any act in violation of the Code of Virginia reasonably related to the practice of dentistry and dental hygiene;

5. Delegating any service or operation which requires the professional competence of a dentist or dental hygienist to any person who is not a dentist or dental hygienist as authorized by this chapter;

6. Certifying completion of a dental procedure that has not actually been completed;

7. Knowingly or negligently violating any applicable statute or regulation governing ionizing radiation in the Commonwealth of Virginia, including, but not limited to, current regulations promulgated by the Virginia Department of Health; and

8. Permitting or condoning the placement or exposure of dental x-ray film by an unlicensed person, except where the unlicensed person has complied with 18VAC60-20-195.

9. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program.

Central Regional Dental Testing Service, Inc.
1725 SW Gage Blvd.
Topeka, KS 66604-3333
www.crdts.org

Ph: 785-273-0380
FX: 785-273-5015
info@crdts.org

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Virginia Board of Dentistry

March 26, 2010

To: CRDTS State Dental Boards
All Dental Boards that recognize the CRDTS Dental Exam for Licensure
All Dental Schools within the CRDTS Region

It is CRDTS' contractual obligation to the State Boards we serve to assess competence in the knowledge, skills, abilities and judgments (KSAJ's) that are essential to the domain of dentistry. When CRDTS withdrew from ADEX as of June 30, 2009, we continued to administer the dental and dental hygiene clinical examinations, as developed by CRDTS, for licensure in those respective professions. At that time, due in part to our concerns regarding security issues with the DSCE and CSCE computer- based examinations, CRDTS opted to defer to the National Boards Parts I and II for determination of candidate competency in the didactic domain of dental practice that does not lend itself to clinical testing. This part of the dental domain includes essential competencies related to life criticality in the occupational analysis, including diagnosis and treatment planning, medical concerns as they may affect dental treatment, more complex case-based situations that integrate the application of multiple disciplines in dentistry, etc. We believe that National Boards assess this particular part of the dental domain—predominantly knowledge and judgment—more comprehensively than any examination currently existing; and we also believe that National Boards have taken appropriate action to ensure the security of its examinations in this newly evolving technological age of instantaneous information dispersal. National Boards Parts I and II, combined with CRDTS' examinations which assess predominantly treatment skills and abilities and clinical judgment in the application of those skills, allow our State Dental Boards to effectively measure competencies in the dental domain and make decisions about licensure.

In deferring to National Boards' preeminence in the didactic domain, it was not CRDTS' intention to require that candidates pass National Boards in order to pass CRDTS. To the best of our knowledge, all Boards of Dentistry in the United States require that candidates successfully complete National Boards to be eligible for licensure, and the candidate is responsible for supplying such documentation to the Board(s) of the jurisdiction(s) in which they wish to be licensed. CRDTS therefore requests the following:

1. **Dental Boards**: We request that you continue to require that each candidate for licensure in your state has supplied to the Board the necessary documentation indicating that the candidate has passed the National Board Part I & II examinations. It is not within our purview to do this for you and CRDTS will only certify that each candidate has passed the clinical examination in Dentistry (CRDTS exam components 2, 3, 4, & 5).

2. **Dental Schools in the CRDTS region:** We are attempting to accumulate data regarding which dental schools in our region require that the National Board examinations Parts I ***and*** Part II be passed by your students as a requirement for graduation. Please complete the enclosed questionnaire and return to the CRDTS central office in Topeka, Kansas.

Thank you in advance for your attention to these important issues. CRDTS appreciates the confidence you have in allowing us to administer an examination for you that effectively assures the public that the candidate for initial licensure has demonstrated minimal competency and is ready for the unsupervised practice of dentistry.

Sincerely,

John C. Cosby, DMD
CRDTS President

-30-

Reen, Sandra

Subject: FW: DANB Develops Certified Oral Preventive Assistant Exam

From: The Dental Assisting National Board [mailto:communications@danb.org]
Sent: Tuesday, May 18, 2010 1:08 PM
To: Board of Dentistry
Subject: DANB Develops Certified Oral Preventive Assistant Exam

For Immediate Release
Contact: Cindy Durley, DANB Executive Director
cdurley@danb.org
1-866-357-3262

DANB Develops Certified Oral Preventive Assistant Exam

CHICAGO (May 18, 2010) – The Dental Assisting National Board, Inc. (DANB) is proud to announce that it is developing a national certification exam program called the Certified Oral Preventive Assistant (COPA). The four component exams of DANB's COPA exam – Coronal Polishing, Sealants, Topical Fluoride, and Topical Anesthetic – are considered expanded functions in most states. DANB shares state dental boards' public protection mission, and encourages states to consider using national DANB expanded functions exams to assess dental auxiliaries' knowledge-based competency at the national level to ensure public protection and enhance intrastate mobility of qualified assistants.

Currently, the dental practice acts in 31 states allow or do not prohibit dental assistants to perform all four of the COPA functions*. Additionally, dental assistants are allowed to:

- Perform Coronal Polishing procedures in 42 states
- Apply Topical Fluoride in 40 states
- Apply Sealants in 32 states
- Apply Topical Anesthetic in 41 states

DANB will begin pretesting qualified candidates for the COPA certification exam, which includes all four component exams, in July 2010. DANB will solicit current DANB CDAs who work in states where all four COPA functions are allowable duties to participate in the pretest at no charge. All pretest candidates must meet COPA eligibility requirements. Pretesting will end on December 31, 2010, and the certification exam program will be available to all qualified dental assistants beginning April 1, 2011.

DANB's COPA certification supports the American Dental Association's (ADA) Oral Preventive Assistant (OPA) workforce model, which the ADA's House of Delegates approved in October 2006. The OPA model was developed to support the dental profession and expansion of the current workforce capacity. For more information on the ADA's OPA model, visit www.ada.org.

DANB's Certified Dental Assistant (CDA) exam covers 88 percent of the tasks reflected in the OPA model. Therefore, eligibility to take DANB's COPA certification exam will be offered to individuals who have either graduated from a Commission on Dental Accreditation (CODA)-accredited dental assisting or dental hygiene program or who have passed DANB's CDA examination.

While DANB supports state autonomy and authority in defining duties delegated to dental assistants and any related requirements, as the national certification agency for dental assistants, DANB supports voluntary professional certification for all dental assistants. DANB believes that it can best fulfill its obligations to its many stakeholder groups, including the public and state regulators by continuing to offer the high-quality, independently and nationally accredited dental auxiliary competency assessment services.

For more information on how DANB exams can assist state dental boards in assessing dental assistant competencies to promote their shared mission of public protection, contact DANB's Executive Director Cindy Durley at cdurley@danb.org or 1-866-357-3262.

For more information on DANB's COPA exam, please see the article in the summer issue of Certified

Press, which will be mailed out in June and posted on DANB's Website at www.danb.org

**DANB can provide state-specific information on the permissibility of delegating the four COPA functions to dental assistants, upon request.*

###

About DANB
DANB is recognized by the American Dental Association as the premier national certification and testing agency for dental assistants. DANB's certification programs are accredited by the National Commission for Certifying Agencies. DANB serves the public by promoting a means of identifying qualified and competent dental assistants and by measuring and promoting excellence in oral healthcare delivery. As a Mark of Dental Assisting Excellence, DANB Certification is a source of pride for those who achieve it. Currently, there are more than 32,000 DANB Certifcants nationwide, and DANB Certifications and Certificates of Competency are recognized or required in 37 states, the District of Columbia, the U.S. Air Force, and the Veterans Administration. For those dental assistants who meet the eligibility and exam requirements, DANB Certification may be earned in the areas of Certified Dental Assistant (CDA) and/or Certified Orthodontic Assistant (COA). In addition to these two national certifications, DANB offers Certificates of Competency in Radiation Health and Safety (RHS) and Infection Control (ICE). The RHS and ICE exams are components of the CDA exam, and ICE is also a component of the COA exam. Individuals may take these components separately in order to earn Certificates of Competency. Passing either or both of these exams demonstrates a dental assistant's competency in these two areas that are important to the health and safety of oral healthcare workers and patients alike.

This e-mail was sent to denbd@dhp.virginia.gov communications@danb.org. You are receiving this e-mail because of your relationship with the Dental Assisting National Board, Inc. (DANB). To view DANB's Privacy Policy, visit www.danb.org/termsandconditions.asp . DANB sends periodic e-mail updates to DANB Individuals. If you no longer wish to receive e-mails from DANB, you may unsubscribe by replying to optout@danb.org with the message "unsubscribe." You will be removed from DANB's e-mail list within 7 business days. You may also unsubscribe by writing to the address below.

The Dental Assisting National Board, Inc. * 444 N Michigan Ave Suite 900 * Chicago IL 60611 * 1-800-FOR-DANB.

DENTIAL LABS

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

A. Licensed dentists may employ or engage the services of any person, firm or corporation to construct or repair, extraorally, prosthetic dentures, bridges, or other replacements for a part of a tooth, a tooth, or teeth. A person, firm or corporation so employed or engaged shall not be considered to be practicing dentistry. No such person, firm or corporation shall perform any direct dental service for a patient, but they may assist a dentist in the selection of shades for the matching of prosthetic devices when the dentist sends the patient to them with a written work order.

B. Any licensed dentist who employs the services of any person, firm or corporation not working in a dental office under his direct supervision to construct or repair, extraorally, prosthetic dentures, bridges, replacements, or orthodontic appliances for a part of a tooth, a tooth, or teeth, shall furnish such person, firm or corporation with **a written work order on forms prescribed by the Board** which shall, at minimum, contain: (i) the name and address of the person, firm or corporation; (ii) the patient's name or initials or an identification number; (iii) the date the work order was written; (iv) a description of the work to be done, including diagrams, if necessary; (v) specification of the type and quality of materials to be used; and (vi) the signature and address of the dentist.

The person, firm or corporation shall retain the original work order and the dentist shall retain a duplicate for three years.

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

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

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

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

Reen, Sandra

From: drjefflevin@aol.com
Sent: Thursday, April 08, 2010 10:39 AM
To: Reen, Sandra

a great guideline by the National Association OF Dental Laboratories

NADL has worked with the U.S. Food and Drug Administration to promote patient safety and ensure laboratories have a voice in any regulation of the industry. NADL is on record supporting regulations that assure patients their restorations are safe for use, regardless of where they are manufactured. NADL's position has been presented consistently to the American Dental Association since 2003.
The National Association of Dental Laboratories believes that every dental patient has a reasonable expectation that the dental restoration placed in his or her mouth is safe, regardless of where it is manufactured. Therefore, in an attempt to provide the necessary documentation for disclosure as well as to document competency, the NADL strongly supports the following:
The necessity of at least one Certified Dental Technician (CDT) in each dental laboratory.
The necessity that all dental laboratories register with either the U.S. Food and Drug Administration or an appropriate state governmental agency.

The written documentation of all materials included in a final restoration and the point of origin (country and laboratory) where the restoration was manufactured.
The necessity that each of these items be documented in the patient's record.

Reen, Sandra

From: drjefflevin@aol.com
Sent: Wednesday, April 07, 2010 8:32 PM
To: Reen, Sandra
Subject: fyi

NEW REQUIREMENTS FOR DENTISTS AND DENTAL LABORATORIES

Effective January 1, 2009, Chapter 466, Florida Statutes, was amended. Please refer to Dental Lab Statutes for complete language.

Section 466.021, Florida Statutes

- Work order form is now referred to as prescription.
- Each prescription shall contain the license number of the dentist, as well as specification of materials to be used in each work product.
- A registered dental laboratory shall disclose in writing at the time of delivery of the final restoration to the prescribing dentist the materials and all certificates of authenticity that constitute each product manufactured and the point of origin of manufacture of each restoration, including the address and contact information of the dental laboratory.
- Failure of a dental laboratory that has accepted a prescription to have the original or electronic copy of each prescription and to ensure the accuracy of each product's material disclosure at the time it is delivered to the prescribing dentist constitutes a misdemeanor of the second degree.
- A dental laboratory accepting prescriptions from dentists is liable for damages caused by inaccuracies in the material disclosure, certificates of authenticity, or point of origin provided by the dental laboratory to the prescribing dentist.

Section 466.032, Florida Statutes

- The dental laboratory owner or a least one employee of any dental laboratory renewing registration on or after July 1, 2010, shall complete 18 hours of continuing education biennially.
- Continuing education course content and manner of documentation at renewal is specified.

Please refer to Rules 64B5-17.006, F.A.C. and 64B5-27-1.003, F.A.C. for additional information

Jeff

Texas State Board of Dental Examiners
333 Guadalupe, Tower 3, Suite 800
Austin, Texas 78701-3942
Phone: (512) 463-6400
Fax: (512) 463-7452
Website: www.tsbde.state.tx.us

DENTAL LABORATORY RENEWAL FORM

Renew Online:
You may renew online 45 days before the expiration date listed on your registration certificate and anytime after your registration certificate expires at the following website address: **www.tsbde.state.tx.us/RenewOnline**

Renew by Mail:
Make your Check or Money Order payable to the State Board of Dental Examiners and mail it to the address listed above.

INCOMPLETE FORMS WILL BE RETURNED

This form must be signed and all questions answered or your payment will be returned without action resulting in non-renewal and possible penalties.

Profession	Renew by Expiration	1 - 90 Days Following Expiration	91 days – 365 Days Following Expiration	366+ days late
Dental Laboratory	$114	$171	$228	Cancelled - Nonrenewable

Renewing an Expired Registration: See Page 2 for instructions for renewing an expired registration certificate.

Required Jurisprudence Assessment for Dental Laboratories: Dental Labs are required to take the online SBDE Jurisprudence Assessment once every three years for registration renewal. Go to: **www.tsbde.state.tx.us/Jurisprudence**. More information is available on Page 2.

LAB INFORMATION

Lab Name and Address: _____

Include full name of City, State, Country and Zip Code _____

_____

Lab Registration Number: _____

Lab Phone Number: (_____) _____

LAB OWNER

Name and Address: _____

Include full name of City, State, Country and Zip Code _____

_____

Owner Phone Number:
(_____) _____

CDT OF RECORD

CDT OF RECORD IS: _____

If CDT of Record has changed since last renewal, list the new CDT of Record here: _____

CDT Certification Number Issued by the National Board of Certification: _____

Expiration Date of CDT Certification: _____

GRANDFATHERED LABS (See requirements for Grandfathered Labs on the next page)

Indicate the name of the designated employee that has obtained the required Continuing Education hours required for renewal of this registration: _____

ADDRESS CHANGE (Complete only if you need to change your address. All correspondence is mailed to your primary address.)

Address: _____ City: _____ State: _____

Country: _____ Zip Code: _____ Phone: (_____) _____

E-Mail Address: (Optional) _____

GENERAL REQUIREMENTS (If this information has not changed since the last registration renewal, you are not required to complete this question below)

All Laboratory renewals must include the following information. List every person having an ownership interest of 20% or greater in the lab. Attach separate sheet if needed.

Name	Address (City, State, Country, Zip Code)	% and Type of Ownership Interest	Date Ownership Obtained

Manager Name: _____ **Mailing Address:** _____

SIGNATURE AND DATE

By signature, I hereby attest that this laboratory is in complete compliance with the Dental Practice Act and Rules and Regulations of State Board of Dental Examiners regarding the operation of a Dental Laboratory in Texas. I understand I may be asked to provide copies of any required certification or continuing education documentation required to renew this registration.

AMOUNT DUE

Renewal Fee: $ _____

Total Payment Enclosed: $ _____

_____ **Signature** _____ **Date**

SEE PAGE 2 FOR MORE INFORMATION

07/15/2009

Certified Dental Technician Required

In accordance with the State Board of Dental Examiners Rule 116.5:

(a) All dental laboratories must have a certified dental technician employed by and working on the premises of the dental laboratory a minimum of 30 hours per week.

(b) A dental laboratory is exempt from subsection (a) of this section if the laboratory is:
  (1) Owned by a licensed dentist engaged in the practice of dentistry in this state or by a professional corporation or partnership in which that dentist is an officer, partner, or employee; and
  (2) Located on the premises within which the dentist practices dentistry.

(c) The exemption under subsection (b) of this section does not apply to a dental laboratory if the laboratory employs three or more dental technicians.

(d) A dental laboratory is exempt from subsection (a) of this section if:
  (1) The dental laboratory was registered with the Board on September 1, 1987;
  (2) The dental laboratory's registration has been renewed each year and all registration fees have been paid;
  (3) The beneficial ownership of at least 51% interest in the laboratory has not transferred; and
  (4) The owner and/or the designated employee of the dental laboratory is employed on the premises of the laboratory for at least 30 hours per week.

(e) The owner of the dental laboratory shall maintain employment records validating compliance with this section for a period of not less than two years.

Grandfathered Labs

Grandfathered status will be maintained if **all** of the following requirements are met:

(1) The registration of the dental laboratory has been renewed each year since September 1, 1987 and all registration fees have been paid.

(2) The beneficial ownership of at least 51% of the laboratory has not been transferred.

(3) The owner is employed on the premises of the lab at least 30 hours per week.

(4) Validate that the designated employee working on the premises of the lab has completed at least 12 hours of continuing education (CE) during the preceding 12-month period. CE hours may be used only for one renewal period. CE hours will be comprised of business management (no more than one course), infection control (at least one course required) and technical competency courses presented by a nationally recognized organization of dentistry or dental technology. A maximum of four hours may be self-study. In lieu of CE, the designated employee may validate current and active certification by the National Board of Certification for Dental Technology.

Penalties

If the owner or manager of a dental laboratory fails to renew the registration before the registration date (January 1) the Board shall suspend the expired registration certificate of the lab. An owner or manager may renew the expired registration within the first 90 days by paying the required renewal fee plus a penalty equal to one-half of the initial registration fee. If the registration has been expired for more than 90 days, but less than one year, the required renewal fee plus a penalty equal to the amount of the initial registration must be submitted. If the registration has been expired for one year or longer, the registration may not be renewed.

Renewing an Expired Dental Laboratory Registration Certificate

A Registered Dental Laboratory renewing a registration certificate that is expired must pay **all past annual renewal fees** in order to bring the registration current and into 'Active' status. Cancelled registration certificates cannot be renewed.

Not Sure if Your Registration is Expired or Cancelled?
Visit the Dental Board website under the "Verify a License" section found under the Main Menu. Select "Dental Laboratories" and enter your information. Search Results will appear. Click on your name. A detailed view of the lab registration will be displayed. The "Status" category will indicate if your registration is Active, Expired, or Cancelled. The Dental Board Website is: **www.tsbde.state.tx.us**

Jurisprudence Assessment Requirement for Dental Laboratories

Effective January 1, 2009, for initial registrations only and once every three years for registration renewals, proof of completion of the Texas Jurisprudence Assessment for dental laboratories." Upon completing the Jurisprudence Assessment a Certificate of Completion can be printed that lists a National Board of Certification (NBC) in Dental Laboratory Technology Continuing Education Course Number. The NBC will award one (1) hour of Professional Development Credit for completing this assessment. The SBDE Jurisprudence Assessment is available at: **www.tsbde.state.tx.us/Jurisprudence.**

Address Changes

In accordance with SBDE Rule 116.3(c), the lab owner or manager must submit to this office within 60 days of any change in owner, location or closure of a lab, the designated CDT or designated employee.

Continuing Education Requirement

In accordance with SBDE Rule 116.6:

(a) A dental laboratory renewing a certificate must provide proof that the designated CDT has met the continuing education requirements of a recognized board of certification for dental technology, or its successor.

(b) A dental laboratory that meets the exemption qualifications in SBDE Rule 116.5 of this chapter must provide, in lieu of the requirement of subsection (a) of this section, proof, that the designated employee has completed at least 12 hours of continuing education during the preceding 12-month period. Continuing education hours may only be used for one renewal period.

(c) Acceptable continuing education shall be comprised of business management, infection control, and technical competency courses presented in seminars or clinics as accepted by a recognized organization of dentistry or dental technology, subject to the following requirements:
  (1) The designated employee must complete at least one course in infection control annually.
  (2) No more than one course in business management may be applied toward the annual continuing education requirement.
  (3) Self-study in a course approved by a recognized organization of dentistry or dental technology may be taken for not more than four hours of the annual continuing education requirement.

(d) In lieu of furnishing proof of continuing education as set forth in subsection (c) of this section, a dental laboratory may furnish proof that the designated dental technician has a current certification from a recognized board of certification for dental technology or its successor. Certification as "retired" does not qualify the technician.

Reen, Sandra

From: drjefflevin@aol.com
Sent: Wednesday, April 07, 2010 4:22 PM
To: Reen, Sandra
Subject: FYI Florida LAB LAWS

Florida State Laws Affecting Dental Laboratories
A Manual Prepared by the Florida Dental Laboratory Association
Order Form
Effective Jan. 1, 2009, the laws and rules governing dental laboratories doing business in Florida will change
significantly due to the laws set in place by the 2008 Florida Legislature. These new requirements address material
disclosure, point of origin disclosure and continuing education for dental technicians. Every owner, manager and
technician should be informed about how to comply with the new law.
This manual will provide you with a clear understanding of your responsibilities on these issues so that your laboratory
is ready. Included with this manual are topics such as
• Florida laws and administrative code affecting dental laboratories;
• Shade Verification guidelines;
• New laboratory prescription information requirements, with a sample prescription form;
• Update on point of origin and disclosure laws taking effect January 1, 2009;
• New continuing education requirements for dental laboratories taking effect February 2012;
• Consequences for not following the new laws and regulations;
• A copy of the bill that passed the 2008 Florida Legislature, in both the official language and legislative staff
analysis format;
• Contact information for the Florida Board of Dentistry;
• Other essential resources to help you maintain compliance.
This manual is prepared in a 3-ring binder so that you can update the information as new information is released.
Florida State Laws Affecting Dental Laboratories
Manual Order Form
Member Non-Member
Number of Printed Manuals $40 each $99 each

Number of Electronic Manuals (CD) $15 each $35 each
(Adobe PDF Format)
TOTAL ENCLOSED: = $ $
Florida Sales Tax: (Per Florida law, all orders mailed to Florida must pay sales tax based on the rate imposed in the county
where the merchandise or service is delivered. Look up your current Florida county sales tax rate on FDLA's website at
www.fdla.net)
Florida County: _____ Amount of FL Sales Tax Due:
_____
Name CDT? Yes No
Laboratory CDL? Yes No
Address
City/State/Zip Code
Email Phone Fax
Payment Information:
_____ Enclosed is my check to "FDLA" _____ Charge to my credit card _____ Visa
_____ MC _____Amex
Card No. Security Code Exp. Date
Name on Card Signature
Fax with credit card information to (850) 222-3019 or mail to 325 John Knox Road, L103, Tallahassee, FL 32303.
For more information,

FDLA Sample Laboratory Procedure Prescription

Dentist Information:

Name: _____

Practice Name: _____

Address: _____

City: _____

Florida License No.: _____

Date Sent to Lab: _____

Phone: _____

Fax: _____

Email: _____

State: _____ Zip: _____

Laboratory Information:

Laboratory Name: _____

Technician Name: _____

Address: _____

City: _____

Florida Registration No.: _____

Date Received by Lab: _____

Phone: _____

Fax: _____

Email: _____

State: _____ Zip: _____

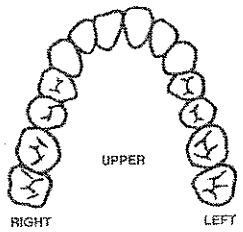
Patient Name or Number: _____ ❑ Male ❑ Female Age: _____

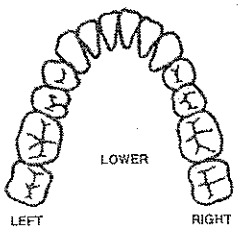
Known Allergies: _____

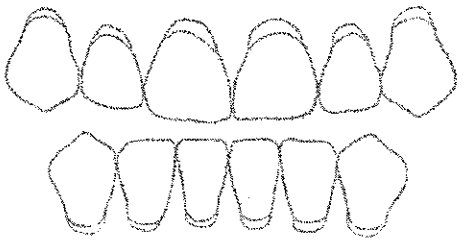
_____

Design Case Here:

Please provide descriptive information to clearly identify each separate and individual piece of work to be performed in the area below. Additionally, please specify materials to be contained in each work product (or use check boxes below).







INSTRUCTIONS:

Shade: _____ ❑ Please schedule shade verification.

The following materials are to be used in producing the above restoration:

❑ _____ ❑ _____

❑ _____ ❑ _____

❑ _____ ❑ _____

❑ _____ ❑ _____

(Laboratory should write in products or brand names available on the lines above.)

Return Request:

Month	Date	Year	Time
_____ /	_____ /	_____	_____

I authorize the above procedure to be performed.

Prescribing Dentist Signature: _____ Date: _____

Signature can be original or electronic.

Copies of this prescription must be maintained, either on paper or stored electronically for a period of four (4) years.

This prescription form is provided as a sample by the Florida Dental Laboratory Association. It is recommended that laboratories reference Chapter 466, Section 466.021 of the Florida Statutes and Section 64B5-17.006 of the Florida Administrative Code before use.

Reen, Sandra

From: drjefflevin@aol.com
Sent: Thursday, April 15, 2010 10:40 AM
To: Reen, Sandra
Subject: Fwd: NC laboratory forms

FYI I thanked them

Jeff

-----Original Message-----
From: Bobby White <bwhite@ncdentalboard.org>
To: drjefflevin@aol.com
Cc: Dr. C. W. Holland <hollanddental@embarqmail.com>
Sent: Thu, Apr 15, 2010 10:30 am
Subject: NC laboratory forms

Dr. Levin:

Dr. Wayne Holland asked me to forward to you copies of laboratory forms work order forms recommended for use in North Carolina by the Dental Board. I will be happy to send hard copies, but the forms can be found on the Board's website: www.ncdentalboard.org under the "Forms" menu tab. Once you click to open the Forms menu simply scroll to the bottom of the page where you will find the "Contractor" and "Subcontractor" laboratory work forms.

I hope this information is helpful. Please let me know if you need any additional information or would like hard copies.

Sincerely,

Bobby D. White
Chief Operations Officer

DENTAL LABORATORY WORK ORDER FORM

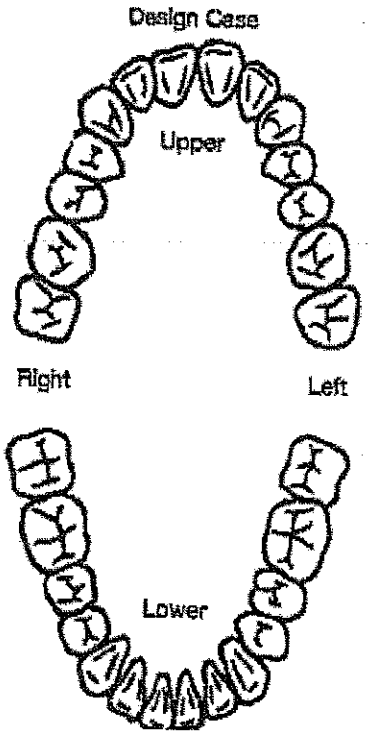
Date: _____

Laboratory:
Name _____
Address _____
Phone # _____

Patient Name or ID #: _____

Description of work to be done. Type and Quality of materials to be used. (Include diagrams if necessary)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



Dentist Signature: _____ Dental Lic. # _____

Dentist Name (Please Print): _____

Dentist Address: _____

Telephone: _____

Laboratory must furnish dentist with subcontractor work order form if the dental lab uses a subcontractor and must comply with all items checked below:

__ Prior to beginning work, the prescribing dentist must be notified of any foreign subcontractor involved in fabrication or component/materials supply.

__ Prior to beginning work, the prescribing dentist must be notified of any domestic subcontractor involved in fabrication or component/materials supply.

__Prescribing dentist must be notified of all materials in the delivered appliance/restoration.

__Prescribing dentist must be notified in writing that materials in the delivered appliance/restoration DO NOT contain more than very small trace amounts (less than 200 ppm) of lead or any other metal not expressly prescribed.

___Before returning finished case to prescribing dentist, the fabricated appliance/restoration must be cleaned, disinfected, and sealed in an appropriate container or plastic bag.

Dental Laboratory Subcontractor Work Order Form

Date: _____

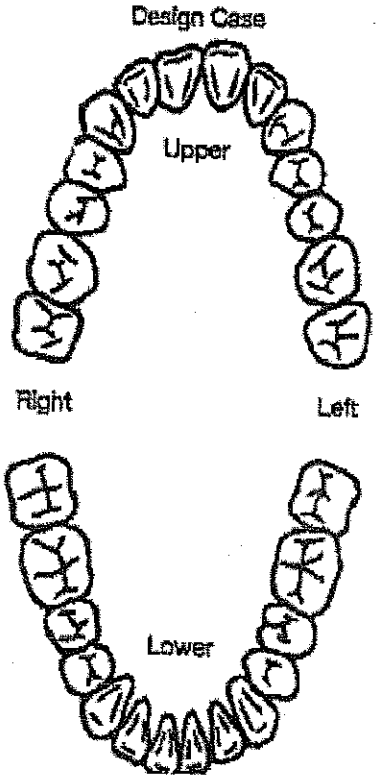
Subcontractor
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Patient Name or ID #: _____
(This information is required and MUST match the Patient Name or ID # on the Original Work Form)

Name & Address
Of Dentist originating work order: _____
Address _____
City _____
State _____ Zip _____

Description of the Work to be done.
Type and quality of materials to be used.
(Attach diagrams or additional pages if necessary.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



Name of person or firm issuing Subcontractor
Work Order Form: _____
Address _____
City _____
State _____ Zip _____

Signature of Person Issuing
Subcontractor Work Order Form: _____

Subcontractor Laboratory must furnish contracting laboratory with written confirmation of all checked items:

__ Prior to beginning work, the contracting laboratory must be notified if subcontractor is a foreign lab involved in fabrication or component/materials supply.

__ Prior to beginning work, the contracting laboratory must be notified if subcontractor is a domestic lab involved in fabrication or component/materials supply.

__Contracting laboratory must be notified of all materials in the delivered appliance/restoration.

__Contracting laboratory must be notified in writing that materials in the delivered appliance/restoration DO NOT contain more than very small trace amounts (less than 200 ppm) of lead or any other metal not expressly prescribed.

___Before returning finished case to contracting laboratory, the fabricated appliance/restoration must be cleaned, disinfected, and sealed in an appropriate container or plastic bag.

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

7/23/09
Date

Disciplinary Board Report for June 11, 2010

This report addresses the three key performance measures for discipline for the third quarter of fiscal year 2010 as well as provides some highlights for where the disciplinary cases now stand.

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

1. We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
   (Dentistry's Clearance rate for the second quarter is 83%)
   (Dentistry's Clearance rate for the third quarter is 109%)

2. We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
   (Dentistry case load of over 250 business days was 8% for the second quarter)
   (Dentistry case load of over 250 business days is 9% for the third quarter)

3. We will investigate and process 90% of patient care cases within 250 work days.
   (Dentistry closed 97% of its patient care cases within 250 work days during the second quarter.)
   (Dentistry closed 93% of its patient care cases within 250 work days during the third quarter.)

According to the most recent Quarterly Performance Measurement released by the Agency on April 29, 2010, the Board of Dentistry received 65 patient care cases and closed 71 compared with the second quarter where the Board received 155 patient care cases and closed 129. The board received a total of 93 patient and non patient care cases during the third quarter and closed a total of 103 patient and non patient care cases.

The 71 cases closed in the second quarter were as follows:

- No Violation/Undetermined – 88 cases
- Violation / IFC, PHCO, Formal – 12 cases
- Violation / CCA – 3 cases

As of this writing there are 5 cases over 250 days. Two cases have outstanding CCAs and we are awaiting their return. Two cases have been returned with additional information having been requested and one case is at probable cause review.

Probable Cause Review Exercise

The board will review a generic standard of care case as a refresher for when to request further investigation, administrative proceedings, sanctions and closure.

Reen, Sandra

From: Monson, Mark
Sent: Friday, May 14, 2010 3:33 PM
To: Board Executives
Cc: Cane, Dianne; Owens, Arne; Paquette, Patricia A.; Siddall, Kathy
Subject: State E-mail Accounts for Board Members

FYI.

According to the Library of Virginia (LVA), business-related e-mails from our board members are considered public records and, therefore, are subject to LVA's records retention policies. In order to accommodate this requirement, we will need to assign all board members a state e-mail account.

We had hoped to be able to do this by July 1. Because of Transformation, we won't be able to implement this until the middle to end of this coming September.

There will be no special requirements or equipment needs for the board members. They will be able to access their state account anywhere on any computer using OWA. Because they will be accessing e-mail only, they will not need Fobs. And, we're hoping that there will be minimal training needs.

Once we get them set up, they will need to be strongly encouraged to use the state account for all their DHP e-mailing. If they don't, we won't be able to meet LVA's records retention requirements. This will be especially important for board chairs. LVA considers board chairs' e-mails to be permanent records that have to be kept indefinitely.

As we get farther along in Transformation, we will need to get from each of you a list of all of the board members.

More will follow later.....

Thanks.

mdm

Implementation of the Educational Requirements for Dental Assistants II

Background: During the regulatory development process, the Regulatory/Legislative Committee worked with numerous drafts of the regulations. The draft used when the provisions for the education requirements were adopted did not include "performing pulp-capping procedure" as one of the duties that might be delegated to dental assistants II in 18VAC60-20-200 (C) even though "performing pulp capping procedures" was being stricken from the list of nondelegable duties in 18VAC60-20-190.

The omission in 18VAC60-20-200 (C) was corrected by the Board when it adopted final regulations at its March 12, 2010 meeting. However, modifying the education requirements to address performing pulp capping procedures was not considered at that time. As a result the education requirements in 18VAC60-20-61(B) of the final regulations adopted by the Board do not address the educational requirements for performing pulp capping procedures.

Ms. Reen discussed this matter with Dr. Levin and with Martha Clements, the Director of Continuing Education and Faculty Development at the VCU School of Dentistry, to learn if pulp capping fits appropriately within any of the four modules established in 18VAC60-20-61(B)(2) and (3) or if another module needs to be developed.

The feedback received was that pulp capping could be included in the laboratory training module for placing and shaping composite resin restorations to be addressed concurrent with liners and bases. It was also suggested that pulp capping could be addressed in the module for amalgam restorations as well.

Options:

1. Decide that performing pulp capping procedures should be a distinct training module and charge the Regulatory/Legislative Committee with developing the requirements for adoption of proposed language at the September 17th Board meeting.

2. Decide that performing pulp capping procedures is appropriately taught in the module on placing and shaping composite resin restorations and/or the module on amalgam restorations. Also decide if the number of hours of the module should be adjusted for the inclusion of pulp capping procedures.

Action: Charge the Regulatory/Legislative Committee with developing proposed language for adoption of a fast track regulatory action at the September 17th Board meeting which should be timed to be effective with the regulations or immediately following the effective date.

EXCERPTS FROM PROPOSED DENTAL ASSISTANT II REGULATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18VAC60-20-190. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-20-81, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

4. Authorization of work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;

~~6. Performing pulp capping procedures;~~

~~7.~~6. Administering and monitoring general anesthetics and conscious sedation except as provided for in § 54.1-2701 of the Code of Virginia and 18VAC60-20-108 C, 18VAC60-20-110 F, and 18VAC60-20-120 F;

~~8.~~7. Condensing, contouring or adjusting any final, fixed or removable prosthodontic appliance or restoration in the mouth, with the exception of placing, packing and carving amalgam and composite resins by dental assistants II with advanced training as specified in 18VAC65-20-61 B;

~~9.~~8. Final positioning and attachment of orthodontic bonds and bands; and

~~10. Taking impressions for master casts to be used for prosthetic restoration of teeth or oral structures;~~

~~11.~~9. Final ~~cementation~~ adjustment and fitting of crowns and bridges in preparation for final cementation~~; and~~

~~12. Placement of retraction cord~~.

18VAC60-20-200. Utilization of dental hygienists and dental assistants II.

~~No dentist shall have more than two~~ A dentist may utilize up to a total of four dental hygienists or dental assistants II in any combination practicing under direction or general supervision at one and the same time, with the exception that a dentist may issue written orders for services to be provided by dental hygienists under general supervision in a free clinic, a public health program, or on a voluntary basis.

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

A. Duties appropriate to the training and experience of the dental assistant and the practice of the supervising dentist may be delegated to a dental assistant under the direction or under general supervision required in 18VAC60-20-210, with the exception of those listed as nondelegable in 18VAC60-20-190 and those which may only be delegated to dental hygienists as listed in 18VAC60-20-220.

B. Duties delegated to a dental assistant under general supervision shall be under the direction of the dental hygienist who supervises the implementation of the dentist's orders by examining the patient, observing the services rendered by an assistant and being available for consultation on patient care.

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;

5. Use of a non-epinephrine retraction cord; and

6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS

Item Number	Duties That May Be Delegated to Dental Assistants	Dental Assistants I and Dental Assistants II Under Indirect Supervision	Only Dental Assistants II Only Under Direct Supervision
A	RESTORATIVE AND ADJUCTION SERVICES		
1	Acid Etch - Apply/wash remove only when reversible	YES	
3	Amalgam: Place	YES	
4	Amalgam: Condense	NO	YES
5	Amalgam: Carve	NO	YES
6	Amalgam: Polish only with slow-speed handpiece and prophy cup	YES	
7	Apply base and cavity liners	NO	YES
8	Apply pit and fissure sealants	YES	
9	Crowns: Fabricate, cement, and remove temporaries	YES	
10	Fabricate temporary/interim restorations outside patient's mouth	YES	
11	Final cementation of crowns and bridges after adjustment and fitting by the dentist	NO	YES
12	Make alginated impressions for study casts and opposing models	YES	
13	Make alginated impressions for athletic mouthguards	YES	
14	Make final impressions for master casts to be used for prosthetic restoration of teeth and oral structures	NO	YES
15	Matrices: place and remove	YES	
16	Measure instrument length	YES	
17	Compliance with OSHA Regulations	YES	
18	Perform pulp capping procedures	NO	YES
19	Perform health assessment using indices	YES	
20	Place and finish composite resin restorations	NO	YES
21	Place and remove retraction cord and associated medicaments with OTC products	NO	YES
22	Prep lab forms for signature by the dentist	YES	
23	Remove excess cement from coronal surfaces of teeth	YES	
24	Remove temporary/interim restorations	YES	
25	Rubber Dams: Place and remove	YES	

DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS

26	Sterilization and disinfection procedures	**YES**	
B	**ANESTHESIA SERVICES**		
1	Apply topical anesthetic	**YES**	
2	Monitoring patient under nitrous oxide	**YES**	
3	Monitoring patient under anxiolysis (minimal sedation)	**YES**	
4	Monitoring patient under conscious sedation (moderate sedation)	**ONLY WITH REQUIRED TRAINING**	
5	Monitoring patient under deep sedation/general anesthesia	**ONLY WITH REQUIRED TRAINING**	
6	Take blood pressure, pulse and temperature	**YES**	
7	Draw and compound medications for administration by dentist	**YES**	
C	**HYGIENE**		
1	Apply dentin desensitizing solutions	**YES**	
2	Apply fluoride varnish, gels, foams and agents	**YES**	
3	Apply pit and fissure sealant	**YES**	
4	Address risks of tobacco use	**YES**	
5	Give oral hygiene instruction	**YES**	
6	Place local antimicrobial agents	**YES**	
7	Polish coronal portion of teeth with rotary hand piece and rubber prophy cup or brush	**YES**	
D	**RADIOLOGY**		
1	Place x-ray film and expose radiographs	**ONLY WITH REQUIRED TRAINING**	
E	**ORTHODONTICS**		
1	Place and remove elastic separators	**YES**	
2	Check for loose bands and brackets	**YES**	
3	Remove arch wires and ligature ties	**YES**	
4	Place ligatures to tie in archwire	**YES**	
5	Select and fit bands for cementation by dentist	**YES**	

DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS

6	Instruct patients in placement and removal of retainers and appliances after dentist has fitted and made adjustments in the mouth	**YES**	
F	**BLEACHING**		
1	Fabricate Bleaching trays	**YES**	
2	Bleaching	**YES**	
3	Bleaching with light but not laser	**YES**	
4	Instructions on bleaching procedures		

Dental Assisting Functions List

The following is a list of 70 dental assisting tasks developed by the ADAA/DANB Alliance in the course of its research. These selected tasks were determined to be representative of a broad range of dental assisting core competencies.

Functions in each state that correspond to the national Core Competency Study functions are **numbered** in the Career Ladder Template, using language directly from the state's dental practice act. Functions listed with **bullets** in the Career Ladder Template are part of the state's practice act but are not specific matches to DANB research.

1. Perform mouth mirror inspection of the oral cavity
2. Chart existing restorations or conditions
3. Phone in prescriptions at the direction of the dentist
4. Receive and prepare patients for treatment, including seating, positioning chair, and placing napkin
5. Complete laboratory authorization forms
6. Place and remove retraction cord
7. Perform routine maintenance of dental equipment
8. Monitor and respond to post-surgical bleeding
9. Perform coronal polishing procedures
10. Apply effective communication techniques with a variety of patients
11. Transfer dental instruments
12. Place amalgam for condensation by the dentist
13. Remove sutures
14. Dry canals
15. Tie in archwires
16. Demonstrate knowledge of ethics/ jurisprudence/patient confidentiality
17. Identify features of rotary instruments
18. Apply topical fluoride
19. Select and manipulate gypsums and waxes
20. Perform supragingival scaling
21. Mix dental materials
22. Expose radiographs
23. Evaluate radiographs for diagnostic quality
24. Provide patient preventive education and oral hygiene instruction
25. Perform sterilization and disinfection procedures
26. Provide pre- and post-operative instructions
27. Place and remove dental dam
28. Pour, trim, and evaluate the quality of diagnostic casts
29. Size and place orthodontic bands and brackets
30. Using the concepts of four-handed dentistry, assist with basic restorative procedures, including prosthodontics and restorative dentistry
31. Identify intraoral anatomy
32. Demonstrate understanding of the OSHA Hazard Communication Standard
33. Place, cure and finish composite resin restorations
34. Place liners and bases
35. Place periodontal dressings
36. Demonstrate understanding of the OSHA Bloodborne Pathogens Standard
37. Take and record vital signs
38. Monitor vital signs
39. Clean and polish removable appliances and prostheses
40. Apply pit and fissure sealants
41. Prepare procedural trays/ armamentaria set-ups
42. Place orthodontic separators
43. Size and fit stainless steel crowns
44. Take preliminary impressions
45. Place and remove matrix bands
46. Take final impressions
47. Fabricate and place temporary crowns
48. Maintain field of operation during dental procedures through the use of retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
49. Perform vitality tests
50. Place temporary fillings
51. Carve amalgams
52. Process dental radiographs
53. Mount and label dental radiographs
54. Remove temporary crowns and cements
55. Remove temporary fillings
56. Apply topical anesthetic to the injection site
57. Demonstrate understanding of the Centers for Disease Control and Prevention Guidelines
58. Using the concepts of four-handed dentistry, assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics, and implants
59. Monitor nitrous oxide/oxygen analgesia
60. Maintain emergency kit
61. Remove permanent cement from supragingival surfaces
62. Remove periodontal dressings
63. Place post-extraction dressings
64. Fabricate custom trays, to include impression and bleaching trays, and athletic mouthguards
65. Recognize basic medical emergencies
66. Recognize basic dental emergencies
67. Respond to basic medical emergencies
68. Respond to basic dental emergencies
69. Remove post-extraction dressings
70. Place stainless steel crown

BOARD OF DENTISTRY
PROPOSED 2011 CALENDAR

JANUARY

S	M	T	W	T	F	S	
						1	
2	3	4	5	6	**7**	8	SCC-C
9	10	11	12	13	14	15	
16	17	18	19	20	**21**	22	SCC-A
23	24	25	26	27	**28**	29	SCC-B
30	31						

FEBRUARY

S	M	T	W	T	F	S	
		1	2	3	4	5	
6	7	8	9	10	11	12	
13	14	15	16	17	**18**	19	SCC-C
20	21	22	23	24	**25**	26	RESERVE
27	28						

MARCH

S	M	T	W	T	F	S	
		1	2	3	**4**	5	SCC-A
6	7	8	9	**10**	**11**	12	Formals/Board
13	14	15	16	17	**18**	19	SCC-B
20	21	22	23	24	25	26	
27	28	29	30	31			

APRIL

S	M	T	W	T	F	S	
					1	2	SCC-C
3	4	5	6	7	8	9	
10	11	12	13	14	**15**	16	SCC-A
17	18	19	20	21	22	23	
24	25	26	27	28	**29**	30	SCC-B

MAY

S	M	T	W	T	F	S	
1	2	3	4	5	6	7	
8	9	10	11	12	**13**	14	SCC-C
15	16	17	18	19	**20**	21	RESERVE
22	23	24	25	26	**27**	28	SCC-A
29	30	31					

JUNE

S	M	T	W	T	F	S	
			1	**2**	**3**	4	Formals/Board
5	6	7	8	9	**10**	11	SCC-B
12	13	14	15	16	17	18	
19	20	21	22	23	**24**	25	SCC-C
26	27	28	29	30			

JULY

S	M	T	W	T	F	S	
					1	2	
3	4	5	6	7	**8**	9	SCC-A
10	11	12	13	14	**15**	16	SCC-B
17	18	19	20	21	22	23	
24	25	26	27	28	29	30	
31							

AUGUST

S	M	T	W	T	F	S	
	1	2	3	4	**5**	6	SCC-C
7	8	9	10	11	12	13	
14	15	16	17	18	**19**	20	SCC-A
21	22	23	24	25	**26**	27	SCC-B
28	29	30	31				

SEPTEMBER

S	M	T	W	T	F	S	
				1	2	3	
4	5	6	7	**8**	**9**	10	Formals/Board
11	12	13	14	15	**16**	17	SCC-C
18	19	20	21	22	23	24	
25	26	27	28	29	**30**		SCC-A

OCTOBER

S	M	T	W	T	F	S	
						1	
2	3	4	5	6	**7**	8	SCC-B
9	10	11	12	13	**14**	15	RESERVE
16	17	18	19	20	21	22	
23	24	25	26	27	**28**	29	SCC-C
30	31						

NOVEMBER

S	M	T	W	T	F	S	
		1	2	3	4	5	
6	7	8	9	10	11	12	
13	14	15	16	17	**18**	19	SCC-A
20	21	22	23	24	25	26	
27	28	29	30				

DECEMBER

S	M	T	W	T	F	S	
				1	**2**	3	Formals/Board
4	5	6	7	8	**9**	10	SCC-B
11	12	13	14	15	16	17	
18	19	20	21	22	23	24	
25	26	27	28	29	30		

FORMAL HEARINGS	BOARD MEETINGS	RESERVE DAYS	SCC – A	SCC – B and Credentials	SCC – C
March 10	March 11	Feb 25	January 21	January 28	January 7
June 2	June 3	May 20	March 4	March 18	February 18
September 8	September 9	Oct 14	April 15	April 29	April 1
December 1	December 2		May 27	June 10	May 13
			July 8	July 15	June 24
			August 19	August 26	August 5
			September 30	October 7	September 16
			November 18	December 9	October 28

Adopted:

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Board of Dentistry

MAY 2 6 2010
DHP

May 24, 2010

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Maryland Drive, Suite 300
Richmond, VA 23233-1463

Re: The Death of Another Child Under Anesthesia

Dear Ms. Reen:

I had previously corresponded with you after the tragic death of Raven Blanco while she was being sedated in her dentist's office. I asked you at that time to consider having Virginia join the 48 other states in better regulating when and under what circumstances a dentist can administer anesthesia to a child. Unfortunately, you did not see fit to take any action.

Another child has recently died in Richmond under similar circumstances. While it's too early to tell exactly what happened in that case, the circumstances are frighteningly similar. A child is receiving anesthesia in a dental office. The child suffers an emergency. The child dies. I don't know all the facts surrounding this case. I only know that on its face it is very disturbing.

To my knowledge, this is at least the third death of this type since 2002. Exactly how many children are going to have to die before the State Dental Board decides to join the twentieth century and try to stop this?

I am very fearful that the investigation into this case is going to determine that this child may well have survived had this procedure been done in a hospital setting. I would ask you once again to put the desires of your members aside and look out for the health and safety of the children who are dying while these procedures are being done in a dentist's office.

I remain available to provide you any additional information you may feel is necessary from my end, but I would ask that you give this matter a little more serious consideration than you did previously.

Respectfully,

Robert J. Haddad

RJH/cte

cc: Mr. & Mrs. Mario J. Blanco, Jr.
Governor Robert F. McDonnell
Kenneth T. Cuccinelli, II, Attorney General

COMMONWEALTH of VIRGINIA

Office of the Attorney General

Kenneth T. Cuccinelli, II
Attorney General

May 18, 2010

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120
7-1-1

Howard M. Casway
Senior Assistant Attorney General
Office of the Attorney General
900 E. Main Street
Richmond, Virginia 23219

RE: Jacobi Hill's death; Use of Anesthesia

Dear Mr. ~~Casway:~~ Howard

Last week, the Richmond Times-Dispatch reported that six-year old Jacobi Hill died on May 11th after undergoing anesthesia for dental work at a VCU clinic. I recall that the Board confronted a similar issue when it conducted a formal disciplinary hearing in December 2008 regarding the actions of Michael J. Hechtkopf, D.D.S. Dr. Hechtkopf performed restorative treatment on an eight-year old female, who became unresponsive while under conscious sedation in the office. Dr. Hechtkopf's patient expired approximately ninety minutes after emergency medical services transferred her to a local hospital.

Since Dr. Hecktkopf's formal hearing, the Board approved a Guidance Document on September 11, 2009, entitled "Policy on Administering Schedule II through VI Controlled Substances for Analgesia, Sedation and Anesthesia in Dental Offices/Practices." In light of Jacobi Hill's recent death, I respectfully request that you persuade the Board to consider the promulgation or the revision of Regulations or Emergency Regulations to address this issue. Alternatively, should the Board believe that legislation more appropriately addresses this challenging area, do not hesitate to call upon this Unit to assist in the drafting of such legislation.

Thank you for your prompt attention to this matter.

Sincerely,

Francis W. Pedrotty

Francis W. Pedrotty
Senior Assistant Attorney General & Director
Health Professions Unit

FWP/vgs

cc: Patrick W. Dorgan, Senior Assistant Attorney General & Chief, Special Prosecutions and Organized Crime