VIRGINIA BOARD OF DENTISTRY

AGENDAS

March 8 and 9, 2012

Department of Health Professions

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

PAGE

March 8, 2012

2:30 p.m. **Executive Committee**
Call to Order – Dr. Hall, President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes - April 22, 2011

Presentation on Budget – Mr. Giles, Budget Manager

Review of Bylaws

March 9, 2012

Board Business

9:00 a.m. **Call to Order – Dr. Hall, President**

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes - December 1, 2011 **P1-P3**
December 2, 2011 **P4-P11**

DHP Director's Report – Dr. Reynolds-Cane

OSCE – Objective Structured Clinical Examination – Dr. Burns **P12-P22**
Oral Pathology Chair, VCU School of Dentistry

Liaison/Committee Reports

- BHP – Dr. Levin
- AADB – Dr. Levin
- SRTA – Dr. Hall
  Ms. Pace

Legislation and Regulation – Ms. Yeatts

- Report of the 2012 General Assembly **P23-P28**
- Status Report on Regulatory Actions **P29**

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Closed Session	
• Discipline Case # 136275	
• Applicant Case # 140969	
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• Compliance Case # 142432	

UNAPPROVED - DRAFT

BOARD OF DENTISTRY
MINUTES OF EXECUTIVE COMMITTEE

Friday, April 22, 2011

Department of Health Professions
9960 Mayland Drive, 2nd Floor
Henrico, Virginia 23233
Board Room 4

CALL TO ORDER:	The meeting was called to order at 9:25 a.m.
PRESIDING:	Jacqueline G. Pace, R.D.H., President
MEMBERS PRESENT:	Robert B. Hall, Jr., D.D.S. Jeffrey Levin, D.D.S. Augustus A. Petticolas, Jr., D.D.S.
OTHER BOARD MEMBERS PRESENT:	Herbert R. Boyd, III, D.D.S. Martha C. Cutright, D.D.S.
STAFF PRESENT:	Alan Heaberlin, Acting Executive Director Donna Lee, Discipline Case Manager Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
COUNSEL PRESENT:	Howard Casway, Senior Assistant Attorney General
QUORUM:	With all members of the Committee present, a quorum was established.
APPROVAL OF MINUTES:	Ms. Pace requested a motion for approval of the minutes of the September 10, 2009 meeting of the Committee. Dr. Petticolas moved the approval of the minutes. The motion was seconded and passed.
ADOPTION OF FINAL REGULATIONS FOR REGISTRATION OF MOBILE DENTAL CLINICS AND PORTABLE DENTAL OPERATIONS:	Ms. Yeatts informed the Committee that the emergency regulations are now in effect, which will expire on July 1, 2011. Dr. Levin moved to adopt the Final Regulations for Registration of Mobile Dental Clinics and Portable Dental Operations with no changes from the proposed regulations. The motion was seconded and passed.
ADOPTION OF FINAL REGULATIONS FOR RECOVERY OF DISCIPLINARY COSTS:	Ms. Yeatts informed the Committee that two written comments were received. Ms. Yeatts further explained that the Board will create a guidance document listing all of the elements that go into the

calculations of the disciplinary costs. The final cost for each case will be part of the Board order.

Dr. Hall moved to adopt the Final Regulations for Recovery of Disciplinary Costs with no changes from the proposed regulations. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the Committee adjourned at 9:40 a.m.

Jacqueline G. Pace, R.D.H., President	Alan Heaberlin, Acting Executive Director
Date	Date

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARINGS
December 1, 2011

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 2:20 p.m. on December 1, 2011 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

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

MEMBERS PRESENT:
Herbert R. Boyd, III, D.D.S.
Martha C. Cutright. D.D.S.
Jeffrey Levin, D.D.S.
Misty Mesimer, R.D.H.
Jacqueline G. Pace, R.D.H.
Augustus A. Petticolas, Jr., D.D.S.

MEMBER ABSENT:
Surya P. Dhakar, D.D.S.
Meera Gokli, D.D.S.
Myra Howard, Citizen Member

STAFF PRESENT:
Sandra K. Reen., Executive Director
Huong Vu, Operations Manager

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

OTHERS PRESENT:
Kelly Wynne, Adjudication Specialist
Sherelle A. Weaver, Court Reporter, Crane-Snead & Associates, Inc.

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

Roy S. Shelburne, D.D.S.
Case No. 140102: Dr. Shelburne appeared in accordance with a Notice of the Board dated November 8, 2011.

Dr. Hall swore in the witnesses.

Following Ms. Wynne's opening statement; Dr. Hall admitted into evidence Commonwealth's exhibits 1 through 4.

Following Dr. Shelburne's opening statement; Dr. Hall admitted into evidence Applicant's exhibits A through C.

Testifying on behalf of the Commonwealth was Vicky Fox, RN, DHP Senior Investigator.

Testifying on behalf of Dr. Shelburne in person were Randy Aldridge, Dr. Charles Blair, DDS, and Jessie Frazer. Testifying on behalf of Dr. Shelburne by phone were Linda Harvey and Dr. Jamie Brown, DDS. Dr. Shelburne testified on his own behalf.

Closed Meeting:

Dr. Petticolas moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Dr. Shelburne. Additionally, it was moved that Board staff, Sandra Reen, Huong Vu, and Board counsel, Howard Casway, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

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

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

Decision:

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

Mr. Casway reviewed the findings and conclusions then reported that the Board decided to reinstate Dr. Shelburne's license on indefinite probation for a period of not less than three years of actual practice with terms to include:

- Dr. Shelburne shall notify the Board, within 10 days of resuming practice, of his practice location(s) and any subsequent changes in his practice activities;
- Unannounced audit(s) of a random sampling of his patient treatment records including financial records shall be conducted as determined by the Board; and
- At the conclusion of three years of practice, Dr. Shelburne may petition the Board for termination of his probation.

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

ADJOURNMENT: The Board adjourned at 6:10 p.m.

Robert B. Hall, Jr., D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
MINUTES
DECEMBER 2, 2011

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:08 a.m. on December 2, 2011 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

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

BOARD MEMBERS PRESENT:
Augustus A. Petticolas, Jr., D.D.S., Vice President
Herbert R. Boyd, III, D.D.S., Secretary-Treasurer
Martha C. Cutright, D.D.S.
Meera A. Gokli, D.D.S.
Myra Howard, Citizen Member
Jeffrey Levin, D.D.S.
Misty Mesimer, R.D.H.
Jacqueline G. Place

BOARD MEMBERS ABSENT: Surya P. Dhakar, D.D.S.

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Dianne L. Reynolds-Cane, M.D., DHP Director
Elaine J. Yeatts, DHP Senior Policy Analyst
Alan Heaberlin, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

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

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

PUBLIC COMMENT: **Ron Downey, DDS,** on behalf of the Virginia Dental Association (VDA) Board of Directors, asked the Board for support of the dental labs legislation. He stated that the Board should not be concerned about costs because registration fees will cover costs. He added that the safety of the patients is most important.

Rick Weingartener, certified dental technician, stated that he knows many garage dental labs where there is no infection control. He added that dentists and patients should be aware of dental materials being used in dental labs.

Charles Gaskins, DDS, gave out a fact sheet on dental labs and stated that he strongly supports the VDA bill. He added that this is strictly a matter of safety issue for patients.

APPROVAL OF MINUTES:

Dr. Hall asked if the Board members had reviewed the September 9, 2011minutes. Dr. Boyd moved to accept the minutes. The motion was seconded and carried.

DHP DIRECTOR'S REPORT:

Dr. Cane thanked Board members for their contributions and said she has nothing new to report at this time.

LIAISON/COMMITTEE REPORTS:

Report on ADEX Annual meeting. Dr. Watkins stated that his report is included in the agenda package and he is here to answer any questions that the Board has. He recommended that the Board join ADEX and noted there is no cost for participation and there are opportunities to participate in development of examinations and pursue a uniform national examination.

Board of Health Professions (BHP). Dr. Levin reported he has been appointed to the BHP then gave an overview on the role of BHP to address cross board issues and to study the need to regulate new professions or facilities.

SRTA. Dr. Hall highlighted his written report stating that SRTA is operating in the black and encourages Virginia's participation in ADEX. He added that Dr. Watkins was appointed to the Examiner Review Committee.

Ms. Pace reported that the Dental Hygiene Committee will also meet in January 2012 and said that the hygiene exam has not changed but the forms were tweaked.

Exam Committee. Dr. Petticolas referred to the Committee minutes and reported that the Committee met on September 9, 2011. On behalf of the Committee, Dr. Petticolas moved that the Board work with SRTA to use mannequins instead of live patients in its exams. The motion was seconded and passed.

Dr. Petticolas then moved that the Board send a letter to the North Carolina Board of Dentistry encouraging acceptance of other exams in addition to its exam. The motion was seconded and passed.

Regulatory/Legislative Committee. Dr. Boyd reported that the Committee met on November 4, 2011and the its recommended actions are presented later in the agenda.

BOARD DISCUSSION/ACTION:

Public Comment Topics. DR. Hall noted that the comments received were in support of the VDA dental lab resolution which is already is on the agenda.

Membership in ADEX. Dr. Gokli spoke in favor of joining ADEX, noting that the other states in SRTA are members. She then moved to join. The motion was seconded and passed.

Oregon Correspondence. Ms. Reen said the executive director of the Oregon Board who also serves as the executive director of ADEX expresses concern about the ADA 's initiative to develop a clinical licensing exam and asks dental boards to consider writing a letter of concern to the ADA. Ms. Mesimer moved that this matter be assigned to the Exam Committee. The motion was seconded and passed.

EXPLORING ALTERNATIVE STRATEGIES FOR EXAMINING CLINICAL SKILLS:

Dr. Petticolas stated that the Exam Committee was charged with exploring alternatives to live patient clinical examinations. He added that at its September 9, 2011 meeting, the Committee decided to have presentations made to the Board about options so the OSCE and Portfolio models will be presented at the March Board meeting. Then he introduced Dr. Gunsolley, Professor of Periodontics at the VCU School of Dentistry, to address research into the use of human subjects in clinical exams.

VALUE OF HUMAN SUBJECTS – WHAT DOES THE EVIDENCE SHOW?:

Dr. Gunsolley gave a PowerPoint presentation addressing:

- Importance of measuring internal and external test validity
- Results of studies conducted by the University of Maryland and NERB and by Florida finding no consistent relationship between live patient examinations and dental school performance
- Results of Canadian study which found concurrence between school performance and OSCE

Dr. Gunsolley then responded to questions. Dr. Petticolas asked why there is a consistent relationship between OSCE and dental school performance. Dr. Gunsolley replied that it is because of the consistency of test conditions achieved especially with the use of mannequins. In response to a question by Dr. Hall, Dr. Gunsolley said that testing on a human patient means that each candidate's test conditions are unique because no two patients are the same and because assessing the consistency of performance through a number of stations provides more and more objective information on the competence of a candidate. Dr. Gunsolley replied to Ms. Reen that he is not aware of any current studies underway and he replied to Dr. Gokli that he believes American dental schools should embrace OSCE. He added that there needs to be a change to achieve valid testing. Ms. Reen asked why the studies were done with candidates from non-credited schools. Dr. Gunsolley stated that Canada is looking at licensing of those students to add to body of literature and Dr. Sarrett, Dean of the VCU School of Dentistry, stated that American Dental Educators Association supports the elimination of live patient exams and added that the data on candidates from non-accredited schools was only one element of the study conducted in Canada. Dr. Levin said he is researching companies that make teeth that simulate tooth decay. Dr. Hall asked if all tooth models have to be the same. Dr. Gunsolley stated that they could have variations. Dr. Archer from the VCU School of Dentistry stated that SRTA is using plastic teeth for its endodontic section that are produced exclusively for its exam. Dr. Gunsolley concluded his presentation by responding to Dr. Petticolas that his recommendation to the Board is to accept the Canadian OSCE exam with the hope that other states would follow.

HEALTHCARE WORKFORCE DATA CENTER DENTISTRY SURVEYS:

Dr. Carter, Ph.D., Executive Director, Board of Health Professions (BHP) and Director, Healthcare Workforce Data Center, stated that the survey information is in the agenda package and she is here to take questions about content and implementation. She said that dentists and dental hygienists will be asked to complete a survey through the 2012 online renewal notices. She responded to Dr. Hall that this is a voluntary process and that the Boards of Medicine and Nursing are getting 94 – 96% response rates. She stated that dentistry's data will be available by the end of March 2012 and a presentation of results would be possible by the end of 2012. She also replied to Dr. Gokli that she

would look into the suggestion of changing the "Asian" entry in the race/ethnicity sections to "Asian American."

LEGISLATION AND REGULATION:

Status Report on Regulatory Actions. Ms. Yeatts reported that the:

- The Periodic Review proposed regulations to establish four chapters are filed for review.
- The regulations on Recovery of Disciplinary Costs are at Governor's Office for approval to publish as final regulations.
- The final regulations for Registration of Mobile Clinics have been approved and will be effective on January 4, 2012. Ms. Reen noted that current registrations will expire and that renewal applications are being accepted now so registrations can be issued on January 4th.
- The regulations for sedation an anesthesia permits are at the Secretary's office for approval. She added that once approved these regs will be effective immediately as emergency regulations. Ms. Reen added that these regulations require registration by March 31st of each year to have renewal be concurrent with license renewal. She said, if approval to publish the regulations is delayed, it may be necessary to defer issuance of the permits to 2013 in order to provide adequate notice to licensees even though the plan was to have licensees registered by March 31, 2012. She said she would confer with Dr. Hall regarding implementation.
- The rule for training in pulp capping for dental assistants II is at the Governor's Office for approval; and
- The amendment of the radiation certification regulation is also at the Governor's office for approval.

VCU School of Dentistry Faculty License 2012 Legislative Proposal. Ms. Yeatts stated that no action is needed from the Board and this is provided as information only. She added that the Regulatory-Legislative Committee recommended some editorial changes to the School which are now included. Dr. Levin moved to recommend support of the legislation to Dr. Cane. The motion was seconded and passed.

VDA 2012 Legislative Proposals.
Resolution for Registration of Dental Laboratories – Ms. Yeatts stated her concerns about not having a draft bill to

review and said that the proposed effective date on July 1, 2012 is not possible because no regulations would be in place. She added that the Board cannot regulate dental labs outside of Virginia because it has no authority to do so. Dr. Boyd recommended that the Regulatory/Legislative Committee be charged with meeting with VDA representatives to discuss this matter. Discussion followed about legislation being premature and the need to make licensees aware of the dental lab work order forms adopted in September. Ms. Reen asked for consideration of the motion adopted by the Regulatory-Legislative Committee at its November 4, 2011 meeting to ask the VDA to pursue a study instead of legislation. She added that it is important for the Board to express its view as this proposal is moving forwarded and stated that no complaints have been received from consumers or dentists about problems with dental labs.

Dr. Boyd moved to send a formal request to the VDA asking that a study resolution be pursued to have the BHP study the need to regulate labs instead of advancing the legislation. The motion was seconded and passed.

Expanding Dept. of Health Remote Supervision of Dental Hygienists - Ms. Yeatts stated that the VDA adopted a resolution to amend §54.1-2722(E) to replace the pilot project for dental hygienists employed by the Virginia Department of Health to work under remote supervision to permit such practice in all Virginia Health Districts. She added that the Board recommended support of the legislation in the past General Assembly. Ms. Mesimer moved to recommend support to Dr. Cane. The motion was seconded and passed.

BOARD DISCUSSION/ACTION:

AADB Proposed Advertising Guidelines. Ms. Reen said this was provided as information.

Guidance Document (GD) for Recovery of Disciplinary Costs. Ms. Reen stated that this GD is the recommendation of the Regulatory-Legislative Committee for discussion and adoption. She added that the highlighted language in "Policy" and "Assessment of Costs" were added after the Regulatory-Legislative Committee meeting on November 4, 2011. Ms. Yeatts noted that the effective date for this GD has to be concurrent with the regs. Ms. Mesimer moved to adopt the GD as presented. The motion was seconded and passed.

REPORT ON CASE ACTIVITY:

Mr. Heaberlin reported that in the first quarter of FY2012 the Board received a total of 159 patient care cases and closed a total of 135 for an 85% clearance rate. He added that:

- the current caseload older than 250 days is 6%,
- The caseload older than 250 business days for Q1 FY2011 was 7%,
- 97% of all cases were closed with 250 business day,
- 222 cases are open and of these 209 have been assigned a priority A-D, and
- 85 cases are in probable cause with 36 at Board member review.

He commented that board staff is currently working on the audits for OMS who perform cosmetic procedures. There were 24 cases opened for audit of which 20 have been closed.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Ms. Reen reported the following:

- Delegation to Dental Assistants Guidance Document 60-7 may need to be amended. She referred the Board to the highlighted language on P94 under the heading "*Duties that may only be delegated to dental assistants II under direct supervision of a dentist.*" Ms. Mesimer moved that "*select and manipulate gypsums and waxes*" be moved to General Services duties. The motion was seconded and passed.

- A Guidance Document (GD) on the training modules for dental assistants II has been recommended by Mr. Casway and is presented for Board action. She stated that the Board's intent to allow completion of one or more of these modules to qualify for registration is not clear in the regs and this GD will clarify that candidates have the option of choosing which modules they want to be certified to perform. She noted that the registration will list which procedure the DA II is qualified to perform. Dr. Boyd moved adoption. The motion was seconded and passed.

- AADB Ethical Behavior Survey was provided as information only. She added that if the Board has any questions, she will explore further and get back to the Board.

- AADB Assessment program is provided as information only. This is an in-depth assessment program that was developed by AADB to provide resources for state boards. She noted that if the Board wants to pursue this then the Board needs to amend the regulations because AADB is not an approved continuing education provider in Virginia. It was decided by consensus to refer this matter to the Regulatory-Legislative Committee for further consideration.

- It is possible to distribute the 2012 renewal notices electronically. She noted that smaller boards have done this procedure and it works well. She added that licensees with no email address on file will get paper notices. She stated that there would be a follow-up e-mail then a paper notice if renewals are not received in specific time parameters. It was agreed by consensus to send electronic renewal notices.

- The Dental Law exam provider contract will expire at the end of 2012. The RFP for a provider has been issued and she will work with the Exam Committee to choose the next provider. She added that a specification in the RFP is to guide the candidate to the applicable regulation if his answer is wrong.

BOARD COUNSEL REPORT: Mr. Casway said he has nothing to report.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 12:05 p.m.

Robert B. Hall, Jr., D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

Virginia Board of Dentistry - March 9, 2012

Definition & Overview of OSCE:

Objective Structure Clinical Examination (OSCE): First developed in 1975 in a Scottish medical school curriculum, it has since grown in popularity among academic, professional and licensure organizations. It can be designed to test specific clinical skills including diagnosis, interpretation and treatment planning.

Multiple Variations of OSCEs:

a. Tangible vs. Electronic OSCEs: tangible tests can include mounted casts, radiographs, dental impressions, carious teeth, syringes, and even live patients. Electronic tests include photographs and images of the tangible material.

b. Timed vs. untimed OSCE "stations": These "stations" can include a clinical scenario that you would be likely to encounter in a general dental practice. Each student moves from one station to the next so that by the end of the OSCE, every student has completed every station. Timed responses might be important in testing something like medical emergencies or chair-side communication skills.

c. Specific discipline based vs. multidisciplinary: Case based clinical scenarios can be tested as well as very specific discipline based material

Strengths of OSCEs:

a. Objectivity: removing the patient and examiner variation
b. Flexibility & versatility: Multiple simultaneous sites of testing
c. Wider range of skills & disciplines being tested.

Content examples:

a. Treat "virtual" patients with specific conditions and/or needs.
b. Establish differential and/or definitive diagnoses.
c. Recognize & treat/manage dental and medical abnormalities.
d. Treat/manage office emergencies.
e. Develop comprehensive treatment plans.

Examples for the VCU School of Dentistry:

D3 multidisciplinary case based OSCE (PowerPoint demonstration)
D4 Removable Prosthodontic OSCE (PowerPoint demonstration)

Examples for the Canadian National Dental Examination: (300 multiple choice written exam plus 103 OSCE questions) - Patient Scenarios likely to be encountered on NDEB examination:

1. Systemically healthy patient with dental needs requiring routine diagnosis and treatment planning
2. Geriatric patient taking multiple medications
3. Child or adolescent with malocclusion
4. Patient with dental/oral pain requiring management

5. Patient with a dental urgency/emergency
6. Patient with a medical urgency/emergency
7. Patient with systemic disease(s) that would affect provision of oral health care
8. Patient with dental concern that leads to an ethical dilemma
9. Patient seeking a second opinion (you will be required to demonstrate effective communication skills)
10. Patient with oral health care needs that exceed your ability to treat
11. Patient with oral soft/hard tissue lesions
12. Patient with complicated restorative and/or periodontal needs
13. Patient with signs suggesting abuse
14. Patient with esthetic concerns
15. Patient with lifestyle and/or behavior affecting oral health
16. Patient for whom a diagnostic test should be ordered

How is the NDEB examination graded?

Each station has been developed by and will be graded by a group of faculty members. Each station will be graded using "critical error" criteria. A critical error is one that would result in (1) ineffective/inappropriate treatment/management of the patient, (2) harm to the patient; or (3) violation of state/federal laws governing dental practice. A passing grade is determined by obtaining less than a predetermined percentage of critical errors and the absence of errors that would actually harm the patient. This predetermined percentage of critical errors is reviewed annually by the Curriculum Committee and was previously set at 15%.

SUMMARY: *An OSCE can be developed in a variety of different forms testing a variety of skills for a variety of different purposes including obtaining a license as a competent entry level dentist in the State of Virginia. (See example of ADA as well as Canadian competencies in Appendix # 2)*

Answers to the previously asked questions from the Va. Board of Dentistry:

Question from Va. Board	VCU response	NDEB response
1.How is the OSCE designed to cover the full continuum of competence?	The designers are the VCU course directors and they insure that the full continuum is covered and updated. Key question: What constitutes a "competent entry level general dentist?"	The NDEB Technical Manual explains the Blueprint process which in turn is based on the Competencies for beginning Dental Practitioners in Canada.
2.How long have you been administering this exam?	Since 2002 for D4 Removable Prosthodontics. Since 2009 for D3 case-based multidisciplinary OSCE	Since 1995. Now they test graduates from Canadian, Australian & Minnesota dental schools.
3.Who owns the content and directs administration of the test?	VCU School of Dentistry with administration by the faculty	An Act of Parliament established the NDEB. The NDEB is a federally established not for profit corporation. The NDEB "owns " the content and is responsible for the administration of the examinations. Student fees support the NDEB exam.
4.How much time is required to develop the OSCE?	8-9 faculty spend roughly 10 hours each, therefore 80-90 hours to develop an electronic OSCE. More time would be necessary for a station tangible OSCE.	We have approximately 3 full staff working on the OSCE and many days of examiner time spent developing questions each year
5.How was it developed?	Cases were selected from the clinic and documented to use on the OSCE.	In 1994 it was modeled after the Medical Council of Canada OSCE
6.How frequently do you update content and equipment?	Annually	For every examination
7.How does this exam meet psychometric standards?	Have not yet tested statistically.	Yes absolutely, Please see the Technical Manual
8.What is the projected cost to develop and administer the test?	Faculty's time is roughly worth $20,000 plus the materials/computer costs.	The budget for the OSCE this year is $563,000

9.What is the amount of space required to set up the stations?	For D3 – a computer terminal. For D4 – a 20 x 30 room	Approximately 43 feet of bench space in a lab or clinic with adequate lighting
10.Does the examination need to be given at a dental school?	No For D3 - just need secure monitored computer terminals.	No but the lighting is important. It has been administered in a hotel with extra lights
11.How many stations are in the exam?	For D3 – 5 cases totally 106 multiple choice questions plus Prescription writing exercise. For D4 – 25 stations	Approximately 50 stations each with 2 questions. For a detailed description please see the NDEB website
12.How many questions are at each station?	For D4 – One question per station.	In general 2
13.What competencies and skills are tested?	For D3 – all disciplines of dentistry at the D3 level For D4 – Removable Pros	Please see Appendix # 1 for frameworks from the NDEB website. The questions are all developed from the frameworks each year.
14.Explain the format of the questions.	For D3 – multiple choice, single responders For D4 – station tangible, single responders	Please see the NDEB website at www.ndeb.ca. Multiple responders with positive and negative credit assigned to each response.
15.How do you assure the candidate's competency in performing individual procedures and/or tasks is tested from start to finish without assistance?	Through the proper construction of the OSCE and proctor monitoring.	There are invigilators (proctors) circulating and there is no opportunity for assistance
16.Who serves as scorers/examiners?	The faculty determine the OBJECTIVE scoring. There is no SUBJECTIVE scoring.	Most of the scoring is done by computer. Examiners who are appointed by the NDEB from individuals recommended by the provincial dental boards score the prescriptions
17. How are scorers and examiners calibrated?	Not necessary once OSCE is constructed by multiple faculty who agree with the answers.	Scoring rubrics are used and calibration is monitored by the scoring program

18.What is the examiner/candidate ratio?	Just enough proctors to assure "no cheating" so it is based on computer terminal layout.	Please look at the NDEB website as I think that you have some misconceptions as to what the OSCE is. It is not a patient based or manikin based examination so there is no examiner/ candidate ratio
19.How is caries removal assessed?	Could be on mounted teeth and/or radiographically.	On models
20.How is taking diagnostic radiographs evaluated?	Proper evaluation of a variety of diagnostic vs. nondiagnostic radiographs.	By making a judgment on whether a radiograph is diagnostic
21.What is the minimum number of candidates required in order to be cost effective?	There is no minimum.	If you are thinking of developing your own I would estimate that at least 300 candidates would be required.
22.What is the maximum number of candidates that can be tested at a time.	Solely based on secure proctored computer terminals.	The NDEB examines 600 in multiple centers on the same day
23.How much does it cost per candidate?	Absorbed in tuition.	The current cost is $400 application fee. $700 for the Written Exam $900 for the OSCE
24.What costs do the candidates incur in addition to the exam fee?	None	See above
25.What supplies or equipment do candidates supply?	None	Magnification is recommended
26.How is the public protected when no actual patients are used?	A properly constructed OSCE can test a broader range of skills needed to adequately protect the public.	Much better as shown in our research, patient based exams do not protect the public as eventually every candidate passes. There is a small but significant never pass rate on NDEB examinations

27.What is the likelihood of equipment failures?	None.	No equipment is used with the NDEB's OSCE
28.How are equipment failures handled?	None	Again I think that you have some misconceptions on what an OSCE is.
29.What problems have been encountered during testing?	Only sporadic computer problems caused by students not following directions ("submit button")	None
30.How frequently is the test administered?	Once annually	March, May and November
31.Is it administered in parts?	No	No
32.What are both the advantages and disadvantages of the OSCE?	Advantages: Non patient based with broader range of tested material. Serves to conserve manpower, costs, and time consumption. Disadvantages: None if the OSCE is properly designed	Relatively expensive but much less than a patient based examination when all costs are included
33.What do you feel are the greatest weaknesses and strengths of this method of evaluation?	It tests the student without the high stakes pressure of conditions outside of the student's control (patients & examiner variability). Eliminates the broad spectrum of student's testing experiences.	No evaluation is 100% accurate but the NDEB process has been shown to have good reliability and has demonstrated validity as shown in our publications
34.Do you still accept patient based exam results?	Still necessary	No
35.Do you have exams addressing dental specialties?	Not at this time but many national specialty board exams are trending towards OSCEs.	No the NDEB mandate is for general dentistry

Listed are some options for the Va. Board of Dentistry IF they decide to proceed with the concept of non-patient based licensure examinations:

1. Use the NDEB like Minnesota does but here is a quote from Dr. Gerrow who provided the answers for the questions that are tabulated above: "*Please make sure that the Virginia Board realizes that the NDEB is not really looking to expand and would be pleased if an American testing agency could develop a test that would work for Minnesota and Virginia. Thanks, Jack*

Jack D Gerrow DDS, MS, Cert Pros, MEd.
Executive Director/Registrar,
National Dental Examining Board of Canada
80 Elgin St
Ottawa, Ontario
Canada K1P 6R2"

2. Encourage SRTA, NERB, WREB, CETA, etc. to adopt, construct & administer a non-patient based OSCE option.

3. Contract with VCU Schools of Education, Information Technology and Dentistry to establish, evaluate, monitor and update a non-patient based certification option. If the Va. Board "owned" the exam, it could serve as a revenue stream.

4. Establish specific criteria with the VCU School of Dentistry to include successful passage of a D3 OSCE, D4 OSCE and submission of a Portfolio of comprehensive patients cared for as a dental student at VCU.

Appendix # 1: NDEB technical manual – Item selection by category & degree of difficulty

Table of **Written Examination** Items By Category

Root Category March 2011

Dental Anatomy/Occlusion/Operative 17 questions
Endodontics/Dental Emergencies 23 questions
Foundation Science 59 questions
Oral Medicine/Pathology/Oral Facial Pain 39 questions
Oral Surgery/Trauma 20 questions
Orthodontics/Pediatrics 20 questions
Periodontics 28 questions
Pharmacology/Therapeutics/Local Anesthesia 17 questions
Prosthodontics/Implants 33 questions
Miscellaneous** 34 questions
Total Scored 290 questions
Rejected due to psychometric analysis 10 questions
Total 300
**Miscellaneous: "Abuse and Neglect", "Anxious Patient", "Ethics and Jurisprudence", "Geriatrics", "Health Promotion/Population Health", "Infection Control", "Informed Consent", "Needs Conversion", "Occupational Hazards", "Prevention", "Radiology", "Records", "Relationship general/oral health", "Scientific Literature", "Special Needs"

Table of **Written Item** Difficulties

Degree of Difficulty March2011

Easy (.90+) 112 questions
Medium (.40 to .89) 171 questions
Difficult (0 to .39) 7 questions
Total 290 questions

Table of **OSCE Examination** Items By Category

Root Category March 2011

Anesthesia 4 questions
Emergency 4 questions
Endodontics 6 questions
Fixed Prosthodontics 11 questions
Multi-Disciplinary 4 questions
Operative 9 questions
Oral Medicine 9 questions
Orthodontics 7 questions
Pain 4 questions
Pediatric Dentistry 8 questions
Periodontics 8 questions
Pharmacology 4 questions
Radiology 12 questions
Removable Prosthodontics 3 questions
Surgery 3 questions

Swelling 5 questions
Total Scored 101 questions
Rejected 2 questions
Total 103 questions

Table of **OSCE Item** Difficulties

Degree of Difficulty March2011

Easy (.90+) 16 questions
Medium (.40 to .89) 78 questions
Difficult (0 to .39) 7 questions
Total 101 questions

Appendix # 2:

Competencies for a beginning dental practitioner according to ADA CODA:.

2-9 Competent to apply critical thinking and problem-solving skills in the comprehensive care of patients, scientific inquiry and research methodology

2-10.a Competent to self-assess development of professional competencies

2-10.b Competent to apply self-directed and lifelong learning skills

2-11 Understand basic biological principles, including core information on the fundamental structures, functions and interrelationships of the body systems

2-12 Understand how the oro-facial complex exists as an important anatomical area in a complex biological interrelationship with the entire body

2-13 Understand abnormal biological conditions and their etiology, epidemiology, differential diagnosis, pathogenesis, prevention, treatment and prognosis of oral and oral-related disorders.

2-14 Competent to apply knowledge of biomedical science in the delivery of patient care

2-15 Competent to apply principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving and maintaining oral health

2-16 Competent to manage a diverse patient population and have the interpersonal and communication skills to function successfully in a multi-cultural work environment

2-17 Competent in the application of legal and regulatory concepts related to the provision and/or support of oral health care services

2-18 Competent to apply the basic principles and philosophies of practice management, models or oral health care delivery, and how to function successfully as the leader of the oral health care team

2-19 Competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care

2-20 Competent to apply principles of ethical decision making and professional responsibility

2-21 Competent to access, critically appraise, apply, and communicate scientific and lay literature as it relates to providing evidence-based patient care

2-22 Competent in providing oral health care within the scope of general dentistry to

patients in all stages of life
2-23.a.1 Competent to conduct patient medical and dental assessments
2-23.a.2 Competent to diagnose patients
2-23.a.3 Competent to provide comprehensive treatment planning
2-23.a.4 Competent to determine and articulate prognosis
2-23.a.5 Competent to obtain informed consent
2-23.b Competent to screen and conduct risk assessment for head and neck cancer
2-23.c Competent to recognize the complexity of patient treatment and identify when referral is indicated
2-23.d Competent in management of health promotion and disease prevention
2-23.e Competent to manage pain and anxiety in patients
2-23.f Competent to provide restorative dentistry
2-23.g Competent to communicate and manage dental laboratory procedures in support of patient care
2-23.h.1 Competent to manage fixed prosthodontic treatment
2-23.h.2 Competent to manage removable prosthodontic treatment
2-23.h.3 Competent to manage dental implant prosthodontic therapies
2-23.i Competent to diagnose and manage periodontal conditions
2-23.j Competent to diagnose and manage pulpal conditions
2-23.k Competent to diagnose and manage oral and maxillofacial mucosal and osseous disorders
2-23.l Competent to perform uncomplicated hard and soft tissue surgery
2-23.m Competent to manage dental emergencies
2-23.n Competent to diagnose and manage malocclusion and space maintenance treatment
2-23.o Competent to self-evaluate the outcomes of treatment, prognosis, and recall strategies
2-24 Competent to assess the treatment needs of patients with special needs

Competencies for a beginning dental practitioner in Canada:

A beginning dental practitioner in Canada must be competent to:
1. recognize the determinants of oral health in individuals and populations and the role of dentists in health promotion, including the disadvantaged.
2. recognize the relationship between general health and oral health.
3. evaluate the scientific literature and justify management recommendations based on the level of evidence available.
4. communicate effectively with patients, parents or guardians, staff, peers, other health professionals and the public.
5. identify the patient's chief complaint/concern and obtain the associated history.
6. obtain and interpret a medical, dental and psychosocial history, including a review of systems as necessary, and evaluate physical or psychosocial conditions that may affect dental management.
7. maintain accurate and complete patient records in a confidential manner.
8. prevent the transmission of infectious diseases by following current infection control guidelines.
9. perform a clinical examination.
10. differentiate between normal and abnormal hard and soft tissues of the maxillofacial complex.

11. prescribe and obtain the required diagnostic tests, considering their risks and benefits.
12. perform a radiographic examination.
13. interpret the findings from a patient's history, clinical examination, radiographic examination and from other diagnostic tests and procedures.
14. recognize and manage the anxious or fearful dental patient.
15. recognize signs of abuse and/or neglect and make appropriate reports.
16. assess patient risk (including, but not limited to, diet and tobacco use) for oral disease or injuries.
17. develop a problem list and establish diagnoses.
18. determine the level of expertise required for treatment and formulate a written request for consultation and/or referral when appropriate.
19. develop treatment options based on the evaluation of all relevant data.
20. discuss the findings, diagnoses, etiology, risks, benefits and prognoses of the treatment options, with a view to patient participation in oral health management.
21. develop an appropriate comprehensive, prioritized and sequenced treatment plan.
22. present and discuss the sequence of treatment, estimated fees, payment arrangements, time requirements and the patient's responsibilities for treatment.
23. obtain informed consent including the patient's written acceptance of the treatment plan and any modifications.
24. modify the treatment plan as required during the course of treatment.
25. provide education regarding the risks and prevention of oral disease and injury to encourage the adoption of healthy behaviors.

HB 195 Higher educational institutions; course credit for military service.

Chief patron: Lewis

Summary as passed House:

Higher education; course credit for military experience. Requires the governing boards of each public institution of higher education, in accordance with guidelines developed by the State Council of Higher Education for Virginia, to implement policies that award academic credit to students for educational experience gained from military service.

01/30/12 House: Impact statement from DPB (HB195E)
02/16/12 Senate: Reported from Education and Health (15-Y 0-N)
02/17/12 Senate: Constitutional reading dispensed (40-Y 0-N)
02/20/12 Senate: Read third time
02/20/12 Senate: Passed Senate (40-Y 0-N)

HB 265 Health Professions, Board of; required to meet annually rather than quarterly.

Chief patron: Peace

Summary as introduced:
Board of Health Professions; meetings. Requires the Board of Health Professions to meet at least annually, rather than quarterly.

01/19/12 House: Read second time and engrossed
01/20/12 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/20/12 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)
01/23/12 Senate: Constitutional reading dispensed
01/23/12 Senate: Referred to Committee on Education and Health

HB 266 Surgery; definition and who may perform.

Chief patron: Peace

Summary as passed House:

Definition of surgery. Defines "surgery" and provides that no person shall perform surgery unless he is (i) licensed by the Board of Medicine as a doctor of medicine, osteopathy, or podiatry; (ii) licensed by the Board of Dentistry as a doctor of dentistry; (iii) jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner; (iv) a physician assistant acting under the supervision of a doctor of medicine, osteopathy, or podiatry; (iv) a midwife performing episiotomies during childbirth; or (vi) acting pursuant to the orders and under the appropriate supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. The bill is identical to SB 543.

02/15/12 House: Enrolled
02/15/12 House: Bill text as passed House and Senate (HB266ER)
02/15/12 House: Impact statement from DPB (HB266ER)
02/15/12 House: Signed by Speaker
02/16/12 Senate: Signed by President

HB 267 Dental laboratories; register with Board of Dentistry.

Chief patron: Peace

Summary as introduced:
Dental laboratories; register with the Board of Dentistry. Requires any individual or business entity engaged in the manufacture or repair of dental prosthetic appliances to register with the Board of Dentistry. The bill also requires the Board to develop regulations governing the operation of dental laboratories.

01/10/12 House: Prefiled and ordered printed; offered 01/11/12 12100510D
01/10/12 House: Referred to Committee on Health, Welfare and Institutions
01/23/12 House: Impact statement from DPB (HB267)
01/24/12 House: Continued to 2013 in Health, Welfare and Institutions

SB 342 Dental laboratories; register with Board of Dentistry.

Chief patron: Newman

02/02/12 Senate: Continued to 2013 in Education and Health (15-Y 0-N)

HB 337 Professions and occupations; unlawful procurement of certificate, license, or permit.

Chief patron: Wilt

Summary as introduced:
Professions and occupations; unlawful procurement of certificate, license, or permit. Clarifies language prohibiting the use, disclosure, or release of questions and answers for examinations for certification or licensure.

01/25/12 House: Passed House BLOCK VOTE (99-Y 0-N)
01/25/12 House: VOTE: PASSAGE #2 (99-Y 0-N)
01/26/12 Senate: Constitutional reading dispensed
01/26/12 Senate: Referred to Committee on General Laws and Technology
02/20/12 Senate: Reported from General Laws and Technology (15-Y 0-N)

HB 344 Dental and dental hygiene school faculty; licensure.

Chief patron: O'Bannon

Summary as introduced:

Dental and dental hygiene school faculty; licensure. Clarifies what patient care activities are allowed for a person enrolled in a Virginia dental education program who has a temporary license to practice dentistry while in the program, clarifies requirements for the Board to issue a faculty license to a qualified person from out of state to teach dentistry or dental hygiene in a Virginia dental school or program, and specifies that a restricted

license for a foreign dentist to teach dentistry in Virginia is a temporary appointment and extends this restricted license expiration from one year to two years. This bill is identical to SB 384.

02/15/12 House: Enrolled
02/15/12 House: Bill text as passed House and Senate (HB344ER)
02/15/12 House: Impact statement from DPB (HB344ER)
02/15/12 House: Signed by Speaker
02/16/12 Senate: Signed by President

HB 346 Nurse practitioners; practice as part of patient care teams.

Chief patron: O'Bannon

Summary as passed House:

Practice of nurse practitioners; patient care teams. Amends provisions governing the practice of nurse practitioners. The bill provides that nurse practitioners shall only practice as part of a patient care team and shall maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician licensed to practice medicine in the Commonwealth. The bill also establishes requirements for written or electronic practice agreements for nurse practitioners, provides that physicians practicing as part of a patient care team may require nurse practitioners practicing as part of that patient care team to be covered by professional malpractice insurance, and amends requirements related to the prescriptive authority of nurse practitioners practicing as part of a patient care team.

01/20/12 House: Read third time and passed House (96-Y 1-N)
01/20/12 House: VOTE: PASSAGE (96-Y 1-N)
01/23/12 Senate: Constitutional reading dispensed
01/23/12 Senate: Referred to Committee on Education and Health
02/15/12 Senate: Assigned Education sub: Health Licensing

HB 347 Prescription Monitoring Program; disclosures.

Chief patron: Miller

Summary as introduced:

Prescription Monitoring Program; disclosures. Modifies the Prescription Monitoring Program to (i) require dispensers of covered substances to report the method of payment for the prescription, (ii) require the Director of the Department of Health Professions to report information relevant to an investigation of a prescription recipient, in addition to a prescriber or dispenser, to any federal law-enforcement agency with authority to conduct drug diversion investigations, (iii) allow the Director to disclose information indicating potential misuse of a prescription by a recipient to the State Police for the purpose of investigation into possible drug diversion, and (iv) allow prescribers to delegate authority to access the Program to an unlimited number, rather than the current limit of two, of regulated health care professionals under their direct supervision. This bill is identical to SB 321.

02/15/12 House: Enrolled
02/15/12 House: Bill text as passed House and Senate (HB347ER)
02/15/12 House: Impact statement from DPB (HB347ER)
02/15/12 House: Signed by Speaker
02/16/12 Senate: Signed by President

HB 937 Spouses of military service members; expediting issuance of business licenses, etc.

Chief patron: Lingamfelter

Summary as passed House:

Professions and occupations; expediting the issuance of licenses for spouses of military service members. Requires a regulatory board within the Department of Professional and Occupational Regulation, the Department of Health Professions, or any board named in Title 54.1 to establish procedures to expedite the issuance of a license, permit, certificate, or other document, however styled or denominated, required for the practice of any business, profession, or occupation in the Commonwealth, of an applicant (i) holding the same or similar license, permit, certificate, or other document required for the practice of any business, profession, or occupation issued by another jurisdiction, (ii) whose spouse is the subject of a military transfer to the Commonwealth, and (iii) who left employment to accompany the applicant's spouse to Virginia, if, in the opinion of the board, the requirements for the issuance of the license, permit, certificate, or other document in such other jurisdiction are substantially equivalent to those required in the Commonwealth. The bill provides for the issuance of a temporary permit under certain circumstances and limits to six months the duration of a temporary permit issued.

02/08/12 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
02/08/12 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)
02/09/12 Senate: Constitutional reading dispensed
02/09/12 Senate: Referred to Committee on General Laws and Technology
02/15/12 House: Impact statement from DPB (HB937H1)

HB 938 Military training, etc.; regulatory boards to accept as equivalent to requirements for licensures.

Chief patron: Lingamfelter

Summary as passed House:

Professions and occupations; qualifications for licensure; substantially equivalent military training and education. Except for the Board of Medicine and the Board of Dentistry, requires the regulatory boards within the Department of Professional and Occupational Regulation, the Department of Health Professions, or any board named in Title 54.1 to accept the military training, education, or experience of a service member returning from active military service in the armed forces of the United States, to the extent that such training, education, or experience is substantially equivalent to the requirements established by law and regulations of the respective board for the issuance of any license, permit, certificate, or other document, however styled or denominated, required for the practice of any business, profession, or calling in the Commonwealth. The bill provides that to the extent that the service member's military training, education or experience, or portion thereof, is not deemed substantially equivalent, the respective board shall credit whatever portion of the military training, education, or experience that is substantially equivalent toward meeting the requirements for the issuance of the license, permit, certificate, or other document. The bill authorizes a regulatory board to require the service member to provide such documentation of his training, education, or experience as deemed necessary to determine substantial equivalency. The bill defines the term "active military service."

02/08/12 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)
02/09/12 Senate: Constitutional reading dispensed
02/09/12 Senate: Referred to Committee on General Laws and Technology

02/15/12 House: Impact statement from DPB (HB938H1)
02/20/12 Senate: Reported from General Laws and Technology (15-Y 0-N)

HB 1107 Public schools; administration of auto-injectable epinephrine.

Chief patron: Greason

Summary as passed House:

Public schools; possession and administration of epinephrine. Requires local school boards to adopt and implement policies for the possession and administration of epinephrine in every school. The school nurse, a school board employee, or an authorized and trained volunteer may adminster the epinephrine to any student believed to be having an anaphylactic reaction. The bill also requires the Department of Health, in conjunction the Department of Education and the Department of Health Professionals to develop and implement policies for the recognition and treatment of anaphylaxis in the school setting. This bill is identical to SB 656.

02/10/12 House: Engrossed by House - committee substitute HB1107H1
02/13/12 House: Read third time and passed House (95-Y 1-N)
02/13/12 House: VOTE: PASSAGE (95-Y 1-N)
02/14/12 Senate: Constitutional reading dispensed
02/14/12 Senate: Referred to Committee on Education and Health

HB 1140 Carisoprodol; added to list of Schedule IV controlled substances.

Chief patron: Hodges

Summary as introduced:
Carisoprodol added to list of Schedule IV controlled substances. Adds carisoprodol to the list of Schedule IV controlled substances in the Drug Control Act.

02/13/12 House: Read second time and engrossed
02/14/12 House: Read third time and passed House BLOCK VOTE (100-Y 0-N)
02/14/12 House: VOTE: BLOCK VOTE PASSAGE (100-Y 0-N)
02/15/12 Senate: Constitutional reading dispensed
02/15/12 Senate: Referred to Committee on Education and Health

HB 1141 Ezogabine; added to list of Schedule V controlled substances.

Chief patron: Hodges

Summary as introduced:
Ezogabine; add to Schedule V. Adds ezogabine to Schedule V of the Drug Control Act.

02/13/12 House: Read second time and engrossed
02/14/12 House: Read third time and passed House BLOCK VOTE (100-Y 0-N)
02/14/12 House: VOTE: BLOCK VOTE PASSAGE (100-Y 0-N)
02/15/12 Senate: Constitutional reading dispensed
02/15/12 Senate: Referred to Committee on Education and Health

SB 146 Dental hygienists; remote supervision by a public health dentist.

Chief patron: Puckett

Summary as introduced:
Dental hygienists; scope of practice. Expands an earlier trial program to allow licensed dental hygienists employed by the Department of Health to provide educational and preventative dental care pursuant to a standing protocol. Also, the bill requires an annual report of services provided by such dental hygienists, including their impact upon the oral health of the citizens of the Commonwealth, to be prepared by the Department of Health and submitted to the Virginia Secretary of Health and Human Resources.

02/20/12 House: Passed House BLOCK VOTE (98-Y 0-N)
02/20/12 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)
02/20/12 House: Reconsideration of House passage agreed to by House
02/20/12 House: Passed House BLOCK VOTE (98-Y 0-N)
02/20/12 House: VOTE: PASSAGE #2 (98-Y 0-N)

SB 384 Dental and dental hygiene school faculty; licensure.

Chief patron: McEachin

Summary as introduced:
Dental and dental hygiene school faculty; licensure. Clarifies what patient care activities are allowed for a person enrolled in a Virginia dental education program who has a temporary license to practice dentistry while in the program, clarifies requirements for the Board to issue a faculty license to a qualified person from out of state to teach dentistry or dental hygiene in a Virginia dental school or program, and specifies that a restricted license for a foreign dentist to teach dentistry in Virginia is a temporary appointment and extends this restricted license expiration from one year to two years.

02/20/12 House: Passed House BLOCK VOTE (98-Y 0-N)
02/20/12 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)
02/20/12 House: Reconsideration of House passage agreed to by House
02/20/12 House: Passed House BLOCK VOTE (98-Y 0-N)
02/20/12 House: VOTE: PASSAGE #2 (98-Y 0-N)

Board of Dentistry
Report of Regulatory Actions
(As of February 21, 2012)

Chapter	Action / Stage Information
Regulations Governing Dental Practice [18 VAC 60 - 20]	Action: Sedation and anesthesia permits for dentists Stage: Emergency/NOIRA - *At Governor's Office for 69 days* *Emergency regulations were required to be in effect on December 30, 2011*
Regulations Governing Dental Practice [18 VAC 60 - 20]	Action: Periodic review; reorganization of chapter Stage: NOIRA - *Register Date: 8/2/10* *Proposed regulations adopted*
Regulations Governing Dental Practice [18 VAC 60 - 20]	Action: Training in pulp capping for dental assistants II Stage: Fast-Track - *At Governor's Office for 189 days*
Regulations Governing Dental Practice [18 VAC 60 - 20]	Action: Radiation certification Stage: Fast-Track - *At Governor's Office for 126 days*
Regulations Governing Dental Practice [18 VAC 60 - 20]	Action: Recovery of disciplinary costs Stage: Final - *At Governor's Office for 187 days*

COMMONWEALTH OF VIRGINIA
Board of Dentistry

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JAN 05 2012
DHP
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JAN 0 5 2012
Board of Dentistry

Petition for Rule-making

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

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)
Nicole M. Cunha C/O The Raven Maria Blanco Foundation, Inc.

Street Address	**Area Code and Telephone Number**	
2748 Sonic Drive	757-222-2876	
City	**State**	**Zip Code**
Virginia Beach	**VA**	**23453**
Email Address (optional)	**Fax (optional)**	
nicole@rmbfinc.org		

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

   Part II of the Regulations Governing Dental Practice sets forth conditions for dentists seeking to renew a dental license. Included in this part are requirements for the payment of fees and requirements for continuing education. Although requirements elsewhere in the regulations govern the use of certain anesthetic agents, no requirements exist mandating that all dentists maintain an ability to respond appropriately to an unexpected medical emergency either resulting directly from treatment (dental and/or anesthesia) or as a random event (e.g. myocardial infarction, stroke, hypoglycemia, seizure). This petition asks the Virginia Board of Dentistry to establish standards in this area through the addition of a new section.

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

At least twelve deaths have occurred during or immediately subsequent to dental treatment during the calendar years 2010-11. Precise numbers may be higher because the dental profession has no mechanism to quantify medical emergencies (fatal or non-fatal) occurring during treatment.

In the last ten years, Virginia has suffered two deaths in dental care facilities, Raven Maria Blanco (private office, Virginia Beach) and Jacobi Hill (Virginia Commonwealth University Dental School, Richmond). As such, Virginia has the highest per capita death rate during dental treatment of any state in the nation.

How many non-lethal medical emergencies have occurred during dental care in Virginia has never been measured or studied. However, there are three reasons why it is reasonable to predict the number of non-lethal emergencies is also increasing during the course of dental treatment.

The population is aging. With increased age, patients are at increased risk of presenting for treatment with the diseases typically associated with aging such as Type II diabetes, coronary artery disease and congestive heart disease.

The public has more complex medical histories. With advances in medical care, people who were once homebound are now maintaining a higher quality of life including undergoing dental care.

Dentistry is more complex. While previous dentists spent much of their time focused on dentures and basic "fillings," today's dentists are routinely providing root canal therapy, periodontal surgery and implant procedures.

Currently, the only medical emergency preparation required for all Virginia dentists is maintaining basic CPR. Given an aging population, with increasingly complex medical histories and receiving increasingly complex treatment, the current standard is insufficient.

The Six Links of Survival was developed to provide dentists with a practical method to assure that dental offices are comprehensively prepared to manage a medical event. The six areas of preparation are:

1. Dentist's training
2. Staff training
3. Mock drills
4. Maintaining a written emergency plan
5. Stocking appropriate medications
6. Maintaining appropriate equipment (e.g. oxygen)

A copy detailing the Six Links of Survival is attached.

Mario Blanco, Nicole Cunha (Virginia residents) and The Raven Maria Blanco Foundation, Inc., a Virginia-based 501(c) 3 charity call upon the Virginia Board of Dentistry to mandate that all Virginia dentists prepare to manage medical emergencies consistent with The Six Links of Survival as a condition of both initial licensure and renewal.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

   The Virginia Board of Dentistry is exists for the sole purpose of assuring the Virginia public that those individuals granted permission to practice dentistry within the commonwealth do so in a safe manner consistent with known scientific principles.

Signature:

Nicole Cunha

Date: 01.02.2012

The Six Links of Survival™ Reference Guide

A Risk Management Resource for Medical Emergency Preparedness

IMEP

Institute of Medical Emergency Preparedness

Nicole Cunha, Executive Director
Sarah Selbe, Operations Manager
Larry J. Sangrik, DDS, National Director of Medical Emergency Preparedness
2748 Sonic Drive, Virginia Beach, VA 23453
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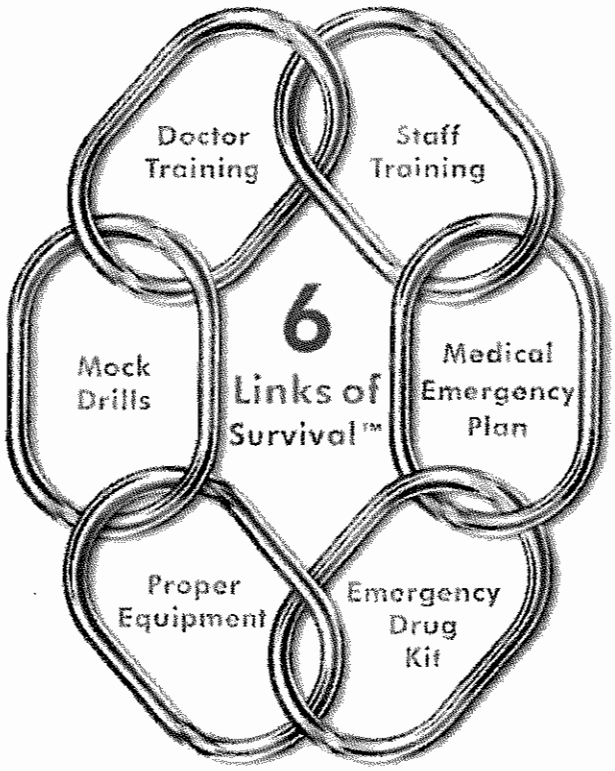

The Six Links of Survival™ was developed in 2003 by Drs. John Roberson and Christopher Rothman and is held by them as copyrighted material. IMEP and Larry J. Sangrik, DDS are authorized to use the *Six Links*™ concept for educational purposes.

Background: The average response time for emergency medical services (EMS) to respond to a 911 call can be 11 minutes in an urban setting and 15 minutes in a rural setting. These times were based on the primary EMS unit being available and not already responding to another call, necessitating an alternate squad being dispatched. Consequently, dental offices should be prepared to manage a medical crisis for up to 30 minutes without outside assistance. The **Six Links of Survival™** is a checklist of the educational needs and physical items necessary to fulfill the needs of a dental patient in that time period between the identification of a medical problem and the arrival of outside assistance.

Educational Links

Link 1: Doctor Training
Link 2: Staff Training
Link 3: Mock Drills

Link 1: Doctor Training, Link 2: Staff Training and **Link 3: Mock Drills** are known as the Educational Links. Educational link compliance demands a consistent pursuit of updated knowledge, data, and information on emergency medicine within the dental office. The training received in dental school or even last year, cannot be assumed sufficient for modern medical emergency response. As with all science and technology, the disparity gap widens quickly as our knowledge base and equipment access is ever-widening. Education vigilance incorporates a system of medical emergency updates akin to consistently monitoring the temperature of a patient. It is vital to track progress to create an MEP sustainable environment. This is a process of continual quality and education improvement. The C.O.R.E. 16 (Critical Office Resuscitation Emergencies) are unpredictable in nature and the industry continues to learn better, safer means of responding to these issues; therefore, the Educational Links are paramount in preparing the dental team.

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The decisions regarding formal and in-office training for medical emergencies are unique to each office setting; but dentists and their staff can use the acronym **"PREPS"** to make sure they are adequately addressing these training needs.

P = Participatory courses and drills are preferable.

R = Renew BLS and other life support courses every 2 years.

E = Everyone in the office should participate in BLS and CE related to medical emergency preparedness.

P = Practice on a regular basis with in-office emergency drills.

S = Stay current by regularly taking medical emergency CE courses.

Once the Educational Links are fully instituted in your practice, they should continue for the lifetime duration of your practice without interruption or discontinuance as this greatly compromises the integrity of the office's safety and readiness.

Link 1: Doctor Training

The dentist is the core of the Six Links of Survival™. Each of the other links depends upon the strength of the dentist's professional leadership. As such, the dentist should participate in an Emergency Medicine lecture either in person or online to stay current with the latest available information on Medical Emergency Preparedness (MEP).

MEP is of the utmost importance to you, your staff, your patients and the facility; and it is vital that each member becomes familiar with both the acronym and the message. MEP is the heartbeat of the rescue operation. The Six Links of Survival™ covers every topic necessary for readying a dental unit to competently handle a crisis; it is the culmination of decades of research and literature on the topic. Six Links of Survival™ training promises your patients and staff the most comprehensive, up-to-date MEP knowledge and skills in the industry.

Basic Life Support (BLS) is imperative. Every dentist should complete the BLS for the Healthcare Provider course that is equivalent to those offered by both the American Heart Association (AHA) and the American Red Cross (ARC). BLS should be taken at least once every two years under the advisory of the AHA which holds this as the maximum interim duration.

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Depending on the patient mix and patient acuity of the facility, more frequent reviews may be appropriate.

The dentist is the team leader, and when a medical emergency occurs, should be expected to guide with efficiency and effectiveness. MEP training should include this sense of importance and urgency in order for the entire team to grasp the gravity of this preparatory instruction.

Highlights

Over the period of two years, a dentist shall take one or more courses on medical emergencies. The sum of the course(s) over the two-year period should cover **all** of the topics in the following three areas:

1. A review of normal physiology with an emphasis on the systems that play important roles during a medical emergency

- Peripheral Nervous System
- Cardiovascular System
- Respiratory System

2. The Six "P's" of Preparation for a medical emergency

1. **Prevention:** proper use of a medical history
2. **Personnel:** staffing requirements and task pre-assignments
3. **Products:** monitors, AEDs and airway adjuncts
4. **Protocols:** office manuals to develop a planned response
5. **Practice:** ongoing training and review
6. **Pharmaceuticals:** having the proper medication on hand

3. Recognition and response to the C.O.R.E. 16 (Critical Office Resuscitation Emergencies) common to dental offices

1. Syncope
2. Angina
3. Myocardial Infarction
4. Cardiac Arrest
5. Hypertension
6. Hypotension
7. Asthma
8. Anaphylaxis
9. Hyperventilation
10. Allergic Reactions

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11. Diabetes (Hypoglycemia)
12. Seizures
13. Sudden Cardiac Arrest (SCA)
14. Cerebrovascular Accident (Stroke)
15. Foreign Body Obstruction (FBO) with Airway Management
16. Local Anesthetic Toxicity

Although not universally available, dentists should favor training that is participatory in nature with hands-on involvement.

Link 2: Staff Training

The importance of staff training cannot be overstated. Both the Dentist and the Staff members should jointly attend an Emergency Medicine lecture, either in person or online, to stay current with the latest information, techniques, and technologies in Medical Emergency Preparedness (MEP). The Staff is composed of the Dental Hygienists, the Dental Assistants, and the Front Office Personnel - each of which is vital to crisis outcome and patient safety. Therefore, each of these members should be incorporated into the MEP training initiative to guarantee complete facility readiness.

Because a medical emergency can occur when the dentist is not physically on the premise (e.g. Registered Dental Hygienist (RDH) general supervision) or the medical crisis may happen to the dentist, all staff should be trained on how to handle an emergency without the participation of the dentist. Currently, RDHs are allowed to administer local anesthesia in 44 states; undoubtedly, they will need comprehensive training in handling an adverse reaction that may occur before, during, or after the injection is received. Similarly, assistants work side-by-side with the dentist and are essential to the team. Likely, they will be one of the first people who witness the medical crisis. Without proper knowledge, valuable moments can be lost in confusion or in a slow reaction to crisis signs and symptoms. Also, the front office personnel facilitate front end action, including overseeing the reception area where events may occur, as well as guiding EMS into the office during a medical emergency. The question is not if staff should be trained, but when and how; our answer is urgently and excellently. Crises are not to be denied, but confronted; and total-staff training arms the office with the competence and confidence to achieve this task.

The MEP acronym and meaning should become part of your team's language fluency and awareness activity. MEP is the critical lifeline for the successful rescue of a distressed patient in your office. The Six Links of

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Survival™ covers every area that your Staff will need to know to be fully prepared for an emergency situation. The Six Links™ is the merging of decades of research and expertise - the core response that is addressed in every book, article, and blurb on crisis management. The Six Links™ is the nucleus of authentic life-affirming action. It is encouraged that every member of the dental team, particularly the staff, be MEP ready and able to fill-in for other members if necessary.

Part of this commitment includes taking the Basic Life Support (BLS) for Healthcare Provider course that is equivalent to those offered by American Heart Association (AHA) or American Red Cross (ARC) at least every two years. AHA states that two years is the absolute maximum time allowable between BLS course completion and that healthcare providers would benefit from more frequent study and practice. Patient mix and patient acuity determines the degree of complication prediction which translates into increased BLS frequency; however, it is crucial to remind the dental team that medical emergencies happen at any time, at any place, to anyone; the issue is whether your staff is ready to respond.

The staff team will assist the team leader if and when a medical emergency occurs in your office. These events are unannounced and unforeseeable. Your role as the TEAM leader should be that you are fluent in MEP response and that your staff is similarly skilled in this area as every second counts in patient suffering and even death. Now is the time to get ready and stay ready.

Highlights

Over the period of two years, each member of the dental team should considering taking one or more courses on medical emergencies. The sum of the course(s) over the two-year period should cover **all** of the topics in the following three areas:

1. A review of normal physiology with an emphasis on the systems that play important roles during a medical emergency

- Peripheral Nervous System
- Cardiovascular System
- Respiratory System

2. The 6 "P's" of Preparation for a medical emergency

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1. **Prevention:** proper use of a medical history
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6. **Pharmaceuticals:** having the proper medication on hand

3. Recognition and response to the C.O.R.E. 16 (Critical Office Resuscitation Emergencies) common to dental offices

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11. Diabetes (Hypoglycemia)
12. Seizures
13. Sudden Cardiac Arrest (SCA)
14. Cerebrovascular Accident (Stroke)
15. Foreign Body Obstruction (FBO) with Airway Management
16. Local Anesthetic Toxicity

Please Note: Although not universally available, dentists should favor training for their staff that is participatory in nature with hands-on involvement.

Dentists should consider developing a mechanism to train newly hired staff to be competent and productive members of the entire team during a medical emergency.

Link 3: Mock Drills

Mock medical emergency drills are paramount for preparation. These should be performed on a monthly basis, with a set date and time to maintain consistency. Most importantly, the tone of the drill should be serious; otherwise, the likelihood is that the instruction will be undermined. Annual drills are not sufficient due to employee turnover and insufficient exposure to the material. The "once a year" mentality sets the staff up for failure instead of success.

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Consider this: if you had to perform CPR/BLS/PALS/ACLS right now, would you be able to? What are the correct steps, life-saving tips - what first and when? If you are honest with yourself, there is a great chance that you will confront more questions than answers. **Recertification should be taken every two years**; however, this minimum is far below optimal. AED use is a perfect example of this natural disparity: could you seamlessly operate this life-saving technology without pause?

The point is that training is a continual and repetitive process. This fact should be stressed in your offices. Mandatory attendance by all members should be expected and documented. Each member has a unique role in a medical emergency and should be expertly prepared to fill that need according to the office's individual medical emergency response plan. This includes total participant knowledge of the plan itself, the contents and uses of the emergency drug kit, as well as the location and operation of the AED. It is also plausible that a member, including the dentist, may be unavailable; therefore, each member should be able to substitute in other positions and the emergency plan should flow without hindrance.

Highlights

- **Mock drills of medical emergencies should occur monthly but no less than every other month.**

- **All of the following C.O.R.E. 16 (Critical Office Resuscitation Emergencies) common to dental offices should be covered within your mock drills:**
    1. Syncope
    2. Angina
    3. Myocardial Infarction
    4. Cardiac Arrest
    5. Hypertension
    6. Hypotension
    7. Asthma
    8. Anaphylaxis
    9. Hyperventilation
    10. Allergic Reactions
    11. Diabetes (Hypoglycemia)
    12. Seizures
    13. Sudden Cardiac Arrest (SCA)
    14. Cerebrovascular Accident (Stroke)
    15. Foreign Body Obstruction (FBO) with Airway Management
    16. Local Anesthetic Toxicity

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- **Mock drills should not be a mere lecture, but an opportunity for interaction of the staff with the dentist. Equipment used in a particular scenario should be demonstrated.**

- **The date, topic covered and list of attendees should be documented.**

  Please Note: Mock drills may be developed within the office or purchased from an outside vendor.

Physical Links

Link 4: Medical Emergency Plan
Link 5: Emergency Drug Kit
Link 6: Proper Equipment

Link 1: Medical Emergency Plan, Link 2: Emergency Drug Kit and **Link 3: Proper Equipment** are known as the Physical Links. The dental team will be accountable for authoring a medical emergency plan specific to their office as well as purchasing the appropriate equipment and necessary emergency medications for their reserves. Action is needed to achieve each of these three links individually. These actions should be taken seriously and in conjunction with the Educational Links. This creates one complete chain cycle known as the Six Links of Survival™.

The C.O.R.E. acronym, meaning Critical Office Resuscitation Emergencies, delineates the primary 16 medical emergencies. Another "CORE" exists to aid in the retention of the Physical Links; this CORE is referred to as Critical Operatory Response Equipment. It consists of the three facets of the Physical Links which a dentist and team will need to access; these are: 1) a written, visible medical emergency plan, 2) all emergency medications, and 3) all proper medical equipment.

The Medical Emergency Plan is the action blueprint; once designed, it should be built into the facility through continual development, maintenance, and practice. This document must be visible at all times and easily accessible for quick retrieval.

Seven foundational medications plus oxygen should be in all dental offices. For ease in remembering, the algorithm A – G, O is used. **Please note:** Oxygen, although technically a medication, is covered under equipment because of its heavy dependency on the related armamentarium.

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A = Aspirin (MI)

B = Bronchodilator (inhaler for use in asthma)

C = Coronary Artery Dilator (e.g. nitroglycerine)

D = Diphenhydramine (histamine blocking agent)

E = Epinephrine (cardiac arrest, analyphyaxis, some asthma)

F = Fainting (ammonia inhalants to stimulate CNS during syncope)

G = Glucose (hypoglycemia)

O = Oxygen

Compliance with the Physical Links is a task to be nurtured by the entire dental team in that medications and equipment need maintenance and monitoring to ensure proper functionality. Proper equipment working condition can only be assured by constant review, testing, and use in mock drills. Emergency medications can be maintained by monthly monitoring and a system of First-In, First-Out use and replacement. Expired medications are unacceptable and potentially dangerous if an emergency arises.

Advance anesthesia techniques demand the availability of more advanced emergency medications in addition to those previously listed.

Link 4: Written Medical Emergency Plan

A medical emergency plan or emergency response plan should be considered for every dental office. This is simple logic. This plan needs to be easily located and visible at all times where it can serve as reminder and guide to the team. The plan should have a Team Leader, the Dentist, as well as a backup who is capable of filling in if needed. Each member of the team will be assigned specific duties and this role should be second nature to the member, meaning that these duties, as indicated on the plan, should be understood thoroughly and without a doubt. Most importantly, each position should have a substitute should a team member be absent from the office. When a medical emergency occurs, the response should be well-organized, tightly controlled, and expertly executed with all members quickly and calmly alerted. This streamlined process includes an alarm system, paging system, lighting system, or some other means of immediately communicating the emergency to all team members to activate the planned response.

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The team leader is responsible for recognizing and initiating the decision to notify EMS. When the EMS order is given, one team member is in charge of making that call. There can be no confusion whether EMS has been contacted. Additionally, it is advisable to become familiar with EMS services in your area. Estimated time of arrival to your office in the event of an emergency should be identified prior to any actual occurrence. The average EMS response time for urban areas is 11 minutes and 15 minutes for rural areas. However, this wait can be longer if EMS is occupied or circumstances prevent expediency. Time is critical and therefore cannot be discounted. There is no embarrassment in calling EMS; a false alarm is better than a funeral. **If in doubt, call EMS out!**

Highlights

1. **Every dental office should consider having a written medical emergency response plan.**

2. **The plan should be kept in an easily accessed area in the clinical portion of the dental facility although multiple placement of the plan may be appropriate in some offices.**

3. **The plan should contain all of the following**

   - Specific task assignments for each member of the dental team, both full and part time. Attention needs to be paid to making sure all tasks are covered even with a reduced staff.

   - General instruction on calling emergency medical services (EMS), including the address and best point of entry into the office for EMS.

   - A general review of CPR guidelines, airway management, and patient positioning.

   - A list of the signs and symptoms and an algorithm outlining the appropriate response for each of the following C.O.R.E. 16 (Critical Office Resuscitation Emergencies) common to dental offices.

     1. Syncope
     2. Angina
     3. Myocardial Infarction
     4. Cardiac Arrest
     5. Hypertension
     6. Hypotension

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7. Asthma
8. Anaphylaxis
9. Hyperventilation
10. Allergic Reactions
11. Diabetes (Hypoglycemia)
12. Seizures
13. Sudden Cardiac Arrest (SCA)
14. Cerebrovascular Accident (Stroke)
15. Foreign Body Obstruction (FBO) with Airway Management
16. Local Anesthetic Toxicity

Please Note: Offices offering dental hygiene services under general supervision should consider having a set of supplemental algorithms for circumstances when the dentist is not on the premises.

The medical emergency response plan may be either made by the individual office or purchased from a vendor and supplemented with office-specific information.

Link 5: Emergency Drug Kit

The list of emergency medications varies in dental offices based on the nature of the dental practice, the medical health of the anticipated clientele and complexity of services offered. All members either administering or assisting with the administration of the drugs during an adverse event should have an in-depth understanding of the associated practical uses and complications of each specific drug. A designated person should be assigned the task of checking the inventory of medications to assure that none will expire before the next anticipated inspection. Inspections should occur at regular intervals (e.g. beginning and ending of daylight savings time). Finally, a system of First-In, First-Out use and replacement should be implemented.

Highlights

The following seven emergency medications should be known by name and function. They are the foundational medications that are required in **all** dental offices. **Multiple doses of each of these medications should be kept on hand at all times. Please Note:** Oxygen, although technically a medication, is covered under equipment because of its heavy dependency on the related armamentarium.

1. Aspirin

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2. Albuterol Inhaler
3. Nitroglycerin
4. Diphenhydramine
5. Epinephrine
6. Ammonia Inhalants
7. Glucose Tablets

An adequate number of the following syringes need to be available for the delivery of the medications via subcutaneous, intramuscular or sublingual techniques.

- 1cc / 25 GA X ⅝ in.
- 5cc / 22 GA X 1 in.

*Offices not routinely loading syringes are encouraged to purchase epinephrine and a pre-loaded device such as a Twin-jet or EpiPen.

Please Note: Some states do not permit EMS units to carry epinephrine. Epinephrine has a short half-life and may need to be re-administered. Consequently, the inventory of epinephrine may need to be increased based on the length of time it takes for EMS to respond and transport to a hospital emergency department.

Link 6: Proper Equipment

The following is a comprehensive list of the fundamental equipment necessary for MEP readiness in your office. Even if the entire team is expertly trained, these items are irreplaceable and highly important to your facility and patient's safety. Your staff should understand the purpose of each item as well as how to use or operate these efficiently and effectively. In many cases, this may take further training (i.e. AED) and frequency of use to gain a familiarity with the practical application of these life-saving machines and products. Mock drills and open forum discussions are ways to gain this mastery. Additionally, it is vital to perform routine maintenance and equipment checks often, tracking these dates, times, and surveyors to ensure that the equipment is kept in optimal operational capacity. Equipment updates, information, and education are also essential to maintaining a Six Links of Survival™ office. The proper training, the proper plan, and the proper equipment allow the proper people to provide patient safety - always.

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Comments on Raven Blanco Foundation Petition

DHP FEB 15 2012

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FEB 15 2012
Board of Dentistry

WILLIAM P. BUCK, D.M.D., P.C.
WILLIAM P. BUCK, JR., D.M.D., P.C.
HENRY E. MCKAY, III, D.D.S., P.C.
CHRISTOPHER M. ROTHMAN, D.D.S., LLC

ORAL AND MAXILLOFACIAL SURGERY

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FAX 933-1353

NORTH SHELBY COUNTY:
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BIRMINGHAM, ALABAMA 35242
991-8500
FAX 991-8597

(OFF VALLEYDALE ROAD ACROSS FROM JEFF STATE COLLEGE)

February 1, 2012

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

RE: Petition currently pending before the Virginia Board of Dentistry regarding medical emergency preparedness in dental offices

Dear Ms. Reen:

I am writing to support the efforts of the Raven Maria Blanco Foundation (RMBF) and Nicole Cunha in their petition to mandate a basic level of medical emergency preparedness for all Virginia dentists as a component of licensure renewal.

Based on my interactions and discussions with dentists, reviewing historical data, surveys and other data we have collected since co-founding the Institute of Medical Emergency Preparedness in 2003, I feel confident that the following statement accurately reflects the level of emergency preparedness of dental offices. It is my belief, the majority of dental offices are NOT prepared to adequately handle a medical crisis. Offices need to be able to rapidly recognize when a medical emergency occurs, initiate treatment and to be able to preserve life while waiting for emergency medical services (EMS) to arrive. You can find many quotes from noted experts and lectures in this field that concur with my view.

The petition submitted by RMBF asks that dental offices prepare in six major areas (The Six Links of Survival): (1) dentist training, (2) staff training, (3) mock emergency drills, (4) having an established medical emergency plan, (5) stocking the appropriate medications, with

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(OFF VALLEYDALE ROAD ACROSS FROM JEFF STATE COLLEGE)

knowledge how to use them, and (6) maintaining the necessary equipment to resuscitate a patient.

This petition is not cumbersome nor unreasonable, it conforms with the ADA Council on Scientific Affairs recommendations and should be the minimum standard accepted by the profession of dentistry. I urge you to lead the dental profession to improve the minimum level of emergency preparedness by starting in Virginia.

Respectfully,

Christopher M. Rothman, DDS

FEB 14 2012

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

RECEIVED
FEB 14 2012
Virginia Board of Dentistry

RE: Letter of Support

To – Virginia Board of Dentistry

To whom it may concern,

Please allow me to introduce myself. I am Alfred L. Heller, DDS MS, Director of the Midwest Implant Institute in Columbus, Ohio. We have been honored to train over 800 dentists, many who have obtained a temporary Ohio dental license, bringing patients to MII to do hands-on live implant surgery on their own patients.

I have been informed by Dr. Larry Sangrik, DDS; one of our former students, that Raven Maria Blanco Foundation, Inc has filed a petition with the Virginia Board of Dentistry. Dr. Sangrik feels that there is a need for support in medical emergency preparaedness in Virginia Dental offices. He is suggesting *The Six Links of Survival* as a resource tool for dentists to prepare their office for medical emergencies. Please consider this letter of support.

Sincerely,

Alfred L. Heller, DDS MS
Director Midwest Implant Institute

Cc: Nicole Cunha, Exe. Dir. Raven Maria Blanco Foundation
Dr. Larry Sangrik

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DHP FEB 14 2012

JOHN B. ROBERSON, D.M.D.

ORAL & MAXILLOFACIAL SURGERY

Diplomate, American Board of Oral & Maxillofacial Surgery
Diplomate, National Dental Board of Anesthesiology

February 7, 2012

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Virginia Board of Dentistry

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

RE: Medical Emergency Preparedness Petition

Dear Ms. Reen:

It gives me great pleasure to write you in regards of support toward the adoption of a medical emergency preparedness program for Virginia dentists, their staff members and their facilities.

I have lectured on the topic of medical emergency preparedness for over 10 years. Additionally, I co-founded the Institute of Medical Emergency Preparedness which is responsible for the development of the Emergency Response System or ERS. The ERS is the most comprehensive medical emergency readiness program ever developed for dentists and their staff with the foundation of this program being the Six Links of Survival. This program is being used by dentists all over the United States not to mention now being implemented in two major dental schools to ready their students for the unknown, unannounced medical emergency.

For a dentist to be truly prepared, the ***"Six Links of Survival"*** should be incorporated in their office. The six links are: (1) **Dentist Training**: adequate and current training for the dentist, (2) **Staff Training**: adequate

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ORAL & MAXILLOFACIAL SURGERY

Diplomate, American Board of Oral & Maxillofacial Surgery
Diplomate, National Dental Board of Anesthesiology

and current training for the entire staff, (3) **Medical Emergency Plan**: an emergency plan with specific duties for each member of the dental team, (4) **Emergency Drugs**: the essential emergency drugs for that office, (5) **Proper Equipment**: (AED, Oxygen, Blood Pressure monitor, etc.) and (6) **Mock Drills**: practicing emergency drills on a regular basis. Like a chain, any breakdown and subsequent failure of the Six Links will occur at the weakest link therefore reducing patient survivability during a medical emergency.

It is without any reservation that I support this petition for the development of a medical emergency preparedness program that will benefit the state of Virginia.

Kindest personal regards,

John B. Roberson, DMD

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Virginia Board of Dentistry

Cc: Nicole Cunha, Raven Mario Blanco Foundation

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Board of Dentistry

LARRY J. SANGRIK, D.D.S.
GENERAL DENTISTRY FOR CHILDREN & ADULTS
COMPASSIONATE CARE FOR FEARFUL PATIENTS
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FEB 0 3 2012
DHP

February 1, 2012

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

RE: Petition currently pending before the Virginia Board of Dentistry regarding medical emergency preparedness in dental offices

Dear Ms. Reen:

I am writing to support the efforts of the Raven Maria Blanco Foundation (RMBF) and Nicole Cunha in their petition to mandate a basic level of medical emergency preparedness for all Virginia dentists as a component of licensure renewal.

Since 1999 I have lectured to thousands of dentists and their staffs on the topic of medical emergency preparedness. I have provided multiple workshops on the topic at ADA Annual Sessions. Additionally, I have presented programs at the Hinman Meeting, the Chicago Midwinter Meeting, the Yankee Dental Congress, the Rocky Mountain Dental Convention as well as many regional, state and local dental society meetings. My medical emergency preparedness program has been presented at three dental schools.

Having lectured nationally, it is my opinion that most dental offices are poorly prepared to address a medical emergency occurring during dental care. While dental office deaths are often related to systemic anesthesia complications, fatalities are believed to be only the "tip of the iceberg" as it related to medical emergencies.

As the petition points out, in addition to the known 12 deaths that have occurred nationally, it is reasonable to expect that non-fatal medical emergencies are on the rise. This can be attributed to an aging population, patients presenting for treatment with increasingly complicated medical histories and increasingly complex dental treatment.

VILLAGE STATION 401 SOUTH STREET, SUITE 3B1 CHARDON, OHIO 44024 TELEPHONE (440) 286-7138

Sadly, despite increasing risk factors for emergencies, the dental profession has not invested in academic research to determine the extent or type of emergencies occurring.

The RMBF petition asks that dental offices prepare in six major areas: (1) dentist training, (2) staff training, (3) mock drills, (4) having an established emergency plan, (5) stocking the appropriate medications, and (6) maintaining the necessary equipment.

I am writing to state that these expectations are both *necessary* and *reasonable*.

Necessity

(1) Currently, Virginia requires dental offices have no medical emergency preparations beyond basic CPR. It is important for the board to differentiate between anesthesia training and medical emergency training. While anesthesia complications have resulted in two recent Virginia deaths (Raven Blanco and Jacobi Hill) and therefore generate the most media coverage, anesthesia complications represent only a small fraction of the total number of medical emergencies believed to be occurring in dental offices.

(2) While I believe most dentists are ethical and desire to provide safe treatment environment; doing so is not easy. The official 2002 guidelines of the American Dental Association are hopelessly outdated and no known effort is under way to update them.

For example, the current ADA guidelines do not contain a recommendation for dental offices to maintain supplemental oxygen for breathing patients. *(The only currently recommendation is to have oxygen available for a non-breathing patient.)* In reality, all medical emergencies *(with the exception of hyperventilation)* benefit from early oxygen intervention while the patient is still breathing in the event the medical problem worsens.

Based on speaking nationally to dentists, my personal experience is that over 90% of the routine dental offices do not have the necessary equipment to provide supplemental oxygen to breathing patients. *("Routine" dental offices are defined as general practitioners or specialists that use only local anesthetic and/or nitrous oxide.)*

Reasonableness

Some may attempt to argue that maintaining standards in the six areas requested in the petition is an unreasonable burden on a typical dentist. This is untrue.

Assuming a dental office (1) *has absolutely none* of the preparations recommended and (2) wishes to purchase everything, *the total cost for everything, including training*, would be under $2750. Multi-doctor offices would have a much lower "per dentist" cost since equipment would be shared. Costs could also be reduced by doctors providing some of their own preparations *(e.g. writing their own emergency plan and/or developing their own mock drills)*. However, commercial vendors exist to provide products and services in all six areas, including mock drills.

The cost of $2750 is based on the following products that I found currently marketed and easily available to dentists:

Doctor & Staff Training	CE (online) for 1 dentist & 5 staff	<$ 150
Mock drills	12 sessions	<$ 150
Medical emergency plan	Professionally prepared & purchase	<$ 350
Medications	Purchased individually	<$ 100
Equipment	Including AED, all O_2 equipment, glucose meter & 3 sizes of BP cuffs	<$2000
Total:		**<$2750**

Conclusion

Sadly, with two deaths in less than 5 years, Virginia is believed to lead the nation on a per capita number of deaths during dental care during that time.

I urge your dental board to take steps to protect the citizen's of your commonwealth and develop standards in the areas requested in the petition.

Sincerely,

Larry J. Sangrik, D.D.S.

cc: Raven Maria Blanco Foundation, Inc.

VIA CERTIFIED MAIL: 7002 0510 0001 4092 0205

Comments from the Virginia Regulatory Townhall

Petition for rulemaking – Board of Dentistry

Commenter: E. Thomas Elstner, Jr. D.M.D. *

Training for medical emergencies

There should be provisions for practitioners who do not administer local anesthetics in their office setting. Currently there is no ACLS focusing on the dental setting.

2/9/12 4:39 pm

Commenter: Rebecca Angus, DDS *

I am in support of this petition.

I am in support of this petition.

2/9/12 7:21 pm

Commenter: Stan Dameron *

Dentists handling of medical emergencies

I am opposed to this new regulation.while it is very unfortunate these 2 deaths occurred,I do not believe they are necessary nor would they change future unfortunate deaths. Every dentist I know already is prepared to handle these situations. I believe it is already the standard of care to be trained and equipped to handle these emergencies in a limited way until EMS is onsite. Even one death is too much, but I don't.think a regulation will prevent future deaths. To have two deaths in what has to be millions of office visits shows it is less likely for someone to die in a dental office than many ordinary daily activities.

2/9/12 9:35 pm

Commenter: Paul W Callahan DDS *

Another costly regulation that does nothing to help public welfare

It is the responsibility of ALL Virginia Regulatory Boards to protect the public. Any death is is one too many, but statistically it is probably safer to go to the dentist that cross the street. These proposed regulations are already the Standard of Care in most offices. A regulation such as this would cost hundreds of thusands of dollars for most practicioners to follow; meaning the time spent documenting training, paying for training for a large staff when not everyone needs to be trained at the same level, etc. So who pays for all this unnecessary documentation and training? The average Virginia resident in the form of increased dental fees. Is this what we want for our patients?

2/10/12 10:40 am

Commenter: Elaine Sours, DDS *

Oppose renewal of license linked to new requirements

I would oppose action by the Virginia Board of Dentistry to adopt the Petition for Rule-making with conditions to seek renewal of a dental license. It is government interference and micro-management to demand blanket compliance. Dentist are caring and compassionate health care providers who already overwhelmingly meet the emergency needs of our patients without a Board mandate.

2/11/12 9:07 am

Commenter: Erika C Mason DDS *

I oppose mandatory training and equipment for the dental practitioner

I think that we as dentist are already prepared and trained to handle emregencies in our dental practices and this is just another goverment hoop that we will have to jump through at the expense of our patients. Although it is unfortunate that there were 2 deaths, the percentage of dental procedures daily in thousands of offices prove that we already have a handle on the protocol of handling emergencies in the dental offices. There is already the law in place for those that do sedation to have certification via the DOCS program so I think that is more than adequate to take care of our patients in the case of a medical emergency. Maybe let's focus on better health histories, refusing to do a procedure if blood pressures are at a certain level, and be more proactivce but not reactive in more training. We are already trained. Maybe the Board of dentistry should supply us with a "standard medical history" that makes sure it asks all the right questions, or a standard medical history update each time the patient comes in. Since we all use our own Medical History forms and updates...maybe that is where the focus needs to be to help us screen better for possible medical emergencies.But you always have the situation that the patient might not supply us with the Complete Truth---so that they CAN be treated and we aren't fully informed of possible medical conditions. I think this is a knee jerk reaction and needs to be weighed out more heavily of "mandated training and equipment" might not be the Best answer !

2/11/12 11:32 am

Commenter: Barry D. Laurent DDS *

A noble premise but the devil is in the details. Oppose!

I googled the "Six Links Guide" and my heart goes out to the Blanco family for their tragic loss; however I mirror Paul Callahan's sentiments. How will the board enforce compliance? Who will perform the inspections to police the requirements and what about the need for a search warrant? Who will pay for the enforcement and what are the consequences should one fail to abide by all the requirements? For example, if a dentist must have a commercially available crycothyrotomy kit (or stated alternative); is he or she then required to use it in an emergency and what happens when our frantic effort causes more harm before EMS arrives? Most of us are caring professionals, and the "Six Links" provides a noble blueprint for us all; but it should remain a voluntary one.

2/12/12 7:39 am

Commenter: Art Halstead *

Strongly Disapprove

Has there been any study to indicate that such a new, broad training requirement for dentists/staffs would have saved the lives of those people that died? There are plenty of solutions out there in search of a home as we've experienced from the dental supply industry. The true costs in time and dollars and the benefits of a bureaucratic approach do not seem to be a wise investment to me. The buying -in by the leaders of the dental profession, without exposing the strategic costs, is unwise in today's litigious society with a political leadership that is actually looking for ways to cut costs. I see this as just another step down the road to making the dental operatory into a surgical suite in the face of a favorable cost/benefit analysis that is not there. There is an ongoing regulation of the solo practitioner out of the profession, for no good moral reasons other than the pursuit of a political power game that having dentists on a Regulatory Board is intended to avoid, thereby protecting all concerned in a strategic sense.

Recommendation: The Board to table this request without action unless it can disapprove it outright, with a solid cost/benefit analysis that exposes the strategic negatives to the proposal, if that analysis would be required due to the political nature/tailwinds of this proposition. I am even reluctant to outlay dollars for such a study to start down this path. My only real concern here is how much effort will be needed to head off this "progressive" movement in the face of all the realities "on the ground"?

I am uncomfortable with givng this sort of proposal any support so that other future Boards might leverage even any minimal support now into a larger movement in the future. The dental societies and the medical insurance industry, on their own, are probably the best proving grounds to provide the current, appropriate level of training without a heavy-handed regulatory approach.

Thank you for allowing this consideration in this forum and for the important and difficult work you do in your advisory efforts to be an honest broker between the public and the dental profession.

2/12/12 2:27 pm

Commenter: William Dougherty III *

oppose- all denists are currently trained in CPR

I oppose the extra regulation. All dentists are already certified in CPR. Regular re-certification is also already mandated.

2/12/12 5:43 pm

Commenter: Watchdog for Coalitions Against The Dental Profession (CADP) *

Be Cautious! Don't be Fooled, Don't play into the empathy game!

This Raven Blanco Foundation may be a plublicity stunt to raise funds, that support their self created non profit slary jobs. Everything about their web site is very exploitive. They list no financial discloures, no board of directors/advisors. They are certainly following the guide for creating an issue that will bring them money and influence, and as they say power. And like all these nonprofits, they appeal to ones suffering to gain support. They can be dangerous, just like all of our local dental nonprofits, run by non dentist, unlisenced advocates if you will, who want to be policy makers over dental matters of which they are trully ignorant. I would question the credibility and intentions of this group. Leave the emotional baggage out of any descision making. Dont treat victims as equals, they are not!

2/12/12 9:40 pm

Commenter: Flavio W.Nasr, DDS *

Against Over-regulation

I oppose this proposal for several reasons. First, all dentists are trained in CPR. Second, these rules will **not** prevent additional deaths. Third, adequate training should be spent in screening patients properly (eventhough patients constantly omit information in their medical histories). Please do not over-regulate. Let common sense prevail. Thank you.

2/13/12 11:59 am

Commenter: Fred N. Kessler, DDS *

Dentists already know how to respond: Use our CPR Training, have an emergency kit, and call 911!

This petition has no basis in reality. As dentists, we all know how to respond as indicated in my Subject Line.

2/13/12 2:33 pm

Commenter: Albert Sasala *

Patients already feel dentistry is too expensive; Do we really want to add to the expense?

If you pass this regulation, it is not only going to cause a large financial burden onto us (the practitioner), but also the patients that we see. We will have no choice but to increase our fees to accommodate these changes. Aren't the insurance companies already making things bad enough? Does our own legislature also have to contribute to the publics financial burdens? Don't let a couple of very unfortunate events cloud your judgement. How long have Dentists been practicing dentistry and how many deaths have occurred in all those years? You must look at the bigger picture and not at the smaller one just because you feel pressured by media or whom ever. Do the right thing and rescind this nonsense.

2/13/12 6:50 pm

Commenter: Jon Piche, DDS *

Oppose

Adding additional regulations will increase the cost of dentistry. More importantly, what is the need for additional regulations based on. Where is the data that demonstrates the need for additional regulation and additional training (well actually proof of training since dentists are trained to handle emergencies)!

2/13/12 9:27 pm

Commenter: Lanny R. Levenson, DDS *

Against Six Links petition

It's my feeling that the "Six Links of Survival as a condition of continuing licensure" would be an unnecessary burden to place on a dental practice. We take courses in dental emergencies and emergencies in a dental practice. Dentists are required to have BLS (CPR) training and some opt for ACLS. I have been a strong believer and was using gloves & masks, autoclavable handpieces, water line treatment, and AED's before being required by law.

Please consider the cost benefit before developing regulations in a situation where the system is working.

2/14/12 2:56 pm

Commenter: Brian Hoard *

Six Links petition

I am not automatically opposed to a standard, but

1) Who is proposing this petition for rulemaking? Is it a special interest group, as in a group of malpractice attorneys or some organization that "sells" CE or inspection services to offices that want to register compliance? I would like the Board of Dentistry to respond to petitions from dentists, not special interest groups, and respond to petitions because they are a good idea, not because special interest groups have their own agendas,. Recent example: Sedation permit. Who originally pushed for that? I believe it was a malpractice attorney who stated, in the petition, that "most conscious sedation leads to deep sedation"--I have read no data to support this, and I contacted him and asked him to provide me with such data--he could not respond. And, here we are, a couple years later, in the process of requiring a sedation permit for conscious sedation/deep sedation. I'm not against a permit, but the proposal is worded as though the Board bought into his flawed philosophy that conscious sedation and deep sedation are paired together. If anything, conscious sedation is closer to anxiolysis, whereas deep sedation is closer to GA (Don't take my word for it, look at the definitions established by the American Association of Anesthesiologists And, believe it or not, I'm actually in favor of a permit...I just don't like the though processes involved in developing one).

2) If you do this, then I think the BOD has to make sure that systems are in place in the state of Virginia, easily accessible and relatively inexpensive, to allow dentists to be in compliance. You can't just make a rule and not have the the resources readily available to practicioners to support it. (I have the same comment with respect to the sedation permit).

3) If it's a permit process, is this yet another permit fee for the dentists of Virginia? (Same question with respect to sedation permit...)

4) Who will do the inspections? GPs? Oral Surgeons? EMS personnel? (Same question about the sedation permit. We are supposed to be applying for those permits now, without any indication as to what they will require, who is establishing the requirements, and how the "certification" will take place).

2/14/12 5:48 pm

Commenter: R.S. Mayberry DDS *

Petition for New Regulations

I am opposed to any more uneccesary regulation, this six steps program is just the latest attempt by someone outside of the profession who has an agenda they are attempting to impose. Currently there is a system in place that will handle any potential shortcomings that unfortunately befall people whether in the dental office or the shopping mall. In this day and age of government interference into the lives of citizens it is time for the profession to realize that we cannot prevent every malady that befalls the public. Life is full of potential disaster, such mishaps happen, and in many cases due to some individuals lack of personal responsibility to prevent their own mishaps. Obviously this is not the situation in every case, but the exceptions to this lack of personal responsibility are so few and far between that the undue regulation of all for the sake of the few if not tyranny is close to it. The times are a changing and the trend is away from such folly not towards more of what has placed us in the dire situation that we all face today. Enough government, we've had enough!

R. S. Mayberry DDS

2/15/12 2:30 pm

Commenter: Ron Vranas, DDS *

Oppose

I am opposed to the additional regulations. Dentists are already trained to manage emergency situations and, if they are using sedation dentistry, are required to obtain regular recertification to keep emergency management skills current. Thousands of sedation cases are performed every day to a successful outcome. Additionally, whether we are using sedation dentistry or not, emergency situations arise in dentistry and are managed to a successful outcome due to our current standard of emergency care. While it is devastating to lose someone in any situation, adding regulations to an already sufficient training protocol will not eliminate these rare events.

2/15/12 4:05 pm

Commenter: Pamela Bonesteel *

How many more children must die?

How many more children must needlessly die before dentists are held accountable? 8 Children in the past year have died while undergoing "routine" dental procedures. IF dentsits were required to have the training and equipment in their offices, perhaps a life could be saved.

Commenter: Katy Sargent *

Strongly Support the 6 links petition

I absolutely believe that each and every dental practice need to institute the six links of dental emergency preparedness, before liscences can be renewed. I don't understand why professionals would be opposed to keeping their practices prepared and as safe as possible. We wouldn't be encountering so many emergencies and tradgedies, if offices were properly equiped and prepared to handle such situations. You can never be too prepared in my opinion!

2/15/12 5:44 pm

Commenter: Maria Blanco *

get the word out !!!

Please ... please.. please ... something has to be done. These poor families have to suffer needlessly. Medical professionals must be required to have emergency training and be required to be updated for new proceedures that are being updated as we speak... Traning is key to our childrens well being.... something must be done!!!!

2/15/12 6:42 pm

Commenter: Melissa Burell *

100% FOR THIS IN ALL STATES!

Strongly WANT, seems the only dont wants are DDS. Well Im sorry this will be an inconvinience to you but, Im tired of watching children die and get seriously hurt where simple steps could have been taken to prevent it.. Do it for the children if nothing else!

2/15/12 7:27 pm

Commenter: Seth-Deborah Roth *

Dental Safety

I am a Nurse Anesthetist and used to give anesthesia in dental offices. I am amazed at the lack of safety that is allowed in dental offices nowadays. There MUST be a person in 100% attendence during anesthesia to the patient. The staff must be trained in advanced CPR. You cannot assist the dentist and watch the patient at the same time. This would never be accepted at a training institute and should never be accepted in private practice. It is pure greed that the dentists charge for anesthesia and no longer employ someone who is qualified to give the anesthesia and monitor the patient 100% of the time. At any moment, a patient can have an unexpected reaction or a wisdom tooth removal can turn bloody or a tooth pop into a sinus or any unexpected complication. If it was you or your child or family member that was in danger ....you would want 100% safety precautions!!

2/15/12 7:51 pm

Commenter: Jamie S. *

YES

I understand the concerns reguarding the increased time and money involved with implimenting this. I have to wonder though if you lost a loved one because a dentist you trusted to care for you child was only able to perform basic CPR wich is the same care that would be expected at a daycare center, would you feel the same?

Don't get me wrong, I think basic CPR is great and everyone should learn it. I also think AED's should be in every school, daycare, mall etc. BUT the idea that a dentist could administer a sedative that could cause respiratory compromise and in turn cardiac arrest, could not be prepared to provide Advance Cardiac Life Support in addition to CPR is frightening! Every minute that passes during cardiac arrest, the patient's chance of survival decreases significantly. Statistics on this are a dime a dozen. Unless you have an ambulance waiting in the parking, it is very rare that one will arrive in less than 6 minutes and often much longer. That is until they pull up to the front door. You also have to consider the time it takes to unload equipment, locate and assess the patient and then start ACLS IF there is a Paramedic on the ambulance. Not all EMS agencies are ALS, there are many that can only provide Basic Life Support. So why would you as dentists not want to be equipped to begin the life saving ACLS protocols as soon as possible to provide your patients with the best possible chance of survival? Because of cost? time? money? the belief that it won't happen to one of your patients? Exactly how many deaths have to occur before the inconveniences are justifiable?

A few years ago my son had a dental procedure that required sedation. I wasn't a Paramedic at the time so I wasn't aware of the possible complicationa and I certainly wasn't equipped to ask the appropriate questions to ensure the staff was prepared in the case of an emergency. I was ignorantly blissfull. I was very fortunate. His procedure went as planned with no complications. Many other parents have not been as lucky. I keep seeing "two deaths" this is proof that I'm not the only one that has had the pleasure of ignorant bliss. There have been many more than that. Is there an agency that accuratly tracks all deaths related to dental procedures nation wide? I haven't been able to find one.

I don't work for this foundation, I'm not a family member or long time friend. I just recently met them but I can tell you this is in no way financially driven. This is driven by a father that misses his daughter every second of every day. A family that has decided to face their grief day in a day out rather than try to move on so other families don't have to suffer the way they have. Their courageous efforts should be celebrated.

2/15/12 9:44 pm

Commenter: More 2 Give Inc *

What if your child died due to lack of Medical Emergency Preparedness?

I strongly agree that the state of Virginia should make it mandatory for Dentist to take a Medical Emergency Preparedness CE Course to renew their license. It's important to know that your kids as well as yourself are in great hands in case of an emergency. Would you want someone you don't know, care for your kids without the proper CPR training? This is the same thing and we can control how many times kids loose their life during a simple dentist procedure by making this mandatory,

2/15/12 11:17 pm

Commenter: Lorraine Perez *

No Question About This...Approval is Necessary

Saying no to this petition is like saying no to the lives of children. We can not stand by and allow dentist office to continue to not do what is necessary or more than enough to be prepared. The safety of our children is top priority. I ask....no...I plead that you pass this petition. Our children...your children...your grandchildren and all children will thank you for it.

2/15/12 11:56 pm

Commenter: Jelisa Joseph *

This is necessary to enjoy the safety of everyone!

A few precautions can save someone's life. Make it his necessary!

2/16/12 6:25 am

Commenter: Karon P. Hardy *

Emergency Training for Dentists

YES

2/16/12 9:26 am

Commenter: H Elder *

Support preparedness

I support proper training for Dentists in order to have conscious sedation. I've been in a dentist office on more than one occasion while they try to awaken a child who is not waking up properly after a "routine" procedure. Why would anyone oppose having the means to revive a CHILD in that situation?

2/16/12 1:37 pm

Commenter: hope mechelle herrington *

dental preparedness

raven maria blanco was my niece. she was only 8 years old when she went to the dentists for routine work and didnt come home. they didnt even have a defibulator in the office. i support this cause and dont understand why any dentist would not. obviously they have not lost a child this way. i should think they would want to do all that they can to educate themselves and be prepared. so what if at takes up your time and a little money. i would rather know that i did all that i could and took every class available to me and my staff than have to live with a child dying under my care and wandering if i had done enough.for those who say the organization is trying to profit, shame on you.my sister and brother in law suffer everyday with this loss 4 years later and always will. DO THE RIGHT THINGype over this text and enter your comments here. You are limited to approximately 3000 words.

2/16/12 1:48 pm

Commenter: Ronald Mamrick *

more government regulation?

I am against any type of legislation like this. I was reading something last night from Kellogg, the guy who is supporting the mid-level providers. To support his case for mid-levels providers he talks about the increasing costs of dental care. He says that the cost of dental care is increasing faster than the rate of inflation. This medical training will require time away from our practices and financial resources. These fees will then be passed onto the dental patient in terms of higher fees than what we are already charging. Is this what we really want? Are Kellogg's stats wrong?

I go once a month to an infusion center where chemotherapy is administered. On numerous occasions over the past four years I have witnessed medical emergency with the administration of chemotherapy. In every instance I am amazed at the staff and their response to the emergencies. Does this take training and practice? Of course it does. Are we administering drugs that frequently require a response like this? I don't think so. I would have to say that most dentists go their entire careers and never have a medical emergency like what I see in the infusion center. I thank God for that. I say all this to say, that medical emergencies are rare in the dentist office. I am not against being prepared for medical emergencies in the dental office but I am against mandating that dentists be required to go to this extreme of medical emergency preparedness. CPR training has been good enough for all these years. ACLS training is already required for those doing sedation. This seems like an additional step to ACLS training.

Thank you for the opportunity to express my opinion.

2/16/12 5:06 pm

Commenter: Maria Cohen *

maria.estrella.cohen@gmail.com

I STRONGLY agreel stronley agree that dental practices should require training and equipment for medical emergencies for licensure and renewal. There is no such thing as TOO much training, why not take the oppurtunity to gain more knoweledge, if an emergency were to occur in your presenece wouldnt you feel better knowing you could help? Calling 911 isnt the proper soulution, neither is CPR. Will emergencys still occur? Yes, but at least they will be handeled in the right manor. I would feel much more secure knowing that the dentist I brought my child to has the proper equipment to handle andy emergency, I do wish this would go further then just dental offices... teachers should be prepared, recepitonests, etc. Help save lives ! PASS THE PETITION! SHARE!

2/16/12 5:25 pm

Commenter: Robert D Argentieri,DDS *

Emergency preparedness and licensure renewal

The proposal stated that Virginia had two deaths in dental offices or institutions in ten years. Is this a lot? Were the deaths related to dental treatment being rendered at the time? Is this incidence rate statistically significant? Would the deaths been avoided if there was a state mandated level of Emergency training in place(since one death took place in the dental school,it can be assumed that at least some of the faculty were trained in advanced cardiac life support, and yet even that level of training,the death was not prevented)? My understanding is that CPR certification including use of an AED, is a current requirement for licensure. The content of criteria for this is standardized and well known. What would be, and who would set, the criteria for training, certification and monitoring of proficiency? If the Board, where would the budget for this additional responsibility come from? While I agree that all practicing dentist should be prepared to deal with a medical emergency arising in their office, the effect of requiring evidence of such training places a huge expense on both the dentist and the monitor(presumably the Board) without actually guaranteeing preparedness in a particular case. I would encourage all my colleagues to take a medical emergencies course if the have not recently done so, and to have staff training in dealing with an emergency, but i think adding an additional requirement for licensure is regulatory overkill. It will increase paperwork and expense without achieving the goal it seeks to attain

2/16/12 5:34 pm

Commenter: Christie Nicholas *

Educate to Save a Life

A parent taking their child in for a dental check up should not have to worry about whether or not their child will make it out alive.

2/16/12 5:42 pm

Commenter: Nicole Cunha *

Six Facts to Support the Six Links & Medical Emergency Preparedness and a Response to CADP

FACT 1: Most medical emergencies occurring in dental offices are neither life-threatening nor cardiac in origin (Malamed, USC). To argue that CPR is all that is required is naïve and statistically wrong.

FACT 2: Calling 911 is NOT an emergency plan. Nationally, the AVERAGE response time for EMS is 11-15 minutes. Dental offices should be able to manage ANY medical emergency (diabetic shock, seizure, MI) for at least 30 minutes without outside assistance.

FACT 3: Currently, the American Dental Association has no standardized guidelines for medical emergency preparedness by dentists. If dentists do not have standards for medical emergencies, only the Board of Dentistry remains to protect the interests of the public.

Fact 4: Curiously, many offices have oxygen for ONLY non-breathing patients. Apparently, many dentists believe that when a patient is struggling for oxygen, the best strategy is to let them stop breathing before helping them.

FACT 5: Not all medical emergencies are complications of sedation/GA. Sharon Freudenberger, Associate Professor at CWRU Dental School was working on her son's tooth when a piece of gauze slipped into his throat. Fortunately, she was prepared and her son is still alive. Unfortunately, a child in NJ died last week while receiving local anesthesia in an office that was already on probation for a previous death. Additionally, Dr. Yagiela, noted author and lecturer, stated that there has been a death in every state from local anesthesia.

FACT 6: Dental leaders in medical emergency management know medical emergencies routinely happen and have concerns about the profession's state of readiness. Malamed has described the current state of affairs as, "Poor" and went on to state, "Office preparation is essential…" Haas said, "The successful management of a medical emergency is one of the great challenges in dentistry." Rosenberg said, "Every dentist will likely manage a medical emergency during the course of their practice."

In response to, **Watchdog for Coalitions Against The Dental Profession (CADP), which I couldn't find any public information on at all...**

- I am the Executive Director, working as a non-salary employee.
- Our combined staff salaries do not exceed $40,000 annually.
- Mario Blanco, the founder of RMBF, provides 95% of all operating capital.
- Since RMBF's inception we have had a board of advisors. There is now a direct link to their page on our website.
- Our 501 (c) 3 2011 financials will be made available to the public once completed.

2/16/12 5:47 pm

Commenter: Sarah Selbe *

Six More Facts to Support the Six Links & Medical Emergency Preparedness

FACT 1: With an aging population (some with complex medical histories) being offered increasingly complex and invasive dental procedures, it is reasonable to believe medical problems occurring during dental appointments are increasing in frequency. However, no academic research has been conducted by any US dental school for over 15 years. In the absence of evidence to the contrary and with a reasonable expectation that non-lethal emergencies are increasing, dental offices should be prepared for any unexpected circumstance.

FACT 2: RMBF provided an 8-hour CERP-approved CE program on MEP last year. The Virginia Dental Association endorsed and advertised the event. Tuition was deliberately low. Less than 12 dentists attended. It is difficult to argue

that Virginia dentists are self-motivated to prepare themselves for medical emergencies.

FACT 3: Implementing the recommendations of the petition would not be a financial burden on Virginia dentists. Assuming a dental office had no current preparations for an emergency AND they were willing to do any of the work themselves (eg preparing an emergency manual), products for everything else cost less than $2,750.

FACT 4: The petition does NOT call for mandatory office inspections nor does it require any expense on the part of the commonwealth. Dentists would merely attest on an affidavit that they have complied with the requirements as part of license renewal. Of course, to provide false information to the board would carry heavy sanctions.

FACT 5: As expected, some rank-and-file Virginia dentists oppose the petition. However, no dental educator or nationally-known lecturer has publicly opposed the petition or any of the concepts contained in it.

FACT 6: If the Virginia dentists can protect the public without direct oversight from the dental board, it is their burden of proof to demonstrate that such means already exist.

2/16/12 6:23 pm

Commenter: Lauren Marie Gonzalez *

Healthcare professionals

Recertification yearly for BLS with AED training is necessary for ALL healthcare professionals since Lay persons shoud not be using this equipment unless properly trained, and although it may be required for licensure for dental professionals, what use is it if there is currently not an AED on site. An AED on site for patient safety will NOT increase the cost of dental care, and I am shocked to hear this from healthcare professionals. As healthcare professionals we take an oath to provide safe patient care, no where in that oath does it say that we will provide it as long as it fits into our budget! That is compromising patient care, and in the end it is patients and families who suffer in the long run over the cost of a dollar. Policy and procedure for sedation and anesthesia administration needs to be regulated at a level where there is continutity of practice and procedure, and it does not differ from office to office!

2/16/12 8:47 pm

Commenter: David E Black,DDS *

Oppose duplicate regulation

All dentists in our state are required to have CPR training. The board has just recently reviewed all the safety regulations in response to the increase in sedation dentistry. We do not need duplicate regulations for dentists that do not sedate patients. The foundation seeking these changes have weak evidence to support the need for these changes that would place a time and expense burden on dentists that are a very low risk population. Do they have any evidence of death resulting from local anesthesia only? Please do not agree to a regulation change that we do not need.

Commenter: Michael J. Link, D.D.S. *

Duplicative regulations into what All Dentists must do!

Currently the Board of Dentistry already has regulations in place to protect the public. All Dentists must be certified in basic life support. If you do sedation, then you are required to have ACLS. The regulations are currently the strictest in the Country. The Dentists that do sedation should be and are well trained. I do not support the need to add more regulations; they are already in place.

2/16/12 9:43 pm

Commenter: Mark Crabtree *

Proposed Regulation is not necessary

This proposed regulation is not needed. The Board of Dentistry has sufficient regulations in place to protect the public. Thus, the proposed changes in the regulations are not necessary and would be a burden to dentists and patients seeking dental care in the Commonwealth of Virginia who will be burdened with increased costs of dental care. I opposed this Petitiion for rule making.

2/16/12 10:10 pm

Commenter: Richard F. Roadcap, DDS *

This proposal is unnecessary

The petitioners' proposal is unncessary and burdensome. Let me share my thoughts:

First, the Board of Dentistry recently approved new regulations for dentists who provide conscious sedation, making Virginia's requirements among the most restrictive in the US.

Second, a large majority of dentists who practice in Virginia use only local anesthesia in their practice, and there have been no reports of deaths due to local anesthesia in the dental office.

Third, all dentists are now required to be trained in CPR as a condition of their license. Adding this burdensome requirement will have the unintended consequence of suspension or loss of license for many competent doctors, if they fail to meet the bureaucratic standard.

I would urge the Board of Dentistry to reject the petitioners' proposal.

2/17/12 12:13 am

Commenter: Lorraine Perez *

With current so called regulations...deaths are still occuring.

For those who are opposing the new regulations...mostly D.D.S personel I might add...if what you say was true and dentists are sufficiently trained in C.P.R. then why would these deaths still occur. It is obvious that in the reform of current health care regulations there is a need for dental regulations as well. The Dental Community has failed to address the continuous problems sufficiently and because of this organizations such as RMBF have had no choice but to step up and advocate for the families and friends of the deceased. Those who accuse RMBF of less than noble intentions are those who do not want to be bothered with the extra effort to ensure the safety of their patients. It is a crying shame. I would be willing to pay more than double in dental costs so long as the safety of my child was ensured and I am confident that most families would feel the same.

The individual who claimed there have been "only 2 deaths" in the last year seems to not understand that 2 deaths is far too many and is not considering the fact that the 2 occured within the last 2 months. The actual number of the previous year is more than a dozen. Do we honestly need more than that to see there is a legitimate problem. Is costs and inconvenience really all there is to fight against?

I not only require but expect those who care of my children and the children of others to do what is necessary and then some. For all those who oppose this regulation on the basis of costs and inconvenience...shame on you!

2/17/12 7:22 am

Commenter: William Griffin *

Oppose This Regulation

Dentists are already trained in this area, and to further add to the existing requirements would be superfluous and costly, both with respect to time and money. The fact that occasionally medical emergencies occur is not reason enough to increase the burden on practitioners. We need to get over this mentality that regulations can prevent every possible negative outcome... "if only..."

2/17/12 9:20 am

Commenter: Paul K. Hartmann *

Good intentions with unintended consequences

Please, please reconsider if you are thinking of passing these regulations. I am an Oral and Maxillofacial Surgeon and I am getting recertified in ACLS this weekend for the fifteenth time. Safety and emergency preparedness are already a part of our practice. We do not need these onerous and redundant regulations added on top of what all of us already practice. Please...no mas!

2/17/12 9:41 am

Commenter: Gregory K. Kontopanos, D.D.S. *

opposed to six links petition

I am opposed to the six links petition.I believe the current requirements for basic life support (CPR and emergency medical training) and ACLS training for those choosing to perform sedation in the dental office setting are sufficient for the protection of our patients.I feel this petitions' outcome would be a duplication of what is already in place.

2/17/12 9:44 am

Commenter: Ron Downey, DDS *

six links petition

No need for these rules. Dentists are already well trained for medical emergencies.

2/17/12 10:04 am

Commenter: Frank Iuorno *

Six Links May Not be the Answer

After looking over the six links of survival I can see at first blush that it would seem appropriate for dental offices to implement such a system. The fact is that, many offices have already done so informally. Any office providing sedation will have these systems in place and staff training is expected and verified. These are the patients most at risk.

2/17/12 11:11 am

Commenter: John Denison, DDS *

Opposed to the Six Links Proposal

I am opposed to the proposal to increase emergency medical training of dentists based on the six links on survival guide. At present all dentists are required to be certified in basic life support. Dentists who provide sedation are already required to have ACLS training. I believe that any additional training would be redundant and serve no other purpose but provide income for the training companies who are lobbying to have this change passed. I believe that emergency situations in dental offices are adequately treated with the training that we already have in place and any additional training would not be necessary. Please use common sense when considering this proposal and vote to no.

2/17/12 11:14 am

Commenter: Elizabeth Cash, DDS *

opposed

Dentists are already trained to handle emergency situations. This would just add additional costs to dental treatment.

2/17/12 11:29 am

Commenter: Ken Stoner *

Current Rules and Regulations are sufficient

Our goal is to make sure the public is protected while in the dental office. Every dental office has an emergency kit, oxygen and a trained doctor and staff. Doctors are required to take continuing education in order to renew their license. The concerns of the public are legitimate. However, the current rules and regulations governing the dental profession adequately protect the public.

Let's not let knee jerk reaction to current events govern our profession. Our current Rules and Regulations, if followed by the dentist, are sufficient to protect the public.

2/17/12 12:05 pm

Commenter: Carl O. Atkins, Jr., D.D.S. *

Current Rules are Enough

The Virginia Board of Dentistry has rules and regulations in place requiring CPR for all practitioners plus ACLS and /or PALS and additional educational requirements for those dentists administering sedation. The American Academy of Pediatric Dentistry has extensive guidelines and clear policies in their Reference Manual that apply to the treatment of children. The American Dental Society of Anesthesiology has guidelines for monitoring patients, certifying assistants and emergency preparedness.

The ADA and the American Academy of Pediatric Dentistry have emergency preparedness and airway management classes utilizing the "SimMan" technology which should supersede ACLS and PALS as these classes become more available and are adopted as standards by our State Dental Boards. These courses recognize our unique practice situation, should become the standard of care.

I applaud and encourage further education in the treatment of children and adults for all practitioners and the petitioner's "Six Links" is another source of continuing education and should be treated as such, rather than as another requirement for licensure.

2/17/12 12:10 pm

Commenter: Elizabeth Miller DDS *

Emergency preparation courses and guidelines for dentists already in place

The ADA as well as the Academies for each dental specialty already have in place emergency preparation guidelines, CE courses, and requirements for how to handle emergencies in the dental office. All dentists are currently required to complete CPR, ACLS and/or PALS training which includes emergency preparedness/airway management. In addition to this training, there are also many CE courses available for dentists which also cover emergencies in the dental office and even include "SimMan" technology to help sharpen dentists cognitive skills and rescue techniques involving emergent scenerios. These courses are an important supplement to the courses already mandated by the ADA, and should not be a requirement for licensure.

2/17/12 12:13 pm

Commenter: Benjamin T. Watson DDS *

Oppose Six Links Survival Ruling

Dentists are already trained in Basic Life Support. Also for those of us who administer oral sedation, we are also required to have ACLS. The Six Links for Survival will just duplicate that which we already do. This will ultimately cost the patient more as the costs will be passed on. I am, as I am sure most all dentists are, already doing a great deal to insure the safety of our patients. We, as a profession, do more than other specialities. Put an end to the continual regulations that interfere with patient care and drives up the cost of healthcare.

2/17/12 1:19 pm

Commenter: Randy Adams DDS *

Dental Petition

I oppose this petition because , I feel our current regulations are sufficientent.

2/17/12 1:31 pm

Commenter: Michael J. Covaney, DDS *

Oppose

2/17/12 1:38 pm

Commenter: Sharon C. Covaney D.D.S. *

oppose

2/17/12 1:38 pm

Commenter: Sharon C. Covaney D.D.S. *

oppose

Commenter: Heath Cash *

opposed

Safety in a medical or dental office should always be a top priority. Training of health care professionals is essential. However, I am opposed to this proposal because regulations are already in place and no evidence has been provided to suggest further regulations will improve patient safety.

2/17/12 2:25 pm

Commenter: Danielle Cohen *

Opposed

I STRONGLY agree that dental practices should require training and equipment for medical emergencies for licensure and renewal. There is no such thing as TOO much training, why not take the oppurtunity to gain more knoweledge, if an emergency were to occur in your presenece wouldnt you feel better knowing you could help? Calling 911 isnt the proper soulution, neither is CPR. Will emergencys still occur? Yes, but at least they will be handeled in the right manor. I would feel much more secure knowing that the dentist I brought my child to has the proper equipment to handle andy emergency, I do wish this would go further then just dental offices... teachers should be prepared, recepitonests, etc. Help save lives ! PASS THE PETITION!

2/17/12 2:29 pm

Commenter: Larry Jewell *

Dental EMT Regulation

Not necessary and would increase cost of care

2/17/12 2:29 pm

Commenter: Barry I Griffin *

Oppose

2/17/12 2:48 pm

Commenter: Sheida Fortunato *

My vote is a resounding "YES", I am in favor of this petition.

I am in favor of the petition to amend regulations to require Virginia dentists to be trained and equipped to manage medical emergencies consistent with the Six Links of Survival as a condition of initial or continuing licensure. I believe that the level of safety and emergency preparedness can never be too high.

In regard to all of those in opposition of the petition (a majority of whom are dentists), I ask you, "why wouldn't you want to have the highest level of knowledge and awareness of safety and emergency preparedness for yourself and every member of your staff in order to protect the lives of your patients at any cost? Wouldn't you want the same for yourself and your loved-ones?"

2/17/12 3:20 pm

Commenter: W. E. Saxon, Jr. DDS *

Oppose Proposed New Emergency Protocol

The death of any patient is a tragedy. However, it is overkill. The supporting material makes comments that are designed to support their petition, but are misleading. The chance that the second death mentioned could have been prevented by these regulations is very remote. A comment by one of the petitioners that says oxygen is only for non-breathing patients in many dental offices is undocumented and incorrect.

Dentists are under too many regulations already. I find it ironic that I cannot give a flu shot, but people without my training are allowed to give them. I cannot give an employee a hepatitis B vaccine shot. If a rescue squad came to my office and I needed an emergency drug from their kit that I didn't have, I probably cannot have access to it. After performing CPR for about 40 years, I find the classes to recertify mainly good for paperwork. I've even had to correct instructors who have taught things incorrectly.

Dentists are trained and can appropriately respond to many emergencies, as well as finding medical problems and making appropriate referrals. Current regulations on sedation would seem to cover the two incidents cited. Comments by supporters of this petition that calling 911 isn't adequate is not fair. When you call a physician's office, almost everyone has the recording that if this is an emergency tohang up and call 911, etc., in other words, don't come to see them. This petition has the potential to place more advanced training requirements on dentists and their staffs than currently exist in medical offices. Please dismiss it.

2/17/12 3:37 pm

Commenter: Catherine Cash Staley *

government

As healthcare providers the safety of our patients is our first priority. More government intervention is never the answer for better patient care!

2/17/12 3:48 pm

Commenter: Townsend Brown, Jr.,DDS ,PC *

Opposed Regulation for Six Links of Survival in Virginia

I strongly oppose a regulation requiring Virginia Dentists to be trained and equipped to manage medical emergencies consistent with the Six Links of Survival as a condition of initial or continuing licensure. The Dental Schools and Speciality Residencies are responsible for teaching medical emergencies in the dental offices. The Board should not be dictated by an individual organizaton in setting standards for the quality of care in Virginia. Many excellent courses are given on Medical Emergencies in the Dental Offices(Dr. Stanley Malamed) so that dentists can receive excellent education and training on medical emergencies.

2/17/12 3:52 pm

Commenter: Richard Rubino, DDS *

Redundant Regulation

Any medical emergency or death is unfortunate. These proposed regulations are not only redundant but will increase the cost of dental care unecessarily. Dental offices currently have emergency drills and medical kits in place to reduce the impact of these occuring. In addition, most dental offices use only local injected anesthesia and possibly nitrous oxide, both of which are extremely safe when used correctely according to their training/education in their four years of dental school. Very few dental offices use sedation or general anesthesia and there are recent new regulations in place already requiring additional training for those dentists who use these techniques.

2/17/12 3:56 pm

Commenter: Jerrold H. Epstein, DDS *

Oppose

Dentists are under strict regulations already. They do not need to made any more stringent.

2/17/12 4:02 pm

Commenter: dr harvey c woodruff iii virginia dental association member *

reuirement for all dentist to be certified in advanced life support systems

the dentist that admisister oral sedation in conjunction with dental procedures, iv sedation, and general anesthesia should be required to take the advanced life support certification. it is unnecesary for those dentist that do not use oral sedation, iv sedation , and general anesthesia to be certified in advanced life suport systems treatment.

sincerely,

harvey c woodruff iii dds ms

2/17/12 4:33 pm

Commenter: Steven J Barbieri *

Oppose additional requirements

I write in opposition to the proposed additional requirements for licensure. Dentists and our staff members are trained to respond to emergencies in the office. This training includes Basic Life Support and use of the Automated External Defibrillator. Many of us practice conscious sedation and are certified in Advanced Cardiac Life Support. This training is administered by the American Heart Association. In addition dentists are equipped to treat respiratory and diabetic emergencies. Patients are at a much higher risk driving to their dental appointment than being at their dental appointment. Dentists are already well prepared to treat any medical emergencies which may remotely arise. Additional regulation is unnessary and unwarranted.

2/17/12 4:45 pm

Commenter: Dr George A Jacobs *

Opposition to new regulation

I am opposed the the proposed regulation. We as a profession has made every effort to protect our patients under the safest conditions possible. The existing regulations are some of the strictest in the nation and do a very good job of safeguarding the public. The current regulations concerning the use of sedation in dentistry are new and have addressed the concerns of the Cunha family. I feel there is no need for further regulation at this time as the majority of dentists do not use sedation other than nitrous oxide and local anesthetics. The proposed regulation appears to be an overkill. The health and welfare of our patients has always been and will continue to be paramount to our profession. Again, I would not be in favor of modifying the current regulations.

2/17/12 4:45 pm

Commenter: Jon Piche *

Increased regulation does not insure increased safety

i am a dentist who has been in practice over 30 years. I have been certified in CPR and ACLS for over 30 years. At one time I was certified in Advanced Trauma Life Support. I have an AED in my office and my staff trains on it. I have all of the proper equipment and drugs. We have emergency scenarios and we practice responses to these scenarios. Does this mean that nothing bad will ever happen and a terrible outcome can never occur...NO. Does increased regulations mean bad things will never happen in health care....NO. Increased regulations will never make people more caring or concerned. Dentists have training in proper response to emergencies. Increasing the regulations will not eliminate the possibility of bad things happening. Dentistry has regulations in place and when bad things happen, there are mechanisms to deal with them. It seems that people think that increasing regulations will eliminate the possibility of tragedy. This is not the case. It is my understanding that one of the recent deaths occured in a dental school setting where all of the recommended measures would likely be in place. Increased regulations will never make any type of medicine without risks. Any parent who feels their child is not safe in an office, needs to go somewhere else. It all comes down to personal responsibility and you can't regulate that.

2/17/12 5:04 pm

Commenter: Cynthia M Southern,DDS *

Oppose

2/17/12 5:08 pm

Commenter: Shelly Shum *

Please consider this from a different angle....

Would you be comfortable going to a physician's office where the only emergency procedures/equipment available was CPR? Just because you aren't expecting an emergency doesn't mean one won't happen. Children react to things very differently than adults. CPR is a good start, but it is not the final answer. I consider dentists medical professionals, and I find it abhorrent that any medical professional would balk at emergency preparedness training. Please, make emergency training for dental professionals mandatory!

2/17/12 5:20 pm

Commenter: Robert J Feild DDS *

Strongly against this reg

I would strongly oppose this regulation as not necessary for general dentists not employing sedation in their practice. Physicians do not have this level of care in their private offices. This is just another example of increasing the cost of dentistery and hurting access to care.

2/17/12 5:25 pm

Commenter: R.M. Crawford III *

Please, mandate the new training & regulations.

Please, mandate the new training & regulations. We cannot let any more people die due to dentist offices that are not properly prepared.

2/17/12 5:40 pm

Commenter: georgean ware *

unbelievable comments left by dentist.

As i look at the petition i am appaled at the number of dentist that do not feel that this training is needed, wake up, its the little bit of time to be equipped to save one life one child ; one adult , one human life . i guess they have never lost a loved one to the hands of a dentist .

LOVE U AND MISS U MICIAH 5/5/11

Commenter: Albert F. Creal, D.D.S. *

Petition Against Increasing Additional Training Requirements

As a practicing dentist, I feel that with a total formal education of 6 years (4 years at MCV D-76 and 2 years at Naval Postgraduate Dental School- Comprehensive Dentistry Program) I am well versed in handling medical emergencies and have had it instilled in me to protect the patient from any harm. To that extent, Dentistry has a wonderful record of continuing education to keep our skills honed and up to date. We already have regulations mandating continued formal training that have proved, at large, successful. As regrettable as any death is, to over-regulate will not ensure that another death is not a possibility.

I do not practice sedation dentistry and feel that to impose standards similar to Advanced Cardiac Life Support is an over qualification requirement that would only increase the cost of general dentistry to the entire population. I would ask that this petition be refused and keep the current adequate regulation in place.

2/17/12 6:46 pm

Commenter: Greg Zoghby, Commenwealth Oral and Facial Surgery *

against the petition

The board of dentistry has set the appropriate standard of care. The measure is redundant and offers little more than addition rules and addition equipment that will offer little in a real emergency. It will certainly create more expense and a new industry. I do not feel this is the way to create new jobs. Stress BLS and ACLS when appropriate. T

2/17/12 7:03 pm

Commenter: Kirk M. Norbo, D.M.D. *

oppose

We as dentists have always held patient safety and welfare as a cornerstone of our profession. The death of any citizen of this commonwealth, in a dental office, is a very emotional and tragic occurance. In some cases when there are undiagnosed medical conditions, no amount of additional training or preparedness can offset these rare and very

sad results. The guidlines recently updated by the Board of Dentistry are some of the most thorough in the country. Another layer of regulations would not improve public safety in Virginia.

2/17/12 8:02 pm

Commenter: Guy Levy *

Opposed

It is my understanding that dentists licensed in Virginia are already mandated to have emergancy training and equipment consistent with the level of care provided. For the dentists involved in the unfortunate patient deaths, would the training/equipment requirement be significantly different under the proposed regulation? As dentists providing sedation, would they not have been required to have the more advanced emergency training and associated equipment per current regulations? If this is the case, what purpose would this proposed regulation serve? Thank you for your consideration.

2/17/12 8:30 pm

Commenter: Christopher Hamlin, DDS *

opposed, as I am preparing to take the Pediatric Advanced Life Support Course

I am wondering why we need this as we are required to complete a very difficult and extensive Pediatric Advanced Life Support Course, every 2 years. This is above and beyond any other emergency type of training, the scope of this course is clearly meant for emergency room physicians, pediatricians, etc. I am happy to comply with this course, but feel that more regulation is not warranted. I can't imagine what else could be covered, that is not covered in this course.

2/17/12 9:36 pm

Commenter: Sayward Duggan, DDS *

Opposed

As the previous comments have stated, dental offices, particulary ones using IV or oral sedation, are already required to have BLS and ACLS training, as well as be properly equipped to handle emergency situations. Over-regulating dentists, particularly in the use of sedation practices, will only discourage dentists from being able to continue offering sedation in their practices. Is it fair to do this to a population of people who truly deserve, need sedation as a means to providing the best possible care?

2/17/12 9:51 pm

Commenter: Catherine Lynn,D.D.S. *

Not Necessary for Non-Sedation Dentistry

The majority of dentists do not do sedation dentistry and therefore this regulation is an unnecessary regulatory nightmare for the state to oversee and the average general dentist to have to uphold. If the dentist does sedation dentistry then I believe the state of Virginia already has requirements over and above the norm to adhere to. As tragic as these 2 deaths are in recent years, undiagnosed medical conditions are a problem that should be diagnosed and investigated by parents and pediatricians prior to sedation no matter what setting it occurs in.

2/17/12 10:10 pm

Commenter: K. Grant *

Why wouldn't you?

It does not make sense for an office to say that they do not need to be prepared for this type of situation. Things happen even without sedation and to be fully prepared for any situation seems like the obvious way to go!

2/17/12 10:25 pm

Commenter: Scott R. Miller, D.D.S. *

A father in opposition

I have two young daughters myself. I would be crushed to think of having to live without them. The existing regulations already require dentists/specialists that sedate patient to have adequate training. This petition will not help protect my children any better than they already are in any office that fulfills existing training requirments.

2/17/12 10:33 pm

Commenter: William Bennett *

Emergeny dental staff training

State registered dental professionals already do have requiremetns for life support. Most dental offces do not utiilize sedation. I believe the two death cases involved the need for patient sedation. If sedation procedures are administered additional training requirements are already in place. Some dentists such as orthodontists may not administer even local anestheia. Will additonal training over and above present requiremetns make an impact over what is now in place? Will this legislation be expanded to other health care providers as well? Many of them administer medictions to patients in their offices on par or over the level of most dentists.

Any death is very unfortunate. Unfortunately, in the best of conditions with the best of training it is a possibility we wish not to consider.. The 6 links is an excellent emegency model and well worth studying. Will making it a legal reqirement to health care providers without regard to what treatment and medications are renedered is ill concieved. Especaily in light of the fact that requirements are already in place.

2/17/12 11:08 pm

Commenter: Timothy A. Leigh, D.D.S. *

oppose additional regulations

The Virginia Board of Dentistry has regulations in place for dentists who use sedation in dentistry. For the dentists that don't perform sedation dentistry, this would be an unnecessary requirement. I oppose this Petition for rule making.

2/17/12 11:18 pm

Commenter: Madelyn Gambrel, DDS, MS *

Oppose more regulations

i am opposed to more regulations being placed on dentists that perform oral sedation. dentists are already required to do annual CPR/BLS training and ACLS training with recertification if they perform sedation. While the death of any child is tragic, more training is not the answer and would likely not have prevented these tragic events.

2/17/12 11:18 pm

Commenter: Elena Black, DDS, PhD *

oppose the added regulation

All dentists that administer oral sedation for dental procedures, iv sedation, and general anesthesia should be required and are most probably already required to take some type of advanced life support certification. However, there is no reason why all dentists should do this. We are all CPR trained. As sad as these children deaths are, these are very rare cases, given the high number of pediatric dental visits and more regulation will not prevent accidents such as these from happening.

2/17/12 11:18 pm

Commenter: Elena Black, DDS, PhD *

oppose the added regulation

All dentists that administer oral sedation for dental procedures, iv sedation, and general anesthesia should be required and are most probably already required to take some type of advanced life support certification. However, there is no reason why all dentists should do this. We are all CPR trained. As sad as these children deaths are, these are very rare cases, given the high number of pediatric dental visits and more regulation will not prevent accidents such as these from happening.

2/17/12 11:21 pm

Commenter: Don Trawick DDS *

Not allo the same

This oroposal suggest that all dental offices are all the same. Whether you perform general anesthesia, sedation dentistry, or use lidocaine, you should all have the training and equipment of an oral surgon doing general anesthesia. There are laws in place each area of dentistry to have adequate training for their designated area. The suggested regulation is cost prohabitive, ill advised, and unrealistic for the profession of dentistry

2/17/12 11:27 pm

Commenter: Samuel W. Galstan, D.D.S. *

Oppose

I am opposed to this regulation, as this topic is already covered in existing regulations. Thank you.

2/18/12 9:02 am

Commenter: Howard Hoffman, D.D.S., F.A.G.D. *

Opposed to the proposed changes in regulations

I am opposed to the proposed changes in the regulations concerning emergency training. This is a redundant and unncecessary change to the regulations. Continuing to provide continuing educaton courses by the local and state dental societies, and by other entities would be a preferable alternative without the need for further involvment by the governmental agency.

2/18/12 10:40 am

Commenter: Christine Austin-Williams *

death after denistry

My daughter went to the dentist to have a crown replaced, my daughter was not given antibiotics which her records was well noted. Needless to say my daughter suffered because of a viral bacteria that set in shortly after. Actually she went to the dentist on Friday August 25, 2006 and was admitted the next day Saturday August 26,2006. My daughter died August 29th, i tried to file a law suite but i was told i could not because she had Sickle Cell Anemia, and the lawyer didn't think he could pursue because i didn't file right away. I didn't know truly what happened to my daughter until i have done the research on my own. What would cause cardiac arrest, well recent dental work. I immediately tried to seek help but with no prevail, i have my daughter medical records from the denistry and the her last admission. I am appalled how the precautions isn't taken when it comes down to denistry. So i would like to come on board and speak my case to have dentisty's take accountability for their work.

In Loving Memory of my daughter De`Annah Christine Austin

Sincerely,

Chrissyee

2/18/12 12:41 pm

Commenter: Mitchell J. Bukzin, D.D.S., Virginia Dental Association *

Petition to change general anesthesia regulations

To Dr. Robert Hall, President, Virginia Board of Dentisty,

The regulations governing the use of sedation and anesthesia are quite thorough and more than adequate for the safety of patients in Virginia. The petition to change the regulations proposed by Nicole Cunha are burdensome and exceed reasonable safety. If successful, the changes will result in significantly higher cost to patients without significantly improving safety.

Sincerely, Mitchell J. Bukzin, D.D.S.

Commenter: Tim Wells *

IN FAVOR of this proposal

I am strongly in favor of this proposal for added training in the dental offices across the state and the nation as a whole. I understand the cost to the professionals and their offices but in light of a death occuring during a procedure I believe it is a cost that needs to occur none the less. I also understand that all dental offices are not the same, some trained more that others, sone do more procedures that others...but as a concerned parent and citizen I think the training should be across the profession not by the office for the fact people can change places of employment at any given time and should be trained for the new office upon arrival, not 6 weeks later when it might be too late.

I also find it quite wierd that 99% of the dentists are opposed and site CPR training in place already as the reason, yet kids are dying in offices year after year...somehow this does not add up. To say 2 out of 1,000,000 is ok is ABSURD. Even 1 out of 1,000,000,000 is absoultely too many. I think those who are saying that it is ok have never been a parent before.

Pass this now before it is too late

2/18/12 6:07 pm

Commenter: Todd Wynkoop, VDA member *

Oppose petition

While I feel the petition is noble in nature, it is flawed in logic. The petition states that the recommended training will prevent loss of life and uses the example of two children who died during dental care. One of those two died while being treated at the dental school where several of the dentists already have the training being proposed. Unfortunately this training did not prevent the tragic loss of life thereby undermining their petition. Currently, BCLS with AED training is required for licensure. Dentists receive emergency medical training in dental school and local dental societies and national meetings offer courses on these topics on a regular basis. Individuals who administer IV sedation or oral sedation are required to be ACLS certified and have the appropriate equipment/supplies to deal with adverse outcomes. I do not feel there is evidence to support this petition and I believe the current regulations are adequate for the public's safety. I would urge the Board of Dentistry to reject the petition.

2/18/12 7:29 pm

Commenter: Debbie Hagan *

I SUPPORT this rule change

Dentists oppose the rule change, some reasons understandable, others, petty and minuscule. Patients support it with vigor and conviction. Which of these two groups deserve protection from harm? Terms I've read here from those who oppose this rule change have been referred to as *"**nonsense**"*; *"**will cost patients to much**"* *"**folly**"* *"**burdensome**"* and *"**over reaching**"* .

My personal favorite is the one who sounds afraid they might actually have to try to save a life, saying "***would we be required to use it***?" I was personally shocked at this comment. Would this person not attempt to save a life other than call 911? If they were trained to sedate, and plan to use that, a bit of effort to save that person's life does not seem out of any standard of care. Or was it the fact there is a CDT code for sedation, but none for life saving measures.

Amazingly, one dentist commenting titled his opposition to the rule change "***Another Costly Regulation that Does Nothing to Help Public Welfare***". What about public safety?

A group calling themselves "Watchdog for Coalitions Against the Dental Profession (CADP)" has called this a "publicity stunt" for the foundation created after the tragic death of their daughter, Raven Marie Blanco in 2007. They end their comment saying, "***Don't treat victims as equals, they are not!***" They would not even leave their name of thier spokesperson. Thier comment sounded like it was a personal attack against the Blanco family.

From reading other comments of those who oppose this rule change, its apparent many feel CPR and pushing three buttons on the phone to call 911 is more than enough, lifesaving measures needed. In reality, it is the bare minimum. Some have suggested they receive all the training they need at the Saturday and Sunday sedation classes, which, by the way, they don't mind spending $2,500 on. This sounds ludicrous to me.

One person, while opposing, actually made the case on why this training is so important. He cited incomplete medical histories and other unknown factors that could lead to a real medical emergency. Yet, another wanted a pass if they did not sedate. No one should get a pass. Medical emergencies arise out of nowhere, it could be an allergic reaction to mouthwash, cardiac arrest from anxiety and a host of other reasons. I am saddened so many dentists do not want to provide more lifesaving measures to protect their patients. The mere fact so many are opposing the rule change reinforces the need for such a rule. It is clear they would not do it on their own, nor do they feel it even necessary to do more than dial 911.

Dentists are "medical professionals". With that comes responsibility to save lives. I think many in this group have forgotten that fact. Your patients call you, doctor, and trust you to be one.

With the increase in sedation dentistry rules must change. Sedation dentistry is marketed to general dentists as an untapped revenue stream. Therefore, it is not unreasonable to provide more protection for their patients and it is clear that would not come voluntarily. In fact, if sedation were not so heavily marketed, this rule change would not be needed. Nor I suspect we would have the following list:

Juan Quiej died 2012
Jermaine Lee Harrison, Jr.died2011
Miciah Bonzani died 2011
Jennifer Olenick died 2011
Marissa Kingery died 2011
Akasmse Tecumseh died 2011
David Liddell died 2010
Dylan Stewart died 2010
Jacobi Hill died 2010
Maddous Cordova died 2009
Cory Moore, Jr. died 2009
Chanel Broomfield died 2009
Jacqueline Martines died 2008
Raven Blanco died 2007
Jonathan Barrera died 2006
Diamond Brownridge died 2006
Dasia Washington died 2006

These are just the children that have died because of a sedation dentistry emergency since 2006. There are an untold number of adults who have died in the past few years as well.

Much of the time there are unintended consequences to any action or *non-action*. These days there seems to be some "special interest group" trying to influence rules and regulations, to their own financial gain I might add.

However, in this particular petition for change, we have victims of an unspeakable and preventable tragedy,who have worked tirelessly for the **past five years** promoting safer dentistry. They are doing what they can to protect others from their same fate. How more evident could it be that the rules must change? It is abundantly evident, going the extra mile in lifesaving measures would not be done voluntarily.

One child's death from a tooth infection in 2007 was powerful enough to change laws in 50 states. Billions of dollars were appropriated to provide access to care for children. Surely, the death of so many from anesthesia emergencies warrants a rule change in at least one state.

Those who have killed, from lack of lifesaving training, have gone on to kill again. Twice in the last year, two separate dentists have had their second patient death. If having a patient die in your office, under your care cannot bring procedure change then regulations must.

I support the rule change. I encourage Virginia dentists to take the lead in providing the safest environment possible for their patients, who put their trust and live in their dentist's hands.

I urge you to pass this rule.

Thank you for your time,

Debbie Hagan

2/18/12 9:02 pm

Commenter: Sarah E. Allen, DDS *

Oppose

I agree with the numerous arguments put forth by other dentists that, while the apparent motivation for this petition is well-intentioned, in the end, it provides one more hoop to jump through and may or may not actually make a difference in terms of medical emergency outcomes. While I agree that dentists should ensure that both they and their staff feel comfortable handling emergencies (as they are indeed both ethically and legally responsible to be), I don't see a need to further dictate how this preparation should be carried out. Lastly, as a dentist whose office actually uses the IMEP program to help prepare for medical emergencies, I think its main utility is in simply providing a framework, but I absolutely do not think such training should be mandated above and beyond the regulations currently in place.

2/18/12 9:11 pm

Commenter: Dr. Anna Abel *

DDS

I am a mother of 3 girls, age from 9, 8 and 5. I empathized with Nicole and her loss. Your family are in our prayer for this difficult time. Our office, our team are required to be up to date with CPR. We have all the emergency equitment including emergency drug kit, first aid, oxygen tank and AED. We also go over the emergency protocols and strategies as well as CPR technique. It is not wise ideal to use of public resourse to place another regulation that already in place. May God confort Nicole and her famliy for their loss.

2/18/12 9:36 pm

Commenter: Jack Weil, D.M.D. *

Against additional regulation

As others have previously stated, the requisite rules governing this area of practice are already in place. Additonal regulation will not enhance patient safety, but will only serve to increase the time and cost necessary to provide care.

2/18/12 9:45 pm

Commenter: J. Gresham *

EVERY SINGLE child should be protected by preparedness

2/18/12 10:55 pm

Commenter: Jackie Miller *

I support emergency training!!

Dentsits should definately be required to have emergency training every year. Too many people, especially children are dying while gettin simple procedures. I think that dentists that feel they shouldn't be required to do this shouldn't be in the field. Things in the medical fields are always changing and it would be good to refresh everyone's brain on what to do in the case of an emergency!!! This is very serious and important! Let's not lose anymore people in the dentist chair, enough lives have already been lost to neglect!!!

2/19/12 10:03 am

Commenter: H.L. Wilson *

I support this petition! What is the harm in EXTRA preparedness?

I can't believe my eyes as I'm reading these comments. Especially the watchdog comment. What a coward! At least the ***other*** dentists left their names. Obviously the training that is currently in place is insufficient. Otherwise, we would not be reading news of patients dying while in a dental chair.

Its a good idea in any profession to receive period training to keep up on the latest techniques and refresh important information. In ***any*** medical profession, it should be mandatory!

Admittedly, most dentists probably ***are*** prepared (and obviously those dentists are all posting here ***against*** the petition), but without some sort of training mandate, how do we identify those who are ***not prepared***?

2/19/12 10:42 am

Commenter: Virginia Society of Oral @ Maxillofacial Surgeons *

VSOMS Comment

The Board of Dentistry currently has in place regulations to assure patient safety in dentistry. The Virginia Society of Oral & Maxillofacial Surgeons encourages review from time to time of such regulations to assure safety for the patients of the Commonwealth.

2/19/12 11:25 am

Commenter: Rhonda J Shodis *

Emergency preparedness

More education is always good!

2/19/12 12:42 pm

Commenter: Jennifer Blais *

continuous train

I am in favor of this petition. Regardless of a persons profession continous training is a must. Skills must be honed and up dated in order to remain effective. In this particularly case, the skills and training will save lifes.

I have read opposion based on cost. I am appaled that anyone would put money over the cost of a child's life! I am a parent and I would gladly pay more for a dentist who was trained and properly prepared to save my child's life in case of an unforseen emergency.

2/19/12 2:49 pm

Commenter: Cathy Garger *

Support

In April, 2011 my only child, Jenny Olenick, 17, died during general anesthesia for a wisdom tooth extraction. The case is now under litigation and I can not discuss the particulars of Jenny's case but I can tell you that emergency preparedness measures were not in place.

I can not tell you the loss of our daughter's wonderful presence in this world because there are no words to convey the magnitude of this loss.

I am aghast that everyone is not trying to get stricter regulations to protect our children. I could tell you countless stories of people who have horror stories to share about dental professionals who are not current on latest emergency training practices and actual mandated rehearsals. We must make certain that no more dentists are allowed to perform even "routine" dental procedures without sufficient and excellent training, rehearsals, and supervision.

I urge you to vote for this legislation. I have already lost the thing dearest to me on this planet. Please vote yes for this bill so that other children may live.

Thank you for your time and consideration.

Cathy Garger

2/19/12 3:04 pm

Commenter: Mark Reitz DDS *

Opposed

We do not need additional regulation at this time,especially from an outside entity.Has there been a significant statewide increase in office emergencies to warrant the new regulation?

2/19/12 3:17 pm

Commenter: Hersche L jones *

Require training & equipment for medical emergencies for licensure and renewal

Oppose this change. Tragic as the event that brought about this proposal, this response is not the way to go.

2/19/12 3:28 pm

Commenter: Joseph A. Catanzano III *

oppose additional regulation

Please help keeping redundant regulation out of dentistry so we can focus on patient care. As a father of one, I empathized with Nicole on her loss. My thoughts and prayers are with you and your family in this difficult time. However, all dentists and clinical team members are required to be up to date with CPR. My office has all the emergency equipment including oxygen tank and AED. We hold quarterly CPR refresher for all team members to go over emergency protocols and strategies as well as CPR techniques. It is not a wise use of public resource to place another regulation that already in place. Again, my deep condolence to Nicole and her family.

2/19/12 4:51 pm

Commenter: Mario Blanco *

Please help

2/19/12 5:04 pm

Commenter: Eva Schatzhuber *

Support

I support this bill!!! Furthering a person's education never hurt a sole!!! Knowledge is key and sometimes we all learn something we didn't know before. Is more training really going to hurt??

2/19/12 5:06 pm

Commenter: John Delossantos *

support

I support this bill!!!

Commenter: Albert Schatzhuber *

support

I support this bill!!

2/19/12 5:28 pm

Commenter: Justin Norbo, D.D.S. *

oppose additional regulations

Dentists who provide sedation to their patients are already required to have advanced life support training. Additional regulations to dentists and their staff for providing basic general dentistry procedures is unnecessary and burdensome.

2/19/12 7:26 pm

Commenter: Berkeley Pemberton, DDS *

Oppose unnecessary regulation

This organization has obviously found a sympathetic cause and is seeking government intervention to force dentists to invest large sums for training and equipment which will statistically never be used. I have practiced dentistry for 41 years and have never had a medical emergency in my office. I voluntarily had most of the equipment mentioned, took detailed medical histories, and was conservative in treating medically compromised patients. Most dentists already do that. Unless it can be proven statistically that these measures will be a substantial benefit in reducing what is already a minimal risk, they should be rejected. As I see it this outfit is looking for publicity and power which will enable them to line their pockets. If this petition is passed a whole cottage industry will develop to sell equipment and do the "in office training" , causing an increase in dental fees.

I urge the board to reject this "feel good" petition as over-regulation.

2/19/12 8:09 pm

Commenter: Roger Wood, DDS VDA *

oppose petition

The Virginia Dental Association, in response to the petition put forth by Nicole Cunha, would like to put forth the following comments that we would ask you and the board to consider when discussing this particular issue.

- We all share in the loss of life that occurs under any circumstance, but, in particular, the child that is lost while undergoing dental treatment. There are no words that can replace that sense of greatest loss.
- We equally are aware of the responsibility of each of our practitioners to maintain the highest standards of care possible to avoid any untoward incidents that may cause harm to our patients. We are strongly invested in the effort to make sure our patients are treated under the safest conditions possible. We want the care provided to all our patients, which would include our own family members, accomplished under the highest standards appropriate and necessary.
- The Virginia Board of Dentistry, through its statutory and regulatory authority, already has created one of the strictest set of regulatory guidelines concerning the issue of the use of sedation in dentistry. These currently are set out in 18VAC 60-20-107, 60-20-108, 60-20-110, 60-20-120, 60-20-135 and 60-20-140. These clearly already address most, if not all, of the concerns expressed by Ms. Cunha.
- The vast majority of dentists do not practice sedation dentistry in their offices and would view this petition as an unnecessary and burdensome requirement which exceeds and addresses an issue already addressed in the current regulations.
- There is no one more conscious and concerned about the safe delivery of dental care than the profession of dentistry. We continually look and evaluate all aspects of our care of the safe delivery of services to our most precious resource- our patients.

In summary, we believe in the appropriate use of regulations to set the standard for that care and, believe, in this instance, that we currently have the regulations in place that address the concerns expressed by Ms. Cunha. We therefore would not be in favor of modifying the current regulations concerning this issue at this time.

Sincerely,

Roger Wood, D.D.S.
President, Virginia Dental Association
February 19, 2012

2/19/12 8:42 pm

Commenter: Michel Hurley, DDS, MD *

New Dental Practice Regulations

At the very least, I would recommend postponing new regulatory activity to be certain such activity would be realistically superior to current regulations.

2/19/12 8:55 pm

Commenter: Ramona M. Zavada *

Important & Critical My Granddaughter Died at the dentist

Please, I need to comment on this very important issue. You see I lost my only Granddaughter Marissa Kingery of Elyria Ohio, a year ago. Marissa died as a result of a simple dental visit to have two baby teeth pulled and a third impacted. She was the patient of Dr. Henry Mazorow who at 81 years old already had a dental death 13 years before as a direct result of failure to properly administer anesthesia to that patient.

Marissa died from lack of oxygen to the brain, she was given an IV sedation in his office without a properly trained anesthesiologist she went into arrest, and more important a team that was not equipped to handle such an emergency.

Marissa was denied oxygen for over 10 minutes. she went into a coma and lingerd 2 weeks. We later found out that Mazorow did not have updated equipment, a crash cart, or proper emergency procedures by trained staff in his outdated office. The 911 tapes clearly state (the Paramedics)"We go there all the time" and the (dental aide) "He is giving her mouth to mouth" I was appauled to hear the 911 tape. Clearly Mazorow was not equipped nor his staff to handle any emergency big or small.

I want the dental industry to change the way they are trained to handle an emergency and how anesthesia is used and administerd in a office setting. I want to see the SIX STEPS OF SURVIVAL that RMBF has worked so hard on placed in every dental office in this country. RMBF was one of the first people to reach out to me when Marissa died. I have been in contact with them since and they are amazing in their effort and this comes from a Father who lost his beloved Raven. Mario is the voice for these Children, and RMBF will continue to fight for these inportant changes, and I stand with them!

I want a national news story on these dental deaths to air, so all Parents can educate themselves, and protect their children. I don't want to see one more Parent or Grandparent suffer the loss of their beautiful child.

I plead for change, for Marissa, Ravin, Jenny and the other beautiful children who died unnecessarily at the dentist. This is a plea for the living children, We need to look at the bigger picture, Dentists are not taking the correct measures to make sure they have emergency procedures in place, it is time, the cost should not be a question, lives are more important then money.

I promised Marissa they day she was taken off life support, that I would not let her die in vain. I will continue to fight for change in the dental industry, again it is time.

Thank You

Ramona Zavada

Columbus, Ohio

2/19/12 9:45 pm

Commenter: Gus C Vlahos DDS *

I oppose additional training and equipment for dental emergencies for licensure and renewal

The lose of any child is bad under any conditions but this occurs daily in our lives. Not just in dental offices but as a child runs into the street after a ball or his pet and is hit by a car. Do we require that all people put up fences to prevent this. One could list more examples but we don't need to over reaction to this tragedy. There are regulation in place on what training a dentist must have for dental emergencies to receive a license or to renew one. I oppose this petition for new regulations.

2/19/12 9:45 pm

Commenter: N. Rello *

What if it were your Child?

I want to ask the dental members a question. If you lost your own child from a simple trip to the dentist. What then would you do to prevent this from ever happening to anyone else? Some of the members treat this as more government regulation, well tough, maybe it is about time the dental industry come under fire for the lack of emergency prepardness and training. Bottom line kids died going to the dentist for routine dental work, something obviously needs to change. By the way the number of children that have died is closer to 40 not 2 as one member stated.

2/19/12 11:25 pm

Commenter: Tammy Quirola *

Support the petition!

I urge the Virginia Dental Board to pass regulations to make it mandatory for all dentists in VA to take Medical Emergency Preparedness Continuing Education Classes in order to renew their license. Dentists should have every possible training to help prevent any type of emergency that can occur during a dental procedure. I am not comfortable taking my child to a dentist who doesn't feel it's necessary to have more training. You can NEVER be too prepared for an emergency - just ask the grieving families of the many many children who have died at the dentist as a result of under-prepared dental offices.

2/19/12 11:32 pm

Commenter: Claire Kaugars, DDS *

Oppose petition

The Virginia Board of Dentistry already has regulations governing the use of sedation. Additional requirements are not needed.

2/19/12 11:33 pm

Commenter: Stepen S. Radcliffe, DDS *

Six Links Petition

I am opposed to the additional requirements as outlined in the Six Links document. Dentists and staff members are currently required to be trained in Basic Life Support and use of the Automated External Defibrillator. Those who use conscious sedation while treating patients are required to be certified in Advanced Cardiac Life Support.

The Six Links document would essentially require that all dentistsc(and staff members) be ACLS certified as a condition of licensure. The cost of compliance (equipment purchases and training) would be huge. Given that we currently have a yearly license renewal it is unlikely that every practicing dentist would be able to comply within the next year.

I also do not believe that this additonal regulatory burden would neccessarily make the delivery of dental care safer. As tragic as the death of any patient is, there is absolutely no level of regulation that is going to guarantee that there will not be another tragic outcome.

Dentists are already well prepared to handle medical emergencies which may occur during treatment.
Additional regulation is unwarranted.

December 16, 2011
10:00 am
9960 Mayland Drive, Suite 200
Henrico, VA 23233

Meeting of the Board of Dentistry (Board) and the Virginia Dental Association (VDA) to discuss the Virginia Dental Laboratory Safety Act Resolution

Attendees: Robert Hall, Jr., DDS, President of the Board
Roger Wood, DDS, President of the VDA
Sandra K. Reen, Executive Director of the Board
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

Summary: On December 16th, Dr. Hall and Dr. Wood met and discussed: the VDA resolution for registration of dental labs and the Board's concerns about proceeding with legislation as addressed in the resolution adopted by the VDA. The following matters were discussed:

- mutual interests for public safety,
- identifying the public need for registration,
- concerns about the dental laboratory work order forms adopted by the Board,
- implementation issues with the adopted VDA resolution for legislation,
- due process considerations versus the expectations of dentists for termination of registration,
- the feasibility and advantages of pursuing a study, and
- actions to be taken.

The actions agreed to were:

- Ms. Reen will pursue having the two dental laboratory work order forms converted for completion electronically and posted on the Board's web page along with the printable forms which are currently available. Also, she will inform Dr. Wood of the outcome.
- Ms. Reen will send Dr. Wood the study criteria used by the Board of Health Professions to assess the need for regulation.
- Dr. Wood will work within the VDA to see if the resolution for legislation can be deferred so that a study resolution can be advanced. It was acknowledged that this may not be possible given that the resolution was adopted by the VDA House of Delegates.
- Ms. Reen will attend the January 19, 2012 meeting of the VDA Board of Directors to assist in the discussion of next steps.
- Ms. Yeatts will develop a draft of a study resolution for Dr. Wood.

DISCUSION DRAFT

Virginia Board of Dentistry
(804) 367-4538 FAX (804) 527-4428 denbd @dhp.virginia.gov

March , 2012

Millard W. Wester, III, D.D.S., President
North Carolina State Board of Dental Examiners
507 Airport Boulevard, Suite 105
Morrisville, NC 27560

Dear Dr. Wester:

During a discussion of a range of examination matters at its December 2011 meeting, the Virginia Board of Dentistry received a report that dental program graduates and licensees in Virginia have expressed an interest in licensure in North Carolina. The report indicated that the North Carolina State Board of Dental Examiners only accepts CITA examination results, an examination which we accept in Virginia but which is not administered here.

Given the rising costs associated with qualifying for a dental license and the logistical issues associated with traveling out of state to take an examination, we decided to make you aware of this interest in your neighboring state and to ask if you might consider accepting other clinical examinations. We have had a very positive experience with accepting all five regional dental clinical examinations. It has contributed to having a steady increase in the number of licensees even though we have quite a few dentists retiring from practice.

I would be happy to discuss this request with you or provide any information that we have to share.

Sincerely yours,

Robert B. Hall, Jr., D.D.S.
President
Virginia Board of Dentistry

COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

Department of Health Professions
Perimeter Center
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Virginia Board of Dentistry
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January 4, 2012

Dr. Bruce Barrette, President
ADEX, Inc.
P.O. Box 8733
Portland, OR 97207-8733

Re: Membership and Examination Acceptance

Dear Dr. Barrette:

I am pleased to report that the Virginia Board of Dentistry (the Board) adopted a motion during its December 2, 2011 meeting to join the American Board of Dental Examiners (ADEX). This letter serves to confirm that the Board agrees to become a member of ADEX, within the meaning of the ADEX Bylaws, subject to the following:

1. The Board understands that ADEX has developed clinical examinations of candidates for licensure as dentists and dental hygienists. The Board has determined that the examinations are sufficient to meet the requirements of the Board for the testing of candidates for licensure as dentists and dental hygienists and agrees to accept the results of such examinations as sufficient to meet the clinical examination requirements for licensure in Virginia. The Board will recognize the results of the Examinations conducted by Regional testing organizations or States using the ADEX Examinations for a minimum of five years following the date of examination.

2. The members of the Board who participate in the administration of an ADEX examination recognize the materials provided by ADEX are subject to copyright protection and acknowledge that all information concerning the scores, reporting and analysis of the results of the examinations are confidential information and will be treated as such.

3. The Board acknowledges that either the Board or ADEX may terminate this Agreement by delivering written notice not less than 120 days before June 30 of each calendar year.

Please confirm acceptance of the membership on the terms stated herein below.

Yours sincerely,

Sandra K. Reen, Executive Director
Virginia Board of Dentistry

pc: Robert B. Hall, Jr., DDS
President, Virginia Board of Dentistry

ACCEPTED:
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

By: _____ Date: JAN. 13, 2012
Dr. Bruce Barrette, President

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

RECEIVED
JAN 2 3 2012
Board of Dentistry

DHP JAN 2 3 2012

Bruce Barrette, D.D.S., President
Stanwood Kanna, D.D.S., Vice-President
William Pappas, D.D.S., Secretary
H. M. "Bo" Smith. DMD, Treasurer
Guy Shampaine, D.D.S., Past President

January 16, 2012

TO: ADEX Member States

FROM: Bruce Barrette, D.D.S., ADEX President

SUBJECT: ADEX 7th Annual Meeting

Enclosed is a copy of the Highlights of the ADEX House of Representatives Meeting, November 6, 2011, Rosemont, IL as well as a draft of the Proceedings of the HOR and the 2010-2011 ADEX Annual Report

The success and achievements of ADEX over the past seven years is due to the commitment of the member state dental boards.

P.O. Box 8733 • Portland, Oregon 97207-8733
Telephone (503) 724-1104
ADEXOFFICE@aol.com
www.adex.org

Highlights of the American Board of Dental Examiners, Inc. (ADEX)
7th House of Representatives
November 6, 2011
Rosemont, IL

The following are highlights of the 7th ADEX House of Representatives:

Officers were elected: Dr. Bruce Barrett, WI, President; Dr. Stanwood Kanna, HI, Vice-President; Dr. William Pappas, NV, Secretary and Dr. H. M. "Bo" Smith, AR, Treasurer.

Representatives from 42 out of 45 State Board, District Hygiene and Consumer Representatives were present.

Presentations were made by:

- Dr. Brian Kennedy, Chairman – ADA's Council on Dental Education and Licensure.
- Mysiha Stokes, Program Manager–Alpine Testing.
- E.W. Looney, CEO-Brightlink.

A Post Dental and Dental Hygiene Exam Analysis report was reviewed by Dr. Stephen Klein, Psychometrician.

District 6 elected, Dr. Michelle Bedell, SC, for a three year term on the Board of Directors.

District 10 re-elected Dr. Richard Dickinson, VT, for another three year term on the Board of Directors.

District 12 elected Dr. Wade Winker, FL, for a term a three year term on the Board of Directors.

Dental and Hygiene Exams: The House approved a motion to approve the dental and hygiene examinations for 2012.

It was announced that the ADEX Board of Directors has elected Dr. Scott Houfek of Wyoming as the Dental Examination Chair for the next three years.

2012 ADEX House of Representatives: The 8th ADEX House of Representatives was scheduled for Sunday, November 11, 2012, Doubletree Hotel, Rosemont, IL.

DRAFT

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

7th ADEX House of Representatives
November 6, 2011

PROCEEDINGS

Call to Order and Introductions: President Bruce Barrette called to order the 7th meeting of the ADEX House of Representatives at 8:05 a.m. on Sunday, November 6, 2011 in the Signature 2 Room, Doubletree Hotel, Rosemont, IL.

Roll Call: President Barrette introduced the members of the House of Representatives: Dentist/Administrator Representatives: Dr. Robert Ray, DC; Dr. David Perkins, CT; Dr. Mark Baird, HI; Maulid Miskell, CO; Dr. Dennis Manning, IL; Dr. Matthew Miller, IN; Dr. Rockwell Davis, ME; Dr. Peter DeSciscio, NJ; Dr. Harold "Bo" Smith, KY; Dr. David Averill, VT; Dr. Maurice Miles, MD; Dr. William Wright, MI; Dr. Patrica Parker, OR; Dr. William Pappas, NV; Dr. Neil Hiltunen, NH; Dr. John Reitz, PA; Dr. Phillip Beckwith, OH; Dr. Scott Houfek, WY; Dr. Wade Winker, FL; Dr. Craig Meadows, WV; Dr. Keith Clemence, WI; Dr. Warren Whitis, AR; Dr. Michael Tabor, TN; Dr. Michelle Bedell, SC; Dr. Henry Levin, RI; Dr. Mina Paul, MA; Dental Hygiene Representatives: Mary Davidson, RDH, OR, District 2; Nan Dreves, RDH, WI, District 4; Mary Johnston, RDH, MI, District 5; Mary Ann Burch, RDH, KY District 6; Cheryl Bruce, RDH, MD, District 7; Sibyl Gant, RDH, DC, District 8; Nancy St. Pierre, RDH, NH, District 9; Karen Dunn RDH, MA, District 10; Irene Stavros, RDH, FL, District 12; Consumer Representatives: Ms. Marian Grey, HI, District 2; Ms. Clance LaTurner, IN, District 5; Mr. Allan Francis, KY, District 6; Mr. Allan Horwitz, PA, District 7; Ms Lynn Joslyn, NH, District 9; Ms. Diane Denk, ME District 10; Ms. Vicki Campbell, FL, District 12.. There were 42 out of 45 State Board, District Hygiene and Consumer Representatives present.

President Barrette introduced ADEX officers, Dr. Stan Kanna, HI, Vice-President and Dr. William Pappas, NV, Treasurer, Dr. Guy Shampaine, MD, Immediate Past President and District 7 Director.

President Barrette also introduced representatives from Associate Member organizations: Dr. Peter Robinson, American Dental Education Association (ADEA); Mr. Ken Randall, American Student Dental Association (ASDA); and Dr. Samuel Low, ADA Trustee.

Presentations from Associate Members

ADEA - Dr. Robinson ADEA had no report.

ASDA - Mr. Ken Randal thanked the House for allowing him to attend on behalf of ASDA.

ADA – Dr. Samuel Low

ADEX Board Of Directors Members in attendance: Dr. M.H. VanderVeen, MI, ADEX Board of Directors – District 5; Dr. Richard Dickinson, VT, ADEX Board of Directors – District 10; Mr. James McKernan, RDH, NV, ADEX Board of Directors - Hygiene Member; Zeno St. Cyr II, MD, ADEX Board of Directors - Consumer Member; Dr. Cathy Turbyne, ME, ADEX Board of Directors – Hygiene Member and Dr. Peter Yaman, MI, Chair ADEX Dental Examination Committee.

Additional Guests: Dr. Stephen Klein, Gansk & Associates, CA, Dr. James Watkins, SRTA, VA; Dr. Richard Marshall, Vice-President-SRTA ; Dr. Robert Jolly, President-SRTA, Kathleen White, Executive Director-SRTA, VA, Dr. Brian Kennedy, CDEL, NY; Myisha Stokes, Alpine Testing Solutions, NV; E.W. Looney, Bright link, GA; Dr. Ron Moser, Maryland Dental Board, MD. Dr. Ellis Hall, NERB, MD; Dr. Jonna Hongo, Oregon Dental Board, OR; Linda Sabat, RDH, ADEX Dental Hygiene Committee Member; Dr. J. Gordon Kinnard, NV, ADEX Quality Assurance Committee Member; Dr. LeeAnn Podruch, VT, Secretary-NERB; and Dr. Maxine Feinberg, NJ, ADEX Dental Hygiene Committee Member.

Also in attendance: Patrick D. Braatz ADEX volunteer Administrator

Adoption of Agenda: Cheryl Bruce, RDH, MD moved and Dr. Dennis Manning, IL seconded a motion to adopt the agenda with the proviso that the President could reorder items if necessary. The motion passed by general consent.

Adoption of Proceedings of the 6th ADEX House of Representatives, November 7, 2010

Dr. Neil Hiltunen, NH, moved and Dr. Henry Levin, RI seconded a motion to adopt the Proceeding of the 6th ADEX House of Representatives, November 7, 2010. The motion passed by general consent.

President Barrette's Report:

Good Morning. It's my privilege, on behalf of the Executive Committee, to welcome you to the 7th Annual meeting of the American Board of Dental Examiners.

This has been not only an exciting year for ADEX but also a busy one. We have adopted and instituted some major changes on the examinations. While maintaining our standards, we have undergone some changes in an effort to make the exams more candidates friendly. Timelines have been, for the most part, eliminated. Criteria has been written and field-tested for the posterior composite and the posterior composite will be an option on the patient based examination. At the same time, the approval of lesions has been made anonymous and moved from the CFEs on the floor to the examiners in the grading area.

With the help of EW Looney and the folks at Brightlight, we have adopted a computer program that is not only collects data from our exam but also is a program that manages time. To our knowledge, no other program has these two capabilities. By utilizing our program, the time in the grading area has been reduced by 1 ½ hours, which gives our candidates that much additional working time. A little later in the program EW will talk about the current program and enhancements in the future.

On the hygiene exam, our dental hygiene exam committee continues to refine and improve the exam. During the past year they have worked especially diligently updating the candidate and examiner's manuals.

We have begun to undertaken a major project in redoing the calibration for both the dental exam and the dental hygiene examinations. I have appointed Dr. Bill Pappas and together we have selected a committee of experienced examiners that includes all facets of our membership to begin addressing this huge undertaking. I know they are working feverishly to make improvements in our calibration instruments and we patiently are waiting for their results. We anticipate that some of their work will be incorporated in the current exam cycle.

Our communication committee has designed and gone live this past year with our website and have been busy exploring ways to explain who we are and get our message out. Later in the program some members of the committee will be talking to you about those efforts.

Another major project that we have initiated is the joint task analysis we've undertaken in conjunction with the Southern Regional Testing Agency (SRTA). Along with Bob Jolly and Kathleen White from SRTA we have spent a lot of effort in laying the foundation for the analysis, which culminated in a joint meeting of 12 of our members and 12 members of SRTA in June in Atlanta to formulate the questions to be asked on the task analysis. The task analysis surveys the entire country inquiring of both new and experienced practitioners on what procedures they are doing in their offices. With the emphasis on the new practitioner it gives us data on what procedures we should be testing for on our examinations. You will hear an update later from Myisha Stokes regarding the task analysis.

During the past year, the Florida board voted to join ADEX and administer the ADEX exams both in dental and dental hygiene and we welcome Florida's decision. Florida has had a long relationship with NERB through NERB's administration of the Florida Exam and to a lesser extent with ADEX. Many people both in Florida and ADEX have worked to achieve this goal and we are grateful for all of their efforts. We look forward to working together with the representatives from Florida as they begin utilizing the ADEX exam.

We also have opened a dialogue with representatives from SRTA. During the past year, Dr. Shampaine and myself have meet with the SRTA Board of directors twice in person, twice on teleconference calls and have attended and addressed their Annual meeting in Portland Maine. We have had frank and open conversations. During those conversations, we both have learned a lot about

each other and in my opinion, have developed the trust and understanding necessary for a successful alliance. State boards from the SRTA states of Arkansas and Tennessee have voted to join ADEX and it is our understanding that Virginia will be voting on membership in December. We are also pleased to announce that SRTA has voted to administer the ADEX dental exam beginning with the 2013 Exam cycle.

In addition, we have reached out to the other testing agencies to begin communicating with them. All of the testing agencies were extended an invitation to participate as equal partners in the task analysis. We have attended both formal and informal meetings with other testing agencies and have approached these meetings with openness and honesty. While the progress has varied depending on the specific testing agency, on a whole, this year has led to an environment far more conducive for open and candid discussions.

We look toward to the future to continue to work and interact with the other testing agencies. At the same time, we eagerly await to see the results of the task analysis and the impact it will have upon our examinations. Our relationships with our member state boards, as always, are the highest priority. Through our communications with the boards with our minutes, the website and personal appearances, we strive to keep them informed.
With Florida beginning to administer the ADEX exam and SRTA coming aboard next year, we will be working hard to make a smooth transition.

The last couple of years have had challenges and at times our vision of a uniform national examination has seemed to be but a distant thought. Today, we are much closer. The progress that has been made this year can only be due to the volunteers that have devoted so much time and energy to making this enterprise succeed. I want to thank the executive committee, the members of the ADEX Board of Directors and everybody who worked on our standing committees. It would be neglectful of me, if I didn't thank our administrator Mr. Patrick Braatz for all of his efforts on behalf of ADEX. I've known Patrick for a long time and am well aware of his talents when it comes to managing an operation but every day I'm amazed at the efficiency and skill, he brings to ADEX. Thanks, Patrick. And thank all of you for taking time out of your busy schedules to support this dream for a uniform national exam.

Presentation from

Dr. Brian Kennedy, Chairman - ADA's Council on Dental Education and Licensure

"Moving Toward Portfolio; Need for Collaboration"

Dr. Kennedy covered the history of Part I, II and the proposed III from 1920s to present, the growth of the regional boards and the attempts to develop some sort of national consensus. He discussed the pressure of PGY-1 in 2003 and the ADA Board of Trustees commitment to significant funding for a process to develop a national exam if the examination community could not come to some sort of agreement.

Dr. Kennedy discussed the January 2005 birth of ADEX and the potential we all saw in 2005. He reviewed the WREBs movement away from ADEX and the number of decreasing states accepting ADEX and then the recent turnaround now with the SRTA and states that make up SRTA and FL, NV, HI being most positive developments. Dr. Kennedy emphasized the recurring history of the ADA House of Delegates adopting positions of eliminating live patient's from the examination process.

Dr. Kennedy related the history of the S21 and 42H workgroups and the intent of the portfolio process to develop a "true" Clinic Integrated Format type of process.

Dr. Kennedy discussed the rise of the patient brokering services and the need to eliminate them from the process as well as the opportunity for a portfolio process to impact dental education. The portfolio product would function with the state boards as being the final decision maker in the licensing process.

Dr. Kennedy also stated categorically, the ADA House of Delegates policy mandates an "independent" evaluation process and the final product would comply with that principle. He emphasized the portfolio will not advocate graduation being licensure being the same as graduation, and the process will be gradual as the process continues and there will never be a system all can agree to simultaneously.

Dr. Kennedy concluded that it is time for collaboration between all parties to move this process forward. We all want the best process that meets the needs of the state boards and the profession.

Myisha Stokes, Program Manager – Alpine Testing Solutions

"Using Job Analysis to inform Test Development"

Myisha Stokes' presented an overview of the Test Development Cycle and Validation process with emphasis on the importance of the Program Design and Job Task Analysis steps recently undertaken by ADEX and SRTA. It was pointed out that these steps were of the more crucial sources of validity evidence. Specifically, after walking through Alpine's Test Development graphic beginning with "Design Program" and ending with "Maintain Test", Myisha refocused on recent steps undertaken by ADEX and SRTA such as Test Design with a discussion centered on intended and unintended use of test scores.

This was followed by a more focused look at validation framework, core elements of defensibility, and domain representation. The presentation progressed into a summary of the job analysis procedure used for ADEX's clinical examinations, inclusive of a description of the committee meetings in Atlanta, the survey process and chosen stratification methods, communication tools used, and concluded with a sample report from the surveys' empirical results. Supporting literature was provided at the conclusion of the presentation.

E. W. Looney – CEO, Brightlink

"Calmer, Fairer & Smarter – ADEX technology Platform Updates"

E.W. Looney talked about the present ADEX Dental Examination computer program, where it is at and where it is going. He also presented a model for making good decisions and working as a team toward achieving objectives.

Dr. Stephen Klein, Gansk & Associates, ADEX Psychometrician:

Dr. Klein reviewed both the Dental and Dental Hygiene post examination Analysis that are found in the 2010-2011 ADEX Annual Report.

Dr. Peter Yaman, Chair ADEX Dental Exam Committee - Dental Examination Overview

Dr. Yaman presented the report of the Examination Committee meeting which was held on Friday November 4, 2011. The following recommendations were made by the examination committee:

The following are the recommendations to the ADEX House of Representatives regarding the Dental Examination.

- That as a result of the recently completed Occupational Analysis that the patient based Periodontal Section of the Dental Examination is not a requirement, but will be offered as an optional portion depending on the requirements of the state starting with the 2013 Examination cycle.

- That the ADEX President appoint a subcommittee to evolve the patient based Periodontal Examination.

- That any restoration will treat all cariuos lesions on a tooth and all tooth surfaces treated would be graded.

- That if two candidates identify separate lesions an the same anterior tooth they would be allowed to treat those lesions unless there is a temporary filling placed by the first candidate, then the second candidate will not be allowed to present the patient, this satisfies the requirement to treat the entire tooth.

- That there be developed for the Dental Examination the separation of detection and removal of calculus.

- That the SRTA RDH Format be adopted for the 2013 Dental Examination Cycle.

- That the Captain be allowed to counsel and discuss with examiners who misapply objective measurable criteria of a critical deficiency.

- That retakes for the restorative examination be limited to 6 hours.

- That if a lesion on the Class III composite was assigned without a contact it can be restored without a contact and examiners should be informed of this change.

- That a second lesion can be assigned anytime during the exam, but the first restoration would have to be graded before the second preporation can be started.

Dr. Scott Houfek moved to accept the Dental Examination Committee Report. Motion approved by general consent.

The next Dental Examination Committee Meeting will be Friday and Saturday November, 9-10, 2012.

Dr. Barrette presented an award to Dr. Yaman thanking him for serving as the Chair of the Dental Exam Committee for the past 3 years.

Nancy St. Pierre - Chair ADEX Dental Hygiene Exam Committee - Dental Hygiene Examination Overview

2012 CHANGES:

1. To allow the candidates to bring the candidate manual, ADEX Forms, and notes written in the manual to the treatment area on the clinic floor.

2. The Candidate may not bring into the clinical examination any paperwork other than ADEX forms, the manual and notes written in the manual

3. To decrease the point value deduction for the pocket qualifying teeth to: -10 points for missing one tooth/surface and -20 missing two or more tooth/surfaces.

4. To allow local Injectable anesthesia during the clinic ADEX DH exam in compliance with the Examination Hosting Sites State statue.

5. The primary quadrant will have at least 6 permanent teeth.

6. Definition of "Qualifying Calculus:" Explorer-detectable subgingival calculus which is DISTINCT and EASILY detected with a #11/12 explorer as it passes over the calculus.
   Must be apical to the gingival margin (subgingival) and may occur with or without associated Supragingival deposits.
   Exhibits such characteristics:
   - Significant enough in quantity to be readily discernible or detectable
   - Definite "jump" or "bump" which easily detected with one or two strokes
   - A deposit that easily "binds" or "catches" the explorer
   - Ledges or ring formations
   - Spiny or nodular formations

7. Interproximal deposit that can be detected from the lingual and or buccal

8. The 2012 Candidate treatment time is 2 hours.

9. To allow the 2 assigned probing teeth to be within or outside the primary quadrant.

10. Keep the current 15 pt penalty rule for the 4 or more errors for calculus detection and removal

2013 CHANGES

1. To provide a "Bubble" marking the area on the Dental Hygiene Examination Grade Form in which to identify the "primary quadrant" i.e.: UR,UL,LL,LR or 1-8,9-16,17-24,25-32.

2. For purposes of the manual, the following words and terms shall have the following meanings:
   "Primary Quadrant" – Quadrant of at least 6 permanent teeth that evidence 12 surfaces of calculus, 8 of which are on surfaces of posterior teeth (premolars/molars), 5 of the posterior (premolars/molars) surfaces must be on proximal (mesial or distal) surfaces and 3 of these proximal (mesial or distal) surfaces must be on molars.
   "Alternative Selection" – Up to 4 approximating posterior teeth (premolars/molars) in one additional quadrant used to satisfy tooth and surface selection criteria not met in the Primary Quadrant.
   "Complete Treatment" – Removal of all supra and subgingival calculus as well as coronal plaque and stain.
   "Posterior teeth" – premolars and molars
   "Proximal surfaces" – mesial and distal surfaces "Approximating teeth" – posterior teeth that are within 2mm of each other

The Candidate must select a Primary Quadrant with at least 6 permanent teeth for Complete Treatment that satisfies the minimum criteria described below:

1. The Primary Quadrant must present 12 surfaces of subgingival calculus on a minimum of 6 teeth.

2. The 12 surfaces of subgingival calculus must be distributed as follows:
   - 8 of these surfaces must be on approximating posterior teeth (premolars and molars). These posterior teeth must be within 2mm of each other.
   - 5 of these posterior (premolars/molars) surfaces must be on mesial or distal proximal surfaces.
   - 3 of these mesial or distal proximal surfaces must be on molars, in particular.
   - One distal surface of a 2nd or 3rd terminal molar may be used.

3. The 4 remaining surfaces are at the choice of the candidate. The Candidate may select an Alternative Selection for Complete Treatment, should the above criteria not be met in the Primary Quadrant.

3. An alternative selection of up to 4 approximating posterior teeth (premolar and molar) in one additional quadrant may be used to satisfy the tooth and surface selection criteria. These posterior teeth must be within 2mm of each other. For Complete Treatment, each tooth in the Alternative Selection must be free of all supra and subgingival calculus as well as coronal plaque and stain.

4. To establish two sections in the ADEX DH exam to demonstrate calculus detection and calculus removal

5. The detection exercise will consist of 3 consecutive teeth , two of which being posterior teeth in the primary quadrant

6. Add four additional teeth and surface for the 12 subgingival calculus removal. The 1,2,3,or 4 surfaces will only be used for grading purposes if the candidates first 12 selections do NOT meet criteria.

7. To eliminate the 6 plaque, stain, and supra calculus removal area on the grade form and add the 6 points to the Hard Tissue Management "SUB" point value now equally 8 pts. To eliminate the 6 plaque, stain, and supra calculus removal area on the grade form and add the 6 points to the Hard Tissue Management "SUB" point value now equally 8 pts.

Dr. Scott Houfek moved to accept the Dental Hygiene Examination Committee Report. Motion approved by general consent.

President Barrette announced that the Board of Directors has selected Dr. Scott Houfek of Wyoming to be the new Dental Examination Committee Chair.

Treasurer Report and ADEX Budget

Dr. William Pappas, ADEX Treasurer reported that the current ADEX Fund Balance is $84,500.00 and that the 2011-2012 Budget is Revenue of $250,000 and proposed expenses of $250,000.00.

Dr. Dennis Manning moved to accept the Treasurer's Report and to approve the 2011- 2012 ADEX Budget. Motion passed by general consent.

Business Session

Proposed Bylaws Amendments: Dr. Robert Ray, Chair of the Bly-Laws Committee reported that there were no recommended changes to the By-Laws.

Dr. Craig Meadows, TN moved and Dr. Scott Houfek, WY seconded a motion to nominate Dr. Harold "Bo" Smith as Treasurer of ADEX for 2011-2011 term. There were no other nominations. The motion passed by general consent.

Dr. Scott Houfek, WY moved and Ms. Nan Kosydar Dreves, RDH, WI seconded a motion to nominate Dr. William Pappas as Secretary of ADEX for 2011-2012 term. There were no other nominations. The motion passed by general consent

Dr. Guy Shampaine, MD moved and Ms. Mary Johnston, RDH, MI seconded a motion to nominate Dr. Stanwood Kanna as Vice-President of ADEX for 2011-2012 term. There were no other nominations. The motion passed by general consent.

Dr. Keith Clemence, WI moved and Dr. Henry Levin, RI seconded a motion to nominate Dr. Bruce Barrette as President of ADEX for 2011 - 2012 term. There were no other nominations. The motion passed by general consent.

Caucuses: The House broke into district caucuses.

District Elections: The following are the caucus election results and include new appointees as well as re-elected representatives:

District 2 Mary Davidson, RDH, OR, Hygiene Representative
Ms. Marian Grey, HI, Consumer Representative
Dr. Rick Thiriot, NV Educator, Dental Exam Committee

District 4: Nan Kosydar Dreves, RDH, WI, Dental Hygiene Representative
Judy Ficks, RDH, Consumer Member
To be Determined, Educator, Dental Exam Committee

District 5: Mary Johnston, RDH, MI, Dental Hygiene Representative
Ms. Clance LaTurner, IN, Consumer Representative
Dr. George Willis, MI, Educator Dental Exam Committee

District 6: Michelle Bedell, DDS, SC, Board of Directors
Mary Ann Burch, RDH, WV, Dental Hygiene Representative
Allan Francis, KY, Consumer Representative
TBD Educator, Dental Exam Committee Member

District 7: Cheryl Bruce, R.D.H., MD, Dental Hygiene Representative
Allan Horwitz, Esq., PA, Consumer Representative
Mariellen Brickley-Raab, RDH, Dental Hygiene Exam Committee
Uri Hangorsky, DDS, PA, Educator Dental Exam Committee

District 8 Sibyl Gant, RDH, DC, Dental Hygiene Representative
Consumer Representative: TBD
Dr. John Bailey, DC, Educator, Dental Exam Committee

District 9: Nancy St. Pierre, RDH, NH, Dental Hygiene Representative
Ms. Lynn Joslyn, NH Consumer Representative
Dr. Marc Rosenblum, NJ, Educator, Dental Exam Committee

District 10: Richard Dickinson, DDS, VT, Board of Directors
Diane Denk, ME, Consumer Representative
Steven DuLong, MA, Educator, Dental Exam Committee

District 12: Wade Winker, DDS, FL Board of Directors
Irene Stavros, RDH, FL, Dental Hygiene Representative
Vicki Campbell, FL, Consumer Representative
Dr. Boyd Robinson, FL Educator, Dental Exam Committee
Dr. Wiliam Kuchenour, FL, Dental Exam Committee

Dr. Scott Houfek moved and Dr. Peter DeSciscio seconded a motion to accept the dental exam. The motion passed by general consent.

Nan Kosydar Dreves, RDH moved and Dr. Scott Houfek seconded a motion to accept the dental hygiene exam.

Dr. Wade Winker moved and Dr. Dennis Manning seconded to amend the motion for the approval of the dental hygiene examination, that ADEX develop a Local Anesthesia component for the Dental Hygiene Examination.

The motion as amended passed by general consent.

Future Meeting Dates

Dr. Scott Houfek moved and Mr. Zeno St. Cyr, II seconded that the next ADEX Meetings be held November 9, 10, 11, 2012. The motion passed by general consent.

Dr. Barrette recognized Mr. Patrick Braatz who has been doing the administrative work of ADEX during the past year as a volunteer. All members of the House rose and gave Mr. Braatz a standing ovation.

Adjournment: Mr. Maulid Miskell moved and Dr. Robert Ray seconded a motion for adjournment. The motion passed by general consent. The meeting was adjourned at 11:30 a.m.

Proc. 7th H of R 11.06.11(1)

ADEX

American Board of Dental Examiners, Inc.

a test development agency for the member state dental boards

2010-2011 Annual Report

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Message from the President

Welcome to the Seventh Annual ADEX House of Representatives. The American board of Dental Examiners (ADEX) has just finished its fifth full year of initial licensure examinations in dentistry and dental hygiene. This has been an especially busy year with much accomplished. Three new states (Arkansas, Florida and Tennessee) have become members. A regional testing agency (SRTA) has voted to administer the ADEX dental examination in 2013. At the same time, we continue to strengthen our examinations with a special emphasis this year on improving our calibration exercises.

ADEX still remains the largest licensure test development entity for dentistry in the United States with 27 state dental boards as members and with approximately 42 states accepting the examinations for licensure. This progress is due to the support and commitment of the member state boards and the volunteers chosen by those state dental boards toward developing the most valid, reliable and defensible examinations possible for the dental profession.

Thank you for your dedication and participation in the 2011 ADEX House of Representatives.

Bruce Barrette, DDS
President, ADEX

ADEX Membership

Membership gives a recognizing state dental board direct involvement in the development and evolution of the examinations through committee appointments; and approval of the final form of the examinations in dentistry and dental hygiene through their appointments to the House of Representatives.

Consumer members of state dental boards are full active voting members of ADEX directly involved in the evolution and participation of the examinations.

Member States

Arkansas
Colorado
Connecticut
District of Columbia
Florida
Hawaii
Illinois
Indiana
Iowa
Kentucky
Maine
Maryland
Massachusetts
Michigan
Nevada
New Hampshire
New Jersey
Ohio
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Wyoming
Vermont
West Virginia
Wisconsin

ADEX

ADEX Districts

ADEX initial districts were drawn to try to equalize the number of dental students, dentists licensed each year, and to some degree practicing dentist numbers.

District 1:	California
District 2:	Alaska, Arizona, ***Colorado, Hawaii***, Idaho, Montana, ***Nevada***, New Mexico, ***Oregon***, Utah, Washington, ***Wyoming***
District 3:	Kansas, Missouri, Nebraska, Oklahoma, Texas
District 4:	***Iowa***, Minnesota, North Dakota, South Dakota, ***Wisconsin***
District 5:	***Illinois, Indiana, Michigan, Ohio***
District 6:	***Arkansas***, Georgia, ***Kentucky, South Carolina***, ***Tennessee***, Virginia, ***West Virginia***
District 7:	***Maryland, Pennsylvania***
District 8:	***Connecticut***, Delaware, ***District of Columbia***, U.S. Virgin Islands
District 9:	***New Hampshire, New Jersey***, New York, ***Rhode Island***
District 10:	***Maine, Massachusetts, Vermont***
District 11:	Alabama, Louisiana, Mississippi, North Carolina, Puerto Rico
District 12:	***Florida***

States highlighted in ***bold italics*** are Member States

ADEX Governance

Governing Principle

ADEX's governing principle is that the governing authority is vested with the active member state boards of dentistry. Representatives are directly appointed by the active state dental board and the directors elected by state board representatives.

Important committee appointments are directly made through the representatives of the active state dental boards.

House of Representatives

Governance is from the Member State Dental Boards in the House of Representatives.

- The House of Representatives consists of dentist or executive director representatives from the member state dental boards. They hold final approval of major examination changes.
- Each state board will designate one representative.
- Representatives are required to have been active voting board members of the member state at some time.
- A Dental Hygiene representative from each ADEX district is required to be or have been an active board member from a member state.
- A Consumer representative from each ADEX district is required to be or have been an active board member from a member state.
- Each state will determine the qualifications of their representative.
- Members from American Dental Association (ADA), American Student Dental Association (ASDA), American Dental Education Association (ADEA), American Dental Hygienists' Association (ADHA), The National Dental Examining Board of Canada (NDEB), Canadian Dental Association (CDA), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) are chosen by their respective organizations.

2010 ADEX House of Representatives

Dentist or Executive Director Representatives

Colorado – Mr. Maulid Miskell,

Connecticut – David Perkins, DDS

District of Columbia – Robert Ray, DMD

Florida – Hal Hearing, DDS

Hawaii – Ms. Sandra Matushima

Illinois – Geri Ann DiFranco, DDS

Indiana – Steve Pirtchard, DDS

Iowa – No Representative

Kentucky – Mr. Brian Bishop

Maine – Rockwell Davis, DDS

Maryland – Maurice Miles, DDS

Massachusetts – Mina Paul, DDS

Michigan – William Wright, DDS

Nevada – William Pappas, DDS

New Hampshire – Neil Hiltunen, DMD

New Jersey – Peter DeSciscio, DDS

Ohio – Phil Beckwith, DDS

Oregon – Patricia Parker, DMD

Pennsylvania – John V. Reitz, DDS

Rhode Island – Craig VanDongen, DDS

South Carolina – No Representative

Vermont – Richard Dickinson, DDS

West Virginia – George "Buck" Conard, DDS

Wisconsin – Dr. Keith Clemmence, DDS

Wyoming – Scott Houfek, DDS

2010 ADEX House of Representatives (con't.)

Dental Hygiene Representatives

Mary Davidson, RDH, OR	District 2
Nan Dreves, RDH, WI	District 4
Mary Johnston, RDH, MI	District 5
Dina Vaughn, BSDH, MS, WV	District 6
Mariellen Brickley-Raab, RDH, MD	District 7
Sibyl Gant, RDH, DC	District 8
Nancy St. Pierre, RDH, NH	District 9
Karen Dunn, RDH, MA	District 10
Irene Stavros, RDH, FL	District 12

Consumer Representatives

Marian Grey, HI	District 2
Ms. Judith Ficks, WI	District 4
Ms. Clance LaTurner, IN	District 5
Mr. Allan D. Francis, KY	District 6
Allan Horwitz, Esq., PA	District 7
No Representative	District 8
No Representative	District 9
Ms. Diane Denk, ME	District 10
Mr. Ben Poitevent, FL	District 12

2010 ADEX House of Representatives (con't.)

Associate Members

American Dental Association – Charles Norman, DDS, ADA Trustee

American Student Dental Association – Mr. Corwyn Hopke, President

American Dental Education Association – Peter Robinson, DDS

American Dental Hygienists' Association – No Representative

National Dental Examining Board of Canada – No Representative

Canadian Dental Association – No Representative

Federation of State Medical Boards – No Representative

National Board of Medical Examiners –No Representative

ADEX Board of Directors

ADEX Officers

Bruce Barrette, DDS	Wisconsin	President
Stanwood Kanna, DDS	Hawaii	Vice-President
Vacant		Secretary
William Pappas, DDS	Nevada	Treasurer
Guy Shampaine, DDS	Maryland	Immediate Past President

ADEX Board of Directors – Up to 17 Members

12 Districts, Examination Committee Chairs, Dental Hygiene Representatives

Directors elected by state board representatives in House of Representatives

Board of Directors

Stan Kanna, DDS	Hawaii	District 2
Bruce Barrette, DDS	Wisconsin	District 4
M.H VanderVeen, DDS	Michigan	District 5
David Narramore, DMD	Kentucky	District 6
Guy Shampaine, DDS	Maryland	District 7
Robert Ray, DMD	DC	District 8
Peter DeSciscio, DMD	New Jersey	District 9
Richard Dickinson, DDS	Maine	District 10
Hal Haering, DDS	Florida	District 12
Ms. Judith Ficks	Wisconsin	Consumer Member
Mr. Zeno St. Cyr, II	Maryland	Consumer Member
Cathy Turbyne, EdD, MS, RDH	Maine	Hygiene Member
James "Tuko" McKernan, RDH,	Nevada	Hygiene Member
Nancy St. Pierre, RDH,	New Hampshire	Chair, Dental Hygiene Examination Committee
Peter Yaman, DDS	Michigan	Chair, Dental Examination Committee

Terms for Current ADEX Board of Directors*

District	Incumbent	Remaining Tenure
District 2	Stan Kanna, DDS	1 Year
District 4	Bruce Barrette, DDS	1 Year
District 5	M. H. VanderVeen, DDS	2 Years
District 6	David Narramore, DMD	0 Years
District 7	Guy Shampaine, DDS	1 Year
District 8	Robert Ray, DMD	2 Years
District 9	Peter DeScisco, DMD	2 Years
District 10	Richard Dickinson, DDS	0 Years
District 12	Hal Haering, DDS	0 Years
Consumer Member	Ms. Judith Ficks	2 Years
Consumer Member	Mr. Zeno St. Cyr, II	1 Year
Hygiene Member	Cathy Turbyne, EdD, MS, RDH	1 Year
Hygiene Member	James "Tuko" McKernan, RDH	2 Years

* All members of the Board of Directors are eligible to serve a second three-year term if elected by their district.

ADEX Committees

Dental Examination Committee

- One (1) dentist from each Member Board.
- One (1) Member Board consumer representative
- 1 Consumer
- The Chair of the Dental Examination Committee
- All appointments are nominated by the representatives of the member state dental boards.

Dental Examination Committee Members

Peter Yaman, DDS, MI – Chair

District 2: (CO, HI, NV, OR, WY)
Peter Carlesimo, DDS, CO
Stan Kanna, DDS, HI
William Pappas, DDS, NV
Jonna Hongo, DMD, OR
Scott Houfek, DDS, WY
Rick Thiriot, DDS, NV Educator

District 4: (IA, WI)
Gary Roth, DDS, IA
Keith Clemmence, DDS, WI
Karen Jahimiak, DDS, WI Educator

District 5: (IL, IN, MI, OH)
Dennis Manning, DDS, IL
Matt Miller, DDS, IN
Chuck Marinelli, DDS, MI
Eleanore Awadalla, DDS, OH
George Willis, DDS, IN, Educator

Dental Examination Committee Members (con't.)

District 6: (AK, KY, SC, TN, WV)
- George Martin, DDS, AR
- Robert Zena, DDS, KY
- Michelle Bedell, DDS, SC
- John M. Douglas, Jr. DDS, TN
- John Dixon, DDS, WV
- Educator Rep

District 7: (MD, PA)
- Guy Shampaine, DDS, MD
- Susan Calderbank, DMD, PA
- Ronald Chenette, DMD, MD, Educator

District 8: (CT, DC)
- Lance Banwell, DDS, CT
- Rahele Rezai, DMD, DC
- John Bailey, DDS, DC, Educator

District 9: (NH, NJ, RI)
- Barbara Rich, DMD, NJ
- Neil S. Hiltunen, DMD, NH
- Henry Levin, DMD, RI
- Marc Rosenblum, DMD, NJ, Educator

District 10: (ME, MA, VT)
- Robert DeFrancesco, DMD, MA
- LeeAnn Podruch, DDS, VT
- Rockwell Davis, DDS, ME
- Stephen DuLong, DMD, MA, Educator

District 12: (FL)
- Wade Winker, DDS, FL
- Boyd Robinson, DDS, FL, Educator

Dental Examination Committee Members (con't.)

Consumer:
Alan Horwitz, Esq., PA

Consultants:
Ogden Munroe, DDS, IL
Terry Rees, DDS, TX

Testing Specialist:
Steven Klein, Ph.D, CA

NERB Administrative Liaison:
Ellis Hall, DDS, MD

Nevada Administrative Liaison:
Kathleen Kelly, NV

ADEX Committees (con't.)

Dental Hygiene Examination Committee

- 1 Dental Hygienist from each district
- 1 Dental Hygiene Educator
- 1 Dentist
- 1 Consumer
- All appointments are nominated by the active member state dental boards.

Dental Hygiene Examination Committee Members

Nancy St. Pierre, RDH, NH – Chair

District 2: Jill Mason, RDH, OR

District 4: Nanette Kosydar Dreves, RDH, WI

District 5: Lynda Sabat, RDH, OH

District 6: Diana Vaughan, RDH WV

District 7: Angie Riccelli, RDH, MS, PA

District 8: Judith Neely, RDH, BS, DC

District 9: Shirley Birenz, RDH, BS, NJ

District 10: Karen Dunn, RDH, MA

Dentist: Maxine Feinberg, DDS, NJ

Educator: Donna Homenko, RDH, PhD, OH

Consumer: Zeno St. Cyr II, MPH, MD

Testing Specialist: Steven Klein, Ph.D, CA

ADEX Committees (con't.)

Budget Committee

William Pappas, DDS, NV - Chair
Scott Houfek, DDS, WY
Neil Hiltunen, DDS, NH
Tony Guillen, DDS, NV
Guy Shampaine, DDS, MD

Bylaws Committee

Robert Ray, DDS, WI - Chair
Garo Chalian, DDS, CO
James "Tuko" McKernan, NV
Alan Horowitz, Esq. PA

Calibration Committee

William Pappas, DDS, NV - Chair
Scott Houfek, DDS, WY
Tony Guillen, DDS, NV
Rick Thiriot, DDS, NV
Neil Hiltunen, DDS, NH
Ogden Munroe, DDS, IL
Ken Van Meter, DDS, VT
Rick Kewlowitz, DDS, FL
Peter Yaman, DDS, MI
Ronald Chenette, DMD MD
Wendell Garrett, DDS, AK

Quality Assurance Committee

Hal Haering, DDS, AZ - Chair
Stanwood Kanna, DDS, HI
Patricia Parker, DMD OR
Scott Houfek, DDS, WY
Robert Sherman, DDS, HI
J. George Kinnard, DDS NV
Barbara Rich, DMD NJ
Nan Kosydar Dreves, RDH, WI
Ronald Chenette, DMD MD
James Haddix, DMD, FL
Guy Shampaine, DDS, MD
Peter Yaman, DDS, MI
Nancy St. Pierre, RDH,NH
Stephen Klein, PhD., CA, Testing Specialist

Communications Committee

Mary Johnston, RDH, MI - Chair
Stanwood Kanna, DDS HI
David Narramore, DMD, KY
Geri Ann DiFranco, DDS, IL
Mary Davidson, RDH, OR
Clance LaTurner, IN
Margo Rheinberger, PhD, MN

ADEX Dental Examination

Content

- Five stand alone examinations
  - Critical skill sets identified by criticality in the Occupational Analysis
- Computerized Examination in Applied Diagnosis and Treatment Planning
- Endodontic Clinical Examination
  - Manikin-based
- Fixed Prosthodontic Clinical Examination
  - Manikin-based
- Restorative Clinical Examination
  - Patient-based
- Periodontal Clinical Examination
  - Patient-based

Scoring

- Criterion based scoring system
- Three (3) independent raters without cross-validation

Rating Levels

- Satisfactory
- Minimally Acceptable
- Marginally Substandard
- Critically Deficient

ADEX Dental Exam Scoring

Criterion-Based Analytical Scoring Rubric:

- More detailed feedback.
- More consistent scoring.
- Allows for the separate evaluation of factors.
- Evaluation of all gradable criteria.
- Scoring methodologies were developed with consultation from the Buros Institute, University of Nebraska and the Rand Institute with input from studies completed by testing specialists from the University of Chicago.
- Three (3) independent raters evaluate all measurable criteria.
- Median score is utilized when there are no matching scores; all zeros must be independently corroborated to be utilized as a critical deficiency.
- Performance criteria-based scoring will be provided to both the candidate and the dental school so that appropriate remediation can be completed prior to a retake when required.
- Clinical sections utilize compensatory grading with critical errors within a skill set.
- No grading across skills.
- Critical errors are those performance deficiencies that would cause treatment to fail. A critical error forces a failure on that skill set examination. Not all criteria have critical errors.

Evaluation Criteria

Objective measurable criteria developed by a panel of experts consisting of examiners, practitioners, and educators.

Amalgam Prep External Outline Criteria (Example)

SATISFACTORY

1. Contact is visibly open proximally and gingivally up to 0.5 mm.
2. The proximal gingival point angles may be rounded or sharp.
3. The isthmus must be 1-2 mm wide, but not more than ¼ the intercuspal width of the tooth.
4. The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The gingival floor is flat, smooth and perpendicular to the long axis of the tooth.
5. The outline form includes all carious and non-coalesced fissures, and is smooth, rounded and flowing.
6. The cavosurface margin terminates in sound natural tooth surface. There is no previous restorative material, including sealants, at the cavosurface margin. There is no degree of decalcification on the gingival margin.

MINIMALLY ACCEPTABLE

1. Contact is visibly open proximally, and proximal clearance at the height of the contour extends beyond 0.5 mm but not more than 1.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 0.5 mm but not greater than 2 mm.
3. The isthmus is more than ¼ and not more than 1/3 the intercuspal width.
4. The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel.

MARGINALLY SUBSTANDARD

1. The gingival floor and/or proximal contact is not visually open; or proximal clearance at the height of contour extends beyond 1.5 mm but not more than 2.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 2 mm but not more than 3 mm.
3. The outline form is inappropriately overextended so that it compromises the remaining marginal ridge and/or cusp(s).
4. The isthmus is less than 1 mm or greater than 1/3 the intercuspal width.
5. The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s).
6. The cavosurface margin does not terminate in sound natural tooth structure; or, there is explorer penetrable decalcification remaining on the cavosurface margin, or the cavosurface margin terminates in previous restorative material. *(See glossary under Previous Restorative Material).*
7. There is explorer-penetrable decalcification remaining on the gingival floor.
8. Non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form.

CRITICAL DEFICIENCY

1. The proximal clearance at the height of contour extends beyond 3 mm on either one or both proximal walls.
2. The gingival clearance is greater than 3 mm.
3. The isthmus is greater than ½ the intercuspal width.
4. The outline form is overextended so that it compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the pulpal-occlusal wall is unsupported by dentin or the width of the marginal ridge is 1 mm or less.

Endodontic Clinical Examination on a Simulated Patient (Manikin)

Part II: Endodontics – 18 Scorable Items

- Anterior Endodontic Procedures 12 Criteria
  - Access Opening
  - Canal Instrumentation
  - Root Canal Obturation
- Posterior Access Opening 6 Criteria

Fixed Prosthodontic Examination on a Simulated Patient (Manikin)

Part III: Fixed Prosthodontics – 43 Scorable Items

- Cast Gold Crown 15 Criteria
- Porcelain-Fused-to-Metal Crown 14 Criteria
- Ceramic Crown Preparation 14 Criteria
- Preparations 1 & 2 evaluated as a mandibular posterior 3-unit bridge

Part V: Restorative – 47 Scorable Items

- Class II Amalgam Preparation 16 Criteria
- Amalgam Finished Restoration 9 Criteria
- Class III Composite Preparation 12 Criteria
- Composite Finished Restoration 10 Criteria

Periodontal Clinical Examination

Treatment Selection (Procedural)

- Patient Selection severity of periodontal disease.

Treatment

1. Subgingival Calculus Detection
2. Subgingival Calculus Removal
3. Plaque/Stain Removal
4. Pocket Depth Measurement
5. Treatment Management

ADEX Dental Post-Exam Analysis

- Technical Report Developed
- Demographic Data/Analysis
  - Conducted by respective administering agencies
  - Synopsis of data provided for Restorative and Periodontal Procedures with several years of history:

Demographic Data on the Candidate Pool
Failure Rate Summaries
Analysis of Candidate Performance by Test Section
Analysis of Failure Rates by Group Assignment
Analysis of Mean Scores by Procedure/Examination Part
Examiners' Score Agreement Summary
Frequency of Rating Assignments
Correlation of Treatment Selection with Restorative Results
Frequency of Penalty Assignments
Annual Schools Report

- Schools are provided with data regarding their performance annually
- Schools are provided individual candidate performance after each examination series.
- School identities are coded so that each school may compare their performance confidentially
- Performance data for each area of examination content is analyzed and presented
- By procedure
- By individual criterion

Examiner Profiles

- Data is collected for each examiner and compiled into profiles providing information to the examiners regarding their evaluations.

Summary of Total Number of Evaluations per Dental Examiner
Summary of Examiner Agreements for each Examination/Procedure
Percentage Rating Level Assigned per Procedure
Summary of Examiner Agreements & Disagreements across all Procedures
Peer Evaluations

- This information is utilized to monitor examiner performance

ADEX Dental Post-Exam Analysis (con't.)

Candidate Results:

- Total CIF Candidates, Class of 2011: 1448

Initial and eventual passing rates by examination

Test	% Pass on 1st Attempt	% Pass by last Attempt	% Did Not Repeat after Initial Fail
DSCE	97	100	2.5
Endodontics	96	100	0.13
Fixed Prosthodontics	88	99	0.53
Periodontics	98	97	1.26
Restorative Dentistry	87	99	1.8
Mean	?	?	?

97% of candidates who took advantage of all opportunities passed all 5 sections by the time they graduated from Dental School.

Inter-Examiner Agreement

Failing the Endodontic, Prosthodontic, or Restorative Dentistry exams was driven by whether or not the candidate committed a "critical" error or had a critical deficiency. Specifically, almost no one failed one of these exams without committing a corroborated critical error or deficiency and no one passed who did. A candidate also can fail by not earning enough points, but that only really occurred on the Periodontal exam.

Given this situation, the analysis of examiner agreement on the Endodontic, Prosthodontic, and Restorative Dentistry exams focused on whether the examiners reached the same conclusion as to whether or not a candidate had a critical deficiency or made a critical error. Examiners achieved consensus (i.e., all three agreed with each other) 98 to 99 percent of the time on whether a critical error or deficiency was present.

ADEX Dental Hygiene Examination

Candidate Results:

Tested as of December 31, 2010: 2374

Test	% Pass on 1st Attempt	% Pass by last Attempt	% Did Not Repeat after Initial Fail
CSE	96	100	2.03
Patient Based Examination	92	100	2.03

For 2010: 100% of candidates who took advantage of all opportunities had passed the examination by the end of 2010.

For 2011: 95% of candidates passed the CSCE on the first attempt, 93% of candidates passed the Patient Based Examination on their first attempt which occurred by the time the graduated Dental Hygiene School.

STATISTICAL ANALYSIS THE 2010 DENTAL HYGIENE EXAM

Stephen Klein, Ph.D. and Roger Bolus, Ph.D.
September 28, 2011

This report provides summary data on ADEX's Clinical Hygiene Examination and on its Computer Simulated Clinical Examination (CSCE) for dental hygienists.[1] Results are for the 2,430 candidates who took both tests for the first time between April 2010 and March 2011. All but 22 of these candidates took these exams by December 2010.

A total score of 75 or higher is needed for passing each test. The percent passing the clinical exam, the CSCE, and both tests on the first try were: 92.2, 94.9, and 87.8 percent, respectively.

[1] Technical reports for the 2007 examinations describe the occupational analyses on which these tests are based and the procedures used to select and train examiners.

Clinical Exam Scoring Rules

Table 1 shows the number of points candidates could receive on each part of the clinical exam. A candidate's score on a part is the median of the scores assigned by three independent examiners. The first two scores are for the "Pre-treatment" portion of the exam and the last three are for the "Post-treatment" portion. The total score is the sum of the five part scores minus any penalty points. Appendix A describes the penalty point deductions that could be assigned.

Table 1
Possible Points Per Section

Section	Number of judgments	Points per judgment	Total points
Pocket Depth Measurement	12	1.5	18
Calculus Detection	12	3.0	36
Calculus Removal	12	3.0	36
Plaque/Stain Removal	6	1.0	6
Hard/Soft Tissue	2	2.0	4
Total			100

Table 2 shows the mean score and standard deviation on each part. A comparison of these means with the corresponding maximum possible scores indicates that most candidates had perfect or near perfect scores on each part. Nevertheless, the reliability (coefficient alpha) of the total score was 0.78, which is high given that (a) candidates usually had different examiners for the pre- and post-treatment sections and (b) there was a significant restriction in the range of scores assigned.

Table 2
Summary Test Statistics by Performance Test Section

Exam Section	Maximum Score	Mean Score	Standard Deviation	Score Reliability
Pocket Depth Measurement	18	17.60	1.02	0.51
Calculus Detection	36	34.81	3.31	0.75
Calculus Removal	36	32.76	4.88	0.69
Plaque/Stain Removal	6	5.98	0.16	0.29
Hard/Soft Tissue	4	3.83	0.38	0.07
Total Score	100	94.98	7.47	0.78

Penalty points were not considered for these calculations, and a candidate's final score on an item corresponded to the score that at least two of the three examiners assigned.

Effect of Penalties

Table 3 shows the number and percentage of candidates that lost points for the reasons noted in Appendix A, such as making a pocket depth qualification error. It also shows the number and percent that failed the exam because of these errors; i.e., these candidates would have passed were it not for the penalties they received. The policy of imposing only the largest applicable penalty (rather than the sum of all the separate ones assigned to the candidate) had no effect on the passing rate. Only two candidates received a deficient (def) score for hard or soft tissue, but neither def was corroborated. There were no pocket depth measurement penalties (and no one failed the exam because of making a pocket depth measurement error). The mean total clinical score before and after penalty points were awarded were 95.0 and 93.5, respectively.

Table 3
Percentage of Candidates Receiving Penalty Points

	Received a penalty for:		Failed because of penalty	
Exam Section	N	Percent	N	Percent
Case Acceptance	102	4.2	4	0.2
Pocket Depth Qualification	31	0.1	16	0.7
Calculus Detection	63	2.6	17	0.7
Calculus Removal	107	4.4	99	4.1
Any section	288	11.9	132	5.4

Inter-Examiner Agreement

Each candidate's work on the Clinical Examination was evaluated by three independent examiners (i.e., the examiners made their judgments without consultation with each other or knowing the scores assigned by other examiners). Table 4 shows that despite the extreme restriction in range noted in Table 2, there was still an adequate overall correlation between examiners in the scores they assigned.[2]

Table 4
Mean Correlation Between Two Examiners on Each Clinical Examination Section and Overall

Exam Section	Correlation
Pocket Depth Measurement	0.335
Calculus Detection	0.429
Calculus Removal	0.338
Plaque/Stain Removal	0.076
Hard/Soft Tissue	0.147
Total	0.353

[2] Correlation coefficients can range from -1.00 to 1.00. The stronger the relationship between the two variables (such as the scores assigned by examiner #1 and examiner #2), the higher the coefficient (regardless of its algebraic sign). For example, a high positive correlation between two examiners indicates that they generally agreed with each other in how they rank ordered the candidates.

Another way to look at examiner agreement is to see how often different examiners would make the same pass/fail decision about an applicant. This analysis (which did not consider penalty points) found that 86.3% of the applicants received a passing grade from all three examiners and 0.5% percent received a failing grade from all three. The total perfect agreement rate was therefore 86.8% (see Table 5). However, an 86.8% agreement rate is only 3.2 percentage points higher than the 83.6% rate that would occur by chance alone.[3]

Table 5
Percent Agreement in Overall Pass/Fail Decisions Among the First, Second, and Third Examiners

3/3 Agree Pass	2/3 Agree Pass	3/3 Agree Fail	2/3 Agree Fail	% All agree	% All Agree by Chance
86.3	10.6	0.5	2.6	86.8	83.6

Comparison of Clinical and CSCE Statistics

Table 6 shows that 87.8% of the candidates passed both tests and 0.7% failed both for an overall agreement rate of 88.5%. However, given the marginal totals, this is very close to the agreement rate that would occur by chance.[4]

Table 6
Correspondence in the Percentage of Pass/Fail Decisions Between the Clinical and CSCE Exams

	Fail Clinical	Pass Clinical	Total
Fail CSCE	0.7	4.4	5.1
Pass CSCE	7.1	87.8	94.9
Total	7.8	92.2	100.0

There was a very low correlation between CSCE and Clinical Examination scores (r = 0.11). If the 0.11 is corrected for the less than perfect reliability of the measures, the correlation between them would still be only 0.14. In short, the degree of agreement in pass/fail

[3] The chance rate is the product of the average of the three examiners' individual passing rates. Specifically, the first, second, and third examiners had passing rates of 94.65%, 94.03%, and 93.91%, respectively. The product of these three rates was 83.65%. Analyses were not conducted of the degree to which different examiners and Hygiene Coordinators would make the same decisions regarding case acceptance, the assignment of penalty points, or tooth selection for pocket depth measurements.

[4] Data on repeaters were not analyzed for this report.

decisions and scores between these two tests was not much higher than what would occur by chance alone.

Table 7 shows that the almost zero correlation between the Clinical and CSCE was **not** the result of their scores being unreliable. They both had adequate reliabilities (coefficient alphas) for making pass/fail decisions, especially given their high passing rates. Taken together, these findings support ADEX's use of a "conjunctive" rule (i.e., a rule that requires candidates to pass both tests in order to pass overall) rather than a "compensatory" rule (that would allow candidates to offset a low score on one test with a high score on the other).

Table 7
Summary Test Statistics for the Clinical and CSCE Exams

Test	Mean	Median	Standard Deviation	Reliability
Clinical	93.5	97.0	10.6	0.78
CSCE	86.2	87.0	6.7	0.77

Clinical scores are after penalty points were imposed.

Appendix A
Clinical Exam Penalty Point And Disqualification Rules

Case Acceptance

There are five case acceptance criteria, the first four of which are initially evaluated by a single examiner and have 2 to 4 scoring levels. The fifth criterion, Pocket Depth Qualification, is evaluated by three examiners. The five criteria are:

- Required Forms (SAT, ACC, SUB, or DEF)
- Blood Pressure (SAT, ACC, or DEF)
- Radiographs (SAT, ACC, SUB, or DEF)
- Teeth Deposit Requirements (SAT or ACC)
- Pocket Depth Qualification

No penalty points are deducted if the first examiner assigns a SAT to all of the first four of these criteria. However, if the examiner assigns a non-SAT score to one or more of them, then a second examiner is called in to evaluate all four criteria. If the two examiners agree on a non-SAT call, then that call stands. The point deductions for a corroborated ACC, SUB, and DEF call are 5, 15, and 30, respectively.

If the two examiners disagree as to the seriousness of a problem, then the penalty for the *least* serious call is used. For instance, if the first and second examiners made calls of DEF and ACC for Blood Pressure, then the 5-point penalty for the ACC call stands.

Pocket Depth Qualification is evaluated by three independent examiners. Candidates select 3 teeth they believe satisfy the requirements. Three examiners independently make their calls as to whether these teeth are satisfactory. There is a 15-point deduction off the candidate's total score if two or three examiners agree that one of the teeth the candidate nominated does not satisfy the requirements; and 30 points are deducted if two or three examiners agree that two or three of the nominated teeth do not satisfy the requirements.

Penalty points do not accumulate across the five case acceptance criteria. Only the *largest* deduction for any of the five criteria is applied. For example, there is a total deduction of 15 points even if a candidate would otherwise lose 10 points for Blood Pressure, 5 points for Radiographs, and 15 points for Pocket Depth Qualification.

Other Point Deductions and Disqualifications

Candidates lose 3 points for each corroborated calculation detection or removal error, such as by saying a surface is calculus free when two or three examiners say it is not free of calculus. Candidates fail the exam if they make: (a) 4 or more corroborated calculus detection errors, (b) 4 or more corroborated calculus removal errors, or (c) a corroborated hard or soft tissue critical error. Candidates lose 1.5 points for each corroborated pocket depth measurement error and 1 point for each plaque and stain removal error.

Updated 10.15.11

For additional info on ADEX contact:

ADEXOFFICE@aol.com

(503) 724-1104

CODA
Commission on Dental Accreditation

211 E. CHICAGO AVENUE SUITE 1900 CHICAGO, IL 60611-2678
TEL: 312 440 4653 FAX: 312 440 2915

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February 13, 2012

Ms. Chauntrell Artis
Campus Executive Director
Centura College
7020 North Military Highway
Norfolk, VA 23518

Re: Dental Assisting Program

Dear Ms. Artis:

At its February 2, 2012 meeting, the Commission on Dental Accreditation (CODA) considered the site visit report on the dental assisting program sponsored by the Centura College in Norfolk, Virginia. The Commission also considered the institution's response to the site visit report.

Following careful review of the information provided, the Commission adopted a resolution to grant the program the accreditation status of "approval with reporting requirements."

After careful review of the response, the Commission determined that the following recommendations contained in the site visit report remains unmet: **#s 1, 2, 5, 6, 7, 8, and 12**. Based on the number and nature of the recommendations left unmet, at this time the Commission is, notifying your institution of its **intent to withdraw** the program's accreditation at the Commission's August 9, 2012 meeting unless all recommendations are met and the program can demonstrate full compliance by that time.

Please review the attached "Summary of Recommendations and Required Documentation" that includes the stated recommendation and required documentation to submit with the progress report to demonstrate compliance.

The Commission requests one paper copy and one comprehensive electronic copy of the detailed progress report on the implementation of the recommendations be submitted to this office by **May 15, 2012** for consideration at the Dental Assisting Education Review Committee's July 17-18, 2012 meeting and the Commission's August 9, 2012 meeting.

Note: The program's documentation for CODA (self-study, application, or reports to CODA, for example) must NOT contain any patient protected health information. If an institution nevertheless provides the Commission and/or Commission site visitors with materials containing patient protected health information (PHI), such materials must be in electronic form and encrypted as outlined by the most recent breach notification

regulations related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In addition, most states have enacted laws to protect sensitive personally identifiable information ("PII") such as social security numbers, drivers' license numbers, credit card numbers, account numbers, etc. Before sending documents such as faculty CVs to CODA, institutions must fully redact the following PII: social security numbers, credit or debit card numbers, driver's license numbers or government-issued ID numbers, account numbers, health information, taxpayer ID, and date of birth.

Please refer to the attached Guidelines for Preparation of Reports and Documentation Guidelines for Selected Recommendations to assist you in developing a focused, concise response to the Commission's recommendations. Please note that if a Review Committee determines that a report does not meet the criteria as outlined in the documentation guidelines, the report will be returned to you and will not be reviewed at the July 17-18, 2012 meeting. The Commission's timelines for demonstration of full compliance will not be modified due to a delayed review resulting from improperly formatted reports.
In addition to the paper copy requested above, please be advised that the Commission requires that all accreditation correspondence/documents/reports and related materials submitted to the Commission for a program's permanent file be done so electronically. The attached Electronic Submission Guidelines will assist you in preparing your report. If the program is unable to provide a comprehensive electronic document, the Commission will accept a paper copy and assess a fee of $250 to the program for converting the document to an electronic version.

Institutions/Programs are expected to meet established deadlines for submission of requested information. If an institution fails to comply with the Commission's request, it will be assumed that the institution no longer wishes to participate in the accreditation program.

The definitions of accreditation classifications are enclosed, along with instructions to assist you in developing the progress report. Also enclosed is a summary of each recommendation and required documentation that must be submitted with the progress report to demonstrate the program's compliance.

By copy of this letter and in accord with Federal regulation, the Commission is providing written notice of its decision to place the program on "intent to withdraw accreditation, February 3, 2011" to the Secretary of the United States Department of Education as well as the appropriate accrediting and state licensing/authorizing agencies. Notice to the public is provided through the Commission's listing of accredited programs.

It should be noted that Commission policy allows for a representative of the program to

appear before the Dental Assisting Review Committee to supplement the written information contained in your progress report. A written request for a special appearance should be submitted to Dr. Anthony J. Ziebert, interim director, Commission on Dental Accreditation, by **June 15, 2012**. If the special appearance request is approved, the special appearance will occur at a specified date and time period prior to the committee's consideration of the program's accreditation classification. If additional written materials will be presented, **ten (10)** copies should be submitted by the institution to this office by **July 13, 2012**.

A copy of the Commission's Evaluation and Operational Policies and Procedures is enclosed. Please review the policy titled "Intent to Withdraw Accreditation." It states:

> "In the event accreditation is withdrawn from a program by the Commission, students currently enrolled in the program at the time accreditation is withdrawn and who successfully complete the program will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission-accredited program. Such graduates may be ineligible for certification/licensure examinations. In view of this, the Commission advises programs that the "intent to withdraw" accreditation may have legal implications for the program and suggests that their institutional legal counsel be consulted regarding how and when to advise applicants and students of the Commission's accreditation actions."

A copy of the Commission's site visit report is enclosed. One copy of this report and the related enclosures has also been sent to the chief administrative officer and program director copied on this letter. The Commission requests that a copy of this report and the related enclosures be forwarded to the chairpersons and appropriate faculty.

The Commission has authorized use of the following statement by institutions or programs that wish to announce their programmatic accreditation by the Commission. Programs that wish to advertise the specific programmatic accreditation status granted by the Commission may include that information as indicated in italics below (see text inside square brackets); that portion of the statement is optional but, if used, must be complete and current.

> The program in dental assisting is accredited by the Commission on Dental Accreditation *[and has been granted the accreditation status of "approval with reporting requirements with intent to withdraw accreditation August 2012"]*. The Commission is a specialized accrediting body recognized by the United States Department of Education. The Commission on Dental Accreditation can be contacted at (312) 440-4653 or at 211 East Chicago Avenue, Chicago, IL 60611. The

Commission's web address is: http://www.ada.org/100.aspx .

The staff of the Commission on Dental Accreditation is available for consultation to all educational programs which fall within the Commission's accreditation purview. Educational institutions conducting programs oriented to dentistry are encouraged to obtain such staff counsel and guidance by written or telephone request. Consultation is provided on request prior to, as well as subsequent to, the Commission's granting accreditation to specific programs. The Commission expects to be reimbursed if substantial costs are incurred.

If this office can be of any assistance to you or members of your staff, please contact me by telephone, at 1-800-621-8099, extension 2705 or by e-mail, at renfrowp@ada.org.

Sincerely,

Patrice Renfrow

Patrice Renfrow, RDH, BS
Manager, Dental Assisting and Dental Laboratory Technology Education
and Interim Manager, Dental Hygiene Education
Commission on Dental Accreditation

PR/ap

Enclosures: CODA Accreditation Status Definitions
Formal Site Visit Report

Sent via e-mail to Program Director:
Guidelines for Preparation of Reports and
Documentation Guidelines for Selected Recommendations
Formal Site Visit Report
Electronic Submission Guidelines
Accreditation Standards for Dental Assisting Education
Evaluation and Operational Policies and Procedures

cc: Ms. Gladys Bennett, director, Education
Ms. Cynthia Porter, dental coordinator, Dental Assisting
Dr. Meera A. Gokli, president, Virginia Board of Dentistry
Dr. Michale McCormis, executive director, Accrediting Commission of Career Schools and Colleges
Ms. Carol Griffiths, director, Accreditation and State Liaison Office, Postsecondary Education, United States Department of Education

Dr. Steven Tonelli, chair, Commission on Dental Accreditation (CODA)
Dr. Anthony Ziebert, senior vice-president, Education and Professional Affairs, American Dental Association; interim director, CODA

Summary of Recommendations and Required Documentation

Please review the following paragraphs that include the stated recommendation and required documentation to submit with the progress report to demonstrate compliance.

Recommendation #1: It is recommended that the curriculum be structured on the basis of, a minimum of, one academic year of full-time study or its equivalent. (DA Standard 2-4) The Commission notes that program out-of-class instructional hours total 424 hours. To demonstrate compliance with DA Standard 2-4, the Commission requests the program submit a breakdown of laboratory and preclinical practice hours. In addition, please submit the total number of didactic instructional hours, with a breakdown of on-site instructional hours and hours outside of class. Please provide evidence that the certificate dental assisting program is the equivalent of one academic year of full-time study in content and length. Please submit all course schedules that indicate time allocations for laboratory, didactic, preclinical and on-site clinical student learning experiences.

Recommendation #2: It is recommended that written documentation of each course in the curriculum be provided and include course content outline including topics to be presented, learning experiences including time allocated for didactic, laboratory, and clinical experiences and specific criteria for course grade evaluation. (DA Standard 2-6, c, d and e) The Commission notes that in response to the Preliminary Draft Site Visit Report, the program submitted the topics to be presented and general course objectives. To demonstrate compliance with DA Standard 2-6, c, d, and e, the Commission requests the program submit revised course documentation that includes specific student learning experiences that are aligned with the course objectives. Please include time allocations for each laboratory, preclinical (including on-site clinical), and didactic learning experiences. In addition, please list all learning experiences outside the classroom. Please indicate and describe the simulations and expectations for all learning experiences outside the classroom/facility and provide all evaluation mechanisms for assessing these learning experiences.

Recommendation #5: It is recommended that students demonstrate competency in taking diagnostically acceptable radiographs on patients in the program or contracted facility prior to taking radiographs during extramural clinical assignments. (DA Standard 2-18)
Recommendation #6: It is recommended that through scheduled instructional sessions, students have the opportunity to develop competence in exposing and processing bitewing and periapical radiographs on a variety of patients. (DA Standard 2-20)

To demonstrate compliance with DA Standards 2-18, and 2-20 the Commission requests

the program submit schedules for use of the radiographic facility that demonstrate the total number of hours each student is scheduled to expose radiographs on patients. In addition, please include a comprehensive faculty (including licensed dentist and clerical support staff) assignment schedule for one academic year. Please provide course documentation that indicates radiographic exposure requirements, patient selection criteria and system of obtaining and scheduling patients for radiographic exposures, and evaluation mechanisms for student exposures.

Recommendation #7: It is recommended that clinical experience assisting a dentist be designed to perfect students' competence in performing dental assisting functions rather than to provide basic instruction. (DA Standard 2-22) To demonstrate compliance with DA Standard 2-22, please submit evidence that students are evaluated and demonstrate competency in the program facility in performing all dental assisting functions required in the standards, prior to their clinical externship.

Recommendation #8: It is recommended that students maintain a record of their activities in each clinical assignment. (DA Standard 2-26) To demonstrate compliance with DA Standard 2-26, please submit copies of actual journals that reflect activities within the office and hours.

Recommendation #12: It is recommended that a radiography facility accommodate initial instruction and practice required for students to develop competence in exposing and processing radiographs with faculty supervision. (DA Standard 4-7) To demonstrate compliance with DA Standard 4-6, please submit a schedule for use and maintenance of the radiography facility by students, faculty and support staff. Please include a comprehensive faculty, dentist and part-time clerical support staff assignment schedule for one academic year.

FORMAL REPORT OF THE COMMISSION ON DENTAL ACCREDITATION TO THE ADMINISTRATION OF THE CENTURA COLLEGE ON THE EVALUATION OF THE DENTAL ASSISTING EDUCATION PROGRAM
Norfolk, VA*

Introduction

An evaluation of the dental assisting program offered by the Centura College was conducted on June 7-8, 2011 by a committee of the Commission on Dental Accreditation composed of Ms. Lesa McCabe, consultant in dental assisting; and Ms. Bunny Bookwalter, Commission staff representative.

The Commission believes that educational institutions offering curricula supportive to the dental profession assume the obligation and responsibility of affording quality educational opportunities which are based on sound educational principles. Commission objectives are also based on the premise that dental assisting education programs should strive continually to improve standards of scholarship and teaching consistent with the purpose and methods of postsecondary education. To assist the institution in appraising its educational effectiveness and identifying ways and means by which its endeavors can be strengthened, dental assisting programs are reviewed periodically by peers in relation to predetermined standards. This peer review of the educational process is based on the program's self-study and conferences with persons involved in the various components of the program.

This report represents the visiting committee's findings and conclusions in the form of recommendations that directly relate to accreditation standards and suggestions for program enhancement. These are found, as appropriate, under headings that parallel the Commission's Accreditation Standards for Dental Assisting Education Programs. Only those standards that warrant comment are included; in all other cases, the visiting committee found that the program met or exceeded the minimum standards.

The Commission on Dental Accreditation has discontinued the use of commendations, effective July 26, 2007. As a result, commendations will no longer be cited within site visit reports for programs under the Commission's purview.

Accreditation History

The dental assisting program offered by the Centura College was initiated in 1996 as Tidewater Tech. This was the Commission's fourth site evaluation of the dental assisting program. At the time of the site visit, the accreditation status for the dental assisting education program was "approval without reporting requirements." Information on the Commission's previous accreditation of the program follows:

* As approved by the Commission on Dental Accreditation for transmittal on February 2, 2012.

Date	Basis of Action	Action
January 1996	Written Application	Preliminary Provisional Approval
January 1998	Site Visit	Provisional Approval
July 1998	Progress Report	Provisional Approval
January 1999	Progress Report and Response to Formal Complaint	Provisional Approval with Intent to Withdraw
July 1999	Progress Report	Approval with Reporting Requirements
January 2000	Progress Report	Approval with Reporting Requirements
January 2001	Progress Report	Approval without Reporting Requirements
January 2005	Site Visit	Approval with Reporting Requirements
July 2005	Progress Report	Approval with Reporting Requirements
January 2006	Progress Report	Approval with Reporting Requirements with Intent to Withdraw
July 2006	Progress Report	Approval without Reporting Requirements
February 2008	Response to Formal Complaint	Approval with Reporting Requirements Intent to Withdraw
July 2008	Special Focused Site Visit	Approval with Reporting Requirements Intent to Withdraw
January 2009	Progress Report	Approval without Reporting Requirements

Review of Recommendations Cited in the Program's Previous Site Visit Report

At the time of the Commission's last evaluation of the program in July 2008, four recommendations were cited in the areas of Educational Program, Administration, Faculty and Staff, and Health and Safety Provisions. During this evaluation, the visiting committee reviewed these areas and found that the program has demonstrated continued compliance with the previous recommendations.

Compliance with Commission Policies

At the time of the site visit, the visiting committee determined that the program was in compliance with the Commission on Dental Accreditation's policies on "Third Party Comments" and "Complaints."

Standard 1. Institutional Effectiveness

There must be an active liaison mechanism between the program and the dental and allied dental professionals in the community. Through review of the self-study document, documents presented on-site and on-site interviews, the visiting committee noted that the program utilizes an advisory committee which meets at least twice a year. The visiting committee identified that committee membership is composed primarily of dental assistants, dental practice managers and dental supply company representatives, with no dentists listed on the committee roster. The visiting committee further noted that terms of service for members have not been established and many members have served on the advisory committee for over five years. It is suggested that the program review its advisory committee membership composition and revise as needed to provide for new input and a mutual exchange of information between dentists and assistants for improving the program and meeting the needs of the community.

Standard 2. Educational Program

The dental assisting program is presented in two, 15-week semesters. Upon completion of the program, graduates are awarded diplomas. Upon completion of all requirements for the accredited dental assisting program, students may return to the program facility to complete an optional expanded function and/or an associate degree program.

The curriculum must be structured on the basis of, a minimum of, one academic year of full-time study or its equivalent at the postsecondary level. Through review of the self-study document, documents presented on-site, on-site observation and interviews, the visiting committee noted that the dental assisting curriculum is presented over 30 weeks that include a 300-hour clinical externship. Students attend classes four days per week, six hours per day. The visiting committee noted that the total number of weeks was reduced from 45 to 30 when the program added the associate degree program and converted from quarter to semester hours. The visiting

committee could not verify that the variety and quality of curriculum content and clinical experience is sufficient to ensure students have the opportunity to acquire the knowledge and skill necessary to perform all dental assisting functions as defined by the Standards. The visiting committee noted that outcomes measures of student achievement include State of Virginia radiology certification and the Dental Assisting National Board (DANB), however, DANB data is limited to four students and is not sufficient to base conclusions. The visiting committee determined that the curriculum is not structured on the basis of the equivalent of one academic year of full-time study.

1. It is recommended that the curriculum be structured on the basis of, a minimum of, one academic year of full-time study or its equivalent. (DA Standard 2-4)

Written documentation of each course in the curriculum must be provided and include: the course description; course content outline including topics to be presented; specific instructional objectives; learning experiences including time allocated for didactic, laboratory and clinical experiences; and specific criteria for course grade calculation.

Through review of the self-study document, documents presented on-site and on-site interviews, the visiting committee noted course syllabi are provided to students. The visiting committee identified multiple inconsistencies within course documentation for all courses in the dental assisting curriculum. The visiting committee determined that course descriptions may not correspond to course objectives and content presented, and course outlines may not include dates and times of laboratory and preclinical evaluations. For example, the college catalog course description for DA 1300 Dental Anatomy includes "the role of the dental assistant as a member of the dental team". Further, course content outlines do not include time allocations for all didactic, preclinical and laboratory experiences. Syllabi for courses with laboratory and/or preclinical content lack objectives for skill performance. In addition, visiting committee could not identify how a final course grade is calculated, based on the criteria presented. Grade assignments are not determined based upon the assessments and student requirements listed for individual courses. It is suggested that the program review all course documentation and revise as needed for consistency with other published school materials.

2. It is recommended that written documentation of each course in the curriculum be provided and include course content outline including topics to be presented, learning experiences including time allocated for didactic, laboratory, and clinical experiences and specific criteria for course grade evaluation. (DA Standard 2-6, c, d and e)

Graduates must demonstrate competency in the knowledge and skill required to perform a variety of clinical supportive treatments, including clean and polish removable appliances.

Through review of the self-study document, documents provided on-site, and on-site interviews, the visiting committee could not verify that the dental assisting curriculum includes content in cleaning and polishing removable appliances. The visiting committee did not identify scheduled skill assessments and assessment mechanisms for this procedure and could not verify that graduates are competent in the skill required to clean and polish removable appliances. The

recommendation related to Dental Assisting Standard 2-8, o was cited at the time of the 2004 comprehensive site visit.

3. It is recommended that graduates be competent in the skill required to perform a variety of clinical supportive treatments, including clean and polish removable appliances. (DA Standard 2-8, o)

The general education aspect of the curriculum must include content at the familiarity level in: oral communications; written communications; and psychology of patient management and interpersonal relations. Through review of the self-study document, documents presented on-site and on-site interviews, the visiting committee verified that content in the psychology of patient management is presented at the familiarity level in DA 1120 Dental Office Procedures. Students are required to prepare a resume in this course, however, the visiting committee did not identify a grading rubric or course documentation that demonstrates the depth to which this content in written communication is presented. In addition, the visiting committee could not verify that content related to oral communications is present within the dental assisting curriculum.

4. It is recommended that the general education aspect of the curriculum include content at the familiarity level in oral communications and written communications. (DA Standard 2-12, a and b)

Students must demonstrate competency in taking diagnostically acceptable radiographs on patients in the program or contracted facility prior to taking radiographs during extramural clinical assignments.

Through scheduled instructional sessions, students must have the opportunity to develop competence in exposing and processing bitewing and periapical radiographs on a variety of patients.

Through review of the self-study document, documents presented on-site and on-site interviews, the visiting committee noted that course documentation for DA1145 Dental Radiology II indicates students are required to expose and develop one full-mouth radiographic survey on a patient prior to the start of their clinical externship. The visiting committee determined, however, that students are not exposing radiographs on patients in the program or contracted facility. The visiting committee noted that the agreement between the program and an off-campus facility for the purpose of student radiographic technique experience, was terminated in 2009. The program appointed a part-time dentist to enable students to expose radiographs on-site, however, due to injury, this dentist was not available at the time of the site visit. The visiting committee further identified that this dentist had not been available to the program for several weeks and did not identify arrangements for a replacement. The visiting committee did not identify requirements for number and type of radiographs on manikins or patients and evaluation mechanisms. The visiting committee could not verify that students have the opportunity to develop competence in exposing radiographs on patients. The recommendation related to Dental Assisting Standard 2-18 was cited at the time of the 2004 comprehensive site visit.)

5. It is recommended that students demonstrate competency in taking diagnostically acceptable radiographs on patients in the program or contracted facility prior to taking radiographs during extramural clinical assignments. (DA Standard 2-18)

6. It is recommended that through scheduled instructional sessions, students have the opportunity to develop competence in exposing and processing bitewing and periapical radiographs on a variety of patients. (DA Standard 2-20)

Clinical experience assisting a dentist must be an integral part of the educational program designed to perfect students' competence in performing dental assisting functions, rather than to provide basic instruction. Through review of the self-study document, and on-site observation and interviews, the visiting committee identified that the program includes a 300-hour clinical externship. The visiting committee could not verify, however, that students are competent in performing dental assisting functions prior to the clinical externship and determined that the clinical experience serves to provide basic instruction.

The visiting committee observed a scheduled demonstration by students, involving the utilization of skills necessary for the fabrication of a temporary crown. The visiting committee observed that students did not demonstrate experience in the utilization of basic equipment such as the high-speed handpiece and lathe. Students and faculty appeared unfamiliar with the location of stored supplies and students appeared unfamiliar with the terminology used for basic supplies and equipment. The visiting committee observed that students and faculty did not follow infection control and safety protocols and did not wear Personal Protective Equipment (PPE). The visiting committee observed students using a curing light without a tinted shield or other eye protection, and observed students and faculty trimming an acrylic temporary crown with a high-speed handpiece without safety goggles in place. A student lost a temporary crown while attempting to polish it on a lathe with a dry polishing wheel, without pumice, operating at high speed. The visiting committee determined that students were not able to demonstrate many skills associated with this multi-step clinical/laboratory procedure.

The visiting committee further identified that staff at externship sites often provide instruction in basic dental assisting functions, infection control, safety measures, appropriate attire and behaviors, and four-handed dentistry principles to students. The visiting committee could not verify that students have sufficient opportunity to synthesize the information learned within the program or obtain sufficient experience to gain confidence in performing specified procedures within the program facility, prior to their clinical externship.

7. It is recommended that clinical experience assisting a dentist be designed to perfect students' competence in performing dental assisting functions rather than to provide basic instruction. (DA Standard 2-22)

Students must maintain a record of their activities in each clinical assignment. Through review of the self-study document and on-site interviews, the visiting committee verified that student externship assessment records are maintained within the program facility. The visiting

committee did not identify documentation to demonstrate that students are required to maintain a record of their activities during their clinical experiences.

8. It is recommended that students maintain a record of their activities in each clinical assignment. (DA Standard 2-26)

Objective student evaluation methods must be utilized to measure all defined laboratory, preclinical and clinical course objectives. Through review of the self-study document and on-site interviews, the visiting committee noted that the program utilizes a variety of competency evaluation mechanisms. The visiting committee identified, however, that some evaluations are performed on an informal basis without objective criteria. Further, the visiting committee identified that faculty are not calibrated on the utilization of evaluation mechanisms or the level of achievement expected or required of students.

9. It is recommended that objective student evaluation methods be utilized to measure all defined laboratory, preclinical and clinical course objective. (DA Standard 2-30)

Standard 3. Administration, Faculty and Staff

Services of institutional support personnel must be adequate to facilitate program operation. Through review of the self-study document and on-site interviews and observation, the visiting committee identified that the program director and faculty are responsible for completing all word processing and clerical work associated with the operation of the dental assisting program. The visiting committee identified that the program director had sole responsibility for typing, collating and binding the self-study document, exhibits and curriculum document and often works evenings and weekends to ensure that tasks ordinarily assigned to support personnel, are completed. The visiting committee identified that other programs within the institution have secretarial and clerical support

10. It is recommended that institutional support personnel be adequate to facilitate program operation. (DA Standard 3-14)

Standard 4. Educational Support Services

The program must provide adequate and appropriately maintained facilities to support the purpose/mission of the program and which are in conformance with applicable regulations. Through review of the self-study documents and on-site observation and interviews, the visiting committee identified that the program enrolls students 10 times per year. Students can also enroll in an optional expanded function component and/or associate degree program. The program facility includes a classroom and laboratory, and two combined clinical and radiographic facilities. All space is shared by multiple groups of students in different modules of study. The visiting committee identified that in 2009-2010, the institution remodeled and re-

equipped the program's dental materials laboratory and increased the number of treatment areas from two to four.

The visiting committee identified that the amount of space within each treatment area is insufficient to accommodate several students, an operator, assistant, and faculty, simultaneously. Further, the visiting committee noted that a chairside assistant does not have access to counter/work space or accessory equipment such as amalgamator, and curing light, during four-handed clinical procedures. The visiting committee observed that a dental procedure planned for instructional purposes could not be completed, as the necessary instruments and equipment were not available.

11. The program must provide adequate facilities to support the purpose/mission of the program. (DA Standard 4-1)

A radiography facility must accommodate initial instruction and practice required for students to develop competence in exposing and processing radiographs with faculty supervision. Through review of the self-study document, and on-site observation and interviews, the visiting committee noted that the dental assisting program utilizes two separate treatment rooms in different locations within the facility. Each treatment room contains two treatment units that share one radiographic unit. The visiting committee noted that one faculty provides pre-clinical radiographic instruction and evaluation simultaneously in both rooms. The visiting committee determined that the distance between the radiographic units may not allow the faculty member to supervise students utilizing both units during radiographic practice sessions. The visiting committee could not determine that the configuration of the dental assisting facility accommodates one faculty member in providing initial instruction and supervision of students exposing and processing radiographs.

12. It is recommended that a radiography facility accommodate initial instruction and practice required for students to develop competence in exposing and processing radiographs with faculty supervision. (DA Standard 4-7)

Accreditation Status

At its February 2, 2012 meeting the Commission on Dental Accreditation adopted a resolution to change the accreditation status of the dental assisting program offered by the Centura College from "approval without reporting requirements" to "approval with reporting requirements with intent to withdraw August 2012."

Publication of Accreditation

The Commission has authorized use of the following statement by institutions or programs that wish to announce their programmatic accreditation by the Commission. Programs that wish to advertise the specific programmatic accreditation status granted by the Commission may include

that information as indicated in *italics* below (see text inside square brackets); that portion of the statement is optional but, if used, must be complete and current.

> The program in dental assisting is accredited by the Commission on Dental Accreditation *[and has been granted the accreditation status of "approval with reporting requirements with intent to withdraw August 2012"]*. The Commission is a specialized accrediting body recognized by the United States Department of Education. The Commission on Dental Accreditation can be contacted at (312) 440-4653 or at 211 East Chicago Avenue, Chicago, IL 60611. The Commission's web address is: http://www.ada.org/100.aspx.

ACCREDITATION STATUS DEFINITIONS

PROGRAMS WHICH ARE FULLY OPERATIONAL

APPROVAL ***(without reporting requirements)*****:** An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

APPROVAL ***(with reporting requirements)*****:** An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within 18 months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause.

(Adopted: 01/98)
(Reaffirmed: 07/05; Revised: 01/99; Effective: 07/99)

PROGRAMS WHICH ARE NOT FULLY OPERATIONAL

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as "not fully operational." The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is "initial accreditation." When "initial accreditation" status is granted to a developing education program, it is in effect through the projected initial enrollment date. However, if enrollment is delayed for two consecutive years, the institution must reapply for "initial accreditation" and update pertinent information on program development. Following this, the Commission will reconsider granting "initial accreditation" status.

> **Initial Accreditation**: Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is in the planning and early stages of development or an intermediate stage of program implementation and not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification "initial accreditation" is granted based upon one or more site evaluation visit(s) and until the program is fully operational.
>
> (CODA: 02/02; Revised 07/08)

Initial Accreditation Status for Accredited Programs

An additional purpose of accreditation recognized by the United States Department of Education (USDE) is the protection of the public through the identification of qualified personnel to staff the health care system. Therefore, the Commission on Dental Accreditation established accreditation classifications, which have proven to be acceptable to educational institutions. Published definitions are a widely recognized means for carrying out accreditation functions.

"Initial Accreditation" status is an accreditation classification that is applicable to developing programs. It is granted when a proposed or developing program demonstrates that it has the potential to meet the accreditation standards.

For this reason, the Commission is firm in its policy that the developing program must not enroll students/residents until "initial accreditation" status has been obtained. If a program enrolls students/residents without first having been granted "initial accreditation" status, the Commission will notify all students/residents enrolled of the possible

ramifications of enrollment in a program operating without accreditation. The Commission will also notify the applicable state board of dentistry.

When "initial accreditation" status is denied and the program wishes to reapply, it is the responsibility of the institution to make use of all possible resources, including consultation with the Commission on Dental Accreditation. (Refer to the Policy on Public Disclosure and Confidentiality for additional information regarding the announcement of an action to deny accreditation).

(CDE: 12/74:19)
(Reaffirmed: 07/07; 07/01; Revised: 07/08; 08/02; 07/96)

OTHER ACCREDITATION ACTIONS

Discontinued: An action taken by the Commission when a program voluntarily discontinues its participation in the accreditation program and no longer enrolls a first year class.

Intent to Withdraw: A formal warning utilized by the Commission on Dental Accreditation to notify an accredited program and the communities of interest that the program's accreditation will be withdrawn if compliance with accreditation standards or policies cannot be demonstrated by a specified date. The warning is usually for a six-month period, unless the Commission extends for good cause.

"Intent to Withdraw" Accreditation

In the event accreditation is withdrawn from a program by the Commission, students currently enrolled in the program at the time accreditation is withdrawn and who successfully complete the program will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission-accredited program. Such graduates may be ineligible for certification/licensure examinations. In view of this, the Commission advises programs that the "intent to withdraw" accreditation may have legal implications for the program and suggests that their institutional legal counsel be consulted regarding how and when to advise applicants and students of the Commission's accreditation actions.

Withdraw: An action taken by the Commission when a program has been unable to demonstrate compliance with the accreditation standards or policies within the time period specified. A final action to withdraw accreditation is communicated to the program and announced to the communities of interest. A statement summarizing the reasons for the Commission's decision and comments, if any, that the affected program has made with regard to this decision, is available upon request from the Commission office. In the event the Commission withdraws accreditation from a program, students currently enrolled in the program at the time accreditation is withdrawn and who successfully complete the program, will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission-accredited program.

(Reaffirmed: 07/07; 07/01; 12/87:9)

American Association of Dental Boards

February 7, 2012

TO: Members, American Association of Dental Boards

FROM: Ms. Molly Nadler, Executive Director, American Association of Dental Boards

RE: AADB Mid-Year Meeting

The American Association of Dental Boards Mid-Year Meeting, being held in conjunction with the American Dental Education Association and the American Dental Association on April 22-23, 2012 at the American Dental Association Headquarters in Chicago, is shaping up to be a must-attend event. The first session of the meeting, on Sunday, April 22, will cover **Prescription Drug Abuse: Considerations for Regulators, Educators and Practitioners** and will include presentations by experts in the field. Leading off the session will be Mr. R. Gil Kerlikowske, nominated by President Obama and confirmed by the U.S. Senate as the Director of the Office of National Drug Control Policy. In his position, Mr. Kerlikowske coordinates all aspects of federal drug control programs and implementation of the President's National Drug Control Strategy. Mr. Kerlikowske will be discussing *Prescription Drug Abuse and the Dentist's Role in Addressing the Epidemic,* which should be of great interest to all state dental boards, educators and practitioners in general. Mr. Robert Burns, Manager, Legislative and Regulatory Policy, ADA Government and Public Affairs will give a presentation on *Prescription Drug Abuse: Regulatory Considerations*. J. David Haddox, DDS, MD, Vice President, Health Policy, Purdue Pharma L.P.* will discuss *Dentists – A Significant Source of Abused Drugs? Reality, REMS, and Recommendations* and Alison Siwek, Manager, ADA Dentist Health and Wellness will speak on the recent ADA grant to develop training programs for appropriate drug prescribing practices. According to Dr. White S. Graves, III, AADB President, "We are honored to have these expert speakers on the program discussing such a critical topic of interest to the entire profession."

Mr. R. Gil Kerlikowske
Director of the Office of National Drug Control Policy

J. David Haddox, DDS, MD, Vice President, Health Policy, Purdue Pharma L.P.*

The Prescription Drug Abuse session will be followed by a session on **New Developments Related to the Dental Therapist**. Leading off this session will be Mr. Jon Holtzee, Director,

ADA State Government Affairs. Stan Hardesty, DDS, will update attendees on the *Development of Accreditation Standards for Dental Therapy Programs*, followed by Samuel Low, DDS, MS, who will present *The Status of the ADA RFP for Portfolio-Style Examinations.*

After a brief business session Monday morning, Dr. Guy Shampaine will give a much anticipated update on the new **AADB Assessment Services Program (ASP)**, of which the Dentist-Professional Review and Evaluation Program (D-PREP) has already reviewed two pilot cases.

The morning session will end with a discussion on **Changes in National Board Examinations and Implications for Dental Education.** David Waldschmidt, PhD, Secretary of the JCNDE, will update participants on *National Examinations and the Committee for an Integrated Examination (CIE)*. Eugene Anderson, PhD, Associate Executive Director and Director, Center for Public Policy and Advocacy, ADEA, and Anne Wells, EdD, Associate Executive Director for Educational Pathways, ADEA, will speak on *ADEA-Future of Advanced Dental Admissions Project.*

The afternoon will conclude with a session on **Commercial Influence and Product Training in the Continuing Education Arena**, with the AGD PACE perspective presented by Otis Helmer, DDS, Chair, AGD, and the ADA CERP perspective presented by Jade Miller, DDS, Chair, CERP.

Lily Garcia, DDS, MS, Professor and Director of the Division of Advanced Education and External Affairs in the Department of Comprehensive Dentistry, UTHSCSA Dental School, will round out the day by giving a *Report on the ADEA Task Force, ADEA Guidelines on Academia-Industry Interactions.*

The JCNDE Advisory Forum will begin at 3:00 p.m. on Monday, directly following the AADB meeting in the Harold Hillenbrand Auditorium. Please remember that the ADA will fund one representative from each state to attend the forum. Airfare, one night hotel fee, ground transportation and a per diem will be provided to each states representative. For more information, please contact Ms. Annie Driscoll at the ADA: 1-800-621-8099, ext. 2676.

We encourage you to register before March 1 for the meeting to avoid any late fees. You can register online at www.dentalboards.org. and clicking on the 'AADB Online Store' tab. If you would like to pay by check, please go to our website and click on the 'Meetings' tab.

This should be a valuable meeting and one that you do not want to miss. If you have any questions, please email Bayley Milton at bmilton@dentalboards.org or call the Central Office: 1-800-621-8099 ext. 2894.

We look forward to seeing you in Chicago.

Enc.
cc: Members, Executive Council, American Association of Dental Boards

*Dr. Haddox's presentation has been made possible through the generosity of Purdue Pharma L.P.

AADB Mid-Year Meeting
Cosponsored by ADA and ADEA
Sunday and Monday, April 22-23, 2012
Sunday, 1:00 p.m. to 5:00 p.m.
Monday, 8:30 a.m. to 3:00 p.m.
ADA Headquarters Building, 2nd Floor Auditorium

PRELIMINARY PROGRAM

SUNDAY, APRIL 22, 2012

12:30 p.m. to 1:00 p.m.	**Registration - ADA Headquarters Building, 2nd Floor Auditorium**
1:00 p.m. to 2:30 p.m.	**Prescription Drug Abuse: Considerations for Regulators, Educators and Practitioners** - Mr. R. Gil Kerlikowski, Director, Office of National Drug Control Policy (ONDCP) - Mr. Robert J. Burns, Manager, Legislative and Regulatory Policy, ADA Government and Public Affairs - J. David Haddox, DDS, MD, CT, Vice President, Health Policy, Purdue Pharma L.P. - Ms. Allison Siwek, IL, Manager, ADA Dentist Health and Wellness **Q & A**
2:30 p.m. to 2:45 p.m.	**Coffee**
2:45 p.m. to 4:00 p.m.	**New Developments Related to the Dental Therapist** - Mr. Jon Holtzee, Director, ADA State Government Affairs **CODA Update on the Development of Accreditation Standards for Dental Therapy Programs** - Stan Hardesty, DDS, NC, AADB Representative to CODA
4:00 p.m. to 4:30 p.m.	**Status of ADA RFP for Portfolio-Style Examinations** - Samuel Low, DDS, MS, FL, Chair, Workgroup on Resolution 42H-2010

MONDAY, APRIL 23, 2012

8:00 a.m. to 9:00 a.m.	**Registration - ADA Headquarters Building, 2nd Floor Auditorium**
8:00 a.m. to 8:30 a.m.	**COFFEE**
8:30 a.m. to 9:00 a.m.	**Business Session** **Executive Council Report**

9:00 a.m. to 10:30 a.m.	**Assessment Services Program (ASP) – Dentist-Professional Review and Evaluation Program (D-PREP) and Expert Review Assessment (ERA)** - Guy Shampaine, DDS, MD **Q & A**
10:30 a.m. to 10:45 a.m.	**Coffee Break**
10:45 a.m. to noon	**Changes in National Board Dental Examinations and Implications for Dental Education** **-Update on National Dental Examinations and the Committee for an Integrated Examination (CIE)** - David Waldschmidt, PhD, IL, Secretary, JCNDE **-ADEA Future of Advanced Dental Education Admissions Project** - Eugene Anderson, PhD, Associate Executive Direct and Director, Center for Public Policy and Advocacy, ADEA - Gerald N. Glickman, DDS, MS, MBA, JD, ADEA President-Elect - Anne Wells, EdD, Associate Executive Director for Educational Pathways, ADEA
Noon to 1:00 p.m.	**LUNCH**
1:00 p.m. to 2:30 p.m.	**Commercial Influence and Product Training in the Continuing Education Arena:** **-Differences between ADA CERP and AGD PACE Standards and Expectations** o **AGD PACE Perspective** – Otis Helmer, DDS, TX, Chair, AGD o **ADA CERP Perspective** - Jade Miller, DDS, NV, Chair, CERP o **Board Perspective** **-Report of the ADEA Task Force, ADEA Guidelines on Academia-Industry Interactions** - Lily T. Garcia, DDS, MS, Professor and Director of the Division of Advanced Education and External Affairs in the Department of Comprehensive Dentistry, UTHSCSA Dental School **Q & A**
2:30 p.m. to 3:00 p.m.	**BREAK**

3:00 p.m. to 5:00 p.m.	**JCNDE ADVISORY FORUM**

5:00 p.m. **Reception – cosponsored by JCNDE and AADB**

Board Attorneys Roundtable –The Board Attorneys Roundtable, Sunday, April 22, 2012, Ritz Carlton Hotel, Lobby 3:00 p.m. to 5:00 p.m. and Monday, April 23, 2012, 9:00 a.m. to 3:00 p.m. at the ADA Headquarters.

Prel. 12 Mid-Year Mtg.

Disciplinary Board Report for March 9, 2012

Today's report addresses the Board's disciplinary case activities for the second quarter of fiscal year 2012 which includes the dates of October 1 to December 31, 2011.

The table below includes all cases that have received Board action since October 1, 2011 through February 17, 2012.

Q1 FY2012	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Oct '11	54	27	3	30
Nov 11	32	14	5	19
Dec 11	50	46	14	60
Jan' 12	*25*	*27*	*21*	*48*
Feb 15, 12	*24*	*15*	*6*	*21*
Totals	185	129	49	178

For the second quarter the Board received a total of 68 patient care cases and closed a total of 85 for a 125% clearance rate. In the first quarter of the year, the board received 159 cases and closed 135. The current pending caseload older than 250 days is 7%. Of the 85 cases closed in the second quarter of 2012, 92% were within 250 days. The Board exceeded the goals for the agency's performance measures for this quarter.

The Board currently has 210 open cases of these 203 have been assigned a priority A-D. Sixty-eight cases are in probable cause with 26 at Board member review. We currently have 21 advertising cases in probable cause. We have 11 Confidential Consent Agreements that have been offered for signature. The Board has 30 cases with the Administrative Proceedings Division and 90 cases are in investigation, 12 cases are scheduled for informal conferences and 3 for a formal hearing.

For comparison, at the last Board meeting, we had 209 open priority A-D cases with 85 in probable cause and 52 were at Board member review.

The agency has indicated there may be a tightening of the performance measures. And, finally, Board staff will be working with Special Conference Committee B on March 16 to revise the Probable Cause Review Form and will make recommendations at the next Board meeting.

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*The Agency's Key Performance Measures.

- We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
- We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
- We will investigate and process 90% of patient care cases within 250 work days.

Virginia Board of Dentistry Dental Inspection Form Date Hours Case#
Commonwealth of Virginia
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-367-4538

PRACTICE NAME				SPECIALTY PRACTICE
STREET ADDRESS	CITY	STATE	ZIP	CURRENT ADDRESS OF RECORD
PHONE:	FAX:	HOURS OF OPERATION:		

STAFF: (Identify dentists, hygienists and assistants)	POSITION	LICENSE	EXP.DATE
Any staff not listed in previous section?	Position		

C NC	18VAC60-20-200 Utilization of Dental Hygienists and Dental Assistant IIs	No more than 4 dental hygienists or dental assistant II in any combination practicing under direction at one and the same time.
C NC NA	18VAC60-20-210 Requirements for Dental Hygienists to practice under general supervision.	Y N Written orders are on file. Y N The services on the original order are to be rendered with a specific time period not to exceed 10 months. Y N The dental hygienist has consented in writing to providing services under general supervision. Y N The patient is informed before the appointment that he will be treated under general supervision. Y N Written basic emergency procedures are established and the hygienist is capable of implementing those procedures.

Posting of Current Licenses, Certificates, and Registrations

C NC NA	54.1-2720	Display of Name of Practitioner. Every person practicing dentistry ...shall display his name at the entrance of the office.
C NC NA	54.1.2721	Dental Licenses are posted in plain view of patients.
C NC NA	54.1-2727	Dental Hygiene Licenses are posted in plain view of patients.
C NC NA	18VAC60-20-16	Dental Assistant II Registrations are posted in plain view of patients.
C NC NA	18VAC60-20-195	Radiation Certificate posted for those who expose dental x-ray and not otherwise licensed.
C NC NA	12VAC5-481-370.A (1) B	Certificate of certification of x-ray machine is posted near the x-ray machine.
C NC NA	18VAC60-20-110	Deep Sedation/General Anesthesia education certificate is posted in plain view of patients.

18VAC60-20-15 Recordkeeping

Records include the following:

C NC NA	Patient's name and date of treatment
C NC NA	Health history Date:_____
C NC NA	Diagnosis and treatment rendered
C NC NA	List of drugs prescribed, administered, dispensed and the quantity
C NC NA	Radiographs
C NC NA	Patient financial records
C NC NA	Name of dentist and dental hygienist providing service
C NC NA	Patient records maintained for not less than three years from the most recent date of service
C NC NA	Number of records reviewed: _____
C NC NA	List patient records with noted deficiencies and attach copy:
C NC NA	§54.1-2719 Laboratory Work Orders Include: (attach example) Y N Name and address of the person, firm or corporation. Y N Patient's name or initials or an ID number. Y N Date work order was written. Y N Description of work to be done; Specifications of the type and materials to be used Y N Signature and address of the dentists

Compliant (C) Non Compliant (NC) Not Applicable (NA)

Environmental Conditions	
C NC	Facility appears neat and clean
C NC	Describe any equipment with broken or missing part; oil/grease on any equipment; and any dirty suction hoses
C NC	Describe sterilization process to include equipment use (should include heat and/or spore indicators.)
C NC	Who processes spore indicators and are results maintained?
C NC	What is office protocol when sterilization equipment indicates equipment is not working properly?
C NC	How are sterilized instruments maintained?
C NC	How are clinical surfaces disinfected and sanitized? Frequency? Solutions used?
C NC	Are sharps containers available? When disposing of sharps/biohazard waste, is there a current contract, bill or receipt to document service?
C NC	Appropriate personal protective equipment including gloves, face protection, eye protection and lead aprons
C NC	Safe and accessible building exits in case of fire or other emergency
C NC	Additional inspection comments:

Drug Security, Inventory and Records		
C NC	CFR 1301.75 (b)	Sch II-V controlled substances are stored in a securely locked, substantially constructed cabinet
C NC	CFR 1304.04 (f)	Inventories and records of Sch II controlled substances are maintained separately from all other records and are readily retrievable
C NC	CFR 1304.04 (f)	Inventories and records of Sch III-V controlled substances are maintained either separately from all of records or in such a form that the information is readily retrievable
C NC		Records of Sch II-V controlled substances are maintained in chronological order
C NC	54.1- 3404. F	Required records are maintained completely and accurately for two years from the date of the transaction
C NC	54.1-3404. C	Records of receipt include the actual date of receipt, name and address of the person from whom received, and the name, strength and quantity of drug received
C NC	54,1-3404. D	Records of drugs sold, administered, dispensed or disposed of include the date of the transaction, name of patient, drug name, quantity of drug, and signature of person making the transaction
C NC	54.1-3404. A& B	Biennial inventory of Sch II-V drugs available was taken on a date within two years of the previous biennial inventory
C NC	54.1-3404. A & B	Biennial inventory is dated and indicates whether it was taken at the opening or close of business. Specify.
C NC	54.1-3404. E	Theft or unusual loss of drugs in Sch II-V is reported to the board of Pharmacy and an inventory taken if the registrant is unable to determine the exact kind and quantity of drug loss
C NC		Expired drugs are stored separate from the working stock of drugs until properly disposed

Equipment Requirements for Anesthesia, Sedation and Analgesia		
18VAC60-20-108 A dentist who administers anxiolysis or inhalation analgesia shall maintain the following operational equipment and be trained in its use	18VAC60-20-110 A dentist who administers deep sedation/general anesthesia shall maintain the following operational equipment	18VAC60-20-120 A dentist who administers conscious sedation shall maintain the following operational and in date drugs
C NC Blood Pressure Monitoring	C NC Full face mask for children/adults	C NC Full face mask for children/ adults
C NC Positive Pressure Oxygen	C NC Oral and Nasopharyngeal airways	C NC Oral and Nasopharyngeal airways
C NC Mechanical (hand) resp bag	C NC ET tubes for children/ adults or airway adjuncts	C NC ET tubes for children/ adults or airway adjuncts
	C NC Laryngoscope for children/adults	C NC Pulse Oximetry and BP Monitoring
	C NC Positive Pressure Oxygen	C NC Pharmacological antagonist agents unexpired

	C NC Mechanical (hand) respiratory bag	C NC Positive Pressure Oxygen
	C NC Pulse Oximetry and BP monitoring	C NC Emergency drugs for resuscitation
	C NC Emergency drugs for resuscitation	C NC Mechanical (hand) resp bag
	C NC EKG/ Temp monitoring equipment	
	C NC Pharmacological antagonist agents unexpired	
	C NC External defibrillator	
	C NC Emergency Drugs for Resuscitation	

Staffing Requirements for Anesthesia, Sedation, & Analgesia

18VAC60-20-108 A dentist who administers anxiolysis or inhalation analgesia shall maintain the following:	18VAC60-20-110 A dentist who administers deep sedation/general anesthesia shall maintain the following:	18VAC60-20-120 A dentist who administers conscious sedation shall maintain the following:
C NC Treatment team: dentist & a second person to assist, monitor & observe the patient	C NC Treatment team: Operating dentist, a second person to monitor & observe the patient, & a third person to assist the operating dentist	C NC Treatment team: Operating dentist & a second person to assist, monitor, & observe the patient.
	C NC Post educational certificate in plain view of the patient	C NC Holds current certification in ACLS posted with dental license and current Drug Enforcement Administration registration
	C NC Holds current certification in ACLS or PALS and current Drug Enforcement Administration registration	

Oral and Maxillofacial Surgeons

Y N 18VAC60-20-250 Has Board Registration
Y N 18VAC60-20-260 Has updated practitioner profile. Attach Profile.
Y N 18VAC60-20-290 Performs cosmetic procedures and is certified by the Board according to §54.1-2709.

Please list all certifications for cosmetic procedures.

Type of Inspection: _____ Case No.: _____

This dental office has been inspected by an inspector or investigator of the Department of Health Professions. The results of the inspection have been noted. I acknowledge that the noted conditions have been deemed by the inspector as not being in compliance and have been explained to me and that I have received a copy of the inspection report.

_____ _____

Signature of Inspector Date Signature of Licensee Date

VIRGINIA BOARD OF DENTISTRY
DELEGATION TO DENTAL ASSISTANTS

DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS I AND II UNDER INDIRECT SUPERVISION OF A DENTIST
GENERAL SERVICES
Prepare patients for treatment/seating/positioning chair/placing napkin
Perform health assessment
Preventive education and oral hygiene instruction
Perform mouth mirror inspection of the oral cavity
Chart existing restorations and conditions as instructed by the dentist
Take, record and monitor vital signs
Transfer dental instruments
Prepare procedural trays/armamentaria set-ups
Maintain emergency kit
Sterilization and disinfection procedures
Compliance with OSHA Regulations and Centers for Disease Control Guidelines
Prep lab forms for signature by the dentist
Maintenance of dental equipment
Select and manipulate gypsums and waxes
RADIOLOGY and IMAGING
Mount and label images
Place x-ray film and expose radiographs **ONLY WITH REQUIRED TRAINING**
Use intraoral camera or scanner to take images for tooth preparation and CAD CAM restorations
RESTORATIVE SERVICES
Provide pre- and post operative instructions
Place and remove dental dam
Maintain field of operation through use of retraction, suction, irrigation, drying
Acid Etch - Apply/wash/dry remove only when reversible
Amalgam: Place only
Amalgam: Polish only with slow-speed handpiece and prophy cup
Apply pit and fissure sealants
Apply and cure primer and bonding agents
Fabricate, cement, and remove temporary crowns/restorations
Make impressions and pour and trim study/diagnostic models and opposing models
Make impressions for athletic/night/occlusal/snore mouthguards and fluoride/bleaching trays
Matrices - place and remove
Measure instrument length
Remove excess cement from coronal surfaces of teeth
Remove sutures
Dry canals with paper points
Mix dental materials
Place and remove post-extraction dressings/monitor bleeding
Rubber Dams: Place and remove
Sterilization and disinfection procedures
Take bite and occlusal registrations
HYGIENE
Apply dentin desensitizing solutions
Apply fluoride varnish, gels, foams and agents
Apply pit and fissure sealant
Address risks of tobacco use
Give oral hygiene instruction
Polish coronal portion of teeth with rotary hand piece and rubber prophy cup or brush
Place and remove periodontal dressings
Clean and polish removable appliances and prostheses

VIRGINIA BOARD OF DENTISTRY
DELEGATION TO DENTAL ASSISTANTS

DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS I AND II UNDER INDIRECT SUPERVISION OF A DENTIST CONTINUED
ORTHODONTICS
Place and remove elastic separators
Check for loose bands and brackets
Remove arch wires and ligature ties
Place ligatures to tie in archwire
Select and fit bands and brackets for cementation by dentist
Instruct patients in placement and removal of retainers and appliances after dentist has fitted and made adjustments in the mouth
Take impressions and make study models for orthodontic treatment and retainers
BLEACHING
Take impressions and fabricate bleaching trays
Apply bleach/whitener
Bleach with light but not laser
Instruct pt on bleaching procedures
SEDATION AND ANESTHESIA SERVICES
Apply topical Schedule VI anesthetic
Monitor patient under nitrous oxide
Monitor patient under minimal sedation/anxiolysis
Monitor patient under moderate/conscious sedation ONLY WITH REQUIRED TRAINING
Monitor patient under deep sedation/general anesthesia ONLY WITH REQUIRED TRAINING
Take blood pressure, pulse and temperature
DUTIES THAT MAY BE DELEGATED TO DENTAL ASSISTANTS I AND II UNDER INDIRECT SUPERVISION OF A DENTAL HYGIENIST
Prepare patients for treatment/seating/positioning chair/placing napkin
Perform health assessment
Preventive education and oral hygiene instruction
Transfer dental instruments
Prepare procedural trays/armamentaria set-ups
Maintain emergency kit
Sterilization and disinfection procedures
Compliance with OSHA Regulations and Centers for Disease Control Guidelines
Maintenance of dental equipment
Polish coronal portion of teeth with rotary hand piece and rubber prophy cup or brush
Place and remove periodontal dressings
Clean and polish removable appliances and prostheses
Mount and label images
Place x-ray film and expose radiographs ONLY WITH REQUIRED TRAINING
DUTIES THAT MAY ONLY BE DELEGATED TO DENTAL ASSISTANTS II UNDER DIRECT SUPERVISION OF A DENTIST
Condense/pack and carve amalgam
Place, cure and finish composite resin restorations only with slow-speed handpiece
Apply base and cavity liners/perform pulp capping procedures
Final cementation of crowns and bridges after adjustment and fitting by the dentist
Make final impressions and fabricate master casts
Place and remove non-epinephrine retraction cord