

# NEVADA STATE BOARD of DENTAL EXAMINERS



BOARD TELECONFERENCE MEETING

OCTOBER 8, 2020

7:00 P.M.

**PUBLIC BOOK**

## **Agenda Item (4)(a)(1)**

### **Draft Minutes:**

**CE Committee Meeting - 08/25/2020**

# Nevada State Board of Dental Examiners



6010 S. Rainbow Blvd., Bldg. A, Ste.1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

## **PUBLIC MEETING NOTICE & AGENDA FOR THE CONTINUING EDUCATION COMMITTEE**

(Ron Lemon, DMD, (Chair); Elizabeth Park, DDS; Kevin Moore, DDS)

### **Meeting Date & Time**

Tuesday, August 25, 2020  
6:00 p.m.

### **Video and Teleconferencing was available for this meeting**

### **DRAFT MINUTES**

### **PUBLIC NOTICE:**

***\*\*Pursuant to the Governor's Executive Order 011, there will be no physical location for this meeting\*\****

**The Nevada State Board of Dental Examiners may hold board meetings via video conference or telephone conference call.  
In the event that there are technical difficulties with Zoom, please use the teleconference number (702) 486-5260 /  
Collaboration Code 67044**

Public Comment time is available after roll call (beginning of meeting) and prior to adjournment (end of meeting). Public Comment is limited to three (3) minutes for each individual. You may provide the Board with written comment to be added to the record.

Persons wishing to comment may appear at the scheduled meeting/hearing or may address their comments, data, views, arguments in written form to: **Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd, A-1, Las Vegas, Nevada 89118; FAX number (702) 486-7046; e-mail address [nsbde@nsbde.nv.gov](mailto:nsbde@nsbde.nv.gov)**. Written submissions should be received by the Board on or before **Monday, August 24, 2020 at 3:00 p.m.** in order to make copies available to members and the public.

The Nevada State Board of Dental Examiners may 1) address agenda items out of sequence to accommodate persons appearing before the Board or to aid the efficiency or effectiveness of the meeting; 2) combine items for consideration by the public body; 3) pull or remove items from the agenda at any time. The Board may convene in closed session to consider the character, alleged misconduct, professional competence or physical or mental health of a person. See NRS 241.030. Prior to the commencement and conclusion of a contested case or a quasi-judicial proceeding that may affect the due process rights of an individual the board may refuse to consider public comment. See NRS 233B.126.

Persons/facilities who want to be on the mailing list must submit a written request every six (6) months to the Nevada State Board of Dental Examiners at the address listed in the previous paragraph. With regard to any board meeting or telephone conference, it is possible that an amended agenda will be published adding new items to the original agenda. Amended Nevada notices will be posted in compliance with the Open Meeting Law.

We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Board office, at (702) 486-7044, no later than 48 hours prior to the meeting. Requests for special arrangements made after this time frame cannot be guaranteed.

Pursuant to NRS 241.020(2) you may contact the Board office at (702) 486-7044, to request supporting materials for the public body or you may download the supporting materials for the public body from the Board's website at <http://dental.nv.gov>. In addition, the supporting materials for the public body are available at the Board's office located at 6010 S Rainbow Blvd, Ste. A-1, Las Vegas, Nevada.

**Note:** Asterisks (\*) "**For Possible Action**" denotes items on which the Board may take action.

**Note:** Action by the Board on an item may be to approve, deny, amend, or tabled.

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58  
59 **1. Call to Order**

60 - Roll call/Quorum  
61

62 Committee Member Lemon called the meeting to order at approximately 6:00 p.m., and Executive  
63 Director, Mr. Frank DiMaggio conducted the following roll call:  
64

Dr. Ron Lemon ----- PRESENT

Dr. Elizabeth Park ----- PRESENT

Dr. D. Kevin Moore ----- PRESENT

65  
66 Executive Staff: Phil Su, General Counsel; Frank DiMaggio, Executive Director; Sandra Spilsbury, Site  
67 Inspection-CE Coordinator.  
68

69 **2. Public Comment:** The public comment period is limited to matters specifically noticed on the agenda. No action may  
70 be taken upon the matter raised during public comment unless the matter itself has been specifically included on the  
71 agenda as an action item. Comments by the public may be limited to three minutes as a reasonable time, place and  
72 manner restriction, but may not be limited based upon viewpoint. The Chairperson may allow additional time at his/her  
73 discretion.  
74

75 Committee Member Lemon stated that the Committee was in receipt of a high volume of public  
76 comment for the record. He asked that the public please limit this portion of public comment to those  
77 that have new public comment regarding any of the agenda items or for anyone that had not submitted  
78 any public comment for the record.  
79

80 Charles Buchanan, a fourth-year dental student at UNLV School of Dental Medicine, commented on  
81 agenda items (5)(c)(d) and (e). He asked the Committee consider extending the exam period beyond  
82 the December 31, 2020 as it would impact current dental students of the class of 2021, as they have  
83 begun taking portions of the WREB and ADEX exams in 2020, but will not be taking the operative portion  
84 until spring of 2021.  
85

86 Dr. Bill Pappas, a current Nevada licensed dentist and President of ADEX, noted that he was present to  
87 answer any questions the committee may have regarding ADEX.  
88

89 Dr. Pooja Mehta, DDS stated that she was a class of 2020 dental graduate, and stated that she was  
90 commenting on agenda items (5)(c)(d) and (5)(e), and spoke in favor of acceptance of the  
91 acceptance of both the WREB and ADEX alternative exams. She spoke on her personal experience with  
92 taking the exams during COVID-19 and asked that the Board take into consideration the unique  
93 difficulties students are facing in 2020.  
94

95 Antonio Ventura stated that he was the immediate past president for the Southern Nevada Dental  
96 Hygienists Association (SNHDA) and a committee member for the Legislative Committee for the Nevada  
97 Dental Hygienists Association (NDHA). He read written testimony as it changed slightly from the testimony  
98 he originally submitted in writing. He stated that the NDHA was in support of the OSCE exam through  
99 WREB as an alternate exam for 2020 CSN and TMCC dental hygiene graduates. Further, they supported  
100 the elimination of patient based exams for candidates who are graduates of the Commission on Dental  
101 Accredited Dental Hygiene programs.  
102

103 Tiffany Richardson stated that she was a member of the CSN Dental Hygiene graduating class of 2020  
104 and added that she was in full support of all ADEX and WREB alternate pathways to licensure; as it would  
105 allow them to adapt to the unique COVID-19 circumstances. She stated that the current statutes do not  
106 stipulate the use of a patient based clinical exam. She spoke on the cons of using patient based exams,  
107 and spoke of the benefits of accepting exam alternatives, and how it would greatly benefit the  
108 community to license more dental hygienists to serve the citizens of Nevada.  
109

110 Kimberly Grover stated that she was the CSN Student American Dental Hygiene Association President  
111 and was still a student trying to receive a license during the pandemic. She stated that due to the  
112 multiple delays in meeting the requirements, and a new dental hygiene class and dental assisting classes  
113 starting in the clinic facility cannot support all the needs of the students. She stated that the schedule is



continually getting extended in unattainable timeline to take a live patient clinic board scheduled test in November. She noted that students and patients are faced with the fear of becoming exposed to COVID-19. She spoke in favor of an alternative to the patient based clinical exam that would be safe for both students and patients, which was the proposed alternative exams, which has been approved in over 28 states. She felt that both were fair and appropriate ways to test students' standardized skills. She spoke in favor of the board approving the ADEX and WREB alternative exams.

Benjamin Abrahams commented that he was in favor of agenda (5)(d), and noted that he had completed portions of the ADEX exam on live patients and another section of the exam was completed on the CompeDont and attested to the fact that both exam sections were very similar to each other, and the he did not see a significant difference in testing on a live patient versus a manikin. He hoped that the Board would strongly consider approving the alternate exam option from ADEX.

Morgan Heath commented on agenda item (5)(c)(d) and (e). She stated that she was a CSN Class of 2020 Dental Hygiene student, and stated that on behalf of the class of 2020 and 2021, she supported the approval of both the WREB and ADEX alternate exams for full licensure. She noted that both graduating classes of 2020 and 2021 were greatly affected by the pandemic. She noted that the option of a patient-less based exam would ease the concern of interstate travel of patients and students and the risks associated with it during the pandemic. She advocated for the Board to approve and accept the alternate exams from WREB and ADEX.

Christine Ho commented that she was addressing (5)(c)(d) and (5)(e). She noted that she was currently licensed in California and was in full support of approving the manikin based WREB and ADEX exams. She noted that she recently completed the manikin based exams and after practicing for years in another state, she confidently spoke of the competence she found the manikin based exams offered. She vouched that the patient-less based exams were efficient and more than adequate in testing the clinical skill levels of dentists and dental hygienists from the Class of 2020 seeking licensure. She spoke in detail regarding the exam sections and how they compared to a live patient exam.

**\*3. Chairman's Report:** Ron Lemon, DMD (For Possible Action)

**\*a. Request to remove agenda item(s)** (For Possible Action)

There were no requests made to remove agenda items.

**\*b. Approve Agenda** (For Possible Action)

Committee Member Lemon called for a motion.

MOTION: Committee Member Moore moved to approve the agenda. Committee Member Lemon seconded the motion. All were in favor, motion passed.

**4. Old Business:** (Informational Purposes Only)

**a. Consideration and recommendation whether training completed during Oral & Maxillofacial Surgery (OMS) Residency satisfies the training requirements pursuant to NAC 631.257(1)** (Informational Purposes Only)

Committee Member Moore stated there appeared to be a bit of info in the regulations already regarding the training requirements and it discussed having different qualifications. He stated upon doing some research of the different programs, there did not appear to be 100% consistency in the OMS programs that include dermal fillers in the curriculum.

Committee Member Lemon stated that in looking at the CODA documents for certifying OMS programs, there was no mention of requirements for standards for dermal or soft tissue fillers. He concurred with Committee Member Moore that if a licensee is able to provide proof that their particular program satisfies the requirements of NAC 631.257, then that would be acceptable.

There was discussion regarding Board approved programs and the criteria that the programs have to meet in order to be approved. Ms. Sandra Spilsbury noted that there were currently 4 or 5 approved CE courses. It was noted that this was discussion was for informational purposes only.

MOTION: Committee Member Moore moved to place this agenda item on the next meeting as an action item to make a recommendation to the Board. Committee Member Lemon seconded the motion. All were in favor, motion passed.

**\*5. New Business:** (For Possible Action)

**\*a. Consideration of approval/rejection of retroactive approval requested by the Pacific Training Institute for Facial Aesthetics for their Level 1, 2, & 4 (total 72-unit program) approved by the Board on April 30, 2020** (For Possible Action)

Committee Member Lemon asked Ms. Sandra Spilsbury to go over the history of this agenda item.

Ms. Spilsbury explained that the Pacific Training Institute for Facial Aesthetics (PTIFA) had originally submitted their program in September 2019 which was placed for consideration on the November 1, 2019 Board meeting agenda; however, the November meeting was cancelled. She noted further that the course was placed on the next meeting agenda of January 2020, however, the Board underwent an unprecedented transition period. She added that the item was tabled in January so that the course could be reviewed by the CE Committee, which took place at the CE Committee meeting held in April. She noted that the CE Committee made the recommendation for approval of the course, which was presented for Board approval on April 30, 2020. She further noted that the course was approved by the Board at its April 30, 2020 meeting. Ms. Spilsbury noted that PTIFA was now requesting retroactive approval of their course.

Committee Member Moore commented that this particular program was approved and passed, however, the Board possibly could have not accepted the program. He stated that he did not see the wisdom in retroactively approving the course for those that completed the course prior to the Board approving the course program on April 30, 2020. It was his opinion for the Committee not to approve the request for retroactive approval of the PTIFA course if taken prior to April 30, 2020.

There was discussion on clarifying the request retroactive approval of the course due to the fact that the course was originally scheduled to go before the Board on November 1, 2019, but was delayed in being considered and potentially approved. Committee Member Moore stated that it was premature for the PTIFA to have Nevada licensees complete the course prior to course being approved by the Board.

Carly Olynyk with PTIFA gave a bit of perspective as to why they made the request for retroactive approval. She noted that they had practitioners licensed in other states who are now practicing and licensed in Nevada that completed their course. However, the practitioners would like to administer Botox and dermal fillers in Nevada, but because they took the course prior to it being approved in Nevada, they are unable to administer in Nevada.

Mr. DiMaggio clarified for the Committee that the request submitted by PTIFA was asking for retroactive approval dating back to March of 2017.

Committee Member Moore expressed his opinion that it would be irresponsible for CE course programs of any sort which were taken prior to obtaining approval from the Board, to assume that the Board will approve their course retroactively.

Carly with PTIFA stated that they have never advertised that their course would be accepted in Nevada prior to the course being approved. She clarified that they have simply had previous students take their course, which is offered in British Columbia, prior to it being approved in Nevada and were asking if the Board would consider retroactively approving the course.

It was clarified for the Committee that if PTIFA was going to be offering their course in Nevada, they would need to have a licensed Nevada dentist instruct the course. However, Ms. Spilsbury noted that the PTIFA course was currently offered in British Columbia, thus requiring for participants to travel to British Columbia to attend the course.

Committee Member Park expressed that she was in agreement with Dr. Moore that the course should not be approved for retroactive approval.

MOTION: Committee Member Moore moved to not approve the retroactive request from PTIFA. Committee Member Park seconded the motion. All were in favor, motion passed.

**\*b. Review, discussion and possible recommendations to the Board of Temporary approval and acceptance of the Western Regional Examining Board's (WREB) Objective Structured Clinical Examination (OSCE) exam for dental hygiene licensure if completed during the period of May 1, 2020 through December 31, 2020 – NRS 631.300 (For Possible Action)**

Committee Member Moore inquired how this agenda item reflected the temporary license application that was already in place. Mr. DiMaggio stated that the Board approved temporary license for dentists and dental hygienists, they issued a memorandum regarding same, and also created applications for a temporary license, which created a pathway to licensure for the class of 2020 graduates. He noted that the temporary license would be valid until the end of the pandemic as declared by Governor Sisolak. Committee Member Moore inquired if that temporary license option could extend through 2021, to which Mr. DiMaggio responded affirmatively.

MOTION: Committee Member Moore made the motion that the Board already offers a temporary license to both dentists and dental hygienists, and therefore did believe there was further action to take on this agenda item. Discussion: Mr. DiMaggio clarified for Committee Member Moore that while he believed Committee Member Moore covered the item, it was not clear what his motion was. Committee Member Lemon stated that this was the beginning of eliminating patients from a board examination. He noted that there was a trend nationally to eliminate live patient exams. Dr. Sharon Osborne from WREB stated that she was present. Committee Member Moore stated that the committee received numerous amounts of comments that many complained that the exam is biased and not standardized. He inquired if Ms. Osborne could elaborate on how moving to a manikin based exam would answer the concerns of students.

Dr. Osborne stated that the patient based exam was standardized. She added that while the patient based exam was not as standardized as the manikin based exam because they have much more control over the manikin. However, the benefit of the patient based exam was that it makes the practice of dentistry much more realistic than any manikin or selective response exam can be. She noted that there will always be pros and cons to different types of exams.

Committee Member Moore inquired what further competency do the exams really show if they are manikin based. Dr. Osborne stated that there are students that have been deemed competent to graduate the program, however, that there are a small percentage of candidates who fail the exam multiple times. She added that those were the candidates that the patient based exams were screening out and that in an ideal world, schools would only pass students who were ready to go out and competently practice, however, that is not the case.

Committee Member Lemon stated that he was in favor of moving towards a patient-less exams. He stated that in his career as an instructor, he has seen many of their top students fail the exams, while many of the weaker students pass the exams, due to lack of consistency in the exams. He stated that simulated exams are consistent from one to another.

It was addressed that WREB's patient-less exam was created rather quickly in response to the pandemic. Lengthy discussion ensued regarding the competency concerns of a patient-less exam, and how would the exam entities evaluate particular sections of the exam. There was discussion regarding concerns of undertrained dentists and dental

hygienists. Committee Member Lemon noted similar concerns when Hurricane Katrina hit, and many students were unable to complete their training; however, they were offered free continuing education courses to assist them in completing their training. He stated that while it was not an ideal option, it was necessary given the circumstances.

Committee Member Moore stated that he would like to make the motion to table agenda item (5)(b) until the pandemic is over, due to the fact that they do not know when the pandemic will be over, and because they have a temporary license option that was already approved by the Board. Committee Member Park seconded the motion. Committee Member Lemon opposed the motion; all others in favor of the motion. Motion passed.

**\*c. Review, discussion and possible recommendations to the Board of Temporary approval and acceptance of the use of manikins by American Board of Dental Examiners' (ADEX) for the Dental Periodontal Scaling Exercise portion of the ADEX dental exam for dental licensure and for the ADEX dental hygiene clinical examination for dental hygiene licensure if completed during the period of May 1, 2020 through December 31, 2020 – NRS 631.240 and NRS 631.300 (For Possible Action)**

Committee Member Lemon invited Dr. Bill Pappas to speak regarding the ADEX exam. Dr. Pappas stated that currently 38 states have approved the ADEX CompeDont exam, which is the dental simulated exam for restorative. He added that 18 of the 38 states have accepted the CompeDont beyond the pandemic. Dr. Pappas noted that ADEX was the only testing agency that has a simulated tooth that has caries, affected dentin, enamel, and that no one else offers it. He spoke on the advantages that the ADEX exam offers with the use of their CompeDont. Dr. Pappas addressed Committee Member Park's concern of students being tested on anesthesia. He clarified that candidates are only tested on their ability to administer local anesthesia and not general anesthesia, which specifically relates to the dental hygiene exam. Dr. Pappas discussed the exam section in length and how they test candidates in the different areas, and noted how their patient-less exam was not created specifically due to the pandemic, and that the CompeDont has been in development for three (3) years. He noted that the manikin for dental and dental hygiene periodontics, and dental hygiene scaling was developed in response to the pandemic, but did not see ADEX extending it permanently beyond the pandemic. Committee Member Moore asked Mr. Su if there was anything in the statutes or regulations that state the exam has to be a live patient based exam. Mr. Su stated that the laws says a 'clinical exam approved by the Board'. Committee Member Moore inquired if the laws clearly state that it must be a patient based exam. Mr. Su responded that ultimately it would be at the discretion of the Board to determine if they would like to accept only a live patient exam or a patient-less exam.

MOTION: Committee Member Park made the motion to recommend that the language is clear that the Board can accept the alternate exam. Committee Member Lemon seconded the motion. Discussion: Committee Member Moore asked that if this motion passed how would it be different than agenda item (5)(b). Committee Member Park asked if it was required that the OSCE portion be accepted by the Nevada statutes. Dr. Pappas stated that the OSCE exam is listed in the statute, under the dental simulated clinical examination – which was the ADEX computer based examination. Committee Member Park clarified that she was referring to NRS 631.300, and whether or not it was clear in the statute. Dr. Pappas stated that it was in the language, in the sense that the Board had the discretion to approve the ADEX or WREB exams. Mr. Su referred the Committee to NAC 631.090, and read the language into the record. He states that the language of the NRS 631.240 requires Board approval for ADEX exam, and just requires a certificate of presentation for the WREB exam. There was discussion regarding accepting a patient-less based exam during the pandemic, and how it was believed that the statute was designed for the Board to determine the exam types they would accept for permanent license and not necessarily for a temporary licensure. Mr. Su noted that the agenda item they are discussing is time limited. Committee Member Moore inquired if agenda (5)(b) and (c) were the same. Mr. Su that section (b) of NRS 631.240 states that the ADEX exam has to be approved by the Board, but requires that WREB exam applicants must provide



a certificate from WREB showing that they have passed the WREB clinical examination. However, that upon reviewing NAC 631.090, it requires that the Board approve both the ADEX and WREB exams. He noted that there was an inconsistency with the NAC and the NRS. Committee Member Park reiterated her motion to accept the use of ADEX clinical exam for hygiene licensure during the period of May 1, 2020 through December 31, 2020 pursuant to NRS 631.240 and NAC 631.300. Committee Member Lemon seconded the motion.

Discussion: Mr. DiMaggio clarified that the motion only approved the ADEX dental hygiene exam and did not the dental portion of the exam. Committee Member Park stated that her motion covered the portion of the agenda item she was comfortable with. Mr. DiMaggio noted that if the Committee did not make a motion regarding the dental portion of the agenda item, then the Committee would have to reconvene and revisit the agenda item.

MOTION: Committee Member Lemon made the motion to recommend the approval of the acceptance of the use of manikins by ADEX for dental periodontal scaling portion of the ADEX exam for the period as stated. Motion failed for lack of second.

Committee Member Moore stated that he was having difficulty understanding the issue with the motion, and why Mr. DiMaggio was requesting for another motion. Mr. DiMaggio explained that the agenda item noted both the dental and dental hygiene exams, however, that the motion made by Committee Member Park only addressed the dental hygiene portion of the exam and did not include or cover the dental exam portion of the agenda item.

Committee Member Park indicated that she read the statute and made her motion based on the statute, and not necessarily on the agenda item as written. Mr. DiMaggio stated that in effort to clarify things for the record, the agenda item addressed the use of manikins as it applied to both dental licensure and dental hygiene licensure. He explained that her motion excluded the manikin from the dental portion of the exam. Committee Member Park stated that she did not use the term 'manikin' because her motion was based on the statute, and therefore did not understand why her motion was creating an issue. Mr. DiMaggio stated that he drafted the agenda items, and that the intent of the agenda items, especially 5c, was as he stated the use of manikins for both dental and dental hygiene exams; therefore, if the vote was for something other than what is listed on the agenda, then it could possibly be an open meeting law violation. Mr. Su concurred with Mr. DiMaggio's statement. Committee Member Park amended her motion to approve agenda item 5(c) in its entirety. Committee Member Lemon seconded the motion. Committee Member Lemon noted that they would need to withdraw the original motion in order to accept all of agenda item (5)(c). Mr. Su responded affirmatively, and stated that the current motion needed to move forward. All were in favor, motion passed.

**\*d. Review, discussion and possible recommendations to the Board of Temporary approval and acceptance of the restorative procedures in the American Board of Dental Examiners' (ADEX) exam for dental licensure to be completed on either a live patient or the CompeDont tooth during the period of May 1, 2020 through December 31, 2020 – NRS 631.240 (For Possible Action)**

Committee Member Lemon inquired if the Committee would like to quickly move forward with this agenda item as it was similar to the previous agenda item, or if the Committee would like to table this item for a future meeting. He called for a motion.

MOTION: Committee Member Moore made motion to accept (5)(d) in its entirety as stated on the agenda. Committee Member Moore inquired what would transpire after the December 31, 2020 date, if the approval would become null and void. Mr. Phil Su clarified that the exam alternative option expired upon the date noted, unless the Board created a new agenda item at a future meeting to extend the time period. Committee Member Lemon

seconded the motion. Committee Member Park opposed; all others were in favor of the motion. Motion passed.

**\*e. Review, discussion and possible recommendations to the Board of Temporary approval and acceptance of the alternatives to the current Western Regional Examining Board's (WREB) exam for dental licensure, including WREB Dental Licensing Examination COVID-19 Options for 2020, if completed during the period of May 1, 2020 through December 31, 2020 – NRS 631.240** (For Possible Action)

**\*f. Consideration and possible recommendation of CE Broker Technical Proposal** (For Possible Action)

Committee Member Lemon stated that due to time constraints, the Committee would need to table this item, and have another meeting scheduled. He called for a motion to table agenda items (5)(e) and (5)(f).

MOTION: Committee Member Moore made the motion to table agenda items (5)(e) and (5)(f). Committee Member Park seconded the motion. All were in favor, motion passed.

**6. Public Comment:** This public comment period is for any matter that is within the jurisdiction of the public body. No action may be taken upon the matter raised during public comment unless the matter itself has been specifically included on the agenda as an action item. The Chairperson of the Board will impose a time limit of three (3) minutes. The Chairperson may allow additional time at his/her discretion.

Ryan Hunter, a dental student, took the manikin WREB boards and is curious how they expect him to practice in Nevada when the dentist that wants him to practice has not been licensed for 5 years, and therefore has no way to practice because of that provision in the temporary license. He noted that they approved the ADEX exam for temporary licensure but they did not approve the WREB exam for temporary licensure. Committee Member Moore stated that item was tabled, however, that the Board has the ultimate decision. He commented that he and many others have already waited a long time for the Board to make a decision.

Randy Wells commented that there were many supporters for the WREB and ADEX manikin based exams, and noted that if they looked at the current times they are in, it was hard for them to have a patient based exam to base licensure off of. He stated that eventually they were going to have to start looking at patient-less based exams for the foreseeable future. He commented that he took the WREB exam, and described what the exam entailed, and felt that the level of competence was apparent in all that they had to complete for the exam. He asked that the Committee reconsider their decisions this evening, as it is hindering him from practicing in Nevada, and with all of the delays, it is inevitable that he will need to look at another state for licensure and employment, though he wishes to practice in Nevada. He stated that with all of the delays, the Board is hindering recent graduates from getting a license. He stated that unless an amendment is made, then he cannot qualify for temporary licensure since his potential employer has not been licensed for 5 years.

Charles Buchannan stated that he had a lot of feedback and the Board would need to return to him for comment.

Kimberly, a CSN dental hygiene student, stated that the timeline of 90 days after the pandemic is lifted by the Governor did not work for them since they would not have time to screen a patient, and that the ADEX manikin exam that was just recommended for approval did not have any available exams offered after the deadline of December 31, 2020; that they would not be able to obtain a temporary license since they cannot graduate until December. She noted that their only option was to take the WREB OSCE exam. She implored the Committee members to please reconsider their decision, since if they do not, they will not be able to obtain a license.

Pooja Mehta commented that she would like to support her dental colleagues and stated that the temporary license does not help them or potential employers, such as her, if the employer has not been licensed for 5 years. She asked that the Committee meet again quickly to address the WREB exams as it would hinder students trying to obtain licensure.

Stephanie, a dental hygiene student of the class of 2020, stated that the temporary license as it stands requires them to get a clinical exam within 90 days of the end of the State of Emergency. She stated that the logistics behind that do not work very well, since the exams are only given one time per year, per location; and that the ability to get in within 90 days is difficult. She noted that they were originally planning to sign up in January for the exam offered in July, just to give the Committee Members an idea of the timeline and the issues they'll most likely face with the 90 day requirement they've placed on the temporary licenses. She stated that she supported the Board accepting the OSCE exam for both the WREB and ADEX. She went on to discuss the available portions of the WREB and ADEX exams and their timelines.

Kent Horsley commented that he agreed with his other colleagues, that the stipulation of requiring a licensed dentist of 5 years in order to supervise temporary license holders is creating a lot of issues for students graduating this year. He noted that students complete their programs with a letter of completion from the school and spoke about the concern the Committee has with schools graduating students who may not be competent and ready to be out in practice. He spoke about the exams and the hardships that graduates are and will be facing with the high standards the Board is setting, and the issues the graduates are facing.

Dr. Aimee Abittan stated that she is a practicing dentist in Nevada, and spoke in favor of a patient-less based exam for permanent licensure, and that it should be considered as an ethical issue. She stated that she would like to see the members of the committee do research into why it is being requested – the acceptance of patient-less exams, especially in the current situation in trying to find patient based exams. She commented that the temporary licensure that is being offered is cumbersome and difficult to satisfy as far as finding someone who will be able to supervise 24/7 while practicing.

Ben Abrahams, a dental student of the graduating class of 2020, asked for clarification on the agenda item (5)(d), if an applicant completes the exams during May 1, 2020 and December 31, 2020, will they be granted full unrestricted licensure or temporary licensure. His concern with temporary licensure is how cumbersome it is finding a dentist that meets the temporary license requirement, and noted that he has been searching for a dentist that meets the requirements for some time and has not been successful. He urged the Board to accept ADEX and WREB manikin based exams during this time for full licensure.

Charles Buchanan he stated that he understood that there was a period where the Board did not have a quorum of its members, and noted that he would try to be as respectful as possible with his comments. He stated that the information regarding both ADEX and WREB had been available since April, and the information has been accessible for several months. He did not understand that why after all the months during the pandemic, the Board is still unclear on the exam matters, since the Board did not need a quorum to research and review the information about the WREB and ADEX exams. He asked how much more time the Board needed to review the information, since the graduates of 2020 have run out of their time and their livelihoods were at the mercy of the Board.

## **7. Announcements**

No announcements were made.

## **\*8. Adjournment** (For Possible Action)

Committee Member Lemon called for a motion to adjourn.

MOTION: Committee Member Moore moved to adjourn the meeting at approximately 7:54 p.m.  
Committee Member Lemon seconded the motion. All were in favor, motion passed.

Respectfully Submitted:

\_\_\_\_\_  
Frank DiMaggio, Executive Director

## **Agenda Item (4)(a)(2)**

### **Draft Minutes:**

**IC Committee Meeting - 08/26/2020**





6010 S. Rainbow Blvd., Bldg. A, Ste.1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

## **NOTICE OF AGENDA & TELECONFERENCE MEETING FOR THE INFECTION CONTROL COMMITTEE**

(Elizabeth Park DDS, (Chair); Ron Lemon DMD; Caryn Solie, RDH)

### **Meeting Date & Time**

Wednesday, August 26, 2020  
6:00 p.m.

**Zoom Video and Teleconferencing was available for this meeting**

### **DRAFT MINUTES**

### **PUBLIC NOTICE:**

***\*\*Pursuant to the Governor's Executive Order 011, there will be no physical location for this meeting\*\****

**The Nevada State Board of Dental Examiners may hold board meetings via video conference or telephone conference call.  
In the event that there are technical difficulties with Zoom, please use the teleconference number (702) 486-5260 /  
Collaboration Code 67044**

Public Comment time is available after roll call (beginning of meeting) and prior to adjournment (end of meeting). Public Comment is limited to three (3) minutes for each individual. You may provide the Board with written comment to be added to the record.

Persons wishing to comment may appear at the scheduled meeting/hearing or may address their comments, data, views, arguments in written form to: **Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd, A-1, Las Vegas, Nevada 89118; FAX number (702) 486-7046; e-mail address [nsbde@nsbde.nv.gov](mailto:nsbde@nsbde.nv.gov)**. Written submissions should be received by the Board on or before **Tuesday, August 25, 2020 at 4:00 p.m.** in order to make copies available to members and the public.

The Nevada State Board of Dental Examiners may 1) address agenda items out of sequence to accommodate persons appearing before the Board or to aid the efficiency or effectiveness of the meeting; 2) combine items for consideration by the public body; 3) pull or remove items from the agenda at any time. The Board may convene in closed session to consider the character, alleged misconduct, professional competence or physical or mental health of a person. See NRS 241.030. Prior to the commencement and conclusion of a contested case or a quasi-judicial proceeding that may affect the due process rights of an individual the board may refuse to consider public comment. See NRS 233B.126.

Persons/facilities who want to be on the mailing list must submit a written request every six (6) months to the Nevada State Board of Dental Examiners at the address listed in the previous paragraph. With regard to any board meeting or telephone conference, it is possible that an amended agenda will be published adding new items to the original agenda. Amended Nevada notices will be posted in compliance with the Open Meeting Law.

We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Board office, at (702) 486-7044, no later than 48 hours prior to the meeting. Requests for special arrangements made after this time frame cannot be guaranteed.

Pursuant to NRS 241.020(2) you may contact the Board office at (702) 486-7044, to request supporting materials for the public body or you may download the supporting materials for the public body from the Board's website at <http://dental.nv.gov>. In addition, the supporting materials for the public body are available at the Board's office located at 6010 S Rainbow Blvd, Ste. A-1, Las Vegas, Nevada.

**Note:** Asterisks (\*) "**For Possible Action**" denotes items on which the Board may take action.

**Note:** Action by the Board on an item may be to approve, deny, amend, or tabled.

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61 **1. Call to Order**

62 - Roll call/Quorum

63  
64 Committee Member Park called the meeting to order at approximately 6:01 p.m., and Mr. Frank  
65 DiMaggio conducted the following roll call:

66 Dr. Elizabeth Park, DDS (Chair) Present

Dr. Ronald Lemon, DMD Present

Ms. Caryn Solie, RDH Present

67  
68 Executive Staff: Phil Su, General Counsel; Frank DiMaggio, Executive Director; Angelica Bejar, Public  
69 Information-Travel Administrator; Sandra Spilsbury, CE ... Coordinator.

- 70  
71 **2. Public Comment:** The public comment period is limited to matters specifically noticed on the agenda. No action may  
72 be taken upon the matter raised during public comment unless the matter itself has been specifically included on the  
73 agenda as an action item. Comments by the public may be limited to three minutes as a reasonable time, place and  
74 manner restriction, but may not be limited based upon viewpoint. The Chairperson may allow additional time at his/her  
75 discretion.

76  
77 Ms. Samantha Sturges, RDH commented that she was currently employed as a part-time IC Inspector for  
78 the Board, and that she was available to offer any feedback to the Committee.

79  
80 Dr. Aimee Abittan commented that Committee Member Park's connection was choppy and stated that  
81 she should perhaps reconnect.

82  
83 The Committee experienced inappropriate interruptions during the meeting, which caused the  
84 Chairwoman to ask that committee take a brief recess.

85  
86 The Committee reconvened at 6:18 p.m. and roll call was re-established. All Committee Members were  
87 present.

88  
89 **\*3. Chairwoman's Report:** *Elizabeth Park, DDS* (For Possible Action)

90  
91 **\*a. Request to remove agenda item(s)** (For Possible Action)

92  
93 **\*b. Approve Agenda** (For Possible Action)

94  
95  
96  
97  
98 **\*4. Consideration, discussion, and possible recommendation to the Board regarding Senior Smiles**  
99 **Program's request for clarification if the Infection Control Inspection requirement for the Senior**  
100 **Smiles Program, approved by the Board on March 12, 2020, would be required if only utilizing single**  
101 **use instruments** (For Possible Action)

102  
103  
104 **\*5. Consideration and Discussion to recommend Approval/Rejection of Public Health Dental Hygiene**  
105 **Program to the Board** (For Possible Action)

106  
107 \*a. Heavenly Smiles Mobile Dental Program (For Possible Action)

108  
109  
110 **\*6. Consideration and Discussion to recommend Approval/Rejection of part-time Infection Control**  
111 **Inspector Employee to the Board** (For Possible Action)

112  
113 \*a. Stacia M Dimmitt, RDH

114 \*b. Jennifer A Nightingale, RDH

115  
116 **\*7. Review, discussion and possible recommendations to the Board regarding the infection control**  
117 **inspector employee application/process** (For Possible Action)

- 120 \*8. **Review, discussion and possible recommendations to the Board regarding calibration training** (For  
121 Possible Action)  
122  
123  
124 \*9. **Review, discussion and possible recommendations to the Board concerning the August 4, 2020**  
125 **CDC Guidance on Dental Settings** (For Possible Action)  
126  
127  
128 \*10. **Consideration, discussion and possible recommendations to the Board regarding of offices found to**  
129 **be non-compliant with Infection Control requirements** (For Possible Action)  
130  
131  
132 \*11. **Consideration, discussion and possible recommendations to the Board regarding the parameters to**  
133 **be set for non-compliant offices** (For Possible Action)  
134  
135  
136 12. **Public Comment:** This public comment period is for any matter that is within the jurisdiction of the public body. No  
137 action may be taken upon the matter raised during public comment unless the matter itself has been specifically included  
138 on the agenda as an action item. The Chairperson of the Board will impose a time limit of three (3) minutes. The Chairperson  
139 may allow additional time at his/her discretion.  
140  
141  
142 13. **Announcements**  
143  
144  
145 \*14. **Adjournment** (For Possible Action)  
146  
147 Chairwoman Park offered her apologies, and called for the meeting be adjourned and rescheduled due  
148 to unfortunate interruptions by public participants.  
149  
150 MOTION: Committee Member Park made the motion to adjourn the meeting at approximately 6:19 p.m.  
151 Committee Member Solie seconded the motion. All were in favor, motion passed.  
152  
153  
154  
155  
156  
157  
158

Respectfully submitted by:

\_\_\_\_\_  
Frank DiMaggio, Executive Director

**Agenda Item (6)(a)**

**Advisory Opinion:**

**Pursuant to NAC 631.220(2), can a dental assistant administer a topical fluoride, specifically Silver Diamine Fluoride**

**- Dr. James Mann**



Nevada Board of Dental Examiners  
6010 S. Rainbow Blvd., Bldg. A, Ste. 1 • Las Vegas, NV 89118  
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046



### PETITION FOR ADVISORY OPINION

Applicant/Licensee: James Mann, DDS Date: March 9, 2020

Address: [REDACTED] Suite No.:           

City: [REDACTED] State: [REDACTED] Zip Code: [REDACTED]

Telephone: [REDACTED] Fax: [REDACTED] Email: [REDACTED]

In the matter of the petition for an advisory opinion of NRS & NAC Chapter 631:

This request is for clarification of the following statute, regulation, or order:

(Identify the particular aspect thereof to which the request is made.)

*Note: If you require additional space you may attach separate pages to the petition form.*

NAC 631.220(2): A dentist who is licensed in the State of Nevada may authorize a dental  
assistant in his or her employ and under his or her supervision only to do one or more of the  
following procedures after the patient has been examined by the dentist:  
(n) Administer a topical fluoride.

The substance and nature of this request is as follows:

(State clearly and concisely petitioner's question.)

*Note: If you require additional space you may attach separate pages to the petition form.*

Does the Nevada Board of Dental Examiners interpret NAC 631.220(2)(n) to include the use of  
Silver Diamine Fluoride by assistants under the supervision of the prescribing dentist? SDF,  
as marketed in the United States, is a 38 percent silver diamine fluoride which is equivalent to  
five percent fluoride (as compared to 5% NaF varnish) in a colorless liquid. The American  
Academy of Pediatric Dentistry supports delegation of application of SDF to auxiliary dental  
personnel or other trained health professionals according to a state's dental practice act.

*(Please submit any additional supporting documentation with the petition form)*

Wherefore, applicant/licensee requests that the Nevada State Board of Dental Examiners grant this petition and issue an advisory opinion in this matter.

  
Applicant/Licensee Signature

## **Agenda item (6)(b)**

### **NAC 631.257(1): OMS Residency Training Requirements**

**NAC 631.257 Administration of certain neuromodulators related to *Clostridium botulinum* and dermal or soft tissue fillers: Required training; submission of proof of completion of training and certain other information with application for renewal. ([NRS 631.190](#), [631.330](#), [631.391](#))**

A holder of a license to practice dentistry who, pursuant to [NRS 454.217](#), injects a neuromodulator that is derived from *Clostridium botulinum* or that is biosimilar to or the bioequivalent of such a neuromodulator or who, pursuant to [NRS 629.086](#), injects a dermal or soft tissue filler, must:

1. Successfully complete a didactic and hands-on course of study in the injection of such neuromodulators and fillers that:

(a) Is at least 24 total hours in length;

(b) Includes at least 4 hours of didactic instruction and at least 4 hours of hands-on instruction in each of the following subjects:

(1) The use of neuromodulators that are derived from *Clostridium botulinum* or that are biosimilar to or the bioequivalent of such neuromodulators in the treatment of temporomandibular joint disorder and myofascial pain syndrome;

(2) The use of neuromodulators that are derived from *Clostridium botulinum* or that are biosimilar to or the bioequivalent of such neuromodulators for dental and facial esthetics; and

(3) The use of dermal and soft tissue fillers for dental and facial esthetics; and

(c) Is approved by the Board.

2. Include with the application for the renewal of his or her license:

(a) Proof acceptable to the Board that he or she has successfully completed the course of study required by subsection 1; and

(b) A statement certifying that each neuromodulator that has been or will be injected by the holder pursuant to [NRS 454.217](#), and each dermal or soft tissue filler that has been or will be injected by the holder pursuant to [NRS 629.086](#), is approved for use in dentistry by the United States Food and Drug Administration.

(Added to NAC by Bd. of Dental Exam'rs by R044-17, eff. 5-16-2018)

**Agenda Item (7)(b)**

**Advisory Opinion:**

**Pursuant to NAC 631.258(1)(b), is a dentist allowed to inject neuromodulators and dermal fillers in the head and neck region**



**From:** [Board of Dental Examiners](#)  
**To:** [Angelica L. Bejar](#)  
**Cc:** [Frank DiMaggio](#)  
**Subject:** FW: Request for an Advisory Opinion  
**Date:** Wednesday, September 2, 2020 11:02:59 AM

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**From:** Robert Talley [mailto: [REDACTED]]  
**Sent:** Wednesday, September 2, 2020 10:54 AM  
**To:** Board of Dental Examiners  
**Subject:** Request for an Advisory Opinion



**Nevada Dental**  
ASSOCIATION

September 2, 2020

Nevada State Board of Dental Examiners  
6010 S. Rainbow Blvd. Ste. 1  
Las Vegas, NV 89118

The Nevada Dental Association is requesting an advisory opinion on NAC 631.258 1b which states:

1. A dentist who is authorized, pursuant to [NRS 454.217](#), to inject a neuromodulator that is derived from *Clostridium botulinum* or that is biosimilar to or the bioequivalent of such a neuromodulator or who is authorized, pursuant to [NRS 629.086](#), to inject a dermal or soft tissue filler, and who has satisfied the requirements of [NAC 631.257](#) shall not:
  - (a) Administer such an injection to a person other than a patient of record; or
  - (b) Inject such a neuromodulator or filler at an injection site that is outside the oral cavity, maxillofacial area or the adjacent and associated structures of the person.

Our question is this: Can a dentist with the proper training as required by the regulation inject a neuromodulator derived from *Clostridium botulinum*, a biosimilar/ bioequivalent neuromodulator or a dermal filler into an area outside of the oral cavity?

The regulation seems to say that injections would be allowed in the maxillofacial area and associated structures which are outside the oral cavity.

Dentists have called the NSBDE office and have been told that they cannot inject outside the oral cavity.

The Nevada Dental Association believes that the NSBDE should clarify that dentists are allowed to inject these neuromodulators and dermal fillers in the head and neck region.

Robert H. Talley DDS  
Executive Director  
Nevada Dental Association

## **Agenda Item (7)(d)**

### **Advisory Opinion:**

**If a Dental Healthcare Provider can instruct parent/guardian to apply single unit of fluoride varnish to their child's teeth through a synchronous teledentistry platform**



PETITION FOR ADVISORY OPINION

Applicant/Licensee: Antonina Capurro Date: August 14, 2020  
Address: [REDACTED] Suite No.:  
City: [REDACTED] State: [REDACTED] Zip Code: [REDACTED]  
Telephone: [REDACTED] Fax: [REDACTED] Email: [REDACTED]

In the matter of the petition for an advisory opinion of NRS & NAC Chapter 631:

This request is for clarification of the following statute, regulation, or order:

(Identify the particular aspect thereof to which the request is made.)

*Note: If you require additional space you may attach separate pages to the petition form.*

NRS 631.215, NRS 631.287, and NRS 631.310

The substance and nature of this request is as follows:

(State clearly and concisely petitioner's question.)

*Note: If you require additional space you may attach separate pages to the petition form.*

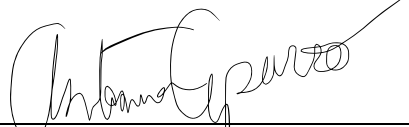
Following a virtual oral health screening or limited dental exam, is it appropriate for a parent to paint a single unit dose of fluoride varnish to their child's teeth if they are being supervised and instructed in real-time by a Nevada licensed dental practitioner (ie. dentist, dental hygienists, and/or dental hygienists that holds a public health endorsement) through a synchronous teledentistry platform.

Fluoride varnish applied in this way could be part of a virtual home visiting model that introduces children and their families to preventive oral health services, increases oral health literacy, reinforces the concept of the dental home, and improves daily oral hygiene practices.

Attached is a project proposal that would utilize the virtual application of fluoride varnish.

*(Please submit any additional supporting documentation with the petition form)*

Wherefore, applicant/licensee requests that the Nevada State Board of Dental Examiners grant this petition and issue an advisory opinion in this matter.

  
Applicant/Licensee Signature

## **Agenda Item 7(e)**

### **Senior Smiles: Request for Clarification regarding IC Inspection**

*Program previously approved by Board March 12, 2020*

Nevada State Board of Dental Examiners  
6010 S. Rainbow Blvd., Ste. A-1  
Las Vegas, NV 89118

Received  
JUL 02 2020  
NSBDE

June 30, 2020

Dear Nevada State Board of Dental Examiners,

I am writing you this letter to inform you of the activities of the Public Health Program, Senior Smiles. Unfortunately the program has not been able to be implemented due to the COVID-19 Pandemic. The nursing home in which I had hoped to begin providing care in has been on a strict lockdown since February 2020 and it is now very difficult to obtain the new CDC recommended personal protective equipment. Therefore, Senior Smiles is postponed.

There is an issue requiring clarification by the board. Upon the initial approval of the Senior Smiles Program, the board decided the program would have to have an infection control inspection prior to beginning to provide care. However, as stated in my program protocol, I will only be using single use items hence making an infection control inspection unnecessary. I am asking the board to please clarify that the Senior Smiles Program will require an infection control inspection only if and or when I submit a request to the board to allow me to provide prophylaxis treatment with reusable instruments. At this time the program is designed to only brush patients' dentition and removable dentures and partials.

Sincerely,

Dea Minnitte-Hamrey, RDH  
License # 101499

[REDACTED]  
[REDACTED]

***Senior Smiles PHE Program Information***

***Program previously approved by Board  
on 03/12/2020***

Nevada State Board of Dental Examiners  
6010 S. Rainbow Blvd. Bldg. A, Ste. 1  
Las Vegas, NV 89118

February 21, 2020

Dear Nevada State Board of Dental Examiners,

I am the director of the Senior Smiles program. I would like to introduce myself. My name is Dea Minnitte-Hamrey. I am a Nevada native, and I have been a dental hygienist for 12 years. I live and work in Hawthorne, Nevada. For nine years, I have been a hygienist for Dr. Bruce Dow, D.D.S in Hawthorne. For those of you who do not know, Hawthorne is a small rural community of approximately 3200 people located 133 miles south of Reno, Nevada.

When Mr. Hugh Qualls, our local hospital's director, approached myself and co-worker, Stephanie Ramsey, RDH regarding providing weekly preventative care to our community's nursing home residents we both were enthusiastic to meet with him and begin the process of creating a program that has become, Senior Smiles.

As the dental director of, Senior Smiles, I assume responsibility of providing safe preventative oral care in accordance with OSHA guidelines, as well as maintaining strict patient privacy. Patient medical histories and treatment records will be kept in their electronic charts through Mt. Grant General Hospital where all nursing home residents are established with primary care providers. Patients will be referred to Dr. Bruce Dow, D.D.S. for care beyond the scope of a dental hygienist.

Both myself and colleague, Stephanie Ramsey, RDH, BS, will be responsible for transporting reusable items to either Mt. Grant Hospital's sterilization area or Dr. Bruce Dow's office for proper processing. We will also be sure to keep both sterilization logs and weekly spore testing results. However, at this time, only single use items will be used because I do not have the funding to purchase reusable instruments.

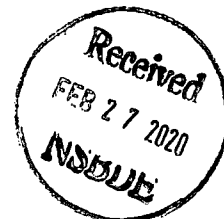
I am aware that I will be required to update the board bi-annually regarding the activity of the Senior Smiles Program. I am also aware that any registered dental hygienist who wishes to participate in my program must be a registered hygienist in the state of Nevada, have their Nevada Public Health Endorsement, have a current CPR training, maintain malpractice insurance coverage, and be in compliance with NAC 631.210.

Thank you for your consideration of my application for both P.H.E. and the Senior Smiles program. I look forward to implementing my program and helping to address basic oral health care needs in my community. Please refer to the attached Senior Smiles Oral Health Protocol for details of the Senior Smiles program.

Sincerely,



Senior Smiles Program Director  
Dea Minnitte-Hamrey, RDH, BS



## Senior Smiles Oral Health Program Protocol


### Dental Director of Senior Smiles:

Dea Minnitte-Hamrey, RDH, BS



### Hospital Director:

Hugh Qualls



### Oral Hygiene Care Providers with active Nevada licenses with P.H.E and current CPR

\*\*\*PHE for the listed RDH's is awaiting approval from the board\*\*\*

Dea Minnitte-Hamrey, RDH, BS License # 101499

Stephanie Ramsey, RDH, BS License # 3670

### Population/s:

Letha L. Seran Nursing Home Facility Residents

Mt Grant General Hospital



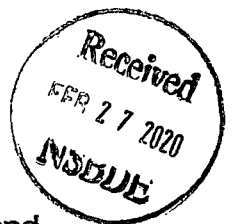
Home bound residents residing in Mineral County and/or neighboring counties including, but not limited to Churchill, Lyon, and Esmerelda.

\*\*At this time, Senior Smiles, does not have the funding to purchase portable dental equipment to provide preventative care to home bound residents, but it is a future goal of the program.

### Procedures:

- \* Periodontal charting
- \* Existing restoration charting
- \* Oral cancer screening
- \* Basic oral hygiene care such as, brushing, flossing both the dentition and removable dentures and/or partials

Each patient will have their own toothbrush, floss and toothpaste labeled with their name that will be kept in zip-lock bags in their rooms at the nursing home. These items will be used daily by certified nursing assistants and weekly by dental hygienists on the





patient. These items will be changed out every three-four months or unless the patient has been sick then the items will be replaced with new ones.

- \* Application of local intra-oral chemotherapeutic agents
  - \* topical anesthetics
  - \* topical desensitizing agents
  - \* fluoride varnish
  - \* silver diamine fluoride
- \* Full mouth debridement (in the future depending on funding)
- \* Scaling and Root Planing (in the future depending on funding)
- \* Prophylaxis (in the future depending on funding)

#### Sterilization Protocol:

Single use items will be utilized until more funding is available to purchase sterilizable equipment/instruments. When sterilizable equipment is purchased, then sterilization will be done at Mt. Grant General Hospital. If sterilization is not able to be completed at Mt. Grant Hospital, such as if their sterilizers fail spore testing, then Dr. Dow, D.D.S. has agreed to allow sterilization to be done in his office. Weekly spore testing will be performed along with sterilization logs.

#### Medical Emergency Protocol:

The Letha L. Seran Nursing Care facility is literally connected to Mt. Grant General Hospital where there are nurses and medical doctors on staff who can assist and treat a medical emergency. The hospital is also equipped with all required medical emergency medications and equipment (Please refer to Mr. Hugh Qualls's attached letter).

When the Senior Smiles program is able to expand and provide care to home bound patients then a portable medical emergency kit will be assembled and taken into each home of the patient for quick access if needed.

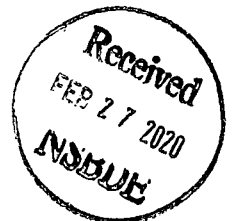
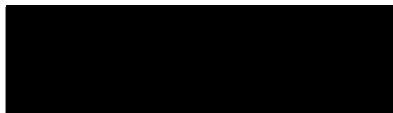
#### Time-Line:

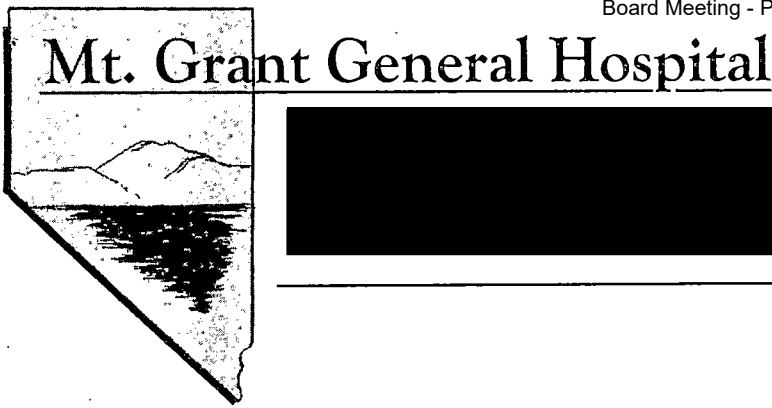
Weekly, starting March 2020 until either Mt. Grand Hospital is no longer able to pay for the service and/or the provider/s are no longer available

#### Referral Mechanism:

Referrals for care beyond the scope of practice of the P.H.E. R.D.H. will be made to:

Dr. Bruce Dow, D.D.S





# Mt. Grant General Hospital

January 15, 2020

Nevada State Board of Dental Examiners  
6010 S. Rainbow Blvd.  
Las Vegas, NV 89118

Dear Board:

This letter verifies that Mt. Grant General has the requested Dental Emergency Kit items available for use by dental hygienists and our staff; these items include:

Epinephrine 1:1000 (injectable)  
Histamine-blocker (injectable)  
Oxygen with positive-pressure administration capability  
Nitroglycerin (sublingual tablet or aerosol spray; be aware of contraindications)  
Bronchodilator (asthma inhaler)  
Sugar (quick source of glucose such as orange juice)  
Aspirin

Please contact me if you have any further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Qualls", is written over a horizontal dashed line.

Hugh Qualls, Administrator



Nevada State Board of Dental Examiners  
6010 S. Rainbow Blvd. Bldg. A, Ste. 1  
Las Vegas, NV 89118

January 10, 2020

Mt. Grant General Hospital  
Letha L. Seran Skilled Nursing Facility  


Dear Nevada State Board of Dental Examiners,

I am writing to receive approval to implement an oral health program titled, Senior Smiles. Senior Smiles will provide weekly oral hygiene care to residents who currently reside in the Letha L. Seran Skilled Nursing Facility at Mount Grant General Hospital located in Hawthorne, Nevada. Registered Dental Hygienists will be performing the oral hygiene services. The hospital's director, Hugh Qualls, is in strong support of this program and has informed me that after a recent audit an oral health program needs to be established.

The oral hygiene care that will be provided to the nursing home residents will include, full mouth debridement, prophylaxis, periodontal charting, existing restoration charting, oral cancer screening, and cleaning of removable dentures and partials. Also, when indicated, there will be the application of local intra-oral chemotherapeutic agents that will include topical anesthetics, topical desensitizing agents, fluoride varnish, and silver diamine fluoride. The facility is equipped with necessary supplies to treat a patient who may have an adverse reaction. Please refer to Mr. Hugh Quall's attached letter confirming this statement.

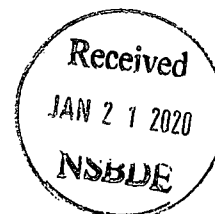
In addition to providing care to the nursing home patients, the dental hygienists will also educate the nursing home's staff on proper oral hygiene care. The frequency of staff training is currently being determined by Hugh Qualls.

Dr. Bruce Dow, D.D.S., the Dental Director of Senior Smiles, has agreed to perform exams, interpret radiographs, and provide restorative care as indicated. Upon approval of Senior Smiles, Dea Minnitte-Hamrey, RDH, BS and Stephanie Ramsey, RDH, BS will apply for Special Health Endorsements.

Sincerely,



Dea Minnitte-Hamrey, RDH, BS License # 101499  

## **Agenda Item 7(f)**

### **PHE Program: Heavenly Smiles Mobile Dental Program**



June 8, 2020

To Nevada State Board of Dental Examiners

CC:	D. Kevin Moore, DDS	President
	David Lee, DMD	Secretary-Treasurer
	Ronald Lemon, DMD	Board Member
	Elizabeth Park, DDS	Board Member
	Ronald West, DMD	Board Member
	W. Todd Thompson, DMD	Board Member
	Jana McIntyre, RDH	Board Member
	Gabrielle Cioffi	Public Member

Re: Approval for a New Public Health Program and Endorsements

From: Janet Crosswhite RDH, BS

Hello, My name is Janet Crosswhite I am a Registered Licensed Dental Hygienist here in Las Vegas, Nevada. I am seeking approval for my mobile dental public health program. I have been working in the dental field for the past 25 years helping to provide the best dental hygiene care possible. Public Health is a very important part of me, I grew up in an inner city where there were areas of extreme poverty. My first dental office position was an office that serviced a community of individuals that could not afford dental services, we serviced a majority of those with Medicaid and other state funded insurances. On several occasions, we would provide those experiencing homelessness an opportunity to have routine exams, dental cleanings, and basic restorative procedures. This was my first experience with servicing the underserve community. I will always have a passion to serve those individuals in need. I am currently working in a small corporation based practice, I absolutely love my position. We are contracted to provide services to Medicaid recipients however, my company has decided to no longer

Received

JUN 09 2020

NSBDE

service this community due to the population needing care vs private insurance recipients. I feel like there is something I have to do to help get those individuals the care that's needed to help them maintain great oral hygiene and one that's free from disease. As we all know our total wellness of health begins with our oral cavity and if there is not enough providers to service a particular community than we know that particular community would have an increased amount of oral disparities. Heavenly smiles mobile dental would be honored to help reduce the amount of individuals suffering from lack of dental care. I know that there are several barriers that prevent those in our community to obtain care, one being transportation. Heavenly Smiles Mobile will come to those who are experiencing these types barriers. Education is the key, I am very happy to announce that in 2017 I returned to school and I enrolled in a dental hygiene bachelor's degree in science program. My main focus was education and public health. I felt this would help me in gaining knowledge for my targeted population of those to serve. I feel very confident that I am able and willing to provide the necessary care under my scope of dental hygiene practice to those individuals in need. I have enclosed a copy of my public health program in full detail and application for an Public Health Endorsement. I can be reached by mobile phone 313-806-4786 for any questions that may arise. Thank you in advance for taking the time out to look over the program and for approval.

Respectively,

 RDH, BS  
Janet Crosswhite RDH, BS

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*A Preventative Dental Hygiene Wellness Provider*

*Heavenly Smiles Mobile Dental LLC*

**A Total Health Wellness Public Health Endorsed Dental Hygiene Program**

[www.heavenlysmilesmobiledental.com](http://www.heavenlysmilesmobiledental.com)

email:

[REDACTED]

contact :

[REDACTED]

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## About the Founder/ CEO Program Director



Janet Crosswhite RDH, BS graduated with her dental hygiene degree from Oakland Community College in Waterford, MI in 2008. In 2019, Janet graduated with her Bachelor's of Science dental hygiene from Northern Arizona University focusing on Public Health and education.

Janet is actively working as a dental hygienist in private practice.

Janet Started her love for dentistry while in high school during her junior year, she was enrolled in an Office Co-op class where she was introduced to gaining skills in clerical and customer service. The program was designed to offer students the opportunity to gain work experience while obtaining a high school diploma. Janet started working for Dr. David Beal DDS as part of the front office team and Janet was trained and introduced to the clinical setting of dentistry. This was a very exciting time for Janet. She would quickly hone skills that has currently helped shape her dental hygiene career.

When moving to Las Vegas the end of 2008, Janet was very excited and nervous to start her career in a new state. When Janet obtained her license in Nevada, one of her first job opportunities was to work in public health with Reachout of America. Reachout was a public health mobile dental company that provided underserved children in a school setting a variety of dental health services such as preventative and restorative dentistry. This was a great experience for Janet and she developed the love for public health. Throughout her practicing years in dental hygiene, Janet has taken pride in learning ways to enhance her delivery of dental hygiene care. Becoming laser certified was a big accomplishment for her practice in preventative care.

Janet, has a great deal of passion for dentistry. She is very passionate in ensuring that everyone has access to dental care, this has led her to reconsider the public health sector in dental hygiene care within rural and underserved communities in Nevada.

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# Nevada Business License

SECRETARY OF STATE



## NEVADA STATE BUSINESS LICENSE

Heavenly Smiles Mobile Dental LLC

Nevada Business Identification # NV20201789255

Expiration Date: 05/31/2021

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which, by law, cannot be waived.



Certificate Number: B20200527815634

You may verify this certificate

online at <http://www.nv.sos.gov>

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on 05/27/2020.

*Barbara K. Cegavske*

BARBARA K. CEGAVSKE  
Secretary of State

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## SECRETARY OF STATE

**DOMESTIC LIMITED-LIABILITY COMPANY (86) CHARTER**

I, BARBARA K. CEGAVSKE, the duly qualified and elected Nevada Secretary of State, do hereby certify that **Heavenly Smiles Mobile Dental LLC** did, on 05/27/2020, file in this office the original Articles of Organization that said document is now on file and of record in the office of the Secretary of State of the State of Nevada, and further, that said document contains all the provisions required by the law of the State of Nevada.



Certificate Number: B20200527815633  
You may verify this certificate  
online at <http://www.nv.gov>

IN WITNESS WHEREOF, I have hereunto set my  
hand and affixed the Great Seal of State, at my  
office on 05/27/2020.

*Barbara K. Cegavske*

BARBARA K. CEGAVSKE  
Secretary of State

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## **Policies and Procedures**

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1. Vision and Mission of the program
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11. Prophylaxis and Scaling and Root Planning
12. Sealant and Fluoride Protocol
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14. Additional References
15. Finance Statement and Timeline
16. Contact Information

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## **Vision Purpose**

Provide communities with a healthy, happy, disease free oral cavity with an infectious Smile.

## **Mission**

Provide access to dental care services to vulnerable populations in a safe, convenient and cost-effective manner, regardless of their ability to pay.

Optimal oral health is a critical component of overall health. We aim to provide free or low-cost dental hygiene services, case management and dental referrals to low income and underserved populations in Nevada in an effort to improve oral and overall wellness. Oral healthcare needs would be met through dental screenings, oral hygiene instruction, problem prevention, education, prophylaxis, scaling and root planning, fluoride application and sealants through evidence-based clinical Best Practices. All patients would receive follow up case management and referrals.

## **Program Parameters**

Heavenly Smiles Mobile Dental, LLC is a cost effective and efficient healthcare delivery model. This program allows licensed dental professionals to deliver mobile care in a variety of settings with minimal overhead costs. The program is founded in a dental hygiene-based model to ensure focus remains on education and disease prevention and obtaining access to available care, versus focusing on collection goals.

All volunteers and employees must and will follow Nevada Statutes, Rules and Regulation that govern the practice of dentistry and dental hygiene as listed in NRS 631 and NAC 631 and 459. They must and will also follow the most current CDC guidelines for infection control in the dental office, and abide by HIPAA

regulations. Liability Insurance must be maintained during the duration of the program.

The program will operate on a full time basis as community needs dictate and on a year-round schedule. Hours may include week days and evenings and weekends. Since the intent is convenience, hours will be determined by site location and fall in line with standard operating hours of the site location. For example, if at a school- will follow school day schedule. All patients that provide consent forms signed by a parent or legal guardian will be seen.

All program locations will be provided, in writing (electronically), for locations being served to the Nevada State Board of Dental Examiners.

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### **Population Served**

At risk Children, Veterans, Elderly Adults at Nursing homes, Schools, Community Health Centers, Churches, Day centers, housing program locations, Shelters, Assisted living facilities and general Dental offices.

### **Documentation**

All patients will be presented with a social/medical history and data collection form. Data collection form may include, but not limited to: demographics, income, insurance, contact information and media release.

Minors must have a parent or legal guardian to complete forms, but in the case of at-risk minor that is homeless or part of a sex trafficking rehabilitation program and no legal guardian are present, then the recipient seeking care and an adult who is affiliated with a program Heavenly Smiles Mobile Dental LLC partners with will sign the consent for treatment.

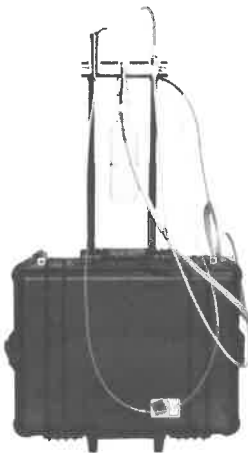
Before treatment, patients will produce a signed medical history form and positive consent for Heavenly Smiles Mobile Dental LLC staff to render treatment. Patients can opt out of any services at any given time.

All records will be kept for a minimum of 5 years and Heavenly Smiles Mobile Dental LLC will adhere to all current state recordkeeping laws.

A form will always be given at the end of the appointment to ensure the patient is aware of all services provided. This form will also have 24-hour contact information for Heavenly Smiles Mobile Dental LLC and will always include a dental referral recommendation to promote establishment of a dental home and need for follow up care.

### **Portable Dental Equipment**

- Mobile dental equipment has been purchased: DNTL Works ProSeal I
- <https://dntlworks.com/product/proseal-i/>
- Impact-resistant case incorporates built-in wheels and retractable handle
- Powerful, quiet vacuum pump with dual hoses for HVE and saliva ejector use
- Integrated, non-retracting water source with air/water syringe for irrigating and drying
- Large waste container with automatic overflow shutoff
- Mini-compressor for air/water syringe use
- Hospital grade power cord with 15 amp circuit breaker
- Made with pride in the USA
- Additional Features
- One-piece design is both durable and rugged
- Powerful vacuum pump with dual-hose design accommodates many brands of HVE and saliva ejector tips
- Impact-resistant case with built-in wheels and retractable handle
- Efficient mini-compressor for air/water syringe use
- Built-in carrying handle



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## **Portable Dental Equipment**



### **Portable Dental Stools Soft-Sided Carrying Case**

- Rugged, large, soft-sided carrying case that will accommodate any one of our DNTLworks portable dental stools. One carrying case for each stool, chair



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### **UltraLite Patient Chair Arm Slings**

Arm slings made specifically for the DNTLworks UltraLite™ Portable Patient Chair

## **Mobile Dental Van** **(in near future)**

**Kare Mobile, Inc.**

[www.kare.mobi](http://www.kare.mobi)

This Van will be personally customized to Heavenly Smiles mobile provider needs by Kare Mobile Inc. All of the equipment is safe and portable besides the dental chair to use within homes, schools, or nursing facilities/ assisted living homes.

**\*\*Upon receiving van the Nevada Board of dental examiners will be notified for inspection before the mobile dental van will be in use.**

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This Van will also give clients a private and calming experience when privacy is an issue. There will be sterilization and handwashing available. Infection Control will be maintained while in use at all times.

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### **Services Offered**

Oral health education, Nutritional Counseling, and problem prevention strategies (including the risks of sugar, tobacco, biofilm, oral piercings), home care instructions (including brushing, flossing, and fluoride), discuss the benefits of dental treatments like prophylaxis, sealants, and fluoride and then provide those services when appropriate to do so. Explain post-operative instructions for all services rendered. Oral screenings to assess oral health needs (including oral cancer exam and periodontal assessment), referrals for follow up dental care and radiographic exam at a partnering dental office location. Dental hygiene services allowed under the Nevada Board of Dental Examiners Dental Hygiene scope of practice.

## **Referral Program/Case Management**

Upon screening and an evidence-based assessment, referrals to a partnering dental office or public dental health clinic will be provided for the treatment and continuing care when: patient experiences regular dental pain, abscess present, rampant caries in multiple quadrants of the mouth, deep caries in one quadrant of the mouth, heavy calculus buildup or deep pocketing requiring local anesthetic versus topical anesthetic to maintain comfort, abnormality found during oral cancer screening, or when regular recall is due. Patient will initial that they have received a referral, explained the reason and its urgency in their chart for documentation.

- Referrals/education shall be given to assist with reimbursement options: NV Medicaid and NV Health Link

Referral Network may include:

1. All dental public health entities in surrounding area. For example: Future Smiles, College of Southern Nevada Department of Dental Hygiene
2. Local dental offices in surrounding area that accept Medicaid and/or accepting New Patients.
  - a. Heavenly Smiles Mobile Dental LLC staff will reach out to local offices and determine if office may be used as part of referral program.
  - b. Referrals will be based on location, transportation and availability.

Heavenly Smiles Mobile Dental will be working very closely to these providers to ensure that the population served will get the best available restorative and comprehensive dentistry possible

Dr. Sheronda Strider-Barraza: Valley Dental 702-644-2222

Dr. Beatrice Stark: Enhance Dental 702-437-1007

Dr. Trudy Reese: Crown Dental 702-804-1500

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## **Infection Control and Clinical Duties**

- Inventory and order program supplies
- Monitor program budget and expenses
- Maintain equipment following manufacturers recommendations, seeking repairs on a as needed
- Set up treatment materials and daily paperwork
- Provide oral health education
- Utilize electronic health records when possible using Tab32 dental software, and maintain paper charts when electronic is not available
- Utilize Personal Protective Equipment as outlined by CDC and OSHA, Nitrile gloves and surgical face masks and shields
- Disposable lab gowns will be available upon site visit
- Assess oral health status and provide oral prophylaxis, using topical anesthetic as needed for patient comfort (referring when topical is not sufficient). Local anesthesia will ONLY be provided while doctor is present at site at all times when necessary. The doctor at site will provide the anesthetic and necessary equipment.
- Assess recall needs and explain reasoning to patient, giving a referral for continued care
- Assess teeth suitable for fluoride and sealant placement
- Provide post-operative instructions for treatment rendered
- Sterilize equipment and instruments for the next treatment day. Instruments will be transported to and from sites in a large plastic tackle box labeled on for clean and one for dirty. Also there will onsite sterilization using the Prestige Medical 2100 classic portable Sterilizer with required spore testing using a third party spore testing company by one of the dental supply companies providing the best cost efficient service.
- Maintain compliance with HIPPA and OSHA requirements

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- Adhere and follow the Current CDC guidelines for handwashing and infection control in the dental office, including the use of plastic barriers, cavi-cide wipes, etc.

<https://www.cdc.gov/infectioncontrol/guidelines/hand-hygiene/index.html>

<https://www.cdc.gov/oralhealth/infectioncontrol/guidelines/index.htm>

- Will have biennial OSHA Infection Control site evaluation and training done by an outside entity/infection control professional.

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## **Sterilization Protocol**



### **Prestige Medical 2100 Classic Portable Sterilizer**

**Onsite and offsite sterilization will be performed**

**Transporting instruments safely in a clear tackle box designated for clean and one for dirty will be available at every site**

The Prestige Medical Classic Portable Dental Autoclave is compact and easy to use, with an 18 minute sterilization cycle.

#### **Dimensions & Capacity:**

- Total Height: 13.2"
- Total Width: 13.4"
- Chamber Diameter: 8.3"
- Chamber Height: 9.3"
- Maximum Load Weight: 6.6 lbs.
- Maximum Instrument Size: 9"

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FDA listed and approved, Light, compact , portable, robust, top loading autoclave easy to operate fast 11 minute, 258.8°F sterilizing cycle. Only weighs 11.5 lbs., 9 L Capacity. Light sequence indicators showing Power to unit, Cycle in Progress, Sterilization in progress, cycle is successful or cycle has failed. Interlock system prevents the lid from being removed while pressure remains in the vessel. TST indicator strips provide independent verification the correct combination of temperature, steam and time has been achieved for successful sterilization. Includes Instrument basket, Depressurization valve to reduce cooling time.

Also use of disposable single use dental instruments will be supplied when available.

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## Radiographic Services

Tele-health using Mouthwatch intra-oral cameras with disposable sleeve protectors will be used and changed after each patient When funding permits; Use of an Apex intraoral sensor and KaVo Nomad Pro 2 Handheld portable Dental X-ray with disposable barriers will be used to allow for an complete exam during synchronized tele-health communication with the doctor.



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X-rays may also be obtained through a licensed dental office under the Doctor's prescription of advised care. Heavenly Smiles Dental, LLC licensed staff may take X-rays if volunteering if/when partnering Dentists open their office for Pro Bono care of the underserved and provide duplicate copies to Community Dental Connections.

## **Prophylaxis and Scaling and Root Planing Protocol**

<https://www.adha.org/resources-docs/2016-Revised-Standards-for-Clinical-Dental-Hygiene-Practice.pdf>

Intra and Extra Oral Exam, Prophylaxis or S/RP , Post-Operative Instructions

1. Introduce yourself and ask if patient has any concerns
2. Review medical history and assess special needs. If patient requires premedication and did not take it prior to appointment, they will be given a referral for the next available date to receive treatment at a dental office versus mobile hygiene service where premed can be given or prescribed by the authority of a dentist. If their medical health is in question, then refer to a medical provider and forgo treatment today. If Blood Pressure is >180 systolic and/or >120 diastolic, then recheck in 5 minutes. If still elevated to this level, do not perform dental treatment and refer to nearest Emergency Room. If blood pressure is above 140/90, continue treatment but monitor during appointment. Recommend consulting a physician to address the



elevated blood pressure condition. \*Adhere to the American Heart Association Guidelines for Blood Pressure (see chart below)

## Blood Pressure Categories



BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
<b>NORMAL</b>	<b>LESS THAN 120</b>	<b>and</b>	<b>LESS THAN 80</b>
<b>ELEVATED</b>	<b>120 – 129</b>	<b>and</b>	<b>LESS THAN 80</b>
<b>HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1</b>	<b>130 – 139</b>	<b>or</b>	<b>80 – 89</b>
<b>HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2</b>	<b>140 OR HIGHER</b>	<b>or</b>	<b>90 OR HIGHER</b>
<b>HYPERTENSIVE CRISIS (consult your doctor immediately)</b>	<b>HIGHER THAN 180</b>	<b>and/or</b>	<b>HIGHER THAN 120</b>

©American Heart Association

[heart.org/bplevels](http://heart.org/bplevels)

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3. Put on Personal Protective Equipment and give patient safety glasses
  4. Place bib around patient and recline if possible, in treatment chair
  5. Do Extra and Intra Oral exams to check for abnormalities
  6. Assess gingival health, complete periodontal charting, and explore dentition to devise a dental hygiene treatment plan. This may include prophylaxis, scaling and root planning, sealants, fluoride varnish, and a dental partner referral. Discuss benefits of these treatments. All patients will receive a periodontal assessment.
  7. Identify treatment urgency= 0- no obvious problems, 1- early dental problems, 2- significant dental issues and 3- severe problems, need immediate attention (decay all 4 quads, visible abscess, pain, inability to eat).
- All patients will receive risk assessments: periodontal disease and caries
8. Strategize preventive dental care plan after assessing plaque, bleeding, amount of calculus, time since last dental visit, diet, and oral habits.
  9. Discuss findings and educate patient in an encouraging way, to invite positive changes and trust. (Likely this will happen during the prophylaxis).

10. Remove plaque, calculus, biofilm, stain, and food debris with sterilized instruments.
11. Coronal polish with prophylactic paste, rinse, floss, rinse.
12. Demonstrate proper brushing and flossing techniques if indicated. Tailor individual needs to include other adjuncts, diet recommendations, etc. using evidence-based clinical Best Practices.
13. Apply sealants and or fluoride varnish if needed.
14. Discuss the need for regular recalls and the importance of referrals if indicated. Document by having patient initial receiving the referral and the reason why it was indicated.

### **Sealant Protocol**

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\*Sealant material will not be placed if tooth cannot be isolated, or caries is present and cavitation is >1mm

Reference: <https://ebd.ada.org/en/evidence/guidelines/pit-and-fissure-sealants>

#### **Follow manufacturer directions.**

1. Provide orange safety glasses to patient
2. Isolate teeth to be sealed, dry excess saliva, and etch 30 seconds (variable
3. depending on etch used)
4. Rinse thoroughly, isolate, dry off with air
5. Apply sealant, lightly covering all pits and grooves, cure 20 seconds
6. Check for adequate coverage, and reapply if needed and cure another 20
7. seconds.
8. Remove isolation, check for excess flash.
9. Give post-operative instructions

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## **Fluoride Protocol**

### Fluoride Varnish Protocol

#### **Follow manufacturer directions.**

1. After prophylaxis or sealant placement (whichever was last), dry teeth
2. Paint thin layer of fluoride varnish on all teeth without large areas of decay
3. Give post-operative instructions not to have anything hot or very crunchy (not
4. abrasive) food/drink for 4 hours, and avoid to also avoid brushing and flossing
5. for 4 hours. Explain the “waxy/coated” feeling will go away after brushing, but discuss again the benefits of fluoride applications (not more than quarterly).

### Silver Diamine Protocol

Informed Consent Required (with photos)

Reference and Protocol Parameters:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4778976/>

Silver Diamine Fluoride (SDF) UCSF Protocol for Arresting Dental Carious Lesions or Treating Tooth Sensitivity

Material: Advantage Silver Arrest (38% SDF, purified water) from Elevate Oral Care. Shelf life: three years unopened. Do not refrigerate. Avoid freezing or extreme heat.

#### Indications:

1. Extreme caries risk (xerostomia or severe early childhood caries).
2. Treatment challenged by behavioral or medical management.
3. Patients with carious lesions that may not all be treated in one visit.
4. Difficult to treat dental carious lesions.
5. Patients without access to dental care.
6. Patients with extreme hypersensitivity.

Maximum dose: 25 µL (1 drop) / 10kg per treatment visit. SDF

Contraindication: Silver allergy.

SDF Relative Contraindications: Ulcerative gingivitis, stomatitis.

SSKI Contraindications: Pregnancy, breastfeeding.

Considerations: • Decayed dentin will darken as the caries lesions arrest. Most will be dark brown or black. • SDF can stain the skin, which will clear in two to three

weeks without treatment. • SDF can permanently stain operatory surfaces and clothes. • A control restoration (e.g., GI via ART or other material) may be considered after SDF treatment. • Saturated solution of potassium iodide (SSKI, Lugol's Solution, various sources) can be used after SDF to decrease color changes. • Re-application is usually recommended, biannually until the cavity is restored or arrested or the tooth exfoliates.

Procedure:

1. Plastic-lined cover for counter, plastic-lined bib for patient.
2. Standard personal protective equipment (PPE) for provider and patient.
3. One drop of SDF into the deep end of a plastic dapping dish (also obtain one drop of SSKI in a separate dapping dish if selected).
4. Remove bulk saliva with saliva ejector.
5. Isolate tongue and cheek from affected teeth with 2-inch by 2-inch gauze or cotton rolls.
6. If near the gingiva, consider applying petroleum jelly with a cotton applicator for safety.
7. Dry affected tooth surfaces with triple syringe or if not feasible dry with cotton.
8. Bend micro sponge, immerse into SDF, remove excess on side of dapping dish.
9. Apply directly onto the affected tooth surface(s) with micro sponge.
10. Allow SDF to absorb for up to one minute if reasonable, then remove excess with gauze or cotton roll. (If using SSKI, apply with a different micro sponge. Repeat one to three times until no further white precipitates are observed. Wait five to 10 seconds between applications. Remove excess with cotton.)
11. Rinse with water.
12. Place gloves, cotton and micro brushes into plastic waste bag

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## **Emergency Protocol**

Emergency Protocol (As Determined by 2015 AHA Update for CPR and ECC)  
Emergency equipment: determine where emergency kit and AED is located at each facility services may be provided and include in policies and procedure manual.

Heavenly Smiles Mobile Dental, LLC Emergency kit will include:

- A. Portable blood pressure cuff and stethoscope, CPR barrier
- B. Emergency Eye Wash Equipment
- C. AED unit will be purchased when funding allows, we will locate an AED unit at ALL sites before procedures are started.

1. Determine responsiveness
2. Check breathing and pulse simultaneously. If no pulse or irregular breathing, activate emergency response system
3. Call 911, ask for help from anyone else at immediate location. Bring emergency kit and AED to the scene when possible
4. Start CPR, but attach/activate AED as soon as it arrives
5. Maintain CPR until rescue personnel take over, only pausing if shock is being delivered as directed by AED.
6. Document

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## References

- American Heart Association, "2015 Guidelines Update for CPR and ECC."
- <https://eccguidelines.heart.org/wp-content/uploads/2015/10/2015-AHA-Guidelines-Highlights-English.pdf>.
- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4778976/>
- Bronstein, Diana, DDS, MS, MS, and Jon B. Suzuki, DDS, PhD, MBA.
- "Periodontal Disease Management." Dimensions of Dental Hygiene Journal, July 2018: 42-45.
- Center for Disease Prevention and Control. "Infection Prevention & Control in Dental Settings." <https://www.cdc.gov/oralhealth/infection-control/index.html>.
- Claiborne, Denise M, PhD, RDH. "The Role of Fluoride in Caries Prevention." Dimensions of Dental Hygiene Journal, February 2018: 34-36.
- Cuny, Eve J, BA, MS. "Surface Disinfection Strategies." Dimensions of Dental Hygiene Journal, January 2018: 24-28.
- Dye, Bruce A, DDS, MPH. et.al. "Oral Health Disparities as Determined by Selected Healthy People 2020 Oral Health Objectives for the United States, 2009-2010." Centers for Disease Control and Prevention. Center for Health Statistics Data Brief No. 104, August 2012. <https://www.cdc.gov/nchs/data/databriefs/db104.htm>.
- Edwards, Julie. "HIPAA, Patient Privacy and Electronic Dental Records." ACCESS Journal, ADHA, August 2018: 11-13.
- Garland, Kandis V., RDH, MS, and Crystal L. Kanderis Lane, RDH, BS.
- "Technology-Related Infection Control Challenges." Dimensions of Dental Hygiene Journal, August 2018: 30-33.
- Glasscoe Waterson, Dianne, MBA, RDH. "Safe standards for high blood pressure." RDH Magazine, August 2018: 28-30.
- Murria, Alicia, RDH. "Homelessness: A Public Health Problem." ACCESS Journal, ADHA, March 2018: 13-14.
- Osuna, Tricia, RDH, BSDH, FAADH. "Arming your operator." RDH Magazine, July 2018: 52-54.
- U. S. Department of Health & Human Services. "Oral Health in America: A Report of the Surgeon General." U. S. National Library of Medicine. National Institutes of Health, May 2000. <https://www.surgeongeneral.gov/library/reports/>.
- Pitts, Elizabeth, RDH, MS and Margherita Fontana, DDS, PhD. "The Role

of the Dental Hygienist in Caries Risk Assessment.” Dimensions of Dental Hygiene Journal, July 2018: 21-24.

- U. S. Department of Health & Human Services, Public Health Service, Centers for Disease Control and Prevention. “A National Call to Action to Promote Oral Health.” NIH, National Institute of Dental and Craniofacial Research, May 2003: 1-53.
- Walters, Molly A., RDH, BSDH, and Laura J. Sleeper, RDH, DHSc.
- “Benefits and Risks of Dental Sealants.” Dimensions of Dental Hygiene Journal, February 2018: 21-23.
- Walters Hunt, Amber, RDH, BSDH, MS et.al. “Strategies for Treating Seniors.” Dimensions of Dental Hygiene, August 2018: 41-4

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## **Public Health Endorsement**

### **NRS 631.287 Dental hygienists: Special endorsement of license to practice public health dental hygiene; renewal.**

1. The Board shall, upon application by a dental hygienist who is licensed pursuant to this chapter and has such qualifications as the Board specifies by regulation, issue a special endorsement of the license allowing the dental hygienist to practice public health dental hygiene. The special endorsement may be renewed biennially upon the renewal of the license of the dental hygienist.

2. A dental hygienist who holds a special endorsement issued pursuant to subsection 1 may provide services without the authorization or supervision of a dentist only as specified by regulations adopted by the Board (Added to NRS by [2001, 2691](#); A [2013, 479](#)

### **NAC 631.145 Dental hygienists: Renewal of special endorsement of license to practice public health dental hygiene. ([NRS 631.190, 631.287](#))**

1. A special endorsement of a license that allows a dental hygienist to practice public health dental hygiene issued by the Board may be renewed biennially in accordance with [NRS 631.287](#).

2. A dental hygienist may apply to renew the special endorsement upon the renewal of his or her license by submitting a report summarizing the services performed by the dental hygienist under the authority of the special endorsement during the immediately preceding biennium.

(Added to NAC by Bd. of Dental Exam'rs by R231-03, eff. 5-25-2004; A by R020-14, 6-23-2014)

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## **Finance Statement and Timeline**

Heavenly Smiles Mobile Dental, LLC will seek grants, private donations, state Medicaid and Private insurance companies to help provide services to those individuals being seen.

*Heavenly Smiles Mobile Dental LLC*  
can be reached at:

Janet E. Crosswhite, RDH, BS

- email at [REDACTED]
- by mail at [REDACTED]
- by phone at [REDACTED]

Received  
JUN 09 2020  
NSBDE

**Agenda Item (7)(g)(1):**

**Application for part-time IC Inspector:**  
**Stacia Dimmitt, RDH**

Board Meeting - Public Book

NEVADA STATE BOARD OF DENTAL EXAMINERS

Page 63

6010 S Rainbow Boulevard, Building A, Suite 1

Las Vegas, NV 89118

(702) 486-7044 (Telephone) / (702) 486-7046 (FAX)

FULL NAME (please print)

Stacia Dimmitt

FULL MAILING ADDRESS

TELEPHONE

EMAIL

LICENSE NO:

102009

(06-27-2014)

APPLICATION FOR INFECTION CONTROL (IC) INSPECTOR

I hereby make application for the part-time position of Infection Control (IC) Inspector:

REQUIREMENTS:

- ✓ 1. Must be licensed and practicing as a dentist or dental hygienist in Nevada for the 5 years preceding the submission of this application;
- ✓ 2. Nevada dental or dental hygiene license must be active and in good standing;
- ✓ 3. Submit a curriculum vitae and any other information you may want considered

1. List ALL states you hold, or have held (regardless of license status), a license to practice dentistry (attach additional sheet if necessary):

NV

2. List of all office addresses in the State of Nevada in which you are currently practicing dentistry (attach additional sheet if necessary):

Office (1) name:

West Reno Dental

Office (1) address:

9680 S. McCarran Blvd 89523

Office (1) telephone:

Office (2) name:

Office (2) address:

Office (2) telephone:

SIGNATURE OF LICENSEE

Stacia Dimmitt

DATE

6/14/2020

Received

JUN 17 2020

NSBDE

Received

JUN 17 2020

NSRD

**Agenda Item (7)(g)(2):**

**Application for part-time IC Inspector:**  
**Jennifer Nightingale, RDH**

**NEVADA STATE BOARD OF DENTAL EXAMINERS**

6010 S Rainbow Boulevard, Building A, Suite 1

Las Vegas, NV 89118

(702) 486-7044 (Telephone) / (702) 486-7046 (FAX)

FULL NAME (please print) Jennifer NightingaleFULL MAILING ADDRESS [REDACTED]TELEPHONE [REDACTED]EMAIL [REDACTED]LICENSE NO: 101672*(07-14-2010)***APPLICATION FOR INFECTION CONTROL (IC) INSPECTOR****I hereby make application for the part-time position of Infection Control (IC) Inspector:****REQUIREMENTS:**

- ✓ 1. Must be licensed and practicing as a dentist or dental hygienist in Nevada for the 5 years preceding the submission of this application;
- ✓ 2. Nevada dental or dental hygiene license must be active and in good standing;
- ✓ 3. Submit a curriculum vitae and any other information you may want considered

1. List ALL states you hold, or have held (regardless of license status), a license to practice dentistry (attach additional sheet if necessary):

NV

2. List of all office addresses in the State of Nevada in which you are currently practicing dentistry (attach additional sheet if necessary):

Office (1) name: Dr. Eric Park DDSOffice (1) address: 1126 Bell St. Gardnerville, NV 89410Office (1) telephone: (775) 782-2251

Office (2) name: \_\_\_\_\_

Office (2) address: \_\_\_\_\_

Office (2) telephone: \_\_\_\_\_

SIGNATURE OF LICENSEE

DATE Aug 7, 2020

**Agenda Item (7)(h):**

**Proposed Draft/Changes to  
IC Inspector Application**

# Nevada State Board of Dental Examiners



6010 S. Rainbow Blvd., Bldg. A, Ste. 1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

## PROPOSED DRAFT RECRUITMENT FOR INFECTION CONTROL INSPECTORS

The Nevada State Board of Dental Examiners (NSBDE) is actively recruiting part-time employees as on-site Infection Control (IC) Inspectors. As an IC Inspector for the Board, you will be assigned to inspect/re-inspect dental offices or facilities (where dental treatments are to be performed) to ensure compliance with the *Guideline for Disinfection and Sterilization in Healthcare Facilities 2008*, adopted by the Centers for Disease Control and Prevention and adopted by NSBDE by reference in NAC 631.178.

Schedules are flexible as you will determine your availability.

### Requirements:

Those who wish to be considered for part-time employment as an IC Inspector for the Board must meet the following:

- Must hold an active Nevada dental or dental hygiene license and have been practicing as a dentist or dental hygienist in Nevada for the 5 years preceding the submission of application.

### Honoraria and Continuing Education:

The Board pays a rate of \$50.00 per hour for those who participate in on-site infection control inspections. In addition, mileage/per diem reimbursement will be made at the current rate for all State of Nevada employees. Inspectors will also receive four (4) hours of continuing education credit for completion of the Infection Control Inspector calibration.

Any licensee interested in part-time employment as an Infection Control Inspector for the Board, may submit the application by email to [nsbde@nsbde.nv.gov](mailto:nsbde@nsbde.nv.gov); by facsimile to (702) 486-7046 or by mail to the address above. If you have any questions, feel free to contact the Board office at (702) 486-7044. Applications received will be placed before the Board for consideration at a regularly scheduled meeting of the Board. Those applicants approved by the Board are required to complete the following:

- Complete the Infection Control Inspector calibration

NEVADA STATE BOARD OF DENTAL EXAMINERS

6010 S Rainbow Boulevard, Building A, Suite 1

Las Vegas, NV 89118

(702) 486-7044 (Telephone) / (702) 486-7046 (FAX)

Page 68

FULL NAME (please print) \_\_\_\_\_

FULL MAILING ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ LICENSE NO: \_\_\_\_\_

**PROPOSED DRAFT**

**APPLICATION FOR INFECTION CONTROL (IC) INSPECTOR**

**I hereby make application for the part-time position of Infection Control (IC) Inspector:**

**REQUIREMENTS:**

1. Must be licensed and practicing as a dentist or dental hygienist in Nevada for the 5 years preceding the submission of this application;
2. Must hold an active Nevada dental or dental hygiene license

1. Submit a curriculum vitae and any other information you may want considered

2. List any prior experience pertaining to Infection Control inspections.

\_\_\_\_\_

3. Do you have any pending Board complaints against you? YES / NO

4. Do you have any history of Board Action(s)? YES / NO

If yes, please describe below (attach additional sheet if necessary):

\_\_\_\_\_

\_\_\_\_\_

5. List ALL states you hold, or have held (regardless of license status), a license to practice dentistry or dental hygiene (attach additional sheet if necessary):

\_\_\_\_\_

6. List of all office addresses in the State of Nevada in which you are currently practicing dentistry or dental hygiene (attach additional sheet if necessary):

Office (1) name: \_\_\_\_\_

Office (1) address: \_\_\_\_\_

Office (1) telephone: \_\_\_\_\_

**SIGNATURE OF LICENSEE** \_\_\_\_\_

**DATE** \_\_\_\_\_



**Agenda Item (7)(h):**

**Current Application for IC  
Inspector**

# Nevada State Board of Dental Examiners



6010 S. Rainbow Blvd., Bldg. A, Ste. 1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

## RECRUITMENT FOR INFECTION CONTROL INSPECTORS

The Nevada State Board of Dental Examiners (NSBDE) is actively recruiting part-time employees as on-site Infection Control (IC) Inspectors. As an IC Inspector for the Board, you will be assigned to inspect/re-inspect dental offices or facilities (where dental treatments are to be performed) to ensure compliance with the *Guideline for Disinfection and Sterilization in Healthcare Facilities 2008*, adopted by the Centers for Disease Control and Prevention and adopted by NSBDE by reference in NAC 631.178.

Schedules are flexible as you will determine your availability.

### Requirements:

Those who wish to be considered for part-time employment as an IC Inspector for the Board must meet the following:

- Must hold an active Nevada dental or dental hygiene license in good standing for the past five (5) years

### Honoraria and Continuing Education:

The Board pays a rate of \$50.00 per hour for those who participate in on-site infection control inspections. In addition, mileage/per diem reimbursement will be made at the current rate for all State of Nevada employees. Inspectors will also receive four (4) hours of continuing education credit for completion of the Infection Control Inspector calibration.

Any licensee interested in part-time employment as an Infection Control Inspector for the Board, may submit the application by email to [nsbde@nsbde.nv.gov](mailto:nsbde@nsbde.nv.gov); by facsimile to (702) 486-7046 or by mail to the address above. If you have any questions, feel free to contact the Board office at (702) 486-7044. Applications received will be placed before the Board for consideration at a regularly scheduled meeting of the Board. Those applicants approved by the Board are required to complete the following:

- Complete the Infection Control Inspector calibration

**NEVADA STATE BOARD OF DENTAL EXAMINERS**

Page 71

6010 S Rainbow Boulevard, Building A, Suite 1  
Las Vegas, NV 89118  
(702) 486-7044 (Telephone) / (702) 486-7046 (FAX)

FULL NAME (please print) \_\_\_\_\_

FULL MAILING ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ LICENSE NO: \_\_\_\_\_

**APPLICATION FOR INFECTION CONTROL (IC) INSPECTOR**

**I hereby make application for the part-time position of Infection Control (IC) Inspector:**

**REQUIREMENTS:**

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\_\_\_\_\_

2. List of all office addresses in the State of Nevada in which you are currently practicing dentistry (attach additional sheet if necessary):

Office (1) name: \_\_\_\_\_

Office (1) address: \_\_\_\_\_

Office (1) telephone: \_\_\_\_\_

Office (2) name: \_\_\_\_\_

Office (2) address: \_\_\_\_\_

Office (2) telephone: \_\_\_\_\_

**SIGNATURE OF LICENSEE** \_\_\_\_\_

**DATE** \_\_\_\_\_

**Agenda item (7)(i)(1):**

**08/04/2020**

**CDC Dental Settings  
Guidelines**

# Coronavirus Disease 2019 (COVID-19)

MENU >

## Guidance for Dental Settings Dental Settings

Interim Infection Prevention and Control Guidance for Dental Settings During the Coronavirus Disease 2019 (COVID-19) Pandemic

Updated Aug. 4, 2020

[Print](#)

Updated Aug. 4, 2020

### Key Points

- Recognize dental settings have unique characteristics that warrant specific infection control considerations.
- Prioritize the most critical dental services and provide care in a way that minimizes harm to patients from delaying care and harm to personnel and patients from potential exposure to SARS-CoV-2 infection.
- Proactively communicate to both personnel and patients the need for them to stay at home if sick.
- Know the steps to take if a patient with [COVID-19 symptoms](#) enters your facility.

This guidance was updated August 4, 2020 and complements CDC's

- [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#)
- [Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic](#)

### Summary of Recent Changes

- Guidance has been rearranged for clarity.
- Updated the definition of fever to either measured temperature  $\geq 100.0^{\circ}\text{F}$  or subjective fever to align with CDC's [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#).
- In areas with moderate to substantial community transmission, during patient encounters with patients not suspected of SARS-CoV-2 infection, CDC recommends that dental healthcare personnel (DHCP):
  - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters, including those where splashes and sprays are not anticipated.
  - Use an N95 respirator or a respirator that offers an equivalent or higher level of protection during aerosol generating procedures.
- Added language that protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
- Included additional guidance on physical distancing and how to respond to SARS-CoV-2 exposures among DHCP and others.

## Background

This interim guidance has been updated based on currently available information about coronavirus disease 2019 (COVID-19) and the current situation in the United States. As dental healthcare facilities begin to restart elective procedures in accordance with guidance from local and state officials, there are precautions that should remain in place as a part of the ongoing response to the COVID-19 pandemic. Most recommendations in this updated guidance are not new (except as noted in the summary of changes above); they have been reorganized into the following sections:

1. Recommended infection prevention and control (IPC) practices for routine dental healthcare delivery during the pandemic
2. Recommended IPC practices when providing dental healthcare for a patient with suspected or confirmed SARS-CoV-2 infection

Dental settings should balance the need to provide necessary services while minimizing risk to patients and dental healthcare personnel (DHCP). CDC has developed a [framework](#) for healthcare personnel and healthcare systems for delivery of non-emergent care during the COVID-19 pandemic. DHCP should regularly consult their state dental boards and [state or local health departments](#) for current local information for requirements specific to their jurisdictions, including recognizing the degree of community transmission and impact, and their region-specific recommendations.

**Transmission:** SARS-CoV-2, the virus that causes COVID-19, is [thought to spread](#) primarily between people who are in close contact with one another (within 6 feet) through respiratory droplets produced when an infected person coughs, sneezes, or talks. Airborne transmission from person-to-person over long distances is unlikely. However, COVID-19 is a new disease, and we are still learning about how the virus spreads and the severity of illness it causes. The virus has been shown to persist in aerosols for hours, and on some surfaces for days under laboratory conditions. SARS-CoV-2 can be spread by people who are not showing symptoms.

**Risk:** The practice of dentistry involves the use of rotary dental and surgical instruments, such as handpieces or ultrasonic scalers and air-water syringes. These instruments create a visible spray that can contain particle droplets of water, saliva, blood, microorganisms, and other debris. Surgical masks protect mucous membranes of the mouth and nose from droplet spatter, but they do not provide complete protection against inhalation of infectious agents. There are currently no data available to assess the risk of SARS-CoV-2 transmission during dental practice.

## Recommendations

### 1. Recommended infection prevention and control (IPC) practices for routine dental healthcare delivery during the pandemic

CDC recommends using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine dental healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection (See [Section 2 for additional practices that should be used when providing dental healthcare for patients with suspected or confirmed SARS-CoV-2 infection](#)). These additional practices for all patients include:

#### Consider if elective procedures, surgeries, and non-urgent outpatient visits should be postponed in certain circumstances.


Provide dental treatment only after you have assessed the patient and considered both the risk to the patient of deferring care and the risk to DHCP and patients of healthcare-associated SARS-CoV-2 transmission. Ensure that you have the appropriate amount of personal protective equipment (PPE) and supplies to support your patients. If PPE and supplies are limited, prioritize dental care for the highest need, most vulnerable patients first – those at most risk if care is delayed. DHCP should apply the guidance found in the [Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic](#) to determine how and when to resume non-emergency dental care. DHCP should stay informed and regularly consult with the [state or local health department](#) for region-specific information and recommendations. [Monitor trends](#) in local case counts and deaths, especially for populations at higher risk for severe illness.

#### Implement Teledentistry and Triage Protocols

- Contact all patients prior to dental treatment.

- Telephone screen all patients for symptoms consistent with COVID-19. If the patient reports symptoms of COVID-19, avoid non-emergent dental care and use the Phone Advice Line Tool for Possible COVID-19 patients. If possible, delay dental care until the patient has ended isolation or quarantine.
- Telephone triage all patients in need of dental care. Assess the patient's dental condition and determine whether the patient needs to be seen in the dental setting. Use teledentistry options as alternatives to in-office care.
- Request that the patient limit the number of visitors accompanying him or her to the dental appointment to only those people who are necessary.
- Advise patients that they, and anyone accompanying them to the appointment, will be requested to wear a cloth face covering or facemask when entering the facility and will undergo screening for fever and symptoms consistent with COVID-19.

## Screen and Triage Everyone Entering a Dental Healthcare Facility for Signs and Symptoms of COVID-19

- Take steps to ensure that everyone (patients, DHCP, visitors) adheres to respiratory hygiene and cough etiquette and hand hygiene while inside the facility.
  - Post visual alerts  (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, break rooms) to provide instructions (in appropriate languages) about hand hygiene and respiratory hygiene and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.
  - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with at least 60% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
  - Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
  - Remove toys, magazines, and other frequently touched objects from waiting room that cannot be regularly cleaned and disinfected.
- Ensure that everyone has donned their own cloth face covering, or provide a facemask if supplies are adequate.
- Screen everyone entering the dental healthcare facility for fever and symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection.
  - Document absence of symptoms consistent with COVID-19.
  - Actively take their temperature. Fever is either measured temperature  $\geq 100.0^{\circ}\text{F}$  or subjective fever.
  - Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection.
- Properly manage anyone with symptoms of COVID-19 or who has been advised to self-quarantine:
  - If a patient is found to be febrile, has signs or symptoms consistent with COVID-19, or experienced an exposure for which quarantine would be recommended, DHCP should follow all precautions recommended in Section 2 Recommended IPC practices when providing dental healthcare for a patient with suspected or confirmed SARS-CoV-2 infection.
  - If a patient has a fever strongly associated with a dental diagnosis (e.g., pulpal and periapical dental pain and intraoral swelling are present) but no other symptoms consistent with COVID-19 are present, dental care can be provided following the practices recommended in Section 1. Recommended infection prevention and control (IPC) practices for routine dental healthcare delivery during the pandemic.
  - If a DHCP is found to be febrile or has signs or symptoms consistent with COVID-19, he or she should immediately return home, should notify occupational health services or the infection control coordinator to arrange for further evaluation, or seek medical attention.
- People with COVID-19 who have ended home isolation can receive dental care following Standard Precautions.

## Monitor and Manage DHCP

- Implement sick leave policies for DHCP that are flexible, non-punitive, and consistent with public health guidance.
- As part of routine practice, DHCP should be asked to regularly monitor themselves for fever and symptoms consistent with COVID-19.
- DHCP should be reminded to stay home when they are ill and should receive no penalties when needing to stay home when ill or under quarantine.



- If DHCP suspect they have COVID-19:
  - Do not come to work.
  - Notify their primary healthcare provider to determine whether medical evaluation is necessary.

- Information about when DHCP with suspected or confirmed COVID-19 may return to work is available in the [Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19](#).
- For information on work restrictions for health care personnel with underlying health conditions who may care for COVID-19 patients, see CDC's Healthcare Workers Clinical Questions about COVID-19: Questions and Answers on [COVID-19 Risk](#).

## Create a Process to Respond to SARS-CoV-2 Exposures Among DHCP and Others

- Request that patients contact the dental clinic if they develop signs or symptoms or are diagnosed with COVID-19 within 2 days following the dental appointment.
- If DHCP experience a potential work exposure to COVID-19, follow CDC's [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#).
  - Information on testing DHCP for SARS-CoV-2 is available in the [Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2](#).
- If patients or DHCP believe they have experienced an exposure to COVID-19 outside of the dental healthcare setting, including during domestic travel, they should follow CDC's [Public Health Guidance for Community-Related Exposure](#). Separate guidance is available for [international travelers](#).
- For more information, including frequently asked questions on infected healthcare personnel, see CDC's Healthcare Workers Clinical Questions about COVID-19: Questions and Answers on [Infection Control](#).

## Implement Universal Source Control Measures

Source control refers to use of [facemasks](#) (surgical masks or procedure masks) or [cloth face coverings](#) to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have signs and symptoms of COVID-19.

- Patients and visitors should, ideally, wear their own cloth facemask covering (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a facemask covering, they should be offered a facemask or cloth face covering, as supplies allow.
  - Patients may remove their cloth facemask covering when in their rooms or patient care area but should put it back on when leaving at the end of the dental treatment.
  - Facemasks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- DHCP should wear a face mask or cloth face covering **at all times** while they are in the dental setting, **including in breakrooms or other spaces where they might encounter co-workers**.
  - When available, surgical masks are preferred over cloth face coverings for DHCP; surgical masks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
  - Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required, as cloth face coverings are not PPE.
  - Respirators with an exhalation valve are not currently recommended for source control, as they allow unfiltered exhaled breath to escape. If only a respirator with an exhalation valve is available and source control is needed, the exhalation valve should be covered with a facemask that does not interfere with the respirator fit
  - Some DHCP whose job duties do not require PPE (such as clerical personnel) may continue to wear their cloth face covering for source control while in the dental setting.
  - Other DHCP (such as dentists, dental hygienists, dental assistants) may wear their cloth face covering when they are not engaged in *direct patient care* activities, and then switch to a respirator or a surgical mask when PPE is required.
  - DHCP should remove their respirator or surgical mask, perform hand hygiene, and put on their cloth face covering when leaving the facility at the end of their shift.



- Educate patients, visitors, and DHCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth face covering.

## Encourage Physical Distancing

Dental healthcare delivery requires close physical contact between patients and DHCP. However, when possible, [physical distancing](#) (maintaining 6 feet between people) is an important strategy to prevent SARS-CoV-2 transmission. Examples of how physical distancing can be implemented for patients include:

- Limiting visitors to the facility to those essential for the patient's physical or emotional well-being and care (e.g., care partner, parent).
  - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- Scheduling appointments to minimize the number of people in the waiting room.
  - Patients may opt to wait in a personal vehicle or outside the dental facility where they can be contacted by mobile phone when it is their turn for dental care.
  - Minimize overlapping dental appointments.
- Arranging seating in waiting rooms so patients can sit at least 6 feet apart.

For DHCP, the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in breakrooms or co-workers or visitors in other common areas. Examples of how physical distancing can be implemented for DHCP include:

- Reminding DHCP that the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions.
- Emphasizing the importance of source control and physical distancing in non-patient care areas.
- Providing family meeting areas where all individuals (e.g., visitors, DHCP) can remain at least 6 feet apart from each other.
- Designating areas for DHCP to take breaks, eat, and drink that allow them to remain at least 6 feet apart from each other, especially when they must be unmasked.

## Consider Performing Targeted SARS-CoV-2 Testing of Patients Without Signs or Symptoms of COVID-19

In addition to the use of universal PPE (see below) and source control in healthcare settings, targeted SARS-CoV-2 testing of patients without signs or symptoms of COVID-19 might be used to identify those with asymptomatic or pre-symptomatic SARS-CoV-2 infection and further reduce risk for exposures in some healthcare settings. Depending on guidance from local and state health departments, testing availability, and how rapidly results are available, facilities can consider implementing pre-admission or pre-procedure diagnostic testing with authorized nucleic acid or antigen detection assays for SARS-CoV-2. Testing results might inform decisions about rescheduling elective procedures or about the need for additional Transmission-Based Precautions when caring for the patient. Limitations of using this testing strategy include obtaining negative results in patients during their incubation period who later become infectious and false negative test results, depending on the test method used.

## Administrative Controls and Work Practices

- DHCP should limit clinical care to one patient at a time, whenever possible.
- Set up operatories so that only the clean or sterile supplies and instruments needed for the dental procedure are readily accessible. All other supplies and instruments should be in covered storage, such as drawers and cabinets, and away from potential contamination. Any supplies and equipment that are exposed but not used during the procedure should be considered contaminated and should be disposed of or reprocessed properly after completion of the procedure.
- Avoid aerosol generating procedures (see below for definition) whenever possible, including the use of high-speed dental handpieces, air/water syringe, and ultrasonic scalers. Prioritize minimally invasive/attraumatic restorative techniques (hand instruments only).
- If aerosol generating procedures are necessary for dental care, use four-handed dentistry, high evacuation suction and dental dams to minimize droplet spatter and aerosols. The number of DHCP present during the procedure should

be limited to only those essential for patient care and procedure support.

- Preprocedural mouth rinses (PPMR)
  - There is no published evidence regarding the clinical effectiveness of PPMRs to reduce SARS-CoV-2 viral loads or to prevent transmission. Although SARS-CoV-2 was not studied, PPMRs with an antimicrobial product (chlorhexidine gluconate, essential oils, povidone-iodine or cetylpyridinium chloride) may reduce the level of oral microorganisms in aerosols and spatter generated during dental procedures.

## Implement Universal Use of Personal Protective Equipment (PPE)

### For DHCP working in facilities located in areas with no to minimal community transmission

- DHCP should continue to adhere to [Standard Precautions](#) (and [Transmission-Based Precautions](#), if required based on the suspected diagnosis).
- DHCP should wear **a surgical mask, eye protection (goggles or a face shield that covers the front and sides of the face), a gown or protective clothing, and gloves** during procedures likely to generate splashing or spattering of blood or other body fluids. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.

### For DHCP working in facilities located in areas with moderate to substantial community transmission

- DHCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), DHCP should follow [Standard Precautions](#) (and [Transmission-Based Precautions](#), if required based on the suspected diagnosis).
- DHCP should implement the **use of universal eye protection** and wear eye protection in addition to their surgical mask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters, including those where splashes and sprays are not anticipated.
- **During aerosol generating procedures DHCP should use an N95 respirator or a respirator that offers an equivalent or higher level of protection such as other disposable filtering facepiece respirators, powered air-purifying respirators (PAPRs), or elastomeric respirators.**
  - Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard ([29 CFR 1910.134](#) [↗](#)).
  - Respirators with exhalation valves are not recommended for source control and should not be used during surgical procedures as unfiltered exhaled breath may compromise the sterile field. If only a respirator with an exhalation valve is available and source control is needed, the exhalation valve should be covered with a facemask that does not interfere with the respirator fit.

There are multiple [sequences recommended for donning and doffing PPE](#). One suggested sequence for DHCP is listed below. Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices (see PPE Optimization Strategies).


- Before entering a patient room or care area:
  1. Perform hand hygiene (wash your hands with soap and water for at least 20 seconds or use a hand sanitizer).
  2. Put on a clean gown or protective clothing that covers personal clothing and skin (e.g., forearms) likely to become soiled with blood, saliva, or other potentially infectious materials.
    - Gowns and protective clothing should be changed if they become soiled.
  3. Put on a surgical mask or respirator.
    - Mask ties should be secured on the crown of the head (top tie) and the base of the neck (bottom tie). If mask has loops, hook them appropriately around your ears.
    - Respirator straps should be placed on the crown of the head (top strap) and the base of the neck (bottom strap). Perform a user seal check each time you put on the respirator.
  4. Put on eye protection (goggles or a face shield that covers the front and sides of the face).
    - Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
    - Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
  5. Put on clean non-sterile gloves

- Gloves should be changed if they become torn or heavily contaminated.

6. Enter the patient room or care area.

- After completion of dental care:

1. Remove gloves.
2. Remove gown or protective clothing and discard the gown in a dedicated container for waste or linen.
  - Discard disposable gowns after each use.
  - **Launder** cloth gowns or protective clothing after each use.
3. Exit the patient room or care area.
4. Perform hand hygiene (wash your hands with soap and water for at least 20 seconds or use a hand sanitizer).
5. Remove eye protection.
  - Carefully remove eye protection by grabbing the strap and pulling upwards and away from head. Do not touch the front of the eye protection.
  - Clean and disinfect reusable eye protection according to manufacturer's reprocessing instructions prior to reuse.
  - Discard disposable eye protection after use.
6. Remove and discard surgical mask or respirator.
  - Do not touch the front of the respirator or mask.
  - Surgical mask: Carefully untie the mask (or unhook from the ears) and pull it away from the face without touching the front.
  - Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
7. Perform hand hygiene.

Employers should select appropriate PPE and provide it to DHCP in accordance with [OSHA's PPE standards \(29 CFR 1910 Subpart I\)](#) . DHCP must receive training on and demonstrate an understanding of:

- when to use PPE;
- what PPE is necessary;
- how to properly **don, use, and doff PPE** in a manner to prevent self-contamination;
- how to properly dispose of or disinfect and maintain PPE;
- the limitations of PPE.

Dental facilities must ensure that any reusable PPE is properly cleaned, decontaminated, and maintained after and between uses. Dental settings also should have policies and procedures describing a recommended sequence for safely donning and doffing PPE.

## PPE Supply Optimization Strategies

Major distributors in the United States have reported shortages of PPE, especially surgical masks and respirators. The anticipated timeline for return to routine levels of PPE is not yet known. CDC has developed a [series of strategies or options to optimize supplies of PPE](#) in healthcare settings when there is limited supply, and a [burn rate calculator](#) that provides information for healthcare facilities to plan and optimize the use of PPE for response to the COVID-19 pandemic. Optimization strategies are provided for gloves, gowns, facemasks, eye protection, and respirators.

These policies are only intended to remain in effect during times of shortages during the COVID-19 pandemic. DHCP should review this guidance carefully, as it is based on a set of tiered recommendations. Strategies should be implemented sequentially. Decisions by facilities to move to contingency and crisis capacity strategies are based on the following assumptions:

- Facilities understand their current PPE inventory and supply chain;
- Facilities understand their PPE utilization rate;

- Facilities are in communication with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies;
- Facilities have already implemented engineering and administrative control measures;
- Facilities have provided DHCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care.

For example, extended use of facemasks and respirators should only be undertaken when the facility is at contingency or crisis capacity and has reasonably implemented all applicable administrative and engineering controls. Such controls include selectively canceling elective and non-urgent procedures and appointments for which PPE is typically used by DHCP. Extended use of PPE is not intended to encourage dental facilities to practice at a normal patient volume during a PPE shortage, but only to be implemented in the short term when other controls have been exhausted. Once the supply of PPE has increased, facilities should return to conventional strategies.

Respirators that comply with international standards may be considered during times of known shortages. CDC has guidance entitled [Factors to Consider When Planning to Purchase Respirators from Another Country](#) which includes a [webinar](#), and [Assessments of International Respirators](#).

## Hand Hygiene

Ensure DHCP practice strict adherence to [hand hygiene](#), including:

- Before and after all patient contact, contact with potentially infectious material, and before putting on and after removing personal protective equipment (PPE), including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
- Use ABHR with at least 60% alcohol or wash hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
- Dental healthcare facilities should ensure that hand hygiene supplies are readily available to all DHCP in every patient care location.

## Equipment Considerations




- After a period of non-use, dental equipment may require maintenance and/or repair. Review the manufacturer's instructions for use (IFU) for office closure, period of non-use, and reopening for all equipment and devices. Some considerations include:
  - Dental unit waterlines (DUWL):
    - Test water quality to ensure it meets standards for safe drinking water as established by the Environmental Protection Agency (< 500 CFU/mL) prior to expanding dental care practices.
    - Confer with the manufacturer regarding recommendations for need to shock DUWL of any devices and products that deliver water used for dental procedures.
    - Continue standard maintenance and monitoring of DUWL according to the IFUs of the dental operator unit and the DUWL treatment products.
  - Autoclaves and instrument cleaning equipment
    - Ensure that all routine cleaning and maintenance have been performed according to the schedule recommended per manufacturer's IFU.
    - Test sterilizers using a biological indicator with a matching control (i.e., biological indicator and control from same lot number) after a period of non-use prior to reopening per manufacturer's IFU.
  - Air compressor, vacuum and suction lines, radiography equipment, high-tech equipment, amalgam separators, and other dental equipment: Follow protocol for storage and recommended maintenance per manufacturer IFU.
- For additional guidance on reopening buildings, see CDC's [Guidance for Reopening Buildings After Prolonged Shutdown or Reduced Operation](#).

## Optimize the Use of Engineering Controls




CDC does not provide guidance on the decontamination of building heating, ventilation, and air conditioning (HVAC) systems potentially exposed to SARS-CoV-2. To date, CDC has not identified confirmatory evidence to demonstrate that viable virus is contaminating these systems. CDC provides the following recommendations for proper maintenance of ventilation systems and patient placement and volume strategies in dental settings.

- Properly maintain ventilation systems.
  - Ventilation systems that provide air movement in a clean-to-less-clean flow direction reduce the distribution of contaminants and are better at protecting staff and patients. For example, in a dental facility with staff workstations in the corridor right outside the patient operatories, supply-air vents would deliver clean air into the corridor, and return-air vents in the rear of the less-clean patient operatories would pull the air out of the room. Thus, the clean air from the corridor flows past the staff workstations and into the patient operatories. Similarly, placing supply-air vents in the receptionist area and return-air vents in the waiting area pulls clean air from the reception area into the waiting area.
  - Consult with facilities operation staff or an HVAC professional to
    - Understand clinical air flow patterns and determine air changes per hour.
    - Investigate increasing filtration efficiency to the highest level compatible with the HVAC system without significant deviation from designed airflow.
    - Investigate the ability to safely increase the percentage of outdoor air supplied through the HVAC system (requires compatibility with equipment capacity and environmental conditions).
  - Limit the use of demand-controlled ventilation (triggered by temperature setpoint and/or by occupancy controls) during occupied hours and when feasible, up to 2 hours post occupancy to assure that the ventilation rate does not automatically change. Run bathroom exhaust fans continuously during business hours.
  - Consider the use of a portable high-efficiency particulate air (HEPA) air filtration unit while the patient is undergoing, and immediately following, an aerosol generating procedure.
    - Select a HEPA air filtration unit based on its Clean Air Delivery Rate (CADR). The CADR is an established performance standard defined by the Association of Home Appliance Manufacturers and reports the system's cubic feet per minute (CFM) rating under as-used conditions. The higher the CADR, the faster the air cleaner will work to remove aerosols from the air.
    - Rather than just relying on the building's HVAC system capacity, use a HEPA air filtration unit to reduce aerosol concentrations in the room and increase the effectiveness of the turnover time.
    - Place the HEPA unit near the patient's chair, but not behind the DHCP. Ensure the DHCP are not positioned between the unit and the patient's mouth. Position the unit to ensure that it does not pull air into or past the breathing zone of the DHCP.
  - Consider the use of [upper-room ultraviolet germicidal irradiation \(UVGI\)](#) as an adjunct to higher ventilation and air cleaning rates.
- Patient placement
  - Ideally, dental treatment should be provided in individual patient rooms, whenever possible.
  - For dental facilities with open floor plans, to prevent the spread of pathogens there should be:
    - At least 6 feet of space between patient chairs.
    - Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).
    - Operatories should be oriented parallel to the direction of airflow if possible.
  - Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.
- Patient volume
  - Ensure to account for the time required to clean and disinfect operatories between patients when calculating your daily patient volume.

- DHCP should ensure that environmental cleaning and disinfection procedures are followed consistently and correctly after each patient (however, it is not necessary that DHCP should attempt to sterilize a dental operatory between patients).
  - Clean and disinfect the room and equipment according to the [Guidelines for Infection Control in Dental Health-Care Settings—2003](#) .
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to clean surfaces **before** applying an Environmental Protection Agency (EPA)-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.
  - Refer to [List N](#)  on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Alternative disinfection methods
  - The efficacy of alternative disinfection methods, such as ultrasonic waves, high intensity UV radiation, and LED blue light against SARS-CoV-2 virus is not known. EPA does not routinely review the safety or efficacy of pesticidal devices, such as UV lights, LED lights, or ultrasonic devices. Therefore, EPA cannot confirm whether, or under what circumstances, such products might be effective against the spread of COVID-19.
  - CDC does not recommend the use of sanitizing tunnels. There is no evidence that they are effective in reducing the spread of COVID-19. Chemicals used in sanitizing tunnels could cause skin, eye, or respiratory irritation or damage.
  - EPA only recommends use of the [surface disinfectants identified on List N](#)  against the virus that causes COVID-19.
- Manage [laundry](#) and [medical waste](#) in accordance with routine policies and procedures.

## Sterilization and Disinfection of Patient-Care Items

- Sterilization protocols do not vary for respiratory pathogens. DHCP should perform routine cleaning, disinfection, and sterilization protocols, and follow the recommendations for Sterilization and Disinfection of Patient-Care Items present in the [Guidelines for Infection Control in Dental Health Care Settings – 2003](#) .
- DHCP should follow the manufacturer's instructions for times and temperatures recommended for sterilization of specific dental devices.

## Education and Training

- Provide DHCP with job- or task-specific [education and training](#) on preventing transmission of infectious agents, including refresher training.
  - [Training: Basic Expectations for Safe Care](#)
- Ensure that DHCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and the environment during the process of removing such equipment.
  - [Using Personal Protective Equipment \(PPE\)](#)
  - [Healthcare Respiratory Protection Resources Training](#)

## 2. Recommended infection prevention and control (IPC) practices when providing dental healthcare for a patient with suspected or confirmed SARS-CoV-2 infection

Surgical procedures that might pose higher risk for SARS-CoV-2 transmission if the patient has COVID-19 include those that generate potentially infectious aerosols or involve anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract (see [Surgical FAQ](#)).

- If a patient arrives at your facility and is suspected or confirmed to have COVID-19, defer non-emergent dental treatment and take the following actions:

- If the patient is not already wearing a cloth face covering, give the patient a facemask to cover his or her nose and mouth.
- If the patient is not manifesting [emergency warning signs for COVID-19](#), send the patient home, and instruct the patient to call his or her primary care provider.
- If the patient is manifesting [emergency warning signs for COVID-19](#) (for example, has trouble breathing), refer the patient to a medical facility, or call 911 as needed and inform them that the patient may have COVID-19.
- If emergency dental care is medically necessary for a patient who has, or is suspected of having, COVID-19, DHCP should follow CDC's [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#).
- Dental treatment should be provided in an individual patient room with a closed door.
- DHCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to [Standard Precautions](#) and **use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection**. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
  - Avoid aerosol generating procedures (e.g., use of dental handpieces, air/water syringe, ultrasonic scalers) if possible.
  - If aerosol generating procedures must be performed
    - Aerosol generating procedures should ideally take place in an airborne infection isolation room.
    - DHCP in the room should wear an N95 or equivalent or higher-level respirator, such as disposable filtering facepiece respirator, PAPR, or elastomeric respirator, as well as eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and a gown.
    - The number of DHCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.
    - Clean and disinfect procedure room surfaces promptly as described in the section on [environmental infection control](#).
  - Limit transport and movement of the patient outside of the room to medically essential purposes.
    - Patients should wear a facemask or cloth face covering to contain secretions during transport. If patients cannot tolerate a facemask or cloth face covering or one is not available, they should use tissues to cover their mouth and nose while out of their room or care area.
  - Consider scheduling the patient at the end of the day.
  - Do not schedule any other patients at that time.
- To [clean and disinfect the dental operatory after a patient with suspected or confirmed COVID-19](#), DHCP should delay entry into the operatory until a sufficient time has elapsed for enough air changes to remove potentially infectious particles. CDC's Guidelines for Environmental Infection Control in Health-Care Facilities (2003) provides a [table to calculate time required for airborne-contaminant removal by efficiency](#).

## Definitions

**Aerosol generating procedures** – Procedures that may generate aerosols (i.e., particles of respirable size, <10 µm). Aerosols can remain airborne for extended periods and can be inhaled. Development of a comprehensive list of aerosol generating procedures for dental healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining their potential for infectivity. There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of aerosol generating procedures for dental healthcare settings. Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.

**Airborne infection isolation rooms** – Single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.

**Air changes per hour:** the ratio of the volume of air flowing through a space in a certain period of time (the airflow rate) to the volume of that space (the room volume). This ratio is expressed as the number of air changes per hour.


**Cloth face covering:** Textile (cloth) covers that are intended for source control. They are not personal protective equipment (PPE) and it is uncertain whether cloth face coverings protect the wearer.

### Community Transmission


- **No to minimal community transmission:** Evidence of isolated cases or limited community transmission, case investigations underway; no evidence of exposure in large communal setting
- **Minimal to moderate community transmission:** Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases
- **Substantial community transmission:** Large scale community transmission, including communal settings (e.g., schools, workplaces)

**Dental healthcare personnel (DHCP)** – Refers to all paid and unpaid persons serving in dental healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including:

- body substances
- contaminated medical supplies, devices, and equipment
- contaminated environmental surfaces
- contaminated air

**Facemask** : Facemasks are **PPE** and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are preferred in dental settings because they are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Respirator:** Is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/National Institute for Occupational Safety and Health (NIOSH), including those intended for use in healthcare.

Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard ([29 CFR 1910.134](#) ). DHCP should be medically cleared and fit tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.

Last Updated Aug. 4, 2020



**Agenda Item (7)(i)(2):**

**CDC Guidelines • August 28, 2020**

# Coronavirus Disease 2019 (COVID-19)

## Guidance for Dental Settings Dental Settings

Interim Infection Prevention and Control Guidance for Dental Settings During the Coronavirus Disease 2019 (COVID-19) Pandemic

Updated Aug. 28, 2020

[Print](#)

### Key Points

- Recognize dental settings have unique characteristics that warrant specific infection control considerations.
- Prioritize the most critical dental services and provide care in a way that minimizes harm to patients from delaying care and harm to personnel and patients from potential exposure to SARS-CoV-2 infection.
- Proactively communicate to both personnel and patients the need for them to stay at home if sick.
- Know the steps to take if a patient with COVID-19 symptoms enters your facility.

This guidance was updated August 28, 2020 and complements CDC's

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic

### Summary of Recent Changes

- Guidance has been rearranged for clarity.
- Updated the definition of fever to either measured temperature  $\geq 100.0^{\circ}\text{F}$  or subjective fever to align with CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.
- In areas with moderate to substantial community transmission, during patient encounters with patients not suspected of SARS-CoV-2 infection, CDC recommends that dental healthcare personnel (DHCP):
  - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters, including those where splashes and sprays are not anticipated.
  - Use an N95 respirator or a respirator that offers an equivalent or higher level of protection during aerosol generating procedures.
- Added language that protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
- Included additional guidance on physical distancing and how to respond to SARS-CoV-2 exposures among DHCP and others.

## Background

This interim guidance has been updated based on currently available information about coronavirus disease 2019 (COVID-19) and the current situation in the United States. As dental healthcare facilities begin to restart elective procedures in accordance with guidance from local and state officials, there are precautions that should remain in place as a part of the ongoing response to the COVID-19 pandemic. Most recommendations in this updated guidance are not new (except as noted in the summary of changes above); they have been reorganized into the following sections:

1. Recommended infection prevention and control (IPC) practices for routine dental healthcare delivery during the pandemic
2. Recommended IPC practices when providing dental healthcare for a patient with suspected or confirmed SARS-CoV-2 infection

Dental settings should balance the need to provide necessary services while minimizing risk to patients and dental healthcare personnel (DHCP). CDC has developed a framework for healthcare personnel and healthcare systems for delivery of non-emergent care during the COVID-19 pandemic. DHCP should regularly consult their state dental boards and state or local health departments for current local information for requirements specific to their jurisdictions, including recognizing the degree of community transmission and impact, and their region-specific recommendations.

**Transmission:** SARS-CoV-2, the virus that causes COVID-19, is thought to spread primarily between people who are in close contact with one another (within 6 feet) through respiratory droplets produced when an infected person coughs, sneezes, or talks. Airborne transmission from person-to-person over long distances is unlikely. However, COVID-19 is a new disease, and we are still learning about how the virus spreads and the severity of illness it causes. The virus has been shown to persist in aerosols for hours, and on some surfaces for days under laboratory conditions. SARS-CoV-2 can be spread by people who are not showing symptoms.

**Risk:** The practice of dentistry involves the use of rotary dental and surgical instruments, such as handpieces or ultrasonic scalers and air-water syringes. These instruments create a visible spray that can contain particle droplets of water, saliva, blood, microorganisms, and other debris. Surgical masks protect mucous membranes of the mouth and nose from droplet spatter, but they do not provide complete protection against inhalation of infectious agents. There are currently no data available to assess the risk of SARS-CoV-2 transmission during dental practice.

## Recommendations

### 1. Recommended infection prevention and control (IPC) practices for routine dental healthcare delivery during the pandemic

CDC recommends using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine dental healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection (See Section 2 for additional practices that should be used when providing dental healthcare for patients with suspected or confirmed SARS-CoV-2 infection). These additional practices for all patients include:

**Consider if elective procedures, surgeries, and non-urgent outpatient visits should be postponed in certain circumstances.**


Provide dental treatment only after you have assessed the patient and considered both the risk to the patient of deferring care and the risk to DHCP and patients of healthcare-associated SARS-CoV-2 transmission. Ensure that you have the appropriate amount of personal protective equipment (PPE) and supplies to support your patients. If PPE

and supplies are limited, prioritize dental care for the highest need, most vulnerable patients first – those at most risk if care is delayed. DHCP should apply the guidance found in the Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic to determine how and when to resume non-emergency dental care. DHCP should stay informed and regularly consult with the state or local health department for region-specific information and recommendations. Monitor trends in local case counts and deaths, especially for populations at higher risk for severe illness.

## Implement Teledentistry and Triage Protocols

- Contact all patients prior to dental treatment.
  - Telephone screen all patients for symptoms consistent with COVID-19. If the patient reports symptoms of COVID-19, avoid non-emergent dental care and use the Phone Advice Line Tool for Possible COVID-19 patients. If possible, delay dental care until the patient has ended isolation or quarantine.
  - Telephone triage all patients in need of dental care. Assess the patient's dental condition and determine whether the patient needs to be seen in the dental setting. Use teledentistry options as alternatives to in-office care.
  - Request that the patient limit the number of visitors accompanying him or her to the dental appointment to only those people who are necessary.
  - Advise patients that they, and anyone accompanying them to the appointment, will be requested to wear a cloth face covering or facemask when entering the facility and will undergo screening for fever and symptoms consistent with COVID-19.

## Screen and Triage Everyone Entering a Dental Healthcare Facility for Signs and Symptoms of COVID-19

- Take steps to ensure that everyone (patients, DHCP, visitors) adheres to respiratory hygiene and cough etiquette and hand hygiene while inside the facility.
  - Post visual alerts  (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, break rooms) to provide instructions (in appropriate languages) about hand hygiene and respiratory hygiene and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.
  - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with at least 60% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
  - Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
  - Remove toys, magazines, and other frequently touched objects from waiting room that cannot be regularly cleaned and disinfected.
- Ensure that everyone has donned their own cloth face covering, or provide a facemask if supplies are adequate.
- Screen everyone entering the dental healthcare facility for fever and symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection.
  - Document absence of symptoms consistent with COVID-19.
  - Actively take their temperature. Fever is either measured temperature  $\geq 100.0^{\circ}\text{F}$  or subjective fever.
  - Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection.
- Properly manage anyone with symptoms of COVID-19 or who has been advised to self-quarantine:
  - If a patient is found to be febrile, has signs or symptoms consistent with COVID-19, or experienced an exposure for which quarantine would be recommended, DHCP should follow all precautions recommended in Section 2 Recommended IPC practices when providing dental healthcare for a patient with suspected or confirmed SARS-CoV-2 infection.

- If a patient has a fever strongly associated with a dental diagnosis (e.g., pulpal and periapical dental pain and intraoral swelling are present) but no other symptoms consistent with COVID-19 are present, dental care can be provided following the practices recommended in Section 1. Recommended infection prevention and control (IPC) practices for routine dental healthcare delivery during the pandemic.
- If a DHCP is found to be febrile or has signs or symptoms consistent with COVID-19, he or she should immediately return home, should notify occupational health services or the infection control coordinator to arrange for further evaluation, or seek medical attention.
- People with COVID-19 who have ended home isolation can receive dental care following Standard Precautions.

## Monitor and Manage DHCP

- Implement sick leave policies for DHCP that are flexible, non-punitive, and consistent with public health guidance.
- As part of routine practice, DHCP should be asked to regularly monitor themselves for fever and symptoms consistent with COVID-19.
- DHCP should be reminded to stay home when they are ill and should receive no penalties when needing to stay home when ill or under quarantine.
- If DHCP suspect they have COVID-19:
  - Do not come to work.
  - Notify their primary healthcare provider to determine whether medical evaluation is necessary.
- Information about when DHCP with suspected or confirmed COVID-19 may return to work is available in the Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19.
- For information on work restrictions for health care personnel with underlying health conditions who may care for COVID-19 patients, see CDC's Healthcare Workers Clinical Questions about COVID-19: Questions and Answers on COVID-19 Risk.

## Create a Process to Respond to SARS-CoV-2 Exposures Among DHCP and Others

- Request that patients contact the dental clinic if they develop signs or symptoms or are diagnosed with COVID-19 within 2 days following the dental appointment.
- If DHCP experience a potential work exposure to COVID-19, follow CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.
  - Information on testing DHCP for SARS-CoV-2 is available in the Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2.
- If patients or DHCP believe they have experienced an exposure to COVID-19 outside of the dental healthcare setting, including during domestic travel, they should follow CDC's Public Health Guidance for Community-Related Exposure. Separate guidance is available for international travelers.
- For more information, including frequently asked questions on infected healthcare personnel, see CDC's Healthcare Workers Clinical Questions about COVID-19: Questions and Answers on Infection Control.

## Implement Universal Source Control Measures

Source control refers to use of facemasks (surgical masks or procedure masks) or cloth face coverings to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have signs and symptoms of COVID-19.

- Patients and visitors should, ideally, wear their own cloth facemask covering (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a facemask covering, they should be offered a facemask or cloth face covering, as supplies allow.

- Patients may remove their cloth facemask covering when in their rooms or patient care area but should put it back on when leaving at the end of the dental treatment.
- Facemasks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- DHCP should wear a face mask or cloth face covering at all times while they are in the dental setting, including in breakrooms or other spaces where they might encounter co-workers.
  - When available, surgical masks are preferred over cloth face coverings for DHCP; surgical masks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
  - Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required, as cloth face coverings are not PPE.
  - Respirators with an exhalation valve are not currently recommended for source control, as they allow unfiltered exhaled breath to escape. If only a respirator with an exhalation valve is available and source control is needed, the exhalation valve should be covered with a facemask that does not interfere with the respirator fit
  - Some DHCP whose job duties do not require PPE (such as clerical personnel) may continue to wear their cloth face covering for source control while in the dental setting.
  - Other DHCP (such as dentists, dental hygienists, dental assistants) may wear their cloth face covering when they are not engaged in *direct patient care* activities, and then switch to a respirator or a surgical mask when PPE is required.
  - DHCP should remove their respirator or surgical mask, perform hand hygiene, and put on their cloth face covering when leaving the facility at the end of their shift.
- Educate patients, visitors, and DHCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth face covering.

## Encourage Physical Distancing

Dental healthcare delivery requires close physical contact between patients and DHCP. However, when possible, physical distancing (maintaining 6 feet between people) is an important strategy to prevent SARS-CoV-2 transmission. Examples of how physical distancing can be implemented for patients include:

- Limiting visitors to the facility to those essential for the patient's physical or emotional well-being and care (e.g., care partner, parent).
  - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- Scheduling appointments to minimize the number of people in the waiting room.
  - Patients may opt to wait in a personal vehicle or outside the dental facility where they can be contacted by mobile phone when it is their turn for dental care.
  - Minimize overlapping dental appointments.
- Arranging seating in waiting rooms so patients can sit at least 6 feet apart.

For DHCP, the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in breakrooms or co-workers or visitors in other common areas. Examples of how physical distancing can be implemented for DHCP include:

- Reminding DHCP that the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions.

- Emphasizing the importance of source control and physical distancing in non-patient care areas.
- Providing family meeting areas where all individuals (e.g., visitors, DHCP) can remain at least 6 feet apart from each other.
- Designating areas for DHCP to take breaks, eat, and drink that allow them to remain at least 6 feet apart from each other, especially when they must be unmasked.

## Consider Performing Targeted SARS-CoV-2 Testing of Patients Without Signs or Symptoms of COVID-19

In addition to the use of universal PPE (see below) and source control in healthcare settings, targeted SARS-CoV-2 testing of patients without signs or symptoms of COVID-19 might be used to identify those with asymptomatic or pre-symptomatic SARS-CoV-2 infection and further reduce risk for exposures in some healthcare settings. Depending on guidance from local and state health departments, testing availability, and how rapidly results are available, facilities can consider implementing pre-admission or pre-procedure diagnostic testing with authorized nucleic acid or antigen detection assays for SARS-CoV-2. Testing results might inform decisions about rescheduling elective procedures or about the need for additional Transmission-Based Precautions when caring for the patient. Limitations of using this testing strategy include obtaining negative results in patients during their incubation period who later become infectious and false negative test results, depending on the test method used.

## Administrative Controls and Work Practices

- DHCP should limit clinical care to one patient at a time, whenever possible.
- Set up operatories so that only the clean or sterile supplies and instruments needed for the dental procedure are readily accessible. All other supplies and instruments should be in covered storage, such as drawers and cabinets, and away from potential contamination. Any supplies and equipment that are exposed but not used during the procedure should be considered contaminated and should be disposed of or reprocessed properly after completion of the procedure.
- Avoid aerosol generating procedures (see below for definition) whenever possible, including the use of high-speed dental handpieces, air/water syringe, and ultrasonic scalers. Prioritize minimally invasive/atraumatic restorative techniques (hand instruments only).
- If aerosol generating procedures are necessary for dental care, use four-handed dentistry, high evacuation suction and dental dams to minimize droplet spatter and aerosols. The number of DHCP present during the procedure should be limited to only those essential for patient care and procedure support.
- Preprocedural mouth rinses (PPMR)
  - There is no published evidence regarding the clinical effectiveness of PPMRs to reduce SARS-CoV-2 viral loads or to prevent transmission. Although SARS-CoV-2 was not studied, PPMRs with an antimicrobial product (chlorhexidine gluconate, essential oils, povidone-iodine or cetylpyridinium chloride) may reduce the level of oral microorganisms in aerosols and spatter generated during dental procedures.

## Implement Universal Use of Personal Protective Equipment (PPE)

For DHCP working in facilities located in areas with no to minimal community transmission

- DHCP should continue to adhere to Standard Precautions (and Transmission-Based Precautions, if required based on the suspected diagnosis).
- DHCP should wear a surgical mask, eye protection (goggles or a face shield that covers the front and sides of the face), a gown or protective clothing, and gloves during procedures likely to generate splashing or spattering of blood or other body fluids. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.

For DHCP working in facilities located in areas with moderate to substantial community transmission


- DHCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), DHCP should follow Standard Precautions (and Transmission-Based Precautions, if required based on the suspected diagnosis).
- DHCP should implement the use of universal eye protection and wear eye protection in addition to their surgical mask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters, including those where splashes and sprays are not anticipated.
- During aerosol generating procedures DHCP should use an N95 respirator or a respirator that offers an equivalent or higher level of protection such as other disposable filtering facepiece respirators, powered air-purifying respirators (PAPRs), or elastomeric respirators.
  - Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134 [\[7\]](#) ).
  - Respirators with exhalation valves are not recommended for source control and should not be used during surgical procedures as unfiltered exhaled breath may compromise the sterile field. If only a respirator with an exhalation valve is available and source control is needed, the exhalation valve should be covered with a facemask that does not interfere with the respirator fit.

There are multiple sequences recommended for donning and doffing PPE. One suggested sequence for DHCP is listed below. Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices (see PPE Optimization Strategies).

- Before entering a patient room or care area:
  1. Perform hand hygiene (wash your hands with soap and water for at least 20 seconds or use a hand sanitizer).
  2. Put on a clean gown or protective clothing that covers personal clothing and skin (e.g., forearms) likely to become soiled with blood, saliva, or other potentially infectious materials.
    - Gowns and protective clothing should be changed if they become soiled.
  3. Put on a surgical mask or respirator.
    - Mask ties should be secured on the crown of the head (top tie) and the base of the neck (bottom tie). If mask has loops, hook them appropriately around your ears.
    - Respirator straps should be placed on the crown of the head (top strap) and the base of the neck (bottom strap). Perform a user seal check each time you put on the respirator.
  4. Put on eye protection (goggles or a face shield that covers the front and sides of the face).
    - Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
    - Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
  5. Put on clean non-sterile gloves.
    - Gloves should be changed if they become torn or heavily contaminated.
  6. Enter the patient room or care area.
- After completion of dental care:
  1. Remove gloves.
  2. Remove gown or protective clothing and discard the gown in a dedicated container for waste or linen.
    - Discard disposable gowns after each use.
    - Launder cloth gowns or protective clothing after each use.
  3. Exit the patient room or care area.
  4. Perform hand hygiene (wash your hands with soap and water for at least 20 seconds or use a hand sanitizer).
  5. Remove eye protection.



- Carefully remove eye protection by grabbing the strap and pulling upwards and away from head. Do not touch the front of the eye protection.
  - Clean and disinfect reusable eye protection according to manufacturer's reprocessing instructions prior to reuse.
  - Discard disposable eye protection after use.
6. Remove and discard surgical mask or respirator.
- Do not touch the front of the respirator or mask.
  - Surgical mask: Carefully untie the mask (or unhook from the ears) and pull it away from the face without touching the front.
  - Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
7. Perform hand hygiene.

Employers should select appropriate PPE and provide it to DHCP in accordance with OSHA's PPE standards (29 CFR 1910 Subpart I) . DHCP must receive training on and demonstrate an understanding of:

- when to use PPE;
- what PPE is necessary;
- how to properly don, use, and doff PPE in a manner to prevent self-contamination;
- how to properly dispose of or disinfect and maintain PPE;
- the limitations of PPE.

Dental facilities must ensure that any reusable PPE is properly cleaned, decontaminated, and maintained after and between uses. Dental settings also should have policies and procedures describing a recommended sequence for safely donning and doffing PPE.

## PPE Supply Optimization Strategies

Major distributors in the United States have reported shortages of PPE, especially surgical masks and respirators. The anticipated timeline for return to routine levels of PPE is not yet known. CDC has developed a series of strategies or options to optimize supplies of PPE in healthcare settings when there is limited supply, and a burn rate calculator that provides information for healthcare facilities to plan and optimize the use of PPE for response to the COVID-19 pandemic. Optimization strategies are provided for gloves, gowns, facemasks, eye protection, and respirators.

These policies are only intended to remain in effect during times of shortages during the COVID-19 pandemic. DHCP should review this guidance carefully, as it is based on a set of tiered recommendations. Strategies should be implemented sequentially. Decisions by facilities to move to contingency and crisis capacity strategies are based on the following assumptions:

- Facilities understand their current PPE inventory and supply chain;
- Facilities understand their PPE utilization rate;
- Facilities are in communication with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies;
- Facilities have already implemented engineering and administrative control measures;
- Facilities have provided DHCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care.

For example, extended use of facemasks and respirators should only be undertaken when the facility is at contingency or crisis capacity and has reasonably implemented all applicable administrative and engineering controls. Such controls include selectively canceling elective and non-urgent procedures and appointments for which PPE is typically used by DHCP. Extended use of PPE is not intended to encourage dental facilities to practice at a normal patient volume during a PPE shortage, but only to be implemented in the short term when other controls have been exhausted. Once the supply of PPE has increased, facilities should return to conventional strategies.

Respirators that comply with international standards may be considered during times of known shortages. CDC has guidance entitled *Factors to Consider When Planning to Purchase Respirators from Another Country* which includes a webinar, and *Assessments of International Respirators*.

## Hand Hygiene

Ensure DHCP practice strict adherence to hand hygiene, including:

- Before and after all patient contact, contact with potentially infectious material, and before putting on and after removing personal protective equipment (PPE), including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
- Use ABHR with at least 60% alcohol or wash hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
- Dental healthcare facilities should ensure that hand hygiene supplies are readily available to all DHCP in every patient care location.

## Equipment Considerations

- After a period of non-use, dental equipment may require maintenance and/or repair. Review the manufacturer's instructions for use (IFU) for office closure, period of non-use, and reopening for all equipment and devices. Some considerations include:
  - Dental unit waterlines (DUWL):
    - Test water quality to ensure it meets standards for safe drinking water as established by the Environmental Protection Agency (< 500 CFU/mL) prior to expanding dental care practices.
    - Confer with the manufacturer regarding recommendations for need to shock DUWL of any devices and products that deliver water used for dental procedures.
    - Continue standard maintenance and monitoring of DUWL according to the IFUs of the dental operatory unit and the DUWL treatment products.
  - Autoclaves and instrument cleaning equipment
    - Ensure that all routine cleaning and maintenance have been performed according to the schedule recommended per manufacturer's IFU.
    - Test sterilizers using a biological indicator with a matching control (i.e., biological indicator and control from same lot number) after a period of non-use prior to reopening per manufacturer's IFU.
  - Air compressor, vacuum and suction lines, radiography equipment, high-tech equipment, amalgam separators, and other dental equipment: Follow protocol for storage and recommended maintenance per manufacturer IFU.
- For additional guidance on reopening buildings, see CDC's *Guidance for Reopening Buildings After Prolonged Shutdown or Reduced Operation*.

## Optimize the Use of Engineering Controls




CDC does not provide guidance on the decontamination of building heating, ventilation, and air conditioning (HVAC)

systems potentially exposed to SARS-CoV-2. To date, CDC has not identified confirmatory evidence to demonstrate that viable virus is contaminating these systems. CDC provides the following recommendations for proper maintenance of ventilation systems and patient placement and volume strategies in dental settings.


- Properly maintain ventilation systems.
  - Ventilation systems that provide air movement in a clean-to-less-clean flow direction reduce the distribution of contaminants and are better at protecting staff and patients. For example, in a dental facility with staff workstations in the corridor right outside the patient operatories, supply-air vents would deliver clean air into the corridor, and return-air vents in the rear of the less-clean patient operatories would pull the air out of the room. Thus, the clean air from the corridor flows past the staff workstations and into the patient operatories. Similarly, placing supply-air vents in the receptionist area and return-air vents in the waiting area pulls clean air from the reception area into the waiting area.
  - Consult with facilities operation staff or an HVAC professional to
    - Understand clinical air flow patterns and determine air changes per hour.
    - Investigate increasing filtration efficiency to the highest level compatible with the HVAC system without significant deviation from designed airflow.
    - Investigate the ability to safely increase the percentage of outdoor air supplied through the HVAC system (requires compatibility with equipment capacity and environmental conditions).
  - Limit the use of demand-controlled ventilation (triggered by temperature setpoint and/or by occupancy controls) during occupied hours and when feasible, up to 2 hours post occupancy to assure that the ventilation rate does not automatically change. Run bathroom exhaust fans continuously during business hours.
  - Consider the use of a portable high-efficiency particulate air (HEPA) air filtration unit while the patient is undergoing, and immediately following, an aerosol generating procedure.
    - Select a HEPA air filtration unit based on its Clean Air Delivery Rate (CADR). The CADR is an established performance standard defined by the Association of Home Appliance Manufacturers and reports the system's cubic feet per minute (CFM) rating under as-used conditions. The higher the CADR, the faster the air cleaner will work to remove aerosols from the air.
    - Rather than just relying on the building's HVAC system capacity, use a HEPA air filtration unit to reduce aerosol concentrations in the room and increase the effectiveness of the turnover time.
    - Place the HEPA unit near the patient's chair, but not behind the DHCP. Ensure the DHCP are not positioned between the unit and the patient's mouth. Position the unit to ensure that it does not pull air into or past the breathing zone of the DHCP.
  - Consider the use of upper-room ultraviolet germicidal irradiation (UVGI) as an adjunct to higher ventilation and air cleaning rates.
- Patient placement
  - Ideally, dental treatment should be provided in individual patient rooms, whenever possible.
  - For dental facilities with open floor plans, to prevent the spread of pathogens there should be:
    - At least 6 feet of space between patient chairs.
    - Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).
    - Operatories should be oriented parallel to the direction of airflow if possible.
  - Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.

- Ensure to account for the time required to clean and disinfect operatories between patients when calculating your daily patient volume.

## Environmental Infection Control

- DHCP should ensure that environmental cleaning and disinfection procedures are followed consistently and correctly after each patient (however, it is not necessary that DHCP should attempt to sterilize a dental operatory between patients).
  - Clean and disinfect the room and equipment according to the Guidelines for Infection Control in Dental Health-Care Settings—2003 .
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to clean surfaces before applying an Environmental Protection Agency (EPA)-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.
  - Refer to List N  on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Alternative disinfection methods
  - The efficacy of alternative disinfection methods, such as ultrasonic waves, high intensity UV radiation, and LED blue light against SARS-CoV-2 virus is not known. EPA does not routinely review the safety or efficacy of pesticidal devices, such as UV lights, LED lights, or ultrasonic devices. Therefore, EPA cannot confirm whether, or under what circumstances, such products might be effective against the spread of COVID-19.
  - CDC does not recommend the use of sanitizing tunnels. There is no evidence that they are effective in reducing the spread of COVID-19. Chemicals used in sanitizing tunnels could cause skin, eye, or respiratory irritation or damage.
  - EPA only recommends use of the surface disinfectants identified on List N  against the virus that causes COVID-19.
- Manage laundry and medical waste in accordance with routine policies and procedures.

## Sterilization and Disinfection of Patient-Care Items

- Sterilization protocols do not vary for respiratory pathogens. DHCP should perform routine cleaning, disinfection, and sterilization protocols, and follow the recommendations for Sterilization and Disinfection of Patient-Care Items present in the Guidelines for Infection Control in Dental Health Care Settings – 2003 .
- DHCP should follow the manufacturer's instructions for times and temperatures recommended for sterilization of specific dental devices.

## Education and Training

- Provide DHCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
  - Training: Basic Expectations for Safe Care
- Ensure that DHCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and the environment during the process of removing such equipment.
  - Using Personal Protective Equipment (PPE)

## 2. Recommended infection prevention and control (IPC) practices when providing dental healthcare for a patient with suspected or confirmed SARS-CoV-2 infection

Surgical procedures that might pose higher risk for SARS-CoV-2 transmission if the patient has COVID-19 include those that generate potentially infectious aerosols or involve anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract (see Surgical FAQ).

- If a patient arrives at your facility and is suspected or confirmed to have COVID-19, defer non-emergent dental treatment and take the following actions:
  - If the patient is not already wearing a cloth face covering, give the patient a facemask to cover his or her nose and mouth.
  - If the patient is not manifesting emergency warning signs for COVID-19, send the patient home, and instruct the patient to call his or her primary care provider.
  - If the patient is manifesting emergency warning signs for COVID-19 (for example, has trouble breathing), refer the patient to a medical facility, or call 911 as needed and inform them that the patient may have COVID-19.
- If emergency dental care is medically necessary for a patient who has, or is suspected of having, COVID-19, DHCP should follow CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.
- Dental treatment should be provided in an individual patient room with a closed door.
- DHCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
  - Avoid aerosol generating procedures (e.g., use of dental handpieces, air/water syringe, ultrasonic scalers) if possible.
  - If aerosol generating procedures must be performed
    - Aerosol generating procedures should ideally take place in an airborne infection isolation room.
    - DHCP in the room should wear an N95 or equivalent or higher-level respirator, such as disposable filtering facepiece respirator, PAPR, or elastomeric respirator, as well as eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and a gown.
    - The number of DHCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.
    - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control.
  - Limit transport and movement of the patient outside of the room to medically essential purposes.
    - Patients should wear a facemask or cloth face covering to contain secretions during transport. If patients cannot tolerate a facemask or cloth face covering or one is not available, they should use tissues to cover their mouth and nose while out of their room or care area.
  - Consider scheduling the patient at the end of the day.
  - Do not schedule any other patients at that time.
- To clean and disinfect the dental operatory after a patient with suspected or confirmed COVID-19, DHCP should delay entry into the operatory until a sufficient time has elapsed for enough air changes to remove potentially infectious particles. CDC's Guidelines for Environmental Infection Control in Health-Care Facilities (2003) provides a table to calculate time required for airborne-contaminant removal by efficiency.

# Definitions

**Aerosol generating procedures** – Procedures that may generate aerosols (i.e., particles of respirable size,  $<10\ \mu\text{m}$ ). Aerosols can remain airborne for extended periods and can be inhaled. Development of a comprehensive list of aerosol generating procedures for dental healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining their potential for infectivity. There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of aerosol generating procedures for dental healthcare settings. Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.

**Airborne infection isolation rooms** – Single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.

**Air changes per hour**: the ratio of the volume of air flowing through a space in a certain period of time (the airflow rate) to the volume of that space (the room volume). This ratio is expressed as the number of air changes per hour.


**Cloth face covering**: Textile (cloth) covers that are intended for source control. They are not personal protective equipment (PPE) and it is uncertain whether cloth face coverings protect the wearer.

## Community Transmission

- **No to minimal community transmission**: Evidence of isolated cases or limited community transmission, case investigations underway; no evidence of exposure in large communal setting
- **Minimal to moderate community transmission**: Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases
- **Substantial community transmission**: Large scale community transmission, including communal settings (e.g., schools, workplaces)

**Dental healthcare personnel (DHCP)** – Refers to all paid and unpaid persons serving in dental healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including:

- body substances
- contaminated medical supplies, devices, and equipment
- contaminated environmental surfaces
- contaminated air

**Facemask** : Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are preferred in dental settings because they are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Respirator**: Is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/National Institute for Occupational Safety and Health (NIOSH), including those

intended for use in healthcare.

Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134 [\[7\]](#)). DHCP should be medically cleared and fit tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.

Last Updated Aug. 28, 2020

**Agenda item (7)(j)(1):**

**Dr. Kerry Davis - Approval of CE Courses**

- **Dental Records**





## Dental Records: Best Practices for Information Management and Retention

### Course Contents

**Course Author(s):** [Wilhemina Leeuw, MS, CDA](#)

**Course Author(s):** [Wilhemina Leeuw, MS, CDA](#)

**CE Credits:** 2 Hour(s)

**Intended Audience:** Dentists, Dental Hygienists, Dental Assistants, Office Managers, Dental Students, Dental Hygiene Students, Dental Assistant Students

**Date Course Online:** 07/01/2017

**Last Revision Date:** 08/18/2020

**Course Expiration Date:** 08/17/2023

**Cost:** Free

**Method:** Self-instructional

**AGD Subject Code(s):** 159



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### [1 \(Read Reviews\)](#)

### [Write Review](#)

#### Introduction

Dental records are a significant component of completing the patient's standard of care. Dental records have evolved significantly due to federal laws and technological advancements. The record has transformed to an electronic record that must be effectively maintained, properly retained and ultimately protected on the behalf of the patient.

#### Conflict of Interest Disclosure Statement

- The author reports no conflicts of interest associated with this course.

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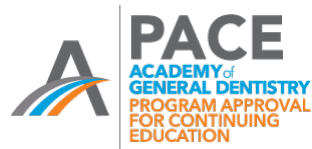
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**Agenda Item (7)(j)(2):**

**Dr. Kerry Davis - CE Course**  
**• Risk Management**



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## 02-5631-17030 (Video): Risk Management - Dental Recordkeeping and Documentation

### Course Abstract:

**Contact Hours (CE):** The Academy of Dental Learning and OSHA Training, LLC, designates this activity for 2 continuing education credits (2 CEs).

**Cost:** \$30.00

**Questions? Contact Us:** Phone: 800-522-1207, Fax: 800-886-3009, or Email: [cesupport@dentalllearning.org](mailto:cesupport@dentalllearning.org)

**Published:** June 2011

**Revised:** December 2017

**Expires:** December 2020

**Format:** Video Lecture - 101 minutes

**Course Instructor:** Philip Barbell, DDS

*No conflicts of interest are reported by the author or by educational planning committee members.*

## Educational Objectives

- Define the dental record.
- Describe how to change the dental record.
- List items in the dental record.
- Describe how HIPPA, confidentiality and security effect handling of the dental record.

## Course Description

Dental Record Keeping is an important cornerstone of any modern dental practice. The dental professional must be precise and consistent with the recording evaluations, diagnoses, treatment progress notes, patient concerns, and confidentiality on the patient's permanent record. This 4 part video series, with author and lecturer, Philip R. Barbell, DDS, gives a comprehensive overview of all aspects of dental record keeping. Dr. Barbell covers crucial elements of the permanent dental record and teaches how to record content in a fashion which eliminates error and exposure to liability. The course reviews how to manage and prevent malpractice situations by keeping accurate records. The ownership of the dental record is also discussed and how to make changes without compromising dental record integrity in the event of litigation. This course is about the creation of best practice methods to create complete, concise, and accurate records for your office. Additionally, HIPAA and issues surrounding confidentiality are covered in detail.

This course in Dental Record Keeping is an excellent review for seasoned professionals and suitable for training those new to a dental office practice environment.

## Course Lecturer:

Philip R. Barbell, DDS, FAGD, FACD, FICD

Dr. Barbell had been a practicing general dentist in New Jersey for 38 years. He is now Director of Risk Management for Dentist's Advantage and serves on the board of the National Society of Dental Practitioners.

He has been involved in organized dentistry at the local, state and national levels, having served as President of Southern Dental Society of New Jersey and New Jersey Dental Association. He has been involved in the insurance arena for his entire professional career and has served as either a board member or officer of several dental insurance entities.

Dr. Barbell has been directly involved at the state and national level on dental association committees dealing with dental plans for over 25 years. He has also been involved in the dental liability area for over 25 years, having served for 11 years as President and Chairman of the Board of a national dentist owned and controlled malpractice insurance company. Dr. Barbell is a member of Southern Dental Society of New Jersey, New Jersey Dental Association and the American Dental Association. He is also a Fellow of the Academy of General Dentistry, the American College of Dentists and the International College of Dentists.

## How to Take This Course

Click on the logo below to open the course video and study materials. Study the course then return to this page and click to Take the Exam. Upon successful completion of the exam you will be asked to

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register and pay over a secure connection. Your exam will grade automatically and your certificate will display for you to save and/or print for your records.

**Contact Hours:** 2.00

**Price:** \$30.00

**Agenda item (7)(j)(3):**

**Dr. Kerry Davis - CE Course**

- **Pain Control, Opioid Prescribing, &  
Substance Abuse Prevention**

# PAIN CONTROL, OPIOID PRESCRIBING, AND SUBSTANCE ABUSE PREVENTION



Instructor: [Harold Crossley, DDS, MS, PhD](#)

**Join us from the convenience of your individual home or office for  
this LIVE interactive course Saturday, Oct 31, 2020**

This program will include the practical pharmacologic management of post-operative dental pain and appropriate opioid prescribing in adults and children. For centuries, opioids have been used to control pain and suffering, but at what cost to us, our families, and our dental practices? What is the new FDA warning about codeine and tramadol in children? Why are NSAIDs more appropriate than opioids for treating post-operative dental pain? What are prescription drug monitoring programs? These questions and more will be answered in this LIVE 3-hour virtual course.

At the conclusion of this course, the attendees will know:

- How to minimize prescribing opioids for controlling post-operative dental pain.
- How to combine over-the-counter (OTC) analgesics to maximize their effects.
- The usefulness of their state's prescription drug monitoring program.
- The progressive nature of addictive disease.

\$295 / Dentist      \$50 / Auxiliary      3 CE Hours

**Saturday, Oct 31, 2020**

**Start Time:** 9am Mountain (11am Eastern, 10am Central, 8am Pacific)



**End Time:** Noon Mountain (2pm Eastern, 1pm Central, 11am Pacific)

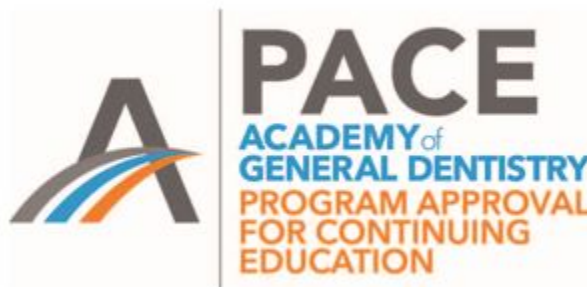
Online Registration closes Friday, Oct 30 @ noon

[Dentist](#) [Auxiliary](#)

## COMMENTS FROM OTHER LIVE DIGITAL COURSES

Well done, Enjoyed convenience of virtual meeting. The ability to ask questions and have them answered in real time was excellent.

I think the professionals answering chat really added to the quality of the course, it makes a "zoom classroom" much more interactive and valuable.



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Provider FAGD/MAGD Credit  
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acceptance by a state or provincial  
board of dentistry or AGD  
endorsement.

Current term of approval  
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**Agenda Item (7)(k)**

**WREB:**

**Interim Clinical Dental Exam**

## **WREB Dental and Dental Hygiene Licensing Examination COVID-19 Options for 2020**

WREB is an independent testing agency that develops, administers, and reports the outcome of practical clinical examinations administered to candidates for licensing in dentistry and dental hygiene. While aware of the needs of students and dental education programs, WREB's sole purpose is to provide state boards with examinations that have high reliability and are supported by a strong validity argument—examinations state boards can rely on to inform licensing decisions. For this reason, WREB is highly responsive to the needs and wishes of state boards that recognize its examinations.

- WREB Dental Examination options are described below (pp. 1-4).
- WREB Dental Hygiene Examination options are described on pp. 5-6.

### **WREB Dental Licensing Examination COVID-19 Options for 2020**

Following are options state boards could consider in response to COVID-19:

#### Dental Examination without Change

WREB's standard dental examination which includes two simulations (Endodontics and Prosthodontics) and two patient-based sections (Operative Dentistry and Periodontics) in addition to the Comprehensive Treatment Planning (CTP) section will continue to be offered as soon as test sites again are able to schedule this type of examination. This option may not address the needs of state boards attempting to respond to the concerns of dental candidates and schools who wish to complete the licensure process within the next several months. Even when re-established, examination administration may be subject to interim restrictions. States that specifically require two patient-based restorative procedures and wish to reduce the burden on licensure candidates imposed by COVID-19 could safely accept WREB's Operative Section as it is scored and validated, which has demonstrated that candidate competency can be reliably assessed with more than 40% fewer patient-based procedures.<sup>i</sup>

#### CTP Only

WREB's CTP (Comprehensive Treatment Planning) Section<sup>ii</sup> is an ASCE (Authentic Simulated Clinical Examination) which requires the candidate to construct responses (as opposed to an OSCE in which the candidate selects responses from options, locations, or choices provided). The CTP ASCE is open-ended and graded by independent, anonymous examiners. It reveals candidate thinking and requires candidates to perform tasks that dentists perform and to make decisions that dentists make, all without choices they can select or cues of any kind. If acceptance of only an OSCE examination is being considered, then acceptance of WREB's CTP ASCE which is an even more authentic demonstration of relevant candidate knowledge, skill, and ability, should be considered.

### COVID-19 Alternative Performance-based Simulation

Patient-based assessment has high fidelity. WREB is not abandoning patient-based assessment but continues to evaluate the validity and viability of assessment alternatives, including simulation. WREB has been developing simulations that soon may be able to replace patient-based assessment for Operative Dentistry and Periodontics, the last two patient-based sections of its current dental examination. These simulations are in development and undergoing review.

In the meantime, the advent of COVID-19 has placed students and their education programs in a difficult and frustrating position. Students need to graduate, move on, obtain employment, or begin their advanced dental education residencies; their education programs need them to graduate and move on in order accept a new entering class and appropriately advance the classes below them. COVID-19 associated risk and social distancing currently completely obstruct student ability to challenge the traditional, patient-based examination. While WREB understands that COVID-19 is creating a crisis for students, for dental education programs, and even for the profession, its singular purpose is to support the needs of state boards in their regulatory role and charge to protect the public.

Students and program directors recently have appealed to state boards and, not knowing exactly how long COVID-19 risk and need for social distancing might continue, state boards in a few states now have appealed to WREB for potential solutions they might consider along with suggestions they've received that include waiving clinical examination requirements altogether, waiving the patient-based sections of the clinical examination, granting a provisional license until the applicant is able to complete the full examination, acceptance of the DLOSCE in lieu of a practical demonstration of clinical skills, and variations of these.

In response and in addition, WREB has field-tested an alternative, performance-based simulation that could be required in lieu of its traditional patient-based Operative Section. This alternative included the field-testing of social distancing for both candidates and examiners.

In the simulation, each candidate is required to successfully perform both preparation and finish of a conventional Class II restoration on a molar and a Class III restoration on a central incisor. All procedures are performed, like they are for the Endodontics and Prosthodontics sections, in full simulation and with rubber-dam isolation. Results are assessed using established Operative Section criteria. Certain critical errors are preserved, and the passing cut-point remains unchanged. The simulation involves social distancing for both candidates and examiners and uses materials (simulation teeth and arches) which are readily available and with which candidates and their programs already are familiar.

This alternative for the Operative Section is intended to be a provisional solution for 2020 (COVID-19) only and is intended neither to replace WREB's patient-based Operative Section in 2020 for states that continue to require it nor to be the simulation WREB intends to offer in the future

when social distancing is not a concern and the validity of a more realistic and involved simulation can be demonstrated.

The second patient-based section of the current WREB dental examination is the Periodontics Section. This section assesses a candidate's understanding of periodontal diagnosis and ability to physically perform initial periodontal therapy (periodontal scaling and root-planing). However, this section already is elective, is not required for licensing in some states, and tests a physical skill that, increasingly, dentists do not themselves perform.<sup>iii</sup> The Periodontics Section, while valued by many states, is, by far, the least discriminating section of the entire examination.<sup>iv</sup> Also, important aspects of periodontal diagnosis and treatment decision-making (things dentists do and are expected to know how to do) already are well covered in the unique CTP Section of WREB's dental examination. State boards may decide to waive or postpone the patient-based Periodontics section until such time as it again may become available to applicants.

These are dental examination options that WREB currently is making available for state board consideration in this highly unusual year. It is assumed that any waiver or exception a state grants due to COVID-19 might be restricted to matriculated students of CODA accredited dental education programs graduating in the spring of 2020 and would not necessarily set a precedent for future years or apply to any other group of applicants. WREB recognizes that all these and related decisions reside with the state and depend on the Board or on the Board's advice to the state authority empowered to grant a variance due to current, emergent COVID-19 circumstances.

Logistic detail regarding the implementation of WREB's dental examination or any of the described alternatives depends on the capacity, limitations, and COVID-19 restrictions imposed by or on any host site where an examination is conducted.

WREB's standard dental examination which includes the fidelity associated with two simulations (Endodontics and Prosthodontics) and two patient-based sections (Operative Dentistry and Periodontics) in addition to CTP will continue to be offered as soon as test sites again are able to host this type of examination.

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<sup>i</sup>Fewer patient-based procedures were required to determine 4,457 candidate pass/fail outcomes for the Operative Section in 2018 (42.0% fewer) and 2019 (41.1% fewer). No significant difference was found between first and second procedure performance for candidates who scored at or above the cut-score on the first procedure. The second procedure added no significant contribution to the assessment of these candidates. Only four of these candidates failed the section despite demonstrating competence on the first procedure; all four scored close to the cut-score and three have already passed upon retake.

<sup>ii</sup> The CTP Section is the most comprehensive section of the WREB Dental Examination. It tests candidate knowledge, skills and abilities that cannot be readily sampled in other ways and includes assessment of meaningful aspects of every other section of the Examination. The CTP Section is designed to integrate the disciplines of dentistry in a practical, clinical way. The construction of appropriately sequenced treatment plans and item responses requires broad understanding of diagnostic, preventive and restorative dentistry, of endodontics, periodontics, and prosthodontics, as well as oral surgical, radiological, pediatric dentistry, and patient-management procedures, and understanding of the relationships between these procedures and their clinical application under various patient conditions.

The CTP Section is open-ended; it's an authentic simulated clinical examination (ASCE)—a practical, performance-based examination. It requires candidates to construct their responses unaided by cues, choices, or locations they can select. In many instances it requires candidates to perform the very tasks dentists perform and, for this reason, has extraordinary fidelity for a computer-based examination. Rigorous examiner training and calibration contributes to high outcome reliability for the CTP examination. And the large reservoir of examination cases, frequent case modification, and the permutation of cases in the forms used every year significantly enhance test security for the CTP examination. All combine to create a strong validity argument for using results of WREB's CTP examination to inform licensing decisions.

<sup>iii</sup> In 2013 74.6% of general practitioners in solo practice employed one or more dental hygienists. For general practitioners in nonsolo practice (including various forms of group practice, "corporate" practice, etc.) 92.2% work in situations where dental hygienists perform scaling and root-planing services. -ADA, Science and Research – Health Policy Institute, Data Center, Dental Practice.

Authors Thomas Wall, M.A., M.B.A.; Albert H. Guay, D.M.D. in their article *Very Large Dental Practices Seeing Significant Growth in Market Share*. Health Policy Institute – Research Brief. August 2015. Point out that:

- From 2002 to 2012, market share increased for dental firms with 20 employees or more, while dental firms with fewer than five employees experienced a decline in market share.
- During the same period, very large dental firms – those with 500 employees or more – also saw increases in number of establishments, number of employees and annual receipts.

The national 2018 Dental Practice Analysis conducted jointly by WREB and CRDTS suggests that dentists, themselves, now are performing very few scaling and root-planing procedures compared to dental hygienists. The 2017 Dental Hygiene Practice Analysis survey specifically asked how often certain procedures were performed by the dentist and 84.6% of respondents said the dentist performed these tasks Rarely or Never.

The average of all general dentists employing dental hygienists in 2013 was 77.2%. From 1990 to 2013 the average number of dental hygienists per dentist in the primary practice (among dentists employing dental hygienists) steadily increased. This trend has been continuing. More and more dentists are having dental hygienists perform basic periodontal services and are using more dental hygienists per capita to do this. Dentists, themselves, are doing fewer and fewer of these tasks. Assessing these skills for dentists, now, may not be supported by the practice (task) analyses that underpin the design of a valid dental licensing examination.

<sup>iv</sup> Evidence in favor of non-requirement includes exceptionally high proportions of candidates performing extremely well on the Periodontics section. Most of the candidates who do fail the Periodontics section multiple times have also failed at least one other section multiple times. Only four (4) out of almost 13,000 (i.e., 0.03%) candidates from 2011 to 2016 remained unsuccessful due to Periodontics Section failure.

## WREB Dental Examination Options Under COVID-19

Option	Exam Type	Description	Availability
WREB Comprehensive Treatment Planning Exam	Written Authentic Simulated Clinical Examination(ASCE)	Constructed response exam requiring students to perform tasks and make decisions with high fidelity to dental practice. For states considering an OSCE examination only as a pathway to licensure WREB's CTP ASCE is a more authentic demonstration of relevant candidate knowledge.	Most candidates completed this exam in the Fall of 2019. For those that have not, they can complete it as soon as Prometric Testing Centers open again. Projected to be May 1, 2020.
Traditional WREB Patient Based Examination	Traditional exam requiring demonstration of skills on a mannikin for Endodontic and Prosthodontics and on a patient for Periodontics and Operative and the written CTP (ASCE) exam.	Although many states require completing two procedures for the Operative section WREB has demonstrated that candidate competency can reliably assessed with 1 patient. For states that require 2 procedures currently they could relax the requirement to require only one procedure.	Depends on the event line of COVID-19; circumstances will vary widely across sites and require willing patients and available volunteers, freedom of air travel, available lodging, etc.
COVID-19 Alternative Performance Based Simulation	Written Authentic Simulated Clinical Examination(ASCE) exam and mannikin based Operative, Endodontics and Prosthodontics sections	Candidate is required to successfully perform both preparation and finish of a conventional Class II restoration on a molar and a Class III restoration on a central incisor. All procedures are performed, like they are for the Endodontics and Prosthodontics sections, in full simulation and with rubber-dam isolation. Results are assessed using established Operative Section criteria. Certain critical errors are preserved, and the passing cut-point remains unchanged.	Can begin as soon as June depending on CDC recommendations, local conditions, etc. Will be administered utilizing appropriate social distancing protocols

## WREB Dental Hygiene Examination Options Under COVID-19

Option	Exam Type	Description	Availability
Dental Hygiene Clinical Examination	Patient Based Examination	WREB's standard dental hygiene examination includes the following components: Patient Qualification; Extraoral/Intraoral examination, Calculus detection and removal, Tissue Management, Periodontal Assessment and Professional Judgment.	Depends on the event line of COVID-19; circumstances will vary widely across sites and require willing patients and available volunteers, freedom of air travel, available lodging, etc.
Comprehensive Dental Hygiene OSCE	Written Exam	The WREB Dental Hygiene OSCE is a multiple-choice written component that assesses these multi-faceted components of dental hygiene care. This is a comprehensive overview of dental hygiene knowledge, radiographic interpretation, AAP staging and grading, extra and intra oral assessment and risk assessment, care plan development, and assessment and treatment of the periodontium. The exam is an avenue to test the skills of an entry-level student, either replacing either replacing the current clinical examination or to be administered in conjunction with a clinical licensure exam should a state board want an additional assessment examination.	Can be administered beginning in June of 2020.





# **WREB Interim Clinical Dental Examination: COVID-19 Performance-Based Simulation Examination**

## **Psychometric Overview**

**May 6, 2020**



**WREB Interim Clinical Dental Examination:  
COVID-19 Performance-Based Simulation Examination  
Psychometric Overview**

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## **WREB Interim Clinical Dental Examination: COVID-19 Performance-Based Simulation Examination**

### **Psychometric Overview**

#### **Introduction**

Results from standardized assessments are one source of evidence used by licensing bodies to make decisions about a candidate's readiness for practice. Licensing examinations must be developed and administered in a valid, reliable, and legally defensible manner. The purpose of this report is to provide test users with an overview of descriptive and technical documentation regarding the nature and quality of the WREB Interim Clinical Dental Examination to support inferences based on examination results.

WREB examinations are developed, administered, and scored in accordance with the *Standards for Educational and Psychological Testing* (AERA, APA, NCME; 2014) and *Guidance for Clinical Licensure Examinations in Dentistry* (AADB, 2005). An overview and description of activities conducted to evaluate the technical quality of the WREB Interim Clinical Dental Examination, with a focus on the new Operative Simulation Section, are provided, including psychometric and statistical results of field-testing. Details of additional activities and research studies relevant to the Interim Clinical Dental Examination are also maintained and available for review by test users, test takers, and other stakeholders.

#### **Background and Overview of the Interim Examination**

WREB has been researching and evaluating the validity and viability of alternatives to patient-based assessment for several years. For example, simulations that could substitute for Operative Dentistry and Periodontics, the two patient-based sections of WREB's standard dental examination, are currently in development and undergoing review. WREB had not planned to implement any of these assessment alternatives during the 2020 dental examination season.

The advent of health risks due to the COVID-19 (SARS-CoV-2) virus and the social-distancing directives that have been in place since March of 2020 has put pressure on many state licensing boards to consider temporary alternatives to the traditional patient-based dental

examination. Several state licensing boards have requested that WREB propose temporary examination alternatives that could be administered during the COVID-19 crisis.

WREB has developed an interim alternative examination that includes existing simulation sections (i.e., Comprehensive Treatment Planning [CTP], Endodontics, and Prosthodontics) and a new, field-tested, restorative dentistry simulation that can serve as a temporary replacement for the patient-based Operative Section while the challenges posed by COVID-19 limit patient-based options. A brief overview of temporary changes to existing examination sections will be provided, followed by a more detailed description of the development and collection of validity evidence for the new Operative Simulation Section.

### **Existing Examination Sections**

**Comprehensive Treatment Planning (CTP) Section.** WREB's existing Comprehensive Treatment Planning (CTP) Section is a performance-based ASCE (Authentic Simulated Clinical Examination) which requires the candidate to construct responses (as opposed to an OSCE in which the candidate selects responses from options, locations, or choices provided). The CTP Section is open-ended and graded by independent, anonymous examiners. It reveals candidate thinking and requires candidates to perform tasks that dentists perform and to make decisions that dentists make, all without choices they can select or cues of any kind. The construction of appropriately sequenced treatment plans and item responses requires broad understanding of diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgical, radiological, pediatric dentistry, and patient-management procedures, as well as the relationships between these procedures and their clinical application under various patient conditions. The CTP examination can result in failure if a candidate commits a critical error, i.e., constructs a response that could result in life-threatening harm, such as administering more than the upper limit of a safe dose of local anesthetic for the weight of a pediatric patient. The CTP Section has been administered to dental licensure candidates since 2014 and will be a required, unchanged section on the WREB Interim Clinical Dental Examination. Details and results of technical analyses and candidate results for the CTP Section have been documented in annual technical reports (e.g., WREB, 2019a).

Over 2,000 dental candidates have already completed the CTP examination for the 2020 season, including 1,035 from dental schools in Nevada and its neighboring states (i.e., California,

Oregon, Utah, and Arizona). For any candidates who have not yet challenged the CTP Section, Prometric testing centers are opening for testing in May 2020 and have established guidelines for social distancing and safety (<https://www.prometric.com/corona-virus-update>).

**Endodontics Simulation Section.** WREB's existing Endodontics Section is a performance-based clinical simulation examination. The candidate is required to perform two endodontic procedures on simulated teeth mounted in a segmented arch which is mounted in a manikin that is positioned to simulate working on a patient. Candidates must maintain the simulated patient position and adhere to Standard (Universal) Precautions throughout the examination. The anterior tooth procedure requires treatment of a maxillary central incisor simulated tooth, including access, instrumentation and obturation. The posterior tooth procedure requires access of a mandibular first molar simulated tooth. Access of the posterior tooth must enable grading examiners to identify all canal orifices. Like all WREB Dental Examination sections, the Endodontics Section is graded by independent, anonymous examiners. The Endodontics Section has been administered since 1985 and will be a required section on the WREB Interim Clinical Dental Examination. Details and results of technical analyses and candidate results for the Endodontics Section have been documented in annual technical reports (e.g., WREB, 2019a).

The only changes to the Endodontics Section are specific COVID-19-related social distancing and infection prevention protocols that must be followed to ensure the safety of all individuals involved in the examination and examination-related activities. Besides adhering to the simulation protocol for patient position and Standard (Universal) Precautions, candidates also are required to follow any additional social-distancing and infection-prevention protocols imposed by the exam site.

**Prosthodontics Simulation Section.** WREB's existing Prosthodontics Section is a performance-based clinical simulation examination. The candidate is required to perform two prosthodontic procedures (three preparations) on simulated teeth in a mounted articulator and manikin that is positioned to simulate working on a patient. Candidates must maintain the simulated patient position and adhere to Standard (Universal) Precautions throughout the examination. Candidates are required to prepare an anterior tooth for a full-coverage crown and prepare two abutments to support a posterior three-unit fixed partial denture prosthesis (i.e., bridge). The three-unit bridge

must have a path of insertion that allows full seating of the restoration. Like all WREB Dental Examination sections, the Prosthodontics Section is graded by independent, anonymous examiners. The current version of the clinical Prosthodontics Section has been administered since 2018 and is required by most states accepting the WREB Interim Clinical Dental Examination. Details, technical analyses, and candidate results are documented in annual technical reports (e.g., WREB, 2019a).

As with the Endodontics Section, the only changes to the Prosthodontics Section specific COVID-19-related social-distancing and infection-prevention protocols that must be followed to ensure the safety of all individuals involved in the examination and examination-related activities. Besides adhering to the simulation protocol and Standard (Universal) Precautions, candidates also are required to follow any additional social-distancing and infection-prevention protocols imposed by the exam site.

**Periodontics Patient-Based Section.** WREB subject matter experts (SMEs) on the Operative and Periodontics Examinations Committee have recommended that due to COVID-19 the patient-based Periodontics Section of the Clinical Dental Examination be waived for 2020 since WREB is unable to demonstrate that a valid replacement is viable. The following evidence supports the decision to recommend temporary waiver or postponement of the Periodontics Section: a) critical aspects of periodontal diagnosis and treatment decision-making are covered throughout the CTP examination, b) the patient-based Periodontics section is the least discriminating section of the Dental Examination due to the very high rate of examination success, and c) recent practice analyses conducted jointly by WREB and CRDTS (WREB, 2019b; WREB, 2020) found that while the practices assessed on WREB's Dental patient-based Periodontics Section and Dental Hygiene Examination continue to be rated as frequently performed and important, these practices are most frequently performed by dental hygienists and rarely or never performed by dentists. Still, the ability of dental candidates to demonstrate competence on a valid, clinical examination of Periodontics continues to be valued by many states, and the patient-based Periodontics Section of WREB's standard patient-based Dental Examination will be available again when it can be administered safely.



### **Operative Simulation Section: Development and Field Testing**

WREB has field-tested an alternative, performance-based restorative dentistry simulation (i.e., Operative Simulation Section) that could be required temporarily in lieu of the traditional patient-based Operative Section. The validation process for the simulated examination included the field-testing of social distancing for both candidates and examiners. The pre-planning and guidelines practiced with the social-distancing and infection-prevention protocols employed in the Operative Simulation Section field tests are described later and will be applied to other simulation sections (i.e., Endodontics and Prosthodontics) of the WREB Interim Clinical Dental Examination.

In the Operative Simulation Section, each candidate is required to successfully perform both preparation and finish of a conventional Class II restoration on a molar and a Class III restoration on a central incisor. All procedures are performed, like they are for the Endodontics and Prosthodontics sections, on simulated teeth, mounted in arches on a manikin with proper operational posture, appropriate employment of Standard (Universal) Precautions including Personal Protective Equipment (PPE), and with rubber-dam isolation. Results are assessed using established Operative Section scoring criteria. Certain critical errors are preserved, and the passing cut-point remains unchanged. The simulation involves social distancing for both candidates and examiners and uses materials (simulation teeth and arches) which are readily available and with which candidates and their programs are already familiar.

WREB maintains the position that any clinical restorative simulation testing, at this time, remains limited with respect to fidelity, which is a critical type of validity evidence. Even with a simulated tooth that attempts to replicate the hardness, texture, disease process, and internal anatomy of human teeth, the simulation does not fully replace the spontaneous judgments, patient management skill, and cognitive-motor coordination involved in treating a live human patient who exhibits an authentic response to local anesthesia, unpredictable movements, and has the ability to feel pain and discomfort. The alternative Operative Simulation Section that WREB is offering for 2020 is intended to be a provisional solution for COVID-19 only and is intended neither to replace WREB's patient-based Operative Section in 2020 for states that continue to require it nor to be the simulation WREB may offer in the future when the validity of a more realistic and involved simulation can be demonstrated.

The following sections will describe several aspects of the Operative Simulation Section, including a) administration procedures reflecting the additional precautions required to minimize

exposure to the COVID-19 virus, b) restorative content assessed, c) grading and scoring, d) examiner preparation and evaluation, and e) the results of field-testing conducted in early 2020.

### **Interim Social Distancing and Infection Prevention Protocol**

Preventing infection by COVID-19 that may arise from airborne transmission or contact with potentially virulent surfaces is critical to ensuring the safety of candidates, dental school personnel, examiners and agency personnel during examination and examination-related activities. Field-testing for the Operative Simulation Section included broad attention to ensuring that a) individuals participating in the examination were sufficiently distant from each other at all times, b) individuals used appropriate PPE, and c) materials and areas remained clean and disinfected. Social-distancing and infection-prevention protocols were field tested for the Operative Simulation Section and will be implemented for all clinical sections of the WREB Interim Clinical Dental Examination. These protocols include but are not limited to the following examination features:

- Limits on numbers of personnel and candidates assigned to the examination at one time and in one location
- Distribution, required completion, and collection/review of a self-assessment survey instrument immediately prior to the examination (e.g., regarding symptoms, recent contact with suspected or known patient with COVID-19, and recent travel)
- Required capture and logging of each participant's temperature
- Assignment of separated arrival times
- Set-up, preparation, and monitoring for entry to the facility and examination area (e.g., survey completion and approval, donning face mask and eye protection, temperature capture, hand sanitization, etc.)
- Installation of floor and location markings throughout examination areas to ensure adherence to social distancing
- Location of assigned simulation stations that conform to social distancing guidelines
- Pre-provision of supplies and examination materials at simulation stations to reduce unnecessary movement

- Specific instructions regarding how to move around laboratory when necessary, how to turn in materials, and how to leave space and building upon completion without congregating
- Monitoring of social distancing, use of PPE, and contact with objects and surfaces throughout the simulation
- Appropriate cleaning and disinfection of all simulation stations and involved surfaces immediately before and following every simulation session

The features described reflect protocols that were in place for the March 30 – April 2 field-tests. These examination protocols may be augmented according to updates for infection prevention from the Center for Disease Control (CDC) or more stringent school-specific requirements. In any case the protocols employed will reflect or exceed CDC guidelines. If the test site has stricter guidelines than the CDC, then the protocol employed will reflect the test site requirements. For example, the CDC guidelines for social distancing stipulated maintaining a minimum distance of at least six feet from other individuals; one of the field-test sites required a minimum distance of ten feet, which was implemented throughout the field test.

WREB will coordinate with each site hosting an examination to develop a document communicating the social-distancing and infection-prevention protocol for that examination site. Prior to the exam this document will be provided to candidates, on-site examiners, and any other individuals who will be involved in examination. Candidates will be expected to conform to the social distancing and infection prevention protocol and may risk dismissal and failure of the examination for gross, willful, or repeated protocol violation.

Scoring sessions where grading examiners evaluate candidate performance on the submitted arches also will be subject to social-distancing and infection-prevention protocols. Similar safety features, including self-assessment and screening, number of grading examiners per room and building, social distancing, surface and material disinfection, and specific instruction regarding safe entry, movement, task performance, and exit of the facility will be provided.

### **Administration and Security**

Time allocated for the simulation is three and one-half (3.5) hours. Candidates are allowed an additional 30 minutes to set up before the session begins.

At the exam site, candidates must provide two valid, non-expired forms of personal identification. Admittance to the exam does not imply that the identification presented was valid. If it is determined that a candidate's identification is fraudulent or otherwise invalid, WREB will report to the appropriate governing agencies or board. Any candidate or other individual who has misreported information or altered documentation in order to fraudulently attempt an examination, will be subject to dismissal and reporting.

Candidates report to the assigned simulation area at the appointed time and must bring with them their personal handpieces, burs, and anything else needed to complete preparations or restorations on the simulated teeth, including the ModuPRO® One opposing arch or equivalent needed to complete the simulation.

Candidates may bring the Operative Simulation Candidate Guide and Dental Exam Candidate Guide into the simulation lab for reference. Notes, textbooks, or other informational material must not be brought into the simulation lab. No magnification other than loupes is allowed. All electronic devices, including cell phones and smart watches, are prohibited in the simulation lab. Unique markings are applied to each arch to prevent manipulation and reinforce examination security.

Assistants are not permitted for the Operative Simulation Section. Candidates may not assist each other. This includes critiquing another candidate's work or discussion of treatment. All candidates are expected to pass the examination on their own merit without assistance.

WREB provides the maxillary arches containing the teeth needed for preparation and restoration. The candidate provides everything needed that is not provided by the test site (school), including a suitable opposing arch. Following preparation, the arch containing the prepared teeth is submitted for grading and a second arch is provided with teeth already prepared for restoration. When placement of the finish restorations is completed, the second arch is submitted for finish grading.

Candidates are to work independently, observe Standard (Universal) Precautions, and work in a manner that simulates performing procedures on a patient throughout the simulation. Any unprofessional, unethical, or inappropriate behavior could result in immediate dismissal and failure of the Operative Simulation. If, after receiving notice of a violation, a candidate repeatedly violates simulation protocol, Standard (Universal) Precautions, or the social distancing and infection

prevention protocol for the exam site, they will be dismissed from the simulation and will fail the Operative Simulation Section.

Additional details of administration procedures and security guidelines are included in the Operative Simulation Candidate Guide, Dental Exam Candidate Guide, Operative Simulation Examiner Manual, and Dental Exam Examiner Manual.

### **Operative Simulation Test Specifications and Grading Criteria**

The Operative Simulation Section consists of one extended examination session during which two (2) operative (restorative) procedures are performed on simulated teeth. The procedures are:

1. Preparation and restoration of a conventional Class II (MO) in tooth 14.
  - The candidate may choose the restorative material (amalgam or composite).
  - The preparation can but need not cross the tooth's oblique ridge.
2. Preparation and restoration of a Class III (ML) in tooth 9 with composite.

The procedures are performed on simulated teeth mounted in a manikin positioned to simulate working on a patient. The simulated tooth has the same anatomy and polymers as the teeth that are required for the Prosthodontics Simulation Section. Vendor supply is available for both testing and candidate practice despite current factory closures. The teeth have no artificial decay that could introduce testing variables not encountered in candidates' current curriculum and training. Additional field testing and candidate clinical experience will be necessary for reliable implementation with artificial decay.

No modification requests are needed, which supports social distancing and infection prevention measures by reducing the handling of materials and number of examiners required to be onsite. Candidates are asked to prepare the teeth as they ideally would for minimal caries requiring restoration and so that their preparations satisfy WREB criteria for a score of "5" and then stop. The Class II preparation design must be conventional and include a pulpal floor. Both preparation and restoration (placement of the restorative material) must be accomplished with a rubber dam. When treatment is completed the arch containing the prepared or restored teeth is submitted for grading. Occlusion is not functionally evaluated.

Current dental terminology (CDT) codes that reflect the range of procedures that may be attempted are listed in Table 1.

Table 1. *Simulated Operative Section Procedure Options with CDT Codes*

<b>Operative Section Restorative Procedure</b>	<b>CDT Code(s)</b>
Direct posterior Class II amalgam restoration (MO, DO or MOD)	D2150, D2160
Direct posterior Class II composite restoration (MO, DO or MOD)	D2392, D2393
Direct anterior Class III composite restoration (ML, DL, MF, DF)	D2331, D2332

WREB examines candidates with varying educational backgrounds and schools may teach different preparation and restoration techniques. WREB does not look for one specific technique and scores performance according to the Operative Simulation scoring criteria described later in this section.

The scoring criteria are based on the scoring criteria employed for the conventional patient-based Operative examination section, with minor revisions, reviewed and approved by the SMEs on the Operative examination committee. The preparation criteria are Outline and Extension, Internal Form, and Operative Environment. The finish criteria are Anatomical Form, Margins, and Finish, Function and Damage. Each grading criterion is defined at five levels of performance for each procedure, with a grade of "3" representing minimal competence. A grade of "5" is defined generally to represent optimal performance, with grades of 4, 3, 2, and 1 corresponding to appropriate, acceptable, inadequate, and unacceptable performance, respectively. The performance level definitions for each type of preparation (i.e., Class II amalgam, Class II composite, and Class III composite) and for the restoration finish are published in the candidate guide and provided in Figures 1 through 4.

OPERATIVE SIMULATION CLASS II – COMPOSITE PREPARATION					
SCORING CRITERIA RATING SCALE					
	5–Optimal	4–Appropriate	3–Acceptable	2–Inadequate	1–Unacceptable
OUTLINE & EXTENSION	Outline is generally smooth and flowing and does not weaken tooth in any manner.	Outline is slightly irregular but does not weaken tooth. Isthmus is slightly wider than required.	Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow.	Outline severely weakens marginal ridge or a cusp. Outline is misshapen and/or forces improper angle of exit.	Outline is grossly improper and/or lacks any definite form.  Unapproved surface prepared.
	Proximal and gingival extensions are visually open less than 1.0 mm	Proximal and/or gingival extensions are slightly overextended.	Proximal and/or gingival extensions are moderately overextended.	Proximal and/or gingival extensions are in contact or obviously overextended.	Proximal and/or gingival extensions are grossly overextended.
	Optimal treatment of fissures.	Near optimal treatment of fissures.	Adequate treatment of fissures. Neither the tooth nor restoration is compromised.	Inadequate treatment of fissures will compromise the tooth or restoration.	Lack of treatment of fissures will seriously compromise the tooth and restoration.
	Proximal cavosurface angles are equal to or slightly greater than 90°. The integrity of both tooth and restoration is maintained.	Cavosurface angles are not optimal, but do not compromise the integrity of the tooth or restoration. Cavosurface has small areas of minor roughness.	Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration.	Improper cavosurface angles or rough cavosurface will cause the final restoration to fail.	Cavosurface angles are grossly improper. Cavosurface has multiple major areas of roughness and/or enamel weakness that will cause the restoration to fail.
INTERNAL FORM	Pulpal floor depth as determined by the lesion or defect does not exceed 2.0 mm from the cavosurface. Axial wall depth at the gingival floor is 1.0 mm-1.5 mm.	Pulpal floor and/or axial wall is slightly shallow or deep.	Pulpal floor and/or axial wall is moderately shallow or deep.	Pulpal floor and/or axial wall is critically shallow or critically deep.	Walls and/or floors are grossly deep. Gross removal of tooth structure jeopardizes the tooth or pulp.  Unapproved surface prepared.
	Conventional design: Internal form is smooth and flowing and has no sharp angles that could weaken or cause voids in the final restoration.	Conventional design: Internal form is mostly smooth and flowing, but some minor roughness and/or sharp angles are present.	Conventional design: Internal form is generally smooth and flowing, but some moderate roughness and/or sharp angles are present.	Conventional design: Internal form is rough and unfinished with major areas of roughness or sharp angles that will lead to restoration failure.	Conventional design: Internal form is grossly rough and/or has gross sharp angles that will lead to restoration failure.
OPERATIVE ENVIRONMENT	No damage to the adjacent tooth.	Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.	Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	Damage to the adjacent tooth will require restoration.

Figure 1. Scoring criteria definitions for the Simulation Class II Composite Preparation, 2020.

OPERATIVE SIMULATION CLASS II – AMALGAM PREPARATION					
SCORING CRITERIA RATING SCALE					
	5–Optimal	4–Appropriate	3–Acceptable	2–Inadequate	1–Unacceptable
OUTLINE & EXTENSION	Outline is generally smooth and flowing and does not weaken tooth in any manner.	Outline is slightly irregular but does not weaken tooth. Isthmus is slightly wider than required.	Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow.	Outline severely weakens marginal ridge or a cusp. Outline is misshapen and/or forces improper angle of exit.	Outline is grossly improper and/or lacks any definite form.  Unapproved surface prepared.
	Proximal and gingival extensions are visually open less than 1.0 mm	Proximal and/or gingival extensions are slightly overextended.	Proximal and/or gingival extensions are moderately overextended.	Proximal and/or gingival extensions are in contact or obviously overextended.	Proximal and/or gingival extensions are grossly overextended.
	Optimal treatment of fissures.	Near optimal treatment of fissures.	Adequate treatment of fissures. Neither the tooth nor restoration is compromised.	Inadequate treatment of fissures will compromise the tooth or restoration.	Lack of treatment of fissures will seriously compromise the tooth and restoration.
	Proximal cavosurface angles are approximately 90°. The integrity of both tooth and restoration is maintained.	Cavosurface angles are not optimal, but do not compromise the integrity of the tooth or restoration. Cavosurface has small areas of minor roughness.	Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration.	Improper cavosurface angles or rough cavosurface will cause the final restoration to fail.	Cavosurface angles are grossly improper. Cavosurface has multiple major areas of roughness and/or enamel weakness that will cause the restoration to fail.
INTERNAL FORM	Proximal walls are clearly convergent occlusally.	Proximal walls are barely convergent occlusally.	Proximal walls are parallel or divergent in one area.	Proximal walls are critically divergent occlusally.	Proximal walls are grossly divergent occlusally.
	Pulpal floor is 1.5 mm-2.0 mm from the cavosurface and provides adequate bulk for strength of restorative material. Axial wall depth at the gingival floor is 1.0 mm-1.5 mm.	Axial wall and/or pulpal floor is slightly shallow or deep, but still provides adequate bulk for strength of restorative material.	Axial wall and/or pulpal floor is moderately shallow or deep, but still provides adequate bulk for strength of restorative material.	Axial wall and/or pulpal floor is critically shallow or deep and does not provide adequate bulk for strength of restorative material.	Walls and/or floors are grossly deep. Gross removal of tooth structure jeopardizes the tooth or pulp.  Unapproved surface prepared.
	Conventional design: Internal form is smooth and has no sharp angles. Retentive grooves, if placed, are near ideal. Axial wall follows external contour of the tooth.	Conventional design: Internal form is mostly smooth, but some minor roughness and/or sharp angles are present. Retentive grooves, if placed, are adequate. Axial wall contour is near optimal.	Conventional design: Internal form is generally smooth, but some moderate roughness and/or sharp angles are present. Retentive grooves, if placed, are too deep or too shallow, or placed in an incorrect location. Axial wall contour is not optimal.	Conventional design: Internal form is rough and unfinished with major areas of roughness or sharp angles that will lead to restoration failure. Retentive grooves, if placed, are too deep or too shallow, or placed in an incorrect location, and will compromise the tooth or restoration.	Conventional design: Internal form is grossly rough and/or has gross sharp angles that will lead to restoration failure. Gross disregard for proper placement of retentive features will compromise the tooth and restoration.
OPERATIVE ENVIRONMENT	No damage to the adjacent tooth.	Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.	Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	Damage to the adjacent tooth will require restoration.

Figure 2. Scoring criteria definitions for the Simulation Class II Amalgam Preparation, 2020.

OPERATIVE SIMULATION CLASS III – COMPOSITE PREPARATION SCORING CRITERIA RATING SCALE					
	5–Optimal	4–Appropriate	3–Acceptable	2–Inadequate	1–Unacceptable
OUTLINE & EXTENSION	Outline provides optimal convenience form (access for caries removal and insertion of restorative material).	Outline is slightly over or under extended.	Outline is moderately over or under extended. Outline is moderately irregular but does not weaken the tooth.	Outline is severely over or underextended.	Outline is grossly improper and/or lacks any definite form.
	Gingival extension is visually open up to 0.5 mm. Facial (or lingual) extension may break proximal contact up to 0.5 mm.	Outline is slightly irregular but does not weaken the tooth.	Gingival margin is moderately overextended.	Gingival wall is in contact or obviously overextended.	Gingival wall is grossly overextended.
	Incisal contact is not broken. Includes proximal contact area.	Includes proximal contact area with slight variation.	Includes proximal contact area with moderate variation.	Incisal extension has broken contact.	Unapproved surface prepared.
	Cavosurface forms a smooth continuous curve with no sharp angles.	Cavosurface is slightly irregular and rough; no sharp angles.	Cavosurface is moderately irregular and rough. A few sharp angles are present.	Mostly below proximal contact area where caries would be expected.	Wholly below proximal contact area where caries would be expected.
	There are no acute cavosurface angles.	Cavosurface angles are not optimal, but do not compromise the integrity of the tooth or restoration.	Cavosurface angles possibly compromise the integrity of the tooth or restoration.	Cavosurface is severely irregular and/or with sharp angles.	Cavosurface has multiple gross irregularities that will cause the restoration to fail.
INTERNAL FORM	Axial wall follows external contour of tooth.	Axial wall generally follows external contour of tooth.	Axial wall does not follow contour of tooth.	Cavosurface angles will lead to enamel fracture or fracture of the restoration.	Cavosurface angles are grossly inappropriate for the situation and will lead to fracture of the restoration.
	Depth does not exceed 1.0 mm beyond the DEJ.	Depth does not exceed 1.5 mm beyond the DEJ.	Depth does not exceed 2.0 mm beyond the DEJ.	Axial wall depth exceeds 2.0 mm beyond the DEJ.	Gross removal of tooth structure jeopardizes the tooth or pulp.
	Internal line angles are rounded and smooth.	Internal walls are well defined and rounded but have some slight irregularities.	Internal walls are rounded, but moderately rough, irregular, and not defined.	Internal walls are severely irregular and not defined.	Grossly irregular and sharp line angles show total disregard for the health of the tooth.
	Internal walls are well defined.		Moderately sharp line angles are present.	Angle of walls undermines enamel, jeopardizes incisal angle, or encroaches on the pulp.	
OPERATIVE ENVIRONMENT	No damage to the adjacent tooth.	Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.	Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.	Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.	Damage to the adjacent tooth will require restoration.

Figure 3. Scoring criteria definitions for the Simulation Class III (Composite) Preparation, 2020.

OPERATIVE SIMULATION FINISH RESTORATION SCORING CRITERIA RATING SCALE					
	5–Optimal	4–Appropriate	3–Acceptable	2–Inadequate	1–Unacceptable
ANATOMICAL FORM	Anatomical form is consistent and harmonious with contiguous tooth structure.	Slight variation in normal anatomical form is present.	Moderate variation in normal anatomical form is present.	Anatomical form is improper. Marginal ridge is poorly shaped.	There is gross lack of anatomical form.
	Proper proximal contour and shape are restored.	There is slight variation of proximal contour and shape.	There is moderate variation of proximal contour and shape.	Anatomy is too deep or too flat.	
	Normal proximal contact area and position are restored.	There is slight variation of normal contact area and position.	There is moderate variation of normal contact area and position.	Proximal contour is poor. Embrasures are severely over or under contoured.	Grossly improper proximal contour or shape.
	Contact is visually closed and resists the passage of lightly waxed floss.	Contact is visually closed and resists the passage of lightly waxed floss.	Lightly waxed floss will pass through the contact with slight resistance.	Contact is visually open; contour is pointed and sharp; or so broad, flat or tight that floss will not pass easily pass through the contact.	Contact is grossly open; contour terminates far from the adjacent tooth or the restoration is bonded to the adjacent tooth.
MARGINS	There are no excesses or deficiencies anywhere along margins.	Slight marginal excesses and/or deficiencies are present.	Moderate marginal excesses and/or deficiencies are present.	A deep open margin is present, or critical excesses or deficiencies are present.	Multiple open margins, or gross excesses, or deficiencies, are present.
FINISH, FUNCTION & DAMAGE	The surface is smooth with no pits, voids or irregularities.	Slight surface irregularities, pitting, or voids are present.	Moderate surface irregularities, pitting, or voids are present.	A marginal overhang catches floss.	A gross marginal overhang shreds floss.
	There is no damage to hard or soft tissue.	Minor damage to hard or soft tissue is evident.	Moderate damage to hard or soft tissue is evident.	Critical surface irregularities, pitting, or voids are present.	Gross surface defects are present and/or the restoration is grossly fractured.
				Severe damage to hard or soft tissue is evident. Open contact risks trapping food debris or overly tight contact makes flossing difficult.	Gross mutilation of hard or soft tissue is evident. Grossly open contact exposes interdental col to potential trauma or fused teeth make flossing impossible.

Figure 4. Scoring criteria definitions for the Simulation Class II and Class III Finishes, 2020.



### Scoring and Results Reporting

Performance for each preparation and finish, is graded by three independent and anonymous examiners who are calibrated to the scoring criteria prior to every examination. Each preparation or finish is scored on the applicable criteria according to rating scales presented above. Examiners are trained to assign a particular grade on the scale only when *all* aspects of performance described for that level have been demonstrated. For example, if performance on the criterion under review meets most aspects of the definition for a grade of “3” but does not quite meet the standard for even one aspect of the definition, then the grade assigned will be a “2,” at most. This holds for all six criteria per restoration.

The median of the three examiner grades is computed for each criterion and is weighted to reflect the level of criticality relevant to minimally competent treatment, e.g., Outline and Extension accounts for 46% of the preparation score and Operative Environment accounts for only 15%. The criterion weights are provided in Tables 2a and 2b.

Tables 2a and 2b. *Operative Simulation Scoring Criteria and Weighting: Preparation, Finish*

Preparation Criteria and Weighting		Finish Criteria and Weighting	
Outline & Extension	46%	Anatomical Form	36.5%
Internal Form	39%	Margins	36.5%
Operative Environment	15%	Finish, Function & Damage	27%

The mean of the preparation and finish scores is the restoration procedure score. The mean of the two procedure scores, after any applicable penalties or deductions, is the final Operative Simulation Section score.

The passing cut score on the Operative Simulation Section is 3.00, which reflects minimally competent performance within the five-point rating scale for all criterion grades that contribute to the final section score. Each performance level definition for a score of 3.00 on a criterion has been worded to describe performance that would be deemed minimally competent via consensus of the subject matter experts on the Operative section examination committee. While methods of standard setting applied to selected-response assessment often rely on SMEs evaluating each test question based on how each SME believes a minimally competent examinee would

perform, standard setting for many performance-based assessments involves defining minimum expectations that can be observed directly in the candidate's performance. The performance level definitions (Figures 1 through 4), as developed by the examination committee, are critical to guiding examiner grading. The definitions are used to describe examples of clinical performance reviewed during examiner training and calibration, which provides performance benchmarks to facilitate examiner adherence to the criteria and a high degree of examiner agreement.

While limitations on travel and group activity size due to COVID-19 remain in effect, the grading of candidate performance will take place in grading sessions after the examination. While this reduces the number of examiners traveling to and grading at the examination site, it also prevents candidates from receiving onsite results immediately. Candidates and state licensing boards will receive results as soon as possible after grading sessions are held. Results reports will indicate clearly whether the Operative Examination was a simulation or involved the treatment of a patient. As with all WREB examinations, results of all examination attempts, regardless of pass or fail outcome, will be available to state licensing boards.

### **Examiner Training and Calibration**

Most examiners are members or designees of their state boards. A small proportion (e.g., approximately twenty percent of examiners in 2019) are dental educators. All examiners must be actively licensed and in good standing, with no license restrictions, and submit proof of license renewal annually. Under social distancing restrictions, the only examiners that may be present at the Operative Simulation Section may be the Chief Examiner and one or more Floor Examiners, depending on the layout and size of the examination environment. There will not be any grading examiners at the examination site unless social distancing and travel guidelines have been eased enough to allow this. Under the current restrictions, grading examiners will grade candidate performance in grading sessions, separate from the examination environment. Grading examiners still will need to complete examiner self-assessments and calibration testing prior to grading.

Clinical examination scores are dependent upon the judgments of grading examiners. A high degree of examiner agreement is critical to assessing candidate ability in a reliable and fair manner. As with the conventional Operative Examination, scoring judgments on the Operative Simulation Section are made by three independent examiners. The median of the three grades

assigned contributes to the candidate's score. The median is more robust to extreme grades assigned than the mean (i.e., conventional average).

Having multiple examiners helps to moderate the effects of varying levels of examiner severity; however, it is essential that all examiners are trained and calibrated to an acceptable level of agreement with respect to the scoring criteria for the examinations in which they participate. Examiners must participate in orientation and calibration sessions that take place before every examination or grading session. During calibration, examiners take assessments (tests) in which they grade examples of clinical performance according to the grading criteria. Their judgments are compared to scores that have been previously selected by the examination committees as representative of the defined levels in the criteria. The examiner team completes calibration tests until they each have demonstrated that they understand and can consistently apply WREB criteria in their assessments. All calibration tests are reviewed regularly for content and psychometric quality by WREB examination committees.

Examiners receive feedback on their performance after each examination. Examiners with low percentages of agreement, high percentages of harshness or lenience, or erratic grading patterns are counseled, remediated, and monitored to ensure increased understanding of criteria definitions. Continued lack of agreement results in dismissal from the examination pool.

The two main approaches employed to evaluate examiner performance include a review of examiner agreement which reflects the degree of exact and adjacent agreement and an estimation of examiner severity employing a probabilistic statistical model which is designed to account for and quantify potential sources of construct-irrelevant variance such as rater bias and error. With three examiners there are multiple ways to define and track examiner agreement. WREB uses a conservative computation of exact and adjacent agreement which involves comparing each examiner rating, i.e., each individual grade assigned to a particular criterion, to the mean of the other two raters' grades assigned for the same criterion, within the same examination attempt. Examiner ratings that may be adjacent to the rating of another rater may still be categorized as harsh or lenient since agreement is defined as the rating falling within one scale point of the *mean* of the other two ratings. Examiner severity is estimated using the Many-faceted Rasch Model (Linacre, 1994; Rasch, 1960/1980) and allows examiner performance to be compared to the performance of all other examiners within the examiner pool along a continuum of harshness to lenience and provides statistical information regarding rater errors such as erratic grading or

grading that shows too little discernment among performance levels (e.g., assigning all or mostly “3”s). Additional details regarding methods and results of examiner evaluation are provided in the WREB Dental Examination Technical Report (WREB, 2019a)

### **Field Testing of the Operative Simulation Section: Overview**

Two Operative Simulation field-tests were planned and conducted between March and May of 2020. A total of 79 dental students from two dental schools participated; three students attempted the examination twice resulting total of 82 attempts. These students planned in advance to challenge the field test examination twice.

The planning of the field tests included the review and revision of the Operative scoring criteria, creating a candidate guide for field test candidates, coordinating with each school to produce social distancing and infection prevention protocols, and developing examiner training and calibration materials.

One field test was conducted on March 30, 2020 at the University of Oklahoma with 20 dental students. A second field test was held on April 1 and 2, 2020 at the University of Utah with 59 dental students. WREB has already been conducting conventional clinical dental examinations at these two schools and their campuses were reasonably accessible to WREB’s dental consultants, given the limitations and recommendations regarding travel due to COVID-19. Oklahoma and Utah are the states of residence of WREB’s two consulting SME dentists, who oversee examination development and administration. The field test conducted at the University of Oklahoma used a simulated tooth constructed of a harder material which generated student concerns reflected in the post-examination candidate survey comments. The second field test, conducted at University of Utah, employed the final choice of material which did not elicit these concerns.

### **Initial Field Test Results: Faculty-graded**

The performance of the 20 field test candidates who attempted the Operative Simulation at the University of Oklahoma were initially graded by their faculty to partially fulfill program competency requirements. The 20 scores based on the University of Oklahoma faculty grading ranged from 2.94 to 4.37, with a mean score of 3.72 ( $SD = 0.41$ ). Candidate scores ( $N = 57$ ) from the same university taking the WREB Operative section during the 2019 season ranged from 3.13

to 4.87, with a mean score of 3.90 ( $SD = 0.40$ ). The field test results were not as high as the examination results from 2019, but an independent samples  $t$ -test conducted to compare the results indicated that the difference is not significant, with a value of  $t(df = 75; \alpha = 0.05) = 1.67$  and mean difference of 0.17 ( $p = 0.10$ ; 95% CI: -0.03, 0.38). The comparison is based on a small sample but provides an initial indication of comparability. There was also no notable difference between mean scores of the anterior tooth (3.73,  $SD = 0.51$ ) and the posterior tooth (3.71,  $SD = 0.44$ ) for the faculty-graded teeth.

After the examination and the grading conducted by faculty, some of the teeth that had been treated by the candidates at the University of Oklahoma field test were modified to reflect specific descriptors in the scoring criteria. These modified teeth and examples of candidate performance were then used in developing examiner training materials. The resulting preparations and finished restorations were photographed and used as exemplars in examiner training and calibration testing. The modified teeth will be graded along with the field-test performances from the other field test examination site, but will also be analyzed separately, as they do not represent the candidates' original performance.

### **Treatment Times**

Candidates were allowed up to four hours to complete the Operative Simulation Field Test. The time spent preparing the preparations and the finishes was recorded for each field-test attempt to determine if the initial time allotted was sufficient. The average total time used for the 82 field test attempts was 2 hours, 10 minutes (130 minutes). The least amount of time needed was 1 hour, 22 minutes and the longest amount of time needed was 3 hours, 52 minutes. All but four candidates (4.8%) completed their procedures in less than 3 hours and 30 minutes. The University of Oklahoma site used more treatment time due to additional time needed for set-up between the preparation and finish procedures. The need for this additional time was eliminated with the use of a single tooth material for the second field test. The time allotted for the examination going forward was reduced to 3 hours and 30 minutes. Table 3 shows the treatment times per field test site.

Table 3. Operative Simulation Treatment Times in Minutes by Field Test Site.

Field Test Site	<i>N</i>	Minimum	Maximum	Mean
	Attempts	Treatment Time	Treatment Time	Treatment Time ( <i>SD</i> )
Univ. of Oklahoma	20	106 min	232 min	174 min (37.5)
Univ. of Utah	62	82 min	190 min	116 min (20.7)
Total	82	82 min	232 min	130 min (35.6)

### Field-Test Candidate Survey Results

Students who participated in one of the two Operative Simulation field tests were sent a link to an online survey. The response rate was 53% (42 out of 79 individual field-test candidates); with a slightly higher response rate for University of Oklahoma participants (65%) than University of Utah participants (49%). Survey responses assisted the development of the examination by prompting improvements to the Candidate Guide and examination schedule and by supporting the final determination of simulated tooth material.

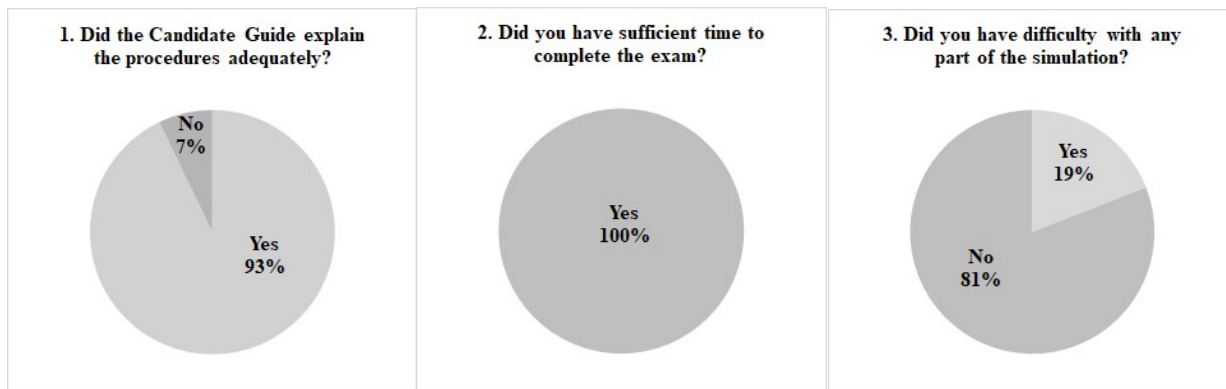
There were seven main questions and all questions offered the option to provide comments. There was a section for additional comments or suggestions at the end. Results for the seven questions are listed below, with a summary of responses and examples of comments.

The first three questions asked about the Candidate Guide, time allotted and whether the field-test candidate had any difficulty with any part of the simulation:

1. Did the Candidate Guide explain the procedures adequately?
2. Did you have sufficient time to complete the exam?
3. Did you have difficulty with any part of the simulation?

Only three of the 42 field-test candidates (93%) responded “No” to Question 1 (Figure 5a) regarding the Candidate Guide. All three noted that the guide could be more clear regarding the depth and extension of the preparation without needing to request extensions and wording to make this clear has been added to the Candidate Guide. All 42 field-test candidates responded that they

had sufficient time to complete the examination (Figure 5b). Eight of the 42 respondents (19%) expressed difficulty with part of the simulation (Figure 5c). In the optional comments, most of these concerns were about the difficulty of adjacent teeth having differing degrees of hardness; all were from field-test candidates at the University of Oklahoma, where a different tooth material was tested. The material that was employed at the second field test did not elicit these concerns and is the final choice of material planned for the Operative Simulation Section.



Figures 5a, b, c. Proportion of Yes or No responses to Field-Test Survey Questions 1, 2 and 3.

Question 4 asked about the level of challenge posed by the examination, overall.

4. Overall, was the exam easy, moderate, or difficult?"

Most respondents (37 of 42 or 88%) answered “Moderate” to Question 4 (Figure 6). Most comments offered regarding Question 4 compared the simulated teeth to natural teeth, e.g., “Going back to cutting on typodonts is always a readjustment! But definitely a valid test of hand skills. Certain aspects are more difficult and certain aspects are less difficult compared to treating human patients” and “The teeth were much softer, so probably required more dexterity than doing it on an actual person but very doable.”

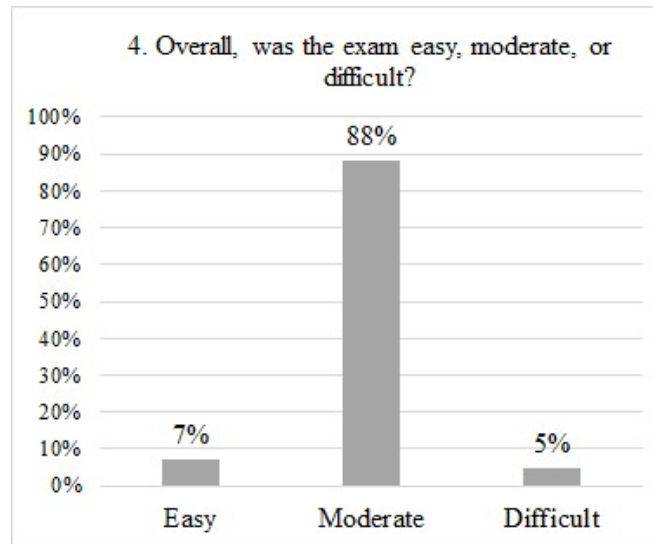


Figure 6. Proportion of different responses to Field-Test Survey Question 4.

Questions 5 and 6 asked about the degree of challenge specifically regarding the preparation and the finish, respectively. Five response options were provided, ranging from Much Less Challenging to Much More Challenging.

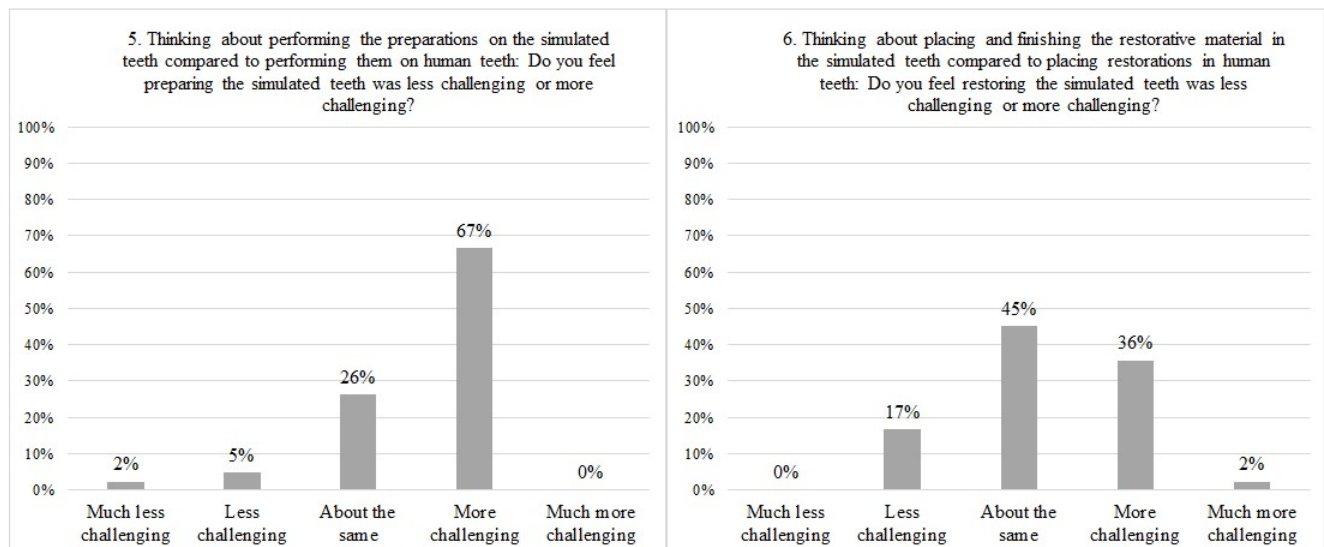
5. Thinking about performing the preparations on the simulated teeth compared to performing them on human teeth: Do you feel preparing the simulated teeth was less challenging or more challenging?
6. Thinking about placing and finishing the restorative material in the simulated teeth compared to placing restorations in human teeth: Do you feel restoring the simulated teeth was less challenging or more challenging?

Many field-test candidates responded “About the Same” or “More Challenging” to Questions 5 and 6, with 93% (Question 5 regarding preparations) and 81% (Question 6 regarding placing and finishing) responding in one of these two categories (Figures 7a and 7b). The preparations were considered “More Challenging” by 28 of 42 (67%) and respondents’ comments were similar to those made about tooth material on Question 4, e.g., “Because simulated teeth are much softer, I feel it takes more skill, accuracy and care to complete the exam” and “You have to have a lot better hand skills on the typodont teeth due to the fact that they are softer. You have to really be good at placement and control of the burr. It also requires better restorative placement as it's easier to



accidentally remove tooth while finishing and polishing.” An example comment from one of the eleven (26%) respondents who selected “About the Same” stated, “More challenging due to the lack of recent practice on teeth with this hardness, but less challenging due to known parameters and no need for modifications.”

Nineteen of 42 (45%) respondents felt that the placing and finishing of the teeth was “About the Same” but only a few offered comments, e.g., “Less challenging due to no need for etching, more challenging from the difference in stability (possible loose screws, extremely tight contacts, no wedging ability).” The source of the loose screws was identified and remedied prior to the second field test. Most comments were associated with the fifteen (36%) responses of “More Challenging,” and involved the tooth material, e.g., “I felt placing the material was the same but polishing and removing flash was much more difficult on typodont teeth” and “Polishing composite on real teeth is MUCH easier than polishing on typodont teeth.” The few comments that accompanied the seven (17%) responses of “Less Challenging” reflected dryness and isolation, e.g., “Obviously, there isn’t any saliva, so keeping a dry field is simple” and “Better isolation.”



Figures 7a, b. Proportion of different responses to Field-Test Survey Questions 5 and 6.

Question 7 asked about the ability to maintain social distancing at the examination.

7. How difficult was it for you to maintain social distancing during the examination?

Most field-test candidates (39 of 42 or 93%) responded that it was “Easy” to maintain social distancing during the examination (Figure 8). All but one comment were associated with responses of “Easy.” Examples include “Really strict and functional rules in place. Wasn’t a problem at all” and “I was at least ten feet away from anyone else in the room at all times.” The other comment, associated with a response of Moderate, stated, “During the announcement portion of the exam, prior to the beginning, it was moderately difficult to maintain social distancing and adequately hear the announcements and questions.” Plans have been implemented for additional information to be provided early to candidates, allowing for questions by phone or email prior to the examination to reduce the need for multiple announcements and possible reasons to encourage crowding.

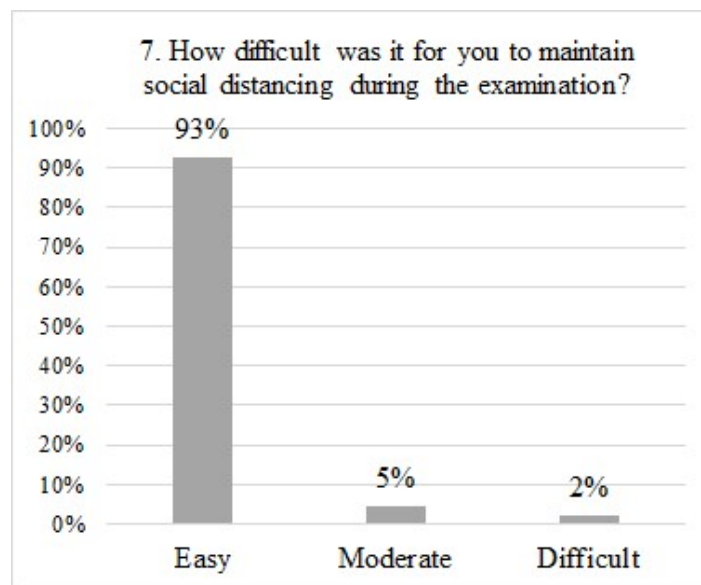


Figure 8. Proportion of different responses to Field-Test Survey Question 7.

Field-test candidates could offer additional comments or suggestions at the end of the survey. Many comments were generally positive or expressed thanks, e.g., “Overall it was great!” and several expressed their interest that this type of restorative examination be an acceptable option

going forward, e.g. “Replace patient exams with typodonts!” Some comments were concerned with the current situation related to COVID-19, e.g., “I think this is a great way to test in a safe environment given the circumstances of the class of 2020.” Most comments reinforced earlier comments regarding tooth material that, as noted above, will not apply, given the final choice of tooth material for the simulation examination. Suggestions regarding the schedule of treatment within the examination were offered by field-test candidates at the first field test; the timing in the second field-test was structured without interruption between the completion of preparations and finishes and is the final schedule planned for the examination.

### **Field-Test Grading Session Overview**

Seven examiners participated in the April 30 – May 1 Operative Simulation field-test grading session, completing calibration exercises and tests prior to grading. Social distancing and infection prevention measures were followed, to ensure the safety of examiners and staff while using electronic scoring equipment and handling arches during grading.

On the first day, five examiners were able to complete the grading of all 82 attempts on the Operative Simulation field tests, with three sets of grades per attempt. On the second day, two additional examiners regraded the attempts, resulting in a total of four sets of grades per attempt. Candidate results and examiner performance were analyzed for the first day, which reflects conventional grading procedures, i.e., three examiners per attempt, as well as with the additional sets of grades from the second day combined, to obtain additional information, statistics and feedback regarding e.g., the effectiveness of calibration, the generalizability of grading criteria, and the performance of field-test candidates.

### **Field-Test Examiner Performance**

Field-test examiner performance was evaluated via two approaches: examiner agreement statistics and examiner severity estimation. Examiner agreement was computed on the examiner team that completed grading on the first day. Examiner severity was conducted with and without the additional grades assigned on the second day. An overview of methods are described above on page 15 and in additional detail in technical reports, e.g., WREB Dental Examination Technical Report (WREB, 2019a).

Percentages of agreement were computed for the three sets of grades assigned on the first day of grading, as would be conducted for an actual examination after all three sets of grades per attempt have been assigned. Over the past ten years, percentages of agreement for the standard Operative Section have ranged from 88.4% to 89.9%, with comparatively balanced percentages of harshness and lenience. Examiner agreement over the years reflects examiner grading teams that have been selected for each examination based on their past examiner performance to ensure an optimal balance of examiner severity level. While nearly all examiners perform within recommended ranges of harshness and lenience percentages, to assign all the examiners that have performed at one end of that continuum to a single examination could introduce a systematic bias. The examiners who participated in the field-test grading session were scheduled based on location and convenience, given the conditions posed by COVID-19. The field-test examiners also included two relatively new examiners, who would not be assigned to the same examination under conventional conditions. Despite these potential threats to optimal examiner team performance, examiner agreement statistics for the field-test grading session were comparable to percentages of agreement, harshness, and lenience for the standard Operative section in previous years. Table 4 provides examiner agreement percentages for the standard Operative Section from the 2019 season and for the Operative Simulation field test grading session.

Table 4. *Percentages of Examiner Agreement, Harshness, and Lenience: Standard Operative Section and Operative Simulation Field Test*

	N Examiners	% Harsh	% Lenient	% Agreement
Standard Operative Section 2019 Season	110	5.5%	5.3%	89.2%
Operative Simulation Field Test Day 1	5	5.6%	5.7%	88.7%

Examiner severity estimated with the many-faceted Rasch model, is reported in Table 5, which provides summaries of results in logit, i.e., log-odds, units. High negative logits reflect more lenience and high positive logits reflect more harshness. For the standard Operative Section examination, most examiners fall within one logit unit of the mean, i.e., between -1.00 and 1.00, and within recommended ranges with respect to infit and outfit mean-square fit statistics, i.e.,

between 0.50 and 1.50. Examiner severity estimates for the first day of the Operative Simulation field test and for all Operative Simulation field-test examiners reflect smaller ranges with no outlying values. Additional details of the Many-faceted Rasch Model analyses are provided later with the results of field-test candidate performance.

Table 5. *Many-Faceted Rasch Model Examiner Severity Analysis Indicators in Logits: Standard Operative Section and Operative Simulation Field Test (Number of examiners provided below each header)*

Indicator	Standard Operative Section 2019 Season ( $N_E = 110$ )	Operative Simulation Field Test Day 1 ( $N_E = 5$ )	Operative Simulation Field Test All ( $N_E = 7$ )
Severity Measure Logit (Range)	-0.88 – 1.06	-0.41 – 0.44	-0.33 – 0.52
Standard Error (Range)	0.05 – 0.16	0.05 – 0.07	0.05 – 0.07
Severity Measure Logit Mean <sup>a</sup>	0.0	0.0	0.0
Severity Measure Logit <i>SD</i>	0.42	0.33	0.31
Infit Mean-Square (Range)	0.54 – 1.77	0.71 – 1.25	0.66 – 1.38
Outfit Mean-Square (Range)	0.52 – 1.72	0.72 – 1.22	0.66 – 1.32

<sup>a</sup> Mean of examiner severity parameters constrained at 0.

### Field-Test Examiner Survey Results

The seven examiners who participated in the Operative Simulation field test grading session were sent a link to an online survey. The response rate was 100%. There were eight main questions and all questions offered the option to provide comments. There was a section for additional comments or suggestions at the end. Results for the eight questions are listed below, with a summary of responses and examples of comments.

Examiners responded unanimously to the first five questions, which asked about materials, instrumentation provided, difficulty of the grading tasks, as well as their understanding of, and ability to follow, the social distancing protocol. Possible responses to the first five questions were

Yes or No, except for Question 3, with possible responses of Easy, Moderate, or Difficult. The first five questions and the common responses are provided in Table 6.

Table 6. *Operative Simulation Grading Session Field-Test Examiner Survey Questions 1 to 5 with Responses*

Questions 1 to 5	Unanimous Response
1. Did the Candidate Guide and Examiner Manual adequately explain the simulation and grading procedures?	Yes, 100%
2. Were the social (physical) distancing instructions clear and easy to understand?	Yes, 100%
3. How difficult was it for you to maintain appropriate social (physical) distancing while serving as an examiner?	Easy, 100%
4. Did you have difficulty with any of the grading tasks?	No, 100%
5. Was the instrumentation provided for your use, everything you needed?	Yes, 100%

Optional comments associated with the first five questions were positive, e.g., regarding ability to maintain social distancing, (Question 3), “I felt very safe” and regarding grading tasks (Question 4), “Calibration was well orchestrated and provided the preparation necessary for us as examiners to perform efficiently and effectively. Nice job!”

Question 6 asked the field-test examiners about how well the calibration exercises prepared them for grading. Figure 9 illustrates the percentages of each response. Five examiners (71%) responded “Very well.” One commented, “It was my first time actually grading so it was very helpful to me.” Two (29%) responded “Well enough” accompanied by the following two comments, “Too detailed which sometimes can create more issues than being useful” and “This was a new exam but we made do,” which suggest that continued review and refinement may be useful. The criteria has already been evaluated and edited based on examiner feedback.

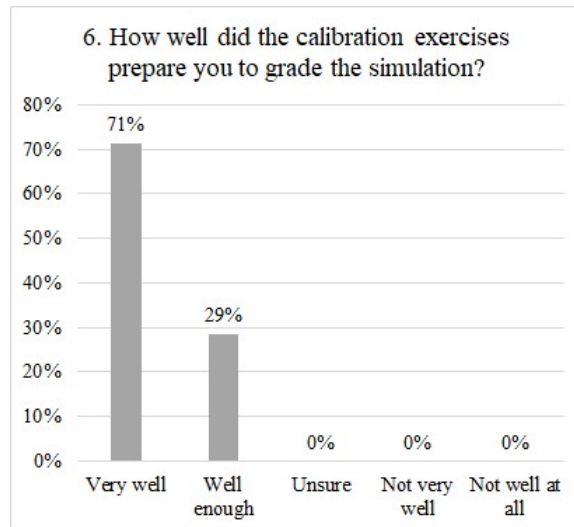


Figure 9. Proportion of different responses to Examiner Survey Question 6.

The grading criteria are nearly the same as the criteria used for the standard Operative Section, except for the removal of a few items, such as caries, pulp exposure and rubber dam isolation that do not apply for the Operative Simulation section. Question 7 asked the field-test examiners how well the modified criteria work for the simulation. Figure 10 shows the percentages of each response. Six examiners (86%) responded “Very well” or “Well enough,” evenly split between the two responses. One examiner responded “Unsure.” Only one comment was offered, “I think it’s easier to see mistakes on a manikin than in the mouth.”

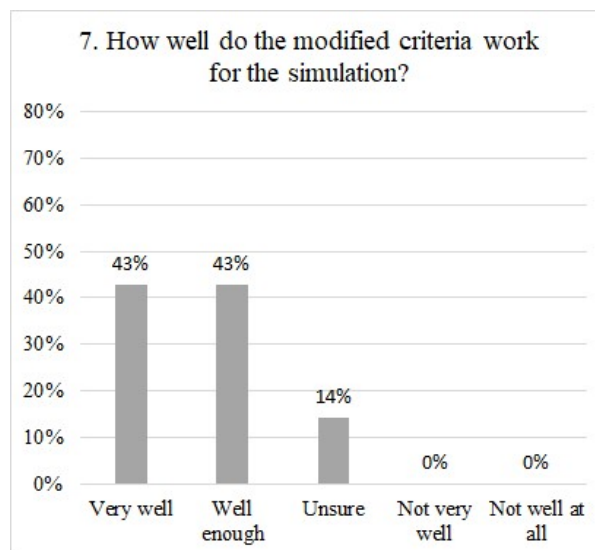


Figure 10. Proportion of different responses to Examiner Survey Question 7.

Question 8 asked field-test examiners whether they felt it was easier or more difficult to assess candidate performance with each candidate having received the same preparations. Figure 11 shows the percentages of each response. Five examiners (71%) felt it was easier, with four of them responding “Definitely easier” and one, “Somewhat easier.” Two examiners (29%) responded “About the same.” Comments included, “I would say that it levels the playing field and we still saw plenty of variation in performance for the finished restoration. Good simulation”, “It was more fair to the candidates!”, “Loved that part” and “As you see the same procedures over and over it becomes easy to compare and evaluate.”

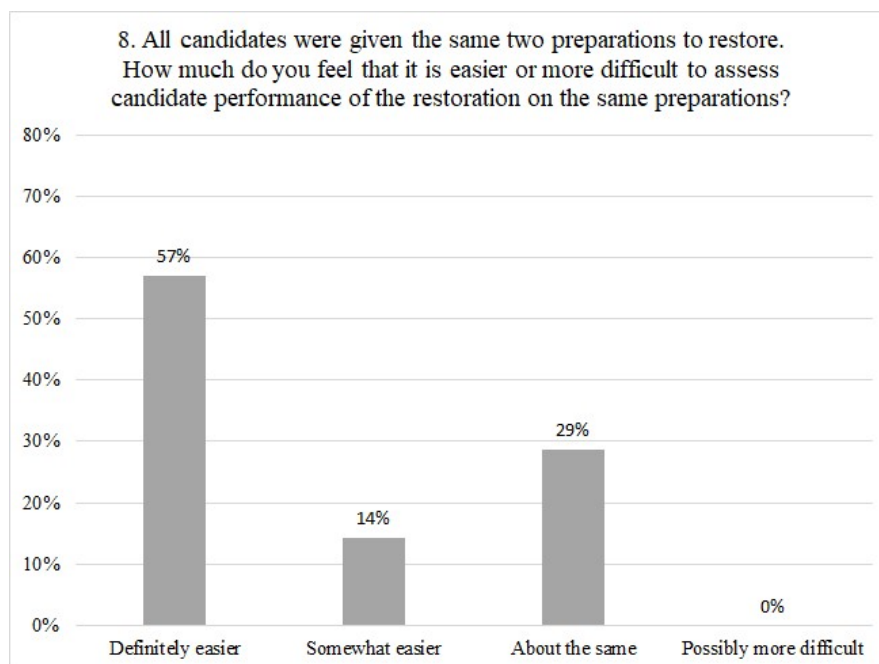


Figure 11. Proportion of different responses to Examiner Survey Question 8.

The section at the end inviting other comments or suggestions elicited one generic positive comment and two substantive comments suggesting that the Operative Examination Committee should consider including a means of failing or deducting points for examiner-validated gross open contact, e.g., “Grading for open contact is somehow still passing the candidate which I think it needs to be one of the automatic failure situations.” Changes to criteria descriptors that will impact scoring and address the suggestions made in the comments have been prepared and recommended to the committee for implementation.



### **Field Test Results: Candidate Performance and Test Quality**

Table 7 provides basic descriptive statistics for the raw and weighted means of medians computed from the three sets of examiner grades for each criterion. Direct comparisons to the standard Operative Section, particularly regarding criterion scores, are limited due to three factors. One is that only 5.5% of procedures performed for the standard Operative Section in 2019 were Class III procedures. All field-test attempts on the Operative Simulation Section included a Class III procedure. Since 2018, most states are accepting the results of performance on one Class II procedure if competence is demonstrated, so many candidates are completing Class II procedures. Years of Operative Section data have shown that the Class III is slightly, but significantly, less challenging than any Class II procedure and therefore, if completed, must be in combination with a Class II procedure. The second limiting factor is that many arches completed in the first, smaller field test, were modified to create additional exemplars of grading criteria performance levels during the development calibration materials and some performance levels may not be distributed within the sample in a comparable manner. The third factor is that the field-test host schools, which were chosen for location and convenience, given the conditions posed by COVID-19 and their students may not be a representative sample of all potential candidates.

Despite field-test limitations to direct comparison, three criteria and final scores (which include point deductions from penalties and loss of all points due to critical errors) were highly comparable. The slightly higher final score mean reflects a more negatively skewed distribution in the field test data; the passing percentage is actually somewhat lower for the field test than the standard Operative section in 2019. The significantly higher means of raw scores and some criteria for the field-tests may be related to the difference in procedure type in the comparison, particularly for Anatomical Form and Margins, which have traditionally scored significantly higher for the Class III procedure. Recent additions, since the field-test, to the criterion definitions for Internal Form related to grading examiner feedback are also expected to result in higher comparability.

Table 7. *Grading Criteria and Section Scores for Standard Operative Section and Operative Simulation Field Test: Means and Standard Deviations of Raw Unweighted Class II Median Criterion Scores, Raw and Final Scores, with t-Tests. Included are t values, probability values (p), effect size values (Cohen's d) degrees of freedom (df), and alpha level ( $\alpha$ ), i.e., significance below 0.05. Number of procedures noted as  $N_p$ , number of attempts noted as N.*

	Standard Operative Section 2019 $N_p = 2,553^a$		Operative Simulation Field Test 2020 $N_p = 164^a$		t-tests $df = 2,715; \alpha = 0.05$		
	Mean	SD	Mean	SD	t value	p value	Cohen's $d^b$
Outline and Extension	3.63	0.75	3.65	0.85	-0.27	0.79	0.02
Internal Form	3.62	0.74	3.85	0.65	-3.90	<0.01	0.33
Operative Environment	4.27	0.67	4.19	0.76	1.42	0.16	0.11
Anatomical Form	3.60	0.70	3.99	0.81	-6.86	<0.01	0.52
Margins	3.65	0.66	3.99	0.72	-6.32	<0.01	0.49
Finish, Function, & Damage	3.94	0.59	3.88	0.85	1.23	0.22	0.08
	$N = 2,166$		$N = 82$		$df = 2,246$		
Overall Raw Score	3.74	0.46	3.88	0.44	-2.76	0.01	0.31
Overall Final Score (with Penalties)	3.71	0.53	3.75	0.75	-0.69	0.49	0.06

<sup>a</sup> Only 5.5% of procedures performed in 2019 were Class III; 50% of Field test Procedures were Class III

<sup>b</sup> Generally accepted interpretations of Cohen's  $d$  effect size values are small,  $d = 0.2$ , medium,  $d = 0.5$  and large,  $d = 0.8$  (Cohen, 1988)

Table 8 provides field-test summary results from the many-faceted Rasch model (MFRM) analysis for graded criteria in logit, i.e., log-odds, values, with results from the 2019 standard Operative Section for reference. The MFRM analysis reported in Table 8 reflects the first day of grading, with complete sets of three grades per examination attempt. Mean-square fit statistics and discrimination parameter estimates are within suggested ranges. Since the criteria have multi-point

rating scales they were also assessed for category functioning, as well, in accordance with Linacre's (2002) rating scale guidelines to assess, e.g., that average parameter estimates of candidate ability increase with each category scale point.

Table 8. *Standard Operative Section and Operative Simulation Field Test: Many-Faceted Rasch Model Criterion Analysis Indicators in Logits.*

	Standard Operative Section 2019 <i>N</i> = 2,166	Operative Simulation Field Test 2020 <i>N</i> = 82
Criterion Measure Logit (Range)	-0.78 – 0.39	-0.37 – 0.43
Standard Error (Range)	0.02 – 0.02	0.08 – 0.10
Criterion Measure Logit Mean <sup>a</sup>	0.0	0.0
Criterion Measure Logit <i>SD</i>	0.50	0.25
Many-Facet Point-Biserial $r^b$ (Range)	0.25 – 0.32	0.23 – 0.37
2pl Discrimination Estimate <sup>c</sup> (Range)	0.92 – 1.08	0.76 – 1.10
Infit Mean-Square (Range)	0.93 – 1.07	0.85 – 1.19
Outfit Mean-Square (Range)	0.92 – 1.08	0.85 – 1.21

<sup>a</sup> Mean of criterion parameters constrained at 0

<sup>b</sup> Correlation between observations and corresponding average observations, excluding current observation

<sup>c</sup> Estimate of discrimination parameter, as calculated for two-parameter logistic IRT model; Rasch (c.f., one-parameter IRT) model fit requires values close to 1.00 (i.e., between 0.5 to 1.5 logits)

Table 9 provides summary statistics for overall test functioning, with 2019 standard Operative Section results for reference. The MFRM analysis reported in Table 9 also reflects the first day complete sets of three grades per examination attempt. Results are highly comparable, even with the large difference in sample size and limitations regarding comparisons noted earlier. The reliability estimate for the Operative Simulation Field Test is quite high for a performance-based assessment, at 0.91, which likely reflects the uniformity of the simulated teeth, in addition to high levels of examiner agreement. An additional MFRM analysis was conducted including all

examiner grades from both days of grading, yielding similar results and an even higher reliability estimate of 0.93, providing additional evidence of calibration effectiveness. (The Rasch person separation reliability estimate is the same or lower than Cronbach's alpha coefficient estimates of internal consistency reliability [Cronbach, 1951]. Minimum and maximum scores are excluded, if applicable; note that in the Many-faceted Rasch Model analysis, minimum and maximum refers to all raw grades, not median grades). Final score statistics include zero scores, which result from validated critical errors.

Table 9. *Standard Operative Section and Operative Simulation Field Test: Overall Test Summary Statistics*

Indicator	Standard Operative Section 2019	Operative Simulation Field Test 2020
<i>N</i> Attempts	2,166	82
Final Score Mean	3.71	3.75
Final Score <i>SD</i>	0.53	0.75
Minimum; Maximum	0.00; 5.00	0.00; 4.68
Standard Error of Measurement ( <i>SEM</i> )	0.21	0.23
Conditional <i>SEM</i> at Passing Score	0.08	0.09
<i>Indicators below are reported in logits.</i>		
Candidate Ability Estimate Mean	1.54	1.08
Candidate Ability Estimate <i>SD</i>	0.87	0.80
Candidate Ability Estimate Min.; Max.	-2.02; 5.04 (-5.59 <sup>a</sup> ; 5.04)	-0.71; 2.89
Person Separation Reliability Estimate <sup>b</sup>	0.85	0.91

<sup>a</sup> If minimum score(s) included: Facets software flags minimums and maximums and estimates test statistics with and without extremes

<sup>b</sup> Equivalent to alpha coefficient internal consistency reliability estimate (Cronbach, 1951), or lower than alpha, since minimum (zero) and maximum (perfect) scores are excluded

The percentage of candidates that scored at or above the passing cut score on the Operative Simulation field tests was 92.7% (76 out of 82). The passing percentage for the second, larger field test was lower than that of the first, due to penalties, including two attempts with validated critical errors (e.g., treated the wrong tooth) that lost all points. Table 10 provides passing percentages for the two Operative Simulation field tests, with the 2019 standard Operative Section passing percentage for reference.

Table 10. *Standard Operative Section and Operative Simulation Field Test: Passing Percentages*

	<i>N</i> Attempts	Passing Count	Failing Count	Passing Percentage
Standard Operative Section 2019 Season	2,166	2,079	87	96.0%
Operative Simulation Field Test 2020 - Total	82	76	6	92.7%
Field Test First Site March 30, 2020 (U. of OK)	20	19	1	95.0%
Field Test Second Site April 1-2, 2020 (U. of UT)	62	57	5	91.9%

## REFERENCES

- American Association of Dental Boards (2005). *Guidance for Clinical Licensure Examinations in Dentistry*. Chicago, IL: AADB.
- American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (2014). *Standards for Educational and Psychological Testing*. Washington, DC: American Educational Research Association.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Earlbaum Associates.
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16, 297-334.
- Linacre, J. M., Engelhard, G., Jr., Tatum, D. S., & Myford, C. M. (1994). Measurement with judges: Many-faceted conjoint measurement. *International Journal of Educational Research*, 21(6), 569-577.
- Linacre, J. M. (2002). Optimizing rating scale category effectiveness. *Journal of Applied Measurement*, 3(1), 85-106.
- Rasch, G. (1960/1980). *Probabilistic models for some intelligence and attainment tests*. Copenhagen: Danish Institute for Educational Research, 1960. Expanded edition, Chicago: The University of Chicago Press, 1980.
- Western Regional Examining Board. (2019a). *WREB 2018 Dental Examination Technical Report*. Phoenix, AZ: WREB.
- Western Regional Examining Board. (2019b). *WREB Practice Analysis for General Dentist*. Phoenix, AZ: WREB.
- Western Regional Examining Board. (2020 report in progress). *WREB Dental Hygiene Practice Analysis Report*. Phoenix, AZ: WREB.

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## **WREB - Overview of 2021 Dental Examination & Results for 2020 YTD**



## WREB Dental Examination 2021

WREB has understood the need for alternatives to patient-based examination. In 2020, in response to the COVID-19 pandemic, WREB developed and administered a non-patient dental examination for states seeking licensure options for recent graduates. WREB has recently announced its development and finalization of an operative dentistry simulation section that requires preparation of teeth with simulated caries and a periodontal manikin section. Both sections will be available in 2021 after field-testing and analyses to evaluate examination validity are completed this fall. All five Dental Examination sections available in 2021 are described below and followed by a brief overview of examination results for 2020 year-to-date.

**Comprehensive Treatment Planning (CTP) Section.** CTP is a performance-based, examiner-graded section that requires candidates to review three patient cases and create treatment plans, construct responses to questions, and perform tasks (e.g., write prescriptions). CTP requires broad understanding of diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgical, radiological, pediatric dentistry, and patient-management procedures. Failure can result if a candidate commits a critical error, i.e., constructs a response that could result in life-threatening harm, e.g., administering more than the upper limit of a safe dose of local anesthetic to a pediatric patient.

**Endodontics Simulation Section.** The Endodontics Section is a performance-based, examiner-graded clinical simulation examination. Candidates must perform two endodontic procedures on simulated teeth mounted in a segmented arch which is mounted in a manikin that is positioned to simulate working on a patient. The anterior tooth procedure requires treatment of a maxillary central incisor simulated tooth, including access, instrumentation and obturation. The posterior tooth procedure requires access of a mandibular first molar simulated tooth. Access of the posterior tooth must enable grading examiners to identify all canal orifices.

**Prosthodontic Simulation Section.** The Prosthodontics Section is a performance-based, examiner-graded clinical simulation examination. Candidates complete two prosthodontic procedures (three preparations) on simulated teeth in a mounted articulator and manikin that is positioned to simulate working on a patient. Candidates are required to prepare an anterior tooth for a full-coverage crown and prepare two abutments to support a posterior three-unit fixed partial denture prosthesis (i.e., bridge). The three-unit bridge must have a path of insertion that allows full seating of the restoration.

**Periodontics Section.** The Periodontics section will be available in either a patient-based form or simulation form. The patient-based form is unchanged. The simulation form will not involve qualifying a patient but will involve the removal of subgingival calculus on teeth in an assigned quadrant mounted in a manikin to simulate performing the procedure on a patient. Grading criteria and scoring for the removal of calculus are as published for performance of the same task on a patient. Candidates can choose to waive or to challenge either the patient-based form or simulation form of the Periodontics section depending on the requirements of the state where they intend to become licensed. As for other simulation sections, an onsite retake opportunity may be available

for the simulation form of the Periodontics section, absent a critical error, depending on candidate logistics and circumstances.

**Operative Dentistry Section.** The Operative section will be available in either a patient-based form or simulation form. The patient-based form is unchanged. The simulation form involves performing a Class II (composite or amalgam) and a Class III composite restoration on a posterior tooth and anterior tooth, respectively. The teeth for preparation have a simulated caries, a DEJ, dentin, enamel, and a pulp chamber. The depth of the simulated caries will require candidates to modify their preparations. As in the past, most modifications will be initially reviewed by a Floor Examiner. Both preparation and restoration will be accomplished with full clinical simulation and with rubber-dam isolation. Candidates can choose to challenge either the patient-based form or simulation form of the Operative section depending on the requirements of the state where they intend to become licensed. As for other simulation sections, an onsite retake opportunity may be available for the simulation form of the Operative section, absent a critical error, depending on candidate logistics and circumstances.

### **WREB Dental Examination Results 2020 Year-to-Date (YTD)**

WREB began administering an alternative dental clinical examination to dental licensure candidates in the spring of 2020 in response to limits on patient-based assessment options posed by the COVID-19 pandemic. The first entirely non-patient WREB Dental Examination was administered in early June of 2020. The examination season is not yet over until early November but twenty-two non-patient examinations have already been conducted in twelve states between early June and the end of August (1,635 exam attempts). The first six examinations of the season administered in six states between February and early March included patient-based sections (298 exam attempts).

A comparison of pass or fail outcomes on the Dental Examination between the 2019 season (32 examinations; 2,411 exam attempts) and the 2020 season, year-to-date (28 examinations, 2,198 exam attempts) indicates no statistically significant difference in proportion passing between 2019 (85.6% passing) and 2020 YTD (85.0% passing)<sup>1</sup>. Figure 1 displays passing percentages for 2019 and 2020 YTD for each Dental exam section and for overall passing status. Section passing percentages are higher than overall passing percentages due to the requirement that all sections attempted must be passed to attain overall success on the Dental exam.

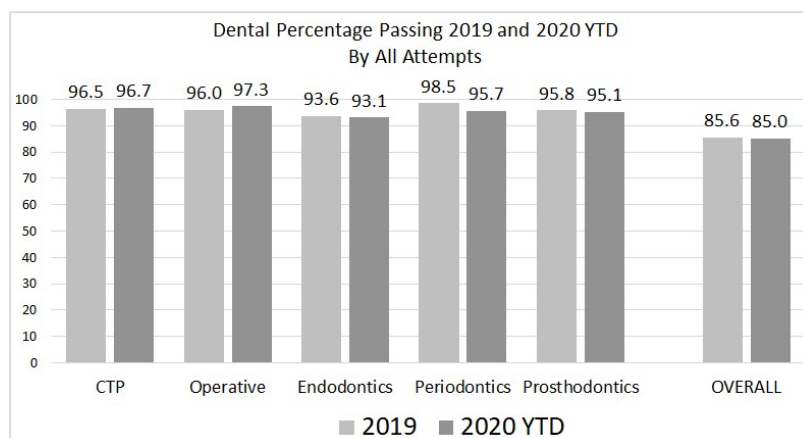
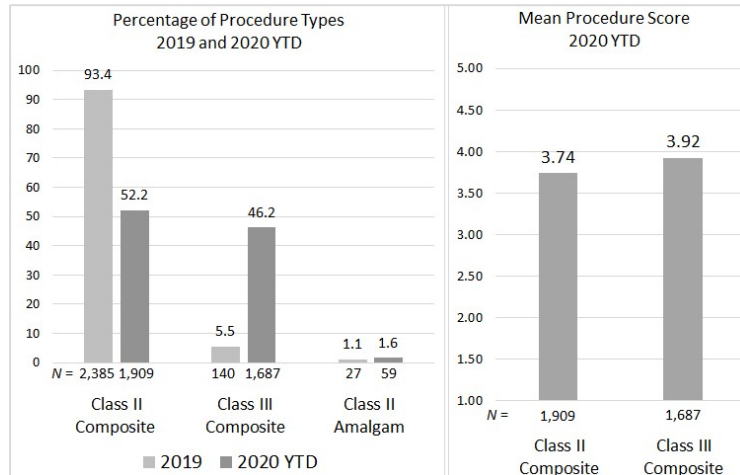


Figure 1. Dental passing percentages for 2019 (2,411 exam attempts) and for 2020 year to date (2,198 exam attempts by September 25, 2020). Note that section passing percentages are higher than the overall percentages because passing the Dental exam requires passing all sections attempted.

Two exam sections show differences for 2020 that are greater than expected across seasons. The patient-based Periodontic section was included in only 15.3% of examination attempts making the impact of individual school performance a highly influential factor in comparison. The Operative Dentistry passing percentage is 96.0% for 2019 and 97.3% for 2020 YTD. The difference does not appear to be due to a significant difference in the level of challenge between the manikin and patient-based examination, but rather is due to an extremely large difference in the proportion of Class III procedures completed for the manikin Operative exam compared to previous exam seasons. The Class III procedure was optional until the introduction of the manikin exam in 2020, which requires completion of one Class II procedure and one Class III procedure. In 2019, only 5.5% of procedures completed were Class III, compared to 46.2% of procedures in 2020 YTD, where 84.6% of all 2020 YTD attempts have been manikin-based. Figure 2a displays the percentage of procedure types completed in 2019 and 2020 YTD. Candidate performance on the Class III procedure has been slightly but consistently higher since 2008, when the Class III became a regular procedure option (i.e., an average of 4.3% higher mean scores per season on Class III than Class II). Figure 2b shows the mean procedure scores for the Class II and Class III composite procedures. The Class III mean is 4.8% higher in 2020 YTD, which is consistent with past results for the Class III procedure and provides evidence that the increase in Operative passing percentage from 96.0% to 97.3% is likely due to the abundance of Class III procedures performed rather than the introduction of the manikin version of the Operative section.



Figures 2a and 2b. (a) Percentage of procedure types completed in 2019 and 2020 YTD. Class III procedures are optional in the patient-based exam (only 15.4% of 2020 YTD attempts were patient-based). Every attempt in the manikin exam (84.6% of 2020 YTD attempts) includes a Class II and Class III. (b) Mean (average) procedure score for Class II and Class III Composite procedures. Number of procedures is provided by “N=” for both graphs.

In addition to comparability in candidate performance, the non-patient dental examination is also showing comparability in examiner quality, exam site comparability, and technical indicators. Additional details of WREB Dental Examination content, results, and technical quality are available upon request.

<sup>1</sup> Results of chi-square analysis [Dental Pass/Fail and 2019/2020 YTD]:  $\chi^2$  ( $df=1$ ,  $N = 4,609$ ,  $\alpha = 0.05$ ) = 0.35; Fisher’s Exact significance  $p = 0.56$ ; effect size Cramér’s  $V < 0.01$ .

## **WREB - Overview of 2021 Dental Hygiene Examination & Results for 2020 YTD**

## WREB Dental Hygiene Examination 2021

WREB has understood the need for alternatives to patient-based examination. In 2020, in response to the COVID-19 pandemic, WREB developed and administered a Dental Hygiene OSCE examination for states seeking licensure options for recent graduates. WREB has recently announced its development and finalization of a manikin examination as another initial licensure alternative for 2021. Dental Hygiene Examination alternatives available in 2021 are described below and followed by a brief overview of examination results for 2020 year-to-date.

**Dental Hygiene Clinical Examination.** The Dental Hygiene Clinical Examination will be available in either a patient-based form or manikin-based form. The patient-based form is unchanged. The manikin exam is comprised of two sections: Assessment Detection and Removable Calculus. Each section is completed on a simulated quadrant that must be mounted in a typodont and positioned to simulate the treatment of a patient. WREB has worked to develop a more realistic colored calculus and periodontal assessment model.

- The Assessment and Detection section requires the candidate to assess periodontal conditions, accurately record periodontal measurements, and note the presence of subgingival calculus on a maxillary quadrant.
- The Removable Calculus has subgingival calculus (of various sizes) placed throughout the quadrant. Candidates must successfully remove the designated key surfaces using ultrasonic and/or hand instrumentation.

Prior to the administration of the manikin examination, a series of field tests will be conducted to ensure the validity of the examination. Field testing for the Removable Calculus section will begin in October and continue with final field testing for the Assessment Detection section. The manikin exam will be ready for implementation in 2021.

**Dental Hygiene Objective Structured Clinical Examination (DH OSCE).** The DH OSCE examination is a standardized, multiple-choice examination that employs images and radiographs to replicate authentic oral conditions and clinical situations. DH OSCE content focuses on the clinical aspects and knowledge-based skills necessary to safely treat a patient in a clinical setting. The content categories assessed are medical history, risk assessment, extraoral/intraoral examination, periodontal assessment, dental hygiene care/treatment plan, and instrumentation. The DH OSCE is tailored to specific clinical aspects of dental hygiene care in order to evaluate critical thinking skills that cannot be assessed comprehensively on the clinic-based examination. The examination is administered at dental hygiene schools by WREB personnel with social distancing and adherence to current COVID-19 guidelines. Site-based administration eliminates the need for students to wait for availability at a testing center.

## WREB Dental Hygiene Examination Results 2020 Year-to-Date (YTD)

In response to requests for alternatives to patient-based examination due to the COVID-19 pandemic, WREB developed a computer-based alternative assessment that approximates the critical thinking and decisions involved in clinical practices since a sufficiently valid and defensible alternative typodont simulation was not yet available. WREB began administering the Dental Hygiene OSCE to dental licensure candidates in the June of 2020. The DH OSCE examination is a comprehensive, computer-based Objective Structured Clinical Examination (OSCE) format that employs images and radiographs to replicate authentic oral conditions and clinical situations. The examination has been administered at sixteen different sites for a total of 617 exam attempts. Some examination sites have resumed patient-based examinations under enhanced infection-prevention conditions. Twenty-two patient-based examinations have taken place for a total of 690 exam attempts in 2020, so far.

Results for 2020 year-to-date have been comparable to results from previous years. Figure 1 shows passing percentages for the Dental Hygiene Examination for 2019 and 2020 YTD. The passing percentages for all attempts includes all attempts, including retakes. The first-attempt passing percentages reflect each candidate's first attempt, only. The retakes passing percentages reflect re-examination results for candidates with previous failures, only. First attempts are higher, since most candidates are able to demonstrate competence the first time challenging the examination. Some candidates who fail upon first attempt, may be truly competent, but were unable to demonstrate competence on the day of the exam. Retakes allow a candidate the opportunity to demonstrate competence again. The likelihood that a truly competent candidate will continue to perform unsuccessfully after multiple retakes becomes lower with each subsequent attempt. Remediation is required after three failures of the examination.

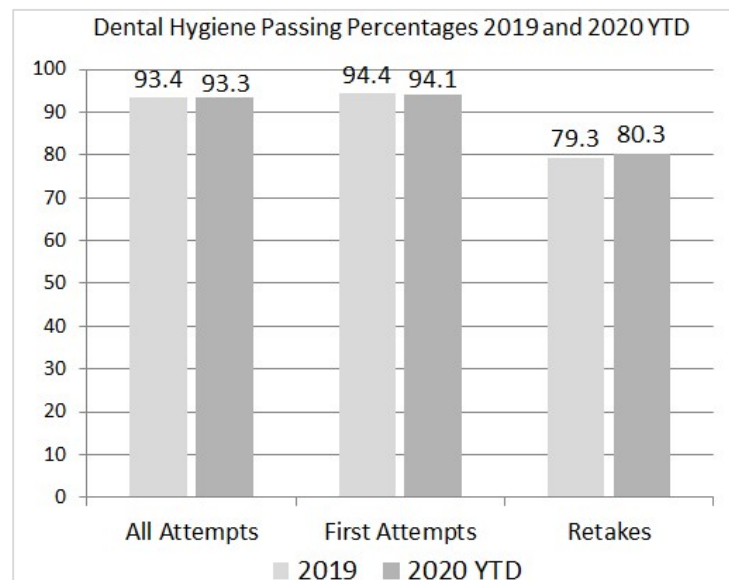


Figure 1. Dental Hygiene passing percentages for 2019 (1,806 exam attempts) and for 2020 year to date (1,307 exam attempts by September 25, 2020).

While the combined examination results are highly comparable, the results for the DH OSCE are slightly higher, (i.e., 95.8% passing), compared to the patient-based examination (i.e., 91.0%) so far in 2020, than for the patient-based examination. However, the retake passing percentage for the DH OSCE (63.6%) is far lower than the retake passing percentage for the patient-based examination (between 75% and 80% for many years) which suggests that the DH OSCE is highly discriminating regarding demonstration of competence.

Major indicators of technical quality for the DH OSCE remain consistent since the initial evaluation prior to operational administration. Estimated values of Cronbach's alpha coefficient of internal-consistency reliability are 0.70 for each test form, which is reasonable for criterion-referenced competency assessment since alpha reliability estimates depend upon sample variability and are attenuated due to the high level of candidate preparedness. Other indicators, such as the Brennan-Kane  $\Phi(\lambda)$  index of dependability and Peng-Subkoviak  $P_0$  estimates of classification consistency provide insight into the reliability of pass-fail outcomes. Dependability index values, which take item variance into account, are high, with values of 0.92 for each test form. Classification consistency values are even higher, with values of 0.97 for each test form, given that mean scores are far enough above the passing cut-score to make misclassification less likely. The mean scale score and passing percentages for each form are identical and no significant difference in pass/fail outcome has been found between forms ( $\chi^2(1, N=617) < 0.0001$ , Fisher's Exact significance  $p = 1.00$ , Cramér's  $V < 0.001$ ). Candidates can expect no difference in level of challenge or test outcome regardless of test form assigned.

Additional details of WREB Dental Hygiene Examination content, results, and technical quality are available upon request.



**Agenda Item (7)(1):**

**ADEX:**

**Use of Manikin in Dental Hygiene and  
Dental Periodontal Scaling**

***(See Board memorandum dated 9/18/2020  
regarding temporary approval and  
acceptance by Board)***



AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Board Meeting - Public Book

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Jeffery Hartsog, D.M.D., Vice-President  
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## ADEX™ Approves Use of Typodont In Dental Hygiene and Dental Periodontal Scaling Clinical Licensure Examinations

2020 ADEX™ Press Release

For Release: May 18, 2020

Email Inquiries: [office@adexexams.org](mailto:office@adexexams.org)

**LAS VEGAS, NEVADA** — The American Board of Dental Examiners, ADEX™, has approved the use and offering of a selected typodont as an option in the dental hygiene licensure examination and the dental periodontal scaling challenge. The typodont selected will be used in calculus detection, calculus removal, and periodontal probing exercises for the ADEX Dental Hygiene Patient Treatment Clinical Examination after completing a feasibility study under the supervision of ACS Ventures, LLC. This will offer dental hygiene licensure boards/agencies the choice to accept this non-patient professional proficiency demonstration or continue to accept the patient required participation for dental hygiene.

Further, the feasibility study included analysis of periodontal scaling proficiency utilizing the selected typodont and was accepted by the ADEX Board of Directors to be offered as an option for the periodontal scaling exercise part of the ADEX Dental Licensure Clinical Examination. This too would give licensure boards, that intend to accept a non-patient clinical assessment of candidates for licensure, an option for such acceptance of demonstrated proficiency.

"While facing circumstances as a result of the COVID-19 crisis, ADEX has endeavored to critically and psychometrically provide licensing jurisdictions options given the current conditions in delivery of dental education, dental treatment, and independent dental skills evaluation. With the previous addition of the CompeDont™ to the ADEX™ dental testing repertoire, licensure boards and agencies have additional non-patient assessment modalities upon which to aid in licensure evaluation during these unprecedented times. These hands-on skill assessments are joined by our computerized Objective Clinical Simulated Examination (OSCE) in both dentistry and dental hygiene, the longest running, continually maintained OSCE in the dental profession in North America," said ADEX President William G. Pappas, D.D.S. "ADEX™ has taken additional steps in dental hygiene by approving and offering both patient and non-patient demonstration options, if desired by licensing boards, to meet the current unique obstacles presented by the COVID-19 crisis," added Beth Jacko-Clemence, R.D.H, and Chair of the ADEX Dental Hygiene Examination Committee. This committee utilized practicing licensed hygienists, hygiene educators, and hygiene students to conduct the feasibility study prior to acceptance and adoption of the use of this particular typodont for examination purposes.

The offering of the typodont based dental hygiene examination and typodont based dental periodontal scaling exercise will commence this summer in the examination series currently scheduled to resume by both The Commission on Dental Competency Assessments (CDCA) and the Council of Interstate Testing Agencies (CITA). As always, it will be at the discretion of state licensing boards/agencies whether to accept these additional offerings in testing modality.

For any questions about the ADEX™ examination please contact: ADEX™ at [office@adexexams.org](mailto:office@adexexams.org) For questions about the administration of ADEX examinations, please contact The Commission on Dental Competency Assessments at: [www.cdcaexams.org](http://www.cdcaexams.org) or the Council of Interstate Testing Agencies at [www.citaexam.com](http://www.citaexam.com)



## **CDCA Typodont Evaluation Report for the ADEX Dental Hygiene Examination**

May 29, 2020

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## Introduction

In April 2020, the Commission on Dental Competency Assessments (CDCA) conducted a product evaluation of a simulated patient (i.e., typodont). The evaluation was designed to determine the suitability of the typodont for use in a clinical skills (i.e., psychomotor skills) assessment for dental hygiene candidates. The results of the evaluation include the summary judgements of 30 subject matter experts (SMEs) who were each provided a typodont and a web based survey for data collection on their experience and perceptions. The CDCA identified ACS Ventures, LLC (ACS) to assist with the design of the product evaluation study and then independently analyze the results. This report summarizes the methodology, results, and conclusions of the study.

## Study Method

To determine the feasibility of using a typodont in the assessment of prospective dental hygienists, multiple sources of validity evidence were collected and analyzed. This evidence consisted of a review of the content and response processes, reliability, and fairness. Content and responses processes were specifically aimed at the degree to which the typodont represents actual practice and the degree to which tasks and scoring criteria remain consistent between modes. It is both pragmatic and a matter of industry expectations (AERA, APA, & NCME 2014) to evaluate the effect of adding or transitioning to a new administration mode. The use of a typodont in the assessment represents a potential, additional mode option if jurisdictions are not able to administer the current examination.

The pursuit of the validity evidence is in service to two evaluation questions: Does the proposed mode result in technical characteristics that are comparable to the current mode? Does the proposed mode yield comparable evidence to support conclusions about entry level competency?

The study consisted of 30 SMEs who served as field test participants. They completed periodontal probing before and after treatment (i.e., instrumentation), calculus detection, and calculus removal skills on the typodont. These field testers included students, dental hygiene faculty, and practitioners.

## Quantitative Data Analyses and Summary

The quantitative data collected were with respect to the amount of agreement among SMEs regarding the pocket depth determined both pre- and post-treatment, and the presence and size of calculus deposits prior to scaling. These data were evaluated for the percent of interrater agreement on each of these skills and were observed to be relatively high (from 82% to 95%). This source of reliability informs readers as to the consistency of the SME judgements for each skill evaluated in this study. In addition, historical reliability data regarding probing, detection, and removal were used to check the reasonableness of the new findings. These data are presented in the following table.

**Table 1 – Periodontal probing, calculus detection, and calculus removal agreement results**

	Field Test	2018	2016
Perio probing – Pre-treatment (+/- 1 mm)	93%	96%	95%
Perio probing – Post-treatment (+/- 1 mm)	95%	N/A	N/A
Calculus detection – Presence and absence (S/M/L)	82%	85%-91%	86%-90%
Calculus detection – Presence and absence (M/L only)	85%	N/A	N/A
Calculus detection – Presence and absence (L only)	92%	N/A	N/A
Calculus removal	92%	91%	N/A



As shown in the table, the calculus detection analysis was performed for different combinations of deposit sizes. Small, medium, and large deposits are represented by the letters S, M, and L, respectively. The least amount of agreement was found in the calculus detection activity when all three sizes of deposits were included in the rate. This rate represents a relatively high rate of agreement and is within 4% of the historical rates of comparison. When deposits were limited to just the medium and large, or just large, the level of agreement increases. Additional discussion of deposit size is included in the next section of this report.

The periodontal probing analysis was performed as a strict interrater agreement rate using the most prevalent examiner rating (i.e., mode) as the reference criterion. For this analysis, SMEs were determined to have agreed when they agreed with each other to a tolerance of plus or minus one millimeter. This metric was chosen as an alternative to a measure of agreement with the intended pocket depth suggested by the typodont manufacturer given. In approaching the analysis in this way, we were able to replicate the current practice on the patient-based examination.

### Qualitative Data Analysis and Summary

Field testers were also asked to complete a qualitative survey regarding their experience with and perceptions of the typodont. This survey consisted of three question types: dichotomous questions for which a yes or no choice must be made; a 5-response option Likert rating from strongly disagree to strongly agree; and open ended comment questions, some of which were prompted by a “No” response from questions of the first type.

The survey aimed to collect data in six categories: Calculus Detection; Calculus Removal; Tissue; Periodontal Probing; Typodont Teeth; Ultrasonic Usage. The data were analyzed by category, response type, and SME type (non-student and student). The yes or no questions were with respect to the operational aspects of the typodont and were generally answered favorably across all categories. The Likert items were designed to measure the degree to which the SMEs believed the experience was realistic. The most prevalent responses to these survey questions were “Agree” and “Not ideal, but sufficient.” Finally, the open-ended comments were coded and counted. The recurrent comments were split between favorable and unfavorable across categories expressing a neutral disposition toward the typodont.

The following highlights the qualitative survey results:

#### Calculus Detection

- Realistic feel of calculus deposits? – Yes (73%), No (27%)
- Realistic placement? – Yes (87%), No (13%)
- Detection similar to that of a patient? Agree (30%), Sufficient (37%), Disagree (33%)
- Respondent Comments:
  - Calculus is too smooth
  - Stiffness of the tissue limited accuracy
  - Calculus deposits difficult to detect
  - Burnished/small deposits were difficult to detect

#### Calculus Removal

- Deposits come off in layers? – Yes (80%), No (20%)
- Realistic using hand instruments? – Yes (77%), No (23%)



- Removal similar to that of a patient? Agree (57%), Sufficient (23%), Disagree (20%)
- Respondent Comments:
  - Tooth material came off with hand scaling
  - Calculus behaved realistically
  - Teeth became loose/fell out
  - Teeth were soft

#### Tissue

- Did the sulcus remain intact after scaling? – Yes (90%), No (10%)
- Could you damage the tissue while hand scaling? – Yes (60%), No (40%)
- Tissue simulates the gingiva found with a patient? Agree (33%), Sufficient (33%), Disagree (33%)
- Respondent Comments:
  - Impressed with tissue
  - Tough/rubbery tissue
  - Not realistic
  - Realistic tissue

#### Periodontal Probing

- Distinguish between enamel and cementum? – Yes (53%), No (47%)
- Mobility during scaling? – Yes (37%), No (63%)
- Teeth similar to that of a patient? Agree (37%), Sufficient (27%), Disagree (36%)
- Respondent Comments:
  - Tooth/teeth came out
  - Teeth are soft
  - Teeth did not move when scaled
  - Did not have gloss or sheen as expected

#### Typodont Teeth

- Distinguish between enamel and cementum? – Yes (53%), No (47%)
- Mobility during scaling? – Yes (37%), No (63%)
- Teeth similar to that of a patient? Agree (37%), Sufficient (27%), Disagree (36%)
- Respondent Comments:
  - Tooth/teeth came out
  - Teeth are soft
  - Teeth did not move when scaled
  - Did not have gloss or sheen as expected

#### Ultrasonic Usage

- Eleven SMEs in the study an ultrasonic scaler.
- Was there any negative effect on the tissue with the ultrasonic? Yes (0%), No (100%)
- Was there any damage to the tooth surface by the ultrasonic? Yes (36%), No (64%)
- Calculus removal experience was similar to a patient? Agree (55%), Sufficient (37%), Disagree (9%)
- Respondent Comments:
  - Teeth are soft
  - Realistic



## Conclusions

Regarding the technical characteristics of the current mode, examiner agreement for probing, calculus detection, and calculus removal was comparable with historical rates. Regarding the degree to which the mode yields comparable evidence to support conclusions about entry level competency, the study found that small and some medium deposits were more difficult to detect and may not represent entry-level skills.

The qualitative data indicated that, with some caveats noted in ratings and comments, the typodont was realistic. Field tester responses to the survey questions were a mixture of favorable and unfavorable ratings which were significantly skewed towards favorability. Therefore, the collection of evidence supports use of this typodont in ADEX examination exercises for jurisdictions that may want to offer both a psychomotor performance examination and a fully non-patient licensure pathway. Notwithstanding this conclusion, the data also suggests that a patient-based demonstration of clinical skills remains a superior comparative option.

## References

American Educational Research Association (AERA), American Psychological Association (APA), & National Council on Measurement in Education (NCME) (2014). *Standards for educational and psychological testing*. Washington, D.C.: American Educational Research Association.





## **CDCA High Fidelity Restorative Simulation Mode Effects Study**

April 20, 2020

**Prepared by:**  
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Chad W. Buckendahl, Ph.D.



## Introduction

In 2019, the CDCA began data collection for a study to evaluate a new type of simulated tooth – the CompeDont™ DTX High Fidelity tooth – as a possible alternative for the demonstration of skills in the ADEX dental licensure examination. Although development of the tooth had been occurring for a few years prior, this was the first larger scale effort to review the performance in a testing setting. The CDCA identified ACS Ventures, LLC (ACS) to evaluate the fidelity of this tooth through a mode effects study where use of this CompeDont™ tooth in an examination setting was compared to traditional examination results. A mode effects study is designed to evaluate examinees' performance on knowledge, skills, or abilities that are administered in more than one format or mode. Common types of mode effects studies are ones that compare a testing program that is administering a test using paper-pencil and computer-based formats. For a clinical skills demonstration, the administration modes being compared in this study are a simulated tooth in a typodont versus a natural tooth in a patient. Specifically, this evaluation compared candidate performance, types of errors, and rater agreement. This report summarizes the results of this study.

## Data and Analyses

In Fall 2019, the CDCA partnered with six dental schools to conduct pilot administrations of the Anterior Restoration procedure (inclusive of preparation and restoration) of the ADEX examination using the CompeDont™ tooth. In total, 548 examinees completed the Anterior Restoration. Examinees represented a diverse group of students from schools selected from multiple geographic regions. In addition, 238 of these examinees (43%) also completed the Posterior Restoration part of the ADEX examination on a patient (i.e., standard administration conditions) as a point of comparison. Across the six administration sites, 66 trained and calibrated examiners participated in the study by evaluating the performance on CompeDont™ and/or natural teeth.

## Posterior Restoration

Because this was a pilot exam set up for the mode effects study, the first focus of the analysis was on the Posterior Restoration tasks that 43% of the examinees completed using a patient as they would in the current operational examination. The purpose of including this element in the study was to determine how performance in the pilot exam compared to an operational exam environment. Specifically, the results from this administration allow for a direct comparison to the results from the 2019 and 2018 operational examination results (e.g., pass rate, types of errors). The results (see Table 1) indicate the pass rate for the pilot exam was slightly lower than the 2019 examinations (5% lower) and the 2018 examinations (3% lower). This observation may be due to variation in the sample of examinees relative to the population. In addition, this may also be somewhat influenced by the timing of the study occurring a few months earlier in the training program than when candidates generally take the examination.

Looking closer at the performance of examinees, the most frequent errors were identified from each administration mode. For the preparation part of the task, the same three errors (Caries, Gingival Contact, Adjacent Tooth Damage) were the most frequent for both the pilot exam and the operational examinations. For the restoration part of the task, there were two consistently frequent errors – interproximal contact and margin excess. Finally, the rater agreement (i.e., how often ratings were confirmed) was consistently high between the operational administrations and the mock exam. This collection of evidence suggests that examinees performed similarly in this pilot exam as they would on an operational examination with a slightly lower pass rate. Therefore, even though the new CompeDont™ tooth was tested in a pilot exam (not an operational one), the results are likely to be comparable to those from an operational exam.

**Table 1. Comparison of Posterior Restoration Results – Pilot Exam vs. 2018/2019 Operational Exams**

	<b>Mock Exam</b>	<b>2019 Operational Exam</b>	<b>2018 Operational Exam</b>
Pass Rate	90%	95%	93%
Most Frequent Errors – Preparation	Caries Gingival contact Adjacent tooth damage	Caries Gingival contact Adjacent tooth damage	Caries Gingival contact Adjacent tooth damage
Most Frequent Errors – Restoration	Interproximal Contact-open/irregular Margin Excess Centric/Excursive Contacts	Interproximal Contact – open irregular Margin Excess Margin Deficiency	Interproximal Contact – open/irregular & closed Margin Excess Margin Deficiency
Rater Agreement	98%	98%	98%

## Anterior Restoration

All Anterior Restorations were performed on the CompeDont™ tooth and, given the comparability of the pilot exam results for the Posterior Restoration, the results of this administration were compared to those from the 2018 and 2019 operational administration (see Table 2). The pass rate for the CompeDont™ tooth was meaningfully lower than the 2019 and 2018 examinations (15% and 14% lower, respectively). When examining performance on the preparation task, two types of errors (Caries Remaining and Outline Extension) were the most common for both the CompeDont™ tooth and operational administrations. For the restoration task, the same three errors were common between modes: Margin Excess, Interproximal Contact, and Margin Deficiency. Finally, the rater agreement was consistently high between the operational administrations with the patient and the pilot exam with the CompeDont™ tooth. This collection of evidence suggests that the CompeDont™ tooth was a similar, but more challenging, task for the examinees. Additional analysis to understand the differences in pass rates is described in the next sections of this report.

**Table 2. Comparison of Anterior Restoration Results – CompeDont™ Tooth Pilot Exam vs. 2018/2019 Operational Exams**

	<b>CompeDont™ Tooth – Pilot Exam</b>	<b>2019 Operational Exam</b>	<b>2018 Operational Exam</b>
Pass Rate	80%	95%	94%
Most common Errors – Preparation	Caries Remaining Outline Extension Axial Walls	Caries Remaining Unrecognized Exposure Outline Extension	Caries Remaining Gingival contact Adjacent tooth damage Outline extension
Most common errors – Restoration	Margin Excess Interproximal contact – open/irregular Margin Deficiency	Interproximal Contact – open/irregular Margin Excess Margin Deficiency	Interproximal contact – open/irregular Margin Excess Margin Deficiency
Rater Agreement	97%	98%	98%

To better understand the differences observed in the pass rates, the results from the CompeDont™ tooth were further explored to determine why 20% of the examinees in the sample failed the Anterior Restoration task. Table 3 shows the specific frequency by which the most common errors were observed for the preparation and restoration tasks between the CompeDont™ tooth-mock exams and the 2018 operational exam. The most notable difference is in the frequency by which a Caries Remaining error was

observed in the preparation task – 15% with the CompeDont™ tooth compared to less than 1% in the 2018 operational exam. To ensure this was not an artifact of the pilot exam situation, the frequency of Caries Remaining was evaluated for the Posterior Restoration. The 2018 operational administration resulted in 1% of examinees having a Caries Remaining error while the pilot exam showed 2.5% having a Caries Remaining error. Therefore, the difference observed in Table 3 is not an artifact of the study but rather likely due to intended design characteristics of the tooth that are further discussed next.

**Table 3. Comparison of Error Frequency – CompeDont™ Tooth Pilot Exam vs. 2018 Operational Exam**

	CompeDont™ Tooth – Pilot Exam	2018 Operational Exam
<b>Preparation</b>		
Caries	15%	<1%
3 Sub Rule: Outline Extension, Gingival Clearance, Axial Walls	7%	<1%
<b>Restoration</b>		
Margin Excess	2%	<1%
Interproximal Contact	1%	<1%

An important design feature of the CompeDont™ tooth is that carious lesions are presented in a way that is more representative of how caries are observed and treated in practice within a typical patient population. Specifically, the CompeDont™ tooth was designed to have varying degrees of average or moderate levels of caries present. This design characteristic requires candidates to exercise their clinical judgment in addition to their psychomotor skills. As a result, it was expected that virtually all CompeDont™ teeth would require modification from an ideal preparation to perform the procedure because of where the caries would be observed. This is different from the current examination where candidates bring their own patients and that a much smaller percentage of these require modifications.

During the examination, candidate requests for modification from an ideal preparation are handled procedurally through a review and approval process. As part of this study, candidate performance was further evaluated based on whether they requested a modification in the pilot exam and these results were compared to the 2018 operational exam. As shown in Table 4, there were many more modifications with the CompeDont™ tooth as compared to the operational exam (74% compared to 31%). As noted above, because the goal with the simulated tooth was to be more representative of job-related practice, this was expected. In fact, an even higher percentage of modifications for the CompeDont™ tooth were expected as compared with the current examination data. In the 2018 results, the pass rates between those who had a modification and those who did not are very similar (94% and 96%). However, the pass rates for the CompeDont™ tooth were much higher for those who had a modification compared to those who did not (83% compared to 73%).

**Table 4. Comparison of Exam Results by Modification (Yes/No) – CompeDont™ Tooth Pilot Exam vs. 2018 Operational Exam**

	CompeDont™ Tooth – Pilot Exam	2018 Operational Exam
<b>Modifications (any approved)</b>		
Count (%)	408 (74%)	1018 (31%)
Pass Rate	83%	94%
<b>No Modifications</b>		
Count (%)	140 (26%)	2264 (69%)
Pass Rate	73%	96%

A follow up question to this finding was whether the pass rate differentiation for the CompeDont™ tooth was due to examinees not knowing when to request a modification (when one was needed) or requesting the wrong modification. The results in Table 5 include the pass rate by whether examinees had any modifications approved and/or denied. The results show that most examinees either had all their modification requests approved (group 1) or did not request any modifications (group 4). The other two smaller groups were those that had at least one modification request denied (and at least one accepted – group 2, or none accepted – group 3). These results indicate that the highest pass rate was observed for those examinees who had one or more modification requests accepted (i.e., they understood what to request and when to request). In addition, 26% of examinees did not request a modification with their pass rate being notably lower (73%).

**Table 5. Comparison of Exam Results by Modification Request Status**

Modification Status	Count	Pass Rate
1. One or more approved (no denials)	325 (59%)	85%
2. One or more accepted & one or more denial	52 (9%)	77%
3. One or more requested – all denied	31 (6%)	71%
4. No modifications requested	140 (26%)	73%
<b>Total</b>	<b>548</b>	<b>80%</b>

## Results and Conclusions

The purpose of this mode effects study was to evaluate the feasibility of the CompeDont™ tooth as a possible alternative to a patient for the ADEX Dental restoration examinations. Data were collected from pilot examinations administered to over 500 dental students from six different schools evaluated by over 60 examiners. The results of this analysis suggest the feasibility of the simulated tooth administered in a typodont as comparable to the operational examination based on the comparison of the Posterior Restoration results from previous administration results. Focusing on the Anterior Restoration, the results indicate that use of the CompeDont™ tooth was sensitive to identify the same critical deficiencies identified in the patient-based examinations. An additional feature of the use of the CompeDont™ tooth is that the normal variation observed in practice by dentists can be modeled to further evaluate candidates' clinical judgment in addition to their psychomotor skills.

Although limitations of the simulation include a lack of some of the patient-based characteristics (e.g., saliva, tongue, patient anxiety), the benefit of additional standardization of the environment for candidates and better representation of job-related characteristics of the tooth may outweigh these limitations. The lower pass rate observed during the pilot examination for the simulated tooth suggests that its use does not offer an easier pathway to licensure and may currently be more challenging. The question is whether it is a fair approach to measuring the clinical judgment and psychomotor skills needed for restoration procedures. The difference in pass rates may be explained in part by the timing of the pilot exam (e.g., examinees taking the exam at an earlier date than normal). However, most of the difference can be attributable to the lack of recognition of caries and a need to modify a preparation from the ideal when it is warranted. Evidence of high examiner reliability provides a source of support. When compared with the current examination where candidates select a patient on which to perform the procedure with rates of modification being relatively low, the CompeDont™ tooth may be a better representation of the job-related environment to measure the important clinical judgments and skills that candidates will need to demonstrate in practice.



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## **ADEX Approves Non-Patient Clinical Examination Option for Dental Hygiene**

For immediate release, May 21, 2020 | Linthicum Heights, MD

Direct inquiries to [sheeler@cdcaexams.org](mailto:sheeler@cdcaexams.org)

**[Back to CDCA Newsroom](#)**

### **Exam Provides Psychomotor Performance Evaluation**

The Commission on Dental Competency Assessments (CDCA) will soon be able to offer dental hygiene licensure candidates a new option to demonstrate readiness for practice. The American Board of Dental Examiners (ADEX) approved the use of a typodont for clinical examinations last week after reviewing an analysis and feasibility study. Read the ADEX announcement [here](#).

The ADEX Dental Hygiene Committee approved the manikin-based option for use in the Patient Clinical Treatment Exam (PTCE) is a response to the COVID-19 crisis should states wish to require a psychomotor demonstration of skills in the absence of patients. The ADEX Examination for Dental Hygiene licensure is made up of two parts, the PTCE and the Computer Simulated Clinical Examination OSCE (CSCE OSCE). Examinations using the approved typodont will be available in early July through CDCA.

Earlier this spring the ADEX Dental Examination Committee approved use of the CompeDont™, a psychometrically validated simulated tooth, for use in the Restorative Examination for dentistry.

At least 11 states already permit the use of a manikin for dental hygiene examinations and/or accept the CSCE OSCE only for licensure. States seeking support in making these decisions are encouraged to contact the CDCA as representatives will be made available to participate in conference calls and meetings. The typodont is also approved for use in Periodontal Scaling assessments for dental licensure candidates.

**Agenda Item (7)(m)**

**ADEX:**

**Restorative Exam & Letter from  
President of ADEX**

***(See Board memorandum dated 9/18/2020  
regarding temporary approval and  
acceptance by Board)***



## **Restorative Examination Performance: *CompeDont*<sup>™</sup> vs. Patient Based**

2020 Patient Based Restorative Candidates (n=2600+)

- Anterior Restorative = **94%** Pass Rate
- Posterior Restorative = **94%** Pass Rate
- Average = **94%** Pass Rate

2020 *CompeDont*<sup>™</sup> Restorative Candidates n=880)

- Anterior Restorative = **95%** Pass Rate
- Posterior Restorative = **93%** Pass Rate
- Average = **94%** Pass Rate

\*Data Courtesy of CDCA



**AMERICAN BOARD OF DENTAL EXAMINERS, INC.**

**William Pappas, D.D.S., President**  
**Jeffery Hartsog, D.M.D., Vice-President**  
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**Renee McCoy-Collins, D.D.S., Treasurer**  
**Bruce Barrette, D.D.S., Past President**

April 29, 2020

Nevada State Board of Dental Examiners  
D Kevin Moore, DDS, President  
6010 S Rainbow, Blvd, Suite A-1  
Las Vegas, NV 89118

Dear President Moore:

On April 2, 2020, the ADEX Dental Examination Committee evaluated the results of a mode effects study evaluating the CompeDont™ tooth as a potential restorative simulated examination platform. The research design of the mode effects study was developed in collaboration with independent psychometricians, and six dental schools throughout the United States. A mode effects study is the appropriate required methodology when proposing an alternate examination process. The tooth has been in development for over three years, and the attached report contains the results of that study. This project was not undertaken in response to the COVID-19 pandemic and was scheduled to be reported to the ADEX member dental boards this August, but since the results have been finalized, they are being provided to you. As a result of the study outcomes, representatives from 30 ADEX member dental boards voted 29-1 to allow the restorative procedures in the ADEX Dental Examination process to be completed on either a live patient or the CompeDont™ tooth.

As part of this process all of the other available typodont teeth, both with and without caries, were evaluated and found to be an inadequate examination simulation. Unlike the CompeDont™ tooth, which has enamel of the same hardness and character of a natural tooth, caries which are variable, transitioning from infected dentin to affected to dentin to sclerotic dentin, and propagates along the DEJ as in a natural tooth, the other available typodont teeth were the same or similar to teeth used in D1 and D2 preclinical training and do not simulate a natural tooth. The CompeDont™ tooth allows administration of the ADEX examination, and all restorative criteria evaluated, just as with the patient.

We know many of our member dental boards are being petitioned to alter examination standards and content. In addition, graduation requirements may be reinterpreted and adjusted which might allow reduced clinical training. ADEX understands that the psychomotor performance examinations become even more important in this environment. ADEX would not consider an off-the-shelf solution which would not offer an examination that would identify the competency issues that are currently tested, or merely reproduce an exercise used in pre-clinical training in dental school. We are pleased to be able to offer for consideration a valid non-patient alternative for those dental boards that would want such an alternative. There would be no PPE requirements, no infectious aerosol, but all of the grading criteria, including preparation modification evaluation, remain in place. The CompeDont™ will provide a challenge in both preparation and restoration for the Class II and the Class III, and are available only to the ADEX testing agencies, the Commission on Dental Competency Assessments (CDCA) and the Council of Interstate Testing Agencies (CITA).

For the Dental Periodontal Scaling Exercise and the Dental Hygiene Clinical Examination (including periodontal probing, calculus detection and calculus removal), the psychometric analysis for a feasibility study will be presented to the ADEX Board of Directors for evaluation and possible adoption of manikin examinations to serve those needs at a properly noticed meeting on May 15, 2020. ADEX will provide you with the analysis and the results of that meeting as soon as possible after that meeting.



If you choose to utilize the CompeDont™ for these challenging times or you would like to move to a patient free examination, the ADEX examination offers the most widely accepted, independent examination for the dental profession. Please contact the ADEX office or our testing agencies, CDCA and CITA, for more information on how to bring the CompeDont™ to your state.

Very Truly Yours,

A handwritten signature in black ink, appearing to read "William G. Pappas". The signature is fluid and cursive, with a long horizontal stroke at the end.

William G. Pappas, D.D.S.  
President, ADEX

Attachment

WGP/kk

## **Agenda Item (7)(o)**

### **Advisory Opinion:**

**From Dr. Capurro - request to support inclusion of licensed dental providers in NAC 652.397 to allow providers to apply for certification and licensure needed to administer COVID-19 waived tests**



Nevada Board of Dental Examiners  
6010 S. Rainbow Blvd., Bldg. A, Ste. 1 • Las Vegas, NV 89118  
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

### PETITION FOR ADVISORY OPINION

Applicant/Licensee: Antonina Capurro Date: May 20, 2020  
Address: [REDACTED] Suite No.:             
City: [REDACTED] State: Nevada Zip Code: [REDACTED]  
Telephone: [REDACTED] Fax: [REDACTED] Email: [REDACTED]

In the matter of the petition for an advisory opinion of NRS & NAC Chapter 631:

This request is for clarification of the following statute, regulation, or order:

(Identify the particular aspect thereof to which the request is made.)

*Note: If you require additional space you may attach separate pages to the petition form.*

NAC 652.397

The substance and nature of this request is as follows:

(State clearly and concisely petitioner's question.)

*Note: If you require additional space you may attach separate pages to the petition form.*

Requesting NSBDE support for inclusion of licensed dental providers to NAC 652.397 which will allow providers to apply for the certification and licensure needed to administer COVID-19 waive tests. Please see documentation attached.

*(Please submit any additional supporting documentation with the petition form)*

Wherefore, applicant/licensee requests that the Nevada State Board of Dental Examiners grant this petition and issue an advisory opinion in this matter.

[Signature]  
Applicant/Licensee Signature

STEVE SISOLAK  
Governor

LISA SHERYCH  
Administrator



RICHARD WHITLEY, MS  
Director

IHSAN AZZAM, Ph.D., M.D.  
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

4150 Technology Way  
Carson City, Nevada 89706  
Telephone (775) 684-4200 • Fax (775) 687-7570  
<http://dpbh.nv.gov>

Dear Nevada State Board of Dental Examiners,

The practice of dental medicine has evolved as research established the relationship between oral health and systemic well-being. Dental professionals serve a fundamental role in providing health care, medical education, and public health improvement programs. During the current pandemic, all healthcare professionals are being called upon to practice at the top of their license to increase access to care.

The coronavirus disease 2019 (COVID-19) is impacting medical and dental communities worldwide. Currently, 95% of dental practices treat patients in their community while taking precautions and practicing safety during the pandemic<sup>1</sup>. Oral health is fundamental to general health, and this is illustrated by the fact that 9% of Americans annually visit their dentist but not their physician<sup>1</sup>. If patients could receive influenza and COVID-19 vaccines during their routine dental appointment, the spread of infectious communicable diseases could be reduced. Dentists and dental hygienists should have the opportunity to provide life-saving vaccinations to their patients and the community to bridge healthcare delivery gaps.

According to Immunize Nevada, vaccines save more than 33,000 lives in the U.S., prevent 14 million disease cases, and save \$43.3 billion in healthcare costs<sup>2</sup>. Vaccinations play a critical role in keeping individuals healthy and eradicating severe diseases for the entire community. The influenza vaccine will be more critical during the COVID-19 pandemic. However, Nevada is ranked 48th in the nation for annual flu vaccination amongst six months to 17-year-olds<sup>2</sup>.

Adopting regulatory language that allows Nevada dentists and dental hygienists to administer vaccinations and provide pandemic vaccination support will increase access to life-saving vaccinations from highly trained practitioners. The Nevada State Board of Dental Examiners (NSBDE) has authority under NRS 631.190 to follow the administrative process outlined in NRS 233B and adopt either emergency or permanent regulations. An inclusion of dentists and dental hygienists into the community of vaccine capable providers will boost Nevada's vaccination rates. Healthcare workforce capacity will be of crucial importance when a COVID-19 vaccination becomes available. Furthermore, clarification and adoption of a regulation to permit Nevada's licensed dental professionals to administer vaccinations are prudent and a potentially significant component of Nevada's COVID-19 response.

Items for consideration:

- The Centers for Disease Control and Prevention has notified Nevada that a coronavirus vaccine may be available in late October or early November 2020 for healthcare workers and high-risk populations. Since there will be a phased approach for vaccine administration, the vaccination may be available for public inoculation by pharmacists and dental professionals(if scope of practice is expanded) in late January/early February 2021.



Nevada Department of  
Health and Human Services  
DIVISION OF PUBLIC AND  
BEHAVIORAL HEALTH

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September 29, 2020

Page 2

- NRS 233B.0395-061 outlines the adoption of proposed permanent or temporary regulations. For the 2020 calendar year, the deadline for proposed regulations was June 30<sup>th</sup>. The Legislative Counsel Bureau (LCB) will begin reviewing proposed permanent regulations after July 1<sup>st</sup> of 2021. Any regulations created now will be temporary as LCB review is not possible until 2021.
- NRS 233B.0613 outlines the process for the creation of emergency regulation. Emergency regulation is active for 120 days from adoption and is not typically renewed after the expiration date.
- [Model standing orders](#), as created by the Oregon Health Authority and outlined in [Oregon's dental vaccination regulation](#), could be recreated for Nevada dental professionals. [Model standing orders](#) are prewritten orders and specific instructions for administration and frequency of a given vaccine. These orders provide a level of clarification and a foundation of immunization knowledge that protects the public's health and safety. It is recommended that NSBDE consider allowing the Division to create these informational guides.
- NSBDE has an unprecedented opportunity to protect, promote, and improve Nevadans' public health by permitting dental professionals to administer vaccines. Oral health professionals can and should be part of Nevada's vaccine distribution task force.

Additionally, NSBDE's review and ruling of advisory opinions submitted by Dr. Capurro, DPBH State Dental Health Officer, are requested. Advisory opinions on the inclusion of dental professionals into NAC 652.397 for in-office waive testing, and fluoride varnish distribution and application as part of the Nevada Action Network have been submitted.

We urge NSBDE to consider adopting a scope of practice expansion for dental professionals to prescribe and administer vaccines as part of a safe and effective disease prevention strategy. Dental professionals can positively impact vaccination rates, improve population health, and encourage dental-medical integration. The Division of Public and Behavioral Health is available to assist NSBDE during the regulatory process.

Thank you for your prompt attention to this matter.

Respectfully,



Lisa Sherych  
Administrator,  
Division of Public and Behavioral Health



Ihsan Azzam, MD, PhD  
Chief Medical Officer,  
Division of Public and  
Behavioral Health



Antonina Capurro, DMD, MPH, MBA  
State Dental Health Officer,  
Division of Public and Behavioral  
Health

CC: Michele White, Chief of Staff, Office of the Governor  
Nevada Dental Association  
Nevada Dental Hygienists' Association

Enclosure:

- a. White paper: Opportunity for Dentistry to Provide Immunizations as Part of the Disease Prevention Strategy During the COVID-19 Pandemic

1. DPBH Letter to NSBDE\_9.29.2020Immunize Nevada. (2018). Nevada Immunization Report Card. Retrieved from [https://immunizenevada.org/sites/default/files/Advocacy/iz%20report%20card\\_2019\\_1.pdf](https://immunizenevada.org/sites/default/files/Advocacy/iz%20report%20card_2019_1.pdf)

## **Opportunity for Dentistry to Provide Immunizations as Part of the Disease Prevention Strategy During the COVID-19 Pandemic**

**Created for the Nevada Oral Health Program**

**by Dr. Capurro, Nevada State Dental Health Officer and Ms. Gomez, Program Intern.**

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### *Synopsis*

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In 2019, Oregon became the first state to allow dentists to provide vaccinations to all patients. Minnesota and Illinois allow dentists to vaccinate against the flu for adults only. Vaccinations are an effective public health tool to reduce the spread of infectious diseases.

According to Immunize Nevada, vaccines save more than 33,000 lives in the U.S., prevent 14 million disease cases, and save \$43.3 billion in healthcare costs (6). Vaccinations play a critical role in keeping individuals healthy and eradicating severe diseases for the entire community. The influenza vaccine will be more critical during the COVID-19 pandemic. However, Nevada is ranked 48<sup>th</sup> in the nation for annual flu vaccination amongst six months to 17-year-olds (6).

Adopting regulatory language that allows Nevada dentists and dental hygienists to administer vaccinations and provide pandemic vaccination support will increase access to life-saving vaccinations from highly trained practitioners. The Nevada State Board of Dental Examiners (NSBDE) has authority under NRS 631.190 to follow the administrative process outlined in NRS 233B and adopt either emergency or permanent regulations. An inclusion of dentists and dental hygienists into the community of vaccine capable providers will boost Nevada's vaccination rates. Healthcare workforce capacity will be of crucial importance when a COVID-19 vaccination becomes available. Furthermore, clarification and adoption of regulation to permit Nevada's licensed dental professionals to administer vaccinations is not only prudent but also a potentially significant component of Nevada's COVID-19 response.

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### *Overview*

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The coronavirus disease 2019 (COVID-19) is impacting medical and dental communities worldwide. Currently, 95% of dental practices treat patients in their community while taking precautions and practicing safety during the pandemic (1). Oral health is fundamental to general health, and this is illustrated by the fact that more than 31 million people annually visit their dentist, but not their physician (1). If patients could receive influenza or COVID-19 vaccines during their routine dental appointment, the spread of infectious communicable diseases could be reduced. Dentists and dental hygienists should have the opportunity to provide life-saving vaccinations to their patients and the community to bridge healthcare delivery gaps.

Recently the Nevada Board of Pharmacy expanded the scope of practice for pharmacy technicians. Initial and continuing education was stipulated, and a framework was created that NSBDE can follow to allow Nevada dentists and dental hygienists to administer vaccinations safely. As part of the pharmacy technician expansion, pharmaceutical technicians must complete a minimum of one-hour training related to vaccines, immunization, and their administration from one of the following: Immunize Nevada, ACPE- approved CPE, in-service training provided by the owner or managing pharmacist to the pharmaceutical technicians working in or for the pharmacy that ensures the competency of the technicians or other board-approved training (11). In addition, the pharmacy technician must complete one hour of continuing education in a course relating to vaccines, immunization, and administration from one of the resources listed above (11).

Like pharmacists, dentists and dental hygienists are considered an essential healthcare provider. As healthcare professionals, they review medical histories, screen for blood pressure and systemic disease, and refer to primary care physicians as needed. Dental professionals are well equipped to provide vaccinations. They routinely provide injections in the head and neck and are trained in anatomy, microbiology, and pharmacology.

There are many cross overs between oral and systemic health. Human papillomavirus (HPV) vaccination is linked to oral cancer prevention. HPV causes 70% of oropharyngeal cancers in the United States (4). The American Dental Association (ADA) recognizes the HPV vaccine as a means of preventing HPV infections, which are associated with oropharyngeal cancer (2). The HPV vaccine protects against HPV-associated oral cancers (2). The national goal for HPV vaccination is 80%. Nevada's level is well below 60% (6). The HPV vaccination rate could be improved if Nevada's dental professionals were part of the public health vaccination team.

The administration of the influenza vaccine will be essential during the fall period of the COVID-19 pandemic. The influenza vaccination is necessary to protect communities from preventable illnesses and outbreaks and reduce unnecessary burdens to the health care system. Nevada is ranked 48<sup>th</sup> for annual flu vaccination amongst 6 months to 17-year olds (6). By allowing dentists to administer immunizations, avoidable illness could be curbed by providing convenient vaccinations to patients by their trusted dental team.

Currently, three states have created legislation to allow dentists to administer specific vaccines. Illinois enacted legislation that permits dentists to administer influenza vaccines to adults upon completing state-defined training (3). Minnesota passed legislation in 2014 that allows dentists to provide the influenza vaccine after taking a Board-approved course. And, Oregon passed a bill in 2019 to authorize trained and certified dentists to prescribe and administer vaccines.

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### *Dental Vaccination Statutes*

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#### **Minnesota**

Under the 2019 Minnesota Statutes 150A.055 Administration of Influenza Immunizations

licensed dentists can administer the influenza immunization to patients 19 years of age and older and only by a licensed dentists who have: immediate access to emergency equipment, including but not limited to oxygen administration equipment, epinephrine, and other allergic reaction response equipment, are trained in or have completed a program approved by the Minnesota Board of Dentistry; specifically the administration of immunizations. Any dentist giving influenza vaccinations must comply with guidelines established by the Advisory Committee on Immunization Practices relating to vaccines and immunizations, which includes, but is not limited to, vaccine storage and handling, vaccine administration and documentation, and vaccine contraindications and precautions. Once a qualified dentist has administered an influenza vaccine to a patient, the dentist shall report the administration to the immunization to the Minnesota Immunization Information Connection or notify the patient's primary physician or clinic of the administration of the immunization (9).

### **Illinois**

Under the administrative code for Illinois dental practice act, dentists administering flu vaccines, vaccinations are limited to patients 18 years of age and older who consent to the administration of the vaccine and are administered under a valid prescription or standing order by a physician. Before being issued a vaccine, vaccine information statements must be provided to patients. Training courses include a minimum of four hours of: the recognition of contraindications and how to handle adverse reactions, the appropriate methods of storage, handling and disposal of vaccines and all used supplies or contaminated equipment, and proper administration and maintenance of written policies and procedures. Reporting requirements include any adverse events to be reported to the Vaccine Adverse Events Reporting System (VAERS) and the patient's primary care provider's name. Any dentist who administers the influenza vaccine must enter all patient-level data on the vaccines in the immunization data registry (I-Care) maintained by the Department of Public Health. Within 30 days after administering the vaccine, the dentist must report the administration to the patient's primary care physician (7).

### **Oregon**

The Oregon House Bill 2220 authorizes trained and certified dentists to prescribe and administer vaccines. The Oregon Board of Dentistry states that a certified dentist may prescribe and administer vaccines to a person with whom the dentist has established a patient relationship. The board may issue a vaccination certificate to a dentist who has completed a training course described in the subsection, pays the certification fee, and meets other board requirements. The dentist must report the prescription and administration of vaccines to the immunization registry created by the Oregon Health Authority (10).

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### *Dental Vaccination Precedent*

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According to the Association of State and Territorial Health Officials (ASTHO), there is a precedent of expanding the scope of practice for dental professionals during public health



emergencies. During the 2009 H1N1 Influenza Pandemic, the following scope of practice expansions occurred(3):

1. Licensed or certified professionals authorized to administer seasonal and H1N1 vaccine as per state health agency instructions and completion of a training program. (I.L.)
2. Commissioner of health authorized to permit dentists to administer seasonal and H1N1 vaccine. (M.A.)
3. Commissioner of health authorized to permit dentists to administer vaccinations if a local board of health requests state assistance to respond to a public health threat. (M.N.)
4. Dentists could administer seasonal and H1N1 vaccinations at places of distribution under limited circumstances. (N.Y.)
5. Dental hygienists could administer seasonal and H1N1 vaccinations at places of distribution under limited circumstances. (N.Y.) (3)

Dentists are routinely called upon during emergencies to lend their skill and expertise to public health disaster relief initiatives. In 2012, New York Governor Andrew Cuomo signed an Executive Order (N.068) that allowed those affected by Hurricane Sandy to receive a tetanus shot from pharmacists, emergency medical technicians, and dentists. Governor Cuomo's Executive Order temporarily expanded the scope of practice of New York dentists during the declaration of a state of emergency.

### **COVID-19 Related Dental Vaccination Proposals**

**According to U.S. Public Health Service:** Per Dr. Tim Ricks USPHS, Chief Dental Officer, approximately 50% of states are considering using oral health professionals to administer the COVID-19 vaccine.

**Maryland:** The Maryland Board of Dentistry is proposing legislation to allow dentists to administer vaccinations. The Board of Dentistry petitioned Maryland Governor Hogan to approve an order declaring that during the pandemic COVID-19 testing and vaccinations are within dentistry's scope of practice.

**Illinois:** Emergency directive adopted. DDS/DMD/RDHs will be involved in a mass vaccination effort to provide influenza and SARS CoV-2 vaccine when available.

**Missouri:** Attempting to expand the dental practice act to allow dentists to provide vaccines. There has been a request to use dentists for mass emergency vaccinations. Dentists are permitted to volunteer to give vaccines within the local health department.

**Wisconsin:** Dental board is reviewing COVID-19 scope of practice expansion.

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### *COVID-19 Vaccination Expansion in Nevada*

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On September 11<sup>th</sup>, Governor Sisolak signed a regulation enabling pharmacy technicians to administer vaccines. The Nevada Board of Dental Examiners can follow the Nevada Board of

Pharmacy's lead to follow similar legislative guidelines for dentists in Nevada to provide immunizations to their patients. Nevada WebIZ is Nevada's statewide Immunization Information System. The system is a confidential system that stores vaccination histories throughout an individual's lifetime. Nevada dentists and dental hygienists could use this system to make informed vaccination decisions, exchange data electronically with medical doctors, and record vaccinations. The Centers for Disease Control and Prevention (CDC) and the American Immunization Registry Association (AIRA) work together to provide guidance and best practices to Nevada WebIZ (5).

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### *DPBH Survey*

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The Nevada Division of Public and Behavior Health (DPBH) surveyed licensed Nevada dentists who hold a DEA license regarding their interest in providing immunizations. The questions included the following:

Would you be interested in receiving and administering the COVID-19 vaccine in early 2021?

Do you currently vaccinate with flu?

Would you be interested in vaccinating for flu?

Do you currently have a refrigerator to store vaccines?

What type of refrigerator do you have?

How large is the inside of your refrigerator?

Is your refrigerator located in a secure area?

Do you currently have a freezer to store vaccines?

What type of freezer do you have?

How large is the inside of your freezer?

Is your freezer located in a secure area?

Roughly how many patients would you be able to vaccinate in a month?

Does your practice currently offer vaccines other than flu to patients in office?

Is your practice currently enrolled in Nevada WebIZ?

How many of your patients have insurance?

How many staff members within the practice are able/approved to vaccinate?

### **DPBH Survey Results**

The DPBH survey was completed by 141 dentists in Nevada. The counties include Carson City, Churchill, Clark, Douglas, Humboldt, Lyon, Washoe, and White Pine counties. 140 of the 141 dentists stated that they would be interested in receiving and administering the COVID-19 vaccine in early 2021.

34% of the dentists reported that they currently vaccinate with the flu. This is most likely a misinterpreted question since dental offices are not authorized to administer vaccines, and 140 participants stated that they do not offer the flu vaccine to their patients. The item may have been misinterpreted as to whether the office staff personally receiving a flu vaccine. Of the

respondents that stated they did not vaccinate for the flu, 78% said they would be interested in vaccinating for the flu.

83% of the survey participants state that they have a refrigerator to store vaccines. 55% say that they have a secure area where the refrigerator is located (only accessible by medical staff). 38% have a somewhat secure area (close to non-medical and medical staff). 46% of participants state that have a freezer to store vaccines and 19% would be interested in purchasing a freezer to store vaccines. 57% state that they have a secure area for freezer storage (not accessible by medical staff).

27% of survey respondents state they can vaccinate 50 patients a month. 23% state they can vaccinate 100 patients per month. 30% state they can vaccinate more than 100 patients a month, and 20% of respondents said they could vaccinate less than 20 patients per month.

### **Patient Population Survey Results**

54% of the dental offices have patient populations that are healthcare personnel

80% of the dental offices have patient populations is 65+ and older

67% of dental offices have patient populations ages 26-64 with underlying medical conditions

54% of the dental offices have a patient population of pregnant women

22% of the dental offices have infant and toddler populations 6-35 months old

63% of the dental offices have patient populations of children 8-10 years old

79% of the dental offices have patient populations of adolescents 11-18 years old

79% of the dental offices have patient populations of adults ages 19-25

87% of the dental offices have patient populations of adults ages 26-64

68% of the dentists surveyed stated that they are not enrolled in Nevada WebIZ, 30% were unsure, and 1 was enrolled in Nevada WebIZ.

### **Dental Insurance**

77% of dental offices reported that over half of their patients have insurance, 12% stated less than half of their patients have insurance. 4 offices reported that all of their patients have insurance, 1 stated that none of their patients have insurance, 11 responded as unknown.

89% of the dental offices stated that less than 5 staff members within the practice are able/approved to vaccinate.

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### *Conclusion*

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Through immunizations, the Nevada dental community can serve an indispensable role as a public health team member to curb the COVID-19 pandemic. Expansion of Nevada dentists and dental hygienists' scope of practice will increase access for patients to receive life-saving

vaccinations from highly trained practitioners. Many dental offices see patients who are most at risk for complications due to COVID-19, including the 65 and older population and patients with underlying medical conditions. Additionally, the inclusion of dental professionals into the community of vaccine capable providers will boost Nevada's low vaccination rates.

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*Addendum*

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**Example of Statutory and Regulatory Language****Illinois****Dental Practice Act (225 ILCS 25/54.3)**

(Section scheduled to be repealed on January 1, 2026)

**Sec. 54.3. Vaccinations.**

(a) Notwithstanding Section 54.2 of this Act, a dentist may administer vaccinations upon completion of appropriate training set forth by rule and approved by the Department on appropriate vaccine storage, proper administration, and addressing contraindications and adverse reactions. Vaccinations shall be limited to patients 18 years of age and older pursuant to a valid prescription or standing order by a physician licensed to practice medicine in all its branches who, in the course of professional practice, administers vaccines to patients or if it is a general policy or recommendation published by the Centers for Disease Control or the Director of Public Health. Methods of communication shall be established for consultation with the physician in person or by telecommunications.

(b) Vaccinations administered by a dentist shall be limited to influenza (inactivated influenza vaccine and live attenuated influenza intranasal vaccine). Vaccines shall only be administered by the dentist and shall not be delegated to an assistant or any other person. Vaccination of a patient by a dentist shall be documented in the patient's dental record and the record shall be retained in accordance with current dental recordkeeping standards. The dentist shall notify the patient's primary care physician of each dose of vaccine administered to the patient and shall enter all patient level data or update the patient's current record. The dentist may provide this notice to the patient's physician electronically. In addition, the dentist shall enter all patient level data on vaccines administered in the immunization data registry maintained by the Department of Public Health.

(c) A dentist shall only provide vaccinations under this Section if contracted with and credentialed by the patient's health insurance, health maintenance organization, or other health plan to specifically provide the vaccinations allowed under this Section. Persons enrolled in Medicare or Medicaid may only receive the vaccinations allowed for under this Section from dentists who are authorized to do so by the federal Centers for Medicare and Medicaid Services or the Department of Healthcare and Family Services.

(d) The Department shall adopt any rules necessary to implement this Section.

(e) This Section is repealed on January 1, 2026.

(Source: P.A. 101-162, eff. 7-26-19.)

**Minnesota****150A.055 Administration of Influenza Immunization****Subdivision 1. Practice of dentistry.**

A person licensed to practice dentistry under sections [150A.01](#) to [150A.14](#) shall be deemed to be practicing dentistry while participating in the administration of an influenza vaccination.

**Subd. 2. Qualified dentists.**

(a) The influenza immunization shall be administered only to patients 19 years of age and older and only by licensed dentists who:

(1) have immediate access to emergency response equipment, including but not limited to oxygen administration equipment, epinephrine, and other allergic reaction response equipment; and

(2) are trained in or have successfully completed a program approved by the Minnesota Board of Dentistry, specifically for the administration of immunizations. The training or program must include:

(i) educational material on the disease of influenza and vaccination as prevention of the disease;

(ii) contraindications and precautions;

(iii) intramuscular administration;

(iv) communication of risk and benefits of influenza vaccination and legal requirements involved;

(v) reporting of adverse events;

(vi) documentation required by federal law; and

(vii) storage and handling of vaccines.

(b) Any dentist giving influenza vaccinations under this section shall comply with guidelines established by the federal Advisory Committee on Immunization Practices relating to vaccines and immunizations, which includes, but is not limited to, vaccine storage and handling, vaccine administration and documentation, and vaccine contraindications and precautions.

**Subd. 3. Coordination of care.**

After a dentist qualified under subdivision 2 has administered an influenza vaccine to a patient, the dentist shall report the administration of the immunization to the Minnesota Immunization Information Connection or otherwise notify the patient's primary physician or clinic of the administration of the immunization.

DHS-7121-ENG

10-15

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

## Immunization Delivery for Dentists

### Applicant Assurance Statement

PROVIDER NAME	NPI
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This Assurance Statement is an addendum to the MHCP Provider Agreement. By signing this statement, I assure that I meet the requirements for administration of influenza immunizations to individuals age 19 and older as mandated in Minnesota Statutes, section 150A.055.

I attest to the completion of training about the administration of immunizations. This training can be an approved program of the Minnesota Board of Dentistry or equivalent. The training must include:

- Educational material on the disease of influenza and vaccination as prevention of the disease
- Contraindications and precautions
- Intramuscular administration
- Communication of risk and benefits of influenza vaccination and legal requirements involved
- Reporting of adverse events
- Documentation required by federal law
- Storage and handling of vaccines

In addition to the above trainings, I also attest to the following:

- \_\_\_\_ I have immediate access to emergency response equipment, including but not limited to oxygen administration equipment, epinephrine, and other allergic reaction response equipment.
- \_\_\_\_ I comply with guidelines established by the federal Advisory Committee on Immunization Practices relating to vaccines and immunizations, which includes, but is not limited to, vaccine storage and handling, vaccine administration and documentation, and vaccine contraindications and precautions.
- \_\_\_\_ I report the administration of these immunizations to Minnesota Immunization Information Connection (MIIC) or the patient's primary physician or clinic.

By initialing the above requirements and signing below, I, the above-named applicant, attest to the accuracy of all information on this form.

SIGNATURE	DATE
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Legal authority

[Minnesota Statutes, Section 150A.055](#)

Fax the signed Applicant Assurance Statement along with the completed MHCP Provider Enrollment application packet and other required documents to 651-431-7462, or upload via the Minnesota Provider Screening and Enrollment (MPSE) portal.

## Oregon:

### [House Bill 2220](#)

SECTION 1. Section 2 of this 2019 Act is added to and made a part of ORS chapter 679.

SECTION 2. (1)(a) In accordance with rules adopted by the Oregon Board of Dentistry, a dentist may prescribe and administer vaccines to a person with whom the dentist has established a patient relationship.

(b) The board shall approve a training course on the prescription and administration of vaccines. The board may approve a training course offered by the Centers for Disease Control and Prevention, the American Dental Association or its successor organization or other similar federal agency or professional organization.

(c) The board may adopt other rules as necessary to carry out this section.

(2) The board shall adopt rules relating to the prescription and administration of vaccines by dentists, including rules requiring dentists to:

(a) Report the prescription and administration of vaccines to the immunization registry created by the Oregon Health Authority pursuant to ORS 433.094;

(b) Prior to administering a vaccine, review the patient's vaccination history in the immunization registry described in this subsection;

(c) Comply with protocols established by the authority for the prescription and administration of vaccines under subsection (1) of this section; and

(d) Comply with any applicable rules adopted by the authority related to vaccines.

(3) In consultation with the board, the authority may adopt rules related to vaccines prescribed and administered by dentists.

SECTION 3. ORS 433.095 is amended to read:

433.095. The Oregon Health Authority shall adopt rules requiring dentists and pharmacists to report information about the administration of vaccines to the immunization registry created under ORS 433.094.

SECTION 4. ORS 679.010 is amended to read:

679.010. As used in this chapter and ORS 680.010 to 680.205, unless the context requires otherwise: (see link for full text)

SECTION 5. ORS 679.020 is amended to read: (see link for full text)

SECTION 6. (1) Section 2 of this 2019 Act and the amendments to ORS 433.095, 679.010 and 679.020 by sections 3 to 5 of this 2019 Act become operative on January 1, 2020.

(2) The Oregon Board of Dentistry and the Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board and the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board and the authority by section 2 of this 2019 Act and the amendments to ORS 433.095, 679.010 and 679.020 by sections 3 to 5 of this 2019 Act.

SECTION 7. This 2019 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect on its passage.

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### *References*

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1. American Dental Association. (2020). *Statement of the American Dental Association to the Committee on Equitable Allocations of Vaccine for the Novel Coronavirus*.
2. American Dental Association. (2020). FDA Adds Oropharyngeal Cancer Prevention as Indication for HPV Vaccine. Retrieved from <https://www.ada.org/en/publications/ada-news/2020-archive/june/fda-adds-oropharyngeal-cancer-prevention-as-indication-for-hpv-vaccine>.
3. Association of State and Territorial Health Officials. (2012). Modified Scope of Practice Used by States in the 2009 H1N1 Influenza Pandemic Fact Sheet. Retrieved from [https://www.astho.org/uploadedFiles/Programs/Preparedness/Public\\_Health\\_Emergency\\_](https://www.astho.org/uploadedFiles/Programs/Preparedness/Public_Health_Emergency_)



- Law/Scope\_of\_Practice\_Toolkit/03-SOP%20H1N1%20State%20SOP%20FS%203-12%20Final.pdf
4. Centers for Disease Control and Prevention. (2018). HPV and Oropharyngeal Cancer. Retrieved from [https://www.cdc.gov/cancer/hpv/basic\\_info/hpv\\_oropharyngeal.htm](https://www.cdc.gov/cancer/hpv/basic_info/hpv_oropharyngeal.htm)
  5. Department of Health and Human Services Nevada Division of Public Health. (2019). Nevada WEBIZ- Our Statewide Immunization Information System. Retrieved from [http://dpbh.nv.gov/Programs/WEBIZ/WEBIZ\\_-\\_Home/](http://dpbh.nv.gov/Programs/WEBIZ/WEBIZ_-_Home/)
  6. Immunize Nevada. (2018). Nevada Immunization Report Card. Retrieved from [https://immunizenevada.org/sites/default/files/Advocacy/iz%20report%20card\\_2019\\_1.pdf](https://immunizenevada.org/sites/default/files/Advocacy/iz%20report%20card_2019_1.pdf)
  7. Joint Committee on Administrative Rules (2016). Section 1220.403 Dentists Administering Flu Vaccines. Retrieved from <https://www.revisor.mn.gov/statutes/cite/150A.055>.
  8. Maryland State Dental Association. (2020). Frequently Asked Questions. Retrieved from: <http://www.msda.com/covid-19.php>
  9. Minnesota Legislature. (2019). 2019 Minnesota Statutes. 150A.055 Administration of Influenza Immunizations. Retrieved from <https://www.revisor.mn.gov/statutes/cite/150A.055>
  10. Oregon State Legislature. (2019). House Bill 2220. Retrieved from <https://olis.leg.state.or.us/liz/2019r1/Downloads/MeasureDocument/HB2220/Enrolled>.
  11. Proposed Regulation of the Nevada State Board of Pharmacy. (2020). Workshop.

**Letters of Support regarding Advisory  
Opinion Request from Dr. Capurro -  
Waived Tests**



## Advisory Committee on the State Program for Oral Health (AC4OH)

### Board Members

*Brandon Abbatangelo, Tina,  
DMD*

*Capelli, David, DMD, PhD*

*Chandler, Terri, RDH*

*Coppes, Max J., MD, PhD,  
MBA, FAAP*

*Davenport, Cathie*

*Garvey, Christina, RDH*

*Liveratti, Mary*

*Mariano, Chris Elaine, APRN,  
CPNP-PC, MSN, RN*

*Prohaska, Benjamin, PA-C,  
BC-ADM*

*Putnam, Bryce, DMD*

*Skelton, Judith, PhD*

*Talley, Robert, DDS*

*Taylor, Kelly, RDH*

August 13, 2020

Nevada State Board of Dental Examiners  
6010 S. Rainbow Blvd., Ste. A-1  
Las Vegas, NV 89118

Re: Support for Dr. Capurro's Request for an Advisory Opinion on NAC 652.397

Dear Nevada State Board of Dental Examiners

The Advisory Committee for Oral Health (AC4OH) appointed by Governor Steve Sisolak was formed to support the State of Nevada's Department of Health and Human Services Oral Health Program with a mission to advocate for optimum oral health for all Nevadans.

The Department of Health and Human Services is responsible for protecting, maintaining, and improving the health of all Nevadans, which includes oral health. As demonstrated through numerous studies, oral health is a vital component of overall health. The AC4OH is committed to collaborating with community dental providers and stakeholders to improve oral health throughout the state and specifically supports partners that can meet the needs of underserved, vulnerable populations.

This letter endorses the request for an Advisory Opinion on NAC 652.397 made by Dr. Antonina Capurro, Nevada State Dental Health Officer. We urge the Nevada State Board of Dental Examiners to support alteration of NAC 652.397 to include licensed dental providers (both dentists and dental hygienists) which will allow dental practitioners to qualify to serve as a director of an exempt laboratory and apply for exempt laboratory license and federal CLIA certification needed to administer waive tests (COVID-19, blood glucose level test – in-office using a glucose meter, HbA1c in-office point of service testing, dip-stick test, etc). Furthermore, we ask the Nevada State Board of Dental Examiners to submit an application for variance to the Nevada State Board of Health for dentally related variances to NAC 652.397 regulations.

In support of this request we offer data from a recent survey conducted by the American Association of Dental Boards. The survey found that 33.3% of survey respondents are allowing dental offices to conduct COVID-19 tests or order COVID-19 tests and an additional 33.3% of respondents are considering future approval for in-office COVID-19 testing. In fact, Utah recently approved the use of D0140 for the administration of COVID-19 testing within a dental office. We urge the Nevada State Board of Dental Examiners to make a similar recommendation.

The AC4OH respectfully asks for your kind consideration of the aforementioned advisory opinion.  
Most Sincerely,

Cathie Davenport  
AC4OH Chairperson

**Additional Documentation regarding  
the inclusion of Dental Professionals  
in NAC 652.397**

## Additional Documentation for Nevada State Board of Dental Examiners Advisory Opinion

### INCLUSION OF DENTAL PROFESSIONALS INTO NAC 652.397

In Nevada, to perform a laboratory test that has been categorized by the Food and Drug Administration (FDA) as a Waived test (ie. blood glucose level test – in-office using a glucose meter, HbA1c in-office point of service testing, dip-stick test, etc.), a State of Nevada Exempt Laboratory License and a federal CLIA certificate is required. This requirement must be met before licensed dental professionals can perform COVID-19 testing categorized as a waive test.

In order to qualify for an exempt laboratory license, a laboratory director must qualify according to NAC 652.397 which lists qualifying professions for this distinction. Currently, the dental profession is not included as qualified persons to be exempt laboratory directors. The Board of Health has jurisdiction over Chapter 652. Support from NSBDE is required before regulations can be submitted to the Board of Health for adoption of changes to this chapter. I humbly request that NSBDE consider this matter and vote to support inclusion of licensed dental providers in NAC 652.397: Director of Exempt Laboratory.

#### Example of NAC 652.397 change:

1. Except as otherwise provided in subsection 2 and NAC 652.395, to qualify to serve as a director of an exempt laboratory, a person must be:

- (a) A licensed physician;
- (b) Qualified for a license as a director of a licensed laboratory pursuant to NAC 652.380;
- (c) Qualified for a license as a director of a registered laboratory pursuant to NAC 652.395; ...
- (h)** A dentists licensed pursuant to chapter 631 of NRS.

**Please note:** While public health dental hygienists could be added to NAC 652.397 as they are allowed to practice without direct supervision according to NAC 631.145, in order to manipulate, collect, or perform a waive laboratory test they must additionally either qualify under NRS 652.210 or obtain certification as an assistant in a medical laboratory pursuant to NRS 652.127. Dentists are specifically listed under NRS 652.210. Any changes to NRS would require legislative action.

### **NRS 652.210 Manipulation of persons for collection of specimens; authorized practices of technical personnel.**

1. Except as otherwise provided in subsection 2 and NRS 126.121 and 652.186, no person other than a licensed physician, a licensed optometrist, a licensed practical nurse,

a registered nurse, a perfusionist, a physician assistant licensed pursuant to chapter 630 or 633 of NRS, a certified advanced emergency medical technician, a certified paramedic, a practitioner of respiratory care licensed pursuant to chapter 630 of NRS, a licensed **dentist** or a registered pharmacist may manipulate a person for the collection of specimens. The persons described in this subsection may perform any laboratory test which is classified as a waived test pursuant to Subpart A of Part 493 of Title 42 of the Code of Federal Regulations without obtaining certification as an assistant in a medical laboratory pursuant to NRS 652.127.

2. The technical personnel of a laboratory may collect blood, remove stomach contents, perform certain diagnostic skin tests or field blood tests or collect material for smears and cultures.

**Proposed Regulation Changes:**  
**NAC 631.028 through NAC 631.220**

## LICENSING

**NAC 631.028 Applications for licensure; payment of fees.** ([NRS 631.190](#), [631.220](#), [631.345](#))

1. An application for licensure must be filed with the Executive Director on a form furnished by the Board. The application must be sworn to before a notary public or other officer authorized to administer oaths and accompanied by the fee required pursuant to [NAC 631.029](#).

2. All such fees must be paid with an instrument which is immediately negotiable.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A 12-15-87; 4-3-89; 9-6-96; R169-01, 4-5-2002; R026-05, 12-29-2005)

**NAC 631.029 Schedule of fees.** ([NRS 631.190](#), [631.240](#), [631.345](#)) The Board will charge and collect the following fees:

Application fee for an initial license to practice dentistry if the applicant has successfully passed a clinical examination administered by the Western Regional Examining Board or a clinical examination approved by the Board and the American Board of Dental Examiners and administered by a regional examination organization other than the Board.....	\$1,200
<i>Application fee for an initial license to practice dental therapy.....</i>	<i>800</i>
Application fee for an initial license to practice dental hygiene.....	600
Application fee for a specialty license by credential.....	1,200
Application fee for a temporary restricted geographical license to practice dentistry.....	600
Application fee for a temporary restricted geographical license to practice dental hygiene.....	150
Application fee for a specialist's license to practice dentistry.....	125
Application fee for a limited license or restricted license to practice dentistry or dental hygiene.....	125
Application and examination fee for a permit to administer general anesthesia, moderate sedation or deep sedation.....	750
Application and examination fee for a site permit to administer general anesthesia, moderate sedation or deep sedation.....	500
Fee for any reinspection required by the Board to maintain a permit to administer general anesthesia, moderate sedation or deep sedation.....	500
Fee for the inspection of a facility required by the Board to ensure compliance with infection control guidelines.....	250
<i>Fee for second or subsequent re-inspection of a facility required by the Board to ensure compliance with infection control guidelines.....</i>	<i>150</i>
Biennial renewal fee for a permit to administer general anesthesia, moderate sedation or deep sedation.....	200
Fee for the inspection of a facility required by the Board to renew a permit to administer general anesthesia, moderate sedation or deep sedation.....	350
Biennial license renewal fee for a general license or specialist's license to practice dentistry.....	600



Biennial license renewal fee for a restricted geographical license to practice dentistry.....	600
Biennial license renewal fee for a restricted geographical license to practice dental hygiene.....	300
Biennial license renewal fee for a general license to practice dental hygiene.....	300
Annual license renewal fee for a limited license to practice dentistry or dental hygiene.....	200
Annual license renewal fee for a restricted license to practice dentistry.....	100
Biennial license renewal fee for an inactive dentist.....	200
Biennial license renewal fee for an inactive dental hygienist.....	50
<i>Fee for second or subsequent audits to ensure compliance with Continuing Education requirements .....</i>	<i>200</i>
Reinstatement fee for a revoked license to practice dentistry or dental hygiene	500
Reinstatement fee to return an inactive or retired dentist or dental hygienist or a dentist or dental hygienist with a disability to active status.....	300
Fee for the certification of a license.....	25
Fee for the certification of a license to administer nitrous oxide or local anesthesia.....	25
Fee for a duplicate wall certificate.....	25
Fee for a duplicate pocket card receipt.....	25
Application fee for converting a temporary license to a permanent license.....	125
Fee for an application packet for an examination.....	25
Fee for an application packet for licensure by credentials.....	25

(Added to NAC by Bd. of Dental Exam'rs by R026-05, eff. 12-29-2005; A by R159-08, 4-23-2009; R066-11, 2-15-2012; R020-14, 6-23-2014; R119-15, 6-28-2016)

**NAC 631.030 Provision of certain information and documentation by applicant for licensure; examination for certain licenses.** ([NRS 631.190](#), [631.220](#), [631.255](#), [631.272](#), [631.274](#), [631.290](#), SB 366 (2019))

1. An applicant for licensure must provide the following information and documentation in his or her application:

- (a) The date and place of his or her birth;
- (b) Certification of graduation from an accredited dental school or college, *from an accredited school or college of dental therapy*, or from an accredited school or college of dental hygiene, whichever is applicable;
- (c) Whether he or she has applied for similar licensure in another state or a territory of the United States or the District of Columbia and, if so, the name of the state or territory of the United States or the District of Columbia, the date and the result of his or her application;
- (d) If he or she has practiced dentistry, *dental therapy* or dental hygiene in another state or a territory of the United States or the District of Columbia, certification from the licensing authority of each state or territory of the United States or the District of Columbia in which he or she has practiced or is practicing that he or she is in good standing and that there are not any disciplinary proceedings affecting his or her standing pending against him or her in the other state or territory of the United States or the District of Columbia;

(e) Whether he or she has terminated or attempted to terminate a license from another state or territory of the United States or the District of Columbia and, if so, the reasons for doing so;

(f) If he or she is not a natural born citizen of the United States, a copy of his or her certificate of naturalization or other document attesting that he or she is legally eligible to reside and work in the United States;

(g) All scores obtained on the examination in which he or she was granted a certificate by the Joint Commission on National Dental Examinations and the date it was issued;

(h) Whether he or she has ever been convicted of a crime involving moral turpitude or has entered a plea of nolo contendere to a charge of such a crime and, if so, the date and place of the conviction or plea and the sentence, if any, which was imposed;

(i) Whether he or she has had any misdemeanor or felony convictions and, if so, any documents relevant to any misdemeanor or felony convictions;

(j) Whether he or she has been held civilly or criminally liable in this State, another state or territory of the United States or the District of Columbia/or misconduct relating to his or her occupation or profession;

(k) Whether he or she has a history of substance abuse and, if so, any documents relevant to the substance abuse;

(l) Whether he or she has been refused permission to take an examination for licensure by this State, any other state or territory of the United States or the District of Columbia, or any regional testing agency recognized by the Board and, if so, any documents relevant to the refusal;

(m) Whether he or she has been denied licensure by this State, any other state or territory of the United States or the District of Columbia and, if so, any documents relevant to the denial;

(n) Whether he or she has had his or her license to practice dentistry, *dental therapy* or dental hygiene suspended, revoked, *been subject to mandatory supervision*, ~~or~~ placed on probation, or has otherwise been disciplined concerning his or her license to practice dentistry, *dental therapy* or dental hygiene, including, without limitation, receiving a public reprimand, in this State, another state or territory of the United States or the District of Columbia and, if so, any documents relevant to the suspension, revocation, *supervision*, probation or other discipline;

(o) A copy of current certification in administering cardiopulmonary resuscitation;

(p) Whether he or she is currently involved in any disciplinary action concerning his or her license to practice dentistry, *dental therapy* or dental hygiene in this State, another state or territory of the United States or the District of Columbia and, if so, any documents relevant to the reprimand or disciplinary action;

(q) Two sets of certified fingerprint cards and an authorization form allowing the Board to submit the fingerprint forms to law enforcement agencies for verification of background information

(r) Whether he or she has any claims against him or her or has committed any actions that would constitute unprofessional conduct pursuant to NRS 631.3475, as amended by section 6 of Senate Bill No. 101, chapter 238, Statutes of Nevada 2017, at page 1256, and section 25 of Assembly bill No. 474, chapter 605, Statutes of Nevada 2017, at page 4414, or NAC 631.230;

(s) An application form that he or she has completed and signed which:

(1) Is furnished by the Board; and

(2) Includes, without limitation, a properly executed request to release information;

(t) If applicable, the statement and proof required by subsection 3;

(u) Evidence that he or she is eligible to apply for a license to practice:

- (1) Dentistry pursuant to NRS 631.230;
- (2) Dental hygiene pursuant to NRS 631.290; *or*
- (3) *Dental therapy pursuant to Senate Bill No. 366 (2019), Section 60.2;*
- (v) The statement required by NRS 425.520; and
- (w) Any other information requested by the Board

~~2.—An applicant for licensure with examination must deliver to the Board, at least 45 days before the examination:~~

- ~~(a) The information and documentation listed in subsection 1;~~
- ~~(b) (x) If applicable, the certified statement and proof required by subsection 3.~~
- ~~(c) (y) A completed and signed application form issued by the Board, including a properly executed request to release information;~~
- ~~(d) (z) A copy of current certification in administering cardiopulmonary resuscitation; and~~
- ~~(e) (aa) A copy of his or her malpractice insurance policy showing the effective dates, which must cover his or her examination dates, and the limits of liability.~~

~~—3.—An applicant for licensure pursuant to NRS 631.272 must deliver to the Board, at least 45 days before the meeting of the Board to consider the applicant for licensure, the documents listed in subsection 2 and proof that the applicant has actively practiced dentistry for the 5 years immediately preceding the date of submission of the application. If the applicant fails to deliver to the Board, at least 45 days before the meeting of the Board to consider the applicant for licensure, any of the documents required pursuant to this subsection, the Executive Director or the Secretary-Treasurer shall reject the application and inform the applicant that he or she is not eligible for consideration for licensure pursuant to NRS 631.272 until the next scheduled meeting of the Board.~~

~~—4.—(bb) Each applicant for licensure must, at least 45 days before the meeting of the Board to consider the applicant for licensure, pass an examination on the contents and interpretation of this chapter and chapter 631 of NRS. The examination will be given on the first Monday of each month. If the first Monday of the month is a legal holiday, the examination will be given on the first Tuesday of the month.~~

~~5.~~ 3. An applicant for licensure who wishes to use laser radiation in his or her practice of dentistry, *dental therapy* or dental hygiene must provide to the Board:

(a) A statement certifying that each laser that will be used by the licensee in the practice of dentistry, *dental therapy* or dental hygiene has been cleared by the Food and Drug Administration for use in dentistry; and

(b) Proof that he or she has successfully completed a course in laser proficiency that:

- (1) Is at least 6 hours in length; and
- (2) Is based on the *Curriculum Guidelines and Standards for Dental Laser Education*, adopted by reference pursuant to [NAC 631.035](#).

[Bd. of Dental Exam'rs, § III, eff. 7-21-82] — (NAC A 10-21-83; 12-15-87; 4-3-89; 9-6-96; R169-01, 4-5-2002; R139-05, 12-29-2005; R159-08, 4-23-2009)

**NAC 631.033 Use of laser radiation in practice: Documentation required with application for renewal of license. (NRS 631.190, 631.330)** Each licensee who uses or wishes to use laser radiation in his or her practice of dentistry, *dental therapy* or dental hygiene must include with the application for renewal of his or her license:

1. A statement certifying that each laser used by the licensee in his or her practice of dentistry, *dental therapy* or dental hygiene has been cleared by the Food and Drug Administration for use in dentistry; and
  2. Proof that he or she has successfully completed a course in laser proficiency that:
    - (a) Is at least 6 hours in length; and
    - (b) Is based on the *Curriculum Guidelines and Standards for Dental Laser Education*, adopted by reference pursuant to [NAC 631.035](#).
- (Added to NAC by Bd. of Dental Exam'rs by R139-05, eff. 12-29-2005)

**NAC 631.035 Use of laser radiation in practice: Adoption by reference of *Curriculum Guidelines and Standards for Dental Laser Education*. ([NRS 631.190](#))**

1. The Board hereby adopts by reference the *Curriculum Guidelines and Standards for Dental Laser Education*, adopted by the Academy of Laser Dentistry. The *Curriculum Guidelines and Standards for Dental Laser Education* is available, free of charge, from the Academy of Laser Dentistry:
    - (a) By mail, at P.O. Box 8667, Coral Springs, Florida 33075;
    - (b) By telephone, at (954) 346-3776; or
    - (c) At the Internet address [http://www.laserdentistry.org/prof/edu\\_curriculumguidelines.cfm](http://www.laserdentistry.org/prof/edu_curriculumguidelines.cfm).
  2. The Board will periodically review the *Curriculum Guidelines and Standards for Dental Laser Education* and determine within 30 days after the review whether any change made to those guidelines and standards is appropriate for application in this State. If the Board does not disapprove a change to an adopted guideline or standard within 30 days after the review, the change is deemed to be approved by the Board.
- (Added to NAC by Bd. of Dental Exam'rs by R139-05, eff. 12-29-2005)

**NAC 631.045 Renewal of license: Certified statement required. ([NRS 631.190](#))** A licensed dentist who owns an office or facility where dental treatments are to be performed in this State must, on the application for renewal of his or her license, execute a certified statement that includes:

1. The location of each office or facility owned by the licensed dentist where dental treatments are to be performed;
2. The name and address of each employee, other than a licensed dentist, *dental therapist* or dental hygienist, who assists at the office or facility in procedures for infection control and the date the employee began to assist in procedures for infection control at the office or facility;
3. A statement that each employee identified in subsection 2:
  - (a) Has received adequate instruction concerning procedures for infection control; and
  - (b) Is qualified to:
    - (1) Operate sterilization equipment and other equipment in compliance with the guidelines adopted by reference in [NAC 631.178](#); and
    - (2) Perform all other applicable activities in compliance with the guidelines adopted by reference in [NAC 631.178](#); and
4. If the licensed dentist is registered to dispense controlled substances with the State Board of Pharmacy pursuant to [chapter 453](#) of NRS, an attestation that the licensed dentist has conducted annually a minimum of one self-query regarding the issuance of controlled substances through the Prescription Monitoring Program of the State Board of Pharmacy.

(Added to NAC by Bd. of Dental Exam'rs by R201-09, eff. 8-13-2010; A by R020-14, 6-23-2014)

**NAC 631.050 Rejection of application; reconsideration and review.** ([NRS 631.160](#), [631.190](#), [631.230](#), [631.260](#), [631.290](#))

1. If the Executive Director or Secretary-Treasurer finds that:
    - (a) An application is:
      - (1) Deficient; *or*
      - (2) Not in the proper form;
      - ~~(3) Delivered to the Board less than the 45 days required before the examination pursuant to subsection 2 of NAC 631.030 or less than the 45 days required before the meeting of the Board to consider the applicant for licensure pursuant to subsection 3 of NAC 631.030; or~~
    - (b) The applicant has:
      - (1) Provided incorrect information;
      - (2) Not attained the scores required by [chapter 631](#) of NRS; or
      - (3) Not submitted the required fee,

➔ the Executive Director or Secretary-Treasurer shall reject the application and return it to the applicant with the reasons for its rejection.
  2. If the Executive Director or Secretary-Treasurer finds that an applicant has:
    - (a) A felony conviction;
    - (b) A misdemeanor conviction;
    - (c) Been held civilly or criminally liable in this State, another state or territory of the United States or the District of Columbia for misconduct relating to his or her occupation or profession;
    - (d) A history of substance abuse;
    - (e) Been refused permission to take an examination for licensure by this State, any other state or territory of the United States or the District of Columbia;
    - (f) Been denied licensure by this State, any other state or territory of the United States or the District of Columbia;
    - (g) Had his or her license to practice dentistry, *dental therapy* or dental hygiene suspended, revoked, *subject to mandatory supervision*, or placed on probation, or has otherwise been disciplined concerning his or her license to practice dentistry or dental hygiene, including, without limitation, receiving a public reprimand, in this State, another state or territory of the United States or the District of Columbia;
    - (h) Not actively practiced dentistry, *dental therapy* or dental hygiene, as applicable, for 2 years or more before the date of the application to the Board;
    - (i) Is currently involved in any disciplinary action concerning his or her license to practice dentistry, *dental therapy* or dental hygiene in this State, another state or territory of the United States or the District of Columbia,

➔ the Executive Director or Secretary-Treasurer may reject the application. If rejected, the application must be returned to the applicant with the reasons for its rejection.
  3. If an application is rejected pursuant to subsection 2, the applicant may furnish additional relevant information to the Executive Director or Secretary-Treasurer, and request that the application be reconsidered. If an application is rejected following reconsideration by the Executive Director or Secretary-Treasurer, the applicant may petition the Board for a review of the application at the next regularly scheduled meeting of the Board.
- [Bd. of Dental Exam'rs, § V, eff. 7-21-82] — (NAC A 4-3-89; 9-6-96; R003-99, 4-3-2000; R169-01, 4-5-2002; R158-08, 12-17-2008; R159-08, 4-23-2009)



**NAC 631.070 Reconsideration of application following request for postponement of action. ([NRS 631.190](#), [631.220](#))**

1. If an applicant requests that the Board postpone its action on his or her application for licensure, he or she may later request the Board to reconsider the application. The request for reconsideration must be made on a form furnished by the Board.

2. If an applicant requests the Board to reconsider the application within 1 year after filing the original application for licensure, the Board will not require the applicant to submit another application for licensure unless the information contained in the original application has changed. The applicant must update the information in the original application by furnishing the Board with a supplement when subsequent changes have taken place.

[Bd. of Dental Exam'rs, § XI, eff. 7-21-82] — (NAC A 4-3-89; R169-01, 4-5-2002)

**NAC 631.090 Examination for license to practice dentistry. ([NRS 631.190](#), [631.240](#))**  
Except as otherwise provided in [NRS 622.090](#), in fulfillment of the statutory requirements of paragraph (b) of subsection 1 of [NRS 631.240](#), an applicant taking the clinical examination approved by the Board and the American Board of Dental Examiners or the clinical examination administered by the Western Regional Examining Board must:

1. Pass the Dental Simulated Clinical Examination or a comparable examination administered by the Western Regional Examining Board, as applicable;

2. Demonstrate proficiency in endodontics as the organization administering the clinical examination requires;

3. Demonstrate proficiency in fixed prosthodontics as the organization administering the clinical examination requires;

4. Demonstrate proficiency in restorative dentistry as the organization administering the clinical examination requires;

5. Demonstrate proficiency in periodontics as the organization administering the clinical examination requires; and

6. Perform such other procedures as the Board requires.

[Bd. of Dental Exam'rs, § XII, eff. 7-21-82] — (NAC A 12-15-87; R169-01, 4-5-2002; R159-08, 4-23-2009)

**NAC 631.140 Reexaminations; completion of failed clinical demonstration. ([NRS 631.190](#), [631.220](#), [631.240](#), [631.280](#), [631.300](#))**

1. Except as otherwise provided in [NRS 622.090](#), an applicant who does not pass all sections of the clinical examination approved by the Board and the American Board of Dental Examiners or the clinical examination administered by the Western Regional Examining Board may apply for a reexamination. The application must be made on a form furnished by the Board.

2. An applicant who does not pass the examination may not take another examination without completing such additional professional training as is required by the Board.

3. An applicant who does not pass the examination solely because he or she fails one of the demonstrations required pursuant to [NAC 631.090](#) may, at the next scheduled examination, complete the remaining demonstration. If the applicant does not successfully complete the remaining demonstration at the next scheduled examination or within the timeline approved by the American Board of Dental Examiners or by the Western Regional Examining Board for a person who takes the examination as part of an integrated curriculum, he or she must retake the entire examination.

4. For the purposes of [NRS 631.280](#), an applicant who attempts to complete successfully a demonstration pursuant to subsection 3 shall not be deemed to have failed the examination twice if he or she fails to complete that demonstration successfully.

[Bd. of Dental Exam'rs, § X, eff. 7-21-82] — (NAC A 4-3-89; 9-6-96; R169-01, 4-5-2002; R159-08, 4-23-2009)

**NAC 631.145 Dental hygienists: Renewal of special endorsement of license to practice public health dental hygiene. ([NRS 631.190](#), [631.287](#))**

1. A special endorsement of a license that allows a dental hygienist to practice public health dental hygiene issued by the Board may be renewed biennially in accordance with [NRS 631.287](#).

2. A dental hygienist may apply to renew the special endorsement upon the renewal of his or her license by submitting a report summarizing the services performed by the dental hygienist under the authority of the special endorsement during the immediately preceding biennium.

(Added to NAC by Bd. of Dental Exam'rs by R231-03, eff. 5-25-2004; A by R020-14, 6-23-2014)

**NAC 631.150 Filing of addresses of licensee; notice of change; display of license. ([NRS 631.190](#), [631.350](#))**

1. Each licensee shall file with the Board the addresses of his or her permanent residence and the office or offices where he or she conducts his or her practice, including, without limitation, any electronic mail address for that practice.

2. Within 30 days after any change occurs in any of these addresses, the licensee shall give the Board a written notice of the change. The Board will impose a fine of \$50 if a licensee does not report such a change within 30 days after it occurs.

3. The licensee shall display his or her license and any permit issued by the Board, or a copy thereof, at each place where he or she practices.

[Bd. of Dental Exam'rs, § XVI, eff. 7-21-82] — (NAC A 9-6-96; R066-11, 2-15-2012; R119-15, 6-28-2016)

**NAC 631.155 Licensee to notify Board of certain events. ([NRS 631.190](#))** Each licensee shall, within 30 days after the occurrence of the event, notify the Board in writing by certified mail of:

1. The death of a patient during the performance of any dental procedure;
2. Any unusual incident occurring in his or her dental practice which results in permanent physical or mental injury to a patient or requires the hospitalization of a patient;
3. The suspension or revocation of his or her license to practice dentistry or the imposition of a fine or other disciplinary action against him or her by any agency of another state authorized to regulate the practice of dentistry in that state;

4. The conviction of any felony or misdemeanor involving moral turpitude or which relates to the practice of dentistry in this State or the conviction of any violation of [chapter 631](#) of NRS;

~~or~~

5. *The filing and service upon him or her of any claim or complaint of malpractice; or*
6. Being held civilly or criminally liable in this State, another state or territory of the United States or the District of Columbia for misconduct relating to his or her occupation or profession.

(Added to NAC by Bd. of Dental Exam'rs, eff. 9-16-85)

**NAC 631.160 Voluntary surrender of license. ([NRS 631.190](#))**

1. If a licensee desires voluntarily to surrender his or her license, he or she may submit to the Board a sworn written surrender of the license accompanied by delivery to the Board of the certificate of registration previously issued to him or her. The Board may accept or reject the surrender of the license. If the Board accepts the surrender of the license, the surrender is absolute and irrevocable. The Board will notify any agency or person of the surrender as it deems appropriate.

2. The voluntary surrender of a license does not preclude the Board from hearing a complaint for disciplinary action filed against the licensee.

*1. If, following a voluntary surrender of license pursuant to this section, the former licensee wishes to again practice in Nevada, he or she must re-apply for a license pursuant to this chapter and NRS 631, and must meet all criteria required for licensure as of the date of his or her reapplication.*

*2. If a licensee voluntarily surrenders his or her license with discipline or during a pending investigation, the Board may require the dentist or hygienist to complete any terms of discipline or corrective action not completed as a result of the surrender, and/or may require additional terms as a condition of licensure as deemed necessary and appropriate by the Board.*

[Bd. of Dental Exam'rs, § XX, eff. 7-21-82]

**NAC 631.170 Placement of license on inactive, retired or disabled status; reinstatement. ([NRS 631.190](#), [631.335](#))**

1. A licensee may request the Board to place his or her license in an inactive or retired status. Such a request must be made in writing and before the license expires.

2. The Secretary-Treasurer may reinstate an inactive license upon the written request of an inactive licensee who has maintained an active license and practice outside this State during the time his or her Nevada license was inactive. To reinstate the license, such an inactive licensee must:

- (a) Pay the appropriate renewal fees;
  - (b) Provide a list of his or her employment during the time the license was inactive;
  - (c) Report all claims of unprofessional conduct or professional incompetence against him or her or any violation of the law which he or she may have committed, including administrative disciplinary charges brought by any other jurisdiction;
  - (d) Report whether he or she has *been served with any claim or lawsuit for dental malpractice, or has* been held civilly or criminally liable in this State, another state or territory of the United States or the District of Columbia for misconduct relating to his or her occupation or profession;
  - (e) Report any appearance he or she may have made before a peer review committee;
  - (f) Submit proof of his or her completion of an amount of continuing education, prorated as necessary, for the year in which the license is restored to active status;
  - (g) Provide certification from each jurisdiction in which he or she currently practices that his or her license is in good standing and that no proceedings which may affect that standing are pending;
  - (h) Satisfy the Secretary-Treasurer that he or she is of good moral character; and
  - (i) Provide any other information which the Secretary-Treasurer may require,
- before the license may be reinstated. In determining whether the licensee is of good moral character, the Secretary-Treasurer may consider whether the license to practice dentistry in



another state has been suspended or revoked or whether the licensee is currently involved in any disciplinary action concerning the license in that state.

3. If a person whose license has been on inactive status for less than 2 years has not maintained an active license or practice outside this State, or if a person's license has been on retired status for less than 2 years, he or she must submit to the Board:

- (a) Payment of the appropriate renewal fees;
  - (b) A written petition for reinstatement that has been signed and notarized;
  - (c) Proof of his or her completion of an amount of continuing education, prorated as necessary, for the year in which the license is restored to active status; and
  - (d) A list of his or her employment, if any, during the time the license was on inactive or retired status,
- ↪ before the license may be reinstated.

4. If a person whose license has been on inactive status for 2 years or more has not maintained an active license or practice outside this State, or if a person's license has been on retired status for 2 years or more, he or she must:

- (a) Satisfy the requirements set forth in paragraphs (a) to (d), inclusive, of subsection 3; and
  - (b) Pass such additional examinations for licensure as the Board may prescribe,
- ↪ before the license may be reinstated.

5. If the license of a person has been placed on disabled status, the person must:

- (a) Satisfy the requirements of paragraphs (a), (b) and (c) of subsection 3;
  - (b) Submit to the Board a list of his or her employment, if any, during the time the license was on disabled status;
  - (c) Pass such additional examinations for licensure as the Board may prescribe; and
  - (d) Submit to the Board a statement signed by a licensed physician setting forth that the person is able, mentally and physically, to practice dentistry,
- ↪ before the license may be reinstated.

*6. For purposes of the requirement for an examination as the Board may prescribe following two years of inactivity, "inactive" as used in subsections 3 and 4 of this section may refer to voluntary placement of a license on inactive status or to inactivity due to voluntary surrender of a license, and/or suspension or revocation of a license or other order by the Board of this State, another state or territory of the United States or the District of Columbia.*

[Bd. of Dental Exam'rs, § XV, eff. 7-21-82] — (NAC A 4-3-89; 11-28-90; 9-6-96; R004-99, 4-3-2000)

**NAC 631.173 Continuing education: Required hours; types of courses and activities; approval of provider or instructor. ([NRS 631.190](#), [631.342](#), [SB366 \(2019\)](#))**

1. Each dentist licensed to practice in this State must annually complete at least 20 hours of instruction in approved courses of continuing education or biennially complete at least 40 hours of instruction in approved courses of continuing education, as applicable, based on the renewal period set forth in [NRS 631.330](#) for the type of license held by the dentist. Hours of instruction may not be transferred or carried over from one licensing period to another.

2. Each dental hygienist licensed to practice in this State must annually complete at least 15 hours of instruction in approved courses of continuing education or biennially complete at least 30 hours of instruction in approved courses of continuing education, as applicable, based on the renewal period set forth in [NRS 631.330](#) for the type of license held by the dental hygienist. Hours of instruction may not be transferred or carried over from one licensing period to another.

3. *Each dental therapist licensed to practice in this State must annually complete at least 18 hours of instruction in approved courses of continuing education or biennially complete at least 40 hours of instruction in approved courses of continuing education, as applicable, based on the renewal period set forth in [NRS 631.330](#) for the type of license held by the dental therapist. Hours of instruction may not be transferred or carried over from one licensing period to another.*

4. In addition to the hours of instruction prescribed in subsections 1 and 2, each dentist, *dental therapist* and dental hygienist must maintain current certification in administering cardiopulmonary resuscitation or another medically acceptable means of maintaining basic bodily functions which support life. Any course taken pursuant to this subsection must be taught by a certified instructor.

~~4.~~ 5. Any provider of or instructor for a course in continuing education relating to the practice of dentistry, *dental therapy* or dental hygiene which meets the requirements of this section must be approved by the Board, unless the course is for training in cardiopulmonary resuscitation or is approved by:

- (a) The American Dental Association or the societies which are a part of it;
- (b) The American Dental Hygienists' Association or the societies which are a part of it;
- (c) The Academy of General Dentistry;
- (d) Any nationally recognized association of dental or medical specialists;
- (e) Any university, college or community college, whether located in or out of Nevada; or
- (f) Any hospital accredited by The Joint Commission.

~~5.~~ 6. To be approved as a provider of a course in continuing education, the instructor of the course must complete a form provided by the Board and submit it to the Board for review by a committee appointed by the Board not later than 45 days before the beginning date of the course. Upon receipt of the form, the committee shall, within 10 days after receiving the form, approve or disapprove the application and inform the applicant of its decision.

~~6.~~ 7. Study by group may be approved for continuing education if the organizer of the group complies with the requirements of subsection ~~5~~ 6 and furnishes the Board with a complete list of all members of the group, a synopsis of the subject to be studied, the time, place and duration of the meetings of the group, and the method by which attendance is recorded and authenticated.

~~7.~~ 8. Credit may be allowed for attendance at a meeting or a convention of a dental and dental hygiene society.

~~8.~~ 9. Credit may be allowed for courses completed via home study, on-line study, self-study or journal study which are taught through correspondence, webinar, compact disc or digital video disc.

~~9.~~ 10. Credit may be allowed for dental and dental hygiene services provided on a voluntary basis to nonprofit agencies and organizations approved by the Board.

(Added to NAC by Bd. of Dental Exam'rs, eff. 9-16-85; A 12-15-87; 9-6-96; R231-03, 5-25-2004; R063-05, 12-29-2005; R159-08, 4-23-2009; R020-14, 6-23-2014)

**NAC 631.175 Continuing education: Approved subjects; minimum requirements for clinical subjects; maximum credit for certain types of courses and activities. ([NRS 631.190, 631.342, SB 366 \(2019\)](#))**

1. Approved subjects for continuing education in dentistry, *dental therapy* and dental hygiene are:

- (a) Clinical subjects, including, without limitation:
  - (1) Dental and medical health;

- (2) Preventive services;
  - (3) Dental diagnosis and treatment planning; and
  - (4) Dental clinical procedures, including corrective and restorative oral health procedures and basic dental sciences, dental research and new concepts in dentistry; and
- (b) Nonclinical subjects, including, without limitation:
- (1) Dental practice organization and management;
  - (2) Patient management skills;
  - (3) Methods of health care delivery; and
  - (4) Teaching methodology.

2. In completing the hours of continuing education required pursuant to [NAC 631.173](#), a dentist must annually complete at least 15 hours in clinical subjects approved pursuant to subsection 1 or biennially complete at least 30 hours in clinical subjects approved pursuant to subsection 1, as applicable, based on the renewal period set forth in [NRS 631.330](#) for the type of license held by the dentist.

3. In completing the hours of continuing education required pursuant to [NAC 631.173](#), a dental hygienist must annually complete at least 12 hours in clinical subjects approved pursuant to subsection 1 or biennially complete at least 24 hours in clinical subjects approved pursuant to subsection 1, as applicable, based on the renewal period set forth in [NRS 631.330](#) for the type of license held by the dental hygienist.

4. *In completing the hours of continuing education required pursuant to [NAC 631.173](#), a dental therapist must annually complete at least 15 hours in clinical subjects approved pursuant to subsection 1 or biennially complete at least 30 hours in clinical subjects approved pursuant to subsection 1, as applicable, based on the renewal period set forth in [NRS 631.330](#) for the type of license held by the dental therapist.*

5. In completing the hours of continuing education required pursuant to [NAC 631.173](#), a dentist who is registered to dispense controlled substances pursuant to [NRS 453.231](#) must complete at least 2 hours of training relating specifically to the misuse and abuse of controlled substances, the prescribing of opioids or addiction during each period of licensure.

~~5.~~ 6. In completing the hours of continuing education required pursuant to [NAC 631.173](#), a dentist, *dental therapist* or dental hygienist must annually complete at least 2 hours in the clinical subject of infection control in accordance with the provisions of the guidelines adopted by reference in [NAC 631.178](#) or biennially complete at least 4 hours in the clinical subject of infection control in accordance with the provisions of the guidelines adopted by reference in [NAC 631.178](#), as applicable, based on the renewal period set forth in [NRS 631.330](#) for the type of license held by the dentist, *dental therapist* or dental hygienist.

~~6.~~ 7. The Board will credit, as a maximum in any one year of an annual or biennial licensing period, the following number of hours of instruction for the following types of courses or activities:

- (a) For approved study by a group, 3 hours.
- (b) For attendance at a meeting or convention of a dental, *dental therapy* or dental hygiene society, 1 hour for each meeting, but not more than 3 hours, exclusive of hours of continuing education offered in conjunction with the meeting.
- (c) For courses completed via home study, on-line study, self-study or journal study through correspondence, webinar, compact disc or digital video disc, not more than 50 percent of the

number of hours of continuing education required by subsection 1 or 2 of [NAC 631.173](#), as applicable.

(d) For all other courses conducted by an approved instructor, the number of hours completed by the dentist or dental hygienist.

(e) For approved dental, *dental therapy* or dental hygiene services provided in approved nonprofit settings, 6 hours, except that not more than 3 hours will be allowed for any day of volunteer services provided.

(Added to NAC by Bd. of Dental Exam'rs, eff. 9-16-85; A 12-15-87; 4-3-89; 9-6-96; R231-03, 5-25-2004; R063-05, 12-29-2005; R149-06, 9-18-2006; R159-08, 4-23-2009; R201-09, 8-13-2010; R020-14, 6-23-2014)

**NAC 631.177 Continuing education: Renewal or reinstatement of license; records; unprofessional conduct; audits. ([NRS 631.190](#), [631.330](#), [631.335](#), [631.342](#), [SB 366 \(2019\)](#))**

1. When requesting a renewal or reinstatement of his or her license, each:

(a) Dentist shall submit a signed, written statement in substantially the following language for each year since his or her last renewal:

I, ....., hereby certify to the Board of Dental Examiners of Nevada that I have obtained at least 20 approved hours of instruction in continuing education during the period July 1, ....., through and including June 30, ..... I also certify to the Board of Dental Examiners of Nevada that I am currently certified in administering cardiopulmonary resuscitation or another medically acceptable means of maintaining basic bodily functions which support life.

Dated this ..... (day) of ..... (month) of ..... (year)

.....  
Signature of Dentist

(b) Dental hygienist shall submit a signed, written statement in substantially the following language for each year since his or her last renewal:

I, ....., hereby certify to the Board of Dental Examiners of Nevada that I have obtained at least 15 approved hours of instruction in continuing education during the period July 1, ....., through and including June 30, ..... I also certify to the Board of Dental Examiners of Nevada that I am currently certified in administering cardiopulmonary resuscitation or another medically acceptable means of maintaining basic bodily functions which support life.

Dated this ..... (day) of ..... (month) of ..... (year)

.....  
Signature of Dental Hygienist

(c) *Dental therapist shall submit a signed, written statement in substantially the following language for each year since his or her last renewal:*

*I, ....., hereby certify to the Board of Dental Examiners of Nevada that I have obtained at least 18 approved hours of instruction in continuing education during the*

*period July 1, ....., through and including June 30, ....., I also certify to the Board of Dental Examiners of Nevada that I am currently certified in administering cardiopulmonary resuscitation or another medically acceptable means of maintaining basic bodily functions which support life.*

*Dated this ..... (day) of ..... (month) of ..... (year)*

.....  
*Signature of Dental Therapist*

(d) Dentist, *dental therapist* or dental hygienist shall submit proof of his or her current certification in administering cardiopulmonary resuscitation or other medically acceptable means of maintaining basic bodily functions which support life.

2. Legible copies of all receipts, records of attendance, certificates and other evidence of attendance by a dentist, *dental therapist* or dental hygienist at an approved course in continuing education must be retained by the dentist, *dental therapist* or dental hygienist and made available to the Board for inspection or copying for 3 years after attendance at the course is submitted to meet the continuing education requirements of the Board. Proof of attendance and completion of the required credit hours of instruction must be complete enough to enable the Board to verify the attendance and completion of the course by the dentist, *dental therapist* or dental hygienist and must include at least the following information:

- (a) The name and location of the course;
- (b) The date of attendance;
- (c) The name, address and telephone number of its instructor;
- (d) A synopsis of its contents; and
- (e) For courses designed for home study, the number assigned to the provider by the Board at the time the course was approved and the name, address and telephone number of the producer or author of the course.

3. The *second* or subsequent failure of a dentist, *dental therapist* ~~and or~~ dental hygienist to obtain or file proof of completion of the credit hours of instruction required by this section and [NAC 631.173](#) and [631.175](#) is unprofessional conduct.

4. The Board will conduct random *initial* audits of dentists, *dental therapists*, or dental hygienists, *and additional follow-up audits as necessary* to ensure compliance with the requirements of this section and [NAC 631.173](#) and [631.175](#).

(Added to NAC by Bd. of Dental Exam'rs, eff. 9-16-85; A 12-15-87; 4-3-89; 9-6-96; R231-03, 5-25-2004; R159-08, 4-23-2009)

**NAC 631.178 Adoption by reference of certain guidelines; compliance with guidelines required. ([NRS 631.190](#))**

1. Each person who is licensed pursuant to the provisions of [chapter 631](#) of NRS shall comply with:

- (a) The provisions of the *Guidelines for Infection Control in Dental Health-Care Settings-2003* adopted by the Centers for Disease Control and Prevention which is hereby adopted by reference. The publication is available, free of charge, from the Centers for Disease Control and Prevention at the Internet address <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm>; and



(b) As applicable to the practice of dentistry, the provisions of the *Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008*, adopted by the Centers for Disease Control and Prevention which is hereby adopted by reference. The publication is available, free of charge, from the Centers for Disease Control and Prevention at the Internet address [http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection\\_Nov\\_2008.pdf](http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf).

2. The Board will periodically review the guidelines adopted by reference in this section and determine within 30 days after the review whether any change made to the guidelines is appropriate for application in this State. If the Board does not disapprove a change to the guidelines within 30 days after the review, the change is deemed to be approved by the Board.

(Added to NAC by Bd. of Dental Exam'rs, eff. 9-6-96; A by R025-05, 11-17-2005; R201-09, 8-13-2010)

**NAC 631.1785 Inspection of office or facility. ([NRS 631.190](#), [631.363](#))**

1. Not later than 30 days after a licensed dentist becomes the owner of an office or facility in this State where dental treatments are to be performed, other than a medical facility as defined in [NRS 449.0151](#), the licensed dentist must request in writing that the Board conduct an initial inspection of the office or facility to ensure compliance with the guidelines adopted by reference in [NAC 631.178](#).

2. Not later than 90 days after receiving a written request pursuant to subsection 1:

(a) The Executive Director shall assign *one or more agent(s)* of the Board to conduct the inspection; and

(b) The agent(s) shall conduct the inspection *utilizing the infection control inspection/survey form provided by the Board.*

3. Not later than 30 days after agent(s) of the Board have completed the initial inspection of an office or facility pursuant to subsection 2, the agent(s) shall issue a report to the Executive Director indicating whether the office or facility is equipped in compliance with the guidelines adopted by reference in [NAC 631.178](#). If the report indicates that the office or facility:

(a) Is equipped in compliance with the guidelines adopted by reference in [NAC 631.178](#), the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility.

(b) Is not equipped in compliance with the guidelines adopted by reference in [NAC 631.178](#) *and/or has infection control inspection deficiencies as noted on the infection control inspection survey utilized by the Board*, the Executive Director *or other agent of the Board* shall, without any further action by the Board, issue a written notice which identifies *critical the* deficiencies to the licensed dentist who owns the office or facility. *Receipt of a copy of the completed infection control inspection survey form is sufficient to satisfy the requirement for written notice of deficiencies.*

(c) *If the notice pursuant to Subsection (b) notes that there is a finding of one or more critical or "Level 1" deficiencies:*

(i) *No patients may be treated in the office or facility until those deficiencies are corrected, as critical deficiencies indicate a potential danger to the public health, safety or welfare, and requires immediate action.*

(ii) *The owner and any employed or independent contracting dentists may voluntarily agree to suspend patient care and treatment at the office or facility pending confirmation of correction of the critical deficiencies. Once correction has been confirmed and acknowledged by the Board or its agent, pursuant to subsection (iv) of this section, patient care may resume at that office or facility.*

- (iii) *If the owner and any employed or independent contracting dentists do not agree to voluntarily suspend patient care and treatment at the office or facility pending confirmation of correction of the critical deficiencies, pursuant to subsection 3 of NRS 233B.127, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the licensed dentist who owns the office or facility and the licenses of any or all of the other licensees employed or independently contracted at the office or facility pending proceedings for revocation or other action. An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order. The owner and any employed or independent contracting dentists will not be permitted to resume patient care and treatment pending further proceedings mandated pursuant to this section and NRS 233B.127(3), which must be instituted and determined within 30 days after the date of the order unless the agency and the licensee mutually agree in writing to a longer period. Acknowledgement of the correction of critical deficiencies pursuant to subsection (iv) of this section will not reverse, revoke, void or otherwise rescind any summary suspension issued pursuant to this paragraph.*
- (iv) *Not later than 72 hours after notification to the Board by the owner and/or any employed or independently contracting dentists of the correction of critical deficiencies, a re-inspection of the office or facility will be conducted to verify that the licensed dentist(s) and the personnel supervised by the dentist(s) have corrected the critical deficiencies. The fees for a first re-inspection are included in the fees charged for the initial inspection. Any subsequent re-inspection(s) will incur additional fees as stated in NAC 631.028.*
- (v) *If critical deficiencies remain following two (2) re-inspections after the initial inspection, even if there has been a voluntary cessation of patient care and treatment at the deficient location, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the licensed dentist who owns the office or facility and/or the licenses of any or all of the other licensees employed or independently contracted at the office or facility pending proceedings for revocation or other action. An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order. The owner and any employed or independent contracting dentists will not be permitted to resume patient care and treatment pending further proceedings mandated pursuant to this section and NRS 233B.127(3), which must be instituted and determined within 45 days after the date of the order unless the agency and the licensee mutually agree in writing to a longer period.*
- (d) *If the notice pursuant to Subsection (b) notes that there is a finding of one or more remedial or "Level 2" deficiencies*
- (i) *Not later than 7 business days after issuing a written notice of deficiencies, the Executive Director shall assign an agent(s) of the Board to conduct a reinspection of the office or facility to determine if the licensed dentist and the personnel supervised by*

*the dentist have taken corrective measures. The agent(s) assigned pursuant to this paragraph shall issue a report to the Executive Director indicating whether the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection survey as noted on the infection control inspection survey utilized by the Board.*

*(ii) If the re-inspection pursuant to subsection (i) indicates that the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection survey as noted on the infection control inspection survey utilized by the Board, the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility.*

*(iii) If the re-inspection pursuant to subsection (i) indicates that the licensed dentist and the personnel supervised by the dentist are not in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection survey as noted on the infection control inspection survey utilized by the Board, the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility. In the event deficiencies are noted pursuant to this section, the President of the Board may, without any further action by the Board, issue an order to the licensed dentist who owns the office or facility and all other licensees employed or independently contracted at the office or facility that any or all of those licensees or personnel must immediately cease and desist from some or all dental treatments at the office or facility until a hearing is held before the Board. An order to cease and desist issued by the President of the Board must contain findings of the circumstances which warrant the issuance of the order. The President of the Board shall not participate in any further proceedings relating to the order. The hearing before the Board must be convened not later than 30 days after the President issues the order to cease and desist.*

*(vi) If Level 2 deficiencies remain following two (2) re-inspections after the initial inspection, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the licensed dentist who owns the office or facility and/or the licenses of any or all of the other licensees employed or independently contracted at the office or facility pending proceedings for revocation or other action or may request that the Board authorize an investigation as a result of the repeated inspection deficiencies. An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order. The owner and any employed or independent contracting dentists will not be permitted to resume patient care and treatment pending further proceedings mandated pursuant to this section and NRS 233B.127(3), which must be instituted and determined within 45 days after the date of the order unless the agency and the licensee mutually agree in writing to a longer period.*

*(e) If the notice pursuant to Subsection (b) notes that there is a finding of one or more "Level 3" deficiencies*



- (i) *Not later than 30 business days after issuing a written notice of deficiencies, the Executive Director shall assign agents of the Board to conduct a reinspection of the office or facility to determine if the licensed dentist and the personnel supervised by the dentist have taken corrective measures, and the agents assigned pursuant to this paragraph shall issue a report to the Executive Director indicating whether the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection survey as noted on the infection control inspection survey utilized by the Board.*
- (ii) *If the re-inspection pursuant to subsection (i) indicates that the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection survey as noted on the infection control inspection survey utilized by the Board, the Executive Director shall, without any further action by the Board, issue a written notice of the agent's findings to the licensed dentist who owns the office or facility.*
- (iii) *If the re-inspection pursuant to subsection (i) indicates that the licensed dentist and the personnel supervised by the dentist are not in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection survey as noted on the infection control inspection survey utilized by the Board, the Executive Director shall, without any further action by the Board, issue a written notice of the agent's findings to the licensed dentist who owns the office or facility. In the event deficiencies are noted pursuant to this section, the President of the Board may, without any further action by the Board, issue an order to the licensed dentist who owns the office or facility and all other licensees employed or independently contracted at the office or facility that any or all of those licensees or personnel must immediately cease and desist from some or all dental treatments at the office or facility until a hearing is held before the Board. An order to cease and desist issued by the President of the Board must contain findings of the circumstances which warrant the issuance of the order. The President of the Board shall not participate in any further proceedings relating to the order. The hearing before the Board must be convened not later than 30 days after the President issues the order to cease and desist.*
- (iv) *If Level 3 deficiencies remain following two (2) re-inspections after the initial inspection, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the licensed dentist who owns the office or facility and/or the licenses of any or all of the other licensees employed or independently contracted at the office or facility pending proceedings for revocation or other action or may request that the Board authorize an investigation as a result of the repeated inspection deficiencies. An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order. The owner and any employed or independent contracting dentists will not be permitted to resume patient care and treatment pending further proceedings mandated pursuant to this section and NRS 233B.127(3), which must be instituted and determined within 45 days after the date of the order unless the agency and the licensee mutually agree in writing to a longer period.*

*(v) The fees for a first re-inspection are included in the fees charged for the initial inspection. Any subsequent re-inspection(s) will incur additional fees as stated in NAC 631.028.*

~~4. Not later than 72 hours after issuing a written notice of deficiencies pursuant to paragraph (b) of subsection 3~~

~~— (a) The Executive Director shall assign agents of the Board to conduct a reinspection of the office or facility to determine if the licensed dentist and the personnel supervised by the dentist have taken corrective measures; and~~

~~— (b) The agents assigned pursuant to paragraph (a) shall conduct the reinspection and issue a report to the Executive Director indicating whether the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178. If the report indicates that the licensed dentist and the personnel supervised by the dentist:~~

~~— (1) Are in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility.~~

~~— (2) Are not in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director may, without any further action by the Board, issue an order to the licensed dentist who owns the office or facility and all other licensees employed at the office or facility that any or all of those licensees or personnel must immediately cease and desist from performing dental treatments and that some or all dental treatments must cease to be performed at the office or facility until a hearing is held before the Board. The hearing before the Board must be convened not later than 30 days after the Executive Director issues the order to cease and desist.~~

~~— 5. Not later than 72 hours after receiving material evidencing critical deficiencies by a licensed dentist who owns an office or facility in this State where dental treatments are to be performed, other than a medical facility as defined in NRS 449.0151, the Executive Director may assign agents of the Board to conduct an inspection of an office or facility to ensure that the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178. An inspection conducted pursuant to this subsection may be conducted during normal business hours with notice to the licensed dentist who owns the office or facility.~~

~~— 6. Not later than 3 days after a dentist receives a written notice pursuant to subsection 5:~~

~~— (a) The Executive Director shall assign agents of the Board to conduct the inspection; and~~

~~— (b) The agents shall conduct the inspection.~~

~~— 7. Not later than 72 hours after agents of the Board have completed the inspection of an office or facility pursuant to subsection 6, the agents shall issue a report to the Executive Director indicating whether the office or facility is equipped in compliance with the guidelines adopted by reference in NAC 631.178. If the report indicates that the office or facility:~~

~~— (a) Is equipped in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility.~~

~~—(b) Is not equipped in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director shall, without any further action by the Board, issue a written notice which identifies all critical deficiencies to the licensed dentist who owns the office or facility.~~

~~—8. Not later than 72 hours after issuing a written notice of deficiencies pursuant to paragraph (b) of subsection 7~~

~~—(a) The Executive Director shall assign agents of the Board to conduct a reinspection of the office or facility to determine if the licensed dentist and the personnel supervised by the dentist have taken corrective measures; and~~

~~—(b) The agents assigned pursuant to paragraph (a) shall conduct the reinspection and issue a report to the Executive Director indicating whether the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178. If the report indicates that the licensed dentist and the personnel supervised by the dentist:~~

~~—(1) Are in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility.~~

~~—(2) Are not in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director may, without any further action by the Board, issue an order to the licensed dentist who owns the office or facility and all other licensees employed at the office or facility that any or all of those licensees or personnel must immediately cease and desist from performing dental treatments and that some or all dental treatments must cease to be performed at the office or facility until a hearing is held before the Board. The hearing before the Board must be convened not later than 30 days after the Executive Director issues the order to cease and desist.~~

9. ~~Pursuant to~~ *Nothing in* subsection 3 *of this section shall prevent the President of the Board, pursuant to* ~~of NRS 233B.127, if an initial inspection of an office or facility conducted pursuant to this section indicates that the public health, safety or welfare imperatively requires emergency action, the President of the Board may,~~ without any further action by the Board, *issuing* an order of summary suspension of the license of the licensed dentist who owns the office or facility and the licenses of any or all of the other licensees employed at the office or facility pending proceedings for revocation or other action *if any inspection pursuant to this section indicates that the public health, safety or welfare imperatively requires emergency action.* An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order.

*10. Nothing in this section shall prohibit the Board from investigating a verified complaint or authorizing an investigation pursuant to this chapter concerning allegations of infection control violations by a licensee or office or facility owned by a licensee or from initiating disciplinary or other action against the licensee for infection control violations.*

(Added to NAC by Bd. of Dental Exam'rs by R201-09, eff. 8-13-2010; A by R020-14, 6-23-2014; R119-15, 6-28-2016)

**NAC 631.179 Random inspection of office or facility; subsequent action by Executive Director. (NRS 631.190, 631.363)**

1. The Executive Director may assign agents of the Board to conduct a random inspection of an office or facility in this State where dental treatments are to be performed to ensure that the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection guidelines pursuant to the Infection Control Inspection/Survey Form utilized by the Board. Random inspections conducted pursuant to this subsection may be conducted during normal business hours without notice to the licensed dentist who owns the office or facility to be inspected.

2. *The inspection and re-inspection procedures and regulations applicable to initial inspections pursuant to NAC 631.1785, are incorporated herein by reference and shall apply equally to random inspections pursuant to this section.*

3. *Nothing in this section shall prohibit the Board from investigating a verified complaint or authorizing an investigation pursuant to this chapter concerning allegations of infection control violations by a licensee or office or facility owned by a licensee or from initiating disciplinary or other action against the licensee for infection control violations.*

~~Not later than 30 days after agents of the Board have completed a random inspection of an office or facility in this State where dental treatments are to be performed to ensure compliance with the guidelines adopted by reference in NAC 631.178, the agents shall issue a report to the Executive Director indicating whether the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178. If the report indicates that the licensed dentist and the personnel supervised by the dentist:~~

~~— (a) Are in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility.~~

~~— (b) Are not in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director shall, without any further action by the Board, issue a written notice which identifies deficiencies to the licensed dentist who owns the office or facility.~~

~~— 3. Not later than 72 hours after a licensed dentist receives a written notice of deficiencies issued pursuant to paragraph (b) of subsection 2:~~

~~— (a) The Executive Director shall assign agents of the Board to conduct a reinspection of the office or facility to determine if the licensed dentist and the personnel supervised by the dentist have taken corrective measures; and~~

~~— (b) The agents assigned pursuant to paragraph (a) shall conduct the reinspection and issue a report to the Executive Director indicating whether the licensed dentist and the personnel supervised by the dentist are in compliance with the guidelines adopted by reference in NAC 631.178. If the report indicates that the licensed dentist and the personnel supervised by the dentist:~~

~~— (1) Are in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director shall, without any further action by the Board, issue a written notice of the agents' findings to the licensed dentist who owns the office or facility.~~

~~— (2) Are not in compliance with the guidelines adopted by reference in NAC 631.178, the Executive Director may, without any further action by the Board, issue an order to the licensed dentist who owns the office or facility and all other licensees employed at the office or facility that any or all of those licensees or personnel must immediately cease and desist from~~

~~performing dental treatments and that some or all dental treatments must cease to be performed at the office or facility until a hearing is held before the Board. The hearing before the Board must be convened not later than 30 days after the Executive Director issues the order to cease and desist.~~

4. ~~Pursuant~~ *Nothing in this section shall prevent the President of the Board, pursuant to subsection 3 of NRS 233B.127, if a random inspection of an office or facility conducted pursuant to this section indicates that the public health, safety or welfare imperatively requires emergency action, the President of the Board may*, without any further action by the Board, *from* ~~issuing~~ *issuing* an order of summary suspension of the license of the licensed dentist who owns the office or facility and the licenses of any or all of the other licensees employed at the office or facility pending proceedings for revocation or other action *if any inspection pursuant to this section indicates that the public health, safety or welfare imperatively requires emergency action*. An order for summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order for summary suspension. The President of the Board shall not participate in any further proceedings relating to the order.

(Added to NAC by Bd. of Dental Exam'rs by R201-09, eff. 8-13-2010)

*NAC 631.\_\_\_\_ Inspection of office or facility during investigation; subsequent action by Executive Director. (NRS 631.190, 631.360, 631.363)*

1. *During the investigation of a verified or authorized complaint pursuant to NRS 631.360 and/or 631.363, at the request of the investigator or Review Panel, the Executive Director may assign an agent(s) of the Board to conduct an inspection of an office or facility in this State where dental treatments are performed or are to be performed to ensure that the licensed dentist(s) and the personnel supervised by the dentist(s) are in compliance with the guidelines adopted by reference in NAC 631.178 and/or the infection control inspection guidelines pursuant to the Infection Control Inspection/Survey Form utilized by the Board. Inspections conducted pursuant to this subsection may be conducted during normal business hours with notice to the licensed dentist who owns the office or facility to be inspected.*

2. *The inspection and re-inspection procedures and regulations applicable to initial inspections pursuant to NAC 631.1785, are incorporated herein by reference and shall apply equally to inspections pursuant to this section.*

3. *Pursuant to subsection 3 of NRS 233B.127, if an inspection of an office or facility conducted pursuant to this section indicates that the public health, safety or welfare imperatively requires emergency action, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the licensed dentist who owns the office or facility and the licenses of any or all of the other licensees employed at the office or facility pending proceedings for revocation or other action. An order for summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order for summary suspension. The President of the Board shall not participate in any further proceedings relating to the order.*

*NAC 631.\_\_\_\_ Inspection of Records*

1. *During the investigation of a verified or authorized complaint pursuant to NRS 631.360 and/or NRS 631.363, if the licensee under investigation fails to provide a copy of records requested pertaining to the investigation, or at the request of the investigator or Review Panel, the Executive Director, the investigator, and/or an agent(s) of the Board*



*assigned by the Executive Director, may appear at the office at which the records are located to inspect and copy the requested records pursuant to NRS 629.061. Inspection of records pursuant to this section shall take place during normal business hours and the licensee and/or custodian of records shall be given notice in accordance with NRS 629.061.*

**NAC 631.1795 Provisions governing inspections do not preclude Board from initiating disciplinary proceedings.** (NRS 631.190) Nothing in NAC 631.1785, ~~and 631.179~~ *and/or NAC 631. \_\_\_\_* prevents the Board from initiating disciplinary proceedings or additional disciplinary proceedings against a licensed dentist who owns an office or facility in this State where dental treatments are to be performed or against other licensees or personnel of the office or facility for failure to comply with the guidelines adopted by reference in NAC 631.178, *and/or the infection control inspection guidelines pursuant to the Infection Control Inspection/Survey Form*

(Added to NAC by Bd. of Dental Exam'rs by R201-09, eff. 8-13-2010)

**NAC 631.190 Specialties.** (NRS 631.190, 631.250, 631.255) The only specialties for which the Board will issue licenses are:

1. Oral and maxillofacial pathology;
2. Oral and maxillofacial surgery;
3. Orthodontia;
4. Periodontia;
5. Prosthodontia;
6. Pediatric dentistry;
7. Endodontia;
8. Public health; ~~and~~
9. Oral and maxillofacial radiology; ~~and~~,
- 10. Dental Anesthesiology.*

[Bd. of Dental Exam'rs, § XXI, eff. 7-21-82] — (NAC A 10-7-85; R158-08, 12-17-2008)

**NAC 631.200 Delegation of duty to supervise dental hygienists and dental assistants.** (NRS 631.190, 631.313) The supervisory duties prescribed in NRS 631.313 may be delegated by one licensed dentist to another.

[Bd. of Dental Exam'rs, § XXIV, eff. 7-21-82] — (NAC A 12-15-87)

***NAC 631. \_\_\_\_ Dental therapists: Authorization to perform certain services; inspection of office or facility during investigation; subsequent action by Executive Director.*** (NRS 631.190, 631.3122, 631.3123, 631.3124, 631.3125; 631.3126; 631.3127)

*1. A dentist who is licensed in this State may enter into a written practice agreement with a dental therapist who is licensed in this State, pursuant to NRS 631.3122. In accordance with the written practice agreement required pursuant to NRS 631.3122, a dental therapist may perform the following acts:*

- (a) Expose radiographs.*
- (b) Conduct an assessment of the oral health of the patient through medical and dental histories, radiographs, indices, risk assessments and intraoral and extraoral procedures that analyze and identify the oral health needs and problems of the patient.*
- (c) After conducting an assessment pursuant to paragraph (b), develop a dental hygiene care plan to address the oral health needs and problems of the patient.*

- (d) Take the following types of impressions:
- (1) Those used for the preparation of diagnostic models;
  - (2) Those used for the fabrication of temporary crowns or bridges; and
  - (3) Those used for the fabrication of temporary removable appliances, provided no missing teeth are replaced by those appliances.
- (e) Remove stains, deposits and accretions, including dental calculus.
- (f) Smooth the natural and restored surface of a tooth by using the procedures and instruments commonly used in oral prophylaxis, except that an abrasive stone, disc or bur may be used only to polish a restoration. As used in this paragraph, "oral prophylaxis" means the preventive dental procedure of scaling and polishing which includes the removal of calculus, soft deposits, plaques and stains and the smoothing of unattached tooth surfaces in order to create an environment in which hard and soft tissues can be maintained in good health by the patient.
- (g) Provide dental hygiene care that includes:
- (1) Implementation of a dental hygiene care plan to address the oral health needs and problems of patients pursuant to paragraph (c).
  - (2) Evaluation of oral and periodontal health after the implementation of the dental hygiene care plan described in subparagraph (1) in order to identify the subsequent treatment, continued care and referral needs of the patient.
- (h) Perform subgingival curettage.
- (i) Remove sutures.
- (j) Place and remove a periodontal pack.
- (k) Remove excess cement from cemented restorations and orthodontic appliances. A dental therapist may not use a rotary cutting instrument to remove excess cement from restorations or orthodontic appliances.
- (l) Train and instruct persons in the techniques of oral hygiene and preventive procedures.
- (m) Recement and repair temporary crowns and bridges.
- (n) Recement permanent crowns and bridges with nonpermanent material as a palliative treatment.
- (o) Place a temporary restoration with nonpermanent material as a palliative treatment.
- (p) Administer local intraoral chemotherapeutic agents in any form except aerosol, including, but not limited to:
- (1) Antimicrobial agents;
  - (2) Fluoride preparations;
  - (3) Topical antibiotics;
  - (4) Topical anesthetics; and
  - (5) Topical desensitizing agents.
- (q) Apply pit and fissure sealant to the dentition for the prevention of decay.
- ➔ After performing any of the services set forth in subsection 1, the dental therapist shall refer the patient to the authorizing dentist for follow-up care or any necessary additional procedures that the dental therapist is not authorized to perform.
2. In accordance with the written practice agreement, a dental therapist may provide any of the following additional care or services:
- (a) Identifying oral and systemic conditions that require evaluation or treatment by dentists, physicians, or other health care professionals and managing referrals to such persons.
  - (b) Providing oral health instruction and disease prevention education, including nutritional counseling and dietary analysis.

*(c) Dispensing and administering via the oral or topical route nonnarcotic analgesics and anti-inflammatory and antibiotic medications as prescribed by a health care professional.*

*(d) Pulp and vitality testing.*

*(e) Applying desensitizing medication or resin.*

*(f) Fabricating mouth guards*

*(g) Changing periodontal dressings.*

*(h) Simple extraction of erupted primary teeth.*

*(i) Emergency palliative treatment of dental pain related to a care or service described in this section.*

*(j) Preparation and placement of direct restoration in primary and permanent teeth.*

*(k) Fabrication and placement of single tooth temporary crowns.*

*(l) Preparation and placement of preformed crowns on primary teeth.*

*(m) Indirect and direct pulp capping on permanent teeth.*

*(n) Suturing and suture removal.*

*(o) Minor adjustments and repairs on removable prostheses.*

*(p) Placement and removal of space maintainers.*

*(q) Nonsurgical extractions of periodontally diseased permanent teeth with tooth mobility. However, a dental therapist shall not extract a tooth for any patient if the tooth is unerupted, impacted, or fractured or needs to be sectioned for removal.*

*(r) Performing other related services and functions authorized and for which the dental therapist is trained.*

*(s) Administer vaccinations pursuant to NAC 652.\_\_\_\_.*

*3. A dental therapist shall not prescribe a controlled substance that is included in schedules II, III, IV or V of the Uniform Controlled Substances Act.*

*4. A dental therapist may supervise dental assistants and dental hygienists to the extent permitted in a written practice agreement.*

**NAC 631.210 Dental hygienists: Authorization to perform certain services; referral of patient to authorizing dentist for certain purposes. ([NRS 631.190](#), [631.310](#), [631.313](#), [631.317](#))**

1. A dentist who is licensed in this State may authorize a dental hygienist in his or her employ and under his or her supervision to:

(a) Place and secure orthodontic ligatures.

(b) Fabricate and place temporary crowns and bridges.

(c) Fit orthodontic bands and prepare teeth for orthodontic bands if the bands are cemented or bonded, or both, into the patient's mouth by the dentist who authorized the dental hygienist to perform this procedure.

(d) Perform nonsurgical cytologic testing.

(e) Apply and activate agents for bleaching teeth with a light source.

(f) Use a laser that has been cleared by the Food and Drug Administration to perform intrasulcular periodontal procedures or tooth whitening procedures if:

(1) The use of such a laser for those purposes is within the scope of the education, experience and training of the dental hygienist;

(2) Before operating the laser, the dental hygienist has provided proof to the supervising dentist that the dental hygienist has successfully completed a course in laser proficiency that:

(I) Is at least 6 hours in length; and



(II) Is based on the *Curriculum Guidelines and Standards for Dental Laser Education*, adopted by reference pursuant to [NAC 631.035](#); and

(3) The supervising dentist has successfully completed a course in laser proficiency that:

(I) Is at least 6 hours in length; and

(II) Is based on the *Curriculum Guidelines and Standards for Dental Laser Education*, adopted by reference pursuant to [NAC 631.035](#).

(g) *Administer vaccinations pursuant to NAC 652.\_\_\_\_.*

➤ The dental hygienist must obtain authorization from the licensed dentist of the patient on whom the services authorized pursuant to this subsection are to be performed.

4. If a dentist who is licensed in this State has in his or her employ and under his or her supervision a dental hygienist who has:

(a) Successfully completed a course of continuing education in the administering of local anesthetics or nitrous oxide-oxygen analgesia, or both, which has been approved by the Board; or

(b) Graduated from an accredited program of dental hygiene which includes the administering of local anesthetics or nitrous oxide-oxygen analgesia, or both, in its curriculum,

➤ the dentist may authorize the dental hygienist to administer local anesthetics or nitrous oxide-oxygen analgesia, or both, as appropriate, if the dental hygienist has received from the Board a certificate or permit certifying the hygienist for this level of administration. The dental hygienist must obtain the authorization from the licensed dentist of the patient on whom the services are to be performed.

5. A dental hygienist in a health care facility may administer local intraoral chemotherapeutic agents and, if he or she has complied with paragraph (a) or (b) of subsection 4, may administer local anesthetics or nitrous oxide-oxygen analgesia, or both, as appropriate, if he or she first:

(a) Obtains written authorization from the licensed dentist of the patient to whom the local anesthetics, nitrous oxide-oxygen analgesia or local intraoral chemotherapeutic agents are to be administered; and

(b) Submits to the Secretary-Treasurer a written confirmation from the director of the health care facility that the facility has licensed medical personnel and necessary emergency supplies and equipment that will be available when the local anesthetics, nitrous oxide-oxygen analgesia or local intraoral chemotherapeutic agents are administered.

6. The Board may authorize a dental hygienist to perform the services set forth in subsection 1 and paragraphs (a) to (n), inclusive, of subsection 2 without supervision by a dentist and without authorization from the licensed dentist of the patient on whom the services are to be performed, at a health facility, a school or a place in this State approved by the Board after the Board:

(a) Issues a special endorsement of the dental hygienist's license.

(b) Approves the treatment protocol submitted by the dental hygienist which includes an explanation of the methods that the dental hygienist will use to:

(1) Treat patients; and

(2) Refer patients to a dentist for:

(I) Follow-up care;

(II) Diagnostic services; and

(III) Any service that the dental hygienist is not authorized to perform.

7. The Board may revoke the authorization described in subsection 6 if the:

(a) Dental hygienist fails to renew his or her license or it is cancelled, suspended or revoked;

- (b) Board receives a complaint filed against the dental hygienist;
  - (c) Dental hygienist commits an act which constitutes a cause for disciplinary action; or
  - (d) Dental hygienist violates any provision of this chapter or [chapter 631](#) of NRS.
- ➔ Nothing in this subsection prohibits a dental hygienist from reapplying for authorization to perform the services described in subsection 6 if the Board revokes the authorization pursuant to this subsection.

8. As used in this section:

- (a) “Health care facility” has the meaning ascribed to it in [NRS 162A.740](#).
- (b) “Health facility” has the meaning ascribed to it in subsection 6 of [NRS 449.260](#).
- (c) “School” means an elementary, secondary or postsecondary educational facility, public or private, in this State.

*1. To the extent that a dental hygienist with a special health endorsement pursuant subsection 6 of this section includes placement of silver diamine and glass ionomer in his or her treatment protocol pursuant to subsection 6(b), the dental hygienist must obtain \_\_\_ hours of education from the Nevada Division of Public and Behavioral Health, Oral Health Program prior to use of this treatment protocol regarding the proper placement of silver diamine and glass ionomer and must follow the Nevada Policy for the Application of Silver Diamine Fluoride by Licensed Public Health Endorsed Dental Hygienists, including the use of the informed consent contained therein, prepared by the Nevada Division of Public and Behavioral Health, Oral Health Program.*

[Bd. of Dental Exam’rs, § XXIII, eff. 7-21-82] — (NAC A 7-30-84; 4-3-89; 3-11-96; R154-97, 1-14-98; R217-99, 4-3-2000; R231-03, 5-25-2004; R139-05, 12-29-2005; R066-11, 2-15-2012; R119-15, 6-28-2016)

**NAC 631.220 Dental assistants: Authorization to perform certain services; supervision by dental hygienist for certain purposes. ([NRS 631.190](#), [631.313](#), [631.317](#))**

1. A dentist who is licensed in the State of Nevada may authorize a dental assistant in his or her employ and under his or her supervision to perform the following procedures before the patient is examined by the dentist:

- (a) Expose radiographs; and
- (b) Take impressions for the preparation of diagnostic models.

2. A dentist who is licensed in the State of Nevada may authorize a dental assistant in his or her employ and under his or her supervision only to do one or more of the following procedures after the patient has been examined by the dentist:

- (a) Retract a patient’s cheek, tongue or other tissue during a dental operation.
- (b) Remove the debris that normally accumulates during or after a cleaning or operation by the dentist by using mouthwash, water, compressed air or suction.
- (c) Place or remove a rubber dam and accessories used for its placement.
- (d) Place and secure an orthodontic ligature.
- (e) Remove sutures.
- (f) Place and remove a periodontal pack.
- (g) Remove excess cement from cemented restorations and orthodontic appliances. A dental assistant may not use a rotary cutting instrument to remove excess cement from restorations or orthodontic appliances.
- (h) Administer a topical anesthetic in any form except aerosol.
- (i) Train and instruct persons in the techniques of oral hygiene and preventive procedures.

- (j) Take the following types of impressions:
    - (1) Those used for the preparation of counter or opposing models;
    - (2) Those used for the fabrication of temporary crowns or bridges; and
    - (3) Those used for the fabrication of temporary removable appliances, provided no missing teeth are replaced by those appliances.
  - (k) Fabricate and place temporary crowns and bridges. This procedure must be checked and approved by the supervising dentist before dismissal of the patient from the office of the dentist.
  - (l) Retract gingival tissue if the retraction cord contains no medicaments that have potential systemic side effects.
  - (m) Remove soft plaque and stain from exposed tooth surfaces, utilizing an appropriate rotary instrument with a rubber cup or brush and a suitable polishing agent. A licensed dentist or dental hygienist shall determine that the teeth to be polished are free of calculus or other extraneous material.
  - (n) Administer a topical fluoride.
  - (o) Apply pit and fissure sealant to the dentition for the prevention of decay. This procedure must be checked and approved by the supervising dentist before dismissal of the patient from the office of the dentist.
  - (p) Fit orthodontic bands and prepare teeth for orthodontic bands if the bands are cemented or bonded, or both, into the patient's mouth by the dentist who authorized the dental assistant to perform this procedure.
3. A dentist who is licensed in the State of Nevada may authorize a dental hygienist to supervise a dental assistant in the assistance of the hygienist's performance of one or more of the following:
- (a) Retract a patient's cheek, tongue or other tissue during a dental operation.
  - (b) Remove the debris that normally accumulates during or after a cleaning or operation by the dental hygienist by using mouthwash, water, compressed air or suction.
  - (c) Train and instruct persons in the techniques of oral hygiene and preventive procedures.
  - (d) Remove soft plaque and stain from exposed tooth surfaces, utilizing an appropriate rotary instrument with a rubber cup or brush and a suitable polishing agent. A licensed dentist or dental hygienist shall determine that the teeth to be polished are free of calculus or other extraneous material.
  - (e) Administer a topical fluoride.
4. A dental hygienist, who is authorized by the Board to perform the services described in subsection 6 of [NAC 631.210](#), may authorize a dental assistant under his or her supervision to assist the hygienist in the performance of the services described in paragraphs (a) to (e), inclusive, of subsection 3.
- [Bd. of Dental Exam'rs, § XXII, eff. 7-21-82] — (NAC A 10-21-83; 10-7-85;

**Agenda Item (7)(r):**

**Voluntary Surrender of License**

## Nevada State Board of Dental Examiners



Received  
AUG 25 2020  
NSBDE

6010 S. Rainbow Blvd., Bldg. A, Ste.1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

## VOLUNTARY SURRENDER OF LICENSE

I, Debbie R. Bartlett, hereby surrender my Dental (Dental Hygiene) (circle one)  
Print name

License number 2117 on the 18th day of Aug, 20 20.

By signing this document, I understand, pursuant to Nevada Administrative Code (NAC) 631.160, the surrender of this license is absolute and irrevocable. Additionally, I understand that the voluntary surrender of this license does not preclude the Board from hearing a complaint for disciplinary action filed against this licensee.

Provide full current mailing address including city, state and zip on the line below:

[Redacted Address]

Email address: [Redacted]

Home Phone: [Redacted]

Cell Phone: [Redacted]

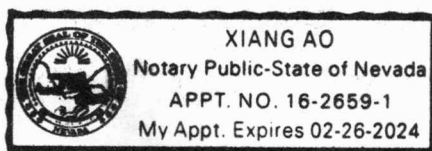
Debbie R. Bartlett  
Licensee Signature

8/18/2020  
Date of Signature (must correspond with notary date)

State of Nevada

County of Clark

The statements on this document are subscribed and sworn before me this 18 day of Aug, 20 20.



Xiang AO  
Notary Public

Feb. 26, 2024  
My Commission Expires

## Nevada State Board of Dental Examiners

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JUL 27 2020

NSBDE



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## VOLUNTARY SURRENDER OF LICENSE

Julie Christine Morris

Print name

, hereby surrender my Dental / Dental Hygiene (circle one)

License number

2007119

on the 22nd day of July, 2020

By signing this document, I understand, pursuant to Nevada Administrative Code (NAC) 631.160, the surrender of this license is absolute and irrevocable. Additionally, I understand that the voluntary surrender of this license does not preclude the Board from hearing a complaint for disciplinary action filed against this licensee.

Provide full current mailing address including city, state and zip on the line below:

Email address:

Home Phone:

Cell Phone:

Licensee Signature

Julie Morris

Date of Signature (must correspond with notary date)

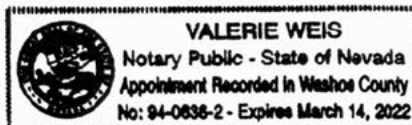
7/22/2020

State of Nevada  
County of Washoe

The statements on this document are subscribed and sworn before me this 22 day of July, 2020.

Notary Public

My Commission Expires



## Nevada State Board of Dental Examiners



Received

SEP 29 2020

NSBDE

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**VOLUNTARY SURRENDER OF LICENSE**

I, JUDY ANN WHITE, hereby surrender my Dental / Dental Hygiene (circle one)  
Print name

License number 102249 on the 28 day of SEPTEMBER, 20 20.

By signing this document, I understand, pursuant to Nevada Administrative Code (NAC) 631.160, the surrender of this license is absolute and irrevocable. Additionally, I understand that the voluntary surrender of this license does not preclude the Board from hearing a complaint for disciplinary action filed against this licensee.

Provide full current mailing address including city, state and zip on the line below:

Email address: [REDACTED]

Home Phone: ( ) [REDACTED]

Cell Phone: ( ) [REDACTED]

SEE ATTACHED LETTER.

[Signature]  
 Licensee Signature

September 28, 2020  
 Date of Signature (must correspond with notary date)

State of Wisconsin

County of Manitowoc

The statements on this document are subscribed and sworn before me this 28<sup>th</sup> day of September, 20 20.

Susan M. Munk

Notary Public

05/25/2021

My Commission Expires



September 28, 2020

Received  
SEP 29 2020  
NSBDE

[REDACTED]

Nevada State Board of Dental Examiners  
6010 S. Rainbow Blvd., Ste. A-1  
Las Vegas, NV 89118

To the Board,

I am writing to retire my dental hygiene license #102249; enclosed please find the corresponding form. This form refers to this action as a "voluntary surrender". Please note that I am "surrendering" my dental hygiene license solely because I am no longer practicing in Nevada. I have not been asked/required to do so by the Nevada State Board of Dental Examiners. No proceedings have been initiated against me to surrender or revoke my license in Nevada or in any other state. There is not now (to my knowledge), or has there ever been any type of disciplinary action expected, pending, or in progress in Nevada or any other state.

Thank you for your attention in this matter.

Respectfully,



Judy Ann White RDH, MPH

State of Wisconsin  
County of Manitowoc

This day September 28, 2020.

Susan M. Menk

Susan M. Menk

Notary Public

My commission expires May 25, 2021.





## **Agenda Item (7)(s)(1)**

**Application to Reactivate License:**  
**- Dr. Michael Husbands**



AUG 18 2020

NSBDE

## Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste. 1

Las Vegas, NV 89118

(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

## APPLICATION TO REACTIVATE AN INACTIVE / RETIRED LICENSE

Name Michael Lee Husbands Current Phone [REDACTED]

Email [REDACTED]

Complete Mailing Address [REDACTED]

I, Michael Lee Husbands, wish to reactivate my inactive Dental Dental Hygiene (circle one) license number 4155, which was placed on inactive/retired status on 6/30/17. I certify (choose one below):

☐ I have maintained an active license and practice (active license and working) outside the state of Nevada during the period my Nevada license has been inactive;

## Requirements for reactivation are:

- ☒ 1. Payment of the reactivation fee of \$300.00 in addition to the pro-rated current active license fees. You will need to contact the Board office for confirmation of the correct fees to pay;
- ☒ 2. Provide a list of employment during the time the Nevada license was inactive;
- ☒ 3. Submit proof of current CPR certification (online certification is NOT acceptable);
- ☒ 4. Submit proof of completion of continuing education credits as follows (courses must be completed within the previous 12 months):
  - a. For Dentists reactivating, 20 credit hours are required (of those 20, a minimum of 10 MUST be live-instruction and a minimum of 2 must be in infection control);
  - b. For Hygienists reactivating, 15 credit hours are required (of those 15, a minimum of 7.5 MUST be live-instruction and a minimum of 2 must be in infection control);
- ☒ 5. A current self-query report from the National Practitioners Data Bank dated (no more than 90 days old; copies not accepted);
- ☒ 6. Provide certification letter (no more than 90 days old) from each state in which you currently hold a license (regardless of the status) to practice dentistry or dental hygiene, that the license is in good standing and that no proceedings which may affect that standing are pending;

☒ I have not maintained an active license and practice (no active license and not working) for one or more years outside the state of Nevada during the period my Nevada license has been inactive or retired;

## Requirements for reactivation are:

1. For licenses on inactive/retired status for less than 2 years:
  - a. Complete items (1) through (5) above.
- ☒ 2. For licenses on inactive/retired status for 2 years or more:
  - a. Complete items (1) through (5) above;  $\Rightarrow$  1, 3, 4, 5 (#2 not apply; not worked as DDS since 2016)
  - b. Pass such additional examinations for licensure as the Board may prescribe.

I attest that I am in compliance with the reporting requirements regarding service of claims or complaints of malpractice, felony or misdemeanor convictions, the suspension, revocation or probation of my license by another licensing jurisdiction or child support order (if applicable) pursuant to NAC 631.155 and NRS 631.225. If not previously reported, **FULL DISCLOSURE OF EACH SUCH CASE MUST BE ENCLOSED WITH THIS REACTIVATION APPLICATION.**

I authorize and empower the Nevada State Board of Dental Examiners or its agent to contact any person, firm, service, agency, or the like to obtain information deemed necessary or desirable by the Board to verify any information contained in my application to reactivate my inactive/retired license based upon this affidavit. I acknowledge I have a continuing responsibility to update all information contained in this application until such time as the Board takes action on this application. Failure of an applicant to update the information prior to final action of the Board is grounds for subsequent disciplinary action.

STATE OF California  
COUNTY OF Riverside

SIGNATURE OF LICENSEE

Michael Lee Husbands

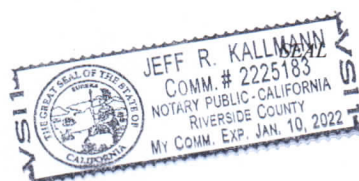
DATE

08/17/2020

SUBSCRIBED TO AND SWORN BEFORE ME, this

17<sup>th</sup>

day of

August, 2020#600-  
MO# [REDACTED]

NOTARY PUBLIC IN AND FOR SAID COUNTY AND STATE

Applications with incomplete contact information will be returned for completion

Rev 08/2020