



## South Dakota State Board of Dentistry

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# SOUTH DAKOTA STATE BOARD OF DENTISTRY NOTICE OF MEETING The Public is Welcome to Attend

### South Dakota State Board of Dentistry

Board Meeting Agenda

10:00 a.m. Friday – June 17, 2016

*or immediately following the Administrative Rules Public Hearing*

SD Housing Development Authority Board Room – 3060 E. Elizabeth St. Pierre, SD

- 1) Call to Order
- 2) Open Forum: *5 minutes for the public to address the Board*
- 3) Approval of Minutes: January 15, 2016 and March 22, 2016
- 4) Financial Report
- 5) Office Update
- 6) Regional Examinations
  - a. Regional Examination Presentation
  - b. ADA/ADEA Correspondence
- 7) Executive Session - SDCL 1-25-2(3) and 1-25-2(4)
- 8) License Applications:
- 9) Old Business
  - a. Continued Competency – Anesthesia
- 10) New Business
  - a. Collaborative Supervision Application
  - b. Nitrous Oxide Course Approval – Western Dakota Technical Institute/Leslie Greager
  - c. Advisory Opinion - Sleep Apnea
  - d. Advisory Opinion – Topical Anesthetic
  - e. Advisory Opinion - Protective Restorations
  - f. Joint Commission on National Dental Examinations (JCNDE) Correspondence
  - g. ARSD Feedback - SDDHA
  - h. Travel Approval – AADB Meetings
  - i. Review of Approved Courses
  - j. Continuing Education Guidelines
  - k. Elections and Appointments
  - l. 2017 Meeting Dates
- 11) Announcements
- 12) Adjourn

SD State Board of Dentistry  
Board Meeting  
SD Housing Development Authority Conference Room  
Friday, January 15, 2016 10:00am

President Roger Wilson called the meeting to order at 10:05 am Central.

Present were: Dr. Roger Wilson, Dr. Amber Determan, Tina Van Camp, Zona Hornstra, Kris O'Connell, Brittany Novotny, and Lisa Harsma.

Present via teleconference: Dr. Robin Hattervig, Dr. Orin Ellwein, Stephen Bucholz, Dr. David Simmons and Jim Tarrant.

Guests included: Ronald Tedrow, Paul Knecht, Dr. Randy Sachau, Dr. Andris Kirsis, Dr. Nathan Schwandt and Keri Thompson.

The Board reviewed the minutes from the October 16, 2015 meeting. Motion to approve the minutes of October 16, 2015 by Van Camp. Second by Determan. Motion carried.

Motion to approve the agenda as presented by Determan. Second by Hornstra. Motion carried.

Ronald Tedrow presented the FY 2015 Financial Audit. Motion to approve the financial audit by Hornstra. Second by Determan, Motion carried.

Novotny presented the financial statements. Motion to approve the financial statements by Determan. Second by Van Camp. Motion carried.

Novotny provided an office update.

Motion to move into Executive Session pursuant to SDCL 1-25-2(3) and (4) by Hattervig. Second by Van Camp. Motion carried. The board went into Executive Session at 10:45 am.

Motion to move out of Executive Session by Van Camp. Second by Determan. Motion carried. The board moved out of Executive Session at 11:47 am.

Motion to dismiss complaint 2.1516 by Hattervig. Second by Determan. Motion carried.

Motion to proceed with the investigation for complaint 7.1415 by Van Camp. Second by Hornstra. Motion carried.

Motion to approve an Interagency Agreement with the Board of Pharmacy with a \$100 hourly rate and capped at \$2,500 by Van Camp. Second by Hornstra. Motion carried.

Motion to approve the dentist credential verification applications of: Robert Mongrain, Timothy Larson, Richard Kava, and Richard Clabaugh III by Determan. Second by Hattervig. Motion carried.

Motion to approve the dentist application of: Danial Hanlon by Van Camp. Second by Determan. Motion carried.

Motion to approve the dental hygienist credential verification application of: Jennifer Beck by Hornstra. Second by Van Camp. Motion carried.

Motion to approve the dental hygienist applications of: Bailey Martin, Jacqueline O'Malley, and Betsie McCarty by Hornstra. Second by Van Camp. Motion carried.

Motion to approve the corporation applications of: Megan Beckwith, D.M.D. PC, Michael H. Doerr D.M.D. PC, and Patrick Anderson DDS, PC by Hattervig. Second by Determan. Motion carried.

O'Connell discussed the draft advisory opinion prepared pursuant to the request of Pat Aylward. Motion to approve the advisory opinion related to the scope of practice of a dental hygienist by Determan. Second by Hornstra. Motion carried.

The board discussed the regional examinations and changes related to the Central Regional Dental Testing Service, Inc. (CRDTS) examination.

The board discussed continued competency as it relates to licensees that hold a Moderate Sedation or General Anesthesia and Deep Sedation Permit. The Board requested feedback from the Anesthesia Credentials Committee and Anesthesia Inspectors.

Paul Knecht discussed the South Dakota Dental Association (SDDA) Ethics Committee.

Formal appearance of Dr. Andris Kirsis regarding application for licensure.

Motion to go into Executive Session pursuant to SDCL 1-25-2(3) by Determan. Second by Hornstra. Motion carried. The board went into Executive Session at 1:05 pm.

Motion to move out of Executive Session by Determan. Second by Hornstra. Motion carried. The board moved out of Executive Session at 1:12 pm.

The Board reviewed proposed changes to ARSD 20:43:01, 20:43:02, and 20:43:05. The Board instructed Novotny to begin the formal rules process this spring with a public hearing to be held in conjunction with the June 17, 2016 board meeting.

Stephen Bucholz presented information regarding the Western Dakota Technical Institute (WDTI) Dental Assistant program. Motion to approved the WDTI Dental Assistant program while the program is under the ADA CODA accreditation process by Hattervig. Second by Determan. Motion carried.

The board reviewed two scope of practice requests. The Board instructed O'Connell to draft an advisory opinion related to sleep apnea for review at the next board meeting and requested additional information related to protective restorations.

Dr. David Simmons presented on the Louisiana State University School of Dentistry Assessment program.

Jim Tarrant presented the American Association of Dental Boards (AADB) Assessment Service Program.

Motion to deny the dental credential application of Andris Kirsis by Determan. Second by Hornstra. Motion carried.

The Board discussed the 2016 Legislative Session and potential legislation impacting the Dental Practice Act.

The Board reviewed the feedback from interested parties related to ARSD 20:43. Novotny noted feedback had not yet been submitted by the South Dakota Dental Hygienists' Association.

The Board announced the following meeting dates: June 17, 2016, October 14, 2016 and January 13, 2017.

Motion to adjourn by Hornstra. Second by Determan. Motion carried. The meeting was adjourned at 4:13 pm.

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Tina Van Camp, Secretary

SD State Board of Dentistry  
Board Meeting  
Teleconference  
March 22, 2016 6:30pm Central

President Wilson called the meeting to order at 6:33 pm Central.

Present were: Dr. Roger Wilson, Dr. Roy Seaverson, Dr. Robin Hattervig, Dr. Tara Schaack, Zona Hornstra, Dr. Amber Determan, Kris O'Connell, and Brittany Novotny.

Motion to move into Executive Session pursuant to SDCL 1-25-2(3) and (4) by Seaverson. Second by Schaack. Motion carried. The board went into Executive Session at 6:36pm.

Dr. Roger Wilson— Yes

Dr. Roy Seaverson— Yes

Zona Hornstra— Yes

Dr. Robin Hattervig— Yes

Dr. Tara Schaack— Yes

Dr. Amber Determan— Yes

Motion to move out of Executive Session by Hattervig. Second by Seaverson. Motion carried. The board came out of Executive Session at 7:15pm

Dr. Roger Wilson— Yes

Dr. Roy Seaverson— Yes

Zona Hornstra— Yes

Dr. Robin Hattervig— Yes

Dr. Tara Schaack— Yes

Dr. Amber Determan— Yes

Motion to approve the Board of Dentistry contracts, as presented, by Schaack. Second by Hattervig. Motion carried.

Dr. Roger Wilson— Yes

Dr. Roy Seaverson— Yes

Zona Hornstra— Yes

Dr. Robin Hattervig— Yes

Dr. Tara Schaack— Yes

Dr. Amber Determan— Yes

Motion to approve the Board of Dentistry contract with Albertson Consulting, as presented, by Seaverson. Second by Determan. Motion carried.

Dr. Roger Wilson— Yes

Dr. Roy Seaverson— Yes

Zona Hornstra— Yes

Dr. Robin Hattervig— Yes

Dr. Tara Schaack— Yes

Dr. Amber Determan— Yes

There being no further business, the meeting was adjourned at 7:20pm.

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Tina Van Camp, Secretary

4:20 PM  
 06/08/16  
 Cash Basis

**South Dakota State Board of Dentistry**  
**Profit & Loss**  
 July 1, 2015 through June 8, 2016

Jul 1, '15 - Jun 8, 16

<b>Income</b>	
<b>4100 · DENTIST LICENSURE</b>	
4105 · Dentist New	750.00
4110 · Dentist Renewal	6,970.00
4115 · Dentist JP Exam	3,600.00
4125 · Dentist Reinstate	4,275.00
4135 · Dentist Nitrous Oxide	280.00
4137 · Dentist Nitrous Oxide Renewal	1,000.00
4142 · Moderate Sed- Ped/Adult Renewal	50.00
4147 · Moderate Sed-Adult only Renewal	50.00
4152 · GA/Deep Sedation Renewal	100.00
<b>Total 4100 · DENTIST LICENSURE</b>	<b>17,075.00</b>
<b>4200 · HYGIENIST LICENSURE</b>	
4205 · Hygienist New	500.00
4210 · Hygienist Renewal	8,550.00
4215 · Hygienist JP Exam	920.00
4220 · Hygienist Anesthesia Renewal	1,680.00
4222 · Hygienist Anesthesia New	360.00
4225 · Hygienist Reinstate	2,070.00
4235 · Hygienist Nitrous Oxide	280.00
4237 · Hygienist Nitrous Oxide Renewal	1,240.00
<b>Total 4200 · HYGIENIST LICENSURE</b>	<b>15,600.00</b>
<b>4300 · RADIOLOGY LICENSURE</b>	
4305 · Radiology New	3,800.00
4307 · Radiology Renewal	1,760.00
4315 · Radiology Reinstate	2,240.00
<b>Total 4300 · RADIOLOGY LICENSURE</b>	<b>7,800.00</b>
<b>4400 · EXPANDED FUNCTIONS LICENSURE</b>	
4405 · EF New	2,600.00
4410 · EF Renewal	1,440.00
4415 · EF Reinstate	1,560.00
4420 · EF Nitrous Oxide	1,640.00
4422 · EF Nitrous Oxide Renewal	900.00
<b>Total 4400 · EXPANDED FUNCTIONS LICENSURE</b>	<b>8,140.00</b>
<b>4500 · CORPORATION LICENSURE</b>	
4505 · Corporation New	700.00
4510 · Corporation Renewal	4,198.35
<b>Total 4500 · CORPORATION LICENSURE</b>	<b>4,898.35</b>
<b>4600 · TEMPORARY LICENSE</b>	500.00
<b>4700 · CREDENTIAL VERIFICATION</b>	
4705 · Dentist Cred. Verification	5,500.00
4715 · Hygienist Cred. Verification	600.00
<b>Total 4700 · CREDENTIAL VERIFICATION</b>	<b>6,100.00</b>
<b>4800 · LIST</b>	4,650.00
<b>4925 · REPLACEMENT CERT</b>	30.00
<b>4950 · MISCELLANEOUS</b>	
4965 · Anes Insp (St. Code 124100) A/R	504.36
<b>Total 4950 · MISCELLANEOUS</b>	<b>504.36</b>
<b>4975 · INTEREST</b>	7,065.27
<b>5000 · VERIFICATION LETTERS</b>	575.00
<b>5025 · Processing Fee</b>	315.00
<b>Total Income</b>	<b>73,252.98</b>
<b>Expense</b>	
124100 · Anesthesia Inspection - A/R	504.36
5203140 · Taxable Meals/In-State	11.00
5204510 · Rents-Other	75.00

4:20 PM  
06/08/16  
Cash Basis

**South Dakota State Board of Dentistry**  
**Profit & Loss**  
July 1, 2015 through June 8, 2016

	<u>Jul 1, '15 - Jun 8, 16</u>
<b>8000 · SALARIES</b>	
510103 · Board & Comm Mbrs Fees	1,260.00
<b>Total 8000 · SALARIES</b>	<u>1,260.00</u>
<b>8100 · BENEFITS (BOARD'S SHARE)</b>	
5102010 · OASI-Employer's Share	97.23
<b>Total 8100 · BENEFITS (BOARD'S SHARE)</b>	<u>97.23</u>
<b>8200 · TRAVEL (EMPL &amp; BOARD)</b>	
520303 · Auto-Priv(In-St) H/Rte	650.58
520307 · Air-Charter-In State	8,972.93
520313 · Non-Employ Travel-In St.	215.00
<b>Total 8200 · TRAVEL (EMPL &amp; BOARD)</b>	<u>9,838.51</u>
<b>8300 · CONTRACTUAL SERVICES</b>	
520406 · Ed&Training Consultant	8,000.00
520408 · Legal Consultant	13,929.75
520409 · Management Consultant	84,660.79
520410 · Medical Consultant	4,484.73
520413 · Other Consulting	1,833.91
5204190 · Computer Services-Private	120.00
5204200 · Central Services	561.56
5204203 · Purchasing Central Serv	16.06
5204204 · Central Services-Records Mngmt	183.68
5204207 · Central Services-Human Resource	294.94
5204340 · Computure Software Maintenance	196.88
520436 · Advertising-Newspaper	691.60
520453 · Telecommunications Srvcs	1,148.69
520474 · Bank Fees and Charges	1,025.39
520496 · Other Contractual	340.88
<b>Total 8300 · CONTRACTUAL SERVICES</b>	<u>117,488.86</u>
<b>8400 · SUPPLIES AND MATERIALS</b>	
520502 · Office Supplies	88.16
520531 · Printing-State	220.00
520532 · Printing-Commercial	560.00
520535 · Postage	1,794.49
<b>Total 8400 · SUPPLIES AND MATERIALS</b>	<u>2,662.65</u>
<b>8600 · OTHER</b>	
520801 · Other	75.00
<b>Total 8600 · OTHER</b>	<u>75.00</u>
<b>Total Expense</b>	<u>132,012.61</u>
<b>Net Income</b>	<u><u>-58,759.63</u></u>

# Remaining Authority by Object/Subobject

Expenditures current through 06/04/2016 09:20:57 AM

HEALTH -- Summary

FY 2016 Version -- AS -- Budgeted and Informational

FY Remaining: 7.4 %

09202 Board of Dentistry - Info						PCT
Subobject	Operating	Expenditures	Encumbrances	Commitments	Remaining	AVL
<b>EMPLOYEE SALARIES</b>						
5101030 Board & Comm Mbrs Fees	8,474	1,920	0	0	6,554	77.3
<b>Subtotal</b>	<b>8,474</b>	<b>1,920</b>	<b>0</b>	<b>0</b>	<b>6,554</b>	<b>77.3</b>
<b>EMPLOYEE BENEFITS</b>						
5102010 Oasi-employer's Share	1,248	148	0	0	1,100	88.1
<b>Subtotal</b>	<b>1,248</b>	<b>148</b>	<b>0</b>	<b>0</b>	<b>1,100</b>	<b>88.1</b>
<b>51 Personal Services</b>						
<b>Subtotal</b>	<b>9,722</b>	<b>2,068</b>	<b>0</b>	<b>0</b>	<b>7,654</b>	<b>78.7</b>
<b>TRAVEL</b>						
5203030 Auto-priv (in-st.) H/rte	1,500	715	0	0	785	52.3
5203070 Air-charter-in State	16,000	14,206	0	0	1,794	11.2
5203100 Lodging/in-state	1,000	62	0	0	938	93.8
5203130 Non-employ. Travel-in St.	2,500	215	0	0	2,285	91.4
5203140 Meals/taxable/in-state	0	11	0	0	-11	0.0
5203150 Non-taxable Meals/in-st	0	21	0	0	-21	0.0
5203260 Air-comm-out-of-state	2,000	0	0	0	2,000	100.0
5203330 Non-employ Travel-out-st.	5,000	0	0	0	5,000	100.0
<b>Subtotal</b>	<b>28,000</b>	<b>15,230</b>	<b>0</b>	<b>0</b>	<b>12,770</b>	<b>45.6</b>
<b>CONTRACTUAL SERVICES</b>						
5204010 Subscriptions	300	0	0	0	300	100.0
5204020 Dues & Membership Fees	11,000	0	0	0	11,000	100.0
5204050 Computer Consultant	7,500	25,000	0	0	-17,500	0.0
5204060 Ed & Training Consultant	0	8,000	0	0	-8,000	0.0
5204080 Legal Consultant	25,000	25,831	0	0	-831	0.0
5204090 Management Consultant	136,410	148,604	16,746	0	-28,940	0.0
5204100 Medical Consultant	0	7,071	45,429	0	-52,500	0.0
5204130 Other Consulting	45,500	5,640	21,860	0	18,000	39.6
5204160 Workshop Registration Fee	0	860	0	0	-860	0.0
5204190 Computer Services-private	0	120	0	0	-120	0.0
5204200 Central Services	1,000	1,555	0	0	-555	0.0
5204203 Central Services	0	16	0	0	-16	0.0
5204204 Central Services	700	360	0	0	340	48.6
5204207 Central Services	1,000	482	0	0	518	51.8
5204310 Audit Services-state	4,000	0	0	0	4,000	100.0
5204330 Computer Software Lease	9,500	0	0	0	9,500	100.0

## Remaining Authority by Object/Subobject

Expenditures current through 06/04/2016 09:20:57 AM

HEALTH -- Summary

FY 2016 Version -- AS -- Budgeted and Informational

FY Remaining: 7.4 %

09202 Board of Dentistry - Info							PCT
Subobject	Operating	Expenditures	Encumbrances	Commitments	Remaining		AVL
5204340 Computer Software Maint	0	197	0	0	-197		0.0
5204350 Advertising-magazines	0	100	0	0	-100		0.0
5204360 Advertising-newspaper	400	692	0	0	-292		0.0
5204480 Microfilm & Photography	0	403	47	0	-450		0.0
5204510 Rents-other	0	75	0	0	-75		0.0
5204530 Telecommunications Svcs	2,500	2,523	0	0	-23		0.0
5204550 Garbage & Sewer	0	18	0	0	-18		0.0
5204590 Ins Premiums & Surety Bds	1,000	532	0	0	468		46.8
5204740 Bank Fees And Charges	7,500	-30	0	0	7,530		100.4
5204960 Other Contractual Service	0	2,193	0	0	-2,193		0.0
<b>Subtotal</b>	<b>253,310</b>	<b>230,242</b>	<b>84,082</b>	<b>0</b>	<b>-61,014</b>		<b>0.0</b>
<b>SUPPLIES &amp; MATERIALS</b>							
5205020 Office Supplies	2,100	476	0	0	1,624		77.3
5205310 Printing-state	1,500	638	0	0	862		57.5
5205320 Printing-commercial	4,600	560	0	0	4,040		87.8
5205350 Postage	4,500	2,606	0	0	1,894		42.1
<b>Subtotal</b>	<b>12,700</b>	<b>4,280</b>	<b>0</b>	<b>0</b>	<b>8,420</b>		<b>66.3</b>
<b>GRANTS AND SUBSIDIES</b>							
5206070 Grants To Non-profit Org	7,500	0	0	0	7,500		100.0
<b>Subtotal</b>	<b>7,500</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,500</b>		<b>100.0</b>
<b>OTHER</b>							
5208010 Other	1,000	93	0	0	907		90.7
<b>Subtotal</b>	<b>1,000</b>	<b>93</b>	<b>0</b>	<b>0</b>	<b>907</b>		<b>90.7</b>
<b>52 Operating Subtotal</b>	<b>302,510</b>	<b>249,845</b>	<b>84,082</b>	<b>0</b>	<b>-31,417</b>		<b>0.0</b>
<b>Total</b>	<b>312,232</b>	<b>251,913</b>	<b>84,082</b>	<b>0</b>	<b>-23,763</b>		<b>0.0</b>

STATE OF SOUTH DAKOTA  
 REVENUE SUMMARY BY BUDGET UNIT  
 FOR PERIOD ENDING: 05/31/2016

AGENCY 09 HEALTH  
 BUDGET UNIT 09202 BOARD OF DENTISTRY

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE	
COMPANY NO 6503		PROFESSIONAL & LICENSING BOARDS				
COMPANY NAME						
092020061807	6503	4293005	DENTIST CREDENTIAL	2,000.00	5,000.00	
092020061807	6503	4293015	HYGIENIST CREDENTIAL	400.00	820.00	
092020061807	6503	4293025	PROCESSING FEE	.00	490.00	
092020061807	6503	4293105	DENTIST NEW LICENSE	1,050.00	2,700.00	
092020061807	6503	4293115	DENTIST JP EXAM	2,475.00	6,300.00	
092020061807	6503	4293135	DENTIST NITROUS OXIDE	120.00	320.00	
092020061807	6503	4293205	HYGIENIST NEW LICENSE	1,900.00	2,000.00	
092020061807	6503	4293215	HYGIENIST JP EXAM	2,415.00	2,760.00	
092020061807	6503	4293222	HYGIENIST ANESTHESIA	840.00	920.00	
092020061807	6503	4293235	HYGIENIST NITROUS OXIDE	640.00	680.00	
092020061807	6503	4293305	RADIOLOGY NEW	440.00	2,200.00	
092020061807	6503	4293405	ADA EXPANDED FUNCTION NEW	240.00	760.00	
092020061807	6503	4293420	ADA EXPAND FUNC ADMIN NIT	.00	240.00	
092020061807	6503	4293505	CORPORATE NEW LICENSE	1,400.00	3,900.00	
092020061807	6503	4293510	CORPORATE RENEWAL	.00	5,150.00	
092020061807	6503	4293600	TEMP LICENSE	200.00	850.00	
092020061807	6503	4293916	RENEWAL - DENTAL	.00	61,485.00	
ACCT:	4293	BUSINESS & OCCUP LICENSING (NON-GOVERNMENTAL)		14,120.00	96,575.00	*
ACCT:	42	LICENSES, PERMITS & FEES		14,120.00	96,575.00	**
092020061807	6503	4491000	INTEREST & DIVIDENDS-PRGM	.00	7,065.27	
ACCT:	4491	INTEREST & DIVIDENDS (NON-GOVERNMENTAL)		.00	7,065.27	*
ACCT:	44	REVENUE FROM THE USE OF MONEY & PROPERTY		.00	7,065.27	**
092020061807	6503	4595000	VERIFICATION LETTERS	100.00	575.00	
092020061807	6503	4595800	LIST OF PRACTITIONERS	150.00	1,950.00	

BA0225R5 06/04/2016

STATE OF SOUTH DAKOTA  
REVENUE SUMMARY BY BUDGET UNIT  
FOR PERIOD ENDING: 05/31/2016

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AGENCY 09 HEALTH  
BUDGET UNIT 09202 BOARD OF DENTISTRY

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE	
092020061807	6503	4595925	REPLACEMENT CERTIFICATE	.00	15.00	
ACCT:	4595			250.00	2,540.00	*
ACCT:	45	CHARGES FOR SALES & SERVICES		250.00	2,540.00	**
CNTR:	092020061807			14,370.00	106,180.27	***
CNTR:	092020061			14,370.00	106,180.27	****
CNTR:	0920200			14,370.00	106,180.27	*****
COMP:	6503			14,370.00	106,180.27	*****
B UNIT:	09202			14,370.00	106,180.27	*****

BA1409R1

STATE OF SOUTH DAKOTA  
CASH CENTER BALANCES  
AS OF: 05/31/2016

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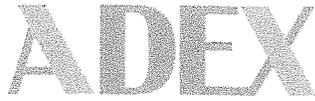
AGENCY: 09 HEALTH  
BUDGET UNIT: 09202 BOARD OF DENTISTRY

COMPANY	CENTER	ACCOUNT	BALANCE	DR/CR	CENTER DESCRIPTION
6503	092000061807	1140000	506,141.17	DR	BOARD OF DENTISTRY
COMPANY/SOURCE TOTAL 6503 618			506,141.17	DR *	
COMP/BUDG UNIT TOTAL 6503 09202			506,141.17	DR **	
BUDGET UNIT TOTAL 09202			506,141.17	DR ***	

Clinical Test Administration Agencies	Acronym	Test Administered	Contact
Central Regional Dental Testing Service	CRDTS	CRDTS	Kimber Cobb
Southern Regional Testing Agency	SRTA	SRTA	Kathleen White
Western Regional Examining Board	WREB	WREB	Beth Cole
Commission on Dental Competency Assessments (Formerly NERB)	CDCA	ADEX	Dr. Ellis Hall
Council of Interstate Testing Agencies	CITA	ADEX	Cindy Jones
American Board of Dental Examiners	ADEX	CDCA and CITA administer ADEX	Patrick Braatz

**June 17, 2016 Attendees:**

Southern Regional Testing Agency	SRTA	SRTA	Dr. Marc Muncy, President
Central Regional Dental Testing Service	CRDTS	CRDTS	Dr. Mary Starsiak, President Elect
Central Regional Dental Testing Service	CRDTS	CRDTS	Kim Laudenslager, Director of Dental Hygiene Administration
American Board of Dental Examiners	ADEX	CDCA and CITA administer ADEX	Dr. William Papas, Vice President
Western Regional Examining Board	WREB	WREB	Representative will Attend Fall Meeting

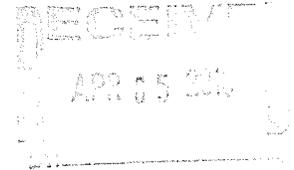


**AMERICAN BOARD OF DENTAL EXAMINERS, INC.**

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April 23, 2016

Roger C. Wilson, DDS, MS, President  
South Dakota Dental Board  
P.O. Box 569  
Rapid City, SD 57709



Dear Dr. Wilson:

I know that the South Dakota Dental Board is doing a review of all of the Dental and Dental Hygiene Licensure Examination this summer and that we are in the process of sending you some information about the American Board of Dental Examiners, Inc. (ADEX) Examination, that information is expected to be completed by the end of May.

On behalf of the American Board of Dental Examiners, Inc. (ADEX), I want to take this opportunity to invite one of your Dental Board Members to attend the 2016 Annual ADEX Meeting.

ADEX will pay the expenses or reimburse the State of Dakota, depending on your ethics laws for this member to attend as our guest.

This would give your Board a firsthand look at the development of the ADEX Examinations as well as the governing structure that allows every member state a vote,

This year's Meetings will be held August 5, 6, 7, 2016 at the Doubletree Hotel in O'Hare – Rosemont, IL.

I have attached some information about the upcoming meetings, but would ask when you have selected a board member to attend that they get in touch with Mr. Patrick Braatz our Chief Operating Officer and he can help the board member with the various arrangements for attending the meetings.

The following is his contact information:

Patrick D. Braatz, COO, ADEX  
P.O Box 50718  
Mesa, AZ 85208  
[ADEXOFFICE@aol.com](mailto:ADEXOFFICE@aol.com)  
503-724-1104

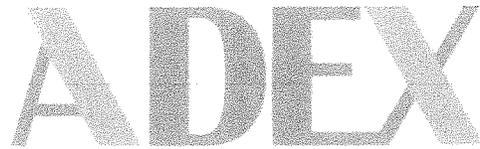
I hope that the Utah Dental Board will accept our invitation and I look forward to meeting that person in Chicago in August.

Sincerely yours,

Stanwood H. Kanna, President  
ADEX

✓ CC: Brittan Novotny, JD, MBA  
Enclosures

**P.O. Box 50718 • Mesa, AZ 85208**  
**Telephone (503) 724-1104**  
[ADEXOFFICE@aol.com](mailto:ADEXOFFICE@aol.com)  
[www.adexexams.org](http://www.adexexams.org)



American Board of Dental Examiners, Inc.

## 12<sup>th</sup> Annual Meeting

SAVE THE DATES

August 5, 6, 7, 2016

ADEX Quality Assurance Committee

ADEX Dental Examination Committee &

Subcommittees

ADEX Dental Hygiene Examination Committee

ADEX Board of Directors

ADEX Reception

ADEX House of Representatives

Doubletree Hotel O'Hare – Rosemont, IL

Official information will be sent in May 2016

Questions contact [ADEXOFFICE@aol.com](mailto:ADEXOFFICE@aol.com)



**ADEX AUGUST 2016  
MEETINGS**

**Doubletree Chicago O'Hare Airport-Rosemont,  
5460 North River Road  
Rosemont, Illinois 60018  
847-292-9100**

**Friday, August 5, 2016**

*10:00 AM – Noon Executive Committee Meeting – Signature Ballroom*

*Noon - 1:00 PM Lunch Buffet – Signature 1ABC*

*1:30 PM – 3:30 PM ADEX Quality Assurance Committee Meeting – Signature Ballroom*

*3:30 PM- 5:00 PM ADEX Board of Directors Meeting – Signature Ballroom*

**Saturday, August 6, 2016**

*7:00 AM - 8:00 AM Breakfast Buffet – Signature 1ABC*

*8:00 AM – 8:30 AM Orientation Meeting for Committee members and Delegates to the ADEX House of Representatives – Signature Ballroom **EVERYONE MUST ATTEND THIS MEETING.***

*8:30 AM - Noon ADEX Dental Examination Subcommittees Meetings*

*Subcommittee on Scoring - Artistry*

*Subcommittee on Periodontics - Leander*

*Subcommittee on Prosthodontics - Duet*

*Subcommittee on Endodontics - Othello*

*Subcommittee on Restorative - Medallion*

*8:30 AM - 5:00 PM ADEX Dental Hygiene Examination Committee Meeting – Chicago Peace*

*Noon - 1:30 PM Lunch Buffet – Signature 1ABC*

*1:30 PM – 5:00 PM ADEX Dental Examination Committee Meeting – Signature Ballroom*

*5:00 PM – 5:30 PM ADEX Board of Directors Meeting – Signature Ballroom*

*6:00 PM - 7:30 PM ADEX Reception – Mezzanine Foyer*

**Sunday, August 7, 2016**

*7:00 AM- 8:00 AM Breakfast Buffet – Signature 1ABC*

*8:00 AM- Noon ADEX House of Representatives Meeting – Signature Ballroom*

*Conclusion of HOR Board of Directors Meeting – Signature Ballroom*



## The Patient Centered Curriculum Integrated Format (PC CIF)

This new format of the ADEX CIF examination was originally called the “Buffalo Format” because it was developed in conjunction with the University at Buffalo and the New York Board of Dentistry and was successfully piloted at the University at Buffalo in 2015. In 2016 the PC CIF is currently being offered to all dental schools that would like to host this format

The PC CIF is a modification of the Curriculum Integrated (CIF) Format that focuses on patient care needs, rather than the candidate’s examination. The examination itself is the identical ADEX Licensing Examination for initial licensure in dentistry. That is the content, criteria, scoring, and performance parameters are identical no matter which format is being administered.

The American Board of Dental Examiners, Inc. (ADEX) and it’s testing agencies have introduced an examination format for candidates at dental schools, which is designed to focus on patient needs to enhance the patient experience in the sections of the examination that evaluate the care provided by the candidate during the examination process.

As context for this approach, the American Dental Association (ADA) has adopted a policy that the only acceptable examination format that includes providing patient treatment is the Curriculum Integrated Format with the adoption of ADA resolution 20 H– 2005, and defined the Curriculum Integrated Format in ADA resolution 1H-2007 which is included as Appendix A.

The ADEX examination was in compliance with the 2005 resolution and substantially in compliance with the 2007 resolution. However, ADEX and it’s testing agencies wanted to comply with all provisions of the ADA definition, as well as adopting an examination format that would fulfill all of the ethical concerns identified in the ADA paper entitled, *Ethical Considerations When Using Patients in the Examination Process*, which had been recently revised in May, 2013. For readers interested in the full text of this document, please see the attached document.

As part of the validity argument for continuing to use the scores and decisions from this new approach, the ADEX examination content, criteria, scoring, and performance parameters remain identical to the previous examination. However, **the new examination administration format now allows the dental school to ensure that the care provided in the examination process is done on a patient of record, and provided within an appropriately sequenced treatment plan as defined by the dental school.** The examination assessments are given multiple times within the school year, to allow for candidate remediation and retake prior to graduation as well as patient scheduling and treatment plans concerns.

Equally important, is that follow-up patient care required as a result of candidate performance is completed under the supervision of the dental school faculty, utilizing the treatment protocols and philosophy of the host dental school. Finally, the patient care provided by the dental student, during the examination process, can also be independently evaluated by the dental school faculty to fulfill the CODA required competencies, if necessary. Patient informed consent is completed for both the dental school and the testing agency throughout the process.

Keeping in mind the technical and legal requirements for licensure examinations, **this format was developed in collaboration with educators, examiners, and representatives from organized dentistry.** The goal was to balance the responsibilities of maintaining the independence of the licensure process with a focus within the examination on the needs of the patient in a continuing effort to develop the most ethical examination process possible when patient care is a component.

The administrative format differences in the PC CIF Format are:

1. Calibrated school faculty may assist candidates in selection of patients of record at the school, for the ADEX Restorative and Periodontal examinations that meet the requirements set by ADEX for the examination process. The faculty's role is to validate that the patient's proposed care is appropriate to be provided under the school's treatment planning protocols.
2. The examiners have final determination about what lesions/cases are accepted for the examination and which are not. The patient's medical status and blood pressure are always evaluated at the time of care. Additionally, the proposed care is also evaluated to validate the treatment being provided meets examination requirements.
3. Faculty and the school's protocols have the final determination *if* care will be provided. The institutional treatment protocols of the dental school will determine the timing of care and the type of care provided. For example a dental school's proposed care based on the extent of caries is preserved; so that re-mineralization and the depth of caries prior to treatment is a school decision.
4. The faculty may also evaluate the treatment provided to the patients and this may or may not be incorporated as part of a school student competency program.
5. Faculty may also enter treatment provided into the school database as it occurs during the examination as dictated by school protocol.
6. The schools faculty will determine, schedule, and supervise any patient follow-up care that may be required.
7. Candidates who are unsuccessful will have their performance explained to them by their faculty and the faculty will supervise any required patient care.
8. The exam scheduling allows for multiple school visits and candidates challenging only those parts of the examination for which they have treatment-planned patients. In this respect the examination process is scheduled over multiple visits allowing the candidate to focus on the patient's needs rather than a single examination date.

Therefore, the school may wish to have several smaller PC CIF examinations at regular intervals rather than one large Perio/Restorative Examination as in the past. This is arranged between the school and the testing agency when scheduling the examination series. The school is usually allowed to schedule the candidates and their patients for each of these smaller exams. Candidates will challenge the procedures for which the school has approved the proposed patient treatment initially, but may take any one (or more) procedures not taken the first time at a later exam. Failing procedures can also be taken at a subsequent session.

## Ethical Considerations When Using Human Subjects/Patients in the Examination Process

Page 1

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### American Dental Association Council on Ethics, Bylaws and Judicial Affairs

The following information is intended to assist dental licensure candidates, as well as examiners and educators involved in the testing process, in recognizing ethical considerations when patients are part of the clinical licensure process.

**Background:** Dental licensure is intended to ensure that only qualified individuals are licensed to provide dental treatment to the public. Most licensing jurisdictions have three general requirements: an educational requirement-graduation from a dental education program accredited by the Commission on Dental Accreditation; a written (theoretical) examination-to determine whether the applicant has achieved the theoretical bases at a level of competence that protects the health, welfare and safety of the public; and a clinical examination in which a candidate demonstrates the clinical knowledge, skills and abilities necessary to safely practice dentistry.

Anecdotal information and experiences reported in the literature by licensees and educators have raised ethical considerations when human subjects/patients are used in the examination process.<sup>1-6</sup> While others disagree, it is recognized that the profession must ensure that the welfare of patients is safeguarded in every step of the clinical licensure examination process.<sup>7</sup>

The licensure examination process is evolving. Many clinical examination agencies continue to monitor developments for applicability and affordability of alternatives to human subjects/patients in providing valid and reliable assessment of clinical competence.

The ADA has voiced its position regarding the use of human subjects/patients in clinical examinations through a series of resolutions culminating with the adoption of the 2005 House of Delegates' Resolution 20H-2005.<sup>8-10</sup> This resolution reaffirms ADA support for the elimination of human subjects/patients in the clinical licensure examination process while giving exception to a more recent methodology for testing known as the curriculum-integrated format (CIF). The 2006 ADA House of Delegates directed the ADA Council on Dental Education and Licensure to develop a definition of CIF and present it to the 2007 House of Delegates. The 2007 House adopted the following definition (1H:2007):

**Curriculum Integrated Format:** An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

Given that currently there are no new technologies that completely eliminate the use of human subjects/patients in the clinical examination processes, the ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA)<sup>11</sup> called on major stakeholders, including the ADA's Council on Dental Education and Licensure (CDEL), to provide input for the development of a statement that would identify key ethical considerations and provide guidance to help ensure the welfare of the patient remains paramount.

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**Ethical Considerations When Using Human Subjects/Patients in the Examination Process**

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1. **Soliciting and Selecting Patients:** The ADA Principles of Ethics and Code of Professional Conduct<sup>12</sup> (ADA Code), Section 3, Principle: Beneficence states that the "dentist's primary obligation is service to the patient" and to provide "competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration given to the needs, desires and values of the patient." The current examination processes require candidates to perform restorative and periodontal treatments on patients. In light of the principle stated above, this may create an ethical dilemma for the candidate when seeking patients to sit for the exam. Candidates should refrain from the following:
  1. Reimbursements between candidates and patients in excess of that which would be considered reasonable (remuneration for travel, lodging and meals).
  2. Remuneration for acquiring patients between licensure applicants.
  3. Utilizing patient brokering companies.
  4. Delaying treatment beyond that which would be considered acceptable in a typical treatment plan (e.g. delaying treatment of a carious lesion for 24 months).
  
2. **Patient Involvement and Consent:** The ADA Code, Section 1, Principle: Patient Autonomy states that "the dentist's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient's needs, desires and abilities." Candidates and dental examiners support patient involvement in the clinical examination process by having a written consent form that minimally contains the following basic elements:
  1. A statement that the patient is a participant in a clinical licensure examination, that the candidate is not a licensed dentist, a description of the procedures to be followed and an explanation that the care received might not be complete.
  2. A description of any reasonably foreseeable risks or discomforts to the patient.
  3. A description of any benefits to the patient or to others which may reasonably be expected as a result of participation.
  4. A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the patient.
  5. An explanation of whom to contact for answers to pertinent questions about the care received.
  6. A statement that participation is voluntary and that the patient may discontinue participation at any time without penalty or loss of benefits to which the patient is otherwise entitled.

3. Patient Care: The ADA Code, Section 3, Principle: Beneficence states that the dentist has a “duty to promote the patient’s welfare.” Candidates can do this by ensuring that the interests of their patient are of primary importance while taking the exam. Examiners contribute to this by ensuring that candidates are adequately monitored during the exam process such that the following treatment does not occur:
  1. Unnecessary treatment of incipient caries.
  2. Unnecessary patient discomfort.
  3. Unnecessarily delaying examination and treatment during the test.
  
4. Follow-Up Treatment: The ADA Code, Section 2, Principle: Nonmaleficence states that “professionals have a duty to protect the patient from harm.” To ensure that the patient’s oral health is not jeopardized in the event that he/she requires follow-up care, candidates and dental examiners should make certain that the patient receives the following:
  1. A clear explanation of what treatment was performed as well as what follow-up care may be necessary.
  2. Contact information for pain management.
  3. Complete referral information for patients in need of additional dental care.
  4. Complete follow-up care ensured by the mechanism established by the testing agency to address care given during the examination that may need additional attention.

Sources:

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1. Dr. Lloyd A. George Nov. 3, 2005 Letter to Dr. James W. Antoon, chair CEBJA
2. CEBJA March 2, 2006 Strategic Issue Discussion – Use of Patients in Clinical Licensure Examinations
3. Richard R. Ranney, D.D.S., et al., “A Survey of Deans and ADEA Activities on Dental Licensure Issues” Journal of Dental Education, October 2003
4. Allan J. Formicola, D.D.S., et al., “Banning Live Patients as Test Subjects on Licensing Examinations,” Journal of Dental Education, May 2002
5. “The Agenda for Change,” Objectives Developed at the Invitational Conference for Dental Clinical Testing Agencies by representatives of the clinical testing agencies and other organizations with an interest in dental licensure sponsored by the American Dental Association. It is considered informational and does not represent policy of the ADA. March 4, 1997
6. ASDA Resolution 202RC-2005, Revision of Policy L-1 Initial Licensure Pathways
7. Position Statement of the American Association of Dental Examiners in Response to ADA Resolution 64H, Oct. 12, 2001
8. ADA HOD Resolution 34-2006, Definition of Curriculum Integrated Format
9. ADA HOD Resolution 20H-2005, Elimination of the Use of Human Subjects in Clinical Licensure/Board Examinations
10. ADA House of Delegates (HOD) Resolution 64H-2000, Elimination of the Use of Human Subjects in Clinical Licensing/Board Examinations
11. CEBJA is the ADA agency responsible for providing guidance and advice and for formulating and disseminating materials on ethical and professional conduct in the practice and promotion of dentistry.
12. The entire text of the ADA Principles of Ethics and Code of Professional Conduct can be found on the ADA website at [www.ada.org](http://www.ada.org).

## ADA RESOLUTION 1H:2007

The ADA has voiced its position regarding the use of patients in clinical examinations through a series of resolutions culminating with the adoption of the 2005 House of Delegates' Resolution 20H-2005.

This resolution reaffirms ADA support for the elimination of patients in the clinical licensure examination process while giving exception to ... testing known as the curriculum-integrated format (CIF)

ADA Resolution 1H:2007 further defined what the ADA meant by a CIF examination.

### Curriculum Integrated Format:

An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation,

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

*Southern Regional Testing Agency, Inc.*

*4698 Honeygrove Road, Suite 2  
Virginia Beach, Virginia 23455-5934  
Tel. (757) 318-9082 / Fax (757) 318-9085  
www.srta.org*

December 2015

State Board of Dentistry

Having responded to a legislature mandated examination review request, I thought that your dental board may also be interested in this data. Please feel free to share this letter with your board members. If possible I would like to contact you and secure a time slot on your Dental Board Agenda. I would like to send one of our examiners to your board meeting to further discuss the SRTA examination. This would only be a discussion, Q &A. Most likely 10-15 minutes in duration. No power point slide show unless that is your preferred method of presentation.

I must let you know, that I respect the State Dental Boards for their efforts in keeping abreast of initial licensure examinations. As you are aware, the ADA during its' July 14, 2015 meeting of the "Taskforce on Licensure", again urged all states to accept all regional clinical licensure examinations. This motion was made to further portability for the students, while continuing to work toward a patient-free examination for licensure.

Prior to addressing the eight questions presented, I would like to advise you that I will be sending via email, electronic versions of our 2016 Candidate Manuals for both Dentistry and Dental Hygiene. As I write this letter now, we are close to leaving the "Draft" stage, but you will be receiving "Draft" copies!

**Question 1:** "How to determine the eligibility of a candidate?"

Candidate eligibility is first based on enrollment at or graduation from a CODA accredited institution. If one has not yet graduated, the dean of the individual's school must provide a letter certifying that the student(s) listed are eligible to take the exam, and are in good standing with an anticipated graduation date within 18 months of the examination date.

For international students that have not graduated from a CODA accredited school or have not successfully completed an AEGD program, the candidate may take the examination based on "State Only" status. The candidate must furnish a letter from a State Board of Dentistry that

*Marcus Muncy, D.D.S. – President*

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*Kathleen M. White – Executive Director*

clearly states that this candidate, if successful on the examination, may be licensed within their state. A copy of the candidate's diploma along with an English translation is also required. All of the candidate records for state only status, remain marked as "Restricted" to the accepting state. (The candidate cannot seek/obtain initial licensure anywhere but in the sponsoring state).

**Question 2:** "Describe topics tested and scoring methodology for each topic". [Note scoring methodology and passing score questions from Question 2- rolled into Question 4].

### **Dental: Manikin based**

Manikin setup used: Acidental Modu-Pro

**Endodontics-** two procedures.

->**Anterior:** Access opening, instrumentation and obturation of tooth #8.

->**Posterior:** Access opening on tooth # 14, must achieve direct access to all three canals.

**Prosthodontics:** - three procedures.

->**PFM (Porcelain-Fused-to-Metal)** crown preparation. Tooth #5. An anterior abutment for a 3-unit bridge, plus an evaluation of the line of draw for the bridge abutment preparations.

->**Cast Metal/All Zirconia** crown preparation on tooth # 3. This is the posterior abutment for the 3-unit bridge.

->**All-Ceramic** crown preparation on tooth #9. Anterior central incisor.

### **Dental Patient-Based**

**Anterior:**

->Class III Composite prep and restoration

**Posterior:**

->Class II (select one of the following three)- Amalgam Prep & restoration; Composite Prep and restoration or slot prep and restoration. (Note: Wyoming requires a slot prep & restoration for initial licensure and we so note this for candidates).

**Periodontal**

->Must select, identify, scale and polish selected teeth keeping within the parameters listed in the candidate manual. Selected teeth must have adequate subgingival calculus, 3 teeth required for pocket depth measurement- these teeth need not be those teeth selected for calculus removal but must be within the treatment selection. This section remains optional based on our task analysis of 2005 and 2011. Candidates may take this section if they so choose without additional cost.

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**Question 4:** “Determining a passing score for individual components and the complete exam”

**Scoring Methodology**

The scoring methodology for all components of the exam is as follows: a triple blind system is used (no one knows status of previous evaluators), all examination materials are numbered using the candidate(s) unique number. The candidates name and school data does not appear on any testing materials. All examiners are vetted current and past State Dental Board members that are experienced practitioners with diverse backgrounds. We also utilize faculty examiners, although they cannot examine in their respective state, the knowledge they gain through their experience is imparted to the students. Examiners are trained and standardized prior to each examination and are evaluated to ensure they are grading to established criteria. The examiners are separated from the candidates and will remain in a separate area of the clinic.

Candidates must observe all signs and follow instructions so as not to breach anonymity. Anonymity is preserved between the scoring examiners and the candidates. Examiners may consult with the SRTA Clinic Floor Coordinator (CFC) or Scoring Area Coordinator (SAC) whenever necessary. Examiners are assigned to grading operatories via a computer generated randomization of those examiners that are available to examine. All times are recorded, from the first “encounter” on the clinic floor (approval of Medical History, BP etc.). Also recorded is every patient check in or out, the examiners in and out times etc. Thus we know from start to finish the stage of each candidate.

The scoring system is criterion referenced and based on an analytical model. The examination is conjunctive in that the contents are divided into 5 separate sections and each section is scored independently. The examination is compensatory within each section for determining the final score within the section. A numeric grade equal to or greater than 75 is a Pass. Less than a numeric grade of 75 is a Fail. This value represents a scale score that is consistent with commonly used interpretive scales for scoring performance. The underlying performance standard that corresponds to minimum competency is based on a combination of standard setting methods, specifically the Dominant Profile Judgment method and the Extended Angoff Method. Both of these methods are discussed in Hambleton and Pitoniak’s chapter about standard setting in *Educational Measurement*, 4<sup>th</sup> ed. (Brennan, 2006). Similar descriptions of these and other methods that are appropriate for credentialing examinations like SRTA’s clinical skills tests can be found in Buckendahl and Davis-Becker’s chapter about standard setting for credentialing examinations in *Setting Performance Standards* (Cizek, 2012).

All scoring and score calculations are completed using specifically designed computer software. Input is via Kindles. Those examiners that follow the first examiner have no means by which to view the “grading” of any previous examiner(s). Statistics are compiled throughout the day and reviewed with the examiners as necessary to ensure all criteria are being consistently assessed. We are the only clinical examination agency that does immediate/on-site remediation of examiners. This enables the examiner to be aware and to self-correct any defined areas.

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A passing determination for a candidate is automatically determined via evaluation by the calibrated grading examiners, based on the defined criteria. Our computer software provides the end result, whether it be numeric or Pass/Fail. On an exam overall approach, the candidate must be successful in all procedures as noted on Page 2 to have "Passed the exam". The candidate retake of single sections may be required to achieve the overall "exam passed" status. (Passing grade numeric is 75).

As a side note, SRТА was the first regional agency in the country to successfully implement computer driven scoring... via PDA's - beginning with the exam cycle of 2008. We of course have continued to enhance our software and we even upgraded to full color Kindles!

### **Question 3: Process for examiner calibration**

Examiner calibration is a multi-step process. An annual (once per exam cycle/year) on-line test is required. This on-line test covers all policies, procedures and protocols. A passing grade of 80% is required for examiners to be eligible to participate in operational scoring.

At each exam site, examiner calibration to the scoring criteria occurs. The calibration takes approximately 4 hours with a 10 question quiz upon completion of each section/segment as outlined on Page 2. All criteria are reviewed during this process. The quizzes consist of photographs of both acceptable and unacceptable preps/restorations. We have 3 different quiz sets which are used throughout the year, such that examiners do not always see the same photos and respond to questions by rote. All examiners must obtain a score of 80% or higher to be considered calibrated and allowed to examine. A failing examiner has one additional attempt to reach 80%. If not successful on the second attempt, the examiner is sent home.

### **Questions 5 - 8: When was the last review of the examination? What were the Results? Updates to the examination? Comparison to other examinations?**

A review of the examination is ongoing with specific milestones that occur at key phases in development and validation. Some of these key milestones include a nationwide job (task) analysis that was most recently conducted in 2011 with a plan to begin conducting the next one in late 2016. This aligns with SRТА's policy to systematically evaluate the content of its examinations relative to the field every 5-6 years. Additional reviews of the examinations occur at least annually with our Examination Committees who review the tasks and scoring criteria associated with each examination to ensure that they continue to align with expectations for minimally competent practice in dentistry or dental hygiene respectively. Ongoing, empirical evaluation of examiners occurs throughout the examination cycle and then annually as part of a technical review of the program. These evaluations focus on the validity and reliability of judgments as applied to candidates' performance. SRТА also maintains an ongoing relationship with a psychometrician (measurement consultant) who provides input on each of these activities.

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The results of these activities support use of the scores for making decisions about candidates' minimum competency in dentistry and dental hygiene, respectively. Content and empirical evidence are evaluated to support this assertion.

Perhaps the best example I can provide as a comparison to other clinical examinations is the nationwide job analysis (task analysis) noted above. This project was conducted in 2011 as a joint effort between SRTA and NERB (now CDCA) under the ADEX partnership. This 2011 nationwide task analysis further points to SRTA as a leader in the development of clinical examinations as the SRTA task analysis of 2006 indicated a lack of the requirement for the periodontal procedure. The periodontal task was deemed as one that was typically referred to periodontists, and not performed by general dentists. Thus, the periodontal procedure became optional in the SRTA examination in 2006 and in the ADEX exam of 2012, when the same conclusion was reached again, via the 2011 task analysis.

SRTA does not include the use of computer assisted examinations in either the Dental or Dental Hygiene exams due to the lack of current data indicating relevancy and assurance that the exam(s) do not duplicate the National Boards in a significant manner.

We continue to have a long-standing relationship with our psychometrician, Chad Buckendahl, PhD. Trust me- we do not make any changes without his blessing! In addition, we would be happy to provide Chad as a supplemental resource for Board Members if they have specific questions about some of the technical features of our examination.

I believe I have answered all of the questions outlined in your letter. Should you find that I missed something or if you need additional clarification, please do not hesitate to contact me.

Again, the Dental and Dental Hygiene candidate manuals are DRAFT versions- close to complete. The Dental forms are newly revised for 2016 and are ready for use.

Again, please feel free to contact me if you have additional questions or if I thoroughly confused you!

Best regards-

Kathleen M. White  
Executive Director

*Marcus Muncy, D.D.S. – President*

*Dianne Embry, R.D.H. - Secretary*

*Robert B. Hall, Jr., D.D.S. - Treasurer*

*Kathleen M. White – Executive Director*

February 26, 2016

Dr. Roger Wilson  
President  
South Dakota State Board of Dentistry  
PO Box 1079  
1351 North Harrison Avenue  
Pierre, SD 57501-1079

Dear Doctor Wilson:

We are writing to express the high level of concern that the American Dental Association (ADA), its Licensure Task Force and Council on Dental Education and Licensure, and the American Dental Education Association (ADEA) have with regard to the status of licensure for dentists in the United States. While licensure portability is an important matter to dental professionals, particularly to those pursuing initial licensure or attempting to relocate to another state, it is clear that the dental boards of a number of states, including your own, continue to engage in conduct that restricts, rather than enhances, that portability.

As you know, there are five clinical test administration agencies for dentistry: the Commission on Dental Competency Assessments (CDCA, formerly NERB); Central Regional Dental Testing Service, Inc. (CRDTS); Council of Interstate Testing Agencies, Inc. (CITA); the Southern Regional Testing Agency, Inc. (SRTA); and the Western Regional Examining Board (WREB). The ADA has conducted a careful analysis of the examinations administered by each of the clinical testing agencies (CDCA and CITA administer the American Board of Dental Examiners (ADEX) dental exam, while CRDTS, SRTA, and WREB administer their own exams) and has come to the conclusion that these examinations adhere to a common set of core design and content requirements that renders them conceptually comparable. In particular, each agency:

- utilizes the *Standards for Educational and Psychological Testing* as the guidelines for evaluating the validity of their exams;
- produces a publically available technical report that documents and summarizes available validity and reliability evidence concerning the examinations;
- utilizes conjunctive scoring, requiring candidates to pass each of a series of tests in order to pass the full examination;
- conducts a practice analysis on a regular basis to ensure that test content reflects normal, everyday tasks performed in general dental practice;
- reduces examiner bias and enhances fairness by ensuring that examiners do not know the identity of the candidate whose performance they are evaluating;

- requires three examiners to evaluate performance on each exam and sub-exam;
- requires examiners to participate in calibration exercises to align examiner perspectives and provide a common frame of reference;
- conducts prospective and retrospective evaluations of examiner consistency and reliability;
- makes a determination of candidate minimal competency in restorative dentistry on a patient-based exam for a Class III composite resin preparation and restoration and either a Class II amalgam or composite resin preparation and restoration;
- makes a determination of candidate minimal competency in periodontics on a patient-based exam for scaling and root planning; and
- utilizes simulation to determine minimal competency in prosthodontics (crown preparation) and endodontics.

Given the aforementioned commonality in design and content requirements, any apparent differences in the performance of these clinical examinations can be called into question and potentially interpreted as simply reflecting sampling error. In light of this, accepting the results from certain clinical examinations and not others appears specious. It has been a longstanding policy of the ADA that it represents unnecessary and meaningless duplication to require a candidate seeking licensure in different states to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction, especially when it is clear that the core requirements, administration, and outcomes are virtually indistinguishable between each examination.

It is our understanding that your state affirmatively elects not to accept the examination results from all of these test administration agencies. The decision of your board, as well as the boards of a number of other states, to accept the test results of only a select number of clinical test administration agencies appears highly arbitrary. Moreover, those decisions have an arguably anticompetitive effect in restricting the mobility of dentists wishing to move from one state to another. As you know, the whole concept of licensure is currently under attack because of its inherent effect on competition; it is therefore incumbent on the dental profession to ensure that any such restraints are not susceptible to a claim that they are unreasonable in nature. Indeed, the House of Delegates of the American Bar Association recently passed a resolution urging bar admission authorities in various states to adopt a Universal Bar Examination in order to facilitate mobility for new lawyers. This concept of mobility among professionals is obviously gaining additional momentum.

In light of these circumstances, we respectfully request that your Board pursue the necessary steps to accept successful completion of all of the clinical test administration agency examinations for dental licensure in your state. Recognizing that the dental board's primary mission is protecting the public in your state, we believe that the board has the authority and autonomy to pursue this change. It will increase portability of dental professionals and access to quality dental care for patients.

Dr. Roger Wilson  
February 26, 2016  
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We would be pleased to meet with you or your board to further discuss this matter.

Sincerely,



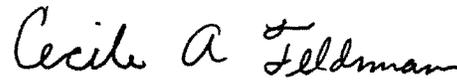
Carol Gomez Summerhays, D.D.S., M.A.G.D.  
President  
American Dental Association



Huw F. Thomas, B.D.S., M.S., Ph.D.  
Dean, Tufts University School of Dental Medicine  
Chair of the ADEA Board of Directors



Gary L. Roberts, D.D.S.  
President-elect



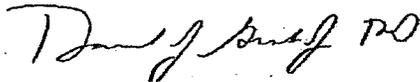
Cecile A. Feldman, D.M.D., M.B.A.  
Dean, Rutgers School of Dental Medicine  
Chair-elect of the ADEA Board of Directors



Gary E. Jeffers, D.M.D., M.S.  
Chair  
2016 ADA Licensure Task Force



Lily T. Garcia, D.D.S., M.S., FACP  
Associate Dean for Education  
University of Iowa College of Dentistry  
Immediate Past Chair of the ADEA Board of Directors



Daniel J. Gesek, Jr., D.M.D.  
Chair  
Council on Dental Education and Licensure

KMH:eg

cc: Ms. Brittany Novotny, executive secretary, South Dakota State Board of Dentistry  
Dr. Grant S. Titze, president, South Dakota Dental Association  
Mr. Paul Knecht, executive director, South Dakota Dental Association  
Dr. James K. Zenk, ADA Trustee, Tenth District  
Dr. Kathleen O'Loughlin, executive director and chief operating officer (ADA)  
Dr. Richard W. Valachovic, president and chief executive officer (ADEA)

### CE Approval Request Form SD State Board of Dentistry

The following information is required for prior approval for courses or in-service.  
Once approved the course will be added to the calendar on the web site.

Date requested: 1/12/2016

Person requesting approval: Leslie K. Graeger, RDH, BSDH

E-Mail: lkgrbrushn.floss@hotmail.com Fax #: \_\_\_\_\_

Date of course: To be determined

Sponsor: Western Dakota Technical Institute

Speaker: Leslie K. Graeger, RDH, BSDH previous speaker  
Copy of their biography is helpful. RDH in SD for 25 years

Topic: Nitrous Oxide / Oxygen Sedation  
Include a course outline.

See email sent 1/11/2016

Location of course: Rapid City, SD

Approved: y/n \_\_\_\_\_ CE type Clinical hr: 16

Leslie wants approval of the NO course  
for a permit to administer N.O.

Title: Nitrous Oxide/ Oxygen Sedation  
Lecture Hours: 8  
Clinical Hours: 8  
Instructor: Leslie K. Greager, RDH, BSDH  
Supervising Dentist: Dr. Rob Lyons, DDS

**Course Goal:** To provide attendees with didactic and clinical education pertaining to the administration and monitoring of nitrous oxide/ oxygen (N<sub>2</sub>O/ O<sub>2</sub>) sedation.

**Course Objectives:**

- After an eight-hour lecture, attendees will understand and have the ability to explain:
  - the term nitrous N<sub>2</sub>O/ O<sub>2</sub> sedation
  - the different levels of sedation
  - the advantages and limitations of using N<sub>2</sub>O/ O<sub>2</sub> sedation in the dental office
  - the enhancement of the effects of N<sub>2</sub>O/ O<sub>2</sub> sedation
  - the uses of N<sub>2</sub>O/ O<sub>2</sub> outside of dentistry
  - the history of N<sub>2</sub>O/ O<sub>2</sub>
  - the manufacturing, storage, transportation, and handling of N<sub>2</sub>O/ O<sub>2</sub>
  - the cost of N<sub>2</sub>O/ O<sub>2</sub> tanks and refills
  - the differences between N<sub>2</sub>O and O<sub>2</sub> tanks re: color, size, markings
  - the physical and chemical characteristics of N<sub>2</sub>O and O<sub>2</sub>
  - the functions of the respiratory system
  - diffusion hypoxia as it relates to N<sub>2</sub>O/ O<sub>2</sub> in dentistry
  - the effects of N<sub>2</sub>O/ O<sub>2</sub> on bodily systems
  - contraindications for use of N<sub>2</sub>O/ O<sub>2</sub>
  - the physical assessment of the patient and evaluation of the medical history prior to N<sub>2</sub>O/ O<sub>2</sub>
  - the steps necessary for the safe and effective administration of N<sub>2</sub>O/ O<sub>2</sub> sedation
  - the main components/ equipment of the N<sub>2</sub>O/ O<sub>2</sub> delivery system
  - the level at which most patients respond favorably to N<sub>2</sub>O/ O<sub>2</sub> administration
  - the levels of over-sedation based on the patient's signs and symptoms
  - the current NIOSH and ADA occupational exposure limits of N<sub>2</sub>O/ O<sub>2</sub> in the working environment
  - the legal and ethical issues related to N<sub>2</sub>O/ O<sub>2</sub> administration
  - the rules and regulations of N<sub>2</sub>O/ O<sub>2</sub> administration based on SD State Board of Dentistry statutes
  - the abuse of N<sub>2</sub>O/ O<sub>2</sub>
  
- After eight-hours of clinical instruction, attendees will have the ability to:
  - assess the patient's pre and post administration status of N<sub>2</sub>O/ O<sub>2</sub> sedation via vital signs and the use of a pulse oximeter
  - administer, titrate, and monitor N<sub>2</sub>O/ O<sub>2</sub> safely and competently
  - calculate and record the percentage of N<sub>2</sub>O/ O<sub>2</sub> delivered to the patient
  - document N<sub>2</sub>O/ O<sub>2</sub> percentages appropriately in the patient's chart
  - demonstrate an understanding of the maintenance, infection control, and trouble shooting of N<sub>2</sub>O/ O<sub>2</sub> equipment

## I. Nitrous Oxide/ Oxygen Sedation

A. Sedation: the act of calming, especially with a sedative; the state of being calm

1. Levels of sedation:

- a. General
- b. Deep
- c. Moderate
- d. Minimal

B. Nitrous Oxide Anxiolysis: the administration of a combination of nitrous oxide and oxygen, producing an altered level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

C. General Anesthesia: drug-induced loss of consciousness during which the patient is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is impaired.

D. Deep Sedation: drug-induced depression of consciousness during which the patient cannot be easily aroused but responds purposefully after repeated or painful stimulation. The ability to independently maintain airway function is impaired.

E. Moderate Sedation: drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No intervention is required to maintain a patent airway. Moderate sedation is achieved when levels of N<sub>2</sub>O/ O<sub>2</sub> are over 50%.

F. Minimal Sedation: drug-induced state during which the patient responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular function are unaffected. Achieved with N<sub>2</sub>O/ O<sub>2</sub> levels less than 50%.

G. N<sub>2</sub>O/ O<sub>2</sub> in Dentistry

1. Combination of N<sub>2</sub>O and O<sub>2</sub>
2. Effective means of alleviating anxiety and mild discomfort during dental procedures
3. Effective in reducing anxiety in patients who may not otherwise seek dental treatment
4. Anxiolytic agent

## II. Benefits of Using N<sub>2</sub>O/ O<sub>2</sub>

A. Manages both fear and pain

B. Provides amnesic properties

C. Passage of time seems quick

D. Equipment allows easy titration of gases

E. Rapid onset

F. Rapid recovery

G. Limitations:

1. Initial cost of equipment
2. Equipment requires routine monitoring
3. Monitoring of evacuation system
4. Apprehension of patient and/ or clinician to sedation
5. Lack of education for auxiliaries to administer and monitor delivery
6. Variety of effects
7. Obstruction of nose hood
8. Insurance and abuse issues

### III. Increasing Effects of N<sub>2</sub>O/ O<sub>2</sub>

A. Music

B. Imagery

C. Hypnosis

D. Electronic dental anesthesia

E. Oral premedication

F. Local anesthesia

### IV. Other Uses of N<sub>2</sub>O/ O<sub>2</sub>

A. Hospitals

B. Emergency medicine

C. Food industry

D. Auto industry

E. Racing industry

F. Computer industry

### V. History of N<sub>2</sub>O/ O<sub>2</sub>

A. Joseph Priestly 1770's

B. Humphrey Davy 1800

- C. Samuel Colt 1800's (firearm)
- D. Medical community 1800's
- E. Horace Wells 1844
- F. Dr. Colton 1860's
- G. Dr. Edmund Andrews 1868
- H. 20<sup>th</sup> Century
- I. Lidocaine 1940's
- J. N<sub>2</sub>O/ O<sub>2</sub> taught in dental schools 1950's
- K. Pain and anxiety control guidelines 1962

## VI. Manufacturing of N<sub>2</sub>O/ O<sub>2</sub>

### A. Process:

1. Raw ingredient is ammonia nitrate
2. Ammonia nitrate is heated to 250 degrees C; decomposes to water and steam
3. Once cooled to room temperature, steam is condensed, and water is removed
4. Crude N<sub>2</sub>O gas is scrubbed to remove contaminants then compressed, dried, cooled, and liquefied

### B. Storage:

1. Liquefied gas stored at 300 psig at 4 degrees F in insulated tanks
2. Sent to gas re-packagers and distributors
3. Hospitals and medical facilities use the majority (80-90%) of N<sub>2</sub>O/ O<sub>2</sub> produced in the US
4. Dentistry uses approximately 10%
5. Remaining used in previously discussed industries

### C. Regulatory Agencies:

1. FDA regulates the manufacturing process
2. DOT oversees the packaging and transportation
3. NFPA code for requirements for appropriate cylinder storage

## VII. Investment

### A. Approximate cost:

1. New tanks \$170.00
2. Refill for N<sub>2</sub>O \$47.00

3. Refill for O2 \$24.00
4. Cost varies by tank size and distance from the distributor

## VIII. N2O/ O2 Tanks

### A. Color Codes for countries

1. USA: N2O is blue/ O2 is green
2. Canada: N2O is blue/ O2 is white

### B. Sizes

### C. Markings: diagram

## IX. Internal Properties In N2O/ O2 Tanks

### A. N2O Tanks

1. Contains 95% liquid and 5% vapor
2. Stored at room temperature; gauge reads 750 psi when full
3. Gas is located above the liquid within the cylinder
4. Gauge reads full until 7/8 of the tank is used due to the liquid being vaporized as the gas is used
5. Nitrous tanks usually last twice as long as oxygen tanks

### B. O2 Tanks

1. Contains 100% vapor (gas)
2. Gauge reads approximately 2000 psi when full
3. Gauge accurately reflects the quantity of oxygen in the tank
4. A half empty tank will read 1000 psi

## X. Properties of N2O and O2 Gas

### A. N2O Gas

1. Sweet smelling, colorless gas; cannot see it
2. Molecular weight is 44
3. Specific gravity is 1.53
4. Heavier than air and oxygen; helpful during administration due to gravitational pull
5. Found naturally in the atmosphere at 6 ppm
6. Gas oxidizes at room temperature; significant due to phenomenon called heat of combustion (increase in the temperature of the gas and metal to a level that ignites any hydrocarbon contaminants, causing a chemical reaction resulting in a fire or explosion)
7. Never store grease, lubricants, or oil near tanks

### B. O2 Gas

1. Odorless, colorless, tasteless gas
2. Makes up 21% of the earth's atmosphere
3. Molecular weight is 32
4. Specific gravity is 1.105 (pure air is 1.0)
5. Like N<sub>2</sub>O, it supports heat of combustion

## X. Respiratory System

### A. Designation

1. Designed to exchange gases (oxygen and carbon dioxide) across pulmonary capillary membranes
2. Does this involuntarily by the medulla oblongata and voluntarily by the cerebral cortex

### B. Upper Airway

1. Nose: warms, humidifies, and filters; must be clear for the administration of N<sub>2</sub>O/O<sub>2</sub>
2. Pharynx: Cylindrical, muscular tube 12-14 cm long; divided into three parts
  - a. Nasopharynx; uppermost part of the nose located behind the nasal cavity; contains the adenoid, tonsils, and openings to the eustachian tubes; soft palate separates nasopharynx from oropharynx
  - b. Oropharynx: opens to the mouth; between the soft palate and epiglottis; serves as the entrance to the larynx and esophagus
  - c. Laryngopharynx: the throat; area of the pharynx from the epiglottis to the cricoid cartilage; contains the larynx

### C. Lower Airway

1. Larynx: houses the vocal cords; false vocal cords prevent entry of foreign objects into the lungs; contact with this area causes cough reflex; N<sub>2</sub>O/O<sub>2</sub> at normal sedation levels does NOT affect cough reflex
2. Trachea: muscular tube continuous with the larynx; begins at C6; surrounded by horseshoe-shaped rings; approximately 11 cm long; divides into two bronchi
3. Carina: highly sensitive, neurologically rich area at the bifurcation of the trachea into the right and left bronchi; back up defense mechanism to the cough reflex
4. Bronchi: right and left
  - a. Right Bronchi: 2.5 cm long; deviates from the trachea at about 25 degrees; divides into 3 branches including 3 upper lobes, 2 middle lobes, and 5 lower lobes
  - b. Left Bronchi: 5 cm long; deviates from the trachea at about 45 degrees; divides into 2 branches which link the 5 upper lobes and 4 lower lobes
5. Bronchioles: have no cartilage, first 16 generations of airways are only conducting; respiration begins at the 17<sup>th</sup> generation (gas exchange occurs in the alveoli)

### D. Anatomy of Respiration

1. Oxygen (O<sub>2</sub>) moves from the lungs across the alveolar membranes into the capillaries, venules, and then to the pulmonary veins
2. Carbon Dioxide (CO<sub>2</sub>) moves from the pulmonary arteries, arterioles to the

- capillaries then across the alveolar membranes into the lungs
3. It is in the alveoli that gas exchange takes place
  4. N<sub>2</sub>O exchange uses the same pathways as normal respiration

#### E. Respiratory Process

1. Medullary center of the brainstem controls the automatic respiratory process of breathing
2. Inspiration is the expansion of the chest creating a vacuum, pulling air into the lungs; controlled by the diaphragm, intercostal muscles, scalenes, and sternocleidomastoids
3. Continues until pressure inside the lungs equals atmospheric pressure
4. Expiration is the passive force of air out of the lungs; controlled by the chest wall and recoil of the lungs
5. Tidal flow is the automatic ebb and flow or movement of air
6. Tidal volume is the amount of gas inspired into the lungs dependent on physical characteristics of the individual

#### F. Minute Ventilation

1. Average adult tidal volume = 500 ml
2. Average adult respiration rate = 12-15/ minute
3. Minute ventilation (volume) = tidal volume X respiration rate
4. 500 ml X 12-15 rpm = approximately 6-7 liters/ minute
5. The flow rate of N<sub>2</sub>O/ O<sub>2</sub> should be equal to the minute ventilation (volume) of the patient
6. Too little gas mixture of N<sub>2</sub>O and O<sub>2</sub> may cause a suffocated feeling and the act of breathing may be laborious
7. Too much gas mixture of N<sub>2</sub>O and O<sub>2</sub> wastes gas and pollutes the environment, exposes personnel to gas, and may dry the patient's eyes as it escapes from the nose mask

#### G. Gas Exchange

1. Simple diffusion across partial pressure gradients are at the alveolus- capillary level
2. Atmospheric Air:
  - a. 20.94% oxygen
  - b. 79.02% nitrogen
  - c. .04% carbon dioxide

#### XI. Diffusion Hypoxia

##### A. Explanation

1. As N<sub>2</sub>O is terminated, capillary tension quickly rises to that above alveolar pressure
2. N<sub>2</sub>O is quickly forced into the alveoli and exhaled through the lungs
3. N<sub>2</sub>O exits faster than the N<sub>2</sub> that replaces it
4. Dilutes the supply of oxygen
5. Oxygen blood saturation is reduced

6. Leave 100% O<sub>2</sub> on the patient for 2-5 minutes
7. Not likely at the concentrations used in dentistry; “prudent practice”

## XII. N<sub>2</sub>O/ O<sub>2</sub> Effects on Body Systems

### A. Cardiovascular System

1. No effect on contractility, output, stroke volume, rate, or arrhythmias
2. Blood flow not affected
3. Positive effect on ischemic diseases due to increased oxygen
4. Blood pressure and heart rate may be lowered due to reduced anxiety; not direct effect
5. No contraindications vs contraindications

### B. Respiratory System

1. Compromised air exchange may make administration difficult
2. Increased pressure in sinus cavity due to expansion of N<sub>2</sub>O
3. May create positive effect for asthma patients
4. No contraindications vs contraindications

### C. Central Nervous System

1. Effects pain perception
2. Decreases sensory perception including pain, sight, and touch
3. Amnesic properties; may dilute memory depending on concentration levels
4. Distortion of spacial relation; feeling of floating or being heavy or light
5. No contraindications vs contraindications

### D. Hematopoietic System

1. Megaloblastic bone marrow changes associated with high doses for long periods of time
2. May reduce absorption of vitamin B<sub>12</sub>; high doses over a long period of time (medical anesthesia)
3. No contraindications vs contraindications

### E. Endocrine System

1. No contraindications vs contraindications

### F. Hepatic System

1. Not metabolized in the liver
2. Does not affect the liver if liver damage is evident
3. No contraindications vs contraindications

### G. Gastrointestinal System

1. N<sub>2</sub>O causes expansion of air spaces in the body; avoid using on patients with intestinal obstruction
2. No known negative effects on patients with ulcers
3. Nausea; may be caused by slight bloating of the stomach
4. No contraindications vs contraindications

#### H. Genitourinary and Reproductive Systems

1. Must obtain medical clearance prior to administration to a pregnant patient
2. Avoid administration during the first trimester; no known negative effect, although may be the blame for negative outcome
3. No known effect to kidney
4. No contraindications vs contraindications

#### I. Neuromuscular System

1. Does not provide direct skeletal muscle relaxation; indirect due to relaxation of patient
2. No known effect on patients with neuromuscular conditions
3. No contraindications vs contraindications

#### J. Vestibular System

1. Increased pressure in the middle ear may cause significant damage
2. Postpone administration of N<sub>2</sub>O/ O<sub>2</sub> until middle ear infection/ disturbance has passed
3. No contraindications vs contraindications

### XIII. Specific Conditions

#### A. Cancer

1. Does not affect metastatic cells
2. Used in the final stage of life for pain and anxiety control
3. Contraindicated for patients taking bleomycin sulfate (antineoplastic agent); may increase the incidence of pulmonary fibrosis

#### B. Allergies

1. No known reported allergies in 160 years
2. Latex allergy patients; contact dermatitis if equipment is not latex free

#### C. Malignant Hyperthermia

1. Unexpectedly occurs due to patient's response to certain drugs
2. Patient can be tested if known family history
3. N<sub>2</sub>O/ O<sub>2</sub> is not a known trigger

#### D. Nutritional Disorders

1. No known affect with any nutritional conditions
2. Ongoing research in this area

#### E. Mind Altering Conditions

1. Careful consideration due to result in euphoria
2. Be sure patients understand the procedure and effects
3. Possible contraindications

#### F. Ophthalmic Considerations

1. Recent retinal surgery; gas bubble in the eye; N<sub>2</sub>O/ O<sub>2</sub> may cause expansion; postpone administration until healing complete/ medical clearance

#### G. Summary of Side Effects

1. Pressure/ volume effect
  - a. N<sub>2</sub>O causes increased pressure and volume in body cavities
  - b. May cause middle ear pressure, auditory acuity, GI distension, air emboli in the blood, tinnitus, flatulence, and nausea
2. Psychological and sexual reactions
  - a. Sexual hallucinations
  - b. Hallucinations
  - c. Dreams
  - d. Claustrophobia
  - e. Apprehension

### XIII. Patient Assessment

A. Medical history review, interview, and questionnaire regarding level of anxiety

B. Risk Assessment using ASA scale

C. Pre-operative vital signs

1. Blood Pressure
2. Pulse
3. Pulse Oximeter

D. Patient Preparation

1. NPO not necessary
2. Informed consent, intent of procedure, and how it will be accomplished

E. Patient Monitoring

1. Continuous
2. Communication, observation, and vital signs

## XV. Equipment for portable and central supply systems

### A. Control Panel

### B. Manifold

1. Connects several cylinders of gas together; as one is depleted, another is used
2. Allows more than one operator to be using gas at the same time; central supply
3. Newer manifold may contain safety and security devices

### C. Copper Tubing

1. Found on central supply delivery system
2. Copper does not support combustion
3. Tubing size differs to prevent improper connection

### D. Pin Index Safety System

1. Found only on portable units
2. Holes are arranged in a specific pattern; prevents placing a tank on an incorrect machine

### E. Regulators

1. Found on both central and portable systems
2. Reduces gas pressure from the tanks before delivery to the tubing
3. Regulates the flow of gas

### F. Flow Meters

1. Visual indicator of amount of gas being delivered
2. Highly calibrated glass tubes
3. Numbers on the tubes represent liters being delivered
4. Middle of the ball is used to indicate amount of gas

### G. Reservoir Bag

1. Provides additional gas for the patient to breathe if inadequate amounts of gas flowing through the hoses
2. Provides a mechanism for monitoring of breathing; aids in determining if more or less gas is needed
3. Assists in an emergency by supplying pressure assisted oxygen

### H. Conduction Tubing

### I. Nasal Hoods

1. Variety of types and sizes

2. Sterilizable or disposable
3. Scavenging apparatus

#### J. Scavenging System

1. Mandatory for the safety of office personnel
  2. Two hole system; one delivers gas to the nasal hood; another evacuates excess gas exhaled by the patient
  3. Tube attached to the high vacuum system (HVC) for portable units
  4. Plumbing exhausts the gas out of the building for central supply systems
  5. Central supply scavenger unit
- a. Ball should be floating at the 45 lpm mark
  - b. Usually indicated by a green area on the gauge

#### XVI. N2O/ O2 Administration Technique

##### A. Steps

1. Assemble and assess armamentarium
- a. Choose appropriate nasal hood
  - b. Bring portable nitrous unit and hood to operatory
  - c. Assemble scavenging system
  - d. Open tanks and check gauges
2. Medical history evaluation; obtain vital signs and informed consent
  3. Turn on flow meter
  4. Activate Oxygen; fill reservoir bag to 2/3 full utilizing O2 flush button
  5. Position the patient in a supine position; secure the nasal hood and adjust the tubing
  6. Establish tidal volume
- a. Observe reservoir bag; increase or decrease tidal volume accordingly
  - b. Allow patient to ask questions at this level
7. Titrate to 10% nitrous oxide/ 90% oxygen for one minute
- a. Verbalize potential effects at this level with patient
  - b. Remind the patient to breathe deeply; avoid conversation
8. Titrate to 20% nitrous oxide/ 80% oxygen for one minute
- a. Verbalize potential effects at this level with patient (warmth, relaxation, paresthesia)
  - b. Remind the patient to breathe deeply; avoid conversation; utilize mouth breathing if experiencing dizziness or nausea
9. If necessary, continue to titrate at 5% every one minute
- a. Ask patient to verbalize what they are experiencing
  - b. Listen and observe patient
10. If 50% nitrous is reached with no symptoms, check for mouth breathing, shallow breathing, loose nasal hood, or a bend/ kink in the tubing
  11. Ask the patient to take three deep breaths and adjust the flow rates accordingly
  12. After procedure, decrease nitrous levels to 0 and increase oxygen levels to 100% for 2-5 minutes
  13. Allow patient to recover in an upright, seated position
  14. Determine complete recovery by obtaining post operative vital signs before releasing the patient
  15. Use appropriate disinfection techniques

## 16. Complete chart documentation

### XVII. Levels of N<sub>2</sub>O/ O<sub>2</sub> Sedation

#### A. Optimal Levels; 25-40% N<sub>2</sub>O

1. Sense of relaxation
2. Happy, comfortable, aware of surroundings
3. Responds rationally and coherently
4. Acknowledges a reduced sense of anxiety and fear
5. Dreamy look or big smile
6. Tingling of extremities
7. Slight ringing in the ears or heightened sense of sound
8. Heaviness in the arms or legs
9. Vitals remain normal (may decrease due to relaxation, not N<sub>2</sub>O)

#### B. Inappropriate Signs/ Symptoms

1. Uncontrolled laughter
2. Sweating
3. Nausea
4. Marked lethargy; closes mouth frequently
5. Unresponsiveness; unaware of surroundings
6. Dysphoria (anxiety, depression, restlessness)
7. Inability to follow commands
8. Dilated pupils; hard stare
9. Agitated or combative
10. Hallucinations

### XVIII. Detection and Monitoring

#### A. National Institute for Occupational Safety and Health (NIOSH)

1. Set the exposure limit for dental personnel at 50 ppm (8 hours time weighted average) in 1977
2. ADA disputes; not based on scientific fact

#### B. Time Weighted Average (TWA) Dosimetry

1. Provides an estimate of the amount of exposure to a gas over a specified period of time
2. A badge is worn for the recommended period of time; returned to the company for analysis; an active material within the badge absorbs N<sub>2</sub>O; the amount is read by an infrared spectrophotometer to determine the parts per million of exposure
3. Inexpensive; provides information for offices which do not utilize N<sub>2</sub>O extensively
4. Information is derived "after the fact"; not beneficial

### C. Infrared Spectrophotometry

1. Utilizes electromagnetic energy to detect levels of N<sub>2</sub>O in the atmosphere; can detect levels lower than 1 ppm
2. Can detect minute levels of gas immediately in the ambient air
3. Rental fee is reasonable
4. Provides instant information in any setting
5. Recommended in order to establish a baseline of exposure levels; recommended for periodic evaluation

### D. Occupational Risks

1. Chronic occupational exposure may cause reproductive difficulty, megaloblastic anemia, or neurologic disorders (controversial)
2. Overexposure is minimal or non-existent if appropriate protocols are followed
3. Chronic abuse differs from chronic exposure

## XVIII. Ethical and Legal Issues

### A. Assessment of medical history

### B. Patient monitoring

1. Legally, two people should be in the operatory at all times
2. Some states mandate only one

### C. Regularly scheduled maintenance of equipment

### D. Accurate record keeping

## XX. Abuse Issues

### A. N<sub>2</sub>O can be readily available; popular college activity

### B. Healthcare personnel are noted recreational users

### C. Lower on the list as compared to other drugs; not a public health abuse concern

### D. Abuse potential outside of the medical and dental clinic

## XXI. South Dakota State Board of Dentistry

### A. Statute 20:43:09:06

1. Certified in administering basic life support by the American Heart Association for the Health Provider, the American Red Cross for the Professional Rescuer, or an equivalent program approved by the board.
2. Has successfully completed a board approved educational course that

substantially meets the objectives required by the State Board of Dentistry.

3. Has completed the course within thirteen prior to application or has completed the course more than thirteen months prior to application but has legally administered N2O/ O2 for a period of time during the three years preceding application and provides a written document from the supervising dentist attesting to the applicants clinical proficiency.

# MEMO

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TO: Brittany Novotny and South Dakota Board of Dentistry  
FROM: Kristine K. O'Connell  
RE: Advisory Opinion  
DATE: March 8, 2016

---

**Whether it is within the scope of practice for a dentist to be able to order a sleep study, diagnose sleep apnea, or treat sleep apnea pursuant to a diagnosis by a medical doctor.**

It is the opinion of the Board of Dentistry ("Board") that it is within the scope of a dentist to order a sleep apnea study. Pursuant to a diagnosis of sleep apnea by a medical doctor, a dentist may provide reversible dental services in addressing a diagnosis of sleep apnea if it is within the scope of the dentist's relevant education, training and experience. SDCL § 36-6A-32.4.

*This advisory opinion was rendered by the Board upon submission of a written request. Although advisory opinions are not judicially reviewable and do not have the force and effect of law, they do serve as a guideline for dentists who wish to engage in safe dental practices. This advisory opinion was adopted at the meeting of the South Dakota Board of Dentistry on \_\_\_\_\_, 2016.*

# MEMO

---

TO: Brittany Novotny  
FROM: Kristine K. O'Connell  
RE: Advisory Opinion  
DATE: May 26, 2016

---

**Whether it is within the scope of practice for a dental hygienist, registered dental assistant or dental assistant to deliver an application of oraquix or other topical anesthesia without an anesthesia permit.**

It is the opinion of the Board of Dentistry ("Board") that ARSD 20:43:09:06:01 addressing local anesthesia refers to injectable local anesthetics which requires an anesthesia permit. It is within the scope of a dental hygienist, registered dental assistant or dental assistant to administer or apply topical anesthesia without an anesthesia permit so long as such administration or application is under the appropriate level of supervision of a dentist, and follows the manufacturers recommended usage and application instructions for the topical application.

*This advisory opinion was rendered by the Board upon submission of a written request. Although advisory opinions are not judicially reviewable and do not have the force and effect of law, they do serve as a guideline for dentists and dental hygienists who wish to engage in safe dental practices. This advisory opinion was adopted at the meeting of the South Dakota Board of Dentistry on \_\_\_\_\_, 2016.*

# MEMO

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TO: Brittany Novotny and South Dakota Board of Dentistry  
FROM: Kristine K. O'Connell  
RE: Advisory Opinion  
DATE: March 8, 2016

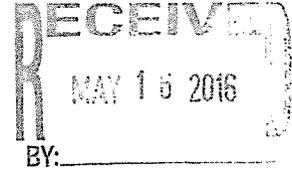
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**Whether it is within the scope of a dental hygienist to prepare and place a protective restoration (such as an application of Fuji Triage, ZOE, or Miracle Mix sedative filling); and if so, under what level of supervision.**

It is the opinion of the Board of Dentistry ("Board") that the placement of the restorative compounds as listed above is a reversible procedure and is included within a dental hygienist's expanded function if said hygienist has had the required professional proficiency and training SDCL § 36-6A-1(19). The performance of this expanded function must be performed under the direct supervision of a dentist as defined in SDCL § 36-6A-18 and 19.

*This advisory opinion was rendered by the Board upon submission of a written request. Although advisory opinions are not judicially reviewable and do not have the force and effect of law, they do serve as a guideline for dental hygienists who wish to engage in safe dental hygiene practices. This advisory opinion was adopted at the meeting of the South Dakota Board of Dentistry on \_\_\_\_\_, 2016.*

May 4, 2016



Ms. Brittany Novotny, Esq.  
Board Administrator/Executive Director  
South Dakota State Board of Dentistry  
P.O. Box 1079  
1351 N. Harrison Ave.  
Pierre, SD 57501

Dear Ms. Novotny:

The Joint Commission on National Dental Examinations (“Joint Commission”) appreciates the opportunity to assist your dental board by providing information concerning the cognitive skills of dental and dental hygiene candidates seeking licensure in your jurisdiction. In our continuing efforts to improve the quality, accuracy, and clinical relevance of information we provide, the Joint Commission is pleased to provide additional details concerning our efforts to introduce the Integrated National Board Dental Examination (INBDE), and share details concerning how and when implementation will occur.

The INBDE is a next generation assessment that will integrate the biomedical, behavioral, and clinical sciences, to provide dental boards with a summative evaluation concerning whether dental licensure candidates possess the level of cognitive skills necessary to safely practice dentistry. **The Joint Commission anticipates the INBDE will be available for administration on August 1, 2020, with full replacement of the National Board Dental Examination (NBDE) scheduled to occur by August 1, 2022.** This letter serves as the official “four years’ notice” the Joint Commission indicated it would provide to stakeholders and communities of interest, concerning these important events.

In anticipation of the release of the INBDE and the discontinuation of Parts I and II, the Joint Commission recommends your dental board undertake the following activities to learn about the INBDE and prepare to use it in licensure decision making:

- Review and monitor INBDE information on the Joint Commission’s website ([www.ada.org/JCNDE/INBDE](http://www.ada.org/JCNDE/INBDE)).
- Attend the National Dental Examiners’ Advisory Forum (NDEAF) annually.
- Review INBDE validity evidence and the results of field testing as these studies occur.
- Prepare to receive INBDE results on the first day of its availability.
- Consider whether any modifications to practice acts, rules, policies, or procedures will be required.
- Prepare to accept candidates who have successfully completed the National Boards. This could occur under either of the following sequences: 1) INBDE or 2) NBDE Parts I and II.
- Communicate information concerning the acceptability of the INBDE to future licensure candidates.

**The Joint Commission recommends your dental board begin working with these considerations now, to ensure your board is prepared for the upcoming changes.** Details concerning the INBDE implementation plan are enclosed. Dates appearing in the plan represent a best-case scenario and are subject to change. The Joint Commission’s website contains additional background information concerning the INBDE, as well as information concerning communications and presentations on this topic to dental boards and communities of interest since 2010.

Thank you for your consideration and attention to this important matter. If you have any questions, please contact the Joint Commission ([nbexams@ada.org](mailto:nbexams@ada.org)) and we will be happy to assist.

Sincerely,

Dr. Luis J. Fujimoto  
Chair, Joint Commission on National Dental Examinations

Enclosure

# INBDE Implementation Plan and Recommended Actions

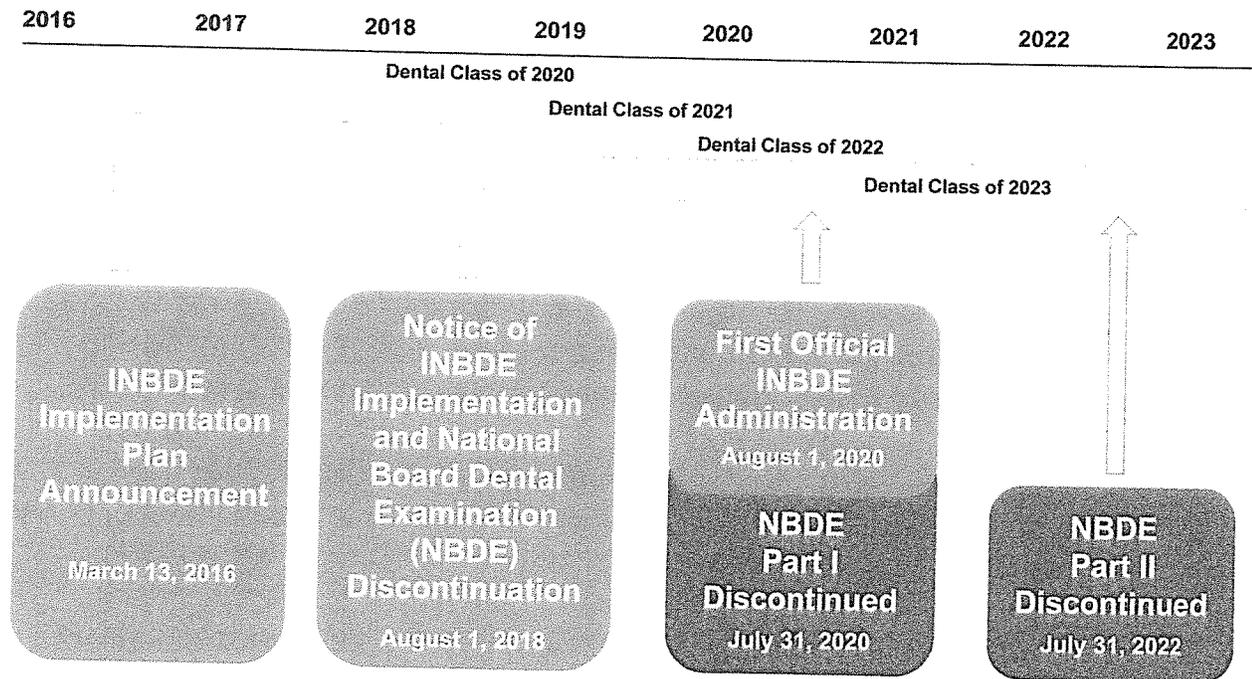
**JCNDE** JOINT COMMISSION  
ON NATIONAL  
DENTAL EXAMINATIONS

April 2016

## INBDE Implementation Plan

- The Integrated National Board Dental Examination (INBDE) is an examination that is currently in development by the Joint Commission on National Dental Examinations (JCNDE).
- The INBDE is intended to replace National Board Dental Examination (NBDE) Parts I and II. The INBDE is intended for use by state dental boards to help inform decision-making concerning the licensure of entry-level dentists.
- To address concerns from stakeholders and communities of interest regarding the timing of INBDE implementation, the JCNDE indicated it would provide four years' notice before the INBDE is implemented and the NBDE discontinued.
- The current presentation is designed to help address concerns regarding timing and provide this advance notification.
- This presentation provides stakeholders and communities of interest with information concerning how INBDE implementation will occur, the information that will be made available to help facilitate the transition, and recommended actions for stakeholders and communities of interest.
- The slide that follows shows key events associated with INBDE implementation, and the sequence of activity associated with the transition.

# Integrated National Board Dental Examination (INBDE) Implementation Plan: "Best Case Scenario"



PRT: March 2016

**Note:** This implementation plan communicates the best case scenario. Dates presented should be interpreted as "no sooner than." Actual dates will be contingent upon field testing results. INBDE Practice Test Questions are anticipated for release in 2019.

## INBDE Implementation Plan

- On August 1, 2018, the Joint Commission intends to provide stakeholders and communities of interest with notice of INBDE implementation and NBDE discontinuation. This notice will include the following:
  - The projected date when the INBDE will be first available for administration, the official name of the new examination, and how results will be reported.\*
  - The dates when NBDE Part I and NBDE Part II will be discontinued.
  - Retesting policies, eligibility rules, and any additional rules needed to facilitate the transition.
- Two years after notification has been provided, NBDE Part I will be discontinued (approx. July 31, 2020). No Part I administrations will occur after this date.
- The first official administration of the INBDE is expected to take place on August 1, 2020.
- Two years after NBDE Part I is discontinued, NBDE Part II will be discontinued (approx. July 31, 2022). No Part II administrations will occur after this date.
- Notification of INBDE implementation and NBDE discontinuation is contingent upon successful completion of the INBDE Field Testing Program (not depicted in the preceding diagram).

\* Similar to Part I and Part II, INBDE results will be reported as "Pass/Fail."

## INBDE Implementation Plan

- In considering the dates provided, please note the following:
  - The plan as presented communicates the “best case scenario.”
  - The dates provided may be delayed if difficulties are encountered. However, the dates will not be “moved up” (e.g., NBDE Part I will be discontinued no sooner than August 1, 2020).
  - The Joint Commission reserves the right to make changes to the plan at any time and as needed, in keeping with the Joint Commission’s mission and purpose.
  - Any significant changes to this plan will be published as soon as information becomes available.
  - The final slide in the current presentation will provide a log of changes made.

## Additional Information from the JCNDE

- Information concerning the INBDE is available via the Joint Commission's website ([www.ada.org/JCNDE/INBDE](http://www.ada.org/JCNDE/INBDE)).
- The following information is currently available and is updated as changes occur:
  - INBDE background
  - INBDE FAQ's
  - Domain of Dentistry and general validity evidence
  - Preliminary test specifications
  - Preliminary sample questions.
- The following information will be posted as soon as it becomes available:
  - INBDE practice test questions (anticipated one year in advance of initial INBDE administration)
  - Technical report(s) providing detailed information concerning validity.

## INBDE Information from other Sources (not the JCNDE)

- INBDE eligibility rules for students of U.S. dental schools accredited by the Commission on Dental Accreditation (CODA).
  - These rules are determined by each dental school.
- Additional school requirements concerning the INBDE (e.g., linking successful completion of the INBDE to graduation requirements).
  - These rules are determined by each dental school.
- Written examination requirements for each state.
  - These requirements are determined by each state dental board.

## INBDE Implementation Plan Considerations

- The requirements of key stakeholders and communities of interest were carefully considered in developing the implementation plan.
  - State Dental Boards
  - Dental Schools
  - US Dental Licensure Candidates
- The following slides indicate specific considerations involving the aforementioned groups, as well as recommended actions.
- The considerations indicated should NOT be regarded as comprehensive of all of the INBDE-related interests of the aforementioned groups.

# State Dental Boards

Implementation Plan Requirement	How Requirement is Addressed
<ul style="list-style-type: none"> <li>• Provide sufficient time for state dental boards to assess and understand INBDE validity evidence.</li> <li>• Provide sufficient time for state dental boards to incorporate the INBDE into licensure decision-making and communicate its acceptability to future licensure candidates.</li> <li>• Provide sufficient time for state dental boards to prepare to receive INBDE results on day one of availability.</li> <li>• Consider whether any modifications to practice acts, rules, policies, or procedures will be required.</li> <li>• Provide sufficient time for state dental boards to accept both exam sequences:               <ol style="list-style-type: none"> <li>1) INBDE and</li> <li>2) NBDE Parts I and II.</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Post and update validity information on JCNDE website as it becomes available.</li> <li>• Communicate validity information on annual basis at National Dental Examiners' Advisory Forum (NDEAF).</li> <li>• Release details of implementation plan in 2016, and provide the following notifications:               <ul style="list-style-type: none"> <li>• INBDE first administration possible as soon as 2020.</li> <li>• NBDE Part I final administration possible in 2020.</li> <li>• NBDE Part II final administration possible in 2022.</li> </ul> </li> <li>• Provide notice in 2016 of JCNDE plans for indicating the official name of the INBDE and how results will be reported. Current discussions indicate the JCNDE is likely to associate the name "NBDE" with the INBDE, to ease the transition with regard to state rules and practice acts.</li> </ul>

## Recommended Actions for State Dental Boards

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website ([www.ada.org/JCNDE/INBDE](http://www.ada.org/JCNDE/INBDE)), and attend the National Dental Examiners' Advisory Forum (NDEAF) annually.
  - Review INBDE validity evidence and the results of field testing as these studies occur.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare to use the INBDE in licensure decision-making.
  - Consider whether any modifications to practice acts, rules, policies, or procedures will be required.
  - Prepare to receive INBDE results on day one of availability.
  - Prepare to accept candidates who have successfully completed the National Boards. This could occur under either of the following sequences: 1) INBDE or 2) NBDE Parts I and II.
  - Communicate information concerning the acceptability of the INBDE to future licensure candidates.

# Dental Schools

Implementation Plan Requirement	How Requirement is Addressed
<ul style="list-style-type: none"> <li>• Provide sufficient time for U.S. dental schools to adjust curricula and prepare students for the INBDE (also consistent with current CODA requirements).</li> <li>• Provide sufficient time for U.S. dental schools to adjust academic policy for incoming students regarding eligibility to sit for National Board Examinations.</li> <li>• Provide sufficient time for U.S. dental schools to adjust academic policy for incoming students regarding school utilization of NBDE Part I and II results (e.g., as prerequisites for students to continue their studies or as a graduation requirement).</li> </ul>	<ul style="list-style-type: none"> <li>• Release details of implementation plan in 2016, and provide the following notifications:               <ul style="list-style-type: none"> <li>• INBDE first administration possible as soon as 2020.</li> <li>• NBDE Part I final administration possible in 2020.</li> <li>• NBDE Part II final administration possible in 2022.</li> </ul> </li> <li>• Post INBDE preliminary sample questions publicly in 2016.</li> <li>• Provide INBDE practice test questions one year before INBDE initial administration.</li> <li>• Provide updates on the INBDE annually at the ADEA conference and subsequently post the presentations online.</li> </ul>

Note: For US candidates, dental schools now approve the eligibility of Part I and Part II examinees and will determine when their students will transition to the new exam, within the feasible available options. For international candidates, eligibility for Parts I and II involves providing proof of dental school graduation (through ECE). This practice is expected to continue for the INBDE.

## Recommended Actions for Dental Schools

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website ([www.ada.org/JCNDE/INBDE](http://www.ada.org/JCNDE/INBDE)), and attend ADEA sessions on the INBDE.
  - Review INBDE validity evidence and field testing results as these studies occur.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare your school and students for the INBDE.
  - Review and revise curricula to prepare students for the INBDE and the updated CODA standards.
  - Review academic policy for incoming students and revise as needed concerning:
    - student eligibility to sit for National Board Dental Examinations.
    - school utilization of NBDE Part I and II results.

# U.S. Dental Licensure Candidates

Implementation Plan Requirement	How Requirement is Addressed
<ul style="list-style-type: none"> <li>• Provide U.S. dental licensure candidates with a reasonable opportunity to demonstrate competence with respect to the knowledge and skills required for licensure and measured by a written examination.</li> <li>• Provide reasonable time and sufficient notice so candidates can plan ahead and take action to avoid being “caught between examination programs” (e.g., preparing for Parts I and II but then finding themselves forced to shift to the INBDE).</li> <li>• Provide sufficient time for candidates to understand retesting policies concerning the INBDE and Parts I and II during the transition period, so candidates can plan and make decisions accordingly.</li> <li>• Provide test specifications and practice materials so candidates can prepare for the INBDE and know what types of questions to expect.</li> </ul>	<ul style="list-style-type: none"> <li>• Begin INBDE administrations before NBDE Part II is discontinued.</li> <li>• Release details of implementation plan in 2016, and provide the following notifications:               <ul style="list-style-type: none"> <li>• INBDE first administration possible as soon as 2020.</li> <li>• NBDE Part I final administration possible in 2020.</li> <li>• NBDE Part II final administration possible in 2022.</li> </ul> </li> <li>• Provide practice test questions one year before initial INBDE administration, and post INBDE preliminary sample questions publicly in 2016.</li> <li>• Provide notice in 2018 concerning INBDE retest policy, and coordinate INBDE retest policy with NBDE retest policy.</li> </ul>

## Recommended Actions for U.S. Dental Licensure Candidates

- Understand the INBDE and keep apprised of new developments.
  - Review information concerning the INBDE on the Joint Commission's website ([www.ada.org/JCNDE/INBDE](http://www.ada.org/JCNDE/INBDE)).
  - Review INBDE test specifications and practice questions.
  - Monitor the website to understand and prepare for any changes as they occur.
- Prepare for the National Board Examinations.
  - Determine which examination track to pursue (NBDE Parts I and II or the INBDE) in consultation with the most recent INBDE implementation plan and:
    - your dental school, its requirements, and your progress in meeting those requirements.
    - the dental boards of states where you intend to apply for licensure.
    - Joint Commission policies (e.g., retesting policies under both examination tracks).
  - Study the areas indicated in the test specifications of your intended examination track.

## Implementation Plan Version History

Version	Date	Changes
1.0	3/13/2016	First publication. Presented to ADEA.
1.1	3/17/2016	Slide 4 – Further clarified that no administrations for Part I or II would be conducted after the dates listed.
1.2	4/25/2016	Slide 10 – State Boards – consider modifications to practice acts, etc. (Mirror information in previous slide.)



American  
Dental  
Hygienists'  
Association

*South Dakota*

February 6, 2016

Dr. Roger Wilson, Chair  
South Dakota State Board of Dentistry  
PO Box 1079  
Pierre, SD 57501

Dear Dr. Wilson and Board Members,

The South Dakota Dental Hygienists' Association has reviewed the rules of the Dental Practice Act and respectfully asks to consider the input on the proposed draft changes.

We thank you for inviting our organization to participate in the process and look forward to working with you in the future.

Kind Regards,

Cindy Dellman  
President, SDDHA



# South Dakota

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Dental Hygienists' Association

February 3, 2016

To: BrittanyNovotny JD, MBA  
Executive Secretary

PO Box 1079  
1351 North Harrison Avenue  
Pierre, SD 57501-10

The South Dakota Dental Hygienists' Association (SDDHA) would like to propose the following changes to rule 20:43:10:02 and 20:43:10:03.

I: Strike the following from 20:43:10:02

- (1) Completion of three years of clinical practice in dental hygiene; and
- (2) Completion of a minimum of 4,000 practice hours. A minimum of 2,000 of those hours must have been completed within two of the three years preceding application.

II: Strike the following from 20:43:10:03

- (4) Verification of completion of three years clinical practice in dental hygiene;
- (5) Verification of completion of a minimum of 4,000 practice hours; and
- (6) Verification of completion of a minimum of 2,000 practice hours within two of the three years preceding application.

**Justification:** The SDDHA recognizes the competencies required to perform all preventive and therapeutic services as indicated in the Collaborative Supervision by a dental hygienist proven through a licensure in good standing with the board. There is no scientific evidence that states that additional hours improve the outcomes of dental services. The current hour requirement also creates a double standard in a contract between a dentist and a dental hygienist as both are licensed professionals in the delivery of dental services; albeit, only one has an additional practice hour requirement.

In addition, the SDDHA supports these changes to increase access to care by increasing contractual collaborative agreements between dental professionals. This proposal also supports the SD Oral health coalition's goals in alignment with the CMS dental health outcome

The South Dakota Dental Hygienists' Association (SDDHA) proposes to strike 20:43:10:05. Reporting Requirements. Each dental hygienist who has rendered services under collaborative supervision must complete a summary report and submit the information to the board at the completion of a program or, in the case of an ongoing program annually.

Justification: The Council on Dental Practice and Division of Legal Affairs states the dental record, also referred to as the patient's chart, is the official office document that records all of the treatment done and all patient-related communications that occur in the dental office. State and federal laws or regulations determine how it is handled, how long it is kept and who may have access to the information. The dental record provides for continuity of care for the patient and is critical in the event of a malpractice insurance claim.

The above statement is suggestive that any information that would need to be acquired can be extrapolated under the state law to release dental information. The SDDHA supports this mechanism of the transfer of information.

Sincerely,

Cindy Dellman, RDH

SDDHA President

## AADB Meeting Report – April 10 & 11, 2016

### AADB organization news:

Executive Director Jim Tarrent resigned, new Executive Director is Richard Hetke  
Website will be changing just after the April meeting.  
Service programs ASP, ERA, DPREP all doing well.  
9 States had impending changes to their practice acts – most involved dental therapist legislation.

Theme of this meeting was “The Evolving Dental Team”

### Looking into the future – Drs. Renee McCoy-Collins and Arthur Jee:

Dentistry is changing – future trends were discussed  
1950’s each dentist averaged one employee, today each dentist averages five employees.  
New dental schools are all private.  
The dental workforce is increasing and expanding.  
Tele-dentistry – needs portability of licenses, the practitioner needs a license in the State where the patient is being treated.  
Pharmacy Clerks – one of the new dental team positions since it takes time to access PDMP before a narcotic prescription can be written.  
Affordable Care Act – in the future, monetary reimbursements for services will depend on treatment outcomes, patient compliance.

### CODA – Dr. Sherin Took:

Dental Therapist standards have been written by CODA  
2013 – Wrote the first draft, then in 2015 - adopted the standards  
Requires a minimum of three years full time instruction; however an advanced standing pathway can be given to assistants and hygienists.  
CODA accredits programs, not institutions or individuals.  
The United States Department of Education oversees CODA.

### Infection Control, CDC and OSAP – Drs. Katherine Weno and John O’Keefe:

CDC develops guidelines for infection control – 2003 was the last document.  
In dentistry, the concern is blood borne pathogens.  
Since 2003, no HIV transmissions have occurred in dental clinics.  
However, since 2003, several cases of hepatitis transmissions have been confirmed.  
The 2003 guidelines are still good but compliance with them is needed.  
The CDC has written a Summary of Infection Control Practices – it is an easier read.  
OSAP – Organization for Safety, Asepsis and Prevention – provides education to support safe dental visits.  
Some states require CE hours of infection control.

### ADA – Dr. Katherine O’Loughlin:

Primary focus of the ADA is to support dentists.  
Stats show that female dentists earn less.  
ADA wants the development of alternative licensure models.  
ADA wants license portability.  
ADA wants to eliminate patient based licensure exams.

Dental Sector Trends – Dr. Marco Vujici:

Children's dental care use is rising.

Working age adult's (age 19 – 64) dental care use is going down – primary reason is cost.

In the future there will be outcome based reimbursement.

Community Dental Health Coordinator – Dr. Jane Grover:

ADA's CDHC pilot program started 2007, concluded 2012

The CDHC coordinates dental care, provides education, helps people navigate the dental health care system, connects people with dental care, and gets people to their dental appointments.

There are CDHC schools in AZ, NM, FL, IL with several more being developed.

Billing code now D99xx for case management, motivational interviews.

Dental Hygiene – Ann Battrell:

DH graduates have been on the rise – 86% increase in the last 20 years.

Number of male dental hygienists is increasing.

53% have full time jobs.

More unemployment – in 2007 95% were employed, in 2008 88% were employed.

Alternate practice – collaborative practice, we also hear that hospitals, nursing homes and pediatric physician practices would like to employ dental hygienists.

Attorneys – Grant Gerber and Lori Lindley:

Some current trends were discussed.

Teledoc case in Texas.

Don't send out cease and desist letters.

Don't get involved with advertising issues.

DNEAF – Dr. David Waldschmidt:

National Dental Board Exams – 2012 started pass/fail reporting

Started developing the Integrated National Board Dental Exam (INBDE) in 2009

Field test of the new INBDE in Sept 2016 with implementation in 2020.

The old part I will be discontinued in 2020, the old part II in 2022.

Submitted for the SDBOD,  
Robin Hattervig, DDS



# South Dakota State Board of Dentistry

P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079

Ph: 605-224-1282

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E-mail: [contactus@sdboardofdentistry.com](mailto:contactus@sdboardofdentistry.com)

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

## SOUTH DAKOTA STATE BOARD OF DENTISTRY BOARD APPROVED COURSES FOR LICENSURE/REGISTRATION/PERMITS:

### 1. DENTISTS

- a. Administer Nitrous Oxide: 20:43:09:05
  - i. Nitrous Oxide Courses taught at American Dental Association Commission on Dental Accreditation (ADA CODA) accredited dental schools.
    1. *NOTE: Prior to 2000 there were Nitrous permits that were lost in a move of the Dental Board office. If a dentist contacts our office concerned because his or her NO permit is not showing and it would have been issued before 2000, he or she can provide a notarized letter that he or she took a NO course in dental school and received a permit from the Board.*
  - ii. Nitrous Oxide Course taught at the University of South Dakota (USD) Department of Dental Hygiene (16 Hours).
- b. General Anesthesia and Deep Sedation Permit: 20:43:09:03 – courses set forth in rule. These are not Board approved.
  - i. ACLS: 20:43:09:03(3) –
    1. American Heart Association Advanced Cardiac Life Support (ACLS)
    2. American Heart Association Pediatric Advanced Life Support (PALS)
- c. Moderate Sedation Permit: 20:43:09:04 –
  - i. ACLS: 20:43:09:04(3) –
    1. American Heart Association Advanced Cardiac Life Support (ACLS)
    2. American Heart Association Pediatric Advanced Life Support (PALS)
  - ii. IV Conscious Sedation
    1. Location: Medical College of Georgia Regents University (*formally known as Georgia School of Dentistry*) - Augusta, GA. Contact: Continuing Ed Dept at (800)221-6437. Hours: 121. Patients: 20
  - iii. Medical Emergencies, Local Anesthesia and Moderate Sedation in Dental Practice
    1. Location: Miami Valley Hospital - Dayton, OH. Contact: Daniel Becker, DDS at (937)208-3844 or [debecker@mvh.org](mailto:debecker@mvh.org). Hours: 96. Patients: 30
  - iv. Conscious Patient Management with IV and Nitrous Sedation in General Dentistry
    1. Location: Montefiore Medical Center - The Bronx, NY. Contact: Christine at (718)920-5996. Hours: 90. Patients: 20
  - v. Mini-Residency: An Intensive Course in Conscious Sedation
    1. Location: University of Alabama - Birmingham, AL. Contact: Ann Marie, BA, MA at (205)996-6494 or [amkaraki@uab.edu](mailto:amkaraki@uab.edu). Hours: 60. Patients: 20
  - vi. Learn IV Sedation
    1. Location: Oregon Academy of General Dentistry - Portland, OR. Contact: Ken Reed at [kr@ktrdmd.com](mailto:kr@ktrdmd.com). Hours: 112. Patients: 22-24
  - vii. Clinical Intravenous Sedation
    1. Location: The Herman Ostrow School of Dentistry of USC - Los Angeles, CA. Contact: Continuing Ed Dept at (213)821-2127 or [cedental@usc.edu](mailto:cedental@usc.edu). Hours: 70. Patients: 20

- viii. Introduction to Conscious Sedation
    - 1. Location: Langley Air Force Base - Langley, VA. Contact: Maj. Robertson at [steven.robertson@langley.af.mil](mailto:steven.robertson@langley.af.mil) or Maj. Bell at [gregory.bell@langley.af.mil](mailto:gregory.bell@langley.af.mil). Hours: 60. Patients: 32
  - ix. Conscious Sedation Training Program
    - 1. Location: University of Minnesota - Minneapolis, MN. Contact: Continuing Ed Dept. at (800)685-1418. Hours: 60. Patients: 20
  - x. IV Training for Moderate Sedation
    - 1. Location: San Francisco, CA; Otsego, MN. Contact: (888)581-4448 or [randy@sedationconsulting.com](mailto:randy@sedationconsulting.com). Hours: 116. Patients: 20-25
  - xi. Moderate Sedation with multiple oral and paternal agents
    - 1. Location: UCLA School of Dentistry. Contact: Lori Sissel at 360-944-3813 or [loris@wendeldental.com](mailto:loris@wendeldental.com). Hours: 80. Patients: 20
  - xiii. ADA CODA accredited General Practice Residency that meets the regulatory requirements
    - 1. Location: ADA CODA Accredited Dental School. Hours: At least 60. Patients: At least 20
- d. CPR
- i. American Heart Association for the Healthcare Provider
  - ii. American Red Cross for the Professional Rescuer
  - iii. Military Training Network (MTN) Healthcare Provider Course
  - iv. American Heart Association Advanced Cardiac Life Support (ACLS)
  - v. American Heart Association Pediatric Advanced Life Support (PALS)
2. **DENTAL HYGIENISTS:**
- a. DH Administer Nitrous Oxide: 20:43:09:06
    - i. Nitrous Oxide Courses taught at ADA CODA accredited dental, dental hygiene or dental assisting schools.
  - b. DH Administer Local Anesthesia: 20:43:09:06.01
    - i. Local Anesthesia Courses taught at ADA CODA accredited dental or dental hygiene schools.
  - c. CPR
    - i. American Heart Association for the Healthcare Provider
    - ii. American Red Cross for the Professional Rescuer
    - iii. Military Training Network (MTN) Healthcare Provider Course
    - iv. American Heart Association Advanced Cardiac Life Support (ACLS)
    - v. American Heart Association Pediatric Advanced Life Support (PALS)
3. **REGISTERED DENTAL ASSISTANTS**
- a. RDA: 20:43:08:03 (1)
    - i. ADA CODA accredited dental assisting programs.
    - ii. Western Dakota Technical Institute (WDTI) dental assisting program (non-accredited).
    - iii. South East Technical Institute (SETI) dental assisting program (non-accredited). *SETI discontinued its dental assisting program effective May 12, 2011. Anyone that graduated prior to that time would be eligible for registration.*
    - iv. DANB Certified Dental Assistant (CDA) Certification (three components: Radiation Health and Safety, Infection Control and General Chairside Assisting)
    - v. Lake Area Technical Institute (LATI) expanded functions dental assistant continuing education course.

1. *Chairside dental assistants that have worked for one year or RDAs that have been out of practice can take this refresher course to qualify for a registration.*
    - a. *Five year rule: If out of practice for five years or more, applicant will need the course to verify competency before a registration will be issued.*
  - b. RDA Administer Nitrous Oxide: 20:43:09:06
    - i. Nitrous Oxide courses taken at all ADA CODA accredited dental, dental hygiene and dental assisting programs.
  - c. CPR
    - i. American Heart Association for the Healthcare Provider
    - ii. American Red Cross for the Professional Rescuer
    - iii. Military Training Network (MTN) Healthcare Provider Course
    - iv. American Heart Association Advanced Cardiac Life Support (ACLS)
    - v. American Heart Association Pediatric Advanced Life Support (PALS)
- 4. RADIOGRAPHERS**
- a. Radiography: 20:43:07:03
    - i. 16 hour Radiography courses taken through an ADA CODA accredited dental, dental hygiene and dental assisting programs.
    - ii. 16 hour Radiography courses taken through WDTI (non-accredited DA program). WDTI offers a standalone 16 hour course or a course that their ADA students take while completing the ADA program. WDTI provides a radiography certificate upon completion of the radiography component.
    - iii. 16 hour Radiography courses taken through SETI (non-accredited DA program). SETI does not offer a standalone 16 hour course. They offer only a 16 hour course that their DA students take while completing the DA program. SETI provides a radiography certificate upon completion of the radiography component. *SETI discontinued its ADA program effective May 12, 2011. Anyone that graduated prior to that time would be eligible for registration.*
    - iv. Radiography component of Dental Assisting National Board (DANB) plus instruction on placement techniques and exposing radiographs from employer.
    - v. Department of the Air Force, Ellsworth Air Force Base 16 hour radiography course taught by Ms. Luann F. Brownson, offered to personnel (active duty, reserve, guard, Red Cross or GS) working as dental technicians at the Ellsworth Air Force Base.
- 5. PERMIT TO MONITOR PATIENTS UNDER ANESTHESIA – DH, RDA and DA**
- a. DH, RDA and DA Monitoring Moderate and Deep/General: 20:43:09:10
    - i. Dental Anesthesia Assistant National Certification Examination (DAANCE)
      1. Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS)
      2. Hours: 36
    - ii. Oral and Maxillofacial Surgery Anesthesia Assistants Program (OMAAP)
      1. Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS)
      2. Hours: 12
    - iii. Anesthesia Assistants Review Course
      1. Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS)
      2. Hours: 12
    - iv. Assistant Sedation/Anesthesia Course
      1. Sponsor: American Dental Society of Anesthesiology (ADSA)
      2. Hours: 12
    - v. Conscious Sedation Consulting Online Sedation Course
      1. Sponsor: Conscious Sedation Consulting
      2. Hours: 8

- vi. Sedation and Anesthesia in the Dental Practice
  - 1. Sponsor: South Dakota Dental Association
  - 2. Hours: 8
- vii. Intravenous Conscious Sedation Course, GRU, College of Dental Medicine
  - 1. Sponsor: Georgia Regents University
  - 2. Hours: 40
- b. CPR
  - i. American Heart Association for the Healthcare Provider
  - ii. American Red Cross for the Professional Rescuer
  - iii. Military Training Network (MTN) Healthcare Provider Course
  - iv. American Heart Association Advanced Cardiac Life Support (ACLS)
  - v. American Heart Association Pediatric Advanced Life Support (PALS)
- 6. **Regional Examination Equivalency**
  - a. California Dental Hygiene State Board Exam—1988



## South Dakota State Board of Dentistry Continuing Education Requirements

### Dentists

Dentists must earn 100 hours of continuing education in every 5-year CE cycle. Twenty-five (25) of those hours must be university-based. A university course must be taken physically at an accredited dental school at a university or the course presenter must be connected to an accredited dental school at a university. Dentists must maintain a current cardiopulmonary resuscitation (CPR) card. The Board of Dentistry will only accept the American Heart Association for Healthcare Providers or the American Red Cross for the Professional Rescuer cards. A dentist that is licensed to administer General Anesthesia/Deep Sedation or Moderate Sedation must have a current Advanced Cardiac Life Support (ACLS) card from the American Heart Association. *See the CPR requirements in the CE guidelines below.* Dentists holding a general anesthesia and deep sedation or moderate sedation permit must complete an additional 25 hours of continuing education in anesthesia related topics for each five-year licensure cycle.

### Dental Hygienists

Dental Hygienists must earn 75 hours of continuing education in every 5-year CE cycle. A Dental Hygienist must have documented at least five hours of continuing education in dental radiography in a five-year period. Dental Hygienists must maintain a current cardiopulmonary resuscitation (CPR) card. The Board of Dentistry will only accept the American Heart Association for Healthcare Providers or the American Red Cross for the Professional Rescuer cards. *See the CPR requirements in the CE guidelines below.*

### Registered Dental Assistants (Expanded Functions)

Registered Dental Assistants must earn 60 hours of continuing education in every 5-year CE cycle. A person who is certified in dental radiography must have documented at least five hours of continuing education in dental radiography in a five-year period. Registered Dental Assistants must maintain a current cardiopulmonary resuscitation (CPR) card. The Board of Dentistry will only accept the American Heart Association for Healthcare Providers or the American Red Cross for the Professional Rescuer cards. *See the CPR requirements in the CE guidelines below.*

### Dental Radiographers

Dental Radiographers are required to earn 5 hours of continuing education specifically in the area of dental radiography in a 5-year cycle.

## **Continuing Education Categories**

### **University-Based:** Dentists need 25 hours in a 5-year CE cycle

The Course or lecture you are attending must be given by an adjunct, associate, or full professor at an accredited dental school at a university or the course presenter must be a professor or adjunct professor at an accredited dental school at a university. Dentists are the only practitioners required to obtain university-based hours. Dental hygienists and registered dental assistants who attend university-based courses or lectures should submit those courses in the clinical category.

### **Home Study:** Limited to 30 hours maximum in a 5-year CE cycle

These are courses or lectures done on one's own time without leaving your home or office. You must demonstrate your participation and knowledge of the course or lecture through a certificate of completion from the continuing education provider. Home study continuing education includes online continuing education courses or courses offered via videotape or CD. If you take the same home study course more than one time during your 5-year cycle, you will only receive credit for one course. You cannot receive credit for the same home study course more than one time during your 5-year cycle.

### **CPR:** Limited to 15 hours maximum in a 5-year cycle

Being certified in cardiopulmonary resuscitation (CPR) is a requirement for licensure for all dentists, dental hygienists, and registered dental assistants. All practitioners/registrants must maintain a current CPR card. The Board of dentistry will only accept the American Heart Association for Healthcare Providers or the American Red Cross for the Professional Rescuer cards. You do not have to take a refresher course every year; just keep your certification current. Credit for CPR courses is hour for hour. *The Board of dentistry does not recognize on-line CPR courses.* Dentists holding a general anesthesia and deep sedation or moderate sedation permit may submit an Advanced Cardiac Life Support (ACLS) card from the American Heart Association to satisfy the CPR requirement. The Board of Dentistry will recognize hours taken for a certified paramedic, certified emergency medical technician and advanced certified life support in the CPR category with the applied 15 hour limit.

### **Practice Management:** Limited to 10 hours maximum in a 5-year cycle

Practice management is defined as courses or lectures taken to benefit oneself for personal or professional gain or enhancing the business aspects of dentistry. Courses and lectures include, but are not limited to practice management, dental ethics, risk management, stress management, communication skills, office ergonomics, HIPPA, domestic violence, etc. Completion of a college business or college computer-business class will be accepted for 10 hours of practice management if the class included at least 10 hours of lecture or class time.

**Nutrition:** Limited to 15 hours maximum in a 5-year cycle

Nutrition is defined as courses or lectures that include topics of dental nutrition. These topics included, but are not limited to diet, exercise, dental nutrition, and health issues affecting dental health (ex. Anorexia nervosa, bulimia, etc.)

**Clinical:** Unlimited

Non-university or clinical courses or lectures are presented by an instructor who is not affiliated with a university; courses or lectures are not taken physically at a university; courses or lectures are presented by fellow colleagues; etc. These courses or lectures emphasize practitioner to patient contact. Examples include, but are not limited to latest techniques in dentistry, clinical courses, specialties, OSHA/infection control, etc. Courses presented by colleagues or other presenters brought into do an in-office presentation should obtain prior course approval from the Board.

**Radiography:** Dental Hygienist and Radiographers must have a minimum of 5 hours of radiography courses in a 5-year cycle. Limited to 20 hours maximum in a 5-year cycle.

Radiography topics can include radiation safety, equipment operation, film processing, emergency procedures, anatomy and positioning of relevant procedures, radiographic quality assurance, correcting and identifying technique and processing errors, and recognition and identification of radiographic information, such as procedures for enhancing interpretation of radiographic information including disease. Home study radiography courses are allowed, if you take the same home study course more than one time during your 5-year cycle, you will only receive credit for one course. You cannot receive credit for the same home study course more than one time during your 5-year cycle.

**Anesthesia/Sedation:** Dentists holding a general anesthesia and deep sedation or moderate sedation permit must complete an additional 25 hours of continuing education in anesthesia related topics for each five-year licensure cycle.

A Board approved anesthesia inspector is eligible for two hours of anesthesia related continuing education for each anesthesia inspection completed with a maximum of ten hours per continuing education cycle.

Dentists holding a general anesthesia and deep sedation or moderate sedation permit may claim 4 hours of anesthesia related continuing education for each ACLS certification completed and may claim a maximum of 8 hours per continuing education cycle (i.e. 2 ACLS certification courses).

## **Other Continuing Education Guidelines**

### **Clinical – Exhibits (State, Regional or National Meetings/Conventions):**

Hour for hour up to five (5) hours of Clinical-Exhibits CE may be earned for each attendance to the exhibits and meetings at a state, regional or national meeting/convention up to twenty-five (25) hours per 5 year CE cycle.

### **Clinical – Course (table clinics of a state, regional or national meetings/conventions)**

One (1) hour Clinical-Course CE may be earned for each attendance at the table clinics of a state, regional or national meeting/convention.

### **Examiners:**

CRDTS and other Regional Board Examiners are allowed five (5) hours University CE per year in the area of the exam for which he/she calibrates. If a CRDTS examiner calibrates in all three different areas (restorative, periodontal, and clinic floor) of the exam, he/she may earn the five (5) hours for each area and therefore up to fifteen (15) hours per year.

### **Clinical - Volunteer Services:**

Up to thirty (30) hours of Clinical-Volunteer CE may be earned per 5 year CE cycle for volunteer service with:

- Ronald McDonald Smile Mobile
- Dakota Smiles Care Mobile
- Donated Dental Services (DDS) programs
- Sanford Children's Hospital: Cleft Lip & Palate Clinic
- Christina's Smile Care Mobile
- Examinations for troops before deployment
- St. Francis Mission Dental Clinic

Clinical-Volunteer CE may be earned for other volunteer activities that involve direct patient care with approval from the Board of Dentistry.

The Board will not approve oral health or oral health career presentations given to elementary and secondary students for continuing education credit. These types of presentations are considered community service.

### **Teleconference or Live Webcast Courses:**

Teleconference or live webcast courses may fall under the categories of Clinical, University, Practice Management, or Radiography depending on the instructor's credentials and the content of the course.

### **Class Instruction/Attendance:**

Dentists, dental hygienists and registered dental assistants teaching seminar classes may have their seminar teaching hours allowed as Clinical CE after completing the CE Course Approval Form and providing a course outline and biography for Board approval. Hour for hour credit will be allowed for instruction of the course as a one-time credit per course during the 5-year cycle. An in-office presentation to dental hygienists and registered dental assistants by another dental professional may be allowed as Clinical CE. You must submit the CE Course Approval Form and provide a course outline and biography of the presenter for Board approval.

Class instruction and/or class attendance at an accredited dental, dental hygiene or dental assisting school may be allowed as University CE. You must provide an outline of teaching content and obtain Board approval. Hour for hour credit may be given for class instruction and /or class attendance up to one half of the required hours during the 5-year cycle. For example, a maximum of 50 hours for dentists, 38 hours for hygienists, and 30 hours for registered dental assistants is allowed.

Upon request, if a licensed practitioner attends an accredited dental or dental hygiene school full time or is completing a specialty or general practice residency while licensed with the Board, the required continuing education credits may be waived for the time period that the licensee is attending the accredited dental or dental hygiene school or completing a specialty or general practice residency.

### **In Office Instruction:**

In office classes presented to staff by the in office dentist are allowed. The Board requires prior approval by submitting the CE Course Approval Form.

**Digital Software Courses:** In office instruction and training of hygienists and registered dental assistants in digital x-rays by digital software professional trainers may be allowed partly as Radiography CE and partly as Practice Management CE. You must complete the CE Course Approval Form and provide a course outline and the Board will determine the number of hours to be applied in each category.

**Practice Management Software Courses:** In office instruction and training of dental hygienists and registered dental assistants in practice management software by the professional trainers may be allowed partly as Practice Management CE. You must complete the CE Course Approval Form and provide a course outline and the Board will determine the number of hours to be applied in each category.

**Specialty Dental Practice/Laboratory:** Instruction of a dental hygienist or registered dental assistant at another specialty dental practice or dental laboratory in order to perform new procedures and tasks, not previously performed, may be allowed as Clinical CE. You must complete the CE Course Approval Form and provide a course outline and the Board will determine the number of hours to be applied in each category. The Board recommends the specialty dental practice submit the CE Course Approval Form and course outline for prior approval.

**Miscellaneous:**

The Board will not approve continuing education classes on the subject of animal dentistry, as the Board issues licenses to dentists performing dental services on humans per SDCL 36-6A-32.

The Board generally recognizes continuing education providers certified through the American Dental Association Continuing Education Recognition Program (ADA CERP), the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) and the American Academy of Dental Hygiene as valid continuing education providers.

Courses submitted for prior approval are listed on the Approved CE Calendar on the Board of Dentistry web site for your convenience.

The South Dakota State Board of Dentistry determines whether or not a continuing education course will be approved and the category each course will fall under (i.e. university, clinical, etc.). If you are uncertain about approval and/or what category a continuing education course will fall under, please contact the South Dakota State Board of Dentistry office.

**Application Review Policy:** It is the policy of the Board to use the Application Review Policy as guidance when determining whether to issue a license, registration or permit. The Board, or a member of the Board, will be consulted as appropriate for complex applications.

### **Regular Applications**

- **Dentist: License Applications** – A completed application will be reviewed by a Board member to determine if an interview is necessary. The Board may approve an application on a case by case basis.
- **Dental Hygienist: License Applications** – A completed application will be reviewed by a Board member to determine if an interview is necessary. The Board may approve an application on a case by case basis.
- **Collaborative Supervision Applications** - A completed application will be reviewed and may be approved by the Board on a case by case basis.
- **Radiographer Applications** - A completed application will be reviewed and may be approved by the board office staff on a case by case basis.
- **Registered Dental Assistant Applications** - A completed application will be reviewed and may be approved by the board office staff on a case by case basis.
- **General Anesthesia and Deep Sedation Permit or Moderate Sedation Permit Applications (temporary and regular applications)** - A completed application will be reviewed and may be approved by a member of the Board or the chair of the Anesthesia Credentials Committee on a case by case basis.
- **All other permit applications** - A completed application will be reviewed and may be approved by the board office staff on a case by case basis.

### **Volunteer and Temporary Applications**

- **Dentist: Temporary Permit Applications** - A completed application will be reviewed and may be approved by a member of the Board on a case by case basis.
- **Dental Hygienist: Temporary Permit Applications** - A completed application will be reviewed and may be approved by a member of the Board on a case by case basis.
- **Dentist and Dental Hygienist: Volunteer Temporary Registration and Permit Applications** – A completed application will be reviewed and may be approved by a member of the Board on a case by case basis.
  - Dentist – Volunteer temporary nitrous oxide, moderate sedation or general/deep sedation: To obtain a temporary permit, the applicant must verify that he or she holds a valid permit to provide this service or is otherwise allowed to provide this service under a regular dental license in his or her home state and that he or she has been regularly providing such service during the three years preceding application, or if the person has graduated less than three years preceding application, that he or she has been regularly providing such service since graduation. The Board reserves the right to inspect any facility where anesthesia is being provided.
  - Dental Hygienist – Volunteer temporary local anesthesia, nitrous oxide and monitoring patients under anesthesia: To obtain a temporary permit, the applicant must verify that he or she holds a valid permit to provide this service or is otherwise allowed to provide this service under a regular dental hygiene license in his or her home state and that he or she has been regularly providing such service during the three years preceding application, or if the person has graduated less than three years

preceding application, that he or she has been regularly providing such service since graduation. The Board reserves the right to inspect any facility where anesthesia is being provided.

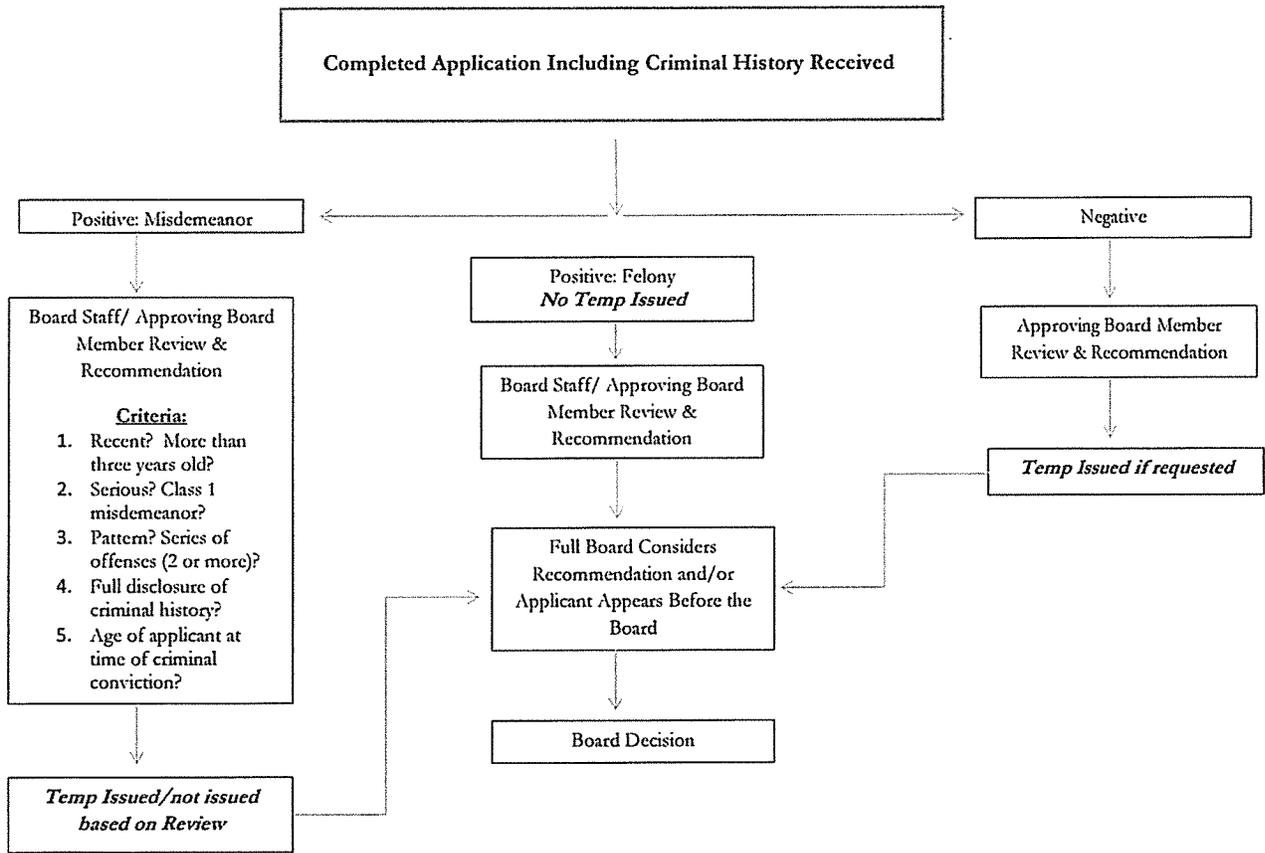
**Continuing Education Audit Policy:** It is the policy of the Board that a continuing education audit will be conducted annually and that it will utilize the Continuing Education Audit Policy as guidance when completing this audit.

It is important that licensees and registrants maintain a file of all the continuing education courses attended during the applicable continuing education cycle. The Board will randomly audit continuing education records and licensees and registrants selected for an audit will be required to provide verification of attendance for all continuing education courses claimed during the applicable continuing education cycle. Verification should include proof of attendance or a certificate of completion. A proof of attendance or a certificate of completion should include the continuing education activity, name of the course, name of the presenter, sponsor of the program, city the course was held in and the number of hours awarded. A certificate of completion must also indicate that the licensee or registrant passed a post-test with a satisfactory score or successfully completed the course.

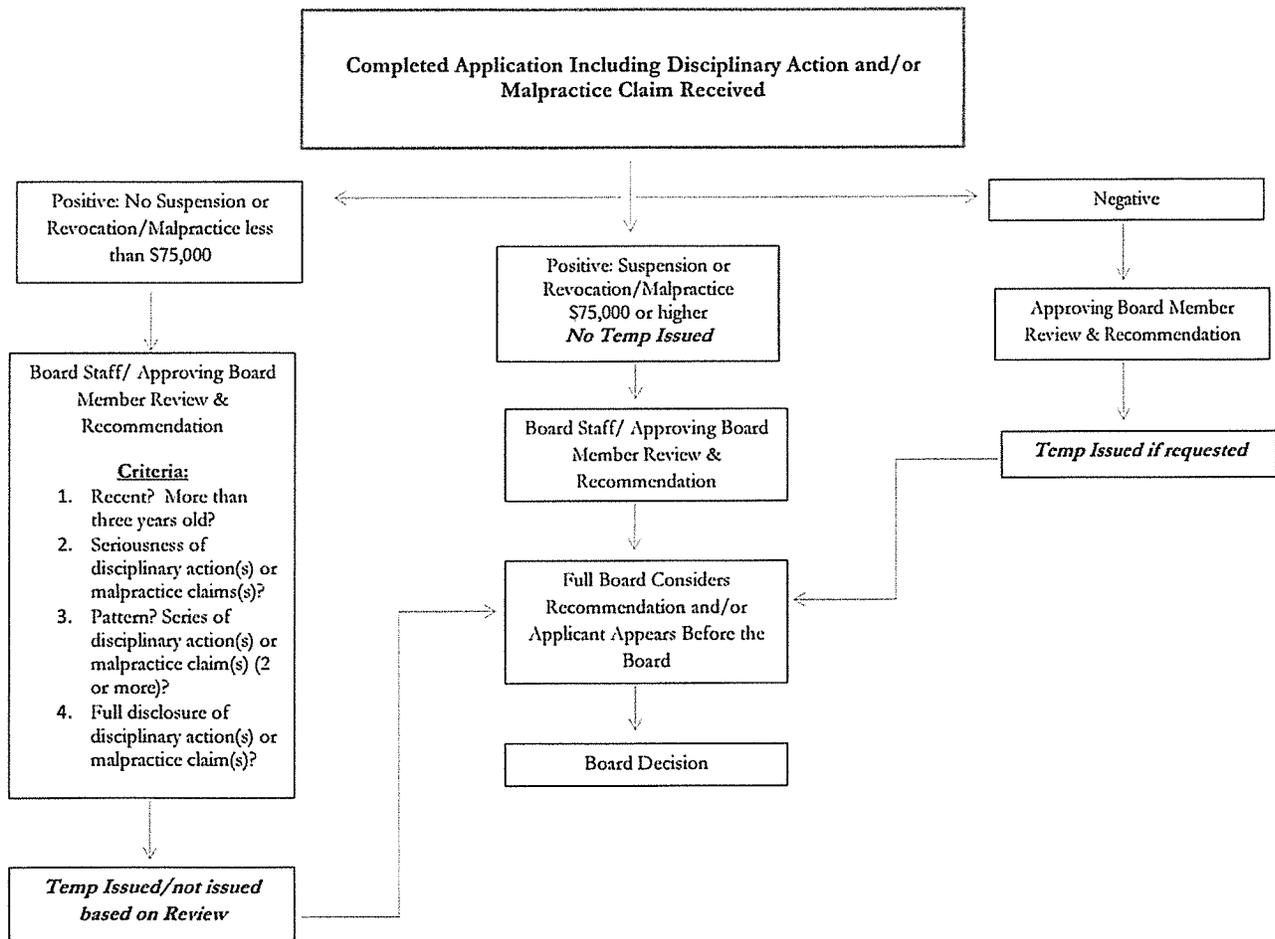
#### AUDIT PROCEDURE

1. A percentage of licensees and registrants required to maintain continuing education hours will be selected for audit. The percentage and other selection criteria will be determined by the Board.
2. Licensees and registrants selected will be notified by the Board. They will be provided a timeframe within which to provide verification of attendance for each continuing education course claimed on his or her continuing education report.
3. If satisfactory verification of attendance cannot be produced, the continuing education course will not be approved and the licensee or registrant will not be given credit for that continuing education course.
4. If a licensee or registrant has no continuing education courses entered or a minimal number of continuing education courses entered in his or her continuing education record and is selected for an audit, that individual will be audited the following year.
5. The Board will consider each audit individually and take action as it deems necessary.

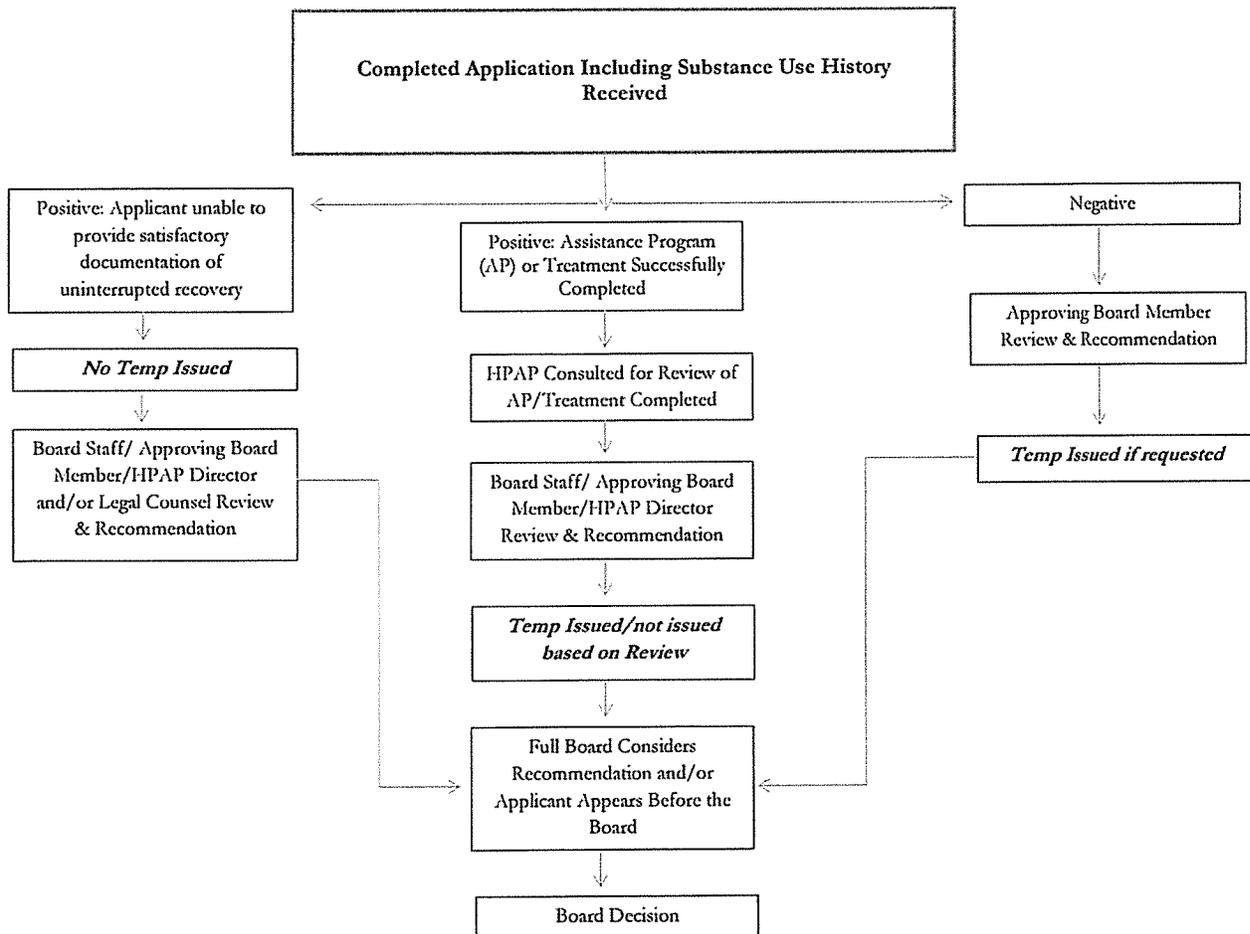
**Criminal History Algorithm:** It is the policy of the Board to use the Criminal History Algorithm as guidance when determining whether to issue a license, registration or permit.



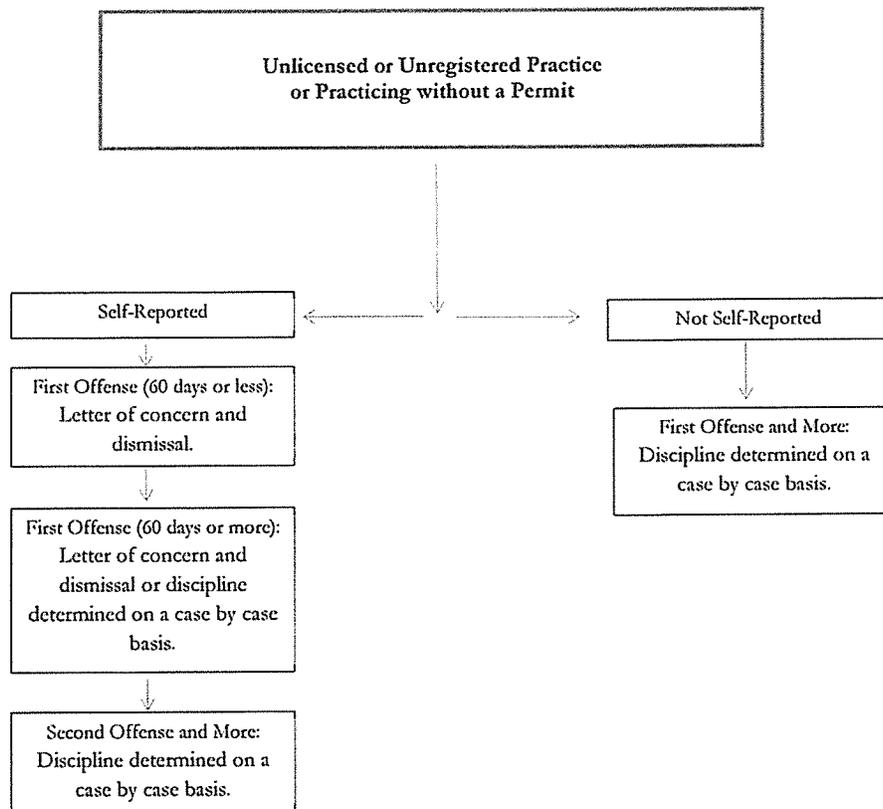
**Disciplinary Action & Malpractice Claim Algorithm:** It is the policy of the Board to use the Disciplinary Action & Malpractice Claims Algorithm as guidance when determining whether to issue a license, registration or permit.



**Substance Use History Algorithm:** It is the policy of the Board to use the Substance Use Algorithm as guidance when determining whether to issue a license, registration or permit.



**Unlicensed, Unregistered or Practicing without a Permit Policy:** It is the policy of the Board to use the Unlicensed, Unregistered or Practicing without a Permit Policy as guidance when reviewing complaints or other matters pertaining to individuals that qualify for a license, registration or permit.



**Reinstatement Following Failure to Renew:** It is the policy of the Board that it will grant a reasonable period of time following July 1<sup>st</sup> to a licensee, registrant or permit holder that has failed to renew to reinstate his or her respective license, registration, or permit(s) by fulfilling all renewal criteria and paying the applicable fee(s). Facts and circumstances surrounding a failure to renew will be considered on a case by case basis.

**Registrant Verification of Competency:** It is the policy of the Board that if a registrant has been out of practice for at least five years preceding the date of application, the individual will be required to verify competency.

**Registered Dental Assistant:** If an applicant has not practiced for at least five years preceding the date of application, the applicant must verify competency by completing the Lake Area Technical Institute (LATI) expanded functions dental assistant continuing education course or by completing the educational course required to obtain a registration.

**Dental Radiographer:** If an applicant has not practiced for at least five years preceding the date of application, the applicant must verify competency by completing the educational course required to obtain a registration.