REMINDER NOTICE TO ALL HEALTH-RELATED LICENSEES AND FUNERAL DIRECTORS

ACT 31 OF 2014 – INITIAL TRAINING AND CONTINUING EDUCATION IN CHILD ABUSE RECOGNITION AND REPORTING REQUIREMENTS

The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing advance notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure.

Additionally, EFFECTIVE WITH THE FIRST LICENSE RENEWAL AFTER JANUARY 1, 2015, all health-related licensees and funeral directors applying for the renewal of a license issued by the Board shall be required to complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements as a condition of renewal.

Please note that Act 31 applies to all health-related licensees, regardless of whether they are subject to the continuing education requirements of the applicable board.

More information regarding this requirement will be posted on the BPOA website as it becomes available.

Approved providers may be reviewed at the following link:
http://www.portal.state.pa.us/portal/server.pt/community/con_ed_providers/21920

Act 31 may be reviewed at the following link:
http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=31.

The Voluntary Recovery Program: Protecting the Public, Rehabilitating Professionals

by Kevin Knipe, MSW, LSW, CCDP
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The State Board of Dentistry is responsible for assuring that dentists, dental hygienists, and expanded function dental assistants practice according to the standards of professional conduct at all times, and that they meet all the requirements of licensure in the Commonwealth,

including continuing education requirements. To carry out this responsibility, the SBOD is authorized to order investigations and prosecutions through the Bureau of Professional Affairs and to discipline those found guilty of violations. Discipline against a licensee is a matter of public record (except as described below) and can take the form of a public reprimand, a period of probation, the suspension or revocation of a license, and/or fines, or any combination of those sanctions. (The Dental Law, 63 P.S. Section 120 et seq.)

If there is evidence that a dental professional is unsafe to practice by reason of chemical impairment and/or mental illness, the Board is authorized to compel the licensee to submit to a mental and/or physical examination by a Board-approved practitioner. Since substance abuse or dependence and mental health disorders are treatable conditions, when deemed appropriate, the Board may offer a licensee the option of a non-disciplinary, non-public method to address impairment issues.

Through the Voluntary Recovery Program (VRP) of the Professional Health Monitoring Program (PHMP), a program of the PA Bureau of Professional and Occupational Affairs (BPOA), those dental professionals suffering from a mental or physical impairment, such as chemical dependency, can receive both appropriate treatment and the monitoring necessary to assure the safety of the general public.

When the Board directs a licensee to the VRP the individual must be assessed by a VRP-approved treatment provider. Only those found to meet the criteria for a diagnosis under the Diagnostic and Statistical Manual of Mental Disorders are eligible for enrollment in the Program. At that point, a licensee is asked to enter into a Consent Agreement with the SBOD for a period of no less than three years stipulating that disciplinary action, including suspension or revocation of the license, will be deferred as long as the licensee adheres to the terms and conditions of the Agreement and maintains satisfactory progress in the program. Only licensees who are willing to enter such an agreement are accepted into the VRP. In order to assure that there is no public record of a licensee's participation in the VRP, those Consent Agreements are presented for the Board's approval with all identifying information redacted.

While in the VRP, licensees must submit to random drug testing, abstain from use of prohibited substances, comply with recommendations made by the VRP-approved treatment provider, submit to monitoring of their practices by a workplace monitor, and attend 12-step mutual help fellowship programs, such as Alcoholics Anonymous and Narcotics Anonymous, or other community-based support groups approved by the VRP.

The VRP is strictly voluntarily and all participants choose to determine if they wish to cooperate throughout the process. Should an individual choose not to cooperate with the VRP at any point, that decision is reported to the PA Department of State Legal Office for review regarding the possible initiation of formal, public disciplinary procedures by the SBOD, in some situations including immediate action to protect the public by removing the licensee from practice.

Reporting an Impaired Dental Professional

In the Commonwealth of Pennsylvania, any hospital or health care facility, peer or colleague who has substantial evidence that a licensed or certified dental professional has an active addictive disease for which the professional is not receiving treatment, is diverting a controlled substance, or is mentally or physically incompetent to carry out the duties of his or her license, is obligated to report the matter to the State Board of Dentistry. (The Dental Law, 63 P.S. Section 11.6(f)).

To report a licensed practitioner suspected of being impaired and/or diverting controlled substances, you may choose one of the following options:

- Obtain a Statement of Complaint form by contacting the Professional Compliance Office at (800) 822-2113 or 717-783-4849, or by downloading the form from the Department of State website: https://www.dos.state.pa.us
- Completing the online Statement of Complaint form via the Department of State website.
- Sending a written narrative to the Professional Health Monitoring Program, P.O. Box 10569, Harrisburg, PA 17105. The written complaint must include the following: name of the licensee suspected of being impaired, licensee's license number, social security number, or home address, and an overview of the event(s) precipitating the report.

Individuals may contact the VIP on their own behalf, and are encouraged to do so.

For further information regarding the VRP, please call (800) 554-3428 (PA residents only) or 717-783-4857.

New Members of the State Board of Dentistry

Ronald E. Plesco, D.M.D.

Dr. Plesco is a 1964 graduate of the University of Pittsburgh and graduated from the University of Pittsburgh School of Dentistry in 1968. He became a member of the U.S. Army shortly after graduation that year, and was appointed to the rank of Captain, serving until 1970. During his final year in the military, Dr. Plesco was appointed Dental Surgeon of the Base Clinic. He also served as an instructor at the University of Pittsburgh while on loan from the Army in 1970.

Dr. Plesco began his private practice of dentistry upon his return to civilian status and continues his practice in Pittsburgh to this date.

David J. Datillo, D.D.S.

Dr. Datillo, a native of Pittsburgh, attended Fordham University and obtained his dental degree from the Medical College of Virginia in 1978. He completed a five-year residency in Oral and

Maxillofacial Surgery at the University of Pittsburgh Medical Center in 1984. Dr. Dattilo served as the Chief of Dental Service at Mercy Hospital of Pittsburgh until 2004, when he was appointed Training Program Director and Division Director of Allegheny General Hospital.

Beginning in 1991, Dr. Dattilo's interests expanded to include dental health care in third world nations, and he participated in surgical missions to West Africa, Peru and Nepal, providing surgical treatment to children and adults suffering from a wide variety of oral and facial deformities.

Dr. Dattilo has published and lectured on a wide variety of his professional interests, including obstructive sleep apnea and facial reconstruction.

Dental Records: Protecting Patients and Supporting Optimal Practice

Part One of a Two Part Overview

John F. Erhard III, DDS,
Secretary
State Board of Dentistry

One of the most important functions of the State Board of Dentistry (SBOD) is to protect the health and safety of the public by setting standards for obtaining and maintaining licensure, and by enforcing the rules and regulations governing safe and effective practice. Because appropriate dental records are essential for the delivery of comprehensive dental care and patient protection, regulations specifically governing the appropriate preparation, maintenance and retention of patient records are upheld by the Board. The regulations governing patient records can be found at 49 Pa. Code § 33.209 and §§ 33.207(a)(3), 33.208(a)(3). Failure to comply with those regulations for any reason – negligence, fraud, or lack of professional competence – can be found to constitute a violation of the regulations and may result in disciplinary action against the licensee.

Pennsylvania guidelines for record keeping are *general*, but follow a set of *universal* principles intended to assure the quality of care for dental patients: (1) a record must be maintained for each patient, and; (2) all records must legibly and completely reflect the evaluation and treatment of the patient. See 49 Pa. Code § 33.209(a). These principles clarify record keeping requirements for licensees and provide legal documentation concerning the patient's care. The SBOD has the authority to order the inspection of dental records, and in some cases these records may be used as evidence in civil and criminal court proceedings.

The information contained within a comprehensive dental patient record includes the following:

- A medical history is a mandatory component of the dental record when prescribing, administering or dispensing a controlled substance, and typically includes: a review of the symptoms and any record of prior surgery, recent hospitalizations, current and recent medications (both prescription and non-prescription), a list of physicians and medical consultations, and any medical or psychological condition that may impact the

patient's dental treatment. It is also a good idea to review the medical history with the patient and have them sign it.

- A dental history, which shall include: chief complaint, symptoms and diagnosis, a description of the treatment or service rendered at each visit and the identity of the person rendering it. Other helpful entries could include: home care practices, relative dietary regimen, and other dental habits, practices and conditions that may affect the patient's dental treatment. Examples include: bruxing, clenching and/or grinding.

Combined medical and dental histories provide for optimal preventive and therapeutic treatment. The findings should always be documented. Oral cancer screening should always be intentionally accomplished and the result documented.

- Objective findings, which includes: the results of the oral and physical examination, including the evaluation of intra and extra oral hard tissue, any previous restorations, appliances and prosthetics, any disease present, or any other system or functional problem that should be addressed. Other objective findings could include: an appropriate radiographic survey along with any comments on the findings, any diagnostic casts, digital imaging displays, recordings of current blood pressure and heart rate, the presence or absence of teeth, developmental abnormalities, attrition, erosion, fracture mobility, any comments on the condition of existing restorations, prosthetic and orthodontic evaluations, any oral disease, including caries, the results of diagnostic tests such as temperature sensitivity, percussion, palpation, etc., periodontal disease, including gingival recession, adequacy of attached keratinized tissue, alveolar bone loss, furcation involvement, periodontal pocketing, biopsy results, laboratory findings, caries risk assessment, and salivary adequacy.

- Progress notes that are thorough, well documented, dated and signed.

The scope of the dental and physical exam is in a large way determined by the scope and type of treatment. The administration of sedation and/or general anesthesia, or the management of chronic pain, would require a more in depth, focused medical physical examination and evaluation than routine restorative dentistry.

Ultimately, integrating all data results in an accurate diagnosis will result in a logical plan of treatment.

Part Two of this Overview will focus on other essential aspects of dental patient recordkeeping.

Dental Records: Protecting Patients and Supporting Optimal Practice

By: John F. Erhard III, DDS, Secretary, State Board of Dentistry

Part Two of a Two Part Overview: Treatment Plan and Record Management

In assuring the quality of care for dental patients, the documentation of a Treatment Plan and appropriately detailed progress notes are as vital as the incorporation of in-depth dental and medical histories in dental patient records.

Regulations specifically governing the preparation, maintenance and retention of patient records appear in Chapter 33 PA Code, Section 33.209 and outline professional standards intended to protect public safety through the promotion of optimal practice. The universal principles that guide effective, ethical record-keeping apply to dental patient records as well: 1) a record must be maintained for each patient, and; 2) all records must legibly and completely reflect the evaluation and treatment of the patient. The State Board of Dentistry is charged with upholding practice regulations, and failure to comply for any reason can be found to constitute a violation and may result in disciplinary action against the dental licensee.

All facets of patient care must be reflected the dental patient record: the dental examination, the patient's medical and dental history, clinical findings, the Treatment Plan, and progress notes. The absence of an adequate Treatment Plan, even in the event of well-executed treatment, may result in less than optimal results for the patient and may be interpreted as a professional shortcoming.

The Treatment Plan:

A well-developed Treatment Plan has multiple uses: it can provide direction to staff in scheduling appointments and making payment arrangements; it can be easily referenced by providers as treatment progresses; it can serve as a communication tool for patient-provider conversations, and it can be reviewed by third parties to determine provider competence and the quality of patient care.

Although Treatment Plans can vary in their length and level of detail, they should link clinical findings with the treatment to be provided.

A basic Treatment Plan includes:

- the patient's chief complaint or reason for seeking care
- a significant history of the patient's medical/systemic care
- a record of care previously provided (both emergency and non-emergency dental control procedures)
- a record of definitive care – direct or indirect restoration or prosthetic provision, for example
- recommended maintenance care

It is important to note that Treatment Plans sometimes present more than one treatment option. If more than one option is offered, details regarding presentation of the benefits and risks associated with each of the options available should be documented.

A complex Treatment Plan, or one that includes more than one option, includes:

- a written sequence of treatment completed and treatment yet to be provided, which should be made available to the patient
- the clinical rationale, provider's thought process and patient discussion to support and justify the treatment selected

Complex Treatment Plans and Significant Risk procedures include: surgical procedures (oral surgery and periodontal procedures), endodontic therapy, orthodontic therapy, select and complex restorative procedures (including fixed and removable prostheses) and cosmetic cases.

Management of acute pain does not require the same level of documentation as the management of chronic pain.

Progress Notes:

All progress notes should be thorough, well documented, and signed. Items to be included in the dental patient record should include the following:

- date of each entry
- purpose, or treatment planned during the appointment
- subjective complaints
- drugs administered during treatment including dosage and route of administration, topical medications, anesthetics, fluoride, oral medication, antibiotics, sedative agents, inhalation agents, parenteral or IV administered agents
- treatment rendered, including any complications
- post-op instructions and follow-up
- prescriptions given (drug, dosage and refill instructions)
- patient conversations, including telephone conversations
- patient compliance, including home care
- copies of any referral for specialty care

All patient referrals should be recorded with the date, reason for the referral, name of the provider (if available), and the outcome (if known).

Patient dental records should NOT include financial information.

Notation should be made in the dental record for the termination of the doctor-patient relationship, transfer or release of patient record information, or inactivation.