GEORGIA BOARD OF DENTISTRY
Board Meeting
2 Peachtree St., N.W., 5th Floor
Atlanta, GA 30303
November 8, 2019
10:00 a.m.

The following Board members were present:
Dr. Greg Goggans, President
Dr. Tracy Gay, Vice-President
Dr. Richard Bennett
Ms. Becky Bynum
Dr. Michael Knight
Dr. Glenn Maron
Mr. Mark Scheinfeld

Staff present:
Tanja Battle, Executive Director
Eric Lacefield, Deputy Director
Max Changus, Assistant Attorney General
Stacy Altman, Chief Investigator
Kimberly Emm, Attorney
Brandi Howell, Business Support Analyst I

Visitors:
Keith Kirshner, Ben Massell Dental Clinic
Lauren Pollow, PDS
Misty Mattingly, GDHA
Charles Craig, GDHA
Hannah Weiss, Smile Direct Club
Scott Lofranco, GDA
Dr. David Bradberry, GDA
Keri Bealing
Dr. Chris Cutler, DCG
Dr. Lyndsay Langston
Dr. Alan Furness, DCG
Kim Turner, Fulton County Board of Health
Shayna Overfelt, CDCA
Dr. Guy Shampaine, CDCA
John Watson, ADSO
Frank Capaldo, GDA
Terry Coleman, Government Solutions

Open Session

Dr. Goggans established that a quorum was present and called the meeting to order at 10:10 a.m.

Introduction of Visitors
Dr. Goggans welcomed the visitors.

Approval of Minutes
Dr. Maron made a motion to approve the Public and Executive Session minutes for the October 11, 2019 meeting. Dr. Knight seconded and the Board voted unanimously in favor of the motion.

Report of Licenses Issued
Dr. Bennett made a motion to ratify the list of licenses issued. Dr. Gay seconded and the Board voted unanimously in favor of the motion.

Correspondence from Natalie West, DH043069

The Board considered this request from Ms. West, who is a military spouse. Ms. West's correspondence requests the Board allow her to obtain the required eleven (11) hours of onsite continuing education online for the 2020-2021 biennium. Dr. Gay made a motion to approve the request. Mr. Scheinfeld seconded and the Board voted unanimously in favor of the motion.

Correspondence regarding sleep screening patients

The Board discussed this correspondence received from a dentist wanting to bring patients in for a sleep screening. The correspondence states that the dentist would like to take a panoramic image and asks if a full medical history is required if the patient is strictly there for a screening to find out if he/she wants to pursue treatment. Dr. Gay stated that before treatment is initiated, the dentist needs to conduct a full exam. Dr. Bennett commented that if a patient is coming to the dentist's office and the dentist is taking a panoramic image, in his opinion, that is considered more than a screening. He stated that the issue seems to be the health history and what documentation is required for the patient. Dr. Bennett stated that at a minimum, the dentist needs to conduct a basic health history if he/she is going to touch a patient. Dr. Maron agreed with Dr. Bennett. Dr. Maron stated that the way he read the letter, is that the dentist is trying to shorten the evaluation. Dr. Bennett made a motion to direct staff to respond by stating it is the Board's opinion that exposing radiographs is considered to be more than a screening and would recommend the dentist have a health history on file for the patient. Dr. Maron seconded and the Board voted unanimously in favor of the motion.

General – Dr. Greg Goggans

Dr. Goggans introduced Stacy Altman, Chief Investigator, to the Board.

Dr. Goggans requested Dr. Maron be added as an ad-hoc member of the Investigative Committee. Dr. Bennett made a motion to approve the request. Dr. Gay seconded and the Board voted unanimously in favor of the motion.

Executive Director's Report – Ms. Tanja Battle

Renewals: Ms. Battle reported that 1940 dentists and 1498 dental hygienists have renewed. She requested the Board and guests to please mind remind all licensees to renew in a timely manner. She stated waiting until the last minute could result in delays should issues arise with individual renewals.

IP Continuing Education Program Applications: Dr. Bennett discussed two Injectable Pharmacologics Continuing Education Program applications from Med Aesthetics Training, LLC, that were tabled from the Board's October meeting. Dr. Bennett stated that the courses as presented, are well done; however, they do not have the required 21 hours, per Board Rule 150-14-.04 . Dr. Bennett made a motion to deny the courses as submitted, but stated that the Board would reconsider the courses if they can provide the required 21 hours. Dr. Gay seconded and the Board voted unanimously in favor of the motion.

Peer Reviewer: Dr. Bennett made a motion to approve Dr. Robert D. Bradberry as a consultant for the Investigative Committee. Dr. Maron seconded and the Board voted unanimously in favor of the motion.

Attorney General's Report – Mr. Max Changus

No report.

Legal Services – Ms. Kimberly Emm

No report.

Rules

Periodontal Maintenance: Dr. Goggans stated that the Board has received written comments from Elizabeth Schroeder, Jamie Combs, Kathryn Zotter, Dr. Kavith Rajavelu, Dr. Kelly A. Vaughn, Patricia Gainey, Suzanne Newkirk, and Wanda Hill. He stated if there were any comments from the audience to please tell the Board who they are, who they represent and if he/she is in favor or against any changes to Rule 150-5-.03 Supervision of Dental Hygienists to include the procedure D4910.

Public comments were received from Misty Mattingly, GDHA: Ms. Mattingly stated that GDHA is in favor of allowing D4910 to be performed under general supervision. She stated a patient under periodontal maintenance has already had treatment and the dental hygienist is just maintaining. She commented that procedures are determined by the dentist. She continued by stating that with the bill that opened up supervision in our state, that allowed dental hygienists to treat more patients. It would be the dentist's decision to allow those procedures. Dr. Bennett responded by stating that Ms. Mattingly said that the frequency of periodontal maintenance is prescribed by the dentist. Ms. Mattingly responded by stating that is traditionally the case. She stated that for periodontal maintenance or even a prophylaxis the dentist will determine the procedure for the patient. Dr. Bennett asked Ms. Mattingly who will make the determination of the next periodontal maintenance frequency if the dentist does not see a patient who has been in the previous diseased process. Ms. Mattingly responded by stating that the dentist should be seeing new patients first and that the patient would be a patient of record. She further stated that the dentist would have already determined what the treatment would be. She stated that when the patient comes in for the treatment, typically they are on a schedule. She stated that direct supervision states the dentist should visit the patient to determine what the dental hygienist needs to do. Dr. Bennett asked if the dentist is not in the office, how would that occur? Ms. Mattingly responded that it would be under general supervision and at no point would the dental hygienist be changing the diagnosis. Dr. Maron asked who would determine if there is a change in the patient's condition if the dentist is not present. Ms. Mattingly responded by stating that it would be the same as now. She stated that if the hygienist notices any change, he/she would send the patient back to be seen by the dentist. Ms. Mattingly stated that if there was something the dentist did not feel comfortable for the hygienists to do, the dentist does have the right to make that determination in their office.

Public comments were received from Dr. David Bradberry: Dr. Bradberry thanked the Board for allowing him to speak. He stated that he is the most recent past president of GDA. He commented that the GDA House of Delegates supports the Board's previous determination that D4910 should not be performed under general supervision and that it opposes any changes to the rule due to GDA's concern over patient safety. Dr. Bradberry stated that the Board will hear testimony from members of the GDA to include clinicians and GDA's general counsel, that taken as a whole will support the Board's current ruling.

Public comments were received from Dr. Christopher Cutler, Dental College of Georgia. Dr. Cutler stated that he is in favor of keeping the rule the way it is concerning the requirement of direct supervision on periodontal maintenance visits. He stated that one can agree that the hygienists through his/her training are able to do an outstanding job of performing proper prophylaxis, but a prophy is not the same. Dr. Cutler stated that is different from a maintenance visit. He stated that if a patient has had a diagnosis of periodontal disease before, the patient generally will be seen every three to four months. He stated that things can change rapidly with the patient's condition. Dr. Cutler stated that it is his opinion that allowing dental hygienists to perform periodontal maintenance under general supervision would have serious long term consequences for the oral health of citizens of Georgia for the reasons stipulated by the Department of Periodontics' letter that was put into record at the Board's Rules Committee Meeting in September 2018.

Public comments were received from Dr. Lyndsay Langston: Dr. Langston stated that she is a Board-certified periodontist and a current private practitioner. Dr. Langston provided the following statement from her partner Dr. Brandon Coleman:

A Brief Overview of the Periodontics Literature on Maintenance

Provided by Brandon Coleman DDS, MS
Diplomate, American Board of Periodontology

The following document attempts to succinctly present the "classic" body of science from the periodontics literature in order to frame the discussion on the role of the dentist in periodontal maintenance. Only literature widely considered to be "key" and "essential" reading by highly influential leaders was included in the following discussion.

Based on various insurance codes and selective quoting of ADA and AAP sources, it may be argued that a state of health on a reduced periodontium is akin to health, and thus, maintenance should fall under general supervision. In my opinion, this argument conflates legalistic terminology and politically neutral documents by the ADA with the hard science concerning periodontal disease. It presents a "red herring" argument to the Board with faulty logic: absence of evidence is not evidence of absence. A "state of health on a reduced periodontium" is still a category within periodontal maintenance and does apply to some patients. However, to argue that maintenance patients are the same as healthy patients presents a gross lack of understanding of periodontal disease.

I have spent years in both academia and clinical practice, and I would suggest that the role of the dentist be framed as one of risk stratification. Quite simply, not all patients are created equally. Those most at risk depend on us as providers to make careful and thoughtful diagnoses on a regular basis. Disease activity is a rare phenomenon – it is difficult to identify and difficult to manage appropriately. It is a low- probability event with seemingly small consequences for making the wrong call. The truth is that most patients would do well most of the time even under a hypothetical system of "supervised neglect". We have seen this in studies of populations with no dental care at all. But, as I would tell my residents in training – we are not called doctor for the times that go right, we are doctors for the times that go wrong. What kind of doctors are we if we only provide for most of our patients most of the time? Who among us would want our internist to only be right a lot of the time? We make difficult decisions with imperfect information. We blend art and science to make a professional opinion. Prognosis and Diagnosis are complex and probabilistic decisions we make on behalf of our patients. Periodontal disease is highly prevalent, easy to misdiagnose, and imposes a non-trivial cost on patients. Hygienists play a pivotal role in the treatment and management of these patients, and we could not function without them. I would never suggest that their role in maintenance should change. But, if dentists choose to delegate the task of triage, risk assessment, diagnosis, and prognosis, then we have delegated that which makes us doctors in the first place. I simply see no benefit to the patient in changing the status quo, and the arguments for such a change appear to be financial under the false flag of clinical. We should not confuse the two. General supervision of maintenance may be appropriate for some patients, but does NOT present a suitable solution for all Georgia patients and is not in the best interest of the public.

1.) **What is periodontal disease?**
   a. A chronic, low-grade infectious process whereby the immune system attempts to resolve a biofilm on an avascular (tooth) surface. As late colonizing anaerobic bacteria arise, the interaction of the immune system and the biofilm create inflammatory mediators that cause resultant damage to hard and soft tissues. It is not the bugs or the person – it is the result of the battleground between the two.
   b. Periodontal disease has no cure and should be thought of as a constellation of chronic diseases. Not unlike diabetes and hypertension, the disease can only be controlled.

c. Recent epidemiological data shows that periodontal disease is highly prevalent. It affects about half of all Americans to some degree, with more severe forms affecting a smaller segment of the population.
d. **Key Points for Consideration:** Periodontal disease must be monitored continually. It requires continually updated diagnosis and prognosis. It is dentistry's hypertension.

2.) What are the goals of maintenance? (From the *AAP Parameters of Care on Maintenance*)

a. Prevent or minimize the *recurrence and progression* of periodontal disease in patients who have been treated for gingivitis, periodontitis and peri-implantitis
b. Prevent or reduce the incidence of tooth loss by close monitoring and *interceptive treatment* as indicated
c. Increase the probability of *locating and treating other diseases or conditions* found within the oral cavity
d. **Key Points for Consideration:** The AAP states 3 goals for maintenance including interceptive therapy and diagnosis of other diseases and conditions. The AAP also stresses first and foremost the chronic nature of periodontal disease – a dentist's role is to carefully monitor and assess recurrence and progression.

3.) Are there different types of maintenance? Yes.

a. Bob Schallhorn, one of the most revered and prominent opinion leaders in the field of periodontics, published a classic paper (JADA 1981) detailing 4 different types of prophylaxis.
    i. Preventive – this is the "prophy" in a disease-free dentition
    ii. Trial – allowing for maintenance during borderline conditions for a period of time to assess the need for further care
    iii. Compromise – slowing the disease progression in patients who are not candidates for surgical therapy (e.g. medically compromised or very poor oral hygiene)
    iv. Post-treatment – designed to prevent disease recurrence in treated patients and allow for ongoing re-evaluation.
b. **Key Points for Consideration:** All 3 of the types of maintenance involving periodontal disease require careful monitoring and ongoing clinical judgment and prognostication from the dentist. All types of maintenance are dynamic. Maintenance REQUIRES the ongoing diagnosis and prognosis of the treating dentist. No form of maintenance is definitive.

4.) How does periodontal disease progress? Chaotically

a. Haffajee and Socransky are key thought leaders with an extensive body of work detailing the microbiology of periodontal disease. They pioneered the concept of the "red complex" and have a classic paper (JCP 1986) explaining disease progression.
b. *Periodontal disease follows an <u>asynchronous random burst progression</u>.* Essentially, acute exacerbations of disease activity are followed by periods of quiescence. The best analogy would be teenagers who develop acne – except this dental acne starts in middle age and never really stops. Periodontal disease patients would be akin to repeated active lesions resultant from the immune system dysregulation.
c. The late Steve Offenbacher showed that severe disease activity reflects neutrophil dysfunction. In fact, patients with severe disease suffer from an immune system problem moreso than a bacterial problem. In other words, their disease is incurable and ***unpredictable***.

d. **Key Points for Consideration*:*** Disease activity cannot be predicted. The role of the dentist is surveillance and prognostication. Periodontal disease activity comes and goes in bursts of potentially severe activity. The maintenance appointment is a snapshot in time and must be used to make key decisions.

5.) How do we assess periodontal disease during maintenance? With Difficulty.

a. Gary Armitage, who authored the 1999 World Workshop document on classification, writes frequently on diagnosis and prognosis. He captures the sentiment of most dentists in a 1996 (Perio 2000) publication. He states that disease activity cannot be assessed by a single parameter such as probing depths. It is a complicated decision blending art and science.

b. Niklaus Lang, the most published periodontist in history, showed in a pivotal study from the 1980's, that repeated measures of BOP are perhaps the best indicator of future attachment loss. Sequential BOP on 4 different occasions indicated 30% risk of attachment loss. BOP is our best indicator of disease activity – and yet – it has very poor predictive value.

c. *Kornman, of Harvard fame and the originator of our current pathophysiology model, has shown that the BEST PREDICTOR of future disease is simply PAST DISEASE! Those who have had disease in the past are the most at risk of continued disease.*

d. Studies by Claffee showed that 6mm probing depths will tend to get worse, while a variety of studies show that non-surgical therapy is simply not predictably efficacious beyond 5mm. Decisions must be made by the clinician.

e. **Key Points for Consideration:** A maintenance exam cannot be done properly without seeing the patient in person and weighing the confluence of factors. Diagnoses cannot be made simply by looking at someone else's charting on a different day. A variety of clinical parameters must be evaluated in real-time to determine a patient's risk.

6.) Is there evidence for differences between disease and healthy patients? Yes.

a. Teles et al (JP 2008) showed that "treated periodontitis subjects under maintenance displayed more rapid attachment loss than periodontally healthy subjects in a preventive regimen. The greater propensity to disease progression may be related to an elevated exposure to periodontal pathogens."

b. *Tonetti (2002), Hirschfield & Wasserman (1978), and Becker (1984) all provide critical longitudinal studies showing that **RISK STRATIFICATION** is essential.* Most patients will be fine most of the time. The role of the dentist is to determine the "at risk" individuals – those that lose the majority of teeth rapidly.

c. **Key Points for Consideration:** There is strong clinical evidence to show that periodontal disease patients are distinct from healthy patients. In truth, there are no studies to show the contrary: that periodontal disease patients can be considered the same as healthy patients. The dentist MUST take ownership of the triage and risk stratification decision. The most "at risk" patients must be identified and managed to the standard of care.

7.) Are implants any different? Very much so.

a. Implants lack a true connective tissue insertion. In other words, implants have less protection, deeper pockets, and have less vascularity in the area. By definition and from day one: Implants are different.

b. Probing around implants requires much more discernment and personal judgment on the part of the clinician to make the diagnosis of peri-implantitis or peri-implant mucositis
c. Peri-implantitis estimates vary, but with increasing prevalence, recent European literature by Lang et al. suggests as many as 40% of all implants will develop problems. 40%!!!!!! The problem will not improve with time. Implants are being placed by more and more providers with less training than the more traditional methods, and implant companies increasingly advocate rough surface implants.
d. Peri-implantitis is a difficult challenge. Treatments are not predictable at present. As such, early and proactive intervention is critical to prevent progression. But again, the diagnosis and prognosis are much more nebulous relative to teeth.
e. **Key Points for Consideration:** The growing threat of peri-implantitis and the difficulty inherent in triage and decision-making in implantology suggests that dentists must make early, proactive diagnoses in order to serve the patient's best interest.

Public comments were received from Dr. Alan Furness: Dr. Furness stated that he would like to reaffirm the Dental College of Georgia's prior position that Dr. Cutler referenced that was put in the minutes from the Board's Rules Committee September 2018 meeting. He stated that DCG's position has not changed.

Public comments were received from Scott Lofranco, GDA: Mr. Lofranco stated that the overwhelming testimony is very clear from a practice standpoint and, as an attorney, he is not able to speak to that. He stated that in regards to statements of support received by the Board regarding D4910 to be allowed under general supervision, there is no clinical assertions in nature. Mr. Lofranco addressed codes D4910 and D1110. He stated that the definition of D1110 states, "Removal of plaque, calculus, and stains from tooth structures in the permanent and transitional dentition. It is intended to control local irrational factors." Mr. Lofranco stated that the definition of D4910 states, "This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planning where indicated, and coronal polishing." Mr. Lofranco stated that on its face, these are two different procedures; however, D4910 is more complex.

Mr. Lofranco stated that his second point relates to another issue why D4910 is different. He stated that D4910 is reimbursed at a higher rate than D110. Mr. Lofranco stated that is because injectable anesthesia is required as the Department of Periodontics at the Dental College of Georgia noted in their letter. He stated that D4910 is reimbursed at a higher rate because it requires closer scrutiny.

Mr. Lofranco stated that his final point is a policy argument. He asked if this is this truly best for the patients? He stated that there should be a concern for potential abuse because of the higher frequency in visits for D4910 versus D1110 coupled with higher reimbursement rates. Mr. Lofranco concluded that allowing D4910 under general supervision goes against the clinical recommendations of the majority of clinical opinions that have been presented to the Board at this time. He stated that GDA remains in full support of the Board's previous ruling that D4910 cannot be performed under general supervision.

Dr. Goggans stated that as it stands the rule is now where D49010 cannot be performed under general supervision. He asked if there were any comments from the board members. Dr. Maron asked GDHA what information came around to make them want to talk about it again since the Board previously voted on this matter a year ago. He asked if it will be brought up again in the future. Ms. Mattingly responded that currently most states allows periodontal maintenance to be a procedure dental hygienists can do without a dentist present in the office. She added that, at some point, she thinks Georgia has to catch up. She stated that this matter will continue to come up in order to advance the care of patients in this state.

Ms. Mattingly stated that there are dentists who submitted correspondences to the Board that are in favor of allowing periodontal maintenance to be performed by dental hygienists under general supervision. She stated that Georgia was the 48th state to allow dental hygienists to work under general supervision. She added that Georgia is constantly being left behind as a state. Ms. Mattingly stated that O.C.G.A. § 43-11-74 requires a dental hygienist to have at least two years of experience in the practice of dental hygiene in order to provide services under general supervision. She stated that means the hygienist would have been working with a dentist that is guiding him or her. Ms. Mattingly stated that it is a partnership between the dentist and hygienist, and they can come together to take care of Georgia's patients together. Dr. Maron asked if Ms. Mattingly had any data that changed from last year to this year. Mr. Lofranco commented that one of the misstatements provided by Ms. Mattingly was Georgia was the 48th state to allow dental hygienists to work under general supervision. He stated that is not true as Georgia did allow supervision in public health and the Department of Corrections. With no further discussion, Dr. Goggans stated that the rule will remain as is.

Appearance

Ms. Shayna Avey-Overfelt and Dr. Guy Shampaine, CDCA, were present and spoke to the Board regarding the CDCA and ADEX licensure examination. Ms. Avey-Overfelt discussed a handout provided to the Board that contained information on the states that currently accept the ADEX examination. Ms. Avey-Overfelt stated that there are two agencies offering ADEX and that is CDCA and CITA. She stated that there are currently 70 dental students that want to come back home to Georgia and do not have access to an exam that the Georgia Board of Dentistry accepts.

Dr. Shampaine stated that he appreciates the opportunity to discuss this with matter with the Board. He stated that he and Ms. Avey-Overfelt were not here to displace the current exam. He stated that they are here to ask the Board to consider the ADEX examination for the candidates around the country that want to come back to Georgia to practice. Dr. Shampaine stated that, traditionally, the candidates do not have to travel. Dr. Shampaine provided information on what ADEX is about. He stated that ADEX is not a testing entity as they give no exams. He stated that ADEX is an organization of dental boards. Dr. Shampaine stated that no testing agency is a member of it. He stated that Georgia was a founding member of ADEX. It was an attempt to give them authority to determine what was on the exam. Dr. Shampaine stated that with ADEX, every person is appointed by the dental board representatives and it is owned by the member dental boards. He stated that there are multiple testing agencies because they existed. He stated the first two were CRDTS and NERB. Dr. Shampaine stated that NERB is now CDCA. He added that CITA is still involved because there are relationships with dental schools, logistics involved. Dr. Shampaine explained that it is important to understand the testing agencies have no say in the content or scoring of the exam.

Dr. Shampaine discussed the ADEX examination construction. He stated that ADEX is a testing development entity strictly and does not administer the examinations. It determines the design and content of the exams, determines the criteria used for evaluating candidate performance and specifies how the evaluations determine the final score. He stated that sections 1-4 of the ADEX exam are identical to the CRDTS exam. He explained it is the same preparations and scoring content. He stated that this would be a very familiar exam for anyone who participates in the CRDTS exam. He stated that the only addition is the Diagnostic Skills Exam (DSE-OSCE).

Dr. Shampaine stated there are seven states that require specialty exams. He explained that CDCA will develop an exam specific for that state, if requested. Dr. Bennett asked if there would be a mechanism for some current board members to see an ADEX exam administered, considering the climate of testing currently. Dr. Shampaine responded that they would be happy to provide the board with a full list of exams and the board members could attend any exam site they would like to.

Dr. Furness commented that the Dental College of Georgia helps administer the CRDTS examination. He stated that when an issue arises, such as a student being unable to take the examination due to an illness, pregnancy, etc., Alabama is the only place the candidate can go. He stated that the candidate may have to fly somewhere to take the exam and that creates a significant hardship for the individual.

Rules

Rule 150-7-.03 Volunteers in Dentistry: Dr. Goggans stated that the Board previously held a public hearing on this rule and the rule was tabled. He stated that the Board discussed it further at the Board's October meeting and some board members wanted another month to review it. He asked if there were any suggested changes to the rule. Mr. Kirshner commented that delivering volunteer services here is most pressing. He asked the Board to consider the conversion of an active license to a volunteer license. He stated that he is conscious of the rule change process taking time. He inquired about a rule waiver mechanism that would allow the licensee to accomplish this until the rule is in effect. Dr. Bennett asked Mr. Kirshner if the proposed language is appropriate or was Mr. Kirshner looking for something different. Mr. Kirshner stated that he believes what the Board has proposed is appropriate. Mr. Lofranco commented that the GDA supports the proposed language as well. Dr. Bennett made a motion to adopt Rule 150-7-.03 Volunteers in Dentistry. Mr. Scheinfeld seconded. Discussion was held regarding the timeframe of when the rule would be effective. Ms. Battle stated that the rule would need to be reviewed and approved by the Governor's office. Mr. Kirshner asked if this would have an impact for this renewal cycle. Ms. Battle responded no. Mr. Kirshner asked if the licensee could submit a rule waiver to convert to a volunteer license, rather than waiting on the rule to be in effect. Ms. Battle responded by stating that it would depend on what portion of the rule the individual was requesting a waiver of. She added that, by law, the waiver must be posted to the registry for 15 days before the Board could consider it. Dr. Goggans stated that the Board does not want to grant or deny something that has is currently being considered by the Governor's office. With there being no further discussion, the Board voted unanimously in favor of the motion.

Dr. Richard Bennett made a motion and Dr. Glenn Maron seconded and the Board voted to enter into **Executive Session** in accordance with O.C.G.A. §43-1-19(h)(2), §43-11-47(h) and §43-1-2(k) to deliberate and receive information on applications, investigative reports, and the Assistant Attorney General's report. Voting in favor of the motion were those present who included Dr. Richard Bennett, Ms. Becky Bynum, Dr. Tracy Gay, Dr. Greg Goggans, Dr. Michael Knight, Dr. Glenn Maron, Mr. Mark Scheinfeld.

Executive Session

Appearance

- K.R.B.

Licensure Overview Committee Appointments/Discussion Cases

- J.S.D.
- T.M.R.
- C.L.C.
- M.M.
- A.F.M.
- J.E.C.
- D.R.C.

Applications

- L.J.K.
- E.D.H.

- B.M.B.
- J.W.B.
- S.S.F.
- C.W.W.
- D.E.H.
- J.E.K.
- M.M.
- S.V.
- E.D.G.
- K.A.S.

- The Board discussed processing of sedation applications.

Investigative Committee Report – Dr. Bert Yeargan
Report presented:

- DENT130202
- DENT180319
- DENT190066
- DENT200083
- DENT200114
- DENT200122
- DENT200144
- DENT200148
- DENT110011
- DENT140116
- DENT180162

Executive Director's Report – Ms. Tanja Battle
- Correspondence from K.C.

Miscellaneous
- The Board discussed examination content and structure.
- The Board discussed applications for faculty licensure.
- The Board discussed peer reviews and referrals to the Attorney General's office.

Attorney General's Report – Mr. Max Changus
Mr. Changus presented the following consent orders for acceptance:
- T.E.M.
- J.M.M.
- T.T.S.
- F.F.W.

Mr. Changus discussed the following cases:
- S.K.K.
- E.B.

Legal Services – Ms. Kimberly Emm
- K.G.E.

- DENT190145
- DENT190227

Miscellaneous
Discussion regarding peer reviews and referrals to the AG's office.

No votes were taken in Executive Session. Dr. Goggans declared the meeting back in Open Session.

Open Session

Dr. Gay made a motion to approve all recommendations based on deliberations made in Executive Session:

Appearance

• K.R.B.	Denied Dental Hygiene Credentials	Denial upheld

Licensure Overview Committee Appointments/Discussion Cases

• J.S.D.	Request to terminate reporting period	Approved request
• T.M.R.	Request to terminate probation	Approved request
• C.L.C.	Renewal Pending	Renew with letter stating the Board has not concluded its consideration of the matter.
• M.M.	Request regarding course required per Consent Order	Board directed staff to respond by stating a 10 hour onsite course must be taken and the individual will need submit the course syllabus to the Board for pre-approval prior to taking the course.
• A.F.M.	Moderate Enteral Conscious Sedation	Approved for provisional permit pending receipt of additional information
• J.E.C.	Request to terminate probation	Approved request
• D.R.C.	Request to terminate probation	Approved request

Applications

• L.J.K.	Dental Hygiene Credentials Applicant	Denied application
• E.D.H.	Dental Credentials Applicant	Approved application
• B.M.B.	Dental Hygiene Reinstatement Applicant	Approved application
• J.W.B.	Dental Hygiene Reinstatement Applicant	Approved application
• S.S.F.	Dental Hygiene Reinstatement Applicant	Approved application
• C.W.W.	Dental Reinstatement Applicant	Table pending receipt of additional information on reinstatement application or submit an application for volunteer licensure
• D.E.H.	Moderate Enteral Conscious Sedation	Approved application
• J.E.K.	Moderate Enteral Conscious Sedation	Table until December meeting
• M.M.	Moderate Enteral Conscious Sedation	Approved application
• S.V.	Moderate Enteral Conscious Sedation	Approved application
• E.D.G.	Moderate Parenteral Conscious Sedation	Approved evaluation

- K.A.S. General Anesthesia Applicant Approved for provisional permit

- The Board discussed processing of sedation applications. No action was taken.

Investigative Committee Report – Dr. Bert Yeargan

Report presented:

Complaint Number	Allegations	Recommendation
DENT130202	Quality of Care/Substandard Practice	Close No Action
DENT180319	Quality of Care/Substandard Practice	Close No Action
DENT190066	Abandonment	Refer to the Department of Law/Further Investigation Required
DENT200083	Advertising	Rescind Closure; Further Investigation Required
DENT200114	Other	Close No Action
DENT200122	Quality of Care/Substandard Practice	Close No Action
DENT200144	Billing	Close No Action; Refer to Medicare/Medicaid
DENT200148	Record Release	Close with a Letter of Concern
DENT110011	Quality of Care/Substandard Practice	Close No Action
DENT140116	Quality of Care/Substandard Practice	Close No Action
DENT180162	Quality of Care/Substandard Practice	Close No Action

Executive Director's Report – Ms. Tanja Battle

- Correspondence from K.C. The Board viewed this correspondence for informational purposes only.

Miscellaneous

- The Board discussed examination content and structure.
- The Board discussed applications for faculty licensure.
- The Board discussed peer reviews and referrals to the Attorney General's office.

Attorney General's Report – Mr. Max Changus

Mr. Changus presented the following consent orders for acceptance:

- T.E.M. Public Consent Order accepted
- J.M.M. Public Consent Order accepted
- T.T.S. Public Consent Order accepted
- F.F.W. Public Consent Order accepted

Mr. Changus discussed the following cases:

- S.K.K. Close with no action
- E.B. Update provided

Legal Services – Ms. Kimberly Emm

- K.G.E. Public Consent Order accepted
- DENT190145 Rescind letter of concern and close with no action
- DENT190227 Close with a letter of concern

Dr. Bennett seconded and the Board voted unanimously in favor of the motion.

With no further business, the Board meeting adjourned at 12:42 p.m.

The next scheduled meeting of the Georgia Board of Dentistry will be held on Friday, December 6, 2019, at 10:00 a.m. at the Department of Community Health's office located at 2 Peachtree Street, N.W., 6th Floor, Atlanta, GA 30303.

Minutes recorded by Brandi Howell, Business Support Analyst I
Minutes edited by Tanja D. Battle, Executive Director