STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
P (916) 263-2300 F (916) 263-2140 | www.dbc.ca.gov

BOARD MEETING AGENDA
DECEMBER 1-2, 2016

Embassy Suites San Francisco Airport Waterfront
150 Anza Boulevard, Burlingame, CA 94010
(650) 342-4600 (Hotel) or (916) 263-2300 (Board Office)

Members of the Board

Steven Morrow, DDS, MS, President
Judith Forsythe, RDA, Vice President
Steven Afriat, Public Member, Secretary

Fran Burton, MSW, Public Member
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDH
Kathleen King, Public Member
Ross Lai, DDS
Huong Le, DDS, MA
Meredith McKenzie, Public Member
Thomas Stewart, DDS
Bruce Whitcher, DDS
Debra Woo, DDS

During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items, unless listed as informational only. It is anticipated that the items of business before the Board on the first day of this meeting will be fully completed on that date. However, should an item not be completed, it may be carried over and heard beginning at 8:00 a.m. on the following day. Anyone wishing to be present when the Board takes action on any item on this agenda must be prepared to attend the two-day meeting in its entirety.

Public comments will be taken on agenda items at the time the specific item is raised. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the President. For verification of the meeting, call (916) 263-2300 or access the Board's website at www.dbc.ca.gov. This Board meeting is open to the public and is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Karen M. Fischer, MPA, Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five business days before the meeting will help to ensure availability of the requested accommodation.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources or technical difficulties that may arise.

Thursday, December 1, 2016

8:00 A.M. FULL BOARD MEETING – OPEN SESSION

The Board will convene Open Session for the purpose of establishing a quorum and will then move directly to Closed Session. The Board will then return to Open Session at 11:00 a.m. and will begin the discussion regarding the items on the agenda.

1. Call to Order/Roll Call/Establishment of Quorum.

CLOSED SESSION – FULL BOARD
Deliberate and Take Action on Disciplinary Matters
The Board will meet in closed session as authorized by Government Code §11126(c)(3). If the Board is unable to deliberate and take action on all disciplinary matters due to time constraints, it will also meet in closed session on December 2, 2016.

CLOSED SESSION – LICENSING, CERTIFICATION, AND PERMITS COMMITTEE

A. Issuance of New License(s) to Replace Cancelled License(s)
The Committee will meet in closed session as authorized by Government Code §11126(c)(2) to deliberate on applications for issuance of new license(s) to replace cancelled license(s)

B. Grant, Deny, or Request Further Evaluation for Conscious Sedation Permit Onsite Inspection and Evaluation Failure Pursuant to California Code of Regulations, Title 16, Section 1043.6
The Committee will meet in closed session as authorized by Government Code Section 11126(c)(2) to deliberate whether or not to grant, deny, or request further evaluation for a Conscious Sedation Permit as it relates to an onsite inspection and evaluation failure.

RETURN TO OPEN SESSION – FULL BOARD (Estimated start time 11:00am)

2. Board President Welcome and Report

3. New Board Member Introduction

4. Approval of the August 18-19, 2016 and October 13, 2016 Board Meeting Minutes

5. Budget Report

6. Discussion and Possible Action to Review and Adopt the Dental Board of California's 2017-2020 Strategic Plan

7. Examinations:

    A. Staff Update on Portfolio Pathway to Licensure

8. Licensing, Certifications and Permits:

    A. Licensing, Certification and Permits Committee Report on Closed Session
    The Board may take action on recommendations regarding applications for issuance of new license(s) to replace cancelled license(s).

    B. Review of Dental Licensure and Permit Statistics

    C. Report on the October 19, 2016 meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee and Discussion and Possible Action to Accept the Elective Facial Cosmetic Surgery Permit Credentialing Committee Recommendation(s) for Issuance of Permit(s)

    D. Discussion and Possible Action Regarding the Draft Report to the Legislature on the Elective Facial Cosmetic Surgery Permit Program as Provided by Business and Professions Code Section 1638.1

    E. Discussion and Possible Action to Initiate a Rulemaking to Adopt California Code of Regulations, Title Section Sections 1044.6, 1044.7, 1044.8 Relating to Elective Facial Cosmetic Surgery Permit Application and Renewal Requirements

    F. Discussion and Possible Action to Initiate a Rulemaking to Adopt California Code of Regulations, Title 16 Section 1028.6 Relating to Licensure by Credential Application Requirements

9. Enforcement:

    A. Enforcement – Statistics and Trends

    B. Review of Fiscal Year 2016-17 First Quarter Performance Measures from the Department of Consumer Affairs

    C. Diversion Program Report and Statistics

10. Pediatric Anesthesia Report

    A. Discussion and Possible Action Regarding the Subcommittee's Recommendations Relating to Pediatric Anesthesia

    B. Discussion and Possible Action to Adopt the Subcommittee's Report Relating to Pediatric Anesthesia and Submit it to the Legislature

11. Update Regarding California Society of Periodontists Request for the Dental Board of California's Endorsement of their Efforts in the Creation of a Periodontal Disease Awareness Month

CONVENE JOINT MEETING OF THE DENTAL BOARD AND DENTAL ASSISTING COUNCIL – SEE ATTACHED AGENDA

**The purpose of this joint meeting is to allow the Board and the Dental Assisting Council to interact with each other, ask questions and participate in discussions.*

RETURN TO FULL BOARD OPEN SESSION

COMMITTEE MEETINGS – SEE ATTACHED AGENDAS

- PRESCRIPTION DRUG ABUSE COMMITTEE
  See attached Prescription Drug Abuse Committee agenda.

RETURN TO FULL BOARD OPEN SESSION

RECESS

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MEMORANDUM

DATE	November 15, 2016
TO	Dental Board Members
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**AGENDA ITEM 2:** Board President Welcome and Report

The President of the Dental Board of California, Steven G. Morrow, DDS, will provide a verbal report.

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MEMORANDUM

DATE	November 15, 2016
TO	Dental Board Members
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**AGENDA ITEM 3:** New Board Member Introduction

On October 7, 2016, Governor Brown appointed Steven Chan, D.D.S., of Fremont to the Dental Board of California. Dr. Chan graduated from Georgetown University School of Dentistry in 1978. He completed a general practice residency followed by a pediatric dental residency at Martin Luther King Jr./Los Angeles County Hospital. He has been in private practice limited to pediatric dentistry in Fremont, CA since 1981.

Dr. Chan is a past President of the California Dental Association and has served as Vice Chair on five of CDA's for profit subsidiary companies and as a member of its political action committee. He is founder of the California Dental Association Foundation.

He served on the policy-making American Dental Association House of Delegates for 18 years. He serves on the Investment Oversight Committee of the American Dental Association Foundation.

Dr. Chan further served as President of the California Society of Pediatric Dentistry. He served additional leadership roles on the Western Society of Pediatric Dentistry and as a member on Councils of the American Academy of Pediatric Dentistry.

Dr. Chan completed a leadership curriculum at the Kellogg Graduate School of Management at Northwestern University in Chicago. He later chaired a subcommittee on the Alameda County Civil Grand Jury investigating government bodies. He also chaired an appointed Citizen's Committee which oversaw the building of a new campus for Ohlone Community College (Fremont).

Dr. Chan completed tenure on the American College of Dentists, this country's honor society for the profession – as President. He serves as President of the ACD Foundation.

Dr. Chan and his wife Suzanne (former Vice Mayor) live in Fremont. They have two sons who are successful entrepreneurs.

BOARD MEETING MINUTES
August 18-19, 2016
Hilton Sacramento Arden West
2200 Harvard Street, Sacramento, CA 95815
916-604-3993 (Hotel) or 916-263-2300 (Board Office)

Members Present
Steven Morrow, DDS, MS, President
Judith Forsythe, RDA, Vice President
Fran Burton, MSW, Public Member
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDH
Kathleen King, Public Member
Ross Lai, DDS
Huong Le, DDS, MA
Meredith McKenzie, Public Member
Thomas Stewart, DDS
Bruce Whitcher, DDS
Debra Woo, DDS

Members Absent
Steven Afriat, Public Member, Secretary

Thursday, August 18, 2016

1. **Call to Order/Roll Call/Establishment of Quorum.**
Dr. Steven Morrow, President, called the meeting to order at 8:58am. In the absence of Mr. Steve Afriat, Secretary, Vice President Judith Forsythe called the roll and a quorum was established.

The Board immediately went into Closed Session.

CLOSED SESSION – FULL BOARD

CLOSED SESSION – LICENSING, CERTIFICATION, AND PERMITS COMMITTEE

RETURN TO OPEN SESSION – FULL BOARD

2. **Licensing, Certification and Permits Committee Report on Closed Session.**
Dr. Steve Morrow, Chair of the Licensing, Certification and Permits (LCP) Committee reported that the committee made the following recommendations:

DDS Candidate S.B. – Approve replacement upon completion of the Law and Ethics training.
Motioned/Seconded (M/S) (Burton/Whitcher) to accept the committee recommendations.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

DDS Candidate A.M. – Approve replacement upon completion of the Law and Ethics training.
M/S (Whitcher/Chappell-Ingram) to accept the committee recommendations.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

DDS Candidate F.Q. – Approve replacement upon completion of the Law and Ethics training.
M/S (Whitcher/Chappell-Ingram) to accept the committee recommendations.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain:** 0

The motion passed.

RDA Candidate G.O. – Approve replacement upon completion of the Law and Ethics training.
M/S (Whitcher/Woo) to accept the committee recommendations.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

RDA Candidate E.S. – Approve replacement upon completion of the Law and Ethics training.
M/S (Whitcher/Woo) to accept the committee recommendations.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

RDA Candidate M.S. – Approve replacement upon completion of the Law and Ethics training.
M/S (Whitcher/Woo) to accept the committee recommendations.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

3. **Approval of the May 11-12, 2016 Board Meeting Minutes.**
Meredith McKenzie commented that she was not absent from the May meeting as indicated by the minutes. She stated that she arrived at noon on Wednesday, May 11, 2016.

M/S (King/Woo) to accept the minutes as amended.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

4. **Welcome by Board President.**
Dr. Steven Morrow, President, introduced Dr. Jayanth Kumar the newly appointed California Dental Director.

5. **Report by Jayanth V. Kumar, DDS, MPH, California Dental Director.**
Dr. Kumar gave a presentation highlighting the Issues, Challenges, and Opportunities California's Dental Providers encounter.

6. **Budget Report.**
Sarah Wallace, Assistant Executive Officer, gave an overview of the information provided.

7. **Discussion and Possible Action Regarding 2017 Board Meeting Dates.**
Linda Byers, Executive Assistant, gave an overview of the information provided. The Board discussed the possible dates for 2017 and agreed upon:

February 23-24, 2017
May 11-12, 2017
August 10-11, 2017
November 2-3, 2017

8. **Update on the Dental Board of California's 2017-2020 Strategic Plan Development.**
Executive Officer, Karen Fischer, gave an overview of the information provided.

9. **Discussion and Possible Action Regarding Adoption of the Revisions to the Board Member Administrative Procedure Manual.**
Ms. Fischer gave an overview of the information provided. She recommended that the paragraph on page 11 regarding "grace period" be stricken.

M/S (Stewart/Forsythe) to remove the sentence on page 11 concerning "grace period".

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

Dr. Whitcher suggested adding the word “stipulated” before the word Surrenders, in the last bullet point in the Closed Session section of page 7.

M/S (Stewart/McKenzie) to accept the manual as amended.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

10. **Discussion and Possible Action Regarding Withdrawal of the Appointment of Shannon Chavez, MD, to the Southern California Diversion Evaluation Committee and; Recommendations for the Appointment of a Southern California Diversion Evaluation Committee Member.**
Ms. Fischer gave an overview of the information provided.

M/S (Stewart/Burton) to withdraw the appointment of Shannon Chavez to the Diversion Evaluation Committee.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

Dr. Stewart gave a summary of his discussion with Diversion Committee candidate Bradford.

M/S (Woo/McKenzie) to appoint John Philip Bradford, DDS as a public member of the Southern Diversion Evaluation Committee.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

The motion passed.

11. **Discussion and Possible Action Regarding the Draft Report to the Legislature Regarding the California Portfolio Pathway to Licensure Program in Accordance with Business and Professions Code Section 1632.6(a).**
Ms. Wallace gave an overview of the draft report relating to the Portfolio Examination and requested the Board review the report pursuant to Business and Professions Code (Code) Section 1632.6 to ensure compliance with the requirements of Section 139 of the Code and certify that the Portfolio Examination meets those requirements in order to submit to the Legislature and the Department of Consumer Affairs by December 1, 2016.

M/S (Burton/King) to approve the draft report to submit to the Legislature.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Lai, Le, McKenzie, Stewart, Whitcher, Woo. **Oppose:** 0 **Abstain: 0**

12. **Examinations:**

A. **Western Regional Examination Board (WREB) Update**

Dr. Huong Le provided a verbal report regarding her attendance at the Dental Examination Review Board on June 24 in Austin, Texas. She also introduced Dr. Nathaniel Tippit, Committee Chair of WREB. Dr. Tippit invited Board member questions and briefly discussed current dental strategies in Texas.

B. **Staff Update on Portfolio Pathway to Licensure**

Ms. Fischer gave an overview on the information provided. Dr. Debra Woo gave a report regarding the efforts at the Arthur A. Dugoni School of Dentistry-University of the Pacific, the acceptance of the portfolio examination in Iowa, and discussions taking place with Kentucky. Dr. Morrow gave a report on the continued success of the Portfolio Pathway to Licensure spreading nationwide and some of the challenges associated.

13. **Licensing, Certifications and Permits:**

A. Review of Dental Licensure and Permit Statistics

Sarah Wallace, Assistant Executive Officer, gave an overview of the information provided.

14. **Enforcement:**

A. Enforcement – Statistics and Trends

Carlos Alvarez, Acting Enforcement Chief, gave an overview of the information provided.

B. Review of Third Quarter Performance Measures from the Department of Consumer Affairs

Mr. Alvarez, Acting Enforcement Chief, gave an overview of the information provided.

C. Diversion Program Report and Statistics

Mr. Alvarez, Acting Enforcement Chief, gave an overview of the information.

CONVENE JOINT MEETING OF THE DENTAL BOARD AND DENTAL ASSISTING COUNCIL

RETURN TO FULL BOARD OPEN SESSION

RECESS

Friday August 19, 2016

15. **Call to Order/Roll Call/Establishment of Quorum.**

Dr. Steven Morrow, President, called the meeting to order at 9:01 a.m. Judith Forsythe, Vice President, called the roll in the absence of the Secretary and a quorum was established.

16. **Executive Officer's Report.**

Karen Fischer, Executive Officer of the Dental Board of California reported on her activities since the last Board meeting as well as the status of each of the Dental Board's units.

17. **Report of Dental Hygiene Committee of California (DHCC) Activities.**
Noel Kelsch, RDHAP, Dental Hygiene Committee President, gave a report on the Committee's staffing, activities and goals.

18. **Subcommittee Report Regarding the Progress of the Pediatric Anesthesia Study Requested by Senator Jerry Hill; Review and Discussion of "Working Document".**
Dr. Whitcher gave a presentation containing an overview of the "Working Document". Kathleen King, Board Member, asked if Amoxicillin is still part of the preoperative treatment. Dr. Whitcher answered that it can be. She also asked if the anesthesiologist for dental treatment done in a hospital setting is a Dentist Anesthesiologist or a Medical Anesthesiologist. Dr. Whitcher answered that the person administering anesthesia in a hospital setting would have to have hospital privileges and could be either. Dr. Whitcher mentioned that insurance companies mandate a surgery center setting for patients under the age of seven needing sedation for dental procedures.

Dr. Leonard Tyko, President of the Oral and Facial Surgeons of California (OFSOC), commented that OFSOC gathered data to determine the number of dental anesthesia procedures performed each year including conducting a survey of the members of OFSOC for the number of pediatric and adult anesthesia procedures performed from 2011 to 2016. From the data it is estimated that in the five years between 2011 and 2015, California Oral and Maxillofacial Surgeons did over one million pediatric deep sedations and general anesthetics. According to the Dental Board's working document there has only been a single death in an Oral and Maxillofacial Surgeons office which makes the risk less than one in a million. Dr. Tyko stated that OFSOC has an excellent safety record and there is no data to support changes to the Oral and Maxillofacial Surgeons model and is therefore unwarranted.

Dr. George Maranov, Chair of the OFSOC Anesthesia Committee, commented that in 2012 the American Association of Oral and Maxillofacial Surgeons established parameters of care for anesthesia in outpatient facilities and a periodic anesthesia evaluation program that is rigorous. He also commented that Auxiliaries are a key component of the team effort needed and to that end the OFSOC has established the Oral and Maxillofacial Surgery Assistant training program that allows auxiliaries to obtain certification to assist in outpatient oral surgery procedures performed under anesthesia. Dr. Maranov stated that OFSOC recommends three changes to the Dental Anesthesia Regulations:

1. Adoption of the American Association of Oral and Maxillofacial Surgeons (AAOMS) parameters of care to all dentists who practice sedation and oral anesthesia.
2. Require the presence of two trained and certified auxiliaries during outpatient moderate, deep, and general anesthesia.

3. Require Capnography monitoring during moderate, deep and general anesthesia sedation consistent with the American Society of Anesthesiologists (ASA) and AAOMS.

Kathleen King asked if the one million sedation cases per five years were adult and pediatric combined. Dr. Tyko answered that this number was pediatric only which is 21 years and younger. He commented that roughly 48% of the total number of cases are pediatric.

Dr. Lai asked if the training that OFSOC offers for auxiliaries is open to any auxiliary or do they have to be a member of OFSOC. Dr. Maranov stated that it is open to any auxiliary.

Dr. Whitcher asked if they had any recommendations that would help the Board address the pediatric age group. Dr. Tyko suggested that children seven and under be treated in a hospital setting, this is the standard insurance companies recognize.

Dr. Paul Reggiardo, California Society of Pediatric Dentists (CSPD) and American Society of Pediatric Dentistry (ASPD), commended the Board and the subcommittee on the depth, breadth and attention to detail contained in the Anesthesia Working Document. He brought a letter for distribution that requests a correction on page 26 regarding the process by which the joint American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) *Guideline for Monitoring Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures* is developed and approved by the governing bodies of both organizations. He stated that the document incorrectly states that it is unclear as to where the input is obtained. Dr. Reggiardo stated that the guidelines are developed jointly by both organizations and not merely forwarded to the AAP by the AAPD for endorsement. AAPD and CSPD look forward to the completion of the comprehensive and impartial analysis by the Dental Board of Pediatric Sedation and the Laws, Regulations and Policies which govern its administration. The organizations support and applaud the open and transparent process by which the subcommittee is moving forward to identify any necessary statutory or other changes to the administration of office-based sedation which improve the margin of safety for pediatric patients; and believe this information is essential in determining the course of action necessary to ensure the highest level of care for the patients.

Brianna Pittman, California Dental Association (CDA), commented that CDA appreciates the significant amount of work that has gone into producing this report. She thanked the Dental Board for the proactive outreach to stakeholders not to just practitioners within Dentistry but to all those who are concerned with pediatric anesthesia safety. CDA looks forward to working with all interested parties to implement the Board's recommendations for improvements in pediatric anesthesia. CDA suggests that additional data and collection methods are needed.
Dr. Whitcher commented that prevention is the first step to diminishing the need for pediatric anesthesia for dental work.

Dr. Larry Trapp, California Society of Dentist Anesthesiologists (CSDA), commented that the report is poorly paginated. He stated that the incident report that the Dental Board requires is inadequate. Dr. Trapp offered to partner with the Board along with the Department of Anesthesiology of Loma Linda University to create a more comprehensive document. He encouraged the Board to not expunge any data related to these cases.

Dr. Diana Belli, Dental Anesthesiologist, commented that she travels from office to office to provide general anesthesia and monitoring, leaving the dentist free to perform just the procedure. She commented that in a former career she specialized in data analytics and noticed that in the report there were only 11 attributes recorded. She feels that there are an additional 28 items that should be tracked. Without tracking all of these attributes an accurate assessment is not possible.

Kathleen King asked Dr. Belli about the additional attributes that she suggests. Dr. Belli listed some of her findings. Kathleen King asked for her recommendations in writing. Dr. Belli agreed to provide them.

Dr. Lai commented that in the case of a poor outcome, the dentist usually contacts their insurance carrier first, who directs them not to talk to anyone about the incident. This poses a dilemma for the dentist who wants to report the incident but has been instructed by the insurance carrier not to. Dr. Whitcher stated that any time an insurance company receives a report they open a claim which can ultimately be used to gather data from the closed claim report.

Jeff Hogue, Specialist in Pediatric Anesthesiology, California Society of Anesthesiologists (CSA), commented that updated terminology is needed. In a previously submitted letter we recommend revision of the Business and Professions Code and all applicable regulations to reflect the current classification of states of sedation in anesthesia; minimum, moderate and deep sedation and general anesthesia, the distinction between oral and parenteral routes of administration should be abandoned and the definition of new permit categories to replace those currently in existence eliminating the term Conscious Sedation and to stratify permits by depth of sedation and pediatric and adult.

Dr. Mark Zakowski, President, California Society of Anesthesiologists (CSA), commented that he is in support of this project and hopes that the definitions of minimal sedation, moderate sedation, and deep sedation/general anesthesia that the ASA uses are adopted. He promotes one standard of care no matter the setting.

Dr. Anna Kaplan urges that there should be a separate anesthesia provider in the room monitoring the patient at all times.

Dr. Paula Whiteman, Governing Board of the American Academy of Pediatrics (AAP), submitted a letter previously that urges all dentists in California comply with the AAP and AAPD guidelines on pediatric anesthesia in dental settings. We recommend the subcommittee integrate the recommendations of the California Society of Anesthesiologists letter that was just provided dated August 17, 2016.

The California American Academy of Pediatrics requests an immediate and full moratorium on the single operator anesthesiologist model when a child is placed under moderate to deep sedation in a dental office.

Dr. Richard Stafford, Past President California Society of Dental Anesthesiologists, former faculty at University of Southern California (USC) and Loma Linda University, recommends that the person providing the anesthesia and the procedure for general anesthesia under the age of 7 be separated. This needs to start immediately.

There was a discussion regarding dental insurance premiums and liability when performing general anesthesia.

Dr. Jimmy Tom, President Elect of the American Society of Dentist Anesthesiologists, Associate Clinical Professor of Dentistry at USC, ADA representative for the ASA task force on moderate sedation provided by non-anesthesiologists, applauded the Board for its efforts so far in improving safety with regards to anesthesia for pediatric patients. He requested a reconsideration of the establishment to have a multi-disciplinary committee or group to analyze, update and possibly change, if necessary, the anesthesia regulations in regards to the California dental anesthesia provisions. The recommendation is for the panel to be comprised of oral surgeons, dentist anesthesiologists, pediatric dentists, periodontists and all others who are involved and have some stake in the provision of dental anesthesiology to patients in California. He commented that it would be nice if this group could look at updating anesthesia provisions continually instead of once every five years like other associations.

Dr. Morrow, President, called a short recess.

Karen Fischer, Executive Officer of the Dental Board of California commented that this is only the first of many discussions regarding this topic. The subcommittee continues to take comments from all interested parties and stakeholders and will incorporate them into the Working Document for review and comment at a future meeting.

19. **Legislation:**

A. 2016 Tentative Legislative Calendar

Ms. Sarkisyan provided an overview of the information provided.

Ms. Burton reminded the Board that the end of the 2016 Legislative session is approaching and it is past the time where Board members can request major changes in legislation.

B. Discussion and Possible Action on the Following Legislation

- **AB 2235 (Thurmond) Board of Dentistry: Pediatric Anesthesia: Committee**

  Ms. Sarkisyan gave an overview of the proposed language of the bill and recommended that the Board maintain its support in concept position.

❖ **AB 2331 (Dababneh) Dentistry: Applicants to Practice**

Ms. Sarkisyan gave an overview of the proposed language of the bill and recommended that the Board take a support position on AB 2331.

Dr. Whitcher asked whether the American Board of Dental Examiners (ADEX) decided which examination format would be included in the language of the bill.

Erin Levi, Capitol Partners, representing ADEX commented that the bill was in third reading and that ADEX left the decision relating to which examination format with the Board to decide is acceptable in the State of California.

(M/S/C) (Burton/Woo) moved for a support position on AB 2331.

Support: Burton, Whitcher, Forsythe, Chappell-Ingram, King, Lai, Le, McKenzie, Morrow, Stewart, Woo. **Oppose:** 0 **Abstain:** 0

Ms. Burton directed staff to submit a letter regarding the Board's position on AB 2331 to the author's office.

❖ **AB 2485 (Santiago) Dental Corps Loan Repayment Program**

Ms. Sarkisyan gave an overview of the proposed language of the bill and recommended that the Board take a support position on AB 2485.

Brianna Pittman representing the California Dental Association (CDA) thanked the Board and staff for the work on the bill.

(M/S/C) (Burton/McKenzie) moved for a support position on AB 2485.

❖ **AB 2859 (Low) Professions and vocations: retired category: licenses**

(M/S/C) (Burton/King) moved for a support position on AB 2859.

Dr. Lai requested clarification regarding the purpose of AB 2859.

Ms. Burton directed staff to contact the author's office and thank him for taking our amendments.

Ms. Chappell-Ingram requested clarification regarding the manner in which to contact the author's office.

Dr. Morrow requested clarification regarding whether a person

selecting a retired status would be able to regain his/her licensure should the licensee choose to return to practice.

Gayle Mathe representing the CDA requested clarification between selecting inactive and returning to practice and selecting the retired status and returning to practice.

Dr. Morrow responded to CDA's comment by stating that life events occur that would prompt someone on retired status to return to practice, while inactive is for those who would like to maintain their license, but choose not to practice.

Ms. Chappell-Ingram requested clarification regarding whether the Board currently has a procedure established for those who would like to return to practice if a person selected the retired status.

Ms. McKenzie commented that the language of the bill proposes to provide those licensees who do not want to practice dentistry any longer an opportunity to apply for the retired status instead of electing to not renew their inactive or active license for five years in order for a licensee's license to be cancelled.

Support: Burton, Whitcher, Forsythe, Chappell-Ingram, King, Lai, Le, McKenzie, Morrow, Stewart, Woo. **Oppose:** 0 **Abstain:** 0

- **SB 482 (Lara) Controlled Substances: CURES database**
  Ms. Burton commented that the Board not take a position as the bill is too far in the legislative process.

- **SB 1155 (Morrell) Professions and Vocations: Licenses: Military Service**
  Ms. Sarkisyan gave an update on the status of the bill and advised the Board not take any action as it has been placed in suspense.

- **SB 1348 (Cannella) Licensure Applications: Military Experience**
  Ms. Sarkisyan gave an update on the status of the bill and advised the Board not to take any action as the bill is on the Governor's desk.

- **SB 1444 (Hertzberg) State Government: Computerized Personal Information Security Plans**
  Ms. Sarkisyan gave an update on the status of the bill and advised the Board not to take any action as the bill is on the Governor's desk.

- ❖ **SB 1478 (Senate Committee Business Professions and Economic Development) Healing Arts**
  Ms. Sarkisyan updated the Board as to the letter submitted as a result of the May 2016 Board meeting.

C. Update on Pending Regulatory Packages

- ➢ **Abandonment of Applications (Cal. Code of Regs., Title 16, Section 1004)**
- ➢ **Dental Assisting Comprehensive Regulatory Proposal; (Cal. Code of Regs., Title 16, Division 10, Chapter 3)**
- ➢ **Elective Facial Cosmetic Surgery Permit Application and Renewal Requirements (New Regulation)**
- ➢ **Licensure By Credential Application Requirements (New Regulation)**
- ➢ **Continuing Education Requirements and Basic Life Support Equivalency Standards (Cal. Code of Regs., Title 16, Sections 1016 and 1017)**
- ➢ **Mobile Dental Clinic and Portable Dental Unit Registration Requirements (Cal. Code of Regs., Title 16, Section 1049)**
- ➢ **Dental and Dental Assistant Fee Increase (Cal. Code Regs., Title 16, Sections 1021 and 1022)**
- ➢ **Definitions for Filing and Discovery (New Regulation)**

Ms. Sarkisyan gave an overview of the information provided.

D. Discussion and Possible Action Regarding Fiscal Year 2016/17 Regulatory Priorities.
Ms. Sarkisyan and Ms. Wallace gave an overview of the information provided including staff's recommendation.

M/S/C (Forsythe/Chappell-Ingram) to accept staff's recommendation to maintain the same regulatory priorities it established in FY 2015-2016 and added three regulatory rulemakings for the regulatory priorities for FY 2016-2017.

E. Discussion of Prospective Legislative Proposals.
Stakeholders are encouraged to submit proposals in writing to the Board before or during the meeting for possible consideration by the Board at a future meeting.

20. **Fee Increase:**

A. Discussion and Possible Action Regarding Comments Received During the 45-Day Public Comment Period and During the Regulatory Hearing for the Board's Proposed Rulemaking to Amend California Code of Regulations, Title 16, Sections 1021 and 1022 Relevant to a Fee Increase.

M/S/C (Stewart/Le) moved to accept staff's recommendation relating to California Code of Regulations (CCR) Section 1021(n).

M/S/C (Le/Burton) moved to accept staff's recommendation relating to CCR Section 1021.

M/S/C (King/Whitcher) to accept staff recommendation relating to CCR Section 1022.

M/S/C (Burton/Lai) moved to accept staff recommendation to modify CCR Subsection 1021(c).

M/S/C (Whitcher/Le) moved to accept staff recommendation to modify CCR Subsections 1021 (q) and (r).

B. Discussion and Possible Action Regarding Adoption of Proposed Amendments to California Code of Regulations, Title 16, Sections 1021 and 1022 Relevant to a Fee Increase.
M/S/C (Burton/Chappell-Ingram) moved to adopt the proposed amendments to CCR Sections 1021 and 1022 relevant to a Fee Increase.

21. **Public Comment on Items Not on the Agenda.**
Moreen Titus, California Dental Hygienist Association, provided a reminder to the Board regarding the letter submitted to the Board on April 21st regarding dental corporations specifically relating to having an agenda item to discuss dental corporations and practice of dentistry as relating to mobile dental units and the identity of the specific dentists operating such units.

Ms. Pittman, CDA, provided updates regarding upcoming CDA events: CDA Cares event on October 15th and 16th; and CDA Presents on September 8th through the 10th. Ms. Pittman also gave an overview of AB 2207 (Wood) regarding Denti-Cal and AB 2744 (Gordon) regarding groupons.

22. **Board Member Comments on Items Not on the Agenda.**
Dr. Lai asked whether Board staff would be able to provide an update on the registered dental assistant (RDA) practical examination manual. Dr. Morrow recalled the Executive Officer's report, and Ms. Fischer discussed that based on the recommendations from the May 2016 Board meeting the RDA practical examination study guide was provided to the RDA candidates and programs.

23. **Adjournment.**
Adjourned 12:30pm.

BOARD MEETING MINUTES
October 13, 2016
HQ2 – HEARING ROOM
1747 North Market Blvd.
Sacramento, CA 95834

Members Present
Steven Morrow, DDS, MS, President
Judith Forsythe, RDA, Vice President
Fran Burton, MSW, Public Member
Katie Dawson, RDH
Ross Lai, DDS
Huong Le, DDS, MA
Thomas Stewart, DDS
Bruce Whitcher, DDS
Debra Woo, DDS

Members Absent
Steven Afriat, Public Member, Secretary
Yvette Chappell-Ingram, Public Member
Kathleen King, Public Member
Meredith McKenzie, Public Member

Thursday, October 13, 2016

1. **Call to Order/Roll Call/Establishment of Quorum.**
Dr. Steven Morrow, President, called the meeting to order at 8:10am. In the absence of Mr. Steve Afriat, Secretary, Vice President Judith Forsythe called the roll and a quorum was established.

The Board immediately went into Closed Session.

CLOSED SESSION – FULL BOARD

9:00 A.M. - RETURN TO OPEN SESSION – FULL BOARD

2.. **Discussion Regarding the Subcommittee's Proposed Pediatric Anesthesia Study Recommendations.**
Dr. Whitcher continued the discussion regarding the Pediatric Anesthesia Study. His presentation provided an overview of the comments received from various professional organizations and stakeholders, subcommittee findings, and preliminary recommendations.

Dr. Thomas Stewart inquired about office inspections and the challenges involved for general anesthesia and conscious sedation evalutions. It was mentioned that recruitment for inspectors was an issue relating to scheduling conflicts and cancellations, as well as qualification of requirements for evaluators.

Dr. Huong Le inquired about how the proposed permit system change may affect patients between the age groups that are unaccounted for in regards to minimal sedation.

Fran Burton asked how the elderly will fit in with the levels of sedation and permitting.

Dr. Debra Woo inquired whether other states require a separate anesthesia provider to be present, which was stated that no other state requires a separate anesthesia provider.

Dr. Morrow discussed the viability of the one year residency program.

Alan Felsenfed, representing the California Dental Association (CDA), stated that CDA will submit official comments to the Board regarding their suggestions and recommendations. Felsenfed stated that CDA held its own sessions to discuss general anesthesia issues in order to obtain data from licensees.

Leonard Tyco, representing the California Oral Maxillofacial Surgery Association (COMSA), thanked the Board for their work and stated their commitment to patient safety and embraced portions of the preliminary recommendations made by the subcommittee.

Alan Kaye, incoming President of the COMSA, read statement of American Association of Oral Surgeons and provided written testimony supporting the recommendations.

Paul Reggiardo, representing the California Society of Pediatric Dentistry, commended the Board on quality of research and work on the documents and the transparency process. He will provide written comments after the Board meeting and is in general agreement with the October 3rd draft recommendations for restructuring the practice model and updating definitions and supports codification of support

Dr. Michael Mashney, representing the California Society of Dentist Anesthesiologists commented that there should be a separate anesthesia provider requirement and supports the finding of the Blue Ribbon Committee recommendation from 2006.

Dr. Guy Acheason discussed the need for periodic completion of advanced airway management course and discussed the differences between capnography and pericardial stethoscope.

Dr. Larry Trapp stated that the Board should stop providing permits to dentists who will perform both the dental procedure and administration of general anesthesia or conscious sedation to a patient.

Dr. Diana Belli, Dental Anesthesiologist, suggested that the Commission on Dental Accreditation should take on the educational issues relating to general anesthesia and conscious sedation training. She stated that training is an issue because of the time frame of training received and the type of training received.

Dr. Jeff Pope, representing the California Society of Anesthesiologists, stated he submitted a letter on August 17, 2016 and he still stands with the letter submitted that

an anesthesiologist should be present in the room when administering general anesthesia.
Paula Whiteman, Governing Board of the American Academy of Pediatrics of California (AAPC), thanked the Board for their work and stated the mission of the AAPC. She also stated that a letter was submitted to the Board and made a point of clarification regarding courses offered for airway training. She requested a moratorium be placed on the administration of general anesthesia and conscious sedation by the single dentist anesthesiologist model until the report is finalized.

3. **Public Comment on Items Not on the Agenda.**
   None.

4. **Board Member Comments on Items Not on the Agenda.**
   None.

5. **Adjournment.**
   Adjourned at 11:52 a.m.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

DATE	December 1, 2016
TO	Dental Board Members
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**Agenda Item 5:** Budget Report

The Board manages two separate funds: 1) Dentistry Fund, and 2) Dental Assisting Fund. The funds are not comingled.The following is intended to provide a summary of expenses for the first quarter of fiscal year (FY) 2016-17 for the Dentistry and Dental Assisting funds.

Dentistry Fund Overview

First Quarter Expenditure Summary for Fiscal Year 2016-17

The first quarter expenditures are based upon the budget report released by the Department of Consumer Affairs (DCA) in November 2016. This report reflects actual expenditures through September 30, 2016. The Board spent roughly $3.5 million or 26% of its total Dentistry Fund appropriation for FY 2016-17.Of that amount, approximately $1.4 million of the expenditures were for Personnel Services and $2.3 million were for Operating Expense & Equipment (OE&E) for this fiscal year.

For comparison purposes, last year at this time the Board spent roughly $3.1 million or 29% of its FY 2015-16 Dentistry Fund appropriation. Approximately 41% of the expenditures were Personnel Services and approximately 61% of the expenditures were OE&E.

Fund Title	Appropriation	Expenditures Through 6-30-16
Dentistry Fund	$13,349,000	$3,483,372

Attachment 1 displays year-to-date expenditures for the Dentistry Fund.

Analysis of Fund Condition

Attachment 1a displays an analysis of the State Dentistry Fund's condition including expenditures for the BreEze system. Without fee increases, the State Dentistry Fund is heading towards insolvency for FY 2018-19. Months in reserve are decreasing and will go negative in FY 2018-19.

Dental Assisting Fund Overview

Frist Quarter Expenditure Summary for Fiscal Year 2016-17

The first quarter expenditures are based upon the budget report released by the Department of Consumer Affairs (DCA) in November 2016. This report reflects actual expenditures through September 30, 2016. The Board spent roughly $622,000 or 23% of its total Dental Assisting Fund appropriation for FY 2016-17. Of that amount, approximately $161,000 of the expenditures was for Personnel Services and $462,000 were for OE&E for this fiscal year.

For comparison purposes, last year at this time the Board spent roughly $577,000 or 28% of its FY 2015-16 Dental Assisting Fund appropriation. Approximately 25% of the expenditures were Personnel Services and approximately 75% of the expenditures were OE&E.

Fund Title	Appropriation	Expenditures Through 6-30-16
Dental Assisting Fund	$2,663,000	$622,380

Attachment 2 displays year-to-date expenditures for the Dental Assisting Fund.

Analysis of Fund Condition

Attachment 2a displays the Dental Assisting Fund's condition including expenditures for the BreEze system. Without fee increases, the State Dentistry Fund is heading towards insolvency for FY 2018-19. Months in reserve are decreasing and will go negative in FY 2018-19.

DENTAL BOARD - FUND 0741
BUDGET REPORT
FY 2016-17 EXPENDITURE PROJECTION

FM 3

OBJECT DESCRIPTION	FY 2015-16 ACTUAL EXPENDITURES (MONTH 13)	FY 2015-16 PRIOR YEAR EXPENDITURES 9/30/2015	FY 2016-17 BUDGET ACT 2016	FY 2016-17 CURRENT YEAR EXPENDITURES 9/30/2016	FY 2016-17 PERCENT SPENT	FY 2016-17 PROJECTIONS TO YEAR END	FY 2016-17 UNENCUMBERED BALANCE
PERSONNEL SERVICES							
Salary & Wages (Staff)	3,281,479	834,920	**4,077,000**	802,196	20%	**3,903,951**	173,049
Statutory Exempt (EO)	108,581	27,084	**96,000**	27,894	29%	**111,576**	(15,576)
Temp Help (Expert Examiners)	0	0	**40,000**	0	0%	**0**	40,000
Physical Fitness Incentive	0	0	**0**	0	0%	**0**	0
Temp Help Reg (907)	142,959	12,666	**199,000**	10,833	5%	**123,000**	76,000
Temp Help (Exam Proctors)	0	0	**45,000**	0	0%	**0**	45,000
BL 12-03 Blanket	64,215	16,415	**0**	18,538		**75,000**	(75,000)
Board Member Per Diem (901, 920)	16,100	3,100	**46,314**	2,800	6%	**17,000**	29,314
Committee Members (911)	4,200	400	**58,686**	400	1%	**4,200**	54,486
Overtime	37,330	2,534	**25,000**	3,711	15%	**38,500**	(13,500)
Staff Benefits	1,804,708	450,358	**2,241,000**	499,741	22%	**2,432,030**	(191,030)
TOTALS, PERSONNEL SVC	5,459,572	1,347,477	**6,828,000**	**1,366,113**	**20%**	**6,705,257**	122,743
OPERATING EXPENSE AND EQUIPMENT							
General Expense	90,116	20,026	**59,000**	26,940	46%	**121,200**	(62,200)
Fingerprint Reports	15,894	2,320	**26,000**	3,147	12%	**22,000**	4,000
Minor Equipment	3,699	0	**6,000**	0	0%	**0**	6,000
Printing	80,185	16,882	**42,000**	29,909	71%	**90,000**	(48,000)
Communication	29,473	6,484	**33,000**	5,081	15%	**30,500**	2,500
Postage	62,527	16,308	**59,000**	8,314	14%	**50,000**	9,000
Insurance	8,056	0	**2,000**		0%	**8,100**	(6,100)
Travel In State	153,609	16,961	**109,000**	23,243	21%	**150,000**	(41,000)
Travel, Out-of-State	263	0	**0**	578		**578**	(578)
Training	6,594	250	**7,000**	3,490	50%	**6,500**	500
Facilities Operations	413,542	421,966	**361,000**	407,310	113%	**407,310**	(46,310)
C & P Services - Interdept.	7,886	7,445	**77,000**	0	0%	**0**	77,000
C & P Services - External	275,983	376,473	**363,000**	484,976	134%	**484,976**	(121,976)
DEPARTMENTAL SERVICES:							
OIS Pro Rata	1,081,773	269,500	**1,190,000**	297,501	25%	**1,190,000**	0
Admin/Exec	795,161	193,750	**813,000**	198,999	24%	**813,000**	0
Interagency Services	0	0	**1,000**	0	0%	**1,000**	0
IA w/ OPES	61,551	61,030	**0**	0	0%	**0**	0
DOI-ProRata Internal	21,629	5,500	**22,000**	5,499	25%	**22,000**	0
Public Affairs Office	51,000	5,750	**143,000**	35,751	25%	**143,000**	0
PPRD	0	6,750	**7,000**	1,749	25%	**7,000**	0
INTERAGENCY SERVICES:							
Consolidated Data Center	32,856	6,556	**18,000**	3,782	21%	**23,000**	(5,000)
DP Maintenance & Supply	21,802	985	**11,000**	0	0%	**22,000**	(11,000)
Central Admin Svc-ProRata	607,194	151,799	**647,000**	215,503	33%	**647,000**	0
EXAMS EXPENSES:							
Exam Supplies	0	0	**43,291**	0	0%	**0**	43,291
Exam Freight	0	0	**166**	0	0%	**0**	166
Exam Site Rental	0	0	**68,586**	0	0%	**0**	68,586
C/P Svcs-External Expert Administration	77,774	20,675	**6,709**	0	0%	**78,000**	(71,291)
C/P Svcs-External Expert Examiners	0	0	**238,248**	0	0%	**0**	238,248
C/P Svcs-External Subject Matter	46,171	1,054	**0**	10,765		**43,000**	(43,000)
Other Items of Expense	7,707	1,920	**1,000**	1,920	192%	**7,700**	(6,700)
Tort Pymts-Punitive	56,427	0	**0**	0		**56,427**	(56,427)
ENFORCEMENT:							
Attorney General	1,056,537	183,833	**1,778,000**	309,419	17%	**1,238,000**	540,000
Office Admin. Hearings	227,114	80,768	**407,000**	126,978	31%	**357,000**	50,000
Court Reporters	11,215	1,264	**0**	3,813		**15,000**	(15,000)
Evidence/Witness Fees	371,666	50,253	**244,000**	43,678	18%	**323,000**	(79,000)
DOI - Investigative	0	0	**0**	0	0%	**0**	0
Vehicle Operations	51,529	6,664	**5,000**	5,941	119%	**50,000**	(45,000)
Major Equipment	0	0	**0**	0	0%	**0**	0
TOTALS, OE&E	5,726,933	1,933,166	**6,788,000**	2,254,285	33%	**6,407,291**	380,709
TOTAL EXPENSE	11,186,505	3,280,643	**13,616,000**	3,620,398	53%	**13,112,548**	503,452
Sched. Interdepartmental							0
Sched. Reimb. - Fingerprints	(15,365)	(3,140)	**(53,000)**	(3,479)	7%	**(53,000)**	0
Sched. Reimb. - Other	(8,000)	(2,585)	**(214,000)**	(2,115)	1%	**(214,000)**	0
Unsched. Reimb. - External/Private	(25,313)	(12,301)					0
Unsch Reimb - Finger Print Fees							0
Probation Monitoring Fee - Variable	(115,886)	(23,782)		(22,529)			0
Invest Cost Recover FTB Collection							0
Unsched. - DOI ICR Civil Case Only							0
Unsched. - Investigative Cost Recovery	(362,177)	(74,428)		(108,903)			0
NET APPROPRIATION	10,659,764	3,164,407	**13,349,000**	3,483,372	26%	**12,845,548**	**503,452**
						SURPLUS/(DEFICIT):	**3.8%**

0741 - Dental Board of California
Analysis of Fund Condition

11/9/2016

(Dollars in Thousands)

2016 Budget Act

		ACTUAL 2015-16	Budget Act CY 2016-17	BY 2017-18
BEGINNING BALANCE		$ 5,634	$ 6,326	$ 3,658
Prior Year Adjustment		$ -69	$ -	$ -
Adjusted Beginning Balance		$ 5,565	$ 6,326	$ 3,658
REVENUES AND TRANSFERS				
Revenues:				
125600	Other regulatory fees	$ 62	$ 69	$ 71
125700	Other regulatory licenses and permits	$ 997	$ 966	$ 964
125800	Renewal fees	$ 10,247	$ 9,583	$ 9,854
125900	Delinquent fees	$ 71	$ 70	$ 69
142500	Miscellaneous services to the public	$ 34	$ -	$ -
150300	Income from surplus money investments	$ 27	$ 11	$ 3
161000	Escheat of unclaimed checks and warrants	$ 4	$ -	$ -
161400	Miscellaneous revenues	$ 2	$ -	$ -
Totals, Revenues		$ 11,444	$ 10,699	$ 10,961
Totals, Revenues and Transfers		$ 11,444	$ 10,699	$ 10,961
Totals, Resources		$ 17,009	$ 17,025	$ 14,619
EXPENDITURES				
Disbursements:				
8880	Financial Information System of California (State Operations)	$ 23	$ 17	$ 17
1110	Program Expenditures (State Operations)	$ 10,660	$ -	$ -
1111	Program Expenditures (State Operations)	$ -	$ 13,349	$ 13,616
Total Disbursements		$ 10,683	$ 13,367	$ 13,634
FUND BALANCE				
Reserve for economic uncertainties		$ 6,326	$ 3,658	$ 985
Months in Reserve		5.7	3.2	0.8

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ON-GOING.

B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1

C. ASSUMES INTEREST RATE AT 0.3%.

DENTAL ASSISTING PROGRAM - FUND 3142
BUDGET REPORT
FY 2016-17 EXPENDITURE PROJECTION

FM 3

OBJECT DESCRIPTION	FY 2015-16 ACTUAL EXPENDITURES (MONTH 13)	FY 2015-16 PRIOR YEAR EXPENDITURES 9/30/2015	FY 2016-17 BUDGET ACT 2016	FY 2016-17 CURRENT YEAR EXPENDITURES 9/30/2016	FY 2016-17 PERCENT SPENT	FY 2016-17 ACTUALS YEAR END	FY 2016-17 UNENCUMBERED BALANCE
PERSONNEL SERVICES							
Salary & Wages (Staff)	390,798	84,456	**497,000**	89,396	18%	**487,596**	9,404
Statutory Exempt (EO)	0	0	**0**	0	0%	**0**	0
Temp Help (Expert Examiners)	0	0	**0**	0	0%	**0**	0
Temp Help (Consultants)	0	0	**0**	0	0%	**0**	0
Temp Help Reg (907)	0	0	**0**	3,982		**3,982**	(3,982)
Temp Help (Exam Proctors)	0	0	**0**	0	0%	**0**	0
Board Member Per Diem (901, 920)	4,200	800	**0**	700		**4,200**	(4,200)
Overtime	3,466	0	**0**	647		**3,800**	(3,800)
Staff Benefits	257,393	57,936	**305,000**	66,213	22%	**361,148**	(56,148)
TOTALS, PERSONNEL SVC	655,857	143,192	**802,000**	**160,938**	**20%**	**860,726**	(58,726)
OPERATING EXPENSE AND EQUIPMENT							
General Expense	8,400	599	**36,000**	1,000	3%	**6,000**	30,000
Fingerprint Reports	54	0	**8,000**	0	0%	**0**	8,000
Minor Equipment	6,369	6,369	**0**	0		**0**	0
Printing	5,573	672	**20,000**	565	3%	**4,700**	15,300
Communication	30	8	**13,000**	0	0%	**30**	12,970
Postage	14,689	6,049	**37,000**	0	0%	**14,000**	23,000
Insurance	0	0	**0**	0	0%	**0**	0
Travel In State	43,566	7,210	**49,000**	7,448	15%	**45,000**	4,000
Training	0	0	**4,000**	0	0%	**0**	4,000
Facilities Operations	82,391	70,786	**64,000**	37,606	59%	**80,000**	(16,000)
Utilities	0	0	**1,000**	0	0%	**0**	1,000
C & P Services - Interdept.	0	0	**288,000**	0	0%	**0**	288,000
C & P Services - External	0	14,000	**28,000**	27,000	96%	**27,000**	1,000
DEPARTMENTAL SERVICES:							
OIS ProRata	579,091	144,750	**671,000**	167,751	25%	**671,000**	0
Admin/Exec	134,858	32,750	**134,000**	32,751	24%	**134,000**	0
Interagency Services	0	0	**73,000**	0	0%	**73,000**	0
IA w/ OPES	0	0	**0**	40,908		**40,908**	(40,908)
DOI-ProRata Internal	3,933	1,000	**4,000**	999	25%	**4,000**	0
Communications ProRata	9,000	1,000	**17,000**	4,251	25%	**17,000**	0
PPRD ProRata	0	1,250	**1,000**	249	25%	**1,000**	0
INTERAGENCY SERVICES:							
Consolidated Data Center	0	0	**3,000**	0	0%	**0**	3,000
DP Maintenance & Supply	909	0	**1,000**	0	0%	**900**	100
Statewide ProRata	91,663	22,916	**97,000**	32,373	33%	**97,000**	0
EXAMS EXPENSES:							
Exam Supplies	15,232	7,938	**3,708**	8,372	226%	**15,000**	(11,292)
Exam Site Rental - State Owned	37,685	37,685	**0**	26,076		**37,000**	(37,000)
Exam Site Rental - Non State Owned	37,550	20,010	**69,939**	0	0%	**37,000**	32,939
C/P Svcs-External Expert Administration	2,983	1,004	**30,877**	12	0%	**3,000**	27,877
C/P Svcs-External Expert Examiners	0	0	**47,476**	0	0%	**0**	47,476
C/P Svcs-External Expert Examiners	0	0	**0**	0	0%	**0**	0
C/P Svcs-External Subject Matter	209,934	40,204	**0**	25,073		**131,000**	(131,000)
Other Items of Expense		0	**0**	0	0%	**0**	0
ENFORCEMENT:							
Attorney General	120,885	17,418	**173,000**	49,138	28%	**147,000**	26,000
Office Admin. Hearings	0	0	**3,000**	0	0%	**0**	3,000
Court Reporters	0	0	**0**	83		**83**	(83)
Evidence/Witness Fees	5,019	0	**0**	0		**5,000**	(5,000)
Vehicle Operations	0	0	**0**	0	0%	**0**	0
Major Equipment	568	0	**0**	0	0%	**0**	0
Special Items of Expense	0	0	**0**	0	0%	**0**	0
TOTALS, OE&E	1,410,382	433,618	**1,877,000**	461,655	25%	**1,590,621**	286,379
TOTAL EXPENSE	2,066,239	576,810	**2,679,000**	622,593	45%	**2,451,347**	227,653
Sched. Reimb. - Fingerprints	(948)	(196)	**(13,000)**	(213)	2%	**(1,000)**	(12,000)
Sched. Reimb. - Other	(705)	0	**(3,000)**	0	0%	**(700)**	(2,300)
NET APPROPRIATION	2,064,586	576,614	**2,663,000**	622,380	23%	**2,449,647**	**213,353**
						SURPLUS/(DEFICIT):	**8.0%**

3142 - Dental Assisting Program
Analysis of Fund Condition

10/28/2016

(Dollars in Thousands)

2016 Budget Act

		Actual 2015-16	Budget Act CY 2016-17	BY 2017-18
BEGINNING BALANCE		$ 2,840	$ 2,634	$ 1,606
Prior Year Adjustment		$ -9	$ -	$ -
Adjusted Beginning Balance		$ 2,831	$ 2,634	$ 1,606
REVENUES AND TRANSFERS				
Revenues:				
125600	Other regulatory fees	$ 13	$ 18	$ 16
125700	Other regulatory licenses and permits	$ 456	$ 278	$ 368
125800	Renewal fees	$ 1,297	$ 1,270	$ 1,268
125900	Delinquent fees	$ 76	$ 69	$ 65
141200	Sales of documents	$ 1	$ -	$ -
142500	Miscellaneous services to the public	$ 3	$ -	$ -
150300	Income from surplus money investments	$ 12	$ 3	$ 2
161000	Escheat of unclaimed checks and warrants	$ 1	$ -	$ -
161400	Miscellaneous revenues	$ 12	$ -	$ -
Totals, Revenues		$ 1,871	$ 1,638	$ 1,719
Totals, Revenues and Transfers		$ 1,871	$ 1,638	$ 1,719
Totals, Resources		$ 4,702	$ 4,272	$ 3,325
EXPENDITURES				
Disbursements:				
8880	Financial Information System for CA (State Operations)	$ 3	$ 3	$ -
1110	Program Expenditures (State Operations)	$ 2,065	$ -	$ -
1111	Program Expenditures (State Operations)	$ -	$ 2,663	$ 2,716
Total Disbursements		$ 2,068	$ 2,666	$ 2,716
FUND BALANCE				
Reserve for economic uncertainties		$ 2,634	$ 1,606	$ 609
Months in Reserve		11.9	7.1	2.6

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ONGOING.

B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1.

C. ASSUMES INTEREST RATE AT 0.3%.

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MEMORANDUM

DATE	November 15, 2016
TO	Dental Board Members
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**AGENDA ITEM 6:** Discussion and Possible Action to Review and Adopt the Dental Board of California's 2017-2020 Strategic Plan

The Dental Board of California (Board) Strategic Plan (Plan) was last updated in 2012, prior to entering into the 2015 Sunset Review Hearings with the Legislature. At that time, the Board adopted a plan with goals and objectives that would be achievable during a four year period of time. The result was the Strategic Plan 2013-2016.

Revisions to the Board's Plan began in July 2016 when Board staff asked the SOLID Training Unit of the Department of Consumer Affairs to facilitate the process. An environmental scan was conducted via focus group discussions with Board staff, Board managers, the Assistant Executive Officer, and the Acting Enforcement Chief; telephone interviews with Board Members and Dental Assisting Council Members, and an online survey which was distributed to Board stakeholders and consumers

A public workshop was held October 13-14, 2016 in Sacramento to review and discuss the results of the environmental scan. Again facilitated by the SOLID team, and using a compilation of the comments received from the environmental scan, Board members, staff managers, and one stakeholder (Ms. Mary McCune, California Dental Association) drafted goals and objectives for a new Plan.

Before you today, for discussion and consideration, is a DRAFT Plan prepared by the SOLID Team. If adopted, the Plan will establish the Board's goals and objectives for the next four years. The 2017-2020 Plan summarizes the Board's accomplishments since the last strategic plan was adopted in 2012, and identifies goals with corresponding objectives to be considered. If the Plan is adopted by the Board, SOLID staff will re-convene with Board staff to develop tasks and measures to ensure the goals and objectives for the future will be met.

Strategic Plan
2017-2020

Adopted:

Table of Contents

TABLE OF CONTENTS 1
MEMBERS OF THE DENTAL BOARD OF CALIFORNIA 2
MESSAGE FROM THE PRESIDENT 3
ABOUT THE BOARD 4
RECENT ACCOMPLISHMENTS 5
STRATEGIC GOALS 6
DENTAL BOARD OF CALIFORNIA MISSION, VISION, AND VALUES 7
GOAL 1: LICENSING AND EXAMINATIONS 8
GOAL 2: CONSUMER PROTECTION AND ENFORCEMENT 9
GOAL 3: EDUCATION 10
GOAL 4: LEGISLATION AND REGULATION 11
GOAL 5: COMMUNICATION AND CUSTOMER SERVICE 12
GOAL 6: ORGANIZATIONAL EFFECTIVENESS 13
GOAL 7: DENTAL WORKFORCE 14
STRATEGIC PLANNING PROCESS 15

MEMBERS OF THE DENTAL BOARD OF CALIFORNIA

Steven Morrow, DDS, President

Judith Forsythe, RDA, Vice President

Steven Afriat, Secretary

Fran Burton, MSW

Steven D. Chan, DDS

Yvette Chappell-Ingram

Katie Dawson, BS RDHAP

Kathleen King

Ross Lai, DDS

Huong Le, DDS, MA

Meredith McKenzie, ESQ.

Thomas Stewart, DDS

Bruce L. Whitcher, DDS

Debra Woo, DDS

Edmund G. Brown, Jr., Governor

Alexis Podesta, Acting Secretary, Business Consumer Services and Housing Agency

Awet Kidane, Director, Department of Consumer Affairs

Karen Fischer, MPA, Executive Officer, Dental Board of California

MESSAGE FROM THE PRESIDENT

It is with a strong sense of pride that I present the Dental Board's Strategic Plan (Plan) for 2017 – 2020. This Plan is a result of the combined efforts of members of the Dental Board, and Board staff. The process was very professionally facilitated by members of the Department of Consumer Affairs SOLID Unit.

This Strategic Plan is best viewed as a "road map" to guide the Board as it moves forward to better achieve its mission, vision, and values. It is also an important tool to ensure that the Board, its staff, and other interested and committed stakeholders are working together to accomplish common goals and outcomes, as identified in the Plan. This Strategic Plan also identifies the actions needed to achieve the Board's goals and provides for strategic performance feedback needed for decision making that will enable the plan to evolve and grow as requirements and other circumstances change.

The members of the Dental Board, individually and collectively, are dedicated to the legislative mandate that protection of the public shall be its highest priority. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public will always be paramount.

Steven G. Morrow, DDS, MS
Dental Board of California President
2016

ABOUT THE BOARD

The Dental Board of California licenses and regulates dentists, registered dental assistants, and registered dental assistants in extended functions. The Board assures the initial and continued competence of its licensees through licensure, investigation of complaints against its licensees, and discipline of those found in violation of the Dental Practice Act (Business and Professions Code Sections 1600 et seq.), monitoring licensees whose licenses have been placed on probation, and managing the Diversion Program for licensees whose practice may be impaired due to abuse of dangerous drugs or alcohol.

The Board's objective is to protect and promote the health and safety of consumers in the State of California. To accomplish this objective, the Board must ensure that only those persons possessing the necessary education, examination and experience qualifications receive licenses; all licentiates obtain the required continuing dental education training; consumers are informed of their rights and how complaints may be directed to the Board; consumer complaints against licentiates are promptly, thoroughly and fairly investigated; and appropriate action is taken against licentiates whose care or behavior is outside of acceptable standards.

The composition of the Board is defined in Business & Professions Code Section 1603 to be fifteen (15) members and includes eight dentists, one licensed Registered Dental Hygienist and one licensed Registered Dental Assistant, all appointed by the Governor; and five public members, three appointed by the Governor, one by the Speaker of the Assembly and one by the Senate President ProTempore. The Board appoints the Executive Officer who oversees a staff of 70. In 2012, the Dental Assisting Council was established as a result of the Board’s 2011 Sunset Review (Senate Bill 540, Chapter 385, Statutes of 2011) The Council is comprised of seven members: the Registered Dental Assistant member of the Board, another member of the Board, and five Registered Dental Assistants.

RECENT ACCOMPLISHMENTS

- Appointed a New Executive Officer
- Hired a New Assistant Executive Officer
- Hired a New Enforcement Chief
- The Governor appointed six new Board members and reappointed three members
- Appointed members to the Dental Assisting Council
- Completed the "Development and Validation of a Portfolio Examination for Initial Dental Licensure" report with the assistance of an outside contractor.
- Promulgated a regulation to implement the requirements of its Portfolio examination as a new pathway to dental licensure in California.
- Promulgated a rule-making to require an Administrative Law Judge (ALJ) to order revocation of a license when issuing a proposed decision that contains any findings of fact that: (1) a license engaged in any act of sexual contact with a patient, client, or customer; or, (2) the licensee has been convicted of or committed a sex offense. This proposal would prohibit the proposed decision issued by the ALJ under such circumstances from containing an order staying the revocation of the license or placing the licensee on probation.
- Revised the Orthodontic Assistant Permit Examination
- Conducted an Occupational Analysis of the Registered Dental Assistant profession
- Conducted an Occupational Analysis of the Registered Dental Assistant in Extended Functions profession
- The Enforcement Program's ongoing efforts to address unlicensed activity resulted in five search warrants, four felony arrests for unlicensed dentistry, and 17 criminal filings.
- Provided educational presentations of the Board's licensing and enforcement roles to graduating dental students at six California dental schools.
- Updated and published the Dental Practice Act in 2012-2016.
- Successfully completed the Board's Sunset Review Report and participated in the Legislative Oversight Process to extend the Board's operating authority until January 1, 2020.
- Successfully transitioned to a new computer system BreEZe
- Conducted a fee audit
- Sponsored legislation to establish the fees for initial dental licensure and biennial renewal of dental licensure at $525 beginning January 1, 2015.
- Updated and adopted the Board Policy and Procedure Manual

STRATEGIC GOALS

1 *LICENSING AND EXAMINATIONS*

2 *CONSUMER PROTECTION AND ENFORCEMENT*

3 *EDUCATION*

4 *LEGISLATION AND REGULATION*

5 *COMMUNICATION AND CUSTOMER SERVICE*

6 *ORGANIZATIONAL EFFECTIVENESS*

7 *DENTAL WORKFORCE*

Dental Board of California Mission, Vision, and Values

Mission

The Dental Board of California's mission is to protect and promote the oral health and safety of California consumers by ensuring the quality of dental health care within the State.

Vision

The Dental Board of California will be a recognized leader in public protection, promotion of oral health, and access to quality care.

Values

Consumer Protection
Professionalism
Accountability
Efficiency
Fairness
Diversity

GOAL 1: LICENSING AND EXAMINATIONS

Provide a licensing process that permits applicants timely access to the workforce without compromising consumer protection. Administer fair, valid, timely, comprehensive, and relevant licensing examinations.

1.1 Develop and maintain communication with Western Regional Examining Board, and other regional testing agencies to sustain the integrity of the examination process.

1.2 Improve the Board's online license and permit renewal system to enhance convenience and effectiveness resulting in timely processing.

1.3 Promote the national movement to a curriculum integrated exam concept and gain further recognition of California's portfolio licensure pathway in other states.

1.4 Support dental schools' utilization of the portfolio licensure pathway.

1.5 Continue to review and improve the Registered Dental Association licensure pathway including communication with stakeholders and possible modification to the existing practical exam.

GOAL 2: CONSUMER PROTECTION AND ENFORCEMENT

Ensure the Board's enforcement and diversion programs provide timely and equitable consumer protection.

1.6 Research the feasibility of an anesthesia data collection plan in order to provide high quality and quantity data for future anesthesia regulations.

1.7 Research the feasibility of implementing in-house stipulations to expedite resolution, reduce costs and safeguard consumer protection.

1.8 Enhance training for subject matter experts in order to provide a more effective representation during the investigative and disciplinary process.

1.9 Contract with a vendor to audit and provide recommendations to improve the enforcement program's workload efficiency and effectiveness.

1.10 Explore the possibility of increasing per diem compensation for expert witnesses so that the Board can recruit the most qualified professionals.

1.11 Explore the feasibility of establishing a probationary unit to improve the effectiveness of probation monitoring and relieve investigator case workload.

GOAL 3: EDUCATION

Set standards to ensure high quality educational services and programs, particularly in relation to international dental schools, registered dental assisting programs and continuing education for licensees.

1.12 Continuously update dental school educational standards consistent with Commission on Dental Accreditation standards to ensure consistency in the approval of foreign dental schools whose education is equivalent to that of the United States.

1.13 Evaluate and improve the continuing education audit process to determine effectiveness.

1.14 Recruit subject matter experts for the dental assisting program, including course curriculum review and site visits, to ensure compliance with the Board's educational regulations.

1.15 Explore the feasibility of augmenting the continuing education program by regulating that providers administer a competency requisite to raise the standard of continuing education.

GOAL 4: LEGISLATION AND REGULATION

Advocate legislation and promulgate regulations that advance the vision and mission of the Dental Board of California.

1.16 Communicate with licensees and staff regarding updates to statutes and regulations to improve and maintain stakeholder awareness in a timely manner.

1.17 Identify and prioritize emerging issues that may be suitable for legislative proposals to stay current with professional standards while maintaining public protection.

1.18 Review and revise, if necessary, laws and regulations to ensure they align with current standard of care and emerging practices.

1.19 Train analytical staff regarding regulatory process and then assign regulations in need of revision to each to reduce regulatory backlog.

GOAL 5: COMMUNICATION AND CUSTOMER SERVICE

Provide the most current information and quality customer service to the Board's stakeholders.

1.20 Improve, update and redesign the Dental Board website to increase user friendliness, minimize frustration, educate stakeholders and result in the creation of a cost effective communication system.

1.21 Continually evaluate and monitor improvements to Versa Online BreEZe in order to maximize ease of use for applicants, licensees and consumers and consequently improve processing times and consumer protection.

1.22 Identify communication weaknesses and implement necessary changes to increase customer satisfaction, eliminate repeat callers, and re-establish trust with staff.

1.23 Research and evaluate various communication methods (print, website, and social media) and make determination on which method effectively communicates with licensees and consumers best.

1.24 Develop consumer centered forms in different languages that comply with the American Disability Act in order to be more inclusive.

1.25 Develop video tutorials to educate applicants, licensees and consumers regarding the application, licensing, BreEZe, complaint, and enforcement processes.

GOAL 6: ORGANIZATIONAL EFFECTIVENESS

Build an excellent organization, with engaged employees, through effective leadership and responsible management.

1.26 Establish, execute and continually evaluate the workforce engagement plan to improve morale and maintain partnership between management and staff.

1.27 Assess and streamline the process for prioritization of workload to improve efficiency.

1.28 Establish staff training in dental terminology and internal processes so staff have a basic understanding of dental terms and processes.

GOAL 7: DENTAL WORKFORCE

Maintain awareness of the changes and challenges within the Dental community and serve as a resource to the Dental workforce.

1.29 Advertise the availability of the loan repayment program to increase access to care in underserved areas.

1.30 Strengthen the relationship with California Dental Director to facilitate a needs assessment and improve access to care for vulnerable populations.

1.31 Develop and implement program to translate the data obtained from the workforce survey required at renewal to determine licensing trends and identify gaps with regards to access to care.

1.32 Support the virtual dental home model to increase access to oral health care for the most vulnerable populations.

1.33 Develop outreach to underserved communities regarding free clinics and communicate about free health care events to support access to care for underserved communities.

Strategic Planning Process

To understand the environment in which the Board operates and identify factors that could impact the Board's success, the California Department of Consumer Affairs' SOLID unit conducted an environmental scan of the internal and external environments by collecting information through the following methods:

- Interviews conducted with 14 Board and Council members completed during the months of July and August 2016.
- Three focus groups with DBC staff, on August 9, 10, and 17, 2016 to identify the strengths and weaknesses of DBC from an internal perspective. There were 51 participants.
- One focus group with BCE managers on August 11, 2016 to identify the strengths and weaknesses of DBC from an internal perspective. Five managers participated.
- Online surveys (qualitative and quantitative) sent to DBC stakeholders in August 2016 to identify the strengths and weaknesses of DBC from an external perspective. 381 completed the surveys. The below table shows how stakeholders identified themselves in the online survey.

The most significant themes and trends identified from the environmental scan were discussed by the Board and management team during a strategic planning session facilitated by SOLID on October 13 and 14, 2016. This information guided the Board in the development of its mission, vision, and values, while directing the strategic goals and objectives outlined in this 2017 – 2020 strategic plan.

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Prepared by:

Department of Consumer Affairs
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Sacramento, CA 95834

This strategic plan is based on stakeholder information and discussions facilitated by SOLID for the Dental Board of California in September and October 2016. Subsequent amendments may have been made after Board approval of this plan.

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MEMORANDUM

DATE	November 15, 2016
TO	Dental Board of California
FROM	Tina Vallery, Licensing Analyst
SUBJECT	**Agenda Items 7(A):** Staff Update on Portfolio Pathway to Licensure

In September 2016, the Board received a request to participate in a site visit with Loma Linda University and Western University of Health Sciences to discuss the implementation of the Portfolio pathway to licensure at their schools. Board staff set up a meeting with the two schools on October 19, 2016. Karen Fischer, Dr. Stephen Casagrande, Bernal Vaba, and Tina Vallery participated in the site visits. Both schools gave us an opportunity to tour their facilities so that we could see where their students are performing their examinations. We then met with faculty members, at both locations, so that we could discuss any implementation questions that they had. During our visit with Loma Linda University, we were given the opportunity to meet with some of the students that are currently participating in the Portfolio examination so that they too could get answers to any questions or concerns that they had.

Plans are in the works for board staff to visit all of the schools over the next year, to keep the lines of communication open and to begin the necessary audits of the examination.

Currently, staff has received and processed thirty-five portfolio applications for the 2015/2016 school year. Twelve (12) applications were submitted by the University of California, San Francisco, nineteen (19) applications were submitted by the University of the Pacific, three (3) applications were submitted by the University of Southern California, and the remaining one (1) application was submitted by the University of California, Los Angeles. To date, thirty-four (34) portfolio applicants have been issued their license. The application that does not have a license issued is due to the applicant not submitting the licensing application and fee.

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MEMORANDUM

DATE	November 15, 2016
TO	Dental Board of California
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**Agenda Item 8(A):** Report from the Licensing, Certification and Permits Committee Regarding Closed Session

Dr. Morrow, Chair of the Licensing, Certification and Permits Committee, will provide recommendations to the Board based on the outcome of the Closed Session meeting.

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MEMORANDUM

DATE	November 15, 2016
TO	Members of the Dental Board of California
FROM	Jorrelle Abutin, Staff Services Analyst
SUBJECT	**Agenda Item 8(B):** Review of Dental Licensure and Permit Statistics

A. Following are statistics of current license/permits by type as of November 15, 2016:

Dental License (DDS) Status	Licensee Population
Active	34,277
Inactive	1,970
Retired	1,284
Disabled	27
Renewal in Process	319
Delinquent	4,879
Total Cancelled Since Licensing was required	14,627

Active: Current and can practice without restrictions *(BPC §1625)*
Inactive: Current but cannot practice, continuing education not required (*CCR §1017.2)*
Retired: Current, has practiced over 20 years, eligible for Social Security and can practice with restrictions *(BPC §1716.1a)*
Disabled: Current with disability but cannot practice *(BPC §1716.1b)*
Renewal in Process: Renewal fee paid with deficiency *(CCR §1017)*
Delinquent: Renewal fee not paid within one month after expiration date *(BPC §163.5)*
Cancelled: Renewal fee not paid 5 years after its expiration and may not be renewed *(BPC §1718.3a)*

Dental Licenses Issued via Pathway	Total Issued in 2016	Total Issued in 2015	Total Issued in 2014	Total Issued to Date	Date Pathway Implemented
WREB Exam	712	747	753	7,516	January 1, 2006
Licensure by Residency	189	162	170	1,491	January 1, 2007
Licensure by Credential	142	116	144	3,004	July 1, 2002
LBC Clinic Contract	9	5	1	33	July 1, 2002
LBC Faculty Contract	6	2	0	14	July 1, 2002
Portfolio	34	7	N/A	40	November 5, 2014
Total	**1,088**	**1,039**	**1,068**		

License/Permit /Certification/Registration Type	Current Active Permits	Delinquent	Total Cancelled Since Permit was Required
Additional Office Permit	2,508	524	6,060
Conscious Sedation Permit	515	38	418
Continuing Education Registered Provider Permit	1,130	645	1,774
Elective Facial Cosmetic Surgery Permit	27	2	N/A
Extramural Facility Registration*	159	N/A	N/A
Fictitious Name Permit	6,554	1,068	5,283
General Anesthesia Permit	863	40	867
Mobile Dental Clinic Permit	36	36	36
Medical General Anesthesia Permit	81	37	158
Oral Conscious Sedation Certification (Adult Only 1,637; Adult & Minors 1,875)	2,427	586	514
Oral & Maxillofacial Surgery Permit	86	8	16
Referral Service Registration*	153	N/A	N/A
Special Permits	42	9	167

*Current population for Extramural Facilities and Referral Services are approximated because they are not automated programs.

Active Licensees by County as of October 31, 2016

County	DDS	Population	Population per DDS
Alameda	1,455	1,638,215	1,126
Alpine	0	1,110	N/A
Amador	23	37,001	1,609
Butte	152	225,411	1,483
Calaveras	20	44,828	2,241
Colusa	4	21,482	5,371
Contra Costa	1,084	1,126,745	1,039
Del Norte	15	27,254	1,817
El Dorado	153	184,452	1,206
Fresno	567	974,861	1,719
Glenn	9	28,017	3,113
Humboldt	80	135,727	1,697
Imperial	37	180,191	4,870
Inyo	10	18,260	1,826
Kern	341	882,176	2,587
Kings	64	150,965	2,359
Lake	52	64,591	1,242
Lassen	22	31,345	1,425
Los Angeles	8,381	10,170,292	1,213
Madera	49	154,998	3,163
Marin	323	261,221	808
Mariposa	3	17,531	5,844
Mendocino	59	87,649	1,486
Merced	93	268,455	2,887
Modoc	5	8,965	1,793
Mono	3	13,909	4,636
Monterey	268	433,898	1,619
Napa	107	142,456	1,331
Nevada	81	98,877	1,221
Orange	3,784	3,169,776	838

County	DDS	Population	Population per DDS
Placer	448	375,391	838
Plumas	18	18,409	1,023
Riverside	1,056	2,361,026	2,236
Sacramento	1,081	1,501,335	1,389
San Benito	21	58,792	2,800
San Bernardino	1,323	2,128,133	1,609
San Diego	2,644	3,299,521	1,248
San Francisco	1,265	864,816	684
San Joaquin	360	726,106	2,017
San Luis Obispo	226	281,401	1,245
San Mateo	876	765,135	873
Santa Barbara	328	444,769	1,356
Santa Clara	2,230	1,918,044	860
Santa Cruz	189	274,146	1,451
Shasta	119	179,533	1,509
Sierra	2	2,967	1,484
Siskiyou	21	43,554	2,074
Solano	288	436,092	1,514
Sonoma	420	502,146	1,196
Stanislaus	275	538,388	1,958
Sutter	54	96,463	1,786
Tehama	27	63,308	2,345
Trinity	4	13,069	3,267
Tulare	207	459,863	2,222
Tuolumne	47	53,709	1,143
Ventura	684	850,536	1,243
Yolo	118	213,016	1,805
Yuba	9	74,492	8,277
Out of State/Country	2,637		
TOTAL	34,221	39,144,818	

The counties with the highest Population per DDS are:

1. Yuba County (1:8,277)
2. Mariposa County (1:5,844)
3. Colusa County (1:5,371)
4. Imperial County (1:4,870)
5. Mono County (1:4,636)

The counties with the lowest Population per DDS are:

1. San Francisco County (1:684)
2. Marin County (1:808)
3. Orange/Placer County (1:838)
4. Santa Clara County (1:860)

The county with the biggest increase in active license dentists since July 27, 2016 is Los Angeles with 94 additional dentists.

B. Following are monthly dental statistics by pathway as of October 31, 2016

Dental Applications Received by Month (2016)													Total Apps: 1256
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Yearly Totals**
WREB	20	54	60	63	107	286	129	82	46	44			**891**
Residency	3	13	18	6	11	30	60	36	6	6			**189**
Credential	3	17	17	10	20	19	16	14	12	14			**142**
Portfolio	0	0	0	3	0	27	4	0	0	0			**34**
Total	**26**	**84**	**95**	**82**	**138**	**362**	**209**	**132**	**64**	**0**			**1256**

Dental Applications Approved by Month (2016)													% of All Apps: 80.7
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Yearly Totals**
WREB	0	4	15	41	52	103	217	143	71	38			**684**
Residency	20	4	11	6	1	0	48	41	26	10			**167**
Credential	28	12	1	9	6	1	20	17	17	18			**129**
Portfolio	0	0	0	0	0	0	30	2	1	1			**34**
Total	**48**	**20**	**27**	**56**	**59**	**104**	**315**	**203**	**115**	**67**			**1014**

Dental Licenses Issued by Month (2016)													% of All Apps: 80.7
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Yearly Totals**
WREB	33	28	36	38	55	49	204	146	75	48			**712**
Residency	3	3	8	9	5	0	41	38	27	11			**145**
Credential	9	12	9	12	8	1	13	14	17	27			**122**
Portfolio	0	0	0	0	0	0	29	2	2	1			**34**
Total	**45**	**43**	**53**	**59**	**68**	**50**	**287**	**200**	**121**	**87**			**1013**

Cancelled Dental Applications by Month (2016)													% of All Apps: 6.8
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Yearly Totals**
WREB	4	3	2	6	7	15	12	10	3	6			**68**
Residency	1	0	0	0	0	4	4	1	0	0			**10**
Credential	0	3	1	0	0	0	1	0	1	1			**7**
Portfolio	0	0	0	0	0	0	0	0	0	0			**0**
Total	**5**	**6**	**3**	**6**	**7**	**19**	**17**	**11**	**4**	**7**			**85**

Withdrawn Dental Applications by Month (2016)													
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Yearly Totals**
WREB	0	1	0	4	7	12	7	5	4	8			**48**
Residency	0	1	2	1	0	2	3	0	2	5			**16**
Credential	1	3	1	0	0	0	1	0	1	4			**11**
Portfolio	0	0	0	0	0	0	0	0	0	0			**0**
Total	**1**	**5**	**3**	**5**	**7**	**14**	**11**	**5**	**7**	**17**			**75**

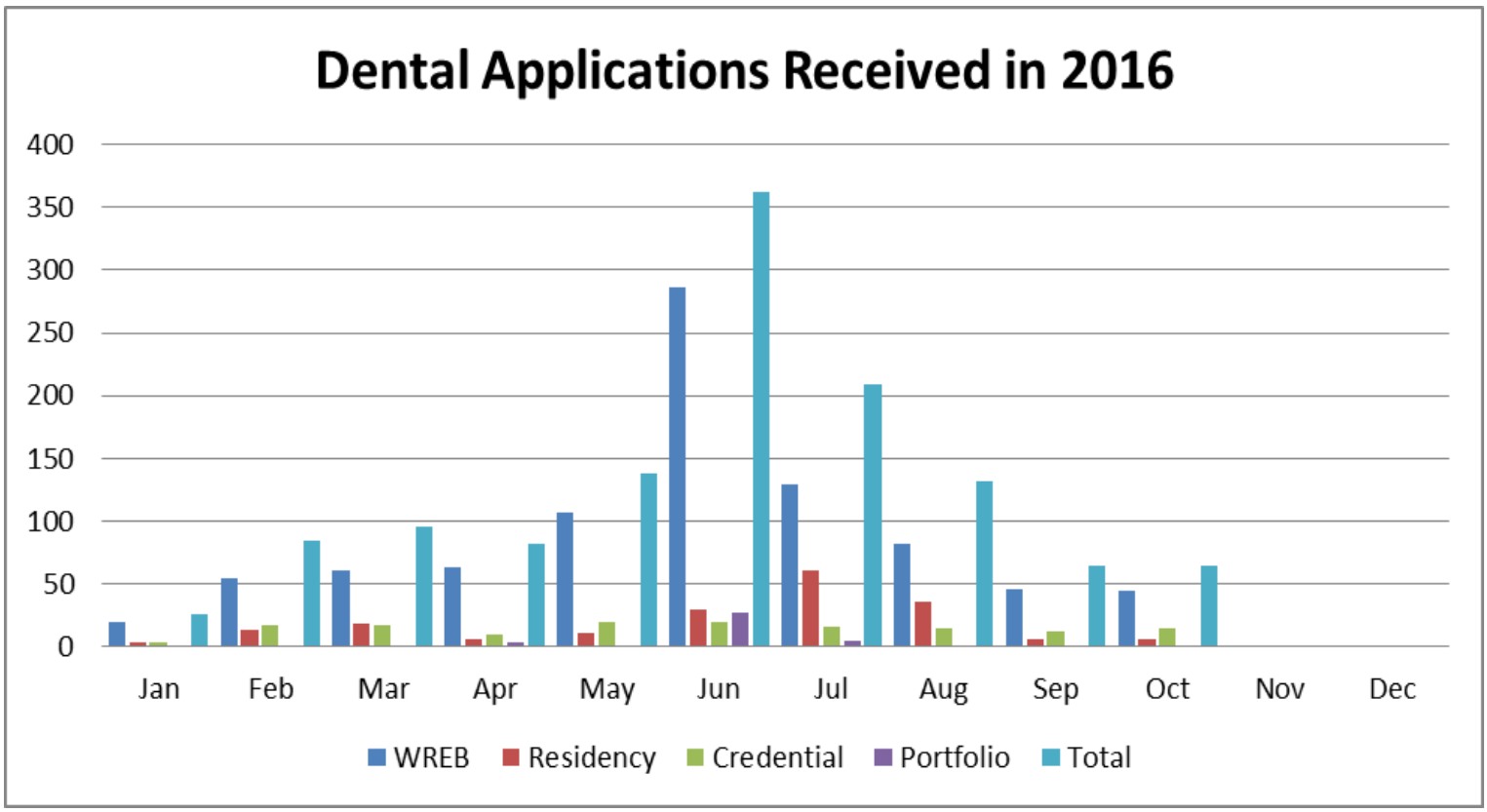
Denied Dental Applications by Month (2016)													% of All Apps: 1.4
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Yearly Totals**
WREB	0	0	0	0	0	0	1	0	0	0			**1**
Residency	1	1	4	0	1	0	0	1	0	2			**10**
Credential	0	1	0	2	1	0	0	1	1	1			**7**
Portfolio	0	0	0	0	0	0	0	0	0	0			**0**
Total	**1**	**2**	**4**	**2**	**2**	**0**	**1**	**2**	**1**	**3**			**18**

*Deficient Applications by pathway: WREB – 125, Residency – 24, Credential – 38, Portfolio – 0, **Total – 187**

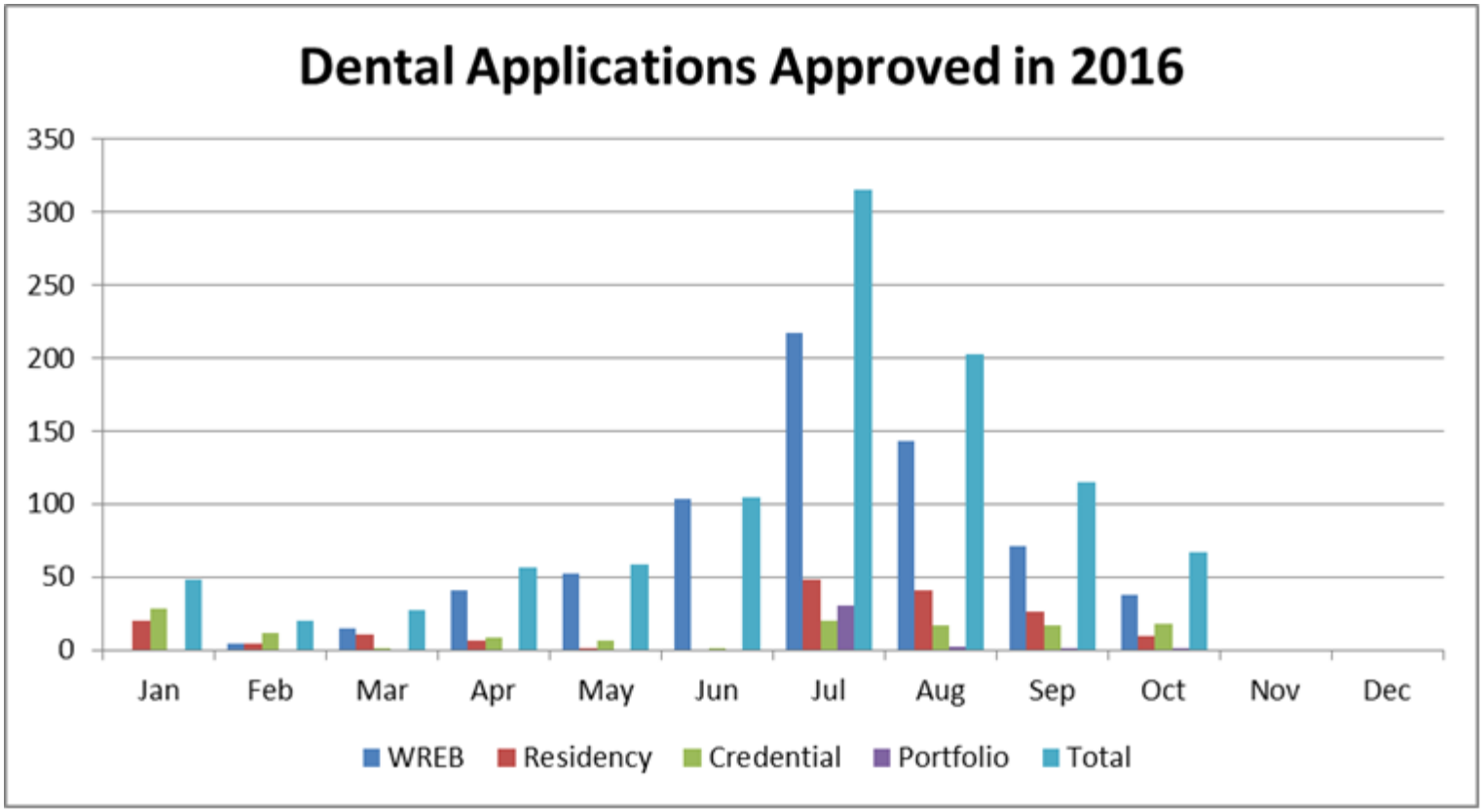
Application Definitions

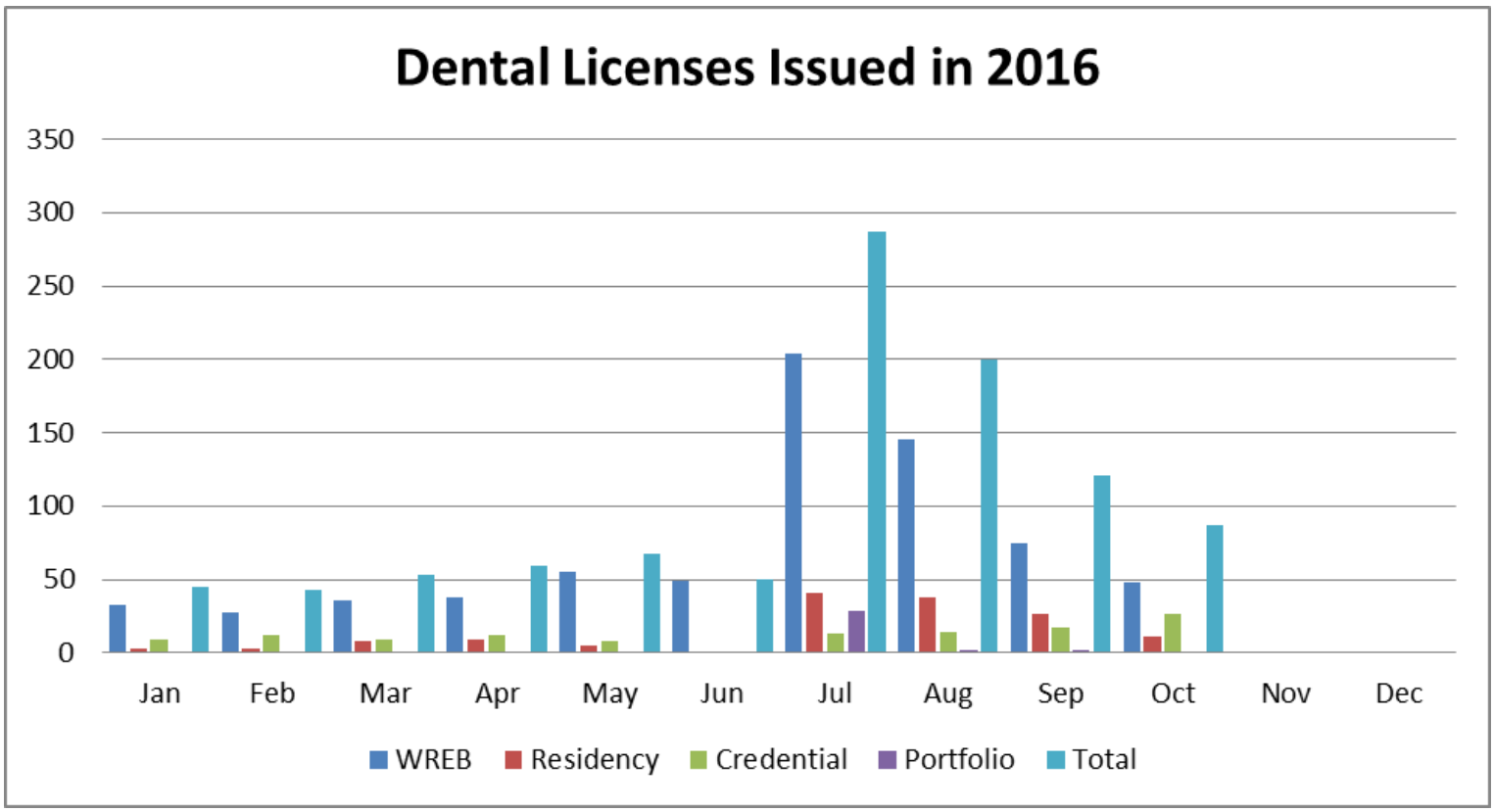
Received	Application submitted in physical form or digitally through Breeze system.
Approved	Application for eligibility of licensure processed with all required documentation.
Cancelled	Board requests staff to remove application (i.e. duplicate).
Withdrawn	Applicant requests Board to remove application.
Denied	Applicant fails to provide requirements for licensure.
Deficient	Application processed lacking one or more requirements.

C. Following are graphs of monthly Dental statistics as of October 31, 2016

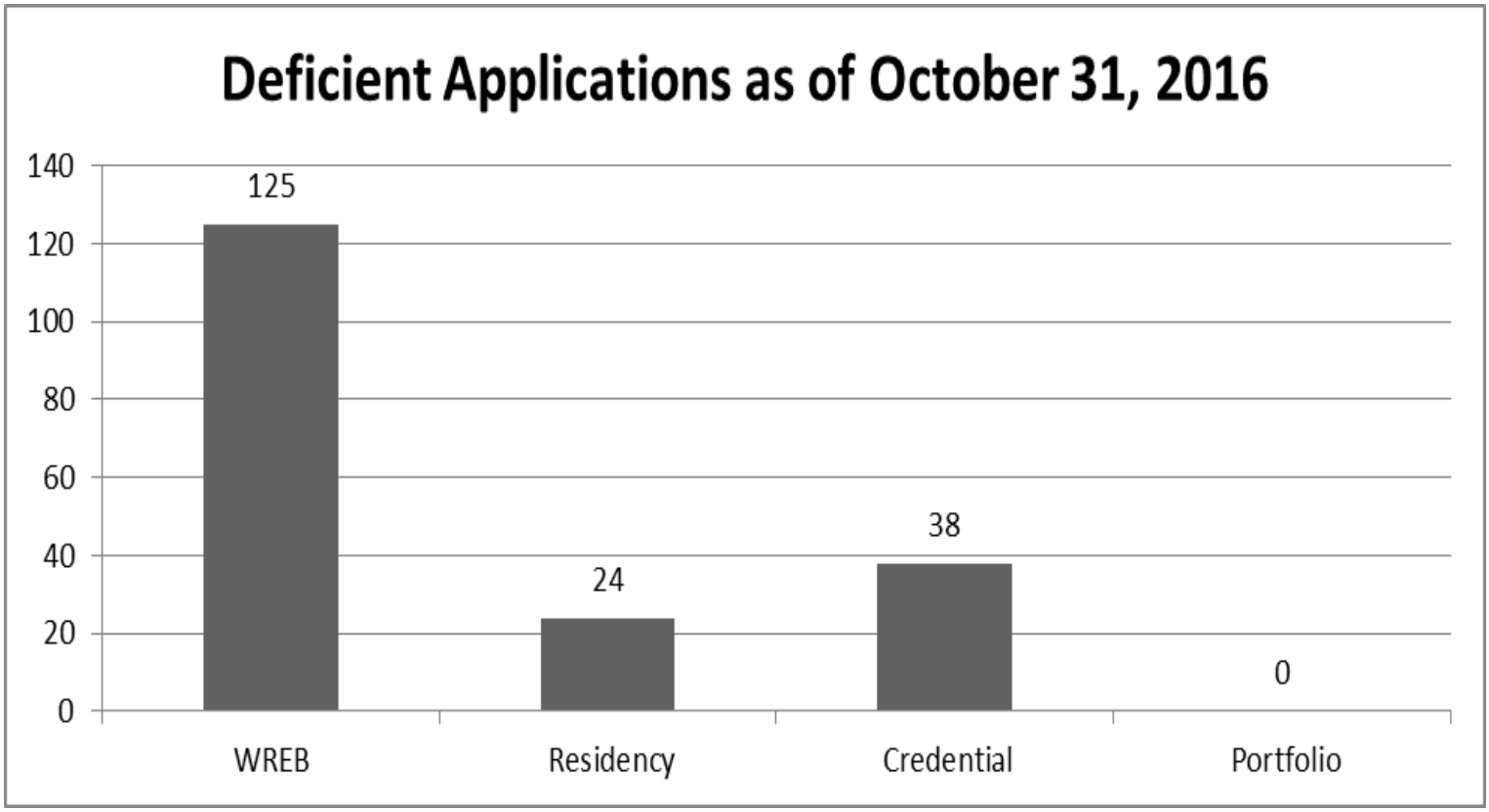


*WREB applications received peaks in June (286 applications) due to new graduates from Dental Schools across the country.

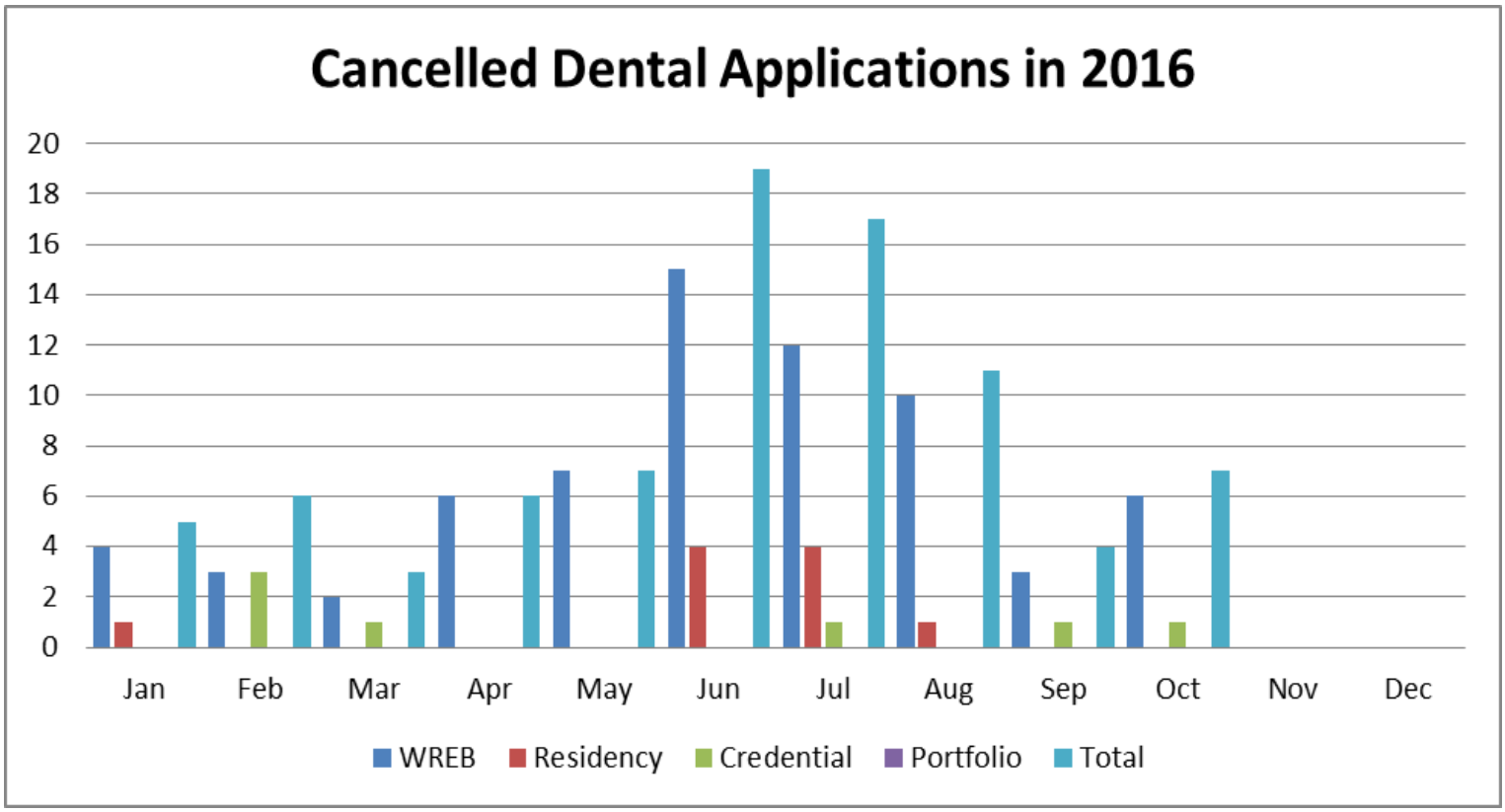




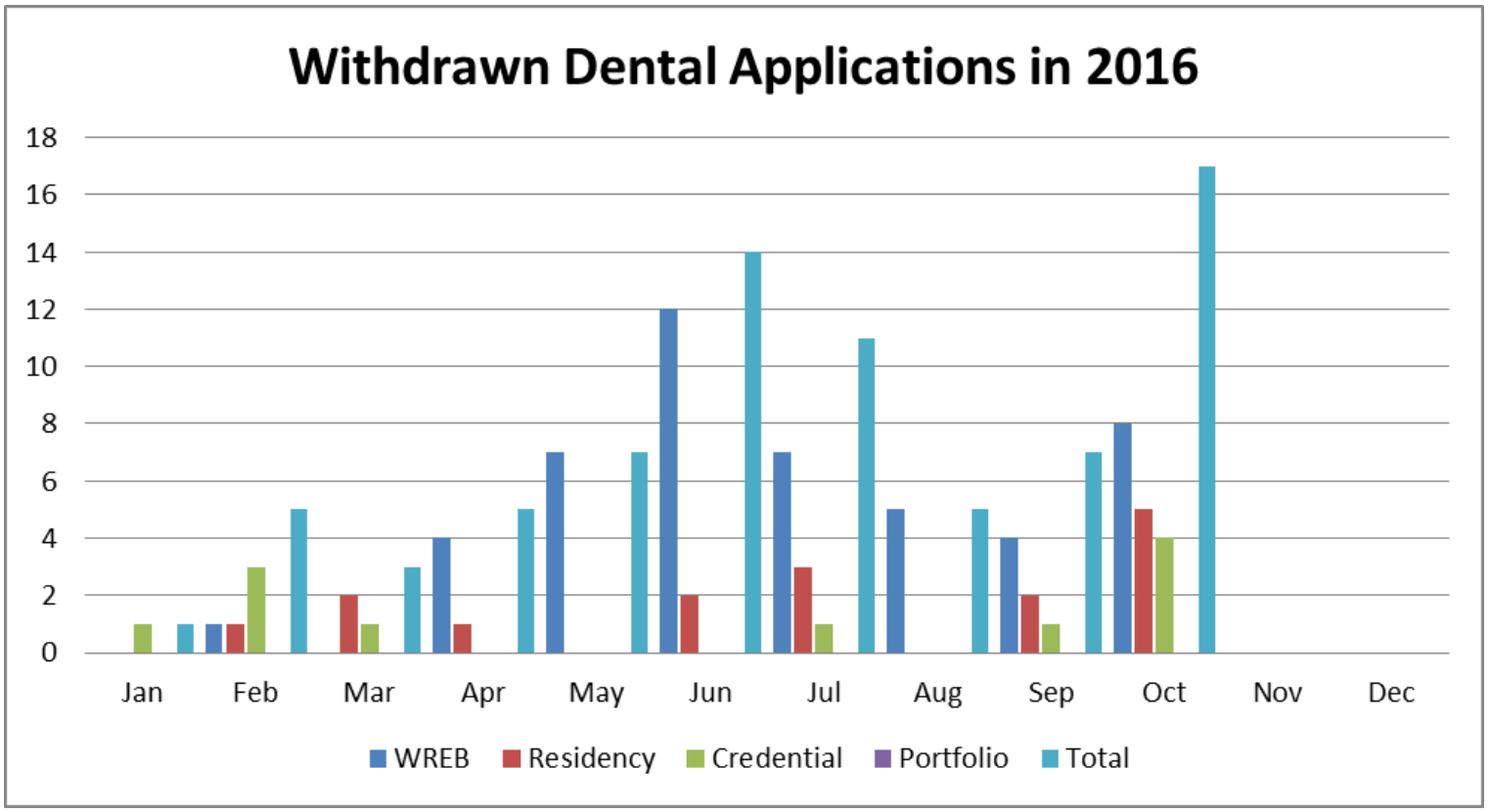
*Licenses issued peak in July (total of 287) and depreciate to the end of the year.



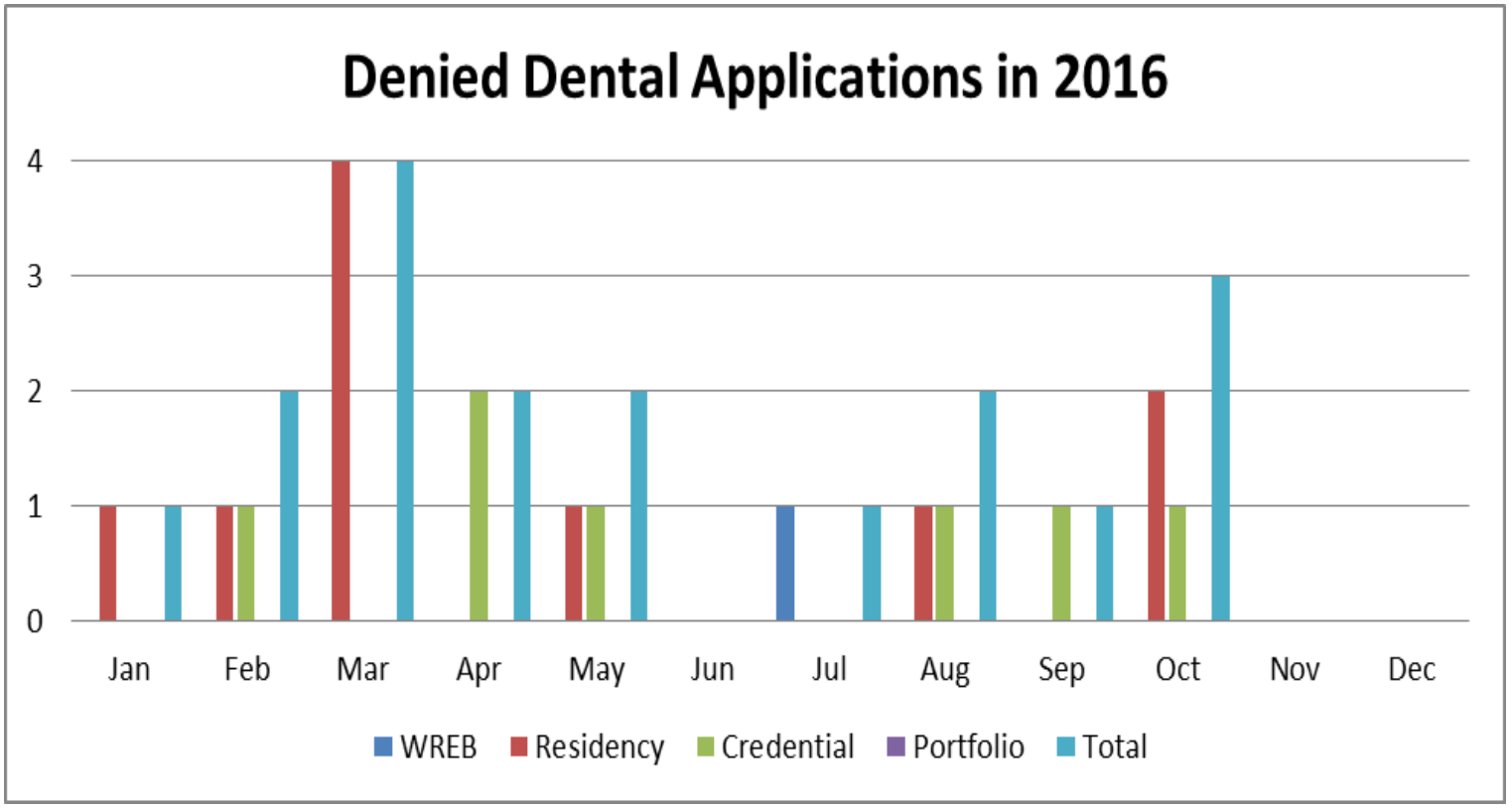
*Deficient: Pending with one or more requirements missing in application



*Cancelled dental applications peak in June (total of 19) and depreciate until October.



*Withdrawn dental applications peak in June (total of 14) and depreciate until October.



*Portfolio applications have no denials in 2016.

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MEMORANDUM

DATE	November 15, 2016
TO	Members of the Dental Board of California
FROM	Nellie Forgét, Program Coordinator Elective Facial Cosmetic Surgery Permit Program
SUBJECT	**Agenda Item 8C:** Report on the October 19, 2016 Meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee; Discussion and Possible Action to Accept Committee Recommendations for Issuance of Permit

Background :

On September 30, 2006, Governor Arnold Schwarzenegger signed Senate Bill 438 (Midgen, Chapter 909, Statutes of 2006), enacting Business and Professions Code (Code) Section 1638.1, which took effect on January 1, 2007. Code Section 1638.1 authorizes the Dental Board of California (Board) to issue Elective Facial Cosmetic Surgery (EFCS) permits to qualified licensed dentists and establishes the EFCS Credentialing Committee (Committee) to review the qualifications of each applicant for a permit.

Pursuant to Code Section 1638.1(a)(2), an EFCS permit that is issued by the Board is valid for a period of two (2) years and is required to be renewed by the permit-holder at the time his or her dental license is renewed. Additionally, every six (6) years, prior to the renewal of the permit-holder's license and permit, the permit-holder is required to submit evidence acceptable to the Committee that he or she has maintained continued competence to perform the procedures authorized by the permit. The Committee is authorized to limit a permit consistent with Code Section 1638.1(e)(1) if it is not satisfied that the permit-holder has established continued competence.

Code Section 1638.1 does not expressly provide the requirements a permit-holder must meet to establish continuing competency, therefore it has become necessary to promulgate a regulation to implement, interpret, and make specific the provisions of Code Section 1638.1 for the purpose of clarifying the necessary requirements that would establish continuing competency for the EFCS permit.

October 19, 2016 Update:

The Committee met on October 19, 2016 via teleconference to consider proposed regulatory language and application revisions and to review two (2) applications for issuance of a permit.

Regulatory Language and Application Revisions:
At the meeting, staff presented the regulatory language and revised EFCS permit application. The Committee approved this language to recommend the Board initiate the rulemaking process at an upcoming meeting.

Recommendation for Issuance of EFCS Permit:
The Committee considered an application from David Webb, DDS. The Committee has made the following recommendation regarding issuance of an EFCS permit to Dr. Webb:

> Applicant: David Webb, DDS, applied for an EFCS permit with unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but not limited to, rhinoplasty and otoplasty) and Category II (cosmetic soft tissue contouring or rejuvenation, which may include, but not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation).

Based on consideration of the application at its October 19, 2016 meeting, the Committee recommends the Board issue a permit to Dr. David Webb for unlimited Category I and Category II privileges.

Additionally, the Committee considered an application from Dr. O.N. The Committee has made the following recommendation regarding issuance of an EFCS permit to Dr. O.N.:

> Applicant: Dr. O.N., applied for an EFCS permit with unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but not limited to, rhinoplasty and otoplasty) and Category II (cosmetic soft tissue contouring or rejuvenation, which may include, but not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation).

Based on consideration of the application at its October 19, 2016 meeting, the Committee recommends the Board deny a permit to Dr. O.N. for unlimited Category I and Category II privileges due to insufficient submittal of operative reports, letter from the program director, and hospital privileges.

Action Requested:
Staff requests the Board take the following actions:
1. Accept the EFCS Credentialing Committee Report,
2. Accept the Committee's recommendation to issue David Webb, DDS, an EFCS Permit a permit for unlimited Category I and Category II privileges, and also to deny issuing an EFCS permit to Dr. O.N.

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MEMORANDUM

DATE	November 16, 2016
TO	Members of the Dental Board of California
FROM	Lusine M Sarkisyan, Legislative & Regulatory Analyst
SUBJECT	**Agenda Item 8(D): EFCS Legislative Report**

The Dental Board of California (Board) is required to submit a report on the Elective Facial Cosmetic Surgery (EFCS) Permit Program pursuant to Business and Professions Code (Code) Section 1638.1.

Attached is the draft report for Board consideration and approval.

Action Requested:
Staff requests that the Board approve the attached EFCS Legislative Report in order to submit to the Legislature pursuant to Section 1638.1 of the Code.

DENTAL BOARD OF CALIFORNIA

REPORT ON THE ELECTIVE FACIAL COSMETIC SURGERY PERMIT PROGRAM AS PROVIDED BY BUSINESS AND PROFESSIONS CODE SECTION 1638.1

SUBMITTED TO:

THE SENATE BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT COMMITTEE

JANUARY 1, 2017

DENTAL BOARD OF CALIFORNIA

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Debra Woo, DDS

ELECTIVE FACIAL COSMETIC SURGERY PERMIT CREDENTIALING COMMITTEE

Robert Gramins, DDS, Chair

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Anil Punjabi, MD, DDS

Peter Scheer, DDS

Brian Wong, M.D.

Bruce L. Whitcher, DDS, Board Liaison to the Committee

EXECUTIVE OFFICER

Karen M. Fischer

Report Prepared by:
The Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815
Telephone: (916) 263-2300
FAX: (916) 263-2140

Introduction

The Dental Board of California (Board) is submitting this report on the Elective Facial Cosmetic Surgery (EFCS) Permit Program pursuant to Business and Professions Code (Code) Section 1638.1 (Senate Bill 438, Chapter 909, Statutes of 2006). The last report was submitted in January 2013, and statute requires additional reports to be submitted every four years thereafter.

On September 30, 2006, Governor Arnold Schwarzenegger signed Senate Bill 438, enacting Code Section 1638.1, which took effect on January 1, 2007. This statute authorizes Oral and Maxillofacial Surgeons licensed by the Board, who are not also licensed as physicians and surgeons by the Medical Board of California, to perform elective facial cosmetic surgery. Additionally, this statute specifies the application requirements for an EFCS permit and establishes a Credentialing Committee (Committee) to review the qualifications of each applicant for a permit.

Code Section 1638.1(e) provides for the establishment of a Committee to be appointed by the Board and specifies that the Committee be comprised of five members consisting of one (1) physician and surgeon with a specialty in plastic and reconstructive surgery, one (1) physician and surgeon with a specialty in otolaryngology, and three (3) oral and maxillofacial surgeons licensed by the Board who are board certified by the American Board of Oral and Maxillofacial Surgeon, all of whom must maintain active status on the staff of a licensed general acute care hospital in California. At its February 9, 2007 meeting, the Board appointed five members to the Committee. The Committee is responsible for reviewing applications for EFCS permits in closed session during Committee meetings and providing recommendations to the Board as to whether an applicant is qualified to be issued a permit.

Code Section 1638.1 specifies the application requirements to obtain an EFCS permit from the Board to perform procedures from the following categories:

- Category I: Cosmetic contouring of the osteocartilaginous facial structure which may include, but is not limited to, rhinoplasty and otoplasty.

- Category II: Cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

The Board may grant unlimited or limited permits upon recommendation of the Committee. An unlimited permit allows the licensee to perform Category I and Category II procedures as defined in B&P code section 1638.1(c)(2)(A)(iii)(I) and (II). A limited permit would limit the procedures that may be performed by the permit holder.

The Committee may recommend permit limitations if it is not satisfied that the applicant has the training or competence necessary to perform certain procedures, or if the applicant has not requested to be permitted for all procedures authorized in the statute. Permits may also be issued for Category I only, unlimited or limited; Category II only, unlimited or limited; or a combination of any of the above.

Report

Code Section 1638.1(k) requires the Board to provide a report to the Joint Committee on Boards, Commissions, and Consumer Protection on January 1, 2009 and every four years thereafter. The report is required to contain information on all of the following:

1. The number of persons licensed pursuant to Section 1634 who apply to receive a permit to perform elective facial cosmetic surgery from the board pursuant to subdivision (a).
2. The recommendations of the credentialing committee to the board.
3. The board's action on recommendations received by the credentialing committee.
4. The number of persons receiving a permit from the board to perform elective facial cosmetic surgery.
5. The number of complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery.
6. Action taken by the board resulting from complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery.

The Board respectfully submits the following information as required by Code Section 1638.1(k):

1. The number of persons licensed pursuant to Section 1634 who apply to receive a permit to perform elective facial cosmetic surgery from the Board pursuant to subdivision (a).

The following table describes the status of applications submitted to the Board from 2013-2017. The applications that are carried over from previous years are most commonly due to application deficiencies.

In 2013 there were five (5) new applications received; four (4) were referred to the Committee for evaluation and four (4) were granted permits. One (1) has not gone before the Committee for review due to deficiencies.

In 2014 there were three (3) new applications received. Two (2) were referred to the Committee for evaluation; one (1) was granted a permit and one (1) was deemed deficient by the committee. One (1) did not go before the Committee for review due to deficiencies.

In 2015 there were three (3) new applications received. One (1) was referred to the Committee for evaluation and was granted a permit. Two (2) did not go before the Committee for review due to deficiencies.

In 2016 there were three (3) new applications received. Two (2) were referred to the Committee for evaluation; two (2) were granted permits and one (1) application was denied due to insufficient hospital privileges, insufficient operative reports, and an unclear letter from the program director specifying the procedures the applicant intended to perform with this permit.

Table 1: Persons Applying for an EFCS Permit

Application Status	2013	2014	2015	2016
New applications received	5	3	3	3
Referred to Committee for Evaluation	4	2	1	2
Permits Granted	4	1	1	2
Have not gone before the Committee for Review	1	1	2	2
Found Ineligible	0	0	0	0
Denied	0	0	0	1
Committee Rejected application	0	0	0	0

2. The recommendations of the Committee to the Board.

In 2013 five (5) applicants applied for permits. Three (3) applicants applied for Category I and II, unlimited permits and two (2) were recommended by the Committee for approval. One (1) application was recommended for approval of a Category I, limited permit and one (1) application was recommended for approval of a Category II, limited permit. One (1) application did not go before the Committee for review due to deficiencies.

In 2014 three (3) applicants applied for permits. Two (2) applicants applied for a Category I and II, unlimited permit. One (1) was recommended to the Board for approval and one (1) was found deficient. One (1) applicant applied for Category I, unlimited and was recommended to the Board for Category I, limited. One (1) applicant applied for Category II, unlimited and was recommended to the Board for Category II, limited. One (1) application did not go before the Committee for review due to deficiencies.

In 2015 three (3) applicants applied for permits. One (1) applicant applied for a Category I and II, unlimited permit and was recommended to the Board for approval. One (1) applicant applied for a Category II, limited permit and was found deficient. One (1) application did not go before the Committee for review due to deficiencies.

In 2016 three (3) applicants applied for permits. Three (3) applicants applied for a Category I and II, unlimited permit and two (2) were recommended to the Board for approval and one (1) applicant was found deficient.

Table 2: Committee Recommendations to the Board

Permit Type	2013	2014	2015	2016
Applied for Category I and Category II, Unlimited	2	1	1	2
Recommended Approval for Category I and Category II, Unlimited	2	1	1	2
Category 1, Unlimited and Category 2, limited	0	0	0	0
Category I, Unlimited	0	0	0	0
Category 1, Limited and Category 2, Unlimited	0	0	0	0
Category II, Unlimited	0	0	0	0
Category I, Limited	1	0	0	1
Category II, Limited	1	0	0	0
Denied	0	0	0	1
Rejected	0	0	0	0
Not yet reviewed	1	1	2	2

3. The Board's actions on recommendations received by the Credentialing Committee.

In 2013 the Board approved four (4) applications; two (2) for Category I and Category II, unlimited permits, one (1) for Category I, limited permit one (1) for Category II, limited permit. In 2014 the Board approved one (1) application for a Category I and Category II, unlimited permit. In 2015 the Board approved one (1) application for a Category I and Category II, unlimited permit. In 2016 the Board approved two (2) applications for Category I and Category II, unlimited permits. The Board denied one (1) application, due to insufficient hospital privileges, insufficient operative reports, and an unclear letter from the program director specifying the procedures the applicant intended to perform with this permit.

Table 3: The Boards Actions

Permit Type	2013	2014	2015	2016
Approved for Category I and Category II, Unlimited	2	1	1	2
Category 1, Unlimited and Category 2, limited	0	0	0	0
Category I, Unlimited	0	0	0	0
Category 1, Limited and Category 2, Unlimited	0	0	0	0
Category II, Unlimited	0	0	0	0
Category I, Limited	1	0	0	1
Category II, Limited	1	0	0	0
Denied	0	0	0	1
Rejected	0	0	0	0

4. The number of persons receiving a permit from the Board to perform elective facial cosmetic surgery.

In 2013 a total of four (4) permits were issued; two (2) for Category I and Category II, unlimited, one (1) for Category I, limited and one (1) for Category II, limited. In 2014 a total of one (1) permit was issued for Category I and Category II, unlimited. In 2015 a total of one (1) permit was issued for Category I and Category II, unlimited. In 2016 a total of two (2) permits were issued for Category I and Category II, unlimited. In total there were eight (8) permits issued; six (6) for Category I and Category II, unlimited, one (1) for Category I, limited, and one (1) for Category II, limited.

Table 4: Permits Issues by the Board

Permit Type	2013	2014	2015	2016	Total
Category I and Category II, Unlimited	2	1	1	2	6
Category 1, Unlimited and Category 2, limited	0	0	0	0	0
Category I, Unlimited	0	0	0	0	0
Category 1, Limited and Category 2, Unlimited	0	0	0	0	0
Category II, Unlimited	0	0	0	0	0
Category I, Limited	1	0	0	1	1
Category II, Limited	1	0	0	0	1
Total Permits Issued	**4**	**1**	**1**	**2**	**8**

5. The number of complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the Board to perform elective facial cosmetic surgery.

There have been no complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery as there have been no complaints filed to date.

6. Action taken by the board resulting from complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the Board to perform elective facial cosmetic surgery.

No action has been taken by the Board resulting from complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery as there have been no complaints filed to date.

Conclusion

The Committee recently approved regulatory language and the EFCS Permit application at its October 19, 2016 EFCS Permit Credentialing Committee meeting and recommended the Board initiate the rulemaking process at a future meeting. The hope is that these changes will make the application process clearer for applicants therefore making the review process easier for the Committee.

The next EFCS Permit Credentialing Committee meeting is scheduled for January 25, 2017. Applications are being received, reviewed and acted upon in a timely fashion. The Credentialing Committee is reviewing the applications with a discerning eye for not all applicants are granted all of the procedures/categories requested.

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MEMORANDUM

DATE	November 1, 2016
TO	Dental Board Members
FROM	Lusine M Sarkisyan, Legislative and Regulatory Analyst
SUBJECT	**AGENDA ITEM 8E:** Discussion and Possible Action to Initiate a Rulemaking to Adopt California Code of Regulation, Title 16, Sections 1044.6, 1044.7, 1044.8 Relating to Elective Cosmetic Surgery Initial Permit Application and Renewal Requirements

Background

On September 30, 2006, Governor Arnold Schwarzenegger signed Senate Bill 438 (Midgen, Chapter 909, Statutes of 2006), enacting Business and Professions Code (Code) Section 1638.1, which took effect on January 1, 2007. This statute authorizes the Board to issue Elective Facial Cosmetic Surgery (EFCS) permits to qualified licensed dentists and establishes the EFCS Credentialing Committee (Committee) to review the qualifications of each applicant for a permit.

During the April 2009 EFCS Permit meeting, draft regulatory language was proposed and since then, the Committee has been working on finalizing the proposed language by reviewing and providing necessary additions and modifications.

The following issues were considered when drafting the proposed language:

- Qualification of the permit specifically relating to the applicant's training or competence;
- Confusion associated with understanding the application requirements;
- Confusion associated with submitting the number of operative reports; and
- Age of operative reports submitted for consideration;

During the October 2016 EFCS Permit meeting, the Committee further discussed the proposed language as it related to the age of operative reports and after further deliberation considered the proposed language. The Committee decided to recommend that the Board adopt their recommendation to initiate the rulemaking.

As a result, Board staff has worked with Board Legal Counsel and the Committee to present the proposed regulatory language adopting CCR Sections 1044.6, 1044.7, and 1044.8. Attached is the proposed regulatory language for the Board's consideration relative to Elective Cosmetic Surgery Initial Permit and Renewal Requirements as it relates to Sections 1044.6, 1044.7, and 1044.8.

Action Requested:

Consider and possibly accept the recommendation of the Committee and approve the proposed regulatory language relative to the Elective Cosmetic Surgery Initial Permit Application and Renewal Requirements , and direct staff to take all steps necessary to initiate the formal rulemaking process, including noticing the proposed language for 45-day public comment, setting the proposed language for a public hearing, and authorize the Executive Officer to make any non-substantive changes to the rulemaking package. If after the close of the 45-day public comment period and public regulatory hearing, no adverse comments are received, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed language to California Code of Regulations, Title 16, Sections 1044.6, 1044.7, and 1044.8 as noticed in the proposed text.

TITLE 16. DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

PROPOSED LANGUAGE

RELATING TO THE ELECTIVE FACIAL COSMETIC SURGERY INITIAL PERMIT AND RENEWAL REQUIREMENTS

Add California Code of Regulations, Title 16, Sections 1044.6, 1044.7, and 1044.8 as follows:

DRAFT

Article 5.6

§1044.6 Operative Reports

For the purposes of this article, an applicant for an Elective Facial Cosmetic Surgery permit shall submit with the application a maximum of 30 operative reports that are representative of procedures the applicant intends to perform. The date of each operative report shall be no more than 6 years from the date the application is submitted to the Board.

§1044.7 Application for Permit to perform elective facial cosmetic surgery pursuant to Business and Professions Code Section §1638.1.

An applicant for a permit to perform Elective Facial Cosmetic Surgery pursuant to Section 1638.1 of the Code shall submit to the Board a completed "Elective Facial Cosmetic Surgery Permit Application " (New 06/15), which is incorporated herein by reference, and shall be accompanied by the fee specified in Section 1021.

Note: Authority cited: Sections 1614, 1638.1Business and Professions Code. Reference: Sections 1638.1, Business and Professions Code.

§1044.8 Renewal of Permit to perform elective facial cosmetic surgery pursuant to Section 1638.1.

For the purpose of maintaining continued competence to perform the procedures authorized by an Elective Facial Cosmetic Surgery permit, in addition to the continuing education required to renew a license to practice dentistry, every 6 years, prior to the renewal of a permit and the permitholder's dental license, the permitholder shall submit to the Board 24 hours of continuing education from a provider approved or recognized in accordance with the American Dental Association's Continuing Education Recognition Program (CERP)or the Academy of General Dentistry's Program Approval for Continuing Education (PACE) , or approved or recognized by the Medical Board of California. The required continuing education shall be specific to the procedures the permitholder is authorized to perform.

Note: Authority cited: Sections 1614, 1638.1(b) Business and Professions Code. Reference: Sections 1638.1, Business and Professions Code.

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Office Use Only
Receipt #:_____
ATS #:_____
Date Received:_____
Initial: _____

Elective Facial Cosmetic Surgery (EFCS) Application for Initial Permit or Permit to Add Allowable Procedures

Business and Professions Code, Section 1638.1-1638.7

PART 1 – APPLICATION INSTRUCTIONS

1. An application must be complete and must be accompanied by all of the following:
   - An application fee of $850, made payable to the Dental Board of California.
   - All the required documentation specified in the application.
2. Applicant must indicate if they are applying through Pathway A or Pathway B.
3. A permit holder seeking to add allowable procedures is required to submit the following documentation:
   - Application form, only completing:
     a) Part 2 – Name, Contact, and Licensure Information
     b) Part 3 – Requirements
        i. Permit category being requested
        ii. Operative Reports reflecting additional procedures
     c) Part 4 – Acknowledgement/Certification

NOTE: All items in this application are mandatory; none are voluntary, unless indicated. Failure to provide any of the requested information will result in the application being deemed incomplete.

PART 2 – NAME, CONTACT, AND LICENSURE INFORMATION

1. Applicant Name:_____
   First Middle Last
2. Social Security Number_____-____-_____

   Individual Taxpayer Identification Number (ITIN)_____-____-_____
3. Address of Record:_____

   Practice Address (if different):_____
4. Telephone Numbers: Home:_____ Office:_____ Cell:_____
5. Email address:_____
6. CA Dental License #(s):_____ Date Issued:_____
7. Other Dental License # (if applicable):_____ State(s) of Issuance:_____
8. Current EFCS permit # (if applicable):_____ Date Issued:_____

PART 3 - REQUIREMENTS

Applicant is requesting a permit for category(ies):

☐ I - cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty

☐ II - cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation

or limited to:_____

_____

_____

The following general requirements are specific requirements for both pathways.

1. Submit Documentation of successful completion of an Oral and Maxillofacial Surgery Residency Program accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association (ADA):
   Dates attended:_____

2. Submit documentation of at least ***10 operative reports, but no more than 30***, from residency training or proctored procedures that are representative of ***procedures that the licensee intends to perform*** from the following categories:
   (I) Cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty.
   (II) Cosmetic soft tissue contouring and rejuvenation, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

   Reports shall contain a detailed narrative of the procedures performed by the applicant, specifying the date and location of the surgery, names of primary surgeons and assistants, and procedures and findings. Reports should be clear and dark enough to reproduce. An Index of Operative Reports, which is included as page 5 of this application, shall be submitted with the reports. These cases should reflect elective cosmetic surgery as defined in B&P §1638.1(g)(1).

3. Submit documentation showing proof of active status on the staff of a general acute care hospital and that the applicant maintains the necessary privileges based on the bylaws of the hospital to maintain that status. This document should include signatures from approving parties to be considered. If applicant's status is provisional, applicant must wait until active status is achieved before applying.

Complete items 4-6 only if applicant is applying through Pathway A

4. Submit Documentation that the applicant is certified, or a candidate for certification, by the American Board of Oral and Maxillofacial Surgery:
   Date Certified:_____
   Re-Certification Date:_____
   Candidate for Certification:_____

5. Submits a letter from the program director of the accredited residency program, or the director of a postresidency fellowship program accredited by the CODA of the ADA stating that the licensee has the education, training, and competency necessary to perform the surgical procedures that the licensee has notified the Board he or she intends to perform.

6. Submit documentation showing the surgical privileges the applicant possesses at any licensed general acute care hospital and any licensed outpatient surgical facility in this state.

Complete item 7 only if applicant is applying through Pathway B

7. Submit documentation showing proof that the applicant has been granted privileges by the medical staff at a licensed general acute care hospital to perform the surgical procedures that the applicant intends has notified the board that he or she intends to perform.

PART 4 – ACKNOWLEDGEMENT/CERTIFICATION

In accordance with California Business and Professions Code Section 142(b), the abandonment date for an application that has been returned to the applicant as incomplete shall be 12 months from the date of returning the application.

Certification – *I certify under the penalty and perjury, under the laws of the State of California, that the information in this application and any attachments are true and correct.*

Applicant's Signature _____ Date _____

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by The Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, Executive Officer, (916)263-2300, in accordance with Business & Professions Code, 1600 et seq. Except for Social Security numbers, and individual taxpayer identification number, the information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Disclosure of your social security number or individual taxpayer identification number is mandatory and collection is authorized by 30 of the Business & Professions Code and Pub. L 94-455 (42 U.S.C.A 405 (c)(2)(C)). Your social security number or individual taxpayer identification number will be used exclusively for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination board, and where licensing is reciprocal with requesting state. If you fail to disclose your social security number or individual taxpayer identification number, you may be reported to the Franchise Tax Board and be assessed a penalty of $100. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the name(s) and address(es) submitted may, under limited circumstances, be made public.

The following table outlines the requirements for each pathway

Pathway A	Pathway B
Proof of successful completion of an oral and maxillofacial surgery residency program accredited by the Commission on Dental Accreditation of the American Dental Association.	Proof of successful completion of an oral and maxillofacial surgery residency program accredited by the Commission on Dental Accreditation of the American Dental Association.
Submits to the board a letter from the program director of the accredited residency program, or from the director of a post-residency fellowship program accredited by the Commission on Dental Accreditation of the American Dental Association, stating that the licensee has the education, training, and competence necessary to perform the surgical procedures that the licensee has notified the board he or she intends to perform.	
Submits documentation to the board of at least 10 operative reports from residency training or proctored procedures that are representative of procedures that the licensee intends to perform from both of the following categories: **(I)** Cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty. **(II)** Cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.	Submits documentation to the board of at least 10 operative reports from residency training or proctored procedures that are representative of procedures that the licensee intends to perform from both of the following categories: **(I)** Cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty. **(II)** Cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.
Submits documentation showing the surgical privileges the applicant possesses at any licensed general acute care hospital and any licensed outpatient surgical facility in this state.	Submits documentation showing proof that the applicant has been granted privileges by the medical staff at a licensed general acute care hospital to perform the surgical procedures that the applicant has notified the board that he or she intends to perform.
Proof that the applicant is on active status on the staff of a general acute care hospital and maintains the necessary privileges based on the bylaws of the hospital to maintain that status.	Proof that the applicant is on active status on the staff of a general acute care hospital and maintains the necessary privileges based on the bylaws of the hospital to maintain that status.
Is certified, or is a candidate for certification, by the American Board of Oral and Maxillofacial Surgery.	

Name: Index of Operative Reports

Operative Report	Surgery Type *(Osteocatilaginous or Soft Tissue)*	Procedure(s)	Date	Position	Facility name and location
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
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MEMORANDUM

DATE	November 1, 2016
TO	Dental Board Members
FROM	Lusine M Sarkisyan, Legislative & Regulatory Analyst
SUBJECT	**AGENDA ITEM 8(F):** Discussion and Possible Action to Initiate a Rulemaking Adopt California Code of Regulation, Title 16, Section 1028.6 Relating to Licensure by Credential Application Requirements

BACKGROUND

In 1996, the Joint Legislative Sunset Review Committee recommended that the Dental Board of California (Board) pursue licensure by credential (LBC) as a method for increasing the number of dentists who could practice in California. As a result, Assembly Bill 1428 (Chapter 507, Statutes of 2001) was signed into law, authored by Assembly Member Sam Aanestad.

After the enactment of AB 1428, there were numerous discussions about applicants' experiences not being up-to-date and the need for application process clarifications. Therefore, Governor Schwarzenegger signed into law Senate Bill 928 (Chapter 464, Statutes of 2004), authored by Senator Sam Aanestad, which required an out-of-state applicant to provide proof that he or she has either been in active clinical practice or a full-time faculty member in an accredited dental education program and in active clinical practice, for a total of at least 5,000 hours in five of the seven years immediately preceding his or her application. This bill clarified that the total 5,000-hour clinical practice requirement may be satisfied over a period of seven consecutive years prior to application to accommodate disruptive circumstances like disability or medical leave, military service obligations, etc. Additionally, Senate Bill 299 (Chapter 4, Statutes of 2006), authored by Senator Wesley Chesbro, was enacted into law to provide that the five year clinical practice requirement could be met by the applicant contracting to practice dentistry full time for two years in a specified licensed primary care clinic or teach two years in an accredited dental education program.

The Board does not currently have regulations in place to interpret the statutory provisions relating to the LBC Licensure pathway and it has become necessary to clarify application requirement via regulation.

Staff has worked with Legal Counsel to develop proposed regulatory language for the Board's consideration. The language was hand carried to the meeting in November

2014, however due to the length of the document and the Board not having had an opportunity to review it before the meeting, the item was tabled for the February 2015 meeting.

At the February 2015 meeting, the Board appointed Doctors Bruce Whitcher, DDS and Debra Woo, DDS to the subcommittee on LBC to work with staff and Legal Counsel in addressing and clarifying issues relating to the application process for the LBC pathway.

In October 2015, staff scheduled a teleconference with the subcommittee and Board Legal Counsel for the purpose of obtaining feedback to staff's questions relating to LBC application requirements and the development of the proposed regulatory language. As a result of this teleconference, the subcommittee recommended that staff obtain Board input on policy issues so as provide feedback necessary to continue developing the regulatory language at the December 2015 Board meeting. Staff took back the feedback received from the Board members from the December 2015 meeting and incorporated them into the proposed regulatory language.

As a result, staff has proposed regulatory language for the Board's consideration which will be hand-carried to the Board meeting.

ACTION REQUESTED

Consider and possibly approve the proposed regulatory language relative to the Licensure by Credential Application requirements, and direct staff to take all steps necessary to initiate the formal rulemaking process, including noticing the proposed language for 45-day public comment, setting the proposed language for a public hearing, and authorize the Executive Officer to make any non-substantive changes to the rulemaking package. If after the close of the 45-day public comment period and public regulatory hearing, no adverse comments are received, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed amendments to California Code of Regulations, Title 16, Section 1028.6 as noticed in the proposed text.

TITLE 16. DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

PROPOSED LANGUAGE

Adopt California Code of Regulations, Title 16, Section 1028.6 as follows:

ARTICLE 2.

§ Section 1028.6. Application for Determination of Licensure Eligibility Pursuant to Section 1635.5 of the Business and Professions Code

(a) The following definitions shall apply to this section:

(1) "Otherwise restricted" means, but shall not be limited to, any of the following:

(A) Practice of dentistry is required to take place at specific locations only;

(B) Practice of dentistry requires supervision;

(C) Private practice of dentistry is prohibited;

(D) Practice of dentistry on specific persons is prohibited;

(E) Dental license is on probation;

(F) Specialty license with State-imposed limitations;

(G) Conditional, provisional, or temporary dental license; or,

(H) Any limitation or condition imposed upon a license by a government agency or any branch of the United States Armed Forces that is related or unrelated to discipline.

(2) "State" shall include any state or territory of the United States and the District of Columbia.

(3) "Disciplinary action" means a restriction or penalty imposed upon a license, such as suspension, revocation, probation, confidential discipline, disciplinary consent order, letter of reprimand or warning, or any other action taken against a dental license by a government agency or any branch of the United States Armed Forces as a result of misconduct.

(4) "Full-time status" means to engage in the practice of dentistry or to provide dental instruction for a minimum of forty (40) hours per week, which may not be accrued in less than four (4) days per week.

(A) Minimum of 30 hours of clinical hands-on care per week, for no less than 45 weeks per year, except as provided for during customary holidays, personal or family illness, and vacation time as described in a separate employment agreement.

(B) Up to 10 hours in practice-related activities, e.g., chart review, meetings, etc. Time spent "on-call" cannot be counted toward the 40-hour week.

(5) "Active clinical practice" means the practice of dentistry, including examination, treatment planning, diagnosis, and the direct provision of dental treatment to patients

(6) "Qualifying event" means an extended personal or family illness, pregnancy, or other natural cause, vacation time as described in a separate employment agreement between the licensee and licensee's employer and other exemptions to the minimum time requirements of this subdivision on a case-by-case basis.

(7) "Fellowship" means to engage in active patient care as defined under "active clinical practice".

(8) "Full time faculty member in active clinical practice" means to engage in direct provision of patient care of a minimum of 30 hours per week at a dental school.

(b) An applicant for licensure as a dentist pursuant to Section 1635.5 of the Business and Professions Code shall submit either of the following applications to the Board, each of which is hereby incorporated by reference: "Application for Determination of Licensure Eligibility (Licensure by Credential Clinical Practice)" (New Form LBC-CLN 1 xx/2015); "Application for Determination of Licensure Eligibility (Licensure by Credential Clinical Practice and Residency)"(New Form LBC-CLR 1 xx/2015); "Application for Determination of Licensure Eligibility (Licensure by Credential Pending Contract for Clinical Practice)"(New Form LBC-CCL 1 xx/2015); and "Application for Determination of Licensure Eligibility (Licensure by Credential Pending Contract for Faculty Practice)"(New Form LBC-CFA 1 xx/2015).

(c) An applicant shall submit proof of completion of 50 units of continuing education (CE) credits relating to dentistry with his or her application as specified in Section 1645 of the Code and Section 1016 of the California Code of Regulations, Title 16.

(d) In addition to the proof or documentation that an applicant is required to submit to the Board pursuant to Section 1635.5 of the Business and Professions Code, each applicant shall submit the following:

(1) The fee established in Section 1021 of the Board's regulations;

(2) Satisfactory evidence that the applicant has met all applicable requirements in Section 1635.5 of the Business and Professions Code;

(3) Two classifiable sets of fingerprints or submit a Live Scan inquiry to establish the identity of the applicant and to permit the Board to conduct a criminal history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check;

(4) Certification of licensure as a dentist from a dental board of any state of the United States in which the applicant has been issued a license to practice dentistry;

(5) A copy of each current, active, and valid license authorizing the applicant to engage in the practice of dentistry issued by any state of the United States that is not revoked, suspended, or otherwise restricted;

(6) Information as to whether the applicant is in default on a United States Department of Health and Human Services education loan pursuant to Section 685 of the Business and Professions Code;

(7) Proof of completion of a Board approved course in infection control, a Board approved course in the California Dental Practice Act, and certification of completion in Basic Life Support, which shall meet the requirements contained within Section 1016 of the Board's regulations;

(e) Program Implementation

(1) Applicant shall submit to the Board proof of at least 5,000 hours in five (5) of the seven consecutive years immediately preceding the date of his or her application unless a qualifying event is applicable subject to Board review and approval. The applicant shall provide independent verification demonstrating that he/she has been engaged in active clinical practice upon request by the Board.

(A) Proof of completion shall be a minimum of 1,000 hours for each full twelve (12) month period of licensure immediately preceding the date of the application, not to exceed 1,800 hours for each full (12) twelve month period .

(2) Applicants who select the contract pathway for a two year full-time position in order to fulfill the clinical practice requirement, as specified in Subparagraphs (B) and (C) of Paragraph (3) of Subdivision (a) of Section 1635.5 of the Business and Professions Code, shall provide quarterly verification letters of employment to the Board.

(3) Those applicants submitting residency experience to qualify for licensure shall also comply with the following:

(A) Applicant shall submit certificate or proof of completion at an approved residency program.

(B) For every one year of residency program completed in an accredited residency training program by the American Dental Association Commission on Dental Accreditation, one year of credit shall be given, with a maximum of two years of credit, towards the clinical practice requirement in Section 1635.5 of the Business and Professions Code

(C) If a dental fellowship is an extension of residency program, then only 2 years of the fellowship will be applied for credit

(4) Faculty members submitting an application shall also comply with the following:

(A) Faculty members who do not hold a license to practice dentistry in this state shall provide proof of an unrestricted dental license in another state.

(B) Only two years of the five years as a faculty member shall be applied as credit towards the clinical practice requirement.

(f) Should an applicant fail to comply with deficiency notices regarding his or her application within 90 days, then the LBC application for consideration shall be deemed to have been abandoned.

Note: Authority Cited: Sections 1614 and 1635.5, Business and Professions Code. Reference: Section 1635.5, Business and Professions Code.

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MEMORANDUM

DATE	November 15, 2016
TO	Dental Board Members
FROM	Carlos Alvarez, Acting Enforcement Chief
SUBJECT	**Agenda Item 9(A):** Enforcement Statistics and Trends

Attached please find Complaint Intake and Investigation statistics for the previous five fiscal years, and quarter one of the current fiscal year. Below is a summary of some of the program's trends (as of September 30, 2016):

Complaint & Compliance Unit

Complaints Received

The total number of complaints received during the first quarter was **898,** averaging 299 complaints per month.

Active Caseload: 1003

The average caseload per Consumer Services Analyst (CSA) during the first quarter was **201** complaint cases.

Complaint Aging

First Quarter

# Months Open	# of Cases	% of Total Cases
0 – 3 Months	459	46%
4 – 6 Months	319	32%
7 – 9 Months	163	16%
10 – 12 Months	17	2%
1 – 3 Years	45	4%

Cases Closed:

The total number of complaint cases closed between July 1, 2016, and September 30, 2016, was 640, averaging 213 per month. The previous five-year average was 203 closures per month.

The average number of days a complaint took to close within this quarter was 105 days (a 14% decrease from last quarter's average of 122 days). Chart 2 displays the average complaint closure age over the previous five fiscal years.

Investigations

Current Open Caseload:

There are currently approximately **855** open investigative cases, **273** probation cases, and **69** open inspection cases.

Average caseload per full time Investigator = 39
Average caseload per Special Investigator = 35
Average caseload per Analyst = 36

# Months Open	# of Cases	% of Total Cases
0 – 3 Months	36	4%
4 – 6 Months	53	6%
6 - 12 Months	172	20%
1 – 2 Years	418	49%
2 – 3 Years	153	18%
3+ Years	23	3%

Since our last report in June 2016, the number of cases over one year old has increased from 61% to 70%. The number of cases in the oldest category (three years and older) has increased from 16 to 23.

Case Closures:

The total number of investigation cases closed, filed with the AGO or filed with the District/City Attorney during the fourth quarter is **253**, an average of approximately **83** per month.

The average number of days an investigation took to complete an investigation during the fourth quarter was **353** days. The previous five-year average number of days to close a case was 378 days (refer to Chart 2).

Chart 2 displays the average closure age over the previous five fiscal years.

Cases Referred for Discipline:

The total number of cases referred to the AGO's during the first quarter was **27** (approximately 9 referrals per month). The three-month average for a disciplinary case to be completed was **844** days.

Chart 2 displays the average closure age over the previous four fiscal years for cases referred for discipline.

Chart 3 – Case Categories

Chart 3 provides a breakdown of the number of cases based on allegation.

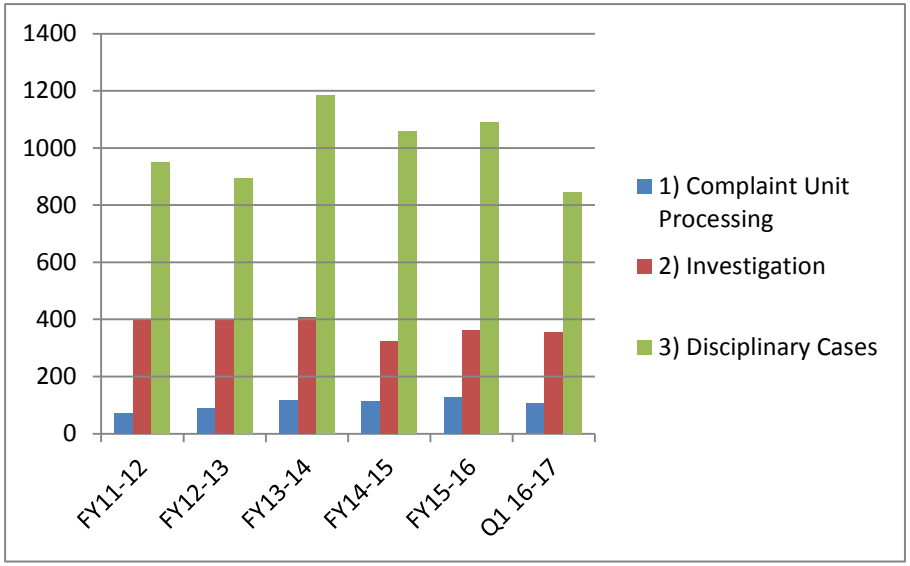
I will be available during the Board meeting to answer any questions or concerns you may have.

Dental Board of California
Chart 1

STATISTICAL DESCRIPTION	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 2016-17				
COMPLAINT UNIT						Jul-Sep	Oct - Dec	Jan - Mar	Apr - Jun	Total
Complaints Received	2813	2874	3021	3557	2326	782				782
Convictions/Arrests Received	750	1083	650	623	349	116				116
Total Intake Received	3563	3957	3671	4180	2675	898				898
Total Complaints Closed	2404	2911	2855	2762	1945	640				640
Pending at end of period	738	1072	1022	989	804	1003				
INVESTIGATIONS										
Cases Opened	916	719	659	1426	255	170				170
Cases Closed	1094	813	955	1195	231	226				226
Referred to AG	174	85	71	188	24	51				51
Referred for Criminal	12	19	28	20	14	0				0
Pending at end of period	1025	767	809	1082	884	855				
Citations Issued	15	27	83	48	10	7				7
ATTORNEY GENERAL'S OFFICE										
Cases Pending at AG	229	183	172	189	210	277				
Administrative Actions:										
Accusation	99	52	71	70	17	24				24
Statement of Issues	41	9	18	4	3	2				2
Petition to Revoke Probation	9	4	8	3	1	1				1
Licensee Disciplinary Actions:										
Revocation	30	27	33	21	3	6				6
Probation	68	51	54	38	11	19				19
Suspension/Probation	2	0	0	0	0	0				0
License Surrendered	6	10	15	9	2	6				6
Public Reprimand	13	11	12	11	3	9				9
Other Action (e.g. exam required, education course, etc.)	8	7	3	11	1	5				5
Accusation Withdrawn	8	10	1	3	2	1				1
Accusation Declined	1	2	0	2	1	4				4
Accusation Dismissed	0	2	1	0	1	0				0
Total, Licensee Discipline	136	120	119	95	24	50				50
Other Legal Actions:										
Interim Suspension Order Issued	6	5	0	0	0	0				0
PC 23 Order Issued	1	2	2	3	0	0				0

Dental Board of California
Chart 2

Average Days to Close	FY11-12	FY12-13	FY13-14	FY14-15	FY15-16	Q1 16-17
1) Complaint Unit Processing	72	88	117	113	126	105
2) Investigation	397	400	407	323	364	353
3) Disciplinary Cases	950	893	1185	1059	1089	844



Dental Board of California
Chart 3

						2016-17					
Allegations	**2011-12**	**2012-13**	**2013-2014**	**2014-2015**	**2015-2016**	**Jul-Sep**	**Oct - Dec**	**Jan - Mar**	**Apr - Jun**	**Total**	**% of Total**
Substance Abuse, Drug Related Abuses	NA	NA	NA	NA	NA	5				5	1%
Mental/Physical Impairment	NA	NA	NA	NA	NA	1				1	0%
Health And Safety	NA	NA	NA	NA	NA	2				2	0%
Unsafe/Unsanitary Conditions	79	92	99	110	32	13				13	1%
Fraud	123	124	218	389	214	59				59	6%
Non-Jurisdictional	251	217	235	266	198	114				114	11%
Incompetence / Negligence	1540	1459	1795	2218	1454	555				555	56%
Other	266	295	163	332	114	32				32	3%
Unprofessional Conduct	205	219	244	250	143	41				41	4%
Sexual Misconduct	13	14	16	20	6	2				2	0%
Discipline by Another State	25	16	10	11	10	2				2	0%
Unlicensed / Unregistered	111	124	201	227	125	45				45	5%
Criminal Charges	854	1137	650	669	353	121				121	12%
Total	3467	3737	3631	4492		992	0	0	0	992	100%

Note: 2015-2016 Q3 stats were not included due to BreeZe conversion

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MEMORANDUM

DATE	November 16, 2016
TO	Dental Board Members
FROM	Carlos Alvarez, Acting Enforcement Chief Dental Board of California
SUBJECT	**Agenda Item 9(B):** Review of Fiscal Year 2016-17 First Quarter Performance Measures from the Department of Consumer Affairs

Performance measures are linked directly to an agency's mission, vision and strategic objectives/initiatives. Data is collected quarterly and reported on the Department's website at: http://www.dca.ca.gov/about_dca/cpei/index.shtml. The Dental Board was notified by DCA that they were experiencing issues and were fixing the First Quarter Performance Measures calculations. The First Quarter Performance Measures will be completed and posted on the DCA website on January 4, 2017.

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MEMORANDUM

DATE	November 16, 2016
TO	Dental Board Members
FROM	Chrystal Williams, Diversion Program Manager
SUBJECT	**Agenda Item 9(C) :** Diversion Program Report and Statistics

The Diversion Evaluation Committee (DEC) program statistics for the first quarter ending September 30, 2016. These statistics are derived from the MAXIMUS monthly reports.

Intake Referrals	**July**	**Aug**	**Sept**
Self-Referral	1	0	0
Enforcement Referral	0	1	0
Probation Referral	0	2	0
Closed Cases	0	2	1
Active Participants	20	23	21

The Board is currently recruiting for a public member position on the Northern DEC; a dental position on the Southern DEC; and dental auxiliary positions on both the Northern and Southern DEC's.

The next DEC meeting is scheduled for December 1, 2016, in Northern California.

ACTION REQUESTED:
No action requested.

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MEMORANDUM

DATE	December 1, 2016
TO	Dental Board Members
FROM	Pediatric Anesthesia Subcommittee - Meredith McKenzie, Public Member and Bruce Whitcher, DDS
SUBJECT	**Agenda Item 10(A):** Discussion and Possible Action Regarding the Subcommittee's Recommendations Relating to Pediatric Anesthesia

Since spring 2016, the Pediatric Anesthesia subcommittee of the Dental Board of California (Board) has been conducting a comparison of California's present laws, regulations, and policies to those of other states and dental associations' policies relating to pediatric anesthesia; a review of the relevant dental and medical literature; and has reviewed all incident reports submitted to the Board in compliance with the reporting requirements of Business & Professions Code Section 1680(z) related to pediatric sedation. In addition, the subcommittee received public comments regarding its pediatric sedation study at three separate meetings held in July, August, and October 2016.

The subcommittee recognizes that few topics generate more controversy than the use of anesthesia, especially for children; and the challenge of reaching a consensus among interested parties on this issue is difficult. Although patient safety is always the foremost concern, the effects of regulatory change on healthcare can be fraught with unintended consequences. Any proposal should, therefore, strike a balance between established practice and evidence based changes that provide greater patient safety.

While the subcommittee concludes that California's present laws, regulations and policies are sufficient to provide protection of pediatric patients during dental sedation, it recommends the following enhancements to current statute and regulations to provide an even greater level of public protection.

SUBCOMMITTEE FINAL RECOMMENDATIONS

1. The board should continue to research the collection of high quality pediatric dental sedation and anesthesia related data to inform decision making.

2. The definitions of general anesthesia, conscious sedation, pediatric and adult oral sedation should be updated.

3. Proposed changes to the sedation and anesthesia permit system:

    a. Pediatric Minimal Sedation Permit for patients under age thirteen (13).

(This permit would replace the existing Oral Conscious Sedation for Minors permit)

i. Education: To be eligible for this permit, the dentist must complete 24 hours of instruction in pediatric sedation plus one clinical case; this training must include airway management and patient rescue from moderate sedation.
ii. Administration is limited to a single dose of a single sedative drug via the oral route, plus nitrous oxide and oxygen that is unlikely to produce a state of unintended moderate sedation.
iii. A minimum of one staff member, in addition to the dentist, trained in the monitoring and resuscitation of pediatric patients must be present.

b. Pediatric Moderate Sedation permit for patients under age 13. (This permit could either be a new pediatric permit or an endorsement on an existing moderate (conscious) sedation permit.)
    i. Education: To be eligible for this permit, the dentist must have completed a Commission on Dental Accreditation (CODA) accredited residency in pediatric dentistry, or equivalent training in pediatric moderate sedation, as determined by the board. The applicant must provide proof of completion of a sufficient number of cases to establish competency, both at time of initial application and at renewal.
    ii. Administration of the drugs utilized is unlikely to produce an unintended state of deep sedation
    iii. Personnel: The dentist and at least one member of the support staff must be trained in pediatric advanced life support and airway management, equivalent to the AAP-AAPD Guidelines or as determined by the board. For children under age 7, two support staff, in addition to the dentist, must be present, and one staff member shall serve as a dedicated patient monitor.

c. Pediatric general anesthesia permit for children under age 13. (This permit could either be a new pediatric permit or an endorsement on an existing general anesthesia permit.)

    i. Education: the dentist must have completed a CODA accredited or equivalent residency training program that provides competency in the administration of deep sedation/general anesthesia for children under age 13. For patients under age 7 the applicant must provide proof of completion of a sufficient number of cases to establish competency, both at time of initial application and at renewal.

    ii. Personnel: The dentist and at least two support staff must be present. The dentist and at least one staff member must be trained in pediatric advanced life support and airway management, equivalent to the AAP-AAPD Guidelines or as determined by the board. One staff member, trained in patient monitoring, shall be dedicated to that task.

    iii. When a dedicated anesthesia provider is utilized, in addition to the dentist, both the dentist and at least one staff member must be trained in pediatric advanced

life support and airway management, equivalent to the AAP-AAPD Guidelines or as determined by the board.

4. Requirements for records and equipment should be updated and include the use of capnography for moderate sedation.

5. The Dental Board should be provided with additional authority to strengthen the onsite inspection and evaluation program.

Stakeholder comments were generally supportive of subcommittee preliminary recommendations 1 and 2. We received comments both in support and in opposition to the use of capnography for moderate sedation. Other preliminary recommendations received little comment.

The subcommittee received comments in opposition to recommendation number 3. This recommendation included proposed changes to the sedation and anesthesia permit requirements. The subcommittee requests that the board consider revised final recommendations for changes to the sedation permit system.

The subcommittee acknowledges that it's study addresses primarily pediatric sedation and anesthesia. We will therefore limit our final recommendations to the patients under age 13, the age that defines the term "pediatric" in California's dental sedation laws and regulations.

The subcommittee recognizes that specific requirements for staff training, continuing education requirements, the future status of existing permits, and the number of cases required establishing competency will require additional development.

The subcommittee recognizes that the manpower and economic considerations for pediatric dental sedation are beyond the scope of the present report. These considerations will be critical to the successful implementation of any changes to dental sedation laws. The subcommittee therefore recommends that there be an analysis of the effects of any proposed new legislation or regulation on access to care for pediatric dental patients prior to the implementation of any changes. Factors such as whether the costs of sedation and anesthesia are reasonable depends on how cost effectiveness is defined and calculated, and on the perspective taken. For example, clinicians often view cost implications differently than would payers or society at large. There needs to be consideration of the resource constraints of the healthcare system (for example, Denti-Cal versus private insurance). Feasibility issues must be considered, including the time, skills, staff, and equipment necessary for the provider to carry out the recommendations, and the ability of patients and systems of care to implement them.

Board Action Requested:
Accept, Reject, or Modify the Subcommittee recommendations.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
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MEMORANDUM

DATE	December 1, 2016
TO	Dental Board Members
FROM	Karen Fischer, Executive Officer
SUBJECT	**Agenda Item 10(B):** Discussion and Possible Action to Adopt the Subcommittee's Report Relating to Pediatric Anesthesia and Submit to the Legislature by January 1, 2017

In February 2016 Senator Jerry Hill, Chair of the Senate Committee on Business, Professions, and Economic Development was made aware of a tragedy in which an otherwise healthy child died after receiving general anesthesia at a dentist's office. He notified the Dental Board of California (Board) of his concern about the rise in the use of anesthesia for young patients and asked the Board to investigate whether California's present laws, regulations, and policies are sufficient to protect the public. In doing the research, Senator Hill asked the Board to review all incident reports collected by the Board related to pediatric anesthesia in California for the past five years.

The Board President appointed a two person subcommittee to work with staff to research this issue; and the study was expanded to include review of incident reports related to all levels of pediatric sedation including conscious sedation, oral conscious sedation, and general anesthesia as well as administration of local anesthetic in California for the past six years (2010-2015). Three meetings were held (July, August, and October) to take public comment on this important issue.

This report reflects four parts of the study: (1) the present laws, regulations, and policies in California; and a comparison of these laws, regulations and policies to those of other states and dental associations, (2) review of relevant dental and medical literature, (3) review of all incident reports in California for patients < 21 years of age, and (4) conclusions.

The report before you today is the revised working document. Minor changes have been made since it was made public in July 2016. This document will become the final report submitted to the Legislature by January 1, 2017 and upon submission will include a Cover Page, Executive Summary, Table of Contents, the report, and Appendices. It will also include a Conclusions/ Recommendations section based on board discussion at the December meeting. (*In an effort to conserve paper, copies of the Appendices are available in the meeting material posted on the Board's web site*.)

Board Action Requested:
Revise as necessary and adopt the report of the Subcommittee for submission to the Legislature by January 1, 2017.

Dental Board of California Pediatric Sedation Study

INTRODUCTION

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BACKGROUND

History of Anesthesia and the Scope of Practice of Dentistry

Although both dentists and physicians contributed to early developments in the field of anesthesiology, each profession evolved differently. Advances in medical anesthesiology evolved slowly until 1923 when a few physicians had the novel idea of creating a separate department of anesthesia in medical schools. This advance allowed all teaching, training, and research endeavors to be organized and supervised by one department head. This marked the beginning of medical anesthesiology as a scientific discipline.

The practice of anesthesiology in dentistry took a different path, with dentists practicing various forms of anesthesia as a technique taught by practitioners to one another. This approach did not initially provide an environment for formal research. Anesthesia techniques developed specifically for dentistry became more widely accepted by the profession in the middle of the 20th century. Drs. Morgan Allison, Adrian Hubbell, Leonard Monheim and others

first utilized new techniques and new anesthetics that became available at the time. Other dentists developed what was then a new technique, termed "conscious sedation" which utilized sub anesthetic doses of general anesthetic drugs along with local anesthesia. These new anesthesia concepts and ideas led to the establishment of the American Dental Society of Anesthesiology (ADSA) in 1953. Among the chief goals of these pioneer dentists was to provide education in advanced pain and anxiety control for all dentists.

Case law has clarified the place of anesthesia within the scope of dental practice. The courts that have reviewed anesthesia scope of practice cases have consistently viewed anesthesiology as being within the scope of practice of dentistry as well as other health care disciplines. However the courts have ruled that individual providers are limited to their scope of practice as defined by state law. Anesthesia should therefore be administered according to the statutes and regulations that each state uses to govern an individual's core license to practice.[1]

History and Function of the Dental Board of California Board

The California legislature created the Dental Board of California (Board) in 1885 to regulate the practice of dentistry. Today, the Board regulates approximately 86,000 licensed dental healthcare professionals in California, including approximately 40,000 dentists, 44,000 registered dental assistants (RDAs) and 1,500 registered dental assistants in extended functions (RDAEFs). In addition, the Board is responsible for setting the duties and functions of approximately 50,000 unlicensed dental assistants. The Board's last sunset review was in 2015.

The practice of dentistry is defined in Business and Professions Code section 1625 as:

"the diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents, and physical evaluation."

The Board meets at least four times throughout the year to address work completed by the various committees, and as noticed on the agenda, may meet in closed session as authorized by Government Code Section 11126 et. seq.

[1] Boynes, S.G., A Guide to Dental Anesthesiology Rules and Regulations, 5th ed., Chicago, No-No Orchard Publishing, 2013. P33.
http://www.mediafire.com/download/b0p8rhh9imk4939/Fifth_Edition__Dental_Anesthesiology_Guide_to_the_Rules_and_Regulations.pdf

The mission of the Board is defined in Business and Professions Code section 1601.2, which states:

"Protection of the public shall be the highest priority for the Dental Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

To meet its obligations, the Board implements regulatory programs and performs a variety of functions. These programs and activities include setting licensure requirements for dentists and dental assistants, including examination requirements, and issuing and renewing licenses, including a variety of permits and certifications. The Board also has its own enforcement division, with sworn and non-sworn staff, which is tasked with investigating both criminal and administrative violations of the Dental Practice Act (Act) and other laws. As part of the disciplinary function of the Board, it also monitors dentists and RDAs who may be on probation, and manages a Diversion Program for licensees whose practice may be impaired due to abuse of dangerous drugs or alcohol.

Board Membership and Committees

The Board is composed of 15 members: eight practicing dentists, one registered dental hygienist (RDH), one RDA, and five public members, which account for one-third of the membership. The Governor appoints the dentists, the RDH, the RDA, and three public members. The Speaker of the Assembly and the Senate Rules Committee each appoint one public member. Of the eight practicing dentists, one must be a member of the faculty of any California dental school, and one is required to be a dentist practicing in a nonprofit community clinic. Members of the Board are appointed for a term of four years, and each member may serve no more than two full terms.

Purpose of State Laws

State laws and regulations are general rules governing people's rights or conduct. Laws and regulations do not contain recommendations, model procedures, lists of resources, or information about practice or procedures, otherwise known as guidance documents.

Laws are developed following a legislative plan that includes an analysis of the existing law, an analysis of the necessity of legislation, a statement that no other regulatory choice would be effective; analysis of potential danger areas (constitutional, legal, practical); and an analysis of the practical implications of the legislative proposal. Regulations are developed to implement, interpret, and make specific the law. Statutes and regulations are of necessity concise and in the case of dental laws, establish the minimum standards for the safe practice of dentistry.

Laws and regulations are usually applied literally and can limit the ability of the licensee to exercise discretion.

Dental Board Enforcement Unit
The Board utilizes its disciplinary process to enforce the Dental Practice Act. The Board has broad authority over its licensees and may issue administrative citations, impose fines, and reprimand, revoke, suspend, or place conditions upon a dental license. All complaints against a licensee are reviewed and if there is sufficient evidence of professional misconduct an accusation is filed.

Accusations may be based on specific acts or omissions of those duties described in the Practice Act, or as established by expert testimony of gross negligence or incompetence sufficient to require discipline. This provision makes it unnecessary to state every conceivable practice standard, as to do so would clearly be impractical.

DEFINITIONS USED IN DENTAL SEDATION AND ANESTHESIA

The American Society of Anesthesiology developed new definitions of levels of sedation in 1999. These definitions were subsequently adopted by most other organizations involved in the provision of sedation and anesthesia care. The Dental Board first suggested adoption of these definitions into its laws in 2005 and again in 2010.

Appendix 2 Table 1 includes a side by side comparison of California's current definitions of oral conscious sedation, parenteral conscious sedation, and general anesthesia with contemporary definitions.

- **analgesia** – the diminution or elimination of pain.
- **anxiolysis** – the diminution or elimination of anxiety.
- **conscious sedation** – a minimally depressed 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 and that is produced by a pharmacological or non-pharmacological method or a combination thereof.
- **deep sedation** – a drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully after repeated verbal or painful stimulation. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. A state of deep sedation may be accompanied by partial or complete loss of protective airway reflexes. Patients may readily pass from a state of deep sedation to the state of general anesthesia.

- **enteral –** any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa.
- **general anesthesia** – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilation is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required. Cardiovascular function may be impaired.
- **incremental dosing** – administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).
- **inhalation –** a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.
- **local anesthesia –** the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.
- **maximum recommended dose (MRD)** – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.
- **minimal sedation** - a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, breathing and cardiovascular functions are unaffected. In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.
- **moderate sedation –** a drug-induced depression of consciousness during which patients respond purposefully to verbal commands or after light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- **parenteral –** a technique of administration in which the drug bypasses the gastrointestinal tract.
- **recovery** – the ability to regain full health, or a return to baseline status.
- **supplemental dosing** - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures.
- **titration** – the administration of small incremental doses of a drug until a desired clinical effect is observed.

- **transdermal –** a technique of administration in which the drug is administered by patch or iontophoresis through skin.
- **transmucosal –** a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

DENTAL BOARD GENERAL ANESTHESIA, CONSCIOUS SEDATION AND ORAL CONSCIOUS SEDATION PERMIT PROGRAMS

Legislative History

The California Dental Practice Act regulates the use of sedation and general anesthesia by California dentists. These laws and regulations may be accessed through the Dental Board of California's website. There is an annual publication of the California Dental Practice Act that is available from the legal and professional document publisher Lexis Nexis.

The Board has long sought to improve the safety of sedation and anesthesia in California, working with the California Dental Association to co-sponsor SB 386 (Keene, 1979), the first legislation to regulate the use of general anesthesia by dentists in California. This bill included a requirement for mandatory office inspections that were based on a voluntary program originally developed by Southern California oral surgeons. Conscious sedation laws, AB 1276 (Tucker, 1986) also sponsored by the Board and CDA, followed as did AB 2006 (Keeley, 1998) and AB 1386 (Laird, 2005), the most recent update of sedation laws. These laws were sponsored as proactive measures to improve patient safety. An exception was AB 564 (Keene, 2001), a bill that established reporting requirements for patient deaths, that was introduced at the request of a mother whose son suffered brain damage after he was given chloral hydrate, an oral sedative, by his dentist.

In 2002 the Board called for a review of anesthesia laws and patient outcomes to see if any improvements could be made to the existing regulatory program. To accomplish this goal the Board appointed the Blue Ribbon Panel on Anesthesia (Panel), an ad hoc committee composed of general dentists and dental specialists who were recognized experts in the field. The Panel reviewed laws in other states, dental association guidelines, death statistics provided by the Board, closed claims from an insurance carrier, as well as current laws.

The Panel's recommendations were approved by the Board and ultimately enacted through statute and regulation beginning in 2006.[2] There is no record of any significant opposition to the recommended changes which included the addition of an adult oral conscious sedation permit, new requirements for pre anesthetic physical evaluation of patients, and improvements

[2] Dental Board of California: Recommendations of the Blue Ribbon Panel, November 7, 2003.

to the office inspection program. The Panel did not recommend that a specific number of personnel be present, nor was there any recommendation for staff training other than basic CPR. There was no recommendation for pre-operative dietary instructions due to controversy about appropriate requirements. At the time the board was aware of the need to update anesthesia terminology to achieve consistency with new definitions adopted by the American Dental Association, but chose to defer this until a later date, and recommended that these changes be made during sunset review.

In 2010 the Board president appointed a subcommittee to study the definitions, to make recommendations for their adoption and to review the relevant statues and regulation for currency. The 2010 subcommittee recommended that the anesthesia and sedation laws be reviewed and updated every 5 years and suggested strategies for accomplishing this task. Once statues were amended, other changes could be implemented by regulation. A series of informal stakeholder meetings followed and the subcommittee submitted a legislative proposal to the board in November 2013. This item was noticed for discussion and possible action at the November 22, 2013 meeting. The California Society of Pediatric Dentists stated support but provided no specific comments. The proposal was identified as a future board priority.

PART 1: THE PRESENT LAWS, REGULATIONS, AND POLICIES IN CALIFORNIA; AND A COMPARISON OF THESE LAWS, REGULATIONS AND POLICIES TO THOSE OF OTHER STATES AND DENTAL ASSOCIATIONS

CURRENT CALIFORNIA SEDATION AND ANESTHESIA LAWS

A summary of California's current dental sedation and anesthesia laws is provided in the attached Appendix 2, Tables 2-8. The California Business and Professions Code (BPC) Sections 1646 and 1647 describe educational qualifications and other requirements necessary for a dentist to become eligible for a permit to administer general anesthesia or sedation. These laws include a requirement for general anesthesia and conscious sedation permit holders to undergo an office inspection every 5 -6 years; completion of continuing education every 2 years; a list of violations that are considered unprofessional conduct; and requirements for a physician and surgeon to obtain a permit to administer general anesthesia in a dental office. BPC Sections 1680 and 1682 describe acts that constitute unprofessional conduct specifically related to sedation and anesthesia.

BPC Section 1647 addresses conscious sedation and includes the statement that "the drugs and techniques used shall have a margin of safety wide enough to render unintended loss of consciousness unlikely". This broad approach to limiting the use of potent sedatives recognizes that almost any drug or combination of drugs, when used in sufficient quantity, can produce

loss of consciousness, particularly in the very young, very old, and medically compromised patients.

The duties of dental assistants are described in BPC Section 1750, and includes patient monitoring and other sedation related duties they may perform. California Code of Regulations (CCR) Section 1070 specifies the educational course and program approval process for dental assistants, including the Dental Sedation Assistant.

CCR Sections 1043 and 1044 provide requirements for supervision of sedated patients, definitions of levels of sedation, and additional details of permit requirements. CCR Section 1043 provides the details of the office inspection program including composition of the inspection team, office facility requirements, equipment requirements, including patient monitors, preoperative evaluation, records, emergency drugs, conduct of the evaluation including a demonstration of general anesthesia and performance of the 13 simulated emergencies, and administrative procedures for the office evaluation process. The Board presently issues the following permits:

1. Pediatric oral conscious sedation
2. Adult oral conscious sedation
3. Parenteral conscious sedation
4. General anesthesia
5. Physician anesthesiologist dental anesthesia

DENTAL SEDATION AND ANESTHESIA LAWS IN OTHER STATES

Compilations of dental sedation and anesthesia laws for all 50 states are available from the American Dental Association[3] [4] , the American Dental Society of Anesthesia[5] and the American Association of Oral and Maxillofacial Surgeons[6] These publications provide summaries of all laws and regulations relevant to general anesthesia and deep sedation as well as moderate and minimal sedation in all 50 states. The Board obtained additional information related to minimal and moderate enteral sedation laws from the Dental Organization for Conscious Sedation

[3]American Dental Association, "Statutory Requirements for General Anesthesia and Deep Sedation Permits", 2009. http://www.ada.org/en/~/media/ADA/Advocacy/Files/anesthesia_general_permit

[4] American Dental Association, "Statutory Requirements for General Anesthesia and Deep Sedation Permits", 2009. http://www.ada.org/en/~/media/ADA/Advocacy/Files/anesthesia_sedation_permit

[5]Boynes, S.G., A Guide to Dental Anesthesiology Rules and Regulations, 5th ed., Chicago, No-No Orchard Publishing, 2013. http://www.mediafire.com/download/b0p8rhh9imk4939/Fifth_Edition__Dental_Anesthesiology_Guide_to_the_Rules_and_Regulations.pdf

[6] American Association of Oral and Maxillofacial Surgeons, State Requirements for General Anesthesia Delivery – Summary, Rosemont, IL, updated 4/19/2016.

(DOCS Education).[7] The Canadian provinces have adopted the American model for dental sedation and anesthesia and utilize a similar regulatory framework. The subcommittee did not review provincial laws for this report.

Laws in California and most other states reference guidelines published by the American Dental Association[8] [9] and the educational standards of the Commission on Dental Accreditation of the American Dental Association [10], and frequently incorporate some but not all of the recommendations included in these guidance documents.

COMPARISON OF CALIFORNIA LAWS WITH LAWS IN OTHER STATES

Methods

The subcommittee summarized information from compilations of state laws for this report. Where information was incomplete or missing, the practice act for that state was downloaded from the state board web site and reviewed for relevant sections. If necessary the individual dental board was contacted to obtain additional information. For some states there were questions that required legal interpretation that could not be completely resolved. Texas, South Carolina, and Alaska have rulemaking in progress so their existing rules were reviewed.

Certain state laws and regulations were relatively uniform across all 50 states. Other state laws were less consistent.

The subcommittee made every effort to verify the accuracy of information presented, however due to the variability, complexity, and ever changing nature of state laws and regulations this report may include some inaccuracies. The Board welcomes the opportunity to provide additions or corrections to this information.

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[7] DOCS Education http://www.sedationregulations.com/

[8] American Dental Association. (2012). Guidelines for the Use of Sedation and General Anesthesia by Dentists. In *Society* (Vol. 80, pp. 75–106). http://doi.org/10.1112/S0024611500012132 http://www.ada.org/en/~/media/ADA/Advocacy/Files/anesthesia_use_guidelines

[9] American Dental Association. (2012). Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. In ADA (Ed.), (pp. 1–18). Chicago. Retrieved from: http://www.ada.org/en/~/media/ADA/Member Center/Files/anxiety guidelines

[10] Commission on Dental Accreditation: (2012). Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery. Retrieved from https://www.ada.org/~/media/CODA/Files/oms.pdf?la=en

AREAS OF COMPARISON

Permitting of Practice Locations

For the majority of states, including California, the permit to administer sedation or general anesthesia is assigned to the individual dentist and not to a facility. The California Dental Board maintains broad authority over its licensees and may conduct an inspection of any dental facility at its own discretion. Although the majority of states, including California, require a periodic facility inspection, only a single facility utilized by the permit holder is usually inspected. The permit holder is assigned the responsibility for assuring that all facilities where sedation is administered are appropriately equipped and staffed as required by law.

The Board identified nine (9) states that require permitting individual practice locations in addition to the dentist. This has the advantage of assuring that facilities are properly equipped, but requires a significantly greater number of inspections. In contrast, the Medical Board of California is responsible for the accreditation of all locations where sedation or anesthesia, other than local anesthesia, is administered. Accreditation is done by three different board approved accrediting entities. Practitioners are approved to administer sedation or anesthesia by the individual facility instead of by the regulatory board. For a discussion of the regulatory structure of outpatient facilities in California see the 2015 report from Klutz Consulting.[11]

Education

Minimal Sedation/Anxiolysis

Minimal sedation is defined as the administration of a dose of a drug to a patient that does not exceed the FDA recommended maximum dose for unmonitored home use. Minimal sedation is not defined in the California sedation laws and a permit to administer minimal sedation is not required. Training in minimal sedation, including the administration of a mixture of nitrous oxide and oxygen, either alone or in combination with minimal oral sedation, may be taught to the level of basic competency at the predoctoral (dental school) level. Nineteen (19) states require completion of a 16-hour course prior to issuing a minimal sedation permit.

Moderate sedation

Dental practice acts in most states specify that moderate sedation is regulated by route of administration. Sixteen states have recently adopted uniform educational standards for moderate sedation regardless of route of administration.

[11] Outpatient Surgery Services in California: Oversight, transparency and quality. B&R Klutz Consulting, 2015. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20S/PDF%20Sacto07292015OutpatientSurgeryKlutz.pdf; accessed 6/16/2016.

Oral (moderate) Conscious Sedation Certification for Adults/Minors

To obtain a California permit for administration of Oral (moderate) Conscious Sedation Certification for Adults/Minors the applicant must have completed an approved post doctoral or residency training program that includes sedation training; or, a board approved course that includes 25 hours of instruction including a clinical component utilizing at least one age-appropriate patient; training for either adult patients or minor patients (13 or younger); training requirements reference the ADA and AAP-AAPD definitions of levels of sedation.(See BPC 1647.12; CCR 1044-1044.5.)

Moderate Parenteral Sedation

In California, to obtain a moderate IV conscious sedation permit, the applicant must complete at least 60 hours of instruction and 20 clinical cases of administration of parenteral (intravenous) conscious sedation for a variety of dental procedures. The course must comply with the requirements of the *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry* of the American Dental Association as approved by the Board (see BPC 1647.3) The majority of states (37/50) require similar training, also to ADA standards; five states (5) require completion of fewer clinical cases or hours of instruction and four (4) states require more. All states accept proof of completion of a CODA accredited residency program that includes sedation training in lieu of course completion.

California, as well as other states, limit moderate sedation providers to utilizing drugs and techniques that have a margin of safety wide enough to render unintended loss of consciousness unlikely. A few states restrict moderate sedation permit holders from using potent anesthetics such as propofol, methohexital, and ketamine.

General Anesthesia

Educational requirements for a general anesthesia permit issued by the Dental Board of California include either completion of a one year of advanced training in anesthesiology and related academic subjects approved by the Board or equivalent experience as determined by the Board (BPC Section 1646). This requirement is further defined in regulation (CCR Section 1043.1) to include either a one year residency in anesthesiology or completion of a Commission on Dental Accreditation (CODA) approved graduate program in oral and maxillofacial surgery.[12] Although this requirement is generally consistent with the laws in the other 49 states there are some variations. For example, some states require completion of either a two year residency in

[12] Commission on Dental Accreditation: (2012). Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery. Retrieved from https://www.ada.org/~/media/CODA/Files/oms.pdf?la=en

dental anesthesiology or a residency in oral and maxillofacial surgery. Other states require completion of at least 3 years of an oral and maxillofacial residency; others require board certification, but most states (33/50) require completion of an advanced residency education program accredited by the CODA that includes training to competency in general anesthesia. The subcommittee was unable to identify a state that restricts a general anesthesia permit holder from using any anesthetic agent, including inhalation agents such as Sevofluorane and the intravenous agent propofol.

ADVANCED EDUCATIONAL PROGRAMS THAT INCLUDE SEDATION TRAINING

Commission on Dental Accreditation (CODA) Accreditation of Advanced Educational Programs

CODA accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Accreditation standards are developed in consultation with those affected who represent broad communities of interest. CODA was established in 1975 and is nationally recognized by the United States Department of Education (USDE) as the sole agency to accredit dental and dental-related education programs conducted at the post-secondary level. A comparison table of CODA accreditation standards for advanced residency programs that include training in sedation and general anesthesia is attached, see **Appendix 1** "**Educational programs that include training in moderate sedation, deep sedation, and general anesthesia".**

American Dental Association (ADA) Educational Guidelines

The ADA "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students" are educational guidelines published by the ADA for programs and courses that teach sedation techniques.[13] These Guidelines have been revised periodically but have been relatively consistent for the past 16 years. The Guidelines for teaching moderate sedation are summarized below. The Guidelines do not address training in deep sedation and general anesthesia and defer to the CODA standards for advanced educational programs, stating that these are advanced specialty techniques. The ADA educational guidelines are summarized as follows:

[13] American Dental Association. (2012). Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. In ADA (Ed.), (pp. 1–18). Chicago.

Moderate Enteral Sedation

- a minimum of 24 hours of instruction plus management of at least 10 adult case experiences (at least 3 live patients in groups no larger than 5 with remainder being on mannequins or by virtual reality)
- participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management to prevent office emergencies
- clinical experience is provided in managing healthy adult patients
- course is not designed for the management of children (age 12 and under)
- additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults (ASA PS II-IV) and special needs patients

Moderate Parenteral Sedation

- a minimum of 60 hours of instruction plus management of at least 20 patients by the intravenous route per participant is required to achieve competency in moderate parenteral sedation.
- participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management for prevention of emergencies
- typically clinical experience provided in managing healthy adult patients (not ASA PS II-IV)
- additional supervised clinical experience is necessary to prepare participants to manage children (age 12 and under) and medically compromised adults.

Continuing Education Requirements

Forty seven states, including California, require general anesthesia permit holders to maintain current certification in Advanced Cardiac Life Support (ACLS). The majority of states, other than California, also require moderate sedation permit holders to complete ACLS. Seventeen states require completion of a Pediatric Advanced Cardiac Life Support (PALS) course usually in practices where children are treated. California does not presently require completion of PALS training. Some professional association guidelines, including the AAP-AAPD Guidelines, recommend completion of PALS training.

Twenty nine states (29), including California, require completion of continuing education courses as a condition of renewal of a sedation or anesthesia permit. Most states require continuing education specifically related to sedation or anesthesia. California requires the completion of 25 hours of anesthesia related continuing education every two years for a general anesthesia permit, the most of any state, and requires 12 hours per renewal for conscious sedation and seven hours for oral sedation. California's continuing education requirements therefore exceed those of most other states.

Preoperative Evaluation

California law requires a preoperative evaluation for all patients undergoing sedation or anesthesia prior to each administration of sedation or anesthesia. This includes an adequate medical history and a focused physical evaluation recorded and updated as indicated. Records must include but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists Classification I-V), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required (CCR Section 1043.3). All other states reviewed have equivalent or lesser requirements.

Personnel

California law requires patients undergoing sedation or anesthesia to be monitored on a one-on-one ratio until fully recovered. In contrast, thirty three (33) other states require that a prescribed number of staff members be present during administration of sedation or general anesthesia. The American Dental Association Guidelines and AAP-AAPD Guidelines recommend that a minimum of two persons, in addition to the dentist, are present whenever general anesthesia or deep sedation is administered; one person in addition to the dentist should be present for the administration of moderate or minimal sedation.

Staff Training and Qualifications

Nearly all states (44/50) including California, require dental assistants to maintain current certification in basic cardiac life support, and most require completion of a provider CPR course that includes use of the AED. Although dental assistants may assist with dental treatment, including sedation and anesthesia care under supervision, practice acts in most states prohibit the administration of anesthesia, other than local anesthesia, by dental assistants or dental hygienists.

Twenty nine (29) states require that an individual be designated to monitor patients undergoing sedation or anesthesia, to observe vital signs including pulse, blood pressure, oxygenation, ventilation and circulation. Fourteen states (14), including California, specify the duties and education for dental assistants participating in sedation and anesthesia care.

California law (BPC Section 1750) specifies that:

" the supervising dentist shall be responsible for determining the competency of the dental assistant to perform basic supported dental procedures as defined, that include monitoring patient sedation, limited to reading and transmitting information from patient monitors, as specified, for the purpose of interpretation and evaluation by the supervising dentist, who "shall be present at chairside during the procedure."

In addition, the supervising dentist is responsible for ensuring that assistants in his or her employ complete required courses, including California law, infection control, and an approved CPR course.

Specialty Training for Dental Assistants

Since 1967, The California Association of Oral and Facial Surgeons has sponsored a training course for dental assistants. The course consists of 24 hours of didactic education, including 10 hours of lecture, completion of progress exams and 14 hours of home study followed by completion of a written exam. Upon successful course completion the assistant is provided with a certificate of completion. A similar course for assistants is offered by the AAOMS but includes a psychometrically validated exam given at secure testing centers.

Dental assistants may complete a Dental Sedation Assisting Course following one year of employment (BPC Sections 1750.4, 1750.5). This course must be approved by the Board and requires completion of 40 hours of didactic education, 28 hours of laboratory instruction and 20 supervised cases that involve sedation or general anesthesia. The assistant may apply to take a secure exam which may qualify them for licensure as a dental sedation assistant (CCR Section 1070.8). The course requires completion of a minimum of 110 hours of education, over four times that required by any other state.

Approved training for sedation assistants in five states consists of the satisfactory completion of courses offered by professional associations such as the AAOMS or the ADSA that require approximately 24 hours of education. We were unable to identify any state that requires the presence of a registered nurse or other medical professional during sedation or anesthesia for dental treatment. We were unable to identify any state that requires the presence of an individual dedicated to both the monitoring and administration of anesthesia or sedation who is not involved in the procedure.

Facilities

State laws specify facility requirements such as a treatment room of adequate size to accommodate the patient and three individuals, adequate lighting, a power operated chair or table, suction, a supply of oxygen, and appropriate backup systems to allow completion of a procedure in the event of a power failure. These requirements are relatively uniform for all states the subcommittee reviewed.

Monitors and Ancillary Equipment

State laws generally require the dentist to equip the treatment room with the appropriate patient monitors and to possess the ancillary equipment necessary to provide safe anesthesia and sedation. Required equipment varies depending on the level of sedation, with additional monitors such as the electrocardiogram (ECG), a defibrillator, and capnography usually

required for general anesthesia but not for moderate or minimal sedation. California's requirements are consistent with those of other states as well as with the recommendations included in professional association guidelines.

Records

State laws specify the records that must be maintained for sedation and anesthesia, including a time dependent record of pulse, blood pressure, oxygen saturation, ECG where appropriate, the doses of medications administered and the time they are given, and any complications. Monitoring of exhaled carbon dioxide is an emerging trend, and this is now required in twenty (20) states not only for deep sedation and general anesthesia but also for moderate sedation. In California monitoring of exhaled CO2 is mandatory only for patients who require endotracheal intubation.

Informed Consent

A written consent form must be completed and signed by the patient, parent or legal guardian prior to the administration of anesthesia or sedation in California as well as other states.

Discharge

State law requires an evaluation of the patient by a qualified person prior to discharge, and notation of their condition in the treatment record. California requires this evaluation notation as do most other states.

Drugs Necessary for the Treatment of Medical Emergencies

State laws require the dentist to possess the drugs necessary for the treatment of medical emergencies and to have the knowledge and ability to use these drugs. The specific medications necessary for the management of sedation and anesthesia related emergencies are listed in the sedation laws of the majority of states, as well as in professional association guidelines. These include medications necessary for the treatment of allergic reactions, respiratory emergencies, cardiac conditions including cardiac arrest, diabetic conditions, high blood pressure, low blood pressure, and antidotes (reversal agents) for sedatives and narcotics. Medications for the treatment of malignant hyperthermia are required where appropriate. Additional medications are usually required when general anesthesia is administered as compared to moderate or minimal sedation. The medications required in California are consistent with those required in other states and recommended by professional association guidelines.

Office Inspections

California, along with 37 other states, requires the state board to conduct an inspection of dental offices where moderate sedation and general anesthesia are given. Inspections are not usually required for offices where minimal sedation or nitrous oxide/oxygen alone are utilized.

Dentists with permits for minimal or moderate enteral sedation are required to certify that they possess the specified equipment and emergency drugs and are capable of managing emergencies.

Facilities such as ambulatory care centers and hospitals where dental treatment may occur are usually accredited and licensed by other state agencies or accrediting organizations.

Most states require an inspection of dental offices by the board of dentistry every five (5) years. The inspection is either very similar to either the process utilized by the California Dental Board or the similar process described in the AAOMS Office Evaluation Manual. The office inspection requires two peer evaluators appointed by the board to inspect the facility, equipment, and emergency drugs. The evaluators must observe at least one clinical case performed by the dentist and his or her staff appropriate for the type of permit they possess. The inspection requires the dentist and his or her team to physically demonstrate the performance of up to thirteen (13) simulated emergencies. The simulated emergencies include airway obstruction, laryngospasm, bronchospasm, respiratory depression, scenarios that are widely recognized as being among the most significant complications of sedation and anesthesia. In addition the dentist and his or her team must demonstrate their skills in basic CPR and for general anesthesia permit holders advanced cardiac life support. This provides the evaluation team with an opportunity to assess the competency of sedation/anesthesia providers in their own facilities and with their own team members, including team dynamics, closed loop communication, and appropriate activation of emergency backup from first responders.

Inspections are usually graded on a pass/fail basis and the results are reported for a final determination by the board. A failing grade requires the inspection to be repeated and a second failure usually results in denial of the permit to administer sedation or general anesthesia.

Pediatric Sedation Requirements

States have taken differing approaches to the regulation of pediatric sedation. Twenty five states, including California have included special requirements for young patients. California requirements apply to patients age 13 or under. An increasing number of states have adopted pediatric sedation educational requirements and permits over the past 10 years.

Nine states (California, Colorado, Florida, Georgia, Kentucky, Louisiana, Missouri, Mississippi, and North Carolina) require a permit for sedating pediatric patients. Sixteen states require specific training to administer moderate/conscious sedation to pediatric patients. Twenty-five states have specific requirements for pediatric sedation administered by the oral route.

A number of states define the pediatric patient as under the age of 12 consistent with ADA Guidelines; however other states use 13, 14, 16 and 18 years of age. Most states, including California, specify that the practitioner must have appropriately sized equipment for pediatric patients. In most states Advanced Cardiac Life Support (ACLS) certification is deemed sufficient for treating pediatric patients; Twenty states currently require Pediatric Advanced Life Support (PALS) certification. California does not presently require certification in PALS.

Although ten states have adopted the AAP-AAPD Guidelines, these apply to minimal and moderate sedation only. The subcommittee was unable to identify any state that requires an individual dedicated to monitoring and administration of deep sedation or general anesthesia for children or adults.

Utilization of Certified Registered Nurse Anesthetist's (CRNA's) and Physician (MD) Anesthesiologists

All states allow anesthesia to be provided in dental offices by CRNA's and physician anesthesiologists. For some states it is difficult to determine the requirements for non-dentist anesthesia providers because they may be regulated by nursing and medical practice acts, not the dental practice act. The subcommittee felt that other professional practice acts were beyond the scope of this review.

Twenty nine states, including California, require a dentist who orders the administration of sedation or anesthesia by a CRNA to possess either a moderate sedation or general anesthesia permit issued by the board that corresponds to the level of sedation administered. A number of states, including California, require a physician anesthesiologist to obtain a permit from the Dental Board if they administer sedation or anesthesia in a dental office.

SUMMARY OF COMPARISON OF CALIFORNIA LAWS AND REGULATIONS TO OTHER STATES

California's laws and regulations for dentists providing general anesthesia and moderate sedation are generally consistent with laws in other states in the following areas:

- Education
- Preoperative evaluation
- Facility
- Monitoring and Equipment
- Records
- Emergency Drugs
- Office inspection
- Pediatric and adult oral conscious sedation

California's laws and regulations differ from those in other states in the following areas:

- Personnel
- Preoperative dietary instructions
- Pediatric moderate sedation (Pediatric Oral Conscious Sedation Permit)

DISCUSSION OF DIFFERENCES

- **Personnel**

California does not require the presence of a specific number of staff for general anesthesia and moderate sedation. Thirty three states specify that there be at least two persons be present, in addition to the dentist, when general anesthesia is administered, and thirty one states specify that at least one person be present when moderate sedation is administered.

In addition, twenty nine states require the presence of a designated anesthesia monitor. Fourteen states specify training requirements for the sedation monitor, usually completion of an educational program offered by a professional association such as the AAOMS or ADSA.

- **Preoperative Dietary Instructions**

California does not presently require that instructions for pre-operative fasting be given. Approximately ten states require instructions based on the planned level of sedation similar to those described in the ADA Guidelines. The ADA Guidelines recommend that preoperative dietary restrictions be considered based on the sedative technique prescribed. Some states require instructions that are consistent with those for general anesthesia, usually according to the "2-4-6" rule, with no oral intake for 2 hours prior to sedation for liquids, 4 hours for breast milk, and 6 hours for solids.

- **Pediatric Sedation**

Although thirty three states have requirements for dentists who administer pediatric sedation, these vary, ranging from completion of a PALS course to completion of an advanced residency education program in pediatric dentistry. Requirements usually include training in pediatric oral sedation similar to California. Ten states, including California, issue a permit to dentists who administer sedation to children under thirteen, most often for moderate parenteral sedation.

For a state-by-state comparison of pediatric sedation regulations see Appendix 2, Table 10.

PROFESSIONAL DENTAL ASSOCIATION GUIDELINES, POSITION PAPERS AND POLICY STATEMENTS

The dictionary definition of "guideline" is "general rule, principle, or piece of advice." Guidelines come in the form of "Statements," "Practice Advisories," "Clinical Policies," or "Recommendations." These documents range from broad descriptions of appropriate monitoring and treatment to those offering specific guidelines on the use of particular drugs or techniques. The guidance documents reviewed by the subcommittee were developed by professional associations.

The subcommittee's charge was to review state laws and association policies from the dental profession, not the medical profession. However, due to requests from stakeholders, the subcommittee addressed requests from all interested parties including the American Academy of Pediatrics and the California Society of Anesthesiologists.

Guidelines and position papers reviewed include:

- American Dental Association *"Guidelines for Use of Sedation and General Anesthesia By Dentists"*
- American Academy of Pediatrics-American Academy of Pediatric Dentistry "*Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures" .*
- American Academy of Pediatrics "*Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*"
- American Society of Anesthesiology – " *Standards for Basic Anesthetic Monitoring*". *Oct 2015*.
- ASA *"Statement on the Anesthesia Care Team"*
- ASA "*Statement on Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation"*
- American Dental Association *"Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students"*
- American Society of Anesthesiology: *"Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists".*
- American Society of Anesthesiology: "*Advisory on Granting Privileges for Deep Sedation to Non-Anesthesiologists Sedation Providers*."

The Center for Medicare and Medicaid Services (CMS) includes dentists among practitioners who are authorized to administer anesthesia under the *Hospital Anesthesia Services Condition of Participation 42 CFR 482.52(a).* CMS Conditions of Participation are federal regulations that describe the health and safety requirements for hospitals and ambulatory surgery centers that participate in the Medicare and Medicaid programs.

The American Academy of Pediatrics submitted the "Guidelines for Monitoring and Management of Pediatric Patients Before, during and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016" for review. This document is fundamentally the same document adopted by the American Academy of Pediatric Dentistry and will therefore not be addressed separately. As previously noted, The California Society of Anesthesiologists submitted three documents for review.

Guidelines for general anesthesia and sedation utilized by dentists are published by the American Dental Association (ADA) as the "Guidelines for Use of Sedation and General Anesthesia By Dentists" and "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students". For children 12 years of age and under, the American Dental Association supports the use of the "American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures" (AAP-AAPD Guidelines)[14] . These guidelines are directed toward all dentists treating children and are not limited to members of specialty organizations or specific professional associations. Both the ADA and the AAP-AAPD Guidelines are currently undergoing revision.

Guidance documents are also published by dental specialty associations, including the American Association of Oral and Maxillofacial Surgeons and the American Society of Dentist Anesthesiologists, that are directed to their members. [15] [16]

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[14] Coté, C. J., & Wilson, S. (2016). Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016. *Pediatrics*, *138*(1), 1–87. http://doi.org/10.1542/peds.2016-1212

[15] AAOMS. (2012). Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012).

[16] American Society of Dentist Anesthesiologists. (2013). American Society of Dentist Anesthesiologists Parameters of Care The Continuum of Sedation and Anesthesia, 1–13.

State dental associations such as the California Dental Association usually incorporate American Dental Association documents by reference into their own guidance documents and do not develop their own. However there are exceptions such as Pennsylvania.

The methodologies used to develop guidelines vary from organization to organization. For example, The American Dental Association Guidelines for the Use of Sedation and Anesthesia by Dentists and the American Academy of Pediatrics – American Association of Pediatric Dentists Guidelines are based on a careful consideration of the available literature and expert opinion. The exact nature of how studies were weighted and how conclusions were drawn is not explicitly described.

Guideline Development Process

There are many publications that describe the clinical guideline development process and full discussion of this topic is beyond the scope of this report. To summarize, the process begins by defining a clinical question. Related evidence is identified through a systematic review of the scientific literature. The quality of evidence is assessed and data are extracted and classified according to the strength of the evidence. When there is insufficient evidence expert opinion is used as a basis for recommendations, however opinion is usually given less weight than results of studies and opinion may be subject to bias. There is currently no optimal process for the assessment of opinion, and the process utilized should be as explicit as possible. In addition to scientific evidence and expert opinion, guidelines must take into account resource implications and the feasibility of interventions. Judgments about whether the costs of tests or treatment are reasonable may depend on the perspective taken, for example clinicians may view cost considerations differently than would payers or the public. Feasibility issues include time, skills staff and equipment necessary for the provider to carry out the recommendations, and the ability of the system of care to implement them.[17] None of the guidelines reviewed by the subcommittee addressed resource considerations or feasibility considerations.

American Dental Association Guidelines

The ADA *Guidelines for the Use of Sedation and General Anesthesia by Dentists* and the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (Sedation and Anesthesia Guidelines) are policy of the ADA and receive final approval by the ADA House of Delegates.

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[17] Shekelle, P. G., Woolf, S. H., Eccles, M., & Grimshaw, J. (1999). Clinical guidelines: developing guidelines. *BMJ (Clinical Research Ed.)*, *318*(7183), 593–596. http://doi.org/10.1136/bmj.318.7183.593

According to the ADA Constitution and Bylaws, the Council on Dental Education and Licensure (CDEL) has subject matter authority for dental anesthesiology and sedation and recommends regular proposed revisions to the Board of Trustees and House of Delegates, with the House of Delegates as the final authority. CDEL's Anesthesiology Committee, comprised of seven sedation and anesthesiology experts and chaired by a CDEL member, develops recommendations for CDEL's consideration using available literature, policies and guidelines of other national health care organizations and expert opinion. All proposed revisions of the Sedation and Anesthesia Guidelines are circulated to anesthesiology communities of interest; comments are invited from any individual or organization.

American Academy of Pediatric Dentistry Guidelines

The AAPD's guideline development process is outlined in an overview statement outlined in their reference manual posted on their website.[18] Guidelines are defined as:

"Systematically developed recommendations designed to assist the practitioner, patient, and caregiver in making decisions relating to specific clinical situations. Guidelines are intended to be more flexible than standards. Guidelines should be followed in most cases, but they recognize that treatment can and should be tailored to fit individual needs, depending on the patient, practitioner, setting, and other factors. Deviations from guidelines could be fairly common and could be justified by differences in individual circumstances. Guidelines are designed to produce optimal outcomes, not minimal standards of practice."

The AAPD Council on Clinical Affairs (CCA) is charged with the development of oral health policy guidelines. Oral health policies and clinical guidelines utilize two sources of evidence: the scientific literature and experts in the field. CCA, in collaboration with the Council on Scientific Affairs, performs a comprehensive literature review for each document. When scientific data do not appear conclusive, experts may be consulted. The CCA's recommendations are submitted to AAPD's Board of Trustees for review, with eventual approval at the AAPD's General Assembly.

In the case of the current *American Academy of Pediatrics-American Academy of Pediatric Dentistry Guidelines for the Monitoring and Management of Pediatric Patients Before, during and After Sedation for Diagnostic and Therapeutic*

[18] American Academy of Pediatric Dentistry. (2011). Definitions and scope of pediatric dentistry. *Reference Manual*, *33*(6), 2–349. Retrieved from http://www.aapd.org/media/Policies_Guidelines/Intro1.pdf.

Purposes [19], the guidelines are developed jointly by the both organizations. Physician anesthesiologists and other pediatric medical specialists are involved in the development of the document, as are AAPD specialists in dentist-administered anesthesia. Non-member dentists, representatives from outside organizations, and members of the public may attend AAPD reference committee hearings where a draft document is being considered before adoption and may ask to speak or provide testimony on any details of the proposed guideline.

The AAP-AAPD Guidelines were last submitted to the ADA House of Delegates for consideration in 2012. The ADA House of delegates voted to support the AAP-AAPD Guidelines for the dental treatment of children under twelve. This approach to policy for the treatment of children has been utilized by the ADA for many years.

Guidelines of the American Society of Anesthesiologists (ASA) and American College of Emergency Physicians (ACEP) are founded on an evidence based review of the sedation literature and the methodologies are quite explicit. Even in these cases the lack of definitive or comparative data on outcomes of sedation necessitate that many of the guidelines are based on "consensus" rather than "evidence".[20] The ASA represents approximately 35,000 practicing anesthesiologists in the United States. Anesthesiology is recognized as a leading specialty of medicine in the field of patient safety research, particularly as it relates to sedation and general anesthesia. Sedation guidance documents in all branches of the healing arts are heavily influenced by standards and guidelines established by ASA.

The ASA periodically publishes guidance documents on a wide variety of topics related to sedation and anesthesia. The ASA Committee on Standards and Practice Parameters, other ASA committees, and task forces periodically collect evidence to determine whether new or existing practice guidelines are needed. The Committee develops these documents, which are then approved by a vote of the ASA membership at the ASA House of Delegates annual meeting.

[19] Coté, C. J., & Wilson, S. (2016). Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016. *Pediatrics*, *138*(1), 1–87. http://doi.org/10.1542/peds.2016-1212

[20] Cravero, J.P: Sedation Policies, Recommendations and Guidelines Across the Specialties and Continents. In, K.P. Mason (ed.), *Pediatric Sedation Outside of the Operating Room: A Multispecialty International Collaboration*, 17.DOI 10.1007/978-1-4939-1390-9_2, © Springer Science+Business Media New York 2015

ASA Standards, Guidelines, Statements and Practice Parameters[21] provide guidance to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. They are not intended as unique or exclusive indicators of appropriate care. The interpretation and application of Standards, Guidelines and Statements takes place within the context of local institutions, organizations and practice conditions. A departure from one or more recommendations may be appropriate if the facts and circumstances demonstrate that the rendered care met the physician's duty to the patient.

Standards provide rules or minimum requirements for clinical practice. They are regarded as generally accepted principles of patient management. Standards may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment.

Guidelines are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and analysis of the current literature, expert opinion, open forum commentary, and clinical feasibility data.

Statements represent the opinions, beliefs, and best medical judgments of the House of Delegates. As such, they are not necessarily subjected to the same level of formal scientific review as ASA Standards or Guidelines. Each ASA member, institution or practice should decide individually whether to implement some, none, or all of the principles in ASA statements based on the sound medical judgment of anesthesiologists participating in that institution or practice.

Practice parameters provide guidance in the form of requirements, recommendations, or other information intended to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. The use of practice parameters cannot guarantee any specific outcome. Practice parameters are subject to periodic revision as warranted by the evolution of medical knowledge, technology and practice. Variance from practice parameters may be acceptable, based upon the judgment of the responsible anesthesiologist.

[21] American Society of Anesthesiologists. Resources, Clinical information, https://www.asahq.org/resources/clinical-information, accessed 7/7/2016.

Practice advisories are systematically developed reports that are intended to assist decision-making in areas of patient care. Advisories provide a synthesis and analysis of expert opinion, clinical feasibility data, open-forum commentary, and consensus surveys. Practice Advisories developed by the American Society of Anesthesiologists (ASA) are not intended as standards, guidelines, or absolute requirements, and their use cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies.

Practice Advisories are not supported by scientific literature to the same degree as standards or guidelines because of the lack of sufficient numbers of adequately controlled studies. Practice Advisories are subject to periodic update or revision as warranted by the evolution of medical knowledge, technology, and practice.

The subcommittee reviewed three documents submitted by the California Society of Anesthesiologists, including :

- *Statement on Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation*
- *The ASA Statement on the Anesthesia Care Team*
- *ASA Standards for Basic Anesthesia Monitoring.*

The subcommittee reviewed the following definitions published by the ASA that apply to these statements.[22]

1.1 Anesthesia Professional: An anesthesiologist, anesthesiologist assistant (AA), or certified registered nurse anesthetist (CRNA).

1.2 Non-anesthesiologist Sedation Practitioner: A licensed physician (allopathic or osteopathic); or dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; who has not completed postgraduate training in anesthesiology but is specifically trained to administer personally or to supervise the administration of deep sedation.

[22] American Society of Anesthesiologists. (2010). Advisory on granting privileges for deep sedation to non-anesthesiologist sedation practitioners. Retrieved from aspx.\nhttp://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/advisory-on-granting-privileges-for-deep-sedation-to-non-anesthesiologist.pdf

1.3 Unrestricted general anesthesia shall only be administered by anesthesia professionals within their scope of practice (anesthesiologists, certified registered nurse anesthetists and anesthesiologist assistants).

National Guidelines Clearinghouse

The U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality hosts the National Guidelines Clearinghouse. The Clearinghouse maintains a database of guidelines that must meet inclusion standards. Clinical practice guidelines must be submitted by a medical specialty association, relevant professional society, government, or healthcare organization and must be based on a systematic review of evidence that is intended to assist practitioners and patients with decisions for specific clinical circumstances. [23] None of the professional association guidance documents we reviewed are listed by the Clearinghouse. It is unclear whether or not they met inclusion criteria or were submitted for consideration by the Clearinghouse.

DISCUSSION OF DIFFERENCES AND SIMILARITIES BETWEEN CALIFORNIA LAWS AND THE ADA AND AAP-AAPD GUIDELINES

A side by side comparison table of California's dental sedation laws, the American Dental Association Guidelines and the AAP-AAPD Guidelines is provided as Appendix 2. Although these guidelines are not recognized by all states they come close to establishing national parameters for sedation and anesthesia care for the dental profession. Other professional dental association guidelines include similar information that appears to be directed toward a specific association membership. The following guidance documents are provided for reference but are not included in the comparison tables.

1. American Association of Oral and Maxillofacial Surgeons, Parameters of Care, Clinical Guidelines
2. American Society of Dentist Anesthesiologists Parameters of Care

Comparison tables to show differences and similarities between California laws and the ADA and AAP-AAPD Guidelines are organized by topic. Please see Appendix 2, Tables 1-9.

Area of comparison

- Definitions Table 1
- Education Table 2

[23] Inclusion Criteria, National Guideline Clearinghouse, https://www.guideline.gov/about/inclusion-criteria.aspx

- Preoperative Evaluation Table 3
- Preoperative dietary instructions Table 3
- Personnel Table 4
- Facility Table 5
- Monitoring and Equipment Table 6
- Records Table 7
- Emergency Drugs Table 8
- Office Inspection Table 9

SUMMARY OF DIFFERENCES AND SIMILARITIES BETWEEN CALIFORNIA LAWS AND THE ADA AND AAP-AAPD GUIDELINES

Areas where California requirements are consistent with professional guidance documents include:

- Preoperative evaluation
- Facility
- Monitoring and equipment
- Records
- Emergency drugs
- Office inspection

Areas where California requirements are different:

- Monitoring
- Personnel
- Education
- Preoperative fasting

DISCUSSION OF AREAS WHERE CALIFORNIA REQUIREMENTS ARE DIFFERENT FROM PROFESSIONAL GUIDANCE DOCUMENTS

Monitoring

The ADA Guidelines are prescriptive and state which monitors should be used for each level of sedation. The ASA Standards for Basic Anesthetic Monitoring use a similar approach.[24]

The ADA guidelines specify that ECG monitoring should be considered during moderate sedation for patients with cardiovascular disease and that use of the ECG is required for

[24] American Society of Anesthesiology. Standards for Basic Anesthetic Monitoring. *Oct 2015*.

patients receiving general anesthesia. They also state when an intravenous line must be established, and how ventilation and respiration are monitored.

In contrast, California law states the dentist must possess the necessary equipment, but leaves the use of the equipment to the discretion of the dentist. The use of a pulse oximeter is required for all levels of sedation. California law specifies the records that must be maintained and specifies the recording intervals for vital signs. It would be impossible for the dentist to maintain the required records without monitoring, therefore adding a specific monitoring requirement for vital signs and pulse oximetry might be considered redundant. Capnography is required for intubated general anesthesia only which is consistent with ADA guidelines. ASA monitoring standards indicate capnography is required for all patients undergoing sedation or anesthesia.

The AAP-AAPD Guidelines follow a similar approach to that used by California and list the drugs and equipment that should be present and available and which records should be maintained, but does not state which monitors or techniques must be used. California law is consistent with AAP- AAPD Guidelines in this area.

The ASA *Statement on Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation* includes the following language:

"Nonanesthesiologist physicians may neither delegate nor supervise the administration or monitoring of deep sedation by individuals who are not themselves qualified and trained to administer deep sedation, and the recognition of and rescue from general anesthesia."

California law permits delegation of limited monitoring duties to dental assistants, but does not permit delegation of the administration of sedation or anesthesia other than nitrous oxide and oxygen. Trained and licensed assistants may assist with sedation or anesthesia as specified. ADA Guidelines and AAP-AAPD Guidelines also describe the role of personnel who may monitor moderate sedation as well as deep sedation/general anesthesia, although the qualifications of these personnel are not specifically addressed, but must be appropriately trained and qualified.

The *ASA Statement on the Anesthesia Care Team* indicates that although the Anesthesia Care Team may include non-physicians, the Team should be directed by an anesthesiologist.

California law does not presently require the presence of an anesthesiologist in a dental office where anesthesia is given and authorizes dentists who hold a general anesthesia permit to administer deep sedation/general anesthesia. The AAP-AAPD Guidelines address the

administration of deep sedation and general anesthesia in dental facilities such as dental offices through a description of the necessary skills and qualifications. For facilities that function under a department of anesthesiology the AAP-AAPD guidelines defer to the ASA policies implemented by the department.

The *ASA Standards for Basic Anesthesia Monitoring* describe which monitors should be used for the different levels of sedation and general anesthesia, and indicate that there should be continuous monitoring with and ECG, pulse oximeter, capnograph and blood pressure recorded every five minutes.

Current California law requires continuous pulse oximetry for all levels of sedation and anesthesia. Although an ECG must be available for dentists who administer general anesthesia, its use is not required. Vital signs must be recorded at 5 minute intervals. Dentists who administer moderate sedation are not required to possess or use an ECG or capnograph, and must record vital signs at regular intervals. The ADA Guidelines specify continuous ECG monitoring for patients receiving deep sedation or general anesthesia, but do not indicate mandatory use of capnography except for intubated patients or those receiving volatile agents. The AAP-AAPD Guidelines indicate that monitors must be available.

Personnel

California does not require that a specific number of staff be present for general anesthesia or moderate sedation. Both the ADA and AAP-AAPD Guidelines specify that there be two persons present in addition to the dentist for general anesthesia or deep sedation, and at least one other person for sedation. The AAP-AAPD Guidelines specify the presence of one person whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration, for deep sedation/general anesthesia. California, like other states, does not have specific requirements for pediatric deep sedation or general anesthesia other than possession of a general anesthesia permit.

Education

California's educational requirements for moderate sedation, adult and pediatric oral conscious sedation (OCS), conscious sedation, and general anesthesia permits are consistent with the ADA Guidelines but differ from the corresponding ADA educational guidelines in several areas. See Appendix 2, Table 2 for a side by side comparison.

- Adult oral conscious sedation permits - California law requires one patient experience. ADA Guidelines recommends three patient experiences.

- Pediatric sedation - In California there are specific training requirements for the Oral Conscious Sedation for Minors permit. The ADA Guidelines specify that additional experience should be required for sedating pediatric patients.
- California does not have age specific requirements for sedation administered via parenteral routes or for ~~p~~ediatric deep sedation/general anesthesia. The ADA and AAP-AAPD also do not provide specific pediatric sedation training requirements and defer to CODA accreditation standards for advanced education.
- California law does not require completion of PALS for dentists who sedate pediatric patients. The value of the PALS course for sedation providers may be limited. A course dedicated to pediatric sedation that focuses on airway management, preferably with a patient simulator component, may be more appropriate.

Preoperative Dietary Instructions

- California does not specify that preoperative dietary instructions be given. ADA Guidelines state that dietary precautions should be considered based on the sedative technique prescribed. The AAP-AAPD Guidelines include the following statement:
- *"the practitioner should evaluate preceding food and fluid intake, ….but because the absolute risk of aspiration during procedural sedation is not yet known, guidelines for fasting periods before elective sedation generally should follow those used for elective general anesthesia. For emergency procedures in children who have not fasted, the risks of sedation and the possibility of aspiration must be balanced against the benefits of performing the procedure promptly. Further research is needed to better elucidate the relationships between various fasting intervals and sedation complication".*
- The 2016 draft ADA guidelines incorporate the ASA Practice Guidelines on Preoperative Fasting by reference.[25]

[25] American Society of Anesthesiologists Committee on standards and practice parameters. (2011). Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures: an updated report by the American Society of Anesthesiologists Com. *Anesthesiology*, *114*(3), 495–511. http://doi.org/10.1097/ALN.0b013e3181fcbfd9

PART 2: LITERATURE REVIEW - SEDATION AND GENERAL ANESTHESIA FOR PEDIATRIC DENTAL PATIENTS

The published literature on pediatric sedation and anesthesia is extensive and a comprehensive review is beyond the scope of this assignment. This section should be considered an overview, not an in depth analysis of the available literature.

The subcommittee considered a number of approaches to a literature review, including an evidence based systematic review. The subcommittee found that recent systematic reviews of the pediatric sedation literature have been completed, although not in the United States.[26] Because there is insufficient evidence to support recommendations for some aspects of pediatric sedation most guidance documents must also rely on a consensus of opinion. This reduces the strength of certain recommendations. Controversies nearly always involve differences of opinion that are unlikely to be resolved by additional systematic reviews.

Search Strategy

The subcommittee conducted an electronic literature search of the Medline, Cochrane Library, and DOSS EBSCO databases. Search terms included safety, morbidity, mortality, complications, moderate sedation, deep sedation, general anesthesia and dental offices; Fields: all; Limits; within the last 10 years, humans, all children from birth through age 21, language: English; clinical trials and literature reviews.

The subcommittee selected articles judged to be relevant pediatric dental sedation safety within the United States healthcare system. Articles on local anesthesia, nitrous oxide and minimal sedation were excluded. In an effort to reduce risk of bias references were requested from stakeholders and interested parties. Additional articles were obtained by reviewing references. Selected articles with abstracts were downloaded into a reference manager. Full text versions of the most relevant articles are provided as references for this report. **See Figure 1**

[26] National Clinical Guideline Center. (2010). Sedation in children and young people. National Institute for Clinical Excellence, Royal College of Surgeons, London.

Figure 1 - Anesthesia outcomes – Literature Reviewed

INVESTIGATOR	YEARS	DATA TYPE	ANESTHESIA RELATED MORTALITY	ANESTHESIA SOLELY RESPONSIBLE
Eichorn et al	1976-1988	1,001,000 anesthetics in ASA I and II - reports to malpractice carrier	1:200,200	---
Lagasse et al	1995-1999	peer review reports ASA I and II patients	1:126,711	0
Li et al	1999-2005	ICD codes, Center for Health Statistics, CDC	8.2/1,000,000 (95% CI 7.4-9.0)	---
Gonzales et al	2001-2011	systematic review of 20 trials pediatric studies all ASA	0.41-13.4/10,000	---
Schiff et al	1999-2010	Core data set – national standardized tracking data base 1,374,678 anesthetics ASA I and II elective cases Secondary German hospitals	26.2/1,000,000 (95% CI 19.4-34.6)	7.3/1000,000 (95%CI 3.9-12.3)

Anesthesia Outcomes Research

Anesthesia outcomes research has undergone considerable evolution over time. Although randomized trials remain the gold standard for clinical evidence, results obtained from such efficacy trials often generalize poorly. Furthermore, conventional randomized trials are limited in that mortality and other serious complications are usually too rare to practically address. There is thus increasing interest in clinical effectiveness studies in which interventions are evaluated over an entire health care environment. Researchers from the Anesthesia Outcomes Consortium at the Cleveland Clinic are presently utilizing innovative randomized effectiveness studies in which decision support systems, combined with electronic anesthesia records are utilized. [27] Cravero and others have reported the development of an integrated outcome database for pediatric anesthesia which holds great promise for the future.[28]

Pediatric Sedation Studies

Review articles identify very few high quality published reports and clinical trials related to pediatric sedation for dentistry. [29] [30] This may be due to the practical difficulties of enrolling sufficient number of children into adequately controlled and blinded studies.

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[27] Kurz A, Sessler D. outcomes research. HSR Proceedings in Intensive Care and Cardiovascular Anesthesia 2012; 4 (1): 5-9.

[28] Cravero JP, Sriswasdi P, Lekowski R, Carpino E, Blum R, Askins N, Zurakowski D, Sinnott S. Creation of an integrated outcome database for pediatric anesthesia. Paediatr Anaesth. 2016 Apr;26(4):345-55. doi: 10.1111/pan.12857.

[29] Mittal, N., Goyal, A., Jain, K., & Gauba, K. (2015). Pediatric Dental Sedation Research: Where Do We Stand Today? *J Clin Pediatr Dent*, *39*(3), 284–291. http://doi.org/10.17796/1053-4628-39.3.284

[30] Ashley, P. F., Williams, C. E., Moles, D. R., & Parry, J. (2015). Sedation versus general anaesthesia for provision of dental treatment to patients younger than 18 years. *Cochrane Database Syst Rev*, *9*, Cd006334. http://doi.org/10.1002/14651858.CD006334.pub4

Ashley et al have published one of the few systematic reviews of pediatric dental sedation, and stated that they found no randomized controlled trials that compared sedation to general anesthesia for pediatric dentistry.[31] Lorenco-Matharau et al, in their systematic review, were able to find weak evidence of the effectiveness of midazolam, but identified few if any high quality pediatric sedation studies.[32]

Lee [33] noted that the study of the safety of pediatric dental anesthesia has been limited. Although there are a number of reports of serious injury or death related to pediatric dental anesthesia, there is also a lack of systematic research in this area. Because significant anesthesia injury is a relatively rare occurrence, it is difficult to study prospectively or by retrospective medical record review, even when data is collected from multiple institutions.

Anesthesia Morbidity and Mortality Data

Morbidity and mortality figures have been used to determine patient risk and, hence, have played a prominent role in establishing malpractice premiums and in efforts to legislate the practice of sedation and general anesthesia in dentistry.[34] Though it is important to know the frequency of these events, their incidence can be misleading, because the numbers do not describe the events. Questions concerning characteristics of the patients, the practitioners, drugs used, patient monitoring, and resuscitative efforts remain obscure. Thus, incidence figures cannot explain why morbidity and mortality occurs, nor how to prevent it. For example, do these events represent acute hypersensitivity reactions of healthy patients in the hands of practitioners performing proficiently or do they result from the negligent efforts of incompetent professionals? Answers to these questions are as important as incidence data for judging safety, assessing patient risk, and for determining the need and direction of future legislative efforts.

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[31] Ashley, P. F., Williams, C. E., Moles, D. R., & Parry, J. (2015). Sedation versus general anaesthesia for provision of dental treatment to patients younger than 18 years. *Cochrane Database Syst Rev*, *9*, Cd006334. http://doi.org/10.1002/14651858.CD006334.pub4

[32] Lourenco-Matharu, L., Ashley, P. F., Furness, S., Loureno-Matharu, L., PF, A., & Furness, S. (2012). Sedation of children undergoing dental treatment. *Cochrane Database of Systematic Reviews*, *3*(3), N.PAG–N.PAG 1p. http://doi.org/10.1002/14651858.CD003877.pub4

[33] Lee, H. H., Milgrom, P., Starks, H., & Burke, W. (2013). Trends in death associated with pediatric dental sedation and general anesthesia. *Paediatr Anaesth*, *23*(8), 741–746. http://doi.org/10.1111/pan.12210

[34] Krippaehne, J. A., & Montgomery, M. T. (1992). Morbidity and mortality from pharmacosedation and general anesthesia in the dental office. *Journal of Oral and Maxillofacial Surgery*. http://doi.org/10.1016/0278-2391(92)90099-L

The subcommittee reviewed anesthesia morbidity and mortality studies of the general and pediatric populations because pediatric morbidity and mortality is thought to represent a subset of adult morbidity and mortality, although there are important differences. Li et al [35] provide recent estimates of anesthesia mortality risk based on studies conducted in Europe, Japan, and Australia. They hypothesize that the paucity of anesthesia mortality studies in the United States in recent years is compounded by several factors. First, improvement in anesthesia safety has made anesthesia-related deaths rare events; and studying rare events usually requires large sample sizes and considerable resources. Second, there is not an established national surveillance data system for monitoring anesthesia mortality. Lastly, clinical practice of anesthesia has expanded so much that it is extremely difficult to gather exposure data. It is estimated that most surgical anesthesia procedures are now performed in ambulatory care settings. The use of anesthesia for therapeutic and diagnostic purposes is also on the rise.

A systematic review of Brazilian and worldwide literature[36] provides a summary of the studies of mortality incidence of pediatric patients who underwent anesthesia in developed countries between 2001 and 2011. This review reports mortality as 0.41-13.4 per 10,000 hospital discharges. Major risk factors include age < 1 year old, ASA III or higher physical status, emergency surgery, general anesthesia and cardiac surgery. Although this report reviewed outcomes from all ASA levels the authors note although rare, anesthesia related mortality still occurs in ASA physical status I-II children.

The subcommittee searched for studies that reported outcomes for relatively healthy patients because dentists are more likely to provide office sedation and anesthesia to ASA I and II patients. A recent report by Schiff[37] provides anesthesia related mortality statistics from the first study to utilize a standardized national tracking data base that allows calculation of the total number or cases, a "denominator", that is not available from closed claims data. This study reports outcomes for 1,374,678 patients, including ASA I and II patients undergoing

[35] Li G, Warner M, Lang BH, Huang L, Sun LS. Epidemiology of anesthesia-related mortality in the United States, 1999-2005.Anesthesiology. 2009 Apr;110(4):759-65. PubMed PMID: 19322941; PubMed Central PMCID: PMC2697561.

[36] Gonzalez, L., Pignaton, W., Kusano, P., Modolo, N., Braz, J., & Braz, L. (2012). Anesthesia-related mortality in pediatric patients: a systematic review. *Clinics*, *67*(4), 381–387. http://doi.org/10.6061/clinics/2012(04)12.

[37] Schiff, J. H., Welker, A., Fohr, B., Henn-Beilharz, A., Bothner, U., Van Aken, H., … Heinrichs, W. (2014). Major incidents and complications in otherwise healthy patients undergoing elective procedures: Results based on 1.37 million anaesthetic procedures. *British Journal of Anaesthesia*, *113*(1), 109–121. http://doi.org/10.1093/bja/aeu094

elective surgery in secondary hospitals, and indicates that risk of death or a serious complication from anesthesia is approximately 10 per million anesthetics.

A 1989 Harvard study[38] reported ASA I-II anesthetic related deaths, following implementation of improved monitoring standards, to be 1:244,000, but due to study limitations the data was not statistically significant. Lagasse[39] includes a review of published research related to anesthesia mortality prior to 1999 and reports similar findings.

The authors of these studies caution the reader that there is no standardized definition of anesthesia related mortality, and that this determination often relies on subjective interpretation of various definitions. Differences in methodology make it difficult to compare mortality rates among different studies because the mortality rate may depend on the surgical population being studied.[40] Although these studies do not support a firm conclusion, they suggest that anesthesia related mortality for ASA I and II patients treated in inpatient facilities may be in the range of 1:250,000.

Office Based Surgery and Anesthesia Outcomes

The subcommittee searched for reports of anesthesia safety data from office based facilities because dental treatment is usually provided in the office setting. Shapiro[41] reports a lack of randomized controlled trials that have measured morbidity and mortality in office based surgery and office based medical procedures. However there are numerous retrospective studies that compare morbidity and mortality outcomes in office, hospital, and ASC settings. The author concludes that much of the available literature confirms that there is a low rate of complications during office-based procedures and that risk in office based surgery is similar to other ambulatory settings.

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[38] Eichhorn JH. Prevention of intraoperative anesthesia accidents and related severe injury through safety monitoring. Anesthesiology. 1989 Apr;70(4):572-7. PubMed PMID: 2929993.

[39] Lagasse, R. S. (2002). Anesthesia safety: model or myth? A review of the published literature and analysis of current original data. *Anesthesiology*, *97*(6), 1609–1617. http://doi.org/10.1097/00000542-200212000-00038

[40] Gonzalez, L., Pignaton, W., Kusano, P., Modolo, N., Braz, J., & Braz, L. (2012). Anesthesia-related mortality in pediatric patients: a systematic review. *Clinics*, *67*(4), 381–387. http://doi.org/10.6061/clinics/2012(04)12

[41] Shapiro, F. E., Punwani, N., Rosenberg, N. M., Valedon, A., Twersky, R., & Urman, R. D. (2014). Office-based anesthesia: Safety and outcomes. *Anesthesia and Analgesia*, *119*(2), 276–285. http://doi.org/10.1213/ANE.0000000000000313

Results from outcome studies of office based surgery usually include complications from surgical procedures, including cosmetic procedures such as liposuction and abdominoplasty with liposuction. These procedures are associated with death from pulmonary embolism and other complications not usually encountered with dental procedures. Data from the AAAASF quality assurance program included over a million outpatient procedures from 2001-2006 and reported a mortality rate of 0.002%.[42] Thirteen of 23 deaths were caused by pulmonary embolism. Studies of office based cosmetic procedures emphasize that there is inherent risk related to certain office based cosmetic procedures that should not be generalized to office based surgery in general.

Much of the knowledge related to anesthesia safety in the ambulatory setting stems from the American Society of Anesthesiologists' (ASA) Closed Claims Database. The ASA Closed Claims Project is described in a subsequent section of this report.

Pediatric Dental Anesthesia Safety Research

The subcommittee's search identified only a handful of studies of anesthesia safety related to pediatric dentistry. One of the best known studies addressed complications of pediatric sedation through critical incident analysis. This study reported that 29% of adverse events were related to dental treatment.[43] The study utilized a panel of four physicians who reviewed 118 reports of adverse sedation events from the FDA adverse event reporting system accumulated between 1969 and 1996, which yielded 51 reports of deaths, 9 cases of permanent neurological injury, and 21 cases of prolonged hospitalization without injury. Additional data was collected from USP adverse events and surveys of pediatric anesthesiologists, intensivists and emergency specialists. Patients were age < 20 years. Cases where general anesthesia or MAC (sedation) was performed by an anesthesiologist were excluded. Inadequate resuscitation, death and permanent neurological injury were more frequent in non-hospital based facilities. As with other studies, presenting events included respiratory events such as desaturation, apnea and laryngospasm with cardiac arrest occurring as a second or third event. The majority of patients were age 6 or less. Causes or contributing factors included drug related events, inadequate monitoring, inadequate resuscitation, and inadequate medical evaluation. The authors recommend improved insurance coverage for

[42] Keyes GR, Singer R, Iverson RE, McGuire M, Yates J, Gold A,Reed L, Pollack H, Thompson D. Mortality in outpatient surgery.Plast Reconstr Surg 2008;122:245–50

[43] Cote, C. J., Notterman, D. A., Karl, H. W., Weinberg, J. A., & McCloskey, C. (2000). Adverse sedation events in pediatrics: a critical incident analysis of contributing factors. *Pediatrics*, *105*(4 Pt 1), 805–814.

dental anesthesia, better training for dentists who use sedation, development of specialty independent guidelines and better regulation of facilities.

This report does not include an estimate of the incidence or prevalence of dental sedation/anesthesia morbidity and mortality. It includes data from a period approximately 27 years. During this time period there have been significant improvements in anesthesia safety and the results may not indicate outcomes from more recent practice.

Lee [44] reported a review of media reports of pediatric deaths related to dental treatment of 44 patients between 1980 and 2011, for patients up to age 21. The majority of deaths occurred between ages 2-5 (46.7%) and 13-21 (29.6%). The majority of deaths occurred in the office setting , the most common treatment location for general dentists, with the majority (45.5%) being related to moderate sedation, 22.7 % relate to general anesthesia and 22.7% not reported. The authors comment that it is not possible to evaluate the incidence and prevalence of pediatric sedation adverse outcomes without establishing an appropriate database.

The dental profession has published numerous studies of outcomes from sedation and anesthesia. Early epidemiological reports were based primarily on retrospective data, voluntary surveys of professional association members, with small sample sizes making them of limited value. These studies are well known and will not be repeated here. Other studies we reviewed were reports of specific drug combinations and techniques that utilized sample sizes of a few hundred patients from a single site. Again we felt these were of limited value.

Perrott[45] et al reported results from a prospective cohort study of 34,191 consecutive patients of whom 71.9% received office based deep sedation/general anesthesia, 15.5 % received conscious sedation, and 12.6 % received local anesthesia. Study methods included an audit of data collection to reduce selection bias and ensure cases were entered consecutively. Data was collected from 79 oral surgeons between January 2001 and December 2001 at 58 study sites between located in six geographical regions of the United States. Most complications were minor and self limiting and two patients required hospitalization. There were no deaths.

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[44] Lee, H. H., Milgrom, P., Starks, H., & Burke, W. (2013). Trends in death associated with pediatric dental sedation and general anesthesia. *Paediatr Anaesth*, *23*(8), 741–746. http://doi.org/10.1111/pan.12210s

[45] Perrott, D. H., Yuen, J. P., Andresen, R. V., & Dodson, T. B. (2003). Office-based ambulatory anesthesia: Outcomes of clinical practice of oral and maxillofacial surgeons. *Journal of Oral and Maxillofacial Surgery*, *61*(9), 983–995. http://doi.org/10.1016/S0278-2391(03)00668-2

Lee [46] et al published a prospective comparison study of the safety of anesthetic outcomes of propofol and methohexital anesthesia administered to 47,710 consecutively assigned patients between January 2001 and December 2007. 0.7 % experienced adverse events, mostly post operative nausea and vomiting without aspiration, laryngospasm in the methohexital group, and syncope or prolonged emergence. Nine patients required hospitalization due allergic reaction to antibiotics and minor surgical complications such as persistent pain or wound problems (3 patients) to prolonged emergence with delirium and one case of bronchospasm with aspiration, one due to new onset dysrhythmia and two were not described. The study reported no deaths or brain damage. The study included 2404 patients who received anesthesia from a physician anesthesiologist or CRNA. This arm of the study was underpowered but reported no significant difference between providers.

Inverso et al [47] compared the complications of moderate sedation with deep sedation/general anesthesia for 29,548 adolescent patients with average age of 17.3 undergoing third molar surgery between January 2001 and December 2010. Prospective data was collected from 79 surgeons at 58 sites across the US. As with previous studies the most common complications were post operative nausea and vomiting, prolonged recovery, syncope, and laryngospasm with a complication rate of 0.8% overall. There were no reports of new neurologic impairment and apparently no deaths. Patients receiving moderate sedation had a nominally lower rate of complications but this was not statistically significant.

Other investigators of anesthesia outcomes have utilized similar sized populations and have noted that very large populations must be studied to fully evaluate the occurrence of rare but serious outcomes such as brain injury or death. These studies may be underpowered to identify rare but serious outcomes such as death and brain damage. Large scale multi center studies are necessary, but the resources necessary to enroll populations of sufficient size and to maintain adequate controls are significant. High quality studies of pediatric dental sedation outcomes might be accomplished through a well established national outcomes registry.

[46] Lee, J. S., Gonzalez, M. L., Chuang, S. K., & Perrott, D. H. (2008). Comparison of Methohexital and Propofol Use in Ambulatory Procedures in Oral and Maxillofacial Surgery. *Journal of Oral and Maxillofacial Surgery*, *66*(10), 1996–2003. http://doi.org/10.1016/j.joms.2008.06.028.

[47] Inverso, G., Dodson, T. B., Gonzalez, M. L., & Chuang, S.-K. (2016). Complications of Moderate Sedation Versus Deep Sedation/General Anesthesia for Adolescent Patients Undergoing Third Molar Extraction. *Journal of Oral and Maxillofacial Surgery*, *74*(3), 474–479. http://doi.org/10.1016/j.joms.2015.10.009

Closed Claims Data

In a 1999 landmark study Cheney at al [48] describes how the study of insurance company closed claims provides a cost-effective approach to data collection with extensive data on injuries that occurred in many different institutions gathered in a centralized location. Typically, a closed claim file consists of the hospital record, the anesthesia record, and narrative statements of the involved healthcare personnel, expert and peer reviews, deposition summaries, outcome reports, and the cost of settlement or jury awards. These files provide a collection of information on the relatively rare events leading to anesthesia-related injury.

Although the use of closed claims circumvents the problem of gaining access to low-frequency adverse events, this approach has inherent limitations that must be considered when interpreting the data. For example, closed claims review does not provide information as to how many anesthetics were administered. Therefore, closed claims data does not provide a denominator for calculating the risk of anesthetic injury. In addition, some injured patients do not file claims, whereas others without any apparent injury do file claims. Closed claims analysis provides a snapshot of anesthesia liability**,** but is not a comprehensive picture of all anesthetic injury**.** Injuries leading to claims are not a random sample of all injuries, and we do not know how closely this snapshot resembles the whole picture of anesthetic injury. Another limitation of closed claims analysis is the retrospective nature of data collection. The information was gathered by the insurance companies for the purpose of resolving the claims, not for patient safety research. Data from different sources may be conflicting, and some data may be missing. In addition, it takes an average of 5 years for cases to become available for review due to the time necessary for them to be resolved. Closed claims analysis **is** useful for generating hypotheses about the mechanism and prevention of anesthetic injury, but cannot be used for testing of those hypotheses. As a retrospective study, it cannot establish a cause-and effect relationship of previous events, nor of changes in claim experience.

Closed claims data also provides information about risk related to the location in which sedation and anesthesia is administered. Domino's [49] original report indicated that the severity of injury was greater for office based claims than for other ambulatory settings, with 40% for death compared to 25% for other ambulatory claims. Respiratory events, airway obstruction,

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[48] Cheney, F. W. (1999). The American Society of Anesthesiologists Closed Claims Project: what have we learned, how has it affected practice, and how will it affect practice in the future? *Anesthesiology*, *91*(2), 552–556. Retrieved from http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1946221

[49] Domino, K. B. (n.d.). Office-Based Anesthesia : Lessons Learned from the Closed Claims Project, 9–12. ASA Newsletter 65 (6) 2001.

bronchospasm, inadequate oxygenation-ventilation and esophageal intubation were the most common complications (29%). These adverse events were deemed preventable through better monitoring.

Monitored anesthesia care (MAC) accounted for 50% of out of operating room claims. Respiratory depression from MAC accounted for 21% of claims and death or permanent brain damage accounted for 40% of MAC claims. Although this proportion is similar to general anesthesia claims and suggests that MAC and general anesthesia have similar risk profiles, Bhananker's study[50] includes outcomes from MAC in both inpatient and outpatient facilities making it difficult to draw conclusions about the safety of MAC in outpatient facilities.

Jiminez[51] et al reported a study of closed pediatric claims between the 1970's and the 1990's. Death and brain damage were the most common reason for claims in the 16 or younger age group. 77% of cases involved relatively healthy patients with ASA PS 1 or 2, and the most common procedures involved the airway. The proportion of claims assessed as preventable by better monitoring decreased from an average of 63% in the 1970's to 16% in the 1990's, possibly due to better monitoring, however cardiovascular events (26%) joined respiratory events as being most important. The authors indicate that the policy implications of the data are unclear; including whether pediatric anesthesia specialists provide safer care for younger higher risk patients and what type of case should be performed in what type of facility.

Closed claims review has also been utilized as a data source to study dental edation/anesthesia related morbidity and mortality. Jastak and Peskin[52] evaluated 13 claims that occurred between 1974 and 1989 from patients of all ages. Adverse outcomes were most often due to airway obstruction or respiratory depression resulting in hypoxia and 10 of 13 cases were judged to be avoidable through the use of better monitoring. The majority of patients had pre existing medical conditions and were rated as ASA II or III. The authors conclude that the very old and very young are at greatest risk.

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[50] Sanjay M. Bhananker, M.D., F.R.C.A.,* Karen L. Posner, Ph.D.,† Frederick W. Cheney, M.D.,‡ Robert A. Caplan, M. D., & Lorri A. Lee, M.D., Karen B. Domino, M.D., M. P. H. (2006). Injury and Liability Associated with Monitored Anesthesia. *Anesthesiology*, *104*(2), 228–234.

[51] Jimenez, N., Posner, K. L., Cheney, F. W., Caplan, R. A., Lee, L. A., & Domino, K. B. (2007). An update on pediatric anesthesia liability: A closed claims analysis. *Anesthesia and Analgesia*, *104*(1), 147–153. http://doi.org/10.1213/01.ane.0000246813.04771.03

[52] Jastak, J. T., & Peskin, R. M. (1991). Major morbidity or mortality from office anesthetic procedures: a closed-claim analysis of 13 cases. *Anesthesia Progress*, *38*(2), 39–44.

Deegan [53] reported 136 claims from the American Association of Oral and Maxillofacial Surgeons National Insurance Company accumulated between 1988 and 1999. At that time AAOMS National insured approximately 55% of the oral surgeons practicing in the US. Thirty seven claims involved serious injury or hypoxic brain damage as the result of both office and inpatient anesthesia. The authors state that there were equal numbers of claims from both conscious sedation and general anesthesia. Unlike most other closed claims studies the authors provide an estimate of the total number of cases performed and an estimate of the incidence of office deaths as 1: 747,000 administrations. There were 23 deaths and one brain damage case from office anesthesia and 11 deaths and 4 brain damage cases from inpatient anesthesia provided by anesthesiologists or nurse anesthetists.

Nkansah [54] et al published a report of anesthesia outcomes for oral and maxillofacial surgeons from the Canadian province of Ontario utilizing claims data from the Regional professional liability program that covers all claims originating from Ontario between 1973 and 1995. The Canadian model of anesthesia delivery is similar to that utilized in the US, with the OMS administering the anesthesia and performing the surgery with trained assistants. The authors provide an estimate of total cases performed during the study interval via survey of members of the professional association. Four deaths occurred, with one administered by a dentist anesthesiologist and three by oral and maxillofacial surgeons. A single case involving anesthesia administered by a physician anesthesiologist was excluded. The author estimates an incidence of mortality of 1.4 per 1,000,000.

A more recent closed claims review by Chicka[55] et al evaluated adverse events during pediatric dental sedation. This study reviewed 17 claims accumulated between 1993 and 2007 from two major insurance carriers. Reports were limited to pediatric cases age <13 with 78% age 5 or less. 13 claims involved sedation, 3 involved local anesthesia alone, and one involved general anesthesia. The average age of the patient was 3.6 years and only one case involved the use of physiologic monitoring. The study included only claims from office based treatment. Over half (53%) were claims from a death or permanent brain damage.

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[53] Deegan, a E. (2001). Anesthesia morbidity and mortality, 1988-1999: claims statistics from AAOMS National Insurance Company. *Anesthesia Progress*, *48*(3), 89–92. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2007373&tool=pmcentrez&rendertype=abstract

[54] Nkansah, P. J., Haas, D. A., & Saso, M. A. (1997). Mortality incidence in outpatient anesthesia for dentistry in Ontario. *Oral Surgery, Oral Medicine, Oral Pathology*, *83*(6), 646–651.

[55] Chicka, M. C., Dembo, J. B., Mathu-Muju, K. R., Nash, D. A., & Bush, H. M. (2012). Adverse events during pediatric dental anesthesia and sedation: a review of closed malpractice insurance claims. *Pediatr Dent*, *34*(3), 231–238.

Bennett et al published the most recent closed claims study of dental cases, reporting information from 113 closed claims cases from the files of a national insurance carrier for approximately 80% of oral and maxillofacial surgeons practicing in the United States.[56] This company tracks the number of anesthetics performed annually. Claims were for cases that resulted in death or brain injury collected over 14 years, between 2000-2013. The authors do not provide details that indicate specific adverse events or contributing factors, but indicate that the majority of adverse outcomes are related to respiratory events. This study did not provide patient age related data. Unlike most other closed claims studies this report provides an estimate of the overall number of cases performed and an estimate of the incidence of anesthesia morbidity and mortality as one per 348,602 cases.

State Board Data

Investigators have attempted to gather information from state dental boards; however collection and storage of data varies state to state which limits the value of this data. State board outcomes data has the potential to inform policy decisions. State laws specify mandatory reporting of patient deaths or hospitalization. This improves the reliability of dental board data compared to closed claims reports or self reporting by the members of professional associations. The total number of patients treated, however, remains unknown. This makes accurate calculation of the incidence and prevalence of adverse events impossible because, as with closed claims data, there is no "denominator". Death and serious injury cases often involve lengthy legal proceedings that require 3 or more years to elapse before information can be made available. Dental boards collect information to manage enforcement actions, not for clinical research, and state records retention and disclosure policies may conflict with data collection. Standardization of data collection across state dental boards has the potential to provide meaningful information, however this has yet to occur.

Krippaehne and Montgomery requested morbidity and mortality information from dental boards in all 50 states and Puerto Rico related to either general anesthesia or sedation in dental offices. The information requested included the formal complaint, the formal order and judgment by the board, expert opinions, and the medical examiner's report. They received responses from all states and Puerto Rico; however, most states had not kept records on such

[56] Bennett, J. D., Kramer, K. J., & Bosack, R. C. (2015). How safe is deep sedation or general anesthesia while providing dental care? *J Am Dent Assoc*, *146*(9), 705–708. http://doi.org/10.1016/j.adaj.2015.04.005

cases and hence, could not contribute to the data base. Forty-three cases were reported by nine states, with mortality comprising 81% of the cases.[57]

Dental board data provides important details of adverse outcomes from sedation and anesthesia that may not be available from other sources. As with closed claims data, dental board data is retrospective, but is still useful in generating a hypothesis about the mechanism of injury and how it might be prevented in the future.

DENTAL SEDATION AND ANESTHESIA OUTCOMES REPORTS

The Pediatric Sedation Research Consortium

The Pediatric Sedation Research Consortium (PSRC) has made significant contributions to pediatric sedation research, demonstrating a remarkable safety record for sedation provided by highly motivated and skilled practitioners from a variety of specialties functioning outside the operating room. The PSRC collected data from 37 participating institutions within large children's hospitals, children's hospitals within hospitals and general/community hospitals. [58] The Consortium has published a series of prospective observational studies that have demonstrated many of the concepts important to the safe administration of pediatric sedation. Over time the PSRC has accumulated a large database of children up to age 21.

The authors of the PSRC studies describe the limitations of their studies. Reporting institutions are self selected for voluntarily reporting of their outcomes, and represent a highly motivated and organized systems that would outperform other, less controlled systems and may represent "best practice." The practice patterns and outcomes of the PSRC represent a highly competent cohort that may not generalize to other clinical settings in which sedation care is provided.[59]

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[57] Krippaehne, J. A., & Montgomery, M. T. (1992). Morbidity and mortality from pharmacosedation and general anesthesia in the dental office. *Journal of Oral and Maxillofacial Surgery*. http://doi.org/10.1016/0278-2391(92)90099-L

[58] Cravero, J. P., Blike, G. T., Beach, M., Gallagher, S. M., Hertzog, J. H., Havidich, J. E., & Gelman, B. (2006). Incidence and nature of adverse events during pediatric sedation/anesthesia for procedures outside the operating room: report from the Pediatric Sedation Research Consortium. *Pediatrics*, *118*(3), 1087–1096. http://doi.org/10.1542/peds.2006-0313

[59] Cravero, J. P., Blike, G. T., Beach, M., Gallagher, S. M., Hertzog, J. H., Havidich, J. E., & Gelman, B. (2006). Incidence and nature of adverse events during pediatric sedation/anesthesia for procedures outside the operating room: report from the Pediatric Sedation Research Consortium. *Pediatrics*, *118*(3), 1087–1096. http://doi.org/10.1542/peds.2006-0313

Although the PSRC studies include data from a wide variety of providers dentists are significantly underrepresented in this series. Only 0.80% or 397 of nearly 50,000 cases were dental cases. Dentists are grouped in the "other" category with pediatric residents or fellows, radiologists, surgeons, advanced practice nurses, certified registered nurse anesthetists, and registered nurses. In addition the PSRC data was accumulated from inpatient facilities such as pediatric hospitals and community hospitals with pediatric sedation services that are not usually utilized for dentistry. As a result it is impossible to generalize results from the PSRC studies to community dental practices. Nevertheless the "best practices" utilized at PSRC facilities have broad application to pediatric sedation in all settings.

Coulores et al reported the results of an analysis of 133,941 procedural sedation records from the PSRC that evaluated a comparison of the major complication frequency of sedation performed by pediatric specialists outside of the operating room. There was no statistical difference between different sedation providers' major complication rates.[60]

Langhan et al reported the results a study of physiologic monitoring practices during pediatric sedation from the PSRC. [61] Data from 114 855 subjects were collected and analyzed. The frequency of use of each physiologic monitoring modality by health care provider type, medication used, and procedure performed varied significantly. The largest difference in frequency of monitoring use was seen between providers using electrocardiography (13%-95%); the smallest overall differences were seen in monitoring use based on the American Society of Anesthesiologists classifications (1%-10%). Guidelines published by the American Academy of Pediatrics, the American College of Emergency Physicians, and the American Society of Anesthesiologists for non anesthesiologists were adhered to for only 52% of subjects.

Despite the variability in monitoring, serious adverse outcomes during procedural sedation were uncommon. The authors conclude that further research is needed to develop evidence-based guidelines regarding the appropriateness of various monitoring modalities and their effect on adverse outcomes that are associated with sedation.

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[60] Couloures, K. G., Beach, M., Cravero, J. P., Monroe, K. K., & Hertzog, J. H. (2011). Impact of provider specialty on pediatric procedural sedation complication rates. *Pediatrics*, *127*(5), e1154–60. http://doi.org/10.1542/peds.2010-2960

[61] Langhan, M. L., Mallory, M., Hertzog, J., Lowrie, L., & Cravero, J. (2012). Physiologic monitoring practices during pediatric procedural sedation: a report from the Pediatric Sedation Research Consortium. *Arch Pediatr Adolesc Med*, *166*(11), 990–998. http://doi.org/10.1001/archpediatrics.2012.1023

Cravero, et al reported the results of a study of data from thirty seven locations that submitted data on 49,836 propofol sedation.[62] The authors state that given the potency of propofol and the nature of pediatric patients, essentially all children administered propofol would clearly be categorized as being deeply sedated or anesthetized. Despite varying guidelines, propofol sedation/anesthesia is delivered to children for procedures in emergency departments, intensive care units, and sedation/anesthesia units all over the United States (and around the world) by pediatric generalists and subspecialists every day.

The authors stress that the results of their study should not reassure providers that propofol sedation/anesthesia of children is safe, but it helps define the competencies required to deliver this care.

SUMMARY OF LITERATURE REVIEW

Review articles identify very few high quality published reports and clinical trials related to pediatric sedation for dentistry. This may be due to the practical difficulties of enrolling sufficient number of children into adequately controlled and blinded studies.

Because significant anesthesia injury is a relatively rare occurrence, it is difficult to study prospectively or by retrospective medical record review, even when data is collected from multiple institutions.

The effect that provider type or personnel type has on outcomes has received little study, particularly as related to pediatric dentistry.

There is no standardized definition of anesthesia related mortality, and this determination often relies on subjective interpretation. Differences in methodology make it difficult to compare mortality rates among different studies because the mortality rate may depend on the surgical population being studied. Available studies do not support a firm conclusion, but suggest that anesthesia related mortality for ASA I and II patients treated in inpatient facilities is in the range of 1:250,000.

Several studies indicate that the most common complications of pediatric sedation include respiratory events such as desaturation, apnea and laryngospasm with cardiac arrest occurring as a second or third event. Complications may be more frequent under age 6, with younger

[62] Cravero, J. P., Beach, M. L., Blike, G. T., Gallagher, S. M., & Hertzog, J. H. (2009). The incidence and nature of adverse events during pediatric sedation/anesthesia with propofol for procedures outside the operating room: a report from the pediatric sedation research consortium. *Anesthesia and Analgesia*, *108*(3), 795–804. http://doi.org/10.1213/ane.0b013e31818fc334

patients and higher ASA physical status classification III or IV at greater risk. Causes or contributing factors include drug related events, inadequate monitoring, inadequate resuscitation, and inadequate medical evaluation.

Although pediatric sedation has an excellent safety record, adverse outcomes sometimes occur in apparently healthy patients indicating that there is inherent risk in sedation and general anesthesia.

Board Statistics

The subcommittee developed an estimate of the number of patients treated under sedation and general anesthesia in California each year. This information would establish a "denominator" that is used to determine the incidence of adverse anesthesia outcomes. Studies of adverse outcomes from closed claims data, dental board reports and media reports do not include a denominator. Unfortunately there is no reliable estimate of the number of cases due to the lack of a national reporting database for adverse anesthesia outcomes.

California is a very large state, with a population over 39 million as of 2015. Approximately 23% of the population is age 18 or under, or approximately 9 million children. With a population this large a significant number of children undoubtedly receive treatment under sedation or general anesthesia. For example if only 1.5% of this population required anesthesia for dental treatment this would result in 135,000 administrations per year.

In an effort to provide utilization statistics, the subcommittee obtained the incidence of billing code utilization for general anesthesia by Denti Cal providers. This reveals that approximately 25,000 patients under age 17 receive general anesthesia through the Denti Cal program each year. Approximately 2.5 million children are currently enrolled in Denti Cal, and approximately half of those enrolled receive services. Based on these assumptions, the anesthesia utilization rate for Denti Cal patients is approximately 1%.

The subcommittee reviewed the medical and dental literature to determine the number of cases of sedation and anesthesia performed. Chicka, et. al.[63] indicate in their study of pediatric dental anesthesia morbidity and mortality that approximately 100,000-250,000 cases were performed annually as of 2005.

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[63] Chicka, M. C., Dembo, J. B., Mathu-Muju, K. R., Nash, D. A., & Bush, H. M. (2012). Adverse events during pediatric dental anesthesia and sedation: a review of closed malpractice insurance claims. *Pediatr Dent*, *34*(3), 231–238.

There are several published estimates of the number of cases performed under anesthesia by oral and maxillofacial surgeons. These studies report that an average oral and maxillofacial surgeon performs approximately 480-505 [64] [65] general anesthetics per year. This figure does not include cases performed utilizing moderate sedation or cases performed by other dental sedation practitioners such as pediatric dentists, periodontists, or dentist anesthesiologists. Assuming that 40% of patients treated by the 675 actively practicing oral and maxillofacial surgeons in California are under age 21, this yields an estimate of 133,000 anesthetics per year.

The California Association of Oral and Maxillofacial Surgeons (CALAOMS) recently conducted a survey of their membership based on data obtained from electronic records. Results of this survey are included in their comments submitted to the Dental Board. CALAOMS estimates that approximately 48% of cases performed under anesthesia were for patients age 21 or under. Their current active membership is 675 oral surgeons.

Based on this data, for the study period January 1, 2010 to December 31, 2015, the subcommittee therefore estimates that approximately 800,000 cases utilizing general anesthesia were performed.

[64] D'Eramo, E. M., Bontempi, W. J., & Howard, J. B. (2008). Anesthesia Morbidity and Mortality Experience Among Massachusetts Oral and Maxillofacial Surgeons. *Journal of Oral and Maxillofacial Surgery*, *66*(12), 2421–2433. http://doi.org/10.1016/j.joms.2008.06.095

[65] Nkansah, P. J., Haas, D. A., & Saso, M. A. (1997). Mortality incidence in outpatient anesthesia for dentistry in Ontario. *Oral Surgery, Oral Medicine, Oral Pathology*, *83*(6), 646–651.

Part 3: DENTAL BOARD OF CALIFORNIA - DATA RELATED TO PEDIATRIC SEDATION AND ANESTHESIA

Part II of this study will address the review of all incident reports related to pediatric sedation/anesthesia in California for a time certain. In the context of this study, "incident report" is defined as the notification the Board received from a licensee in accordance with reporting requirements of Business & Professions Code (BPC) Section 1680(z) relating to (1) the death of a patient during the performance of any dental or dental hygiene procedure; (2) the discovery of the death of a patient whose death is related to a dental or dental hygiene procedure performed by the dentist; and (3) the removal to a hospital or emergency center for medical treatment for a period exceeding 24 hours of any patient to whom oral conscious sedation, conscious sedation, or general anesthesia was administered, or any patient as a result of dental or dental hygiene treatment. While some notifications provide specific details of the incident, other notifications have minimal information. The regulation does not specify what information is required to be included in the notification to the Board.

This report will therefore reflect data related to incident reports of death and hospitalizations related to use of local anesthetic, oral conscious sedation, conscious sedation, general anesthesia, and "other" incidents NOT related to sedation for pediatric patients reported over a six year period, January 1, 2010 – December 31, 2015. For the purposes of this report, the age of a pediatric patient is defined as 21 years and younger.

In order to identify instances of pediatric hospitalizations and deaths reported to the Board, reports from the Consumer Affairs System (CAS) database were pulled for cases tracked with specific violation codes related to the Board's reporting requirements under BPC Section 1680(z). Reports pulled from the database were based on coding entered by complaint intake staff upon initial receipt of the notification and/or complaint.

Eight Board staff, including two Dental Consultants, and four investigative staff, reviewed the available incident reports, investigative files, and cases identified and recorded in the Boards database. There is no mechanism to sort data by age, therefore approximately 325 records and investigative files were reviewed in order to determine the number of pediatric hospitalizations and deaths reported or investigated by the Board in relation to dental treatment.

A portion of the cases identified in the database were not able to be reviewed as the files were not able to be located, or were purged pursuant to the Board's records retention schedule.

NOTIFICATION OF PEDIATRIC DEATHS

Review of the incident reports combined with additional information obtained during the course of the Board's investigations revealed that during the six year period identified as January 1, 2010 through December 31, 2015, the Board received notice of nine pediatric deaths, four of which involved general anesthesia. A summary of the findings by year follows:

Review of records indicated that in 2010 the Board received no notification of pediatric deaths.

In 2011, three cases were received. Board review indicated the following:

- Investigation into the treatment of a three year old child under oral conscious sedation resulted in a referral to the Office of the Attorney General and an accusation was filed; the accusation was subsequently withdrawn.

  The patient was treated in a dental office for restorations of 20 teeth under oral conscious sedation on December 9, 2011. During the procedure the patient was awake and crying; additional sedation was administered by the provider. The patient was discharged to parent at 11:30 a.m., and did not wake after the procedure. 911 was called at 3:00 p.m.; the patient was pronounced dead the following evening.

- Investigation into the treatment of a four year old patient under general anesthesia on November 11, 2011, indicated insufficient evidence to proceed with disciplinary action.

  The patient was treated under general anesthesia, administered by a medical anesthesiologist at a hospital, for dental caries and gingivitis. The patient had a complex cardiac history and treatment was rendered at a large children's hospital. The dental procedures were completed uneventfully, and the patient was extubated. In the recovery room the patient experienced cardiac arrest, and expired after 45 minutes of resuscitation efforts. A coroner's report, and review by six corner bureau staff concluded it was a natural death.

- Investigation related to the treatment of a nine year old child under local anesthetic (xylocaine) on December 5, 2011, indicated no violation.

  On December 5, 2011, a severely compromised nine year old patient was treated for extractions of six primary teeth under local anesthetic, at a sub-acute care facility. The patient's health history was significant for spinal muscular atrophy type 1, global delay, reactive airway disease, asthma, osteopenia, chronic respiratory failure, anemia, aspiration pneumonia, constipation, failure to thrive, g-tube, gastric hypo motility, gerd, osteoporosis, quadriplegic, bed ridden, and nonverbal.

  The patient was transported by paramedics to a university dental school subacute facility to treat dental pain. Treatment was provided under the supervision of the patient's accompanying paramedics who provided transport; the patient experienced a medical emergency. The paramedics declined the offer of the dental school's emergency medical assistance and took the patient to the ER. The patient expired at the hospital after cardiac arrest in the sub-acute care facility.

Review of records indicated that in 2012 the Board received no notification of pediatric deaths.

The Board received four notifications related to pediatric death in the year 2013. Of the four notifications received, three notifications were related to the treatment of a single patient by multiple providers, thereby reflecting only two incidents for this year.

- Investigation was initiated upon receipt of notification related to the treatment of an 11 year old child on May 22, 2013. The investigation found no violation occurred related to the treatment.

  The patient had a history of mucopolysaccharidosis Type VII, and behavioral issues, and required treatment of decay under general anesthesia. Treatment of tooth #3 was initiated, at a university health clinic for children with anesthesia administered by an anesthesiologist. During the treatment, irregular cardiac patterns were detected, and treatment was halted. The medical team attempted to stabilize the patient without success.

- Investigation was initiated upon receipt of notification related to the death of a 19 year old patient. Three investigations were initiated as three dental providers were involved in the treatment. Two investigations resulted in referral to the Office of the Attorney General, and one investigation resulted in a closure with no violation.

  Provider #1 saw patient on January 14, 2014, February 1, 2013, February 28, 2013, and March 6, 2013, for issues related to pain. Provider #1 placed a MODLB onlay on tooth #30, on February 1, 2013. Patient was seen by provider #1 an additional two times; February 28, 2013, and March 6, 2013 (#30 bite adjustment), for continued issues with pain. On March 16, 2013, patient's mother called as patient continued to have pain, and spoke to provider #1 who felt patient had discomfort from grinding and recommended a night guard.

  A second opinion was requested from provider #2, who attempted to fix the crown at #30 two times (March 20, 2013, March 22, 2013) without success. Provider #2 referred patient to provider #3, an endodontist on March 22, 2013, who on the same day performed a partial root canal treatment on tooth #30, and prescribed antibiotics, pain pills, and made a follow up appointment. The patient accompanied her mother to the pharmacy to fill the prescriptions. When the mother returned to the car, the patient was unresponsive. 911 was called, the patient passed four days later; the cause of death is listed as sepsis, clinical dental infection with multiple dental procedures, clinical.

  Review of records indicated that in 2014 the Board received no notification of pediatric deaths.

  The Board received four notifications related to pediatric death in the year 2015.

- Investigation was conducted upon receipt of notification related to treatment rendered to a 17 year old patient under general anesthesia on April 1, 2015. The investigation indicated insufficient evidence to proceed with disciplinary action.

The 17 year old patient had history significant for cerebral palsy, seizure disorder, 1P36 chromosomal deletion syndrome, chronic constipation, and thrombocytopenia secondary to valproic acid. Medical consultations were obtained from the patient's neurologist, hematologist, and GI doctor prior to treatment under general anesthesia for decay, prophy, x-rays, and dental pain. Treatment was performed at a pediatric children's hospital by two dental providers. X-rays were taken, the prophy was performed, and one primary over retained tooth and four permanent teeth were extracted, without issue.

Patient was transferred to post anesthesia care unit, but was not able to be removed from the respirator. Five days later the patient suffered complications involving pneumonia and the parents asked the patient be removed from life support.

- Investigation was conducted upon notification of the death of a six year old patient, who was placed under general anesthesia for dental treatment. The investigation resulted in referral to the Office of the Attorney General; outcome is pending.

  The six year old patient presented to a dental office for the extraction of a mesiodens in the area of #9 under general anesthesia on March 13, 2015. Following the administration of a local anesthetic, the provider reported not being able to hear the patient breathing. Oxygen/mask bag was applied, and 911 was called; the oxygen/mask bag was unsuccessful. While waiting for EMS, the provider unsuccessfully attempted to intubate patient; the provider continued with mask/bag ventilation until EMT arrived. After two days of treatment, MD ordered compassionate withdrawal of care. Cause of death listed as hypoxic encephalopathy due to cardiac arrest.

- Investigation was conducted upon notification of the death of a three year old patient after treatment in a pediatric dental office. The investigation resulted in the referral to the Office of the Attorney General; outcome is pending.

  The three year old patient presented to a pediatric dental office for restorative treatment in all four quadrants under oral sedation, with a papoose board on February 25, 2015. The patient was in treatment for four hours and was in recovery for two hours when he became tachycardic and his oxygen saturation decreased. Patient was given oxygen and was monitored, about one hour later (3 hours after treatment), 911 was called. Patient was transported to the hospital, and expired 4 days later; cause of death listed a malignant hyperthermia, with cerebral edema and hypoglycemia as underlying causes.

- Investigation related to the treatment of a three year old child under local anesthetic (lidocaine, septocaine, and nitrous oxide) on July 30, 2015, is ongoing.

  On July 30, 2015, the three year old patient was undergoing dental treatment under nitrous oxide and local anesthetic, and became non-responsive. CPR was initiated, and paramedics were called. Patient was transported to the hospital and passed on August 1, 2015. The cause of death was not known at the time the report was submitted to the Board.

A simplified summary of the Board's findings related to pediatric deaths for the years 2011, 2013, and 2015 follows. There were no reported pediatric deaths in 2010, 2012, or 2014.

YEAR OF OCCURRENCE	AGE	TYPE(S) OF ANESTHESIA OR ANESTHETIC ADMINISTERED	TREATMENT/SETTING	DISCIPLINE
2010	NO DEATHS REPORTED			
2011	3	Oral Conscious sedation	Dental office	Accusation withdrawn 8/21/15
2011	4	General anesthesia	Hospital with Anesthesiologist	Closed insufficient evidence
2011	9	Local anesthetic	Sub-acute care facility/Hospital	No violation
2012	NO DEATHS REPORTED			
2013	11	General anesthesia	Hospital with Anesthesiologist	No violation
2013	19	Local anesthetic	Dental offices	2 Accusations filed 12/28/15 (and one finding of no violation)
2014	NO DEATHS REPORTED			
2015	3	Pediatric oral sedation	Pediatric dental office	Accusation 9/30/15
2015	3	Local anesthetic and nitrous oxide	Hospital	Pending
2015	6	General anesthesia	Dental office	Accusation filed 2/24/2016
2015	17	General anesthesia	Hospital	No violation

NOTIFICATION OF PEDIATRIC HOSPITALIZATIONS

Board staff conducted additional review of hospitalizations of pediatric patients from January 1, 2010 through December 31, 2015. The following chart summarizes the number of instances; and breaks down incidents by the year of occurrence, the patient's age, and the type of sedation used, if applicable.

Summary of Pediatric Hospitalization by Year and Patient Age 2010-2015						
Year	Age	Conscious Sedation	General Anesthesia	Local Anesthetic	Unknown	Grand Total
2010	3		1			1
	18			1		1
2010 Total			1	1		2
2011	17				1	1
2011 Total					1	1
2012	3		1			1
	6		1	1		2
	14		1			1
	18		1	1		2
2012 Total			4	2		6
2013	1.5			1		1
	1.7		1			1
	3	1	1			2
	4				1	1
	15		1			1
	17	2	1	1		4
	18		1			1
	20	1				1
	unknown				1	1
2013 Total		4	5	2	2	13
2014	2.5		1			1
	3	1	1			2
	4	1	2	2		5
	5		1			1
	6	1	1			2
	7			1		1
	14		1			1
	17		1			1
	19			1		1
2014 Total		3	8	4		15
2015	2	1	2			3
	3.5	1				1
	8		1			1
	14		1			1
	15		1			1
	21		1			1
2015 Total		2	6			8
Grand Total		9	24	9	3	45

For the purpose of this inquiry, the Board has examined all identified notifications and investigations of pediatric deaths and hospitalizations. During the course of an investigation, the Board gathers information and evidence, and conducts investigations with the intent to determine if dental treatment was rendered within the community standard of care.

Any notifications of potential violations are initially received and reviewed by the Complaint and Compliance Unit (CCU). CCU staff initially review and enter the complaint in the database. The matter is then referred to an analyst within the CCU to determine priority, gather records, and prepare for review by an in-house dental consultant. The in-house dental consultant determines at a general level, if the treatment was within the community standard of care. If the in-house consultant finds a deviation from the community standard of care, the matter is referred to investigation.

Of note, each case has different factors and components, and depending on the circumstances of the investigation, the matter may be identified as a priority matter. Reports of patient death are immediately referred to investigation, and are handled and investigated as a priority matter.

Upon initial receipt by investigative staff, the case is reviewed and evaluated for potential Dental Practice Act (DPA) and community standard of care violations. Matters are reviewed by investigative staff upon first receipt for prioritization. Upon investigation of each individual case, evidence is obtained, records are gathered, and interviews are conducted.

The investigative evidence gathered is then forwarded to a subject matter expert (SME) in the area of treatment, for review and determination of violation(s) of the community standard of care and the DPA. The SME prepares a report of his or her findings, and based on the findings, the Board will proceed accordingly; i.e., referral to the Office of the Attorney General, case closure; with no violation or insufficient evidence, a citation and fine, etc.

Cases are referred to the Office of the Attorney General for consideration of disciplinary action, including revocation, suspension, or probation. Matters closed with no violation are a result of a finding that the treatment rendered did not deviate from the community standard of care. A case closed with insufficient evidence, did not support that a violation occurred to the degree that charges can successfully be filed with the Office of the Attorney General.

Because of the broad range of complaint types, information gathered is specific to each case, and varies widely from investigation to investigation. The information obtained during the course of the investigation is germane to the specific case and allegations. The Board does not have the ability to maintain detailed scientific research data through its tracking mechanisms for investigations conducted.

In conclusion, there were nine major complications, and all resulted in death of the patient. There were no reports of serious permanent sequelae such as brain damage or permanent disability following hospitalization, with most patients discharged after a brief hospital stay. Of the nine major complications, three involved office sedation/anesthesia, three occurred in hospital, and three involved local anesthesia or local + nitrous oxide/oxygen. Of the three cases that involved office sedation or anesthesia, two involved the use of oral conscious sedation and one involved the use of general anesthesia.

The data available from published studies and board statistics for California do not support a statistical analysis due to the small number of serious adverse outcomes, but do not indicate that any type of provider or sedation delivery model has better outcomes.

Although pediatric dental sedation has an excellent safety record, adverse outcomes sometimes occur in apparently healthy patients, indicating that there may be inherent risk in sedation and general anesthesia. Nevertheless it is important to continue efforts to improve outcomes for all patients who receive sedation and general anesthesia for dental treatment.

PART 4: CONCLUSION

APPENDIX 1

Dental advanced educational programs that include training in moderate sedation, deep sedation, and general anesthesia

Commission on Dental Accreditation Advanced Educational Programs

The Commission on Dental Accreditation (CODA) was established in 1975 and is nationally recognized by the United States Department of Education (USDE) as the sole agency to accredit dental and dental-related education programs conducted at the post-secondary level. CODA accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Accreditation standards are developed in consultation with those affected who represent broad communities of interest. A comparison table of education for training in various levels of sedation is included as Appendix 2 Table 1.

Postgraduate CODA approved residencies that require deep sedation-general anesthesia training.

Oral and Maxillofacial Surgery (OMS) (48-72 months of Post Graduate Education)[1]

OMS's complete, at a minimum, a post graduate CODA approved residency of 48 months (single degree-DDS). Approximately half of those trained complete a 72 month residency (dual degree-DDS,MD).

The following CODA approved post graduate residency training programs (after dental school-4 years) require 36 months for dental anesthesiology, 30 months for periodontics, 24 months for pediatric dentistry, and 12-24 months for general practice (GPR).

OMS Sedation / General Anesthesia Training During Residency Training

- During OMS training, a resident completes the equivalency of a PGY1 year of anesthesia training.
- During the four or six year residency, each resident receives didactic education in subjects related to anesthesia including anatomy, pharmacology, and physiology, patient evaluation, risk assessment, anesthesia and sedation techniques, patient monitoring, and diagnosis and management of emergency complications. They also complete a structured course in physical diagnosis including patient evaluation and risk assessment.

[1] CODA. (2012). Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery. Retrieved from https://www.ada.org/~/media/CODA/Files/oms.pdf?la=en

- The clinical training currently includes five (5) months on the hospital medical anesthesia service functioning at an anesthesia resident (PGY1) level with responsibility for patient evaluation, risk assessment, anesthesia and sedation techniques, patient monitoring, and diagnosis and management of complications.
- Clinical experience shall also include training to competency in airway management (simple, direct/ fiber optic intubation, emergency tracheotomy).
- CODA training requirements require the resident to perform 300 cases of general anesthesia of which 50 are pediatric patients and 150 of the 300 must be ambulatory anesthesia for OMS. Pediatric patients are defined as under age 18.
- CODA approved training also requires hospital based rotations with the resident functioning at a PGY1 level: two (2) months on the medicine service (for non MD programs); four (4) months on the general or a sub-specialty surgery service; and a rotation on the hospital emergency service.

- In addition, the OMS resident is required to complete the following certifications: Advanced Trauma Life Support (ATLS); Certification and currency in Advanced Cardiac Life Support (ACLS); and Pediatric Advanced Life Support (PALS).

Dental Anesthesiology[2] (36 months Post Graduate Education)

Note: until recently, a CODA approved residency in dental anesthesiology was 24 months. The current residents in dental anesthesiology must receive didactic instruction at an advanced in-depth level for applied biomedical sciences foundational to dental anesthesiology, physical diagnosis and evaluation, methods of anxiety and pain control, complications and emergencies, and pain management.

The clinical requirements must include a minimum of 24 months in anesthesia with a minimum of this period of 6 months devoted to dental anesthesiology. Twelve months over the 36 month period must be assigned full-time to a hospital anesthesia service. They must complete 800 total cases of deep sedation/general anesthesia: 300 cases must be intubated general anesthetics including 50 nasal intubations and 25 advanced airway management techniques; 125 children age 0-7seven; and 75 patients with special needs. At least 100 of 800 cases must be out-patient anesthesia for dentistry and the resident must be the provider. Additionally, the resident must participate in four (4) months of clinical medical rotations of internal medicine; intensive care; pain medicine; pediatrics; or pulmonary medicine.

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[2] CODA. (2012). Accreditation Standards For Advanced General Dentistry Education Programs in Dental Anesthesiology. Retrieved from https://www.ada.org/~/media/CODA/Files/anes.pdf?la=en

Postgraduate CODA approved residencies that include moderate sedation training.

Periodontics (30 months Post Graduate Education)
The periodontics training standards state the program must provide training in the methods of pain control and sedation. They must achieve knowledge in all areas of minimal, moderate, and deep sedation and be trained to a level of competency in adult minimal enteral and moderate parenteral sedation.

Pediatric Dentistry[3] (24 months Post Graduate Education)

The pediatric dentistry training standards require education in anatomy, pharmacology, and principles and objectives of sedation and general anesthesia as behavioral guidance techniques including indications and contraindications for their use in accordance with the ADA Standards for Teaching of Pain Control and Sedation to Dentists and Dental Students. Clinical experience must include infants, children, adolescents, and patients with special needs for inhalation analgesia (nitrous oxide/oxygen) and sedation. Therefore they must perform 20 inhalation analgesia cases as primary operator, 50 patient encounters in which sedative agents (other than nitrous oxide/oxygen) by any route are used and must act as the operator in a minimum of 25 sedation cases.

General Practice Residency (12-24 months Post Graduate Training)

The general practice residency standards require the resident to receive education and training beyond pre-doctoral training including pain and anxiety control utilizing behavioral and/or pharmacological techniques. For clinical experience, residents must be assigned to an anesthesia rotation for a minimum 70 hours to gain experience in preoperative evaluation, assessment of the effects of behavioral and pharmacologic techniques, venipuncture technique, patient monitoring, airway management, understanding of the use of pharmacologic agents, recognition and treatment of anesthetic emergencies, and assessment of patient recovery from anesthesia. Additional clinical experience includes interpreting clinical and other diagnostic data from other health care providers, using the services of clinical medicine and pathology, and performing a history and physical evaluation and collecting other data necessary to establish a medical assessment.

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[3] CODA. (2015). Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry. Retrieved from https://www.ada.org/~/media/CODA/Files/ped.pdf?la=en

American Society of Anesthesiologists Training recommended for non-anesthesiologists seeking privileges to administer deep sedation[4]

EDUCATION AND TRAINING

The non-anesthesiologist sedation practitioner will have satisfactorily completed a formal training program in (1) the safe administration of sedative and analgesic drugs used to establish a level of deep sedation, and (2) rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation. This training may be a formally recognized part of a recently completed Accreditation Council for Graduate Medical Education (ACGME) residency or fellowship training (e.g., within two years), or may be a separate deep sedation educational program that is accredited by Accreditation Council for Continuing Medical Education (ACCME) or equivalent providers recognized for dental, oral surgical and podiatric continuing education, and that includes the didactic and performance concepts below. A knowledge-based test is necessary to objectively demonstrate the knowledge of concepts required to obtain privileges. The following subject areas will be included:

3.1 Contents of the following ASA documents (or their more current version if subsequently modified) that will be understood by practitioners who administer sedative and analgesic drugs to establish a level of deep sedation.

3.1.1 Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. Anesthesiology 2002: 96; 1004-1017.

3.1.2 Continuum of Depth of Sedation; Definition of General Anesthesia and Levels of Sedation/Analgesia (ASA HOD 2004, amended 2009)

3.1.3 Standards for Basic Anesthetic Monitoring (Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 25, 2005)

3.1.4 Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures (Approved by ASA House of Delegates on October 21, 1998, and effective January 1, 1999)

3.2 Appropriate methods for obtaining informed consent through pre-procedure counseling of patients regarding risks, benefits and alternatives to the administration of sedative and analgesic drugs to establish a level of deep sedation.

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[4] American Society of Anesthesiologists. (2010). Advisory on granting privileges for deep sedation to non-anesthesiologist sedation practitioners. Retrieved from aspx.\nhttp://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/advisory-on-granting-privileges-for-deep-sedation-to-non-anesthesiologist.pdf

3.3 Skills for obtaining the patient's medical history and performing a physical examination to assess risks and co-morbidities, including assessment of the airway for anatomic and mobility characteristics suggestive of potentially difficult airway management. The non-anesthesiologist sedation practitioner will be able to recognize those patients whose medical condition requires that sedation needs to be provided by an anesthesia professional, such as morbidly obese patients, elderly patients, pregnant patients, patients with severe systemic disease, patients with obstructive sleep apnea, or patients with delayed gastric emptying.

3.4 Assessment of the patient's risk for aspiration of gastric contents as described in the ASA Practice Guidelines for Preoperative Fasting. In urgent, emergent or other situations where gastric emptying is impaired, the potential for pulmonary aspiration of gastric contents must be considered in determining

3.4.1 The target level of sedation

3.4.2 Whether the procedure should be delayed

3.4.3 Whether the sedation care should be transferred to an anesthesia professional for the delivery of general anesthesia with endotracheal intubation.

3.5 The pharmacology of

3.5.1 All sedative and analgesic drugs the practitioner requests privileges to administer to establish a level of deep sedation

3.5.2 Pharmacological antagonists to the sedative and analgesic drugs

3.5.3 Vasoactive drugs and antiarrhythmics.

3.6 The benefits and risks of supplemental oxygen.

3.7 Recognition of adequacy of ventilatory function: This will include experience with patients whose ventilatory drive is depressed by sedative and analgesic drugs as well as patients whose airways become obstructed during sedation. This will also include the ability to perform capnography and understand the results of such monitoring. Non-anesthesiologist practitioners will demonstrate competency in managing patients during deep sedation, and understanding of the clinical manifestations of general anesthesia so that they can ascertain when a patient has entered a state of general anesthesia and rescue the patient appropriately.

3.8 Proficiency in advanced airway management for rescue: This training will include appropriately supervised experience to demonstrate competency in managing the airways of patients during deep sedation, and airway management using airway models as well as using high-fidelity patient simulators. The non-anesthesiologist practitioner must demonstrate the ability to reliably perform the following:

3.8.1. Bag-valve-mask ventilation

3.8.2 Insertion and use of oro- and nasopharyngeal airways

3.8.3 Insertion and ventilation through a laryngeal mask airway

3.8.4 Direct laryngoscopy and endotracheal intubation

This will include clinical experience on no less than 35 patients or equivalent simulator experience (See ACGME reference). The facility with oversight by the Director of Anesthesia Services will determine the number of cases needed to demonstrate these competencies, and may increase beyond the minimum recommended.

3.9 Monitoring of physiologic variables, including the following:

3.9.1 Blood pressure.

3.9.2 Respiratory rate.

3.9.3 Oxygen saturation by pulse oximetry with audible variable pitch pulse tone.

3.9.4 Capnographic monitoring. The non-anesthesiologist practitioner shall be familiar with the use and interpretation of capnographic waveforms to determine the adequacy of ventilation during deep sedation.

3.9.5 Electrocardiographic monitoring. Education in electrocardiographic (EKG) monitoring will include instruction in the most common dysrhythmias seen during sedation and anesthesia, their causes and their potential clinical implications (e.g., hypercapnia), as well as electrocardiographic signs of cardiac ischemia.

3.9.6 Depth of sedation. The depth of sedation will be based on the ASA definitions of "deep sedation" and "general anesthesia." (See below).

3.10 The importance of continuous use of appropriately set audible alarms on physiologic monitoring equipment.

3.11 Documenting the drugs administered, the patient's physiologic condition and the depth of sedation at five-minute intervals throughout the period of sedation and analgesia, using a graphical, tabular or automated record which documents all the monitored parameters including capnographic monitoring. The importance of monitoring the patient through the recovery period and the inclusion of specific discharge criteria for the patient receiving sedation.

3.12 Regardless of the availability of a "code team" or the equivalent, the non-anesthesiologist practitioner will have advanced life support skills and current certificate such as those required for Advanced Cardiac Life Support (ACLS). When granting privileges to administer deep sedation to pediatric patients, the non- anesthesiologist practitioner will have advanced life support skills and current certificate such as those required for Pediatric Advanced Life Support (PALS). Initial ACLS and PALS training and subsequent retraining shall be obtained from the American Heart Association or another vendor that includes "hands-on" training and skills demonstration of airway management and automated external defibrillator (AED) use.

3.13 Required participation in a quality assurance system to track adverse outcomes and unusual events including respiratory arrests, use of reversal agents, prolonged sedation in recovery process, larger than expected medication doses, and occurrence of general anesthesia, with oversight by the Director of Anesthesia services or their designee.

3.14 Knowledge of the current CMS Conditions of Participation regulations and their interpretive guidelines pertaining to deep sedation, including requirements for the pre- anesthesia evaluation, anesthesia intra-operative record, and post-anesthesia evaluation.

Separate privileging is required for the care of pediatric patients. When the non-anesthesiologist practitioner is granted privileges to administer sedative and analgesic drugs to pediatric patients to establish a level of deep sedation, the education and training requirements enumerated in #1-15 above will be specifically defined to qualify the practitioner to administer sedative and analgesic drugs to pediatric patients.

4. LICENSURE

4.1 The non-anesthesiologist sedation practitioner will have a current active, unrestricted medical, osteopathic, or dental license in the state, district or territory of practice. (Exception: practitioners employed by the federal government may have a current active license in any U.S. state, district or territory.)

4.2 The non-anesthesiologist sedation practitioner will have a current unrestricted Drug Enforcement Administration (DEA) registration (schedules II-V).

4.3 The privileging process will require disclosure of any disciplinary action (final judgments) against any medical, osteopathic or dental license by any state, district or territory of practice and of any sanctions by any federal agency, including Medicare/Medicaid, in the last five years.

4.4 Before granting or renewing privileges to administer or supervise the administration of sedative and analgesic drugs to establish a level of deep sedation, the health care organization shall search for any disciplinary action recorded in the National Practitioner Data Bank (NPDB) and take appropriate action regarding any Adverse Action Reports.

5. PERFORMANCE EVALUATION

5.1 Before granting initial privileges to administer or supervise administration of sedative and analgesic drugs to establish a level of deep sedation, a process will be developed to evaluate the practitioner's performance and competency. For recent graduates (e.g., within two years), this may be accomplished through letters of recommendation from directors of residency or fellowship training programs that include deep sedation as part of the curriculum. For those who have been in practice since completion of their training, performance evaluation may be accomplished through specific documentation of performance evaluation data transmitted from department heads or supervisors at the institution where the individual previously held privileges to administer deep sedation. Alternatively, the non-anesthesiologist sedation practitioner could be proctored or supervised by a physician or dentist who is currently privileged to administer sedative and analgesic agents to provide deep sedation. The Director of Anesthesia Services with oversight by the facility governing body will determine the number of cases that need to be performed in order to determine independent competency in deep sedation.

5.2 Before granting ongoing privileges to administer or supervise administration of sedative and analgesic drugs to establish a level of deep sedation, a process will be developed to re-evaluate the practitioner's performance at regular intervals. Re- evaluation of competency in airway management will be part of this performance evaluation. For example, the practitioner's performance could be reviewed by an anesthesiologist or a non-anesthesiologist sedation practitioner who is currently privileged to administer deep sedation. The facility will establish an appropriate number of procedures that will be reviewed.

6. PERFORMANCE IMPROVEMENT

Privileging in the administration of sedative and analgesic drugs to establish a level of deep sedation will require active participation in an ongoing process that evaluates the practitioner's clinical performance and patient care outcomes through a formal facility program of continuous performance improvement. The facility's deep sedation performance improvement program will be developed with advice from and with outcome review by the Director of Anesthesia Services.

6.1 The organization in which the practitioner practices will conduct peer review of its clinicians.

6.2 The performance improvement program will assess up-to-date knowledge as well as ongoing competence in the skills outlined in the educational and training requirements described above.

6.3 Continuing medical education in the delivery of anesthesia services is required for renewal of privileges.

6.4 The performance improvement program will monitor and evaluate patient outcomes and adverse or unusual events.

6.5 Any of the following events will be referred to the facility quality assurance committee for evaluation and performance evaluation:

6.5.1 Unplanned admission

6.5.2 Cardiac arrest

6.5.3 Use of reversal agents

6.5.4 Use of assistance with ventilation requiring bag-valve-mask ventilation or laryngeal or endotracheal airways.

6.5.5 Prolonged periods of oxygen desaturation (<85% for 3 minutes)

6.5.6 Failure of the patient to return to 20% of pre-procedure vital signs

7. DEFINITIONS

Anesthesia Professional: An anesthesiologist, anesthesiologist assistant (AA), or certified registered nurse anesthetist (CRNA).

Non-anesthesiologist Sedation Practitioner: A licensed physician (allopathic or osteopathic); or dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; who has not completed postgraduate training in anesthesiology but is specifically trained to administer personally or to supervise the administration of deep sedation.

Appendix 2

Table of Contents

Comparison of California requirements for minimal, moderate and deep sedation/general anesthesia with American Dental Association Guidelines[1] and American Academy of Pediatrics – American Academy of Pediatric Dentistry Guidelines[2]

Table 1 4

California definitions compared to ADA and ADA-AAPD Guidelines 4

Table 2 8

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia 8

Continuing Education – Comparison of State Requirements with Association Guidelines 12

Table 3. 16

Pre operative evaluation requirements for minimal sedation, moderate sedation deep sedation and general anesthesia 16

Table 4. 20

Personnel Requirements – Clinical Guidelines - Comparison of CA, ADA, and AAP-AAPD Guidelines 20

Sedation and Anesthesia Assisting Requirements in the 50 States 22

Table 5. 25

Facility Requirements - Clinical Guidelines – Comparison of California, ADA and AAP-AAPD Guidelines 25

Table 6. Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia 27

State Requirements 32

Table 7. 33

Record Requirements - Clinical Guidelines for Minimal sedation, Moderate sedation, Deep Sedation, and General Anesthesia 33

Table 8. 36

[1] American Dental Association. (2012). Guidelines for the Use of Sedation and General Anesthesia by Dentists. In *Society* (Vol. 80, pp. 75–106). http://doi.org/10.1112/S0024611500012132

[2] Coté, C. J., & Wilson, S. (2016). Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016. *Pediatrics*, *138*(1), 1–87. http://doi.org/10.1542/peds.2016-1212

Emergency drugs - California sedation laws compared to ADA and ADA-AAPD Guidelines.....36
Table 9.....38
State Mandated Office Inspection Requirements.....38
1. California office inspection laws.....38
2. Summary of Requirements in 50 states.....41
Table 10.....43
Pediatric Sedation Laws for the 50 States – Summary.....43

Table 1

California definitions compared to ADA and ADA-AAPD Guidelines

California requirements for minimal sedation, moderate sedation and general anesthesia **California law has specific requirements for pediatric patients for oral (moderate) conscious sedation only.(age 13 and under)**	**ADA Guidelines for use of sedation and general anesthesia by dentists; For pediatric patients ADA supports AAP-AAPD Guidelines (age 12 and under)**	**AAP-AAPD Guidelines exclusively for monitoring and management of pediatric patients; (age 21 and under)**
	Minimal Sedation	
Minimal sedation not defined in CA Law. See BPC 1647, Conscious Sedation and BPC 1647.10 Use of Oral Conscious Sedation for Pediatric patients; 1647.18 Use of Oral Conscious Sedation for Adult Patients.	"A minimally depressed level of consciousness produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command." "Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected." "The drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation. The ADA Guidelines add a definition of "combination inhalation-enteral conscious sedation" for when the intent is anxiolysis only. When the intent is conscious (moderate) sedation that definition applies.	*Minimal sedation* (old terminology *anxiolysis*): a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

	Oral Conscious Sedation	
oral conscious sedation (pediatric and adult) **see BPC 1674.10** **Oral conscious sedation means** a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command." "The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral conscious sedation."	*Author's note: The ADA Guidelines include definitions of both conscious sedation and moderate sedation, and gives clinical guidelines for each. However the preferred term appears to be moderate sedation because it is accompanied by clinical guidelines.*	
	Moderate Sedation	
CA term is " conscious sedation" BPC 1647.1 Conscious sedation means a minimally depressed level of consciousness produced by a pharmacologic or nonpharmacologic method, or a combination thereof, that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command." Conscious sedation does not include that administration of oral medication or the administration of a mixture of nitrous oxide and oxygen, whether alone or with each other.	The term "conscious sedation" has been replaced by the ADA with the term "moderate sedation", defined as "a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation." "No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained." "Drugs or techniques should maintain a margin of safety wide enough to render unintended loss	Moderate sedation (old terminology conscious sedation or sedation/analgesia): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands (eg, *open your eyes* either alone or accompanied by light tactile stimulation—a light tap on the shoulder or face, not a sternal rub). For older patients, this level of sedation implies an interactive state; for younger patients,age-appropriate behaviors (eg, crying) occur and are expected. Reflex withdrawal, although a normal response to a painful stimulus, is not considered as the only age-appropriate

The drugs and techniques used in conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. For the very young or handicapped, incapable of the usual verbal response, a minimally depressed level of consciousness should be maintained. Further, patients whose only response is reflex withdrawal from painful stimuli shall not be considered to be in a state of conscious sedation.	of consciousness unlikely." "Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist." "A patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation. The ADA Guidelines also include the following cautionary statement: "Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended." For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.	purposeful response (eg, it must be accompanied by another response, such as pushing away the painful stimulus so as to confirm a higher cognitive function).With moderate sedation, no intervention is required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. However, in the case of procedures that may themselves cause airway obstruction (eg, dental or endoscopic), the practitioner must recognize an obstruction and assist the patient in opening the airway. If the patient is not making spontaneous efforts to open his/her airway so as to relieve the obstruction, then the patient should be considered to be deeply sedated.
	Deep sedation	
Deep Sedation in California is described in BPC 1647 (c) as part of a continuum for which the educational standards for general anesthesia should be applied. Deep sedation is not otherwise defined in the California law.	The ADA defines deep sedation as "- a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require	• *Deep sedation* (deep sedation/analgesia): a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (see discussion of reflex withdrawal above) after repeated verbal or painful stimulation (eg,

	assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. The ADA provides identical clinical guidelines for deep sedation or general anesthesia.	purposefully pushing away the noxious stimuli). The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. A state of deep sedation may be accompanied by partial or complete loss of protective airway reflexes.
	General Anesthesia	
Defined as a "controlled state of depressed consciousness or unconsciousness, accompanied by a partial or complete loss of protective reflexes, produced by pharmacologic or non-pharmacologic method, or a combination thereof." (BPC 1646)	A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.	*General anesthesia*: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
CA requires a pediatric oral (moderate) conscious sedation permit for children 13 or under	Pediatrics For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.	

Table 2

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

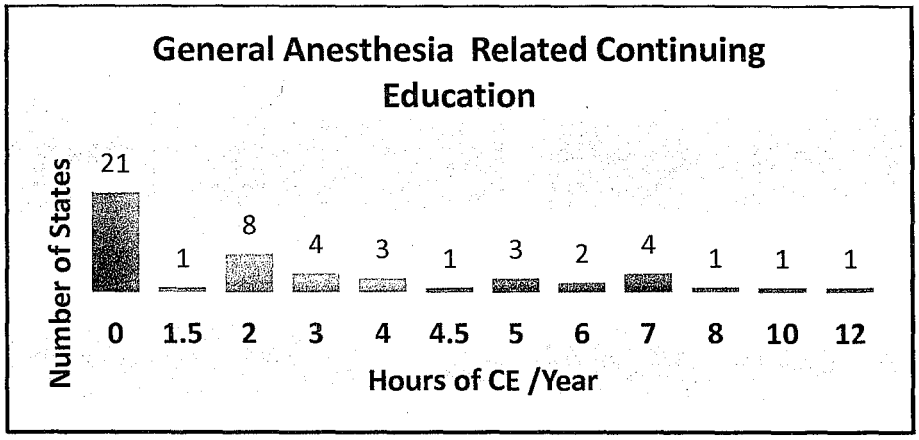
California requirements for moderate sedation and general anesthesia	**ADA Guidelines for use of sedation and general anesthesia by dentists**	**AAP-AAPD Guidelines for monitoring and management of pediatric patients**
	Educational Requirements	
	Minimal Sedation	
Minimal Sedation is not specifically defined in California sedation laws. Training in minimal sedation, including the administration of a mixture of nitrous oxide and oxygen, either alone or in combination with minimal oral sedation, may be taught to the level of basic competency at the predoctoral (dental school) level. (see ADA Educational Guidelines)	The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for including a "hands on" component. Such courses should be AHA or ARC approved. Minimal sedation requires a. training to the level of competency in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, or a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced, or b. an equivalent advanced education program accredited by the ADA Commission on Dental Accreditation. .	No specific educational requirements are provided in these guidelines, however personnel qualifications are stated. "The practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). Because the level of intended sedation may be exceeded, the practitioner must be sufficiently skilled to provide rescue should the child progress to a level of deep sedation. The practitioner must be trained in, and capable of providing, at the minimum, bag-valve-mask ventilation so as to be able to oxygenate a child who develops airway obstruction or apnea. Training in, and maintenance of, advanced pediatric airway skills is required; regular skills reinforcement is strongly encouraged."

	Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration: Current certification in Basic Life Support for Healthcare Providers 1. Completion of a nitrous oxide competency course. 2. While length of a course is only one of many factors, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course. Not intended for the management of sedation in children, which requires additional course content and clinical learning experience.	
	Moderate Sedation	
California Moderate enteral sedation courses for adults and minors	**Moderate Enteral Sedation**	

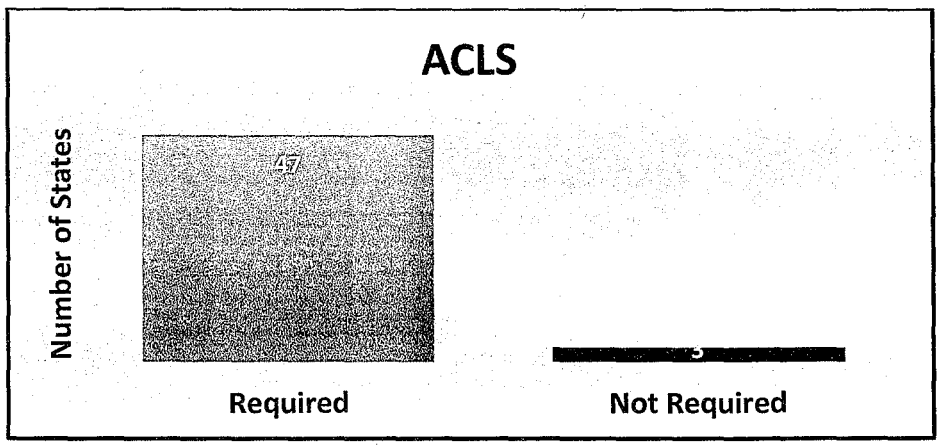
Completion of approved post doctoral or residency training; or, a board approved course that includes 25 hours of instruction including a clinical component utilizing at least one age-appropriate patient; training for either adult patients or minor patients (13 or younger); training requirements reference ADA, AAPD definitions of levels of sedation.(See BPC 1647.12; CCR 1044-1044.5.)	A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation. Participants combining enteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult patients; **this course in moderate enteral sedation is not designed for the management of children (aged 12 and under).** Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted.	No specific educational requirements are provided in these guidelines, however personnel qualifications are stated.
Conscious Sedation (moderate IV sedation)	**Moderate Parenteral Sedation**	**Moderate Sedation**

At least 60 hours of instruction; Satisfactory completion of at least 20 cases of administration of conscious sedation for a variety of dental procedures. Course must comply with the requirements of the *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry* of the American Dental Association (see BPC 1647.3)	A minimum of 60 hours of instruction plus management of at least 20 patients using the intravenous route; clinical experience in managing a compromised airway is critical to prevention of emergencies; Management of children and medically compromised adults requires additional experience; course completion does not result in clinical competency	The practitioner must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). (ed. Specific educational requirements are not described.)
General Anesthesia	**Deep Sedation or General Anesthesia**	**Deep Sedation**
Completion of a residency program in general anesthesia of not less than one calendar year, that is approved by the board; or a graduate program in oral and maxillofacial surgery which has been approved by the Commission on Dental Accreditation. (CCR 1043) (A dentist who orders administration of anesthesia by a nurse anesthetist must meet the requirements for California general anesthesia permit.(BPC 2827).	**C. Deep Sedation or General Anesthesia** 1.Completion of an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with these guidelines; and 2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.	Ed. Specific educational requirements are not addressed in this document At least one individual must be present who is trained in, and capable of, providing advanced pediatric life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is required.

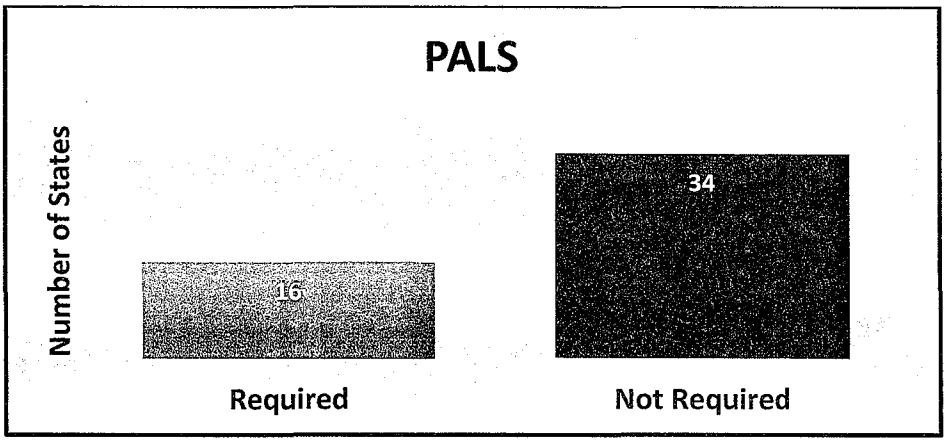
Continuing Education – State Requirements

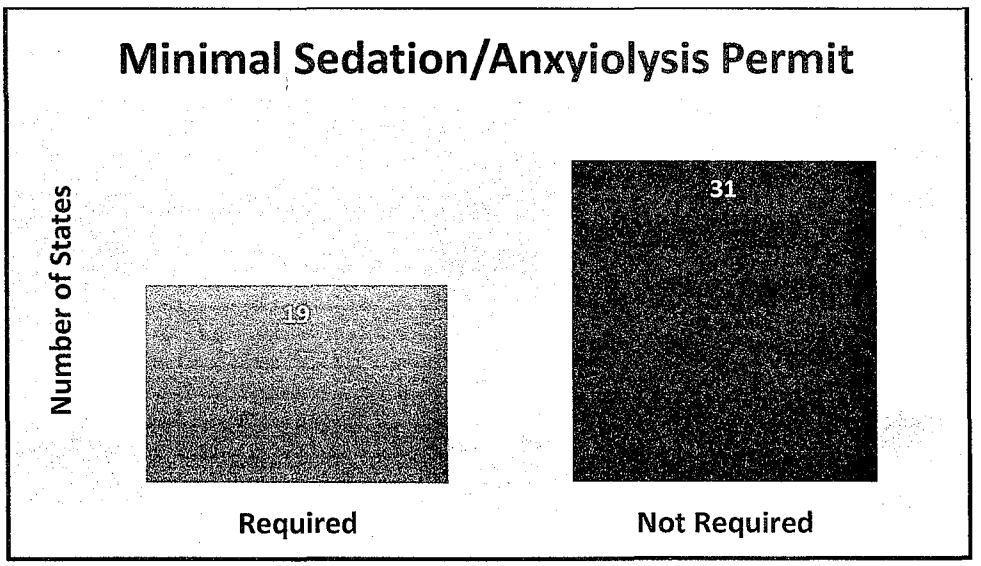


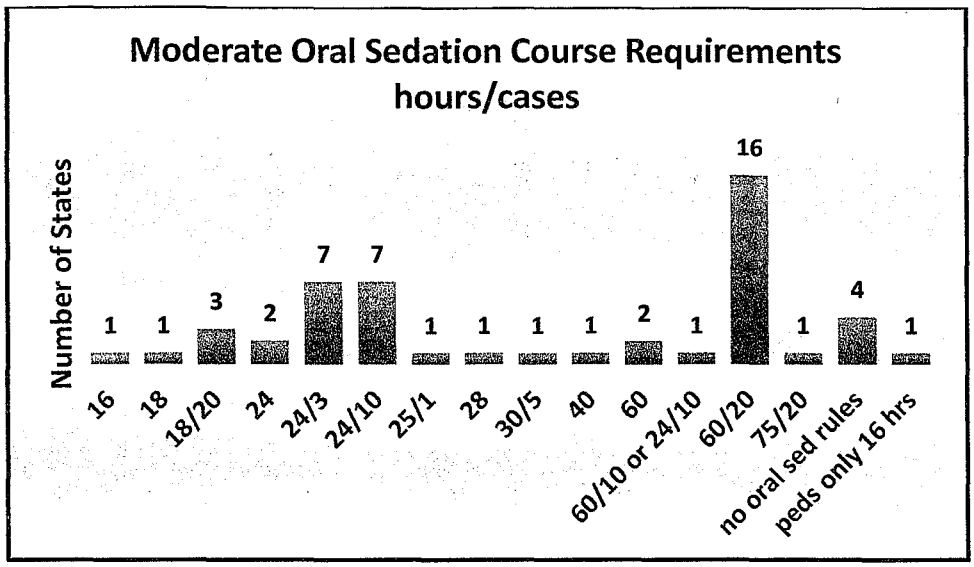
ACLS for General Anesthesia Permits

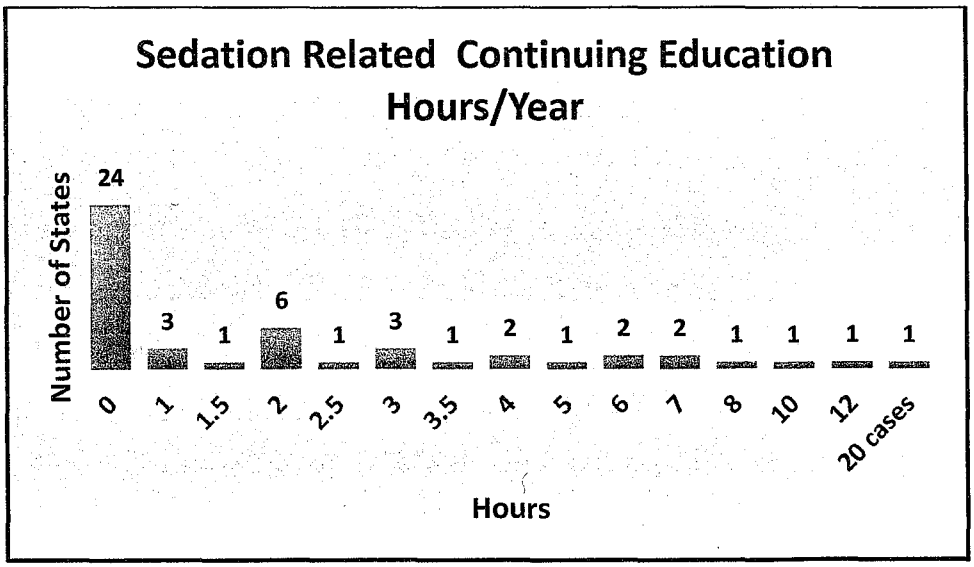


Pediatric Advanced Life Support for General Anesthesia Permit Holders






Moderate Oral Sedation Course Requirements
hours/cases
Number of States
1
1
3
2
7
7
1
1
1
1
2
1
16
1
4
1
16
18
18/20
24
24/3
24/10
25/1
28
30/5
40
60
60/10 or 24/10
60/20
75/20
no oral sed rules
peds only 16 hrs


Sedation Related Continuing Education
Hours/Year
Number of States
24
3
1
6
1
3
1
2
1
2
2
1
1
1
1
0
1
1.5
2
2.5
3
3.5
4
5
6
7
8
10
12
20 cases
Hours

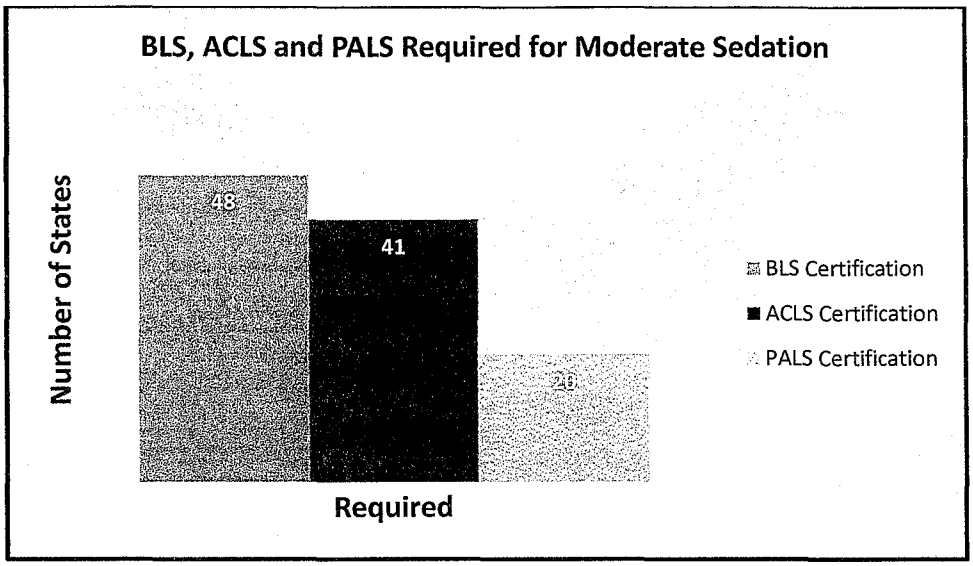

BLS, ACLS and PALS Required for Moderate Sedation
Number of States
48
41
20
Required
BLS Certification
ACLS Certification
PALS Certification

Table 3.

Pre operative evaluation requirements for minimal sedation, moderate sedation deep sedation and general anesthesia

	ADA Guidelines	AAP-AAPD Guidelines
The term Minimal sedation is not used in CA. Laws related to oral moderate sedation apply (CCR sec. 1044)	**Minimal sedation**	General Guidelines are provided for all levels of sedation
Preoperative evaluation Adequate medical history and physical evaluation records updated prior to each administration of oral conscious sedation. Such records shall include, but are not limited to an assessment including at least visual examination of the airway, the age, sex, weight, physical status (American Society of Anesthesiologists Classification), and rationale for sedation of the minor or adult patient. (CCR 1043.3 (i)) Written informed consent must be obtained for all patients undergoing general anesthesia or conscious sedation, or as appropriate, from the parent or legal guardian of the patient. (BPC 1682 (d)) **There is no specific requirement for preoperative dietary precautions.**	Preoperative evaluation and preparation 1. In healthy or medically stable individuals (ASA I, II) a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist. 2. Pre-Operative Preparation • The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained. • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed. • Baseline vital signs must be obtained unless the patient's behavior prohibits such determination. • A focused physical evaluation must be performed	**Health evaluation** Age and weight. • Health history, including: 1) allergies and previous allergic or adverse drug reactions, 2) medication/drug history. 3) relevant diseases, physical abnormalities, and neurologic impairment that might increase the potential for airway obstruction, such as a history of snoring or obstructive sleep apnea,4) pregnancy status, 5) a summary of previous relevant hospitalizations, 6) history of sedation or general anesthesia and any complications or unexpected responses, and 7) relevant family history, particularly related to anesthesia. • Review of systems with a special focus on abnormali ties of cardiac, pulmonary, renal, or hepatic function. Vital signs, including heart rate, blood pressure, res- spiratory rate, and temperature • Physical examination, including a focused evaluation of the airway (tonsillar hypertrophy,abnormal anatomy• Physical status

	as deemed appropriate. • Preoperative dietary restrictions must be considered based on the sedative technique prescribed. • Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.	evaluation [ASA classification • Name, address, and telephone number of the child's medical home. Dietary precautions **Dietary precautions** Before sedation, the practitioner should evaluate preceding food and fluid intake. It is likely that the risk of aspiration during procedural sedation differs from that during general anesthesia involving tracheal intubation or other airway manipulation. However, because the absolute risk of aspiration during procedural sedation is not yet known, guidelines for fasting periods before elective sedation generally should follow those used for elective general anesthesia. For emergency procedures in children who have not fasted, the risks of sedation and the possibility of aspiration must be balanced against the benefits of performing the procedure promptly Further research is needed to better elucidate the relationships between various fasting intervals and sedation complications
Conscious (Moderate) Sedation	**Moderate Sedation**	**Moderate Sedation** See above section
Adequate medical history and physical evaluation records updated prior to each administration of general anesthesia or conscious sedation. Such records shall include, but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists	Patient Evaluation In healthy or medically stable individuals (ASA I, II) evaluation should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require	

Classification), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required.(CCR 1043.3 (i)) **There are no specific requirements for preoperative dietary restrictions**. A written informed consent must be isgned by the patient or guardian, see BPC 1682 (d)	consultation with their primary care physician or consulting medical specialist. 2. Pre-operative Preparation • The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained. • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed. • Baseline vital signs must be obtained unless the patient's behavior prohibits such determination. • A focused physical evaluation must be performed as deemed appropriate. • Preoperative dietary restrictions must be considered based on the sedative technique prescribed. • Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver.	
General Anesthesia	**Deep Sedation or General Anesthesia**	**Deep Sedation**
no specific dietary restrictions Equipment for an IV must be available, but does not need to be established. Dentist discretion advised for cases where it may be difficult or impossible to establish IV access.	1. Patient Evaluation In healthy or medically stable individuals (ASA I, II) at least a review of their current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting	Ed. See above section for health evaluation. This applies to all levels of sedation.

	medical specialist. 2. Pre-operative Preparation • The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained. • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed. • Baseline vital signs must be obtained unless the patient's behavior prohibits such determination. • A focused physical evaluation must be performed as deemed appropriate. • Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed. • Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver. • An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.	

Table 4.

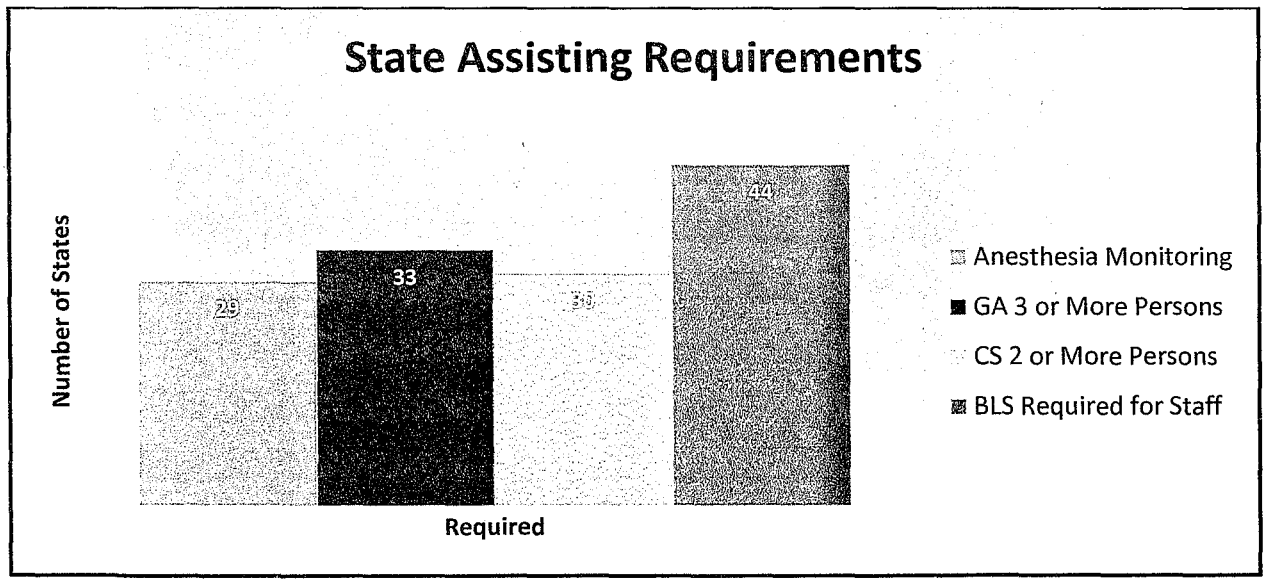
Personnel Requirements – Clinical Guidelines - Comparison of CA, ADA, and AAP-AAPD Guidelines

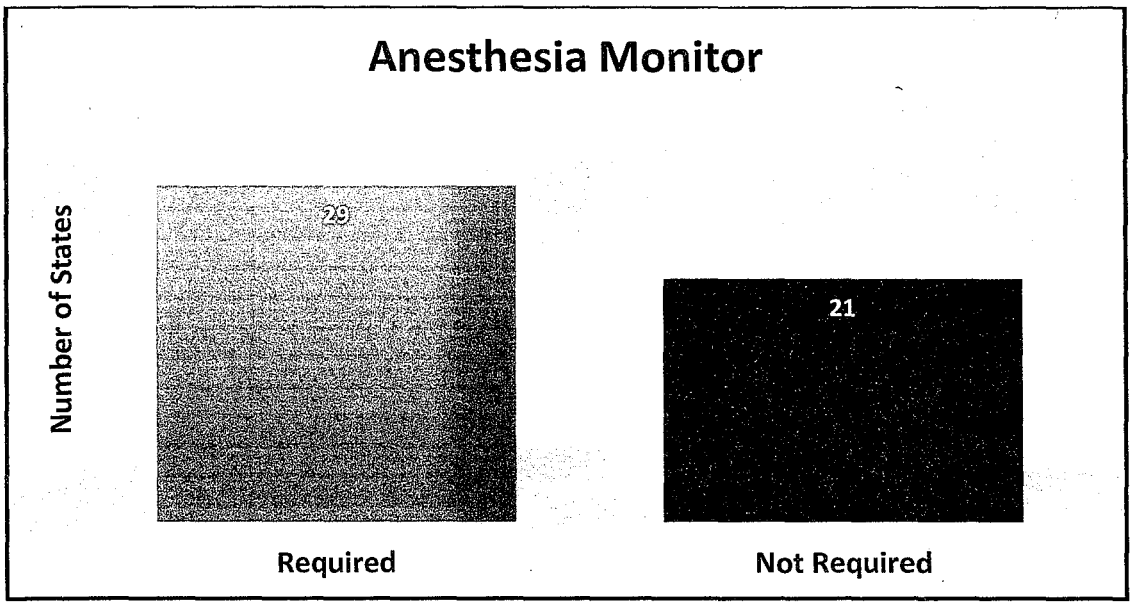
California	ADA Guidelines	AAP-AAPD Guidelines
Minimal sedation	**Minimal sedation**	**Minimal sedation**
	At least one additional person trained in BLS + dentist	Children who have received minimal sedation generally will not require more than observation and intermittent assessment of their level of sedation. Some children will become moderately sedated despite the intended level of minimal sedation; should this occur, then the guidelines for moderate sedation apply.
Moderate sedation	**Moderate sedation**	**Moderate sedation**
BPC 1682 Each patient is continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer conscious sedation or general anesthesia. The patient must be closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from conscious sedation or general anesthesia. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one.	At least one person trained in BLS for providers+dentist	The use of moderate sedation shall include provision of a person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration.44 This individual must be trained in and capable of providing pediatric basic life support. The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies

Staff must be certified in basic cardiac life support (CPR) and recertified		
	A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.	One person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration. This individual must be trained in and capable of providing pediatric basic life support. The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies.
Deep sedation/general anesthesia	**Deep sedation/general anesthesia**	**Deep sedation/GA**
Same as moderate sedation	A minimum of three (3) individuals must be present. • A dentist qualified in accordance with Part III. C. of these Guidelines to administer the deep sedation or general anesthesia. • Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider. • When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.	There must be one person available whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration. At least one individual must be present who is trained in, and capable of, providing advanced pediatric life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is required.

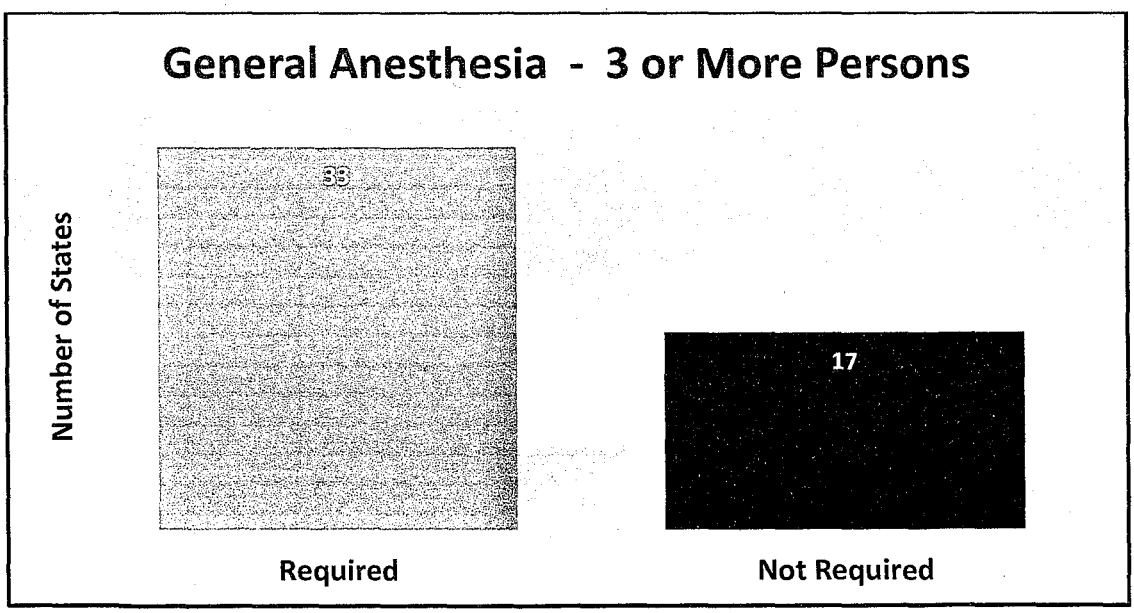
	A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.	

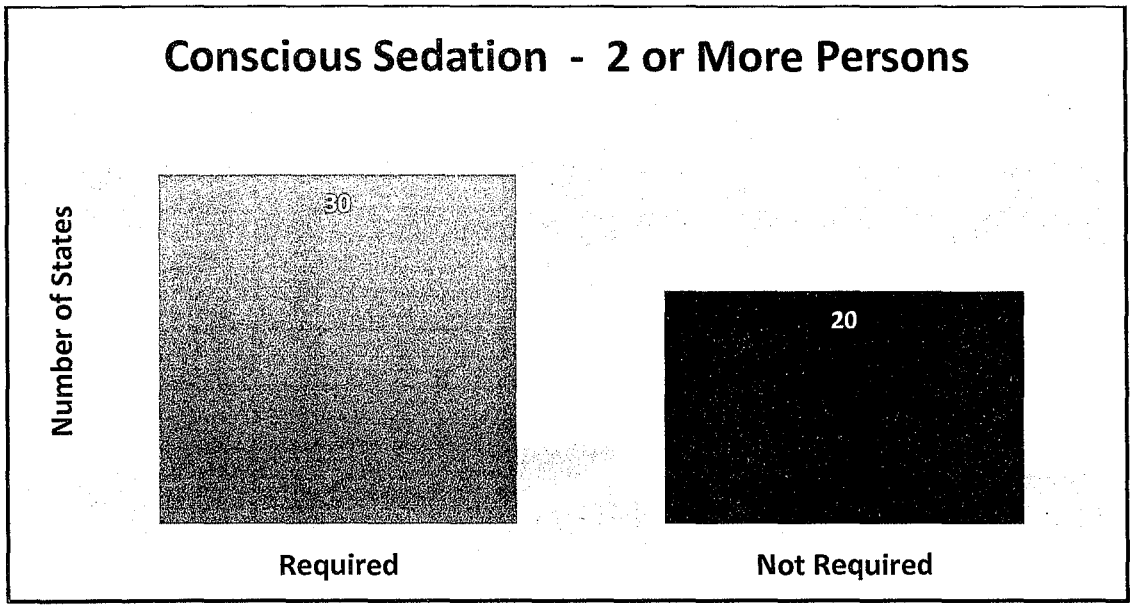
Sedation and Anesthesia Assisting Requirements in the 50 States





Sedation and Anesthesia Assisting Requirements in the 50 States





Sedation and Anesthesia Assisting Requirements in the 50 States

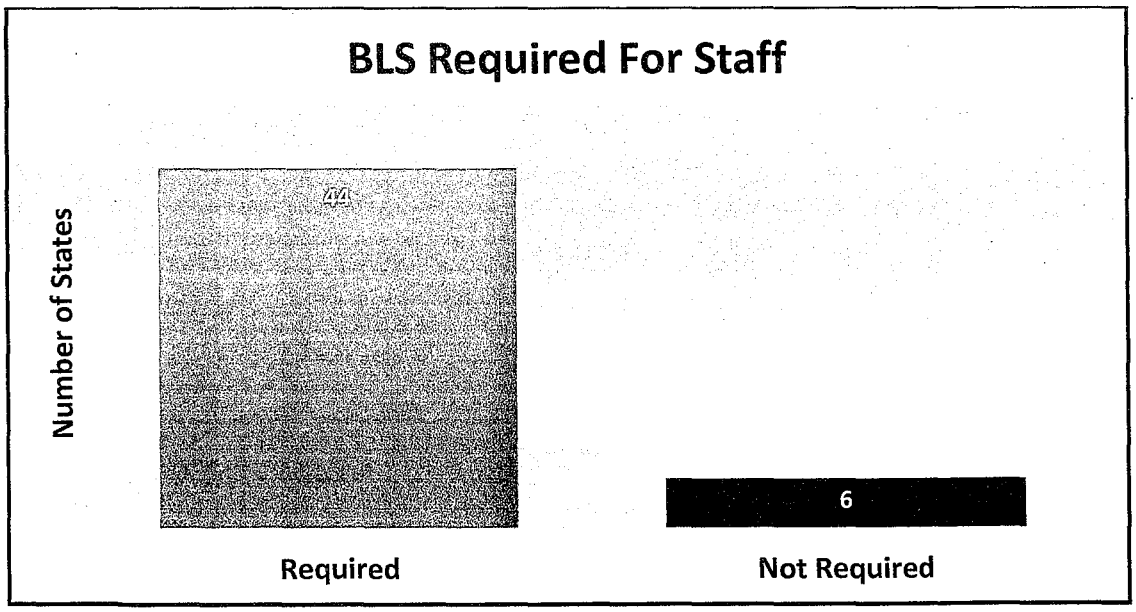


Table 5.

Facility Requirements - Clinical Guidelines – Comparison of California, ADA and AAP-AAPD Guidelines

California Requirements	ADA Guidelines	AAP-AAPD Guidelines
Facilities **See CCR 1044.5 Facility and Equipment Standards – these are the same for all levels of sedation and anesthesia** (a) Office Facilities and Equipment. The following office facilities and equipment shall be available and shall be maintained in good operating condition: (1) An operating theater large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient. (2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation. (3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit	Facility requirements not specifically stated, except as listed under equipment requirements below. A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. • When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm. • An appropriate scavenging system must be available if gases other than oxygen or air are used.	**Facilities** The practitioner who uses sedation must have immediately available facilities, personnel, and equipment to manage emergency and rescue situations. The most common serious complications of sedation involve compromise of the airway or depressed respirations resulting in airway obstruction, hypoventilation, hypoxemia, and apnea. Hypotension and cardiopulmonary arrest may occur, usually from inadequate recognition and treatment of respiratory compromise. Other rare complications may also include seizures and allergic re-actions. Facilities providing pediatric sedation should monitor for, and be prepared to treat, such complications.

completion of any operation underway at the time of general power failure. (4) Suction equipment which permits aspiration of the oral and pharyngeal cavities. A backup suction device which can operate at the time of general power failure must also be available. (5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of allowing the administering of greater than 90% oxygen at a 10 liter/minute flow at least sixty minutes (650 liter "E" cylinder) to the patient under positive pressure, together with an adequate backup system which can operate at the time of general power failure. (6) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theater.		

Table 6. Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

California Requirements	ADA Guidelines	AAP-AAPD Guidelines
Oral Conscious Sedation	Minimal Sedation	All Levels of Sedation
CCR 1044: An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Ancillary equipment, which must include the following, and be maintained in good operating condition: (1) Age-appropriate oral airways capable of accommodating patients of all sizes. (2) An age-appropriate sphygmomanometer with cuffs of appropriate size for patients of all sizes. (3) A precordial/pretracheal stethoscope. (4) A pulse oximeter	Monitoring: A dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include: Oxygenation: • Color of mucosa, skin or blood must be evaluated continually. • Oxygen saturation by pulse oximetry may be clinically useful and should be considered. Ventilation: • The dentist and/or appropriately trained individual must observe chest excursions continually. • The dentist and/or appropriately trained individual must verify respirations continually. Circulation: • Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).	**On-site monitoring and rescue equipment** An emergency cart or kit must be immediately accessible. This cart or kit must contain equipment to provide the necessary age- and size-appropriate drugs and equipment to resuscitate a non breathing and unconscious child. The contents of the kit must allow for the provision of continuous life support while the patient is being transported to a medical facility or to an-other area within a medical facility. All equipment and drugs must be checked and maintained on a scheduled basis (see Appendices C and D for suggested drugs and emergency life support equipment to consider before the need for rescue occurs). Monitoring devices, such as electrocardiography (**ECG**) machines, pulse oximeters (with size-appropriate oximeter probes), end-tidal carbon dioxide monitors, and defibrillators (with size-appropriate defibrillator paddles), must have a safety and function check on a regular basis as required by local or state regulation.

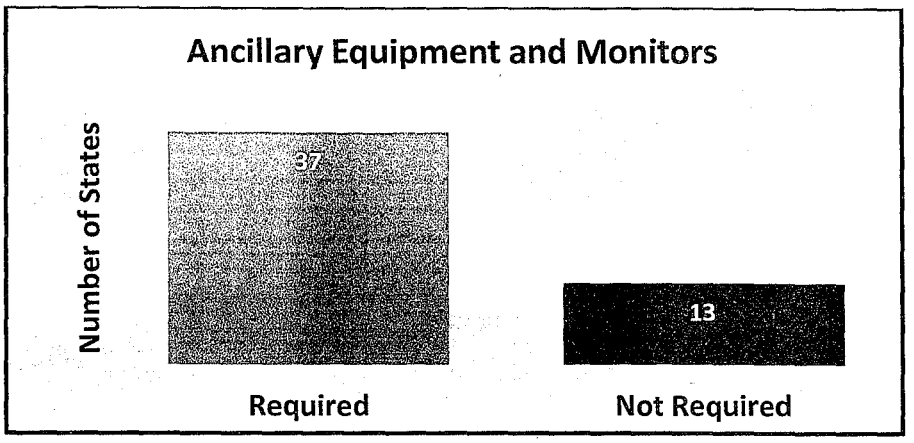
Conscious Sedation	Moderate sedation	
1682 (c) Acts constituting unprofessional conduct: Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior equipment required by the board. BPC 1043.3 (7) Ancillary equipment, which must include the following maintained in good operating condition: (A) Laryngoscope complete with adequate selection of blades and spare batteries and bulb. (This equipment is not required for conscious sedation.) (B) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.) (C) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device). (D) Tonsillar or pharyngeal type suction tip adaptable to all office outlets. (E) Endotracheal tube forcep . (This equipment is not required for conscious sedation.) (F) Sphygmomanometer and stethoscope. (G) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.) (H) Adequate equipment for the establishment of an intravenous infusion. (I) Precordial/pretracheal stethoscope. (J) Pulse oximeter. (K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)	Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include: Consciousness: • Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed. Oxygenation: • Color of mucosa, skin or blood must be evaluated continually. • Oxygen saturation must be evaluated by pulse oximetry continuously. Ventilation: • The dentist must observe chest excursions continually. • The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO2 or by verbal communication with the patient. Circulation: • The dentist must continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record).	**S** =Size-appropriate **suction** catheters and a functioning **suction** apparatus (eg, Yankauer-type suction) **O** = An adequate **oxygen** supply and functioning flow meters/other devices to allow its delivery **A** = **Airway:** size-appropriate airway equipment [nasopha-ryngeal and oropharyngeal airways, laryngoscope blades (checked and functioning), endotracheal tubes, stylets, face mask, bag-valve-mask or equivalent device (functioning)] **P** = **Pharmacy:** all the basic drugs needed to support life during an emergency, including antagonists as indicated **M** = **Monitors:** functioning pulse oximeter with size-appropriate oximeter probes141,142 and other monitors asappropriate for the procedure (eg, noninvasive blood pressure, end-tidal carbon dioxide, ECG, stethoscope) **E** = Special **equipment or drugs** for a particular case (eg, defibrillator) Appendix D includes a list of suggested drugs and equipment that MAY be needed to rescue a sedated patient.

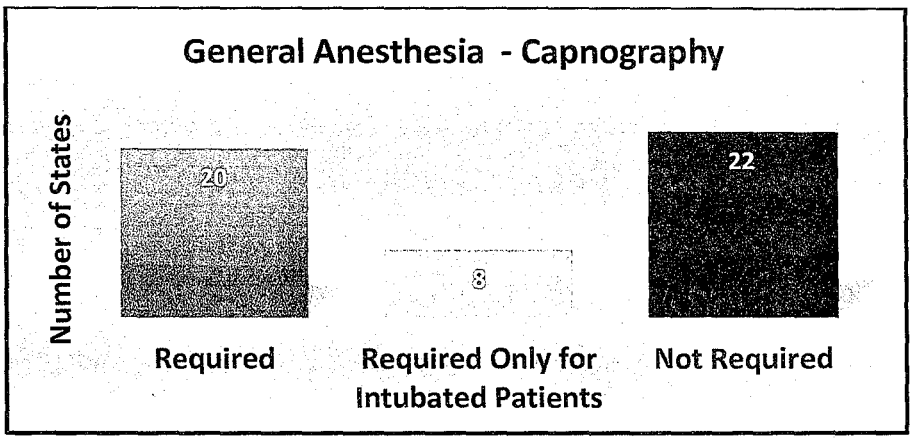
	• Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.	Appendix D. Emergency Equipment† That May Be Needed to Rescue a Sedated Patient ‡ **Intravenous Equipment** Assorted IV catheters (eg, 24-, 22-, 20-, 18-, 16-gauge) Tourniquets Alcohol wipes Adhesive tape Assorted syringes (eg, 1-, 3-, 5-, 10-mL) IV tubing Pediatric drip (60 drops/mL) Pediatric burette Adult drip (10 drops/mL) Extension tubing 3-way stopcocks IV fluid Lactated Ringer solution Normal saline solution D_5 0.25 normal saline solution Pediatric IV boards Assorted IV needles (eg, 25-, 22-, 20-, and 18-gauge) Intraosseous bone marrow needle Sterile gauze pads **Airway Management Equipment** Face masks (infant, child, small adult, medium adult, large adult) Breathing bag and valve set Oropharyngeal airways (infant, child, small adult, medium adult, large adult) Nasopharyngeal airways (small, medium, large) Laryngeal mask airways (1, 1.5, 2, 2.5, 3, 4, and 5) Laryngoscope handles (with extra batteries) Laryngoscope blades (with extra light bulbs) Straight (Miller) No. 1, 2, and 3 Curved (Macintosh) No. 2 and 3 Endotracheal tubes (2.5,

		3.0, 3.5, 4.0, 4.5, 5.0, 5.5, and 6.0 uncuffed and 6.0, 7.0, and 8.0 cuffed) Stylettes (appropriate sizes for endotracheal tubes) Surgical lubricant Suction catheters (appropriate sizes for endotracheal tubes) Yankauer-type suction Nasogastric tubes Nebulizer with medication kits Gloves (sterile and nonsterile, latex free) † The choice of emergency equipment may vary according to individual or procedural needs. ‡ The practitioner is referred to the SOAPME acronym describe
Conscious (Moderate) Sedation and General Anesthesia	Deep Sedation or General Anesthesia	Deep Sedation
1682 (c) Acts constituting unprofessional conduct: Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior equipment required by the board. 1043.3 Onsite inspections The following office facilities and equipment shall be available and shall be maintained in good operating condition: Ancillary equipment, which must include the following maintained in good operating condition: Ancillary Equipment: (K) Laryngoscope complete with adequate selection of blades and spare	Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include: Oxygenation: • Color of mucosa, skin or blood must be continually evaluated. • Oxygenation saturation must be evaluated continuously by pulse oximetry. Ventilation: • Intubated patient: End-tidal CO2 must be continuously monitored and evaluated. • Non-intubated patient: Breath sounds via auscultation and/or	Equipment In addition to the equipment previously cited for moderate sedation, an electrocardiographic monitor and a defibrillator for use in pediatric patients should be readily available. *Vascular Access* Patients receiving deep sedation should have an intravenous line placed at the start of the procedure or have a person skilled in establishing vascular access in pediatric patients immediately available.

batteries and bulb. (This equipment is not required for conscious sedation.) (L) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.) (M) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device). (N) Tonsillar or pharyngeal type suction tip adaptable to all office outlets. (O) Endotracheal tube forcep . (This equipment is not required for conscious sedation.) (P) Sphygmomanometer and stethoscope. (Q) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.) (R) Adequate equipment for the establishment of an intravenous infusion. (S) Precordial/pretracheal stethoscope. (T) Pulse oximeter. (K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)	end-tidal CO2 must be continually monitored and evaluated. • Respiration rate must be continually monitored and evaluated. Circulation: • The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry. • The dentist must continually evaluate blood pressure. Temperature: • A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia. • The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.	

State Requirements





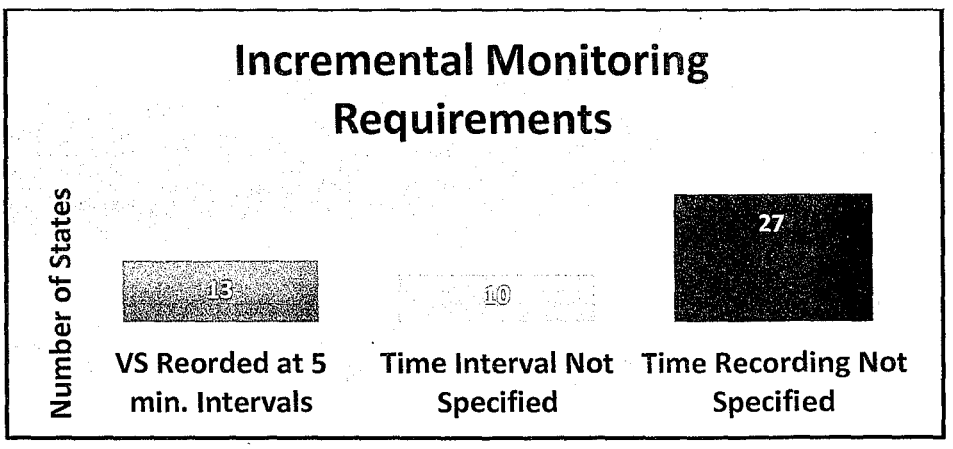


Table 7.

Record Requirements - Clinical Guidelines for Minimal sedation, Moderate sedation, Deep Sedation, and General Anesthesia

California Record Requirements	**ADA Guidelines**	**AAP-AAPD Guidelines**
Oral (Moderate) Conscious Sedation	Minimal Sedation	All levels of Sedation
Oral conscious sedation records shall include baseline vital signs. If obtaining baseline vital signs is prevented by the patient's physical resistance or emotional condition, the reason or reasons must be documented. The records shall also include intermittent quantitative monitoring and recording of oxygen saturation, heart and respiratory rates, blood pressure as appropriate for specific techniques, the name, dose and time of administration of all drugs administered including local and inhalation anesthetics, the length of the procedure, any complications of oral sedation, and a statement of the patient's condition at the time of discharge. (CCR 1044.5)	Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored physiological parameters.	**Documentation prior to treatment – see preoperative evaluation** **Documentation during treatment** The patient's chart shall contain a time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs. Before sedation, a "time out" should be performed to confirm the patient's name, procedure to be per-formed, and site of the procedure. During administration, the inspired concentrations of oxygen and inhalation sedation agents and the duration of their administration shall be documented. Before drug administrations, special attention must be paid to calculation of dosage (ie, mg/kg). The patient's chart shall contain documentation at the time of treatment that the patient's level of consciousness and responsiveness, heart rate, blood pressure, respiratory rate,

		and oxygen saturation were monitored until the patient attained predetermined discharge criteria. A variety of sedation scoring systems are available and may aid this process. Adverse events and their treatment shall be documented. **Documentation after treatment** The time and condition of the child at discharge from the treatment area or facility shall be documented; this should include documentation that the child's level of consciousness and oxygen saturation in room air have returned to a state that is safe for discharge by recognized criteria Patients receiving supplemental oxygen before the procedure should have a similar oxygen need after the procedure. Because some sedation medications are known to have a long half-life and may delay the patient's complete return to baseline of pose the risk of resedation some patients might benefit from a longer period of less-intense observation (eg, a step-down observation area) before discharge from medical super-vision.133 Several scales to evaluate recovery have been devised and validated. A recently described and simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet environment.
Conscious Sedation and General Anesthesia	**Moderate Sedation**	
The following records shall be	Documentation	

maintained: (2) General anesthesia and/or conscious sedation records, which shall include a time-oriented record with preoperative, multiple intraoperative pulse oximetry (every 5 minutes intraoperatively and every 15 minutes postoperatively for general anesthesia) and blood pressure and pulse readings, (both every 5 minutes intraoperatively for general anesthesia) drugs, amounts administered and time administered, length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at time of discharge.(CCR 1043.3)	Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record). • Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.	
	Deep Sedation or General Anesthesia	
	Documentation Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record) • Pulse oximetry and end-tidal CO2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.	

Table 8.

Emergency drugs - California sedation laws compared to ADA and ADA-AAPD Guidelines

California - required emergency drugs	ADA Guidelines	AAP-AAPD Guidelines
Pediatric and Adult Oral Conscious Sedation (CCR 1044.5)	Minimal Sedation	All Levels of Sedation
An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Emergency drugs of the following types shall be available: (1) Epinephrine (2) Bronchodilator (3) Appropriate drug antagonists (4) Antihistaminic (5) Anticholinergic (6) Anticonvulsant (7) Oxygen (8) Dextrose or other antihypoglycemic	The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.	Appendix C. Drugs That May Be Needed to Rescue a Sedated Patient Albuterol for inhalation Ammonia spirits Atropine Diphenhydramine Diazepam Epinephrine (1:1000, 1:10 000) Flumazenil Glucose (25 percent or 50 percent) Lidocaine (cardiac lidocaine, local infiltration) Lorazepam Methylprednisolone Naloxone Oxygen Fosphenytoin Racemic epinephrine Rocuronium Sodium bicarbonate Succinylcholine * The choice of emergency drugs may vary according to individual or procedural needs
Conscious Sedation and General Anesthesia CCR 1043.3	Moderate Sedation	
Drugs: Emergency drugs of the following types shall be available:	• The qualified dentist is responsible for the sedative management,	

(1) Epinephrine (2)Vasopressor(other than epinephrine) (3) Bronchodilator (4) Muscle relaxant (This is not required for conscious sedation.) (5) Intravenous medication for treatment of cardiopulmonary arrest (This is not required for conscious sedation.) (6) Appropriate drug antagonist (7) Antihistaminic (8) Anticholinergic (9) Antiarrhythmic (This is not required for conscious sedation.) (10) Coronary artery vasodilator (11) Antihypertensive (This is not required for conscious sedation.) (12) Anticonvulsant(13) Oxygen (14)50% dextrose or other antihypoglycemic	adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.	
	Deep Sedation General Anesthesia	
	• The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.	

Table 9.

State Mandated Office Inspection Requirements

1. **California laws related to office inspections**
2. **Graphs summarizing requirements in 50 states**

1. California office inspection laws

General Anesthesia

1646.4. (a) Prior to the issuance or renewal of a permit for the use of general anesthesia, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure, unless within that time period the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once every five years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) The board may contract with public or private organizations or individuals expert in dental outpatient general anesthesia to perform onsite inspections and evaluations. The board may not, however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

Conscious Sedation

1647.7. (a) Prior to the issuance or renewal of a permit to administer conscious sedation, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure unless, within that time period, the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once in every six years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) An applicant who has successfully completed the course required by Section 1647.3 may be granted a one-year temporary permit by the board prior to the onsite inspection and evaluation. Failure to pass the inspection and evaluation shall result in the immediate and automatic termination of the temporary permit.

(c) The board may contract with public or private organizations or individuals expert in dental outpatient conscious sedation to perform onsite inspections and evaluations. The board may not,

however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

16 CCR § 1043.3

§ 1043.3. Onsite Inspections.

Also see CCR 1043, 1043.2, 1043.4, 1043.5, 1043.6, 1043.7, 1043.8

All offices in which general anesthesia or conscious sedation is conducted under the terms of this article shall, unless otherwise indicated, meet the standards set forth below. In addition, an office may in the discretion of the board be required to undergo an onsite inspection. For the applicant who administers in both an outpatient setting and at an accredited facility, the onsite must be conducted in an outpatient setting. The evaluation of an office shall consist of three parts:
(a) Office Facilities and Equipment. The following office facilities and equipment shall be available and shall be maintained in good operating condition:
(1) An operating theatre large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient.
(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.
(3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure.
(4) Suction equipment which permits aspiration of the oral and pharyngeal cavities. A backup suction device which can operate at the time of general power failure must also be available.
(5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of allowing the administering of greater than 90% oxygen at a 10 liter/minute flow at least sixty minutes (650 liter "E" cylinder) to the patient under positive pressure, together with an adequate backup system which can operate at the time of general power failure.
(6) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theatre.
(7) Ancillary equipment:
(A) Laryngoscope complete with adequate selection of blades and spare batteries and bulb. (This equipment is not required for conscious sedation.)
(B) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.)
(C) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device).
(D) Tonsillar or pharyngeal type suction tip adaptable to all office outlets.
(E) Endotracheal tube forcep. (This equipment is not required for conscious sedation.)
(F) Sphygmomanometer and stethoscope.
(G) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.)
(H) Adequate equipment for the establishment of an intravenous infusion.
(I) Precordial/pretracheal stethoscope.
(J) Pulse oximeter.
(K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)
(b) Records. The following records shall be maintained:
(1) Adequate medical history and physical evaluation records updated prior to each administration of general anesthesia or conscious sedation. Such records shall include, but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists Classification), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required.
(2) General Anesthesia and/or conscious sedation records, which shall include a time-oriented record with preoperative, multiple interaoperative, and postoperative pulse oximetry (every 5 minutes intraoperatively and every 15 minutes postoperatively for general anesthesia) and blood pressure and pulse readings, (both every 5 minutes intraoperatively for general anesthesia) drugs, amounts administered and time administered, length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at time of discharge.
(3) Written informed consent of the patient or if the patient is a minor, his or her parent or guardian.
(c) Drugs. Emergency drugs of the following types shall be available:
(1) Epinephrine
(2) Vasopressor (other than epinephrine)
(3) Bronchodilator
(4) Muscle relaxant (This is not required for conscious sedation.)
(5) Intravenous medication for treatment of cardiopulmonary arrest (This is not required for conscious sedation.)
(6) Appropriate drug antagonist
(7) Antihistaminic
(8) Anticholinergic

(9) Antiarrhythmic (This is not required for conscious sedation.)
(10) Coronary artery vasodilator
(11) Antihypertensive (This is not required for conscious sedation.)
(12) Anticonvulsant
(13) Oxygen
(14) 50% dextrose or other antihypoglycemic
(d) Prior to an onsite inspection and evaluation, the dentist shall provide a complete list of his/her emergency medications to the evaluator.
Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1646.2, 1646.3, 1647.3 and 1647.6, Business and Professions Code.

HISTORY

1. Amendment filed 4-1-91; operative 5-1-91 (Register 91, No. 18).
2. Editorial correction of subsection (a)(4) (Register 95, No. 16).
3. Amendment filed 2-27-2006; operative 3-29-2006 (Register 2006, No. 9).
This database is current through 7/1/16 Register 2016, No. 27
16 CCR § 1043.3, 16 CA ADC § 1043.3

Oral Conscious Sedation

16 CCR § 1044.5

See also CCR sections 1044, 1044.1, 1044.2, 1043.3, 1044.4

§ 1044.5. Facility and Equipment Standards.

A facility in which oral conscious sedation is administered to patients pursuant to this article shall meet the standards set forth below.
(a) Facility and Equipment.
(1) An operatory large enough to adequately accommodate the patient and permit a team consisting of at least three individuals to freely move about the patient.
(2) A table or dental chair which permits the patient to be positioned so the attending team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.
(3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit completion of any treatment which may be underway at the time of a general power failure.
(4) An appropriate functional suctioning device that permits aspiration of the oral and pharyngeal cavities. A backup suction device that can function at the time of general power failure must also be available.
(5) A positive-pressure oxygen delivery system capable of administering greater than 90% oxygen at a 10 liter/minute flow for at least sixty minutes (650 liter "E" cylinder), even in the event of a general power failure. All equipment must be age-appropriate and capable of accommodating the patients being seen at the permit-holder's office.
(6) Inhalation sedation equipment, if used in conjunction with oral sedation, must have the capacity for delivering 100%, and never less than 25%, oxygen concentration at a flow rate appropriate for an age appropriate patient's size, and have a fail-safe system. The equipment must be maintained and checked for accuracy at least annually.
(b) Ancillary equipment, which must include the following, and be maintained in good operating condition:
(1) Age-appropriate oral airways capable of accommodating patients of all sizes.
(2) An age-appropriate sphygmomanometer with cuffs of appropriate size for patients of all sizes.
(3) A precordial/pretracheal stethoscope.
(4) A pulse oximeter.
(c) The following records shall be maintained:
(1) An adequate medical history and physical evaluation, updated prior to each administration of oral conscious sedation. Such records shall include, but are not limited to, an assessment including at least visual examination of the airway, the age, sex, weight, physical status (American Society of Anesthesiologists Classification), and rationale for sedation of the minor patient as well as written informed consent of the patient or, as appropriate, parent or legal guardian of the patient.
(2) Oral conscious sedation records shall include baseline vital signs. If obtaining baseline vital signs is prevented by the patient's physical resistance or emotional condition, the reason or reasons must be documented. The records shall also include intermittent quantitative monitoring and recording of oxygen saturation, heart and respiratory rates, blood pressure as appropriate for specific techniques, the name, dose and time of administration of all drugs administered including local and inhalation anesthetics, the length of the procedure, any complications of oral sedation, and a statement of the patient's condition at the time of discharge.
(d) An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while

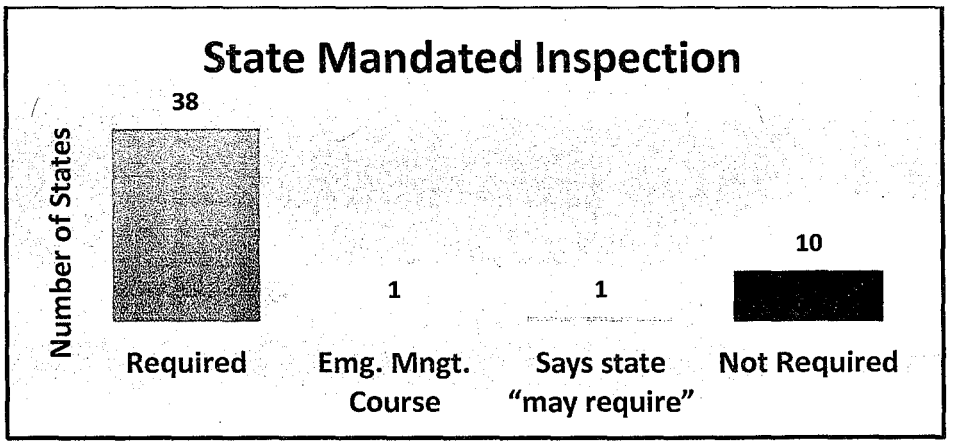
the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Emergency drugs of the following types shall be available:
(1) Epinephrine
(2) Bronchodilator
(3) Appropriate drug antagonists
(4) Antihistaminic
(5) Anticholinergic
(6) Anticonvulsant
(7) Oxygen
(8) Dextrose or other antihypoglycemic
Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1647.10, 1647.16, 1647.22 and 1647.24, Business and Professions Code.

HISTORY

1. New section and new forms OCS-5 and OCS-3 filed 3-14-2000; operative 4-13-2000 (Register 2000, No. 11).
2. Amendment of section and Note and repealer of printed forms (this action incorporates applicable forms within article 5.5 by reference) filed 12-13-2007; operative 12-13-2007 pursuant to Government Code section 11343.4 (Register 2007, No. 50).
This database is current through 7/1/16 Register 2016, No. 27
16 CCR § 1044.5, 16 CA ADC § 1044.5

2. Summary of Requirements in 50 states

General Anesthesia Permits



Moderate (Parenteral) Sedation Permit

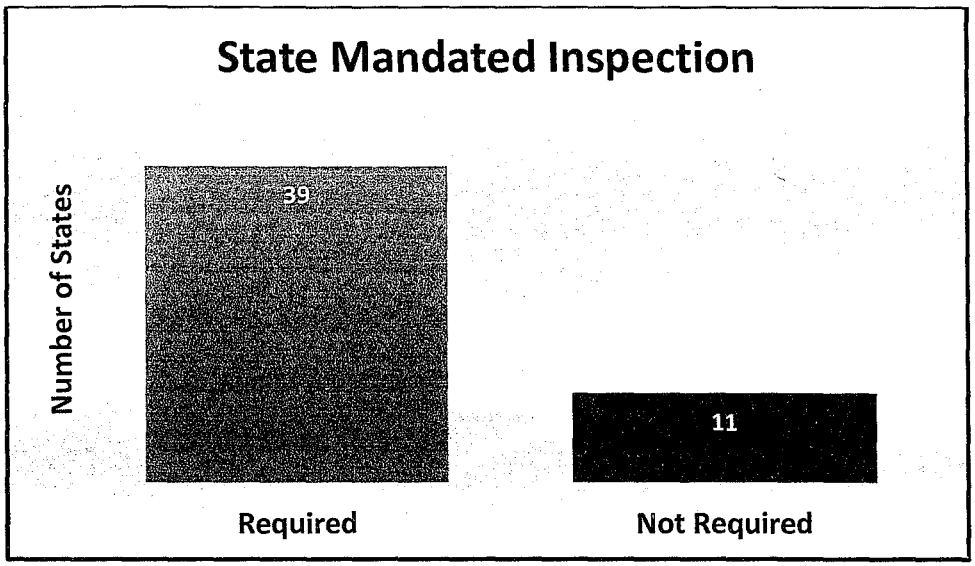

State Mandated Inspection
Number of States
39
11
Required
Not Required

Table 10.

Pediatric Sedation Laws for the 50 States – Summary

Pediatric sedation requirements

Individual states have taken different approaches to the regulation of pediatric sedation. Twenty five states, including California have special requirements for young patients. California requirements apply to patients age 13 or under. An increasing number of states have adopted pediatric sedation educational requirements, equipment requirements, and permits over the past 10 years. All states regulate moderate sedation and deep sedation/GA , regardless of route of administration.

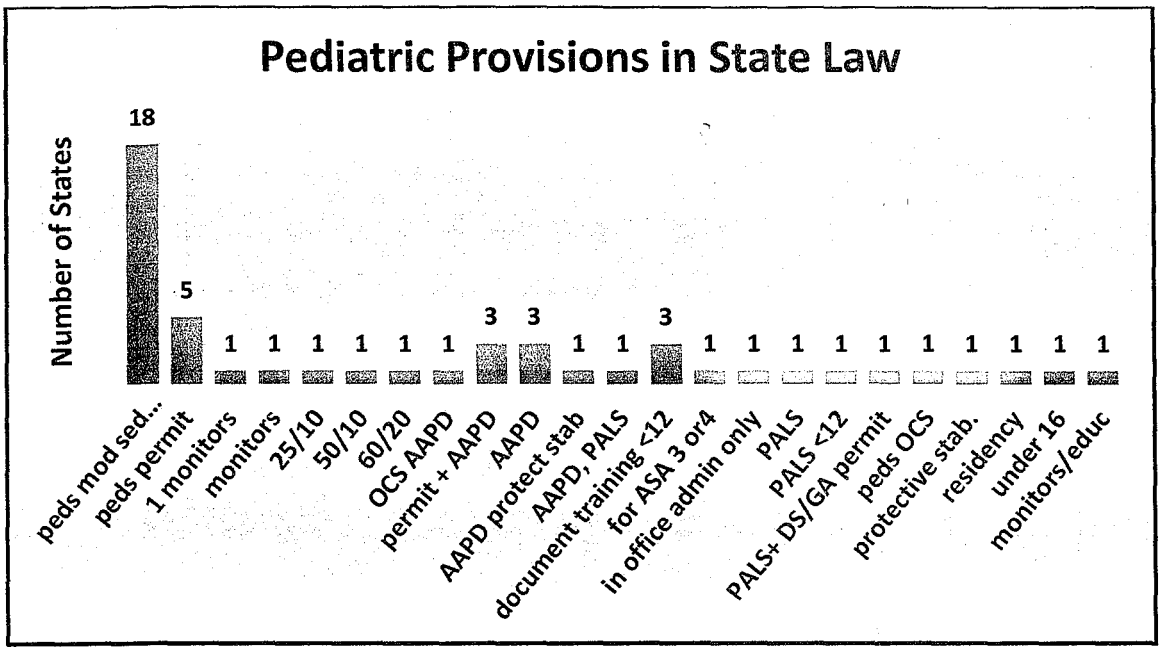
Ten states (California, Colorado, Florida, Georgia, Kentucky, Louisiana, Missouri, Missisippi, North Carolina and Oklahoma) require permits for sedating pediatric patients.

Sixteen states require specific training, some in addition to adult sedation training, to administer moderate/conscious sedation to pediatric patients.

Approximately twenty nine states have specific requirements for pediatric sedation administered by the oral route.

States differ in their definition of the pediatric patient. Several states define the pediatric patient as being under the age of 12 consistent with ADA Guidelines; however other states use 13, 14, 16 and 18 years of age. Most states, including California, specify that the practitioner must have appropriately sized equipment for pediatric patients. In some states ACLS certification is deemed sufficient for treating pediatric patients; Twenty states currently require PALS certification. California does not presently require certification in PALS.

Although ten states have adopted the AAP-AAPD Guidelines, these usually apply to minimal and moderate sedation. Most states do not have specific requirements for the administration of deep sedation/general anesthesia to children.



OCS = oral conscious sedation; 25/10 etc. = classroom hours/supervised cases; PALS= pediatric advanced life support course; all numbers are approximate.

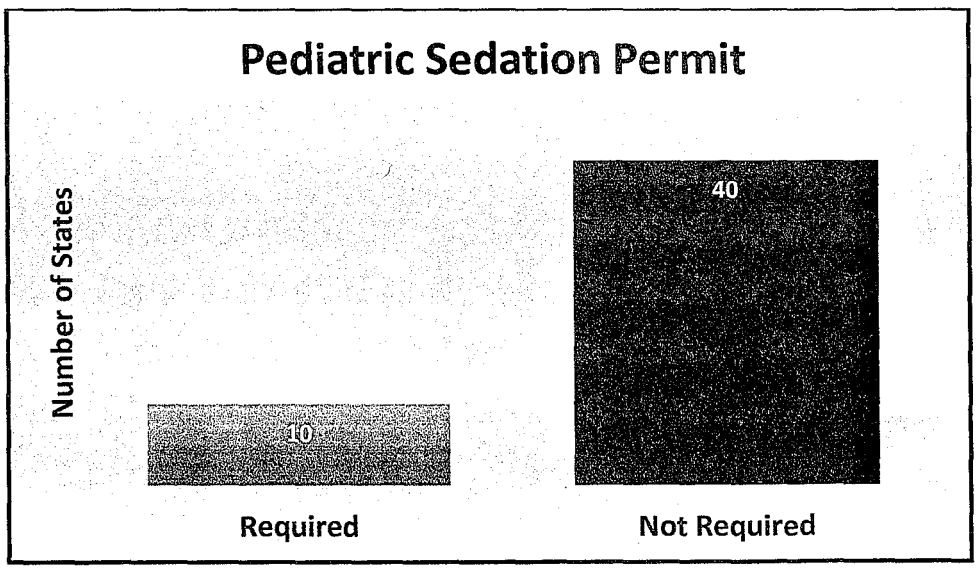


Table 1 California definitions compared to ADA and ADA-AAPD Guidelines[ii]		
California requirements for minimal sedation, moderate sedation and general anesthesia **California law has specific requirements for pediatric patients for oral (moderate) conscious sedation only.(under age 13)**	**ADA Guidelines for use of sedation and general anesthesia by dentists; For pediatric patients ADA supports AAP-AAPD Guidelines (age 12 and under)**	**AAP-AAPD Guidelines exclusively for monitoring and management of pediatric patients; (age 21 and under)**
	Minimal Sedation	
Minimal sedation not defined in CA Law. See BPC 1647, Conscious Sedation and BPC 1647.10 Use of Oral Conscious Sedation for Pediatric patients; 1647.18 Use of Oral Conscious Sedation for Adult Patients.	"A minimally depressed level of consciousness produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command." "Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected." "The drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation. The ADA Guidelines add a definition of "combination inhalation-enteral conscious sedation" for when the intent is anxiolysis only. When the intent is conscious (moderate) sedation that definition applies.	*Minimal sedation* (old terminology *anxiolysis*): a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
	Oral Conscious Sedation	
oral conscious sedation (pediatric and adult)	*Author's note: The ADA Guidelines include definitions of both*	

see BPC 1674.10 **Oral conscious sedation means** a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command." "The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral conscious sedation."	*conscious sedation and moderate* *sedation, and gives clinical guidelines for both terms However the preferred term appears to be moderate sedation because it is accompanied by clinical guidelines.*	
	Moderate Sedation	
CA term is " conscious sedation" BPC 1647.1 Conscious sedation means a minimally depressed level of consciousness produced by a pharmacologic or nonpharmacologic method, or a combination thereof, that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command." Conscious sedation does not include that administration of oral medication or the administration of a mixture of nitrous oxide and oxygen, whether alone or with each other. The drugs and techniques used in conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.	The term "conscious sedation" has been replaced by the ADA with the term "moderate sedation", defined as "a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation." "No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained." "Drugs or techniques should maintain a margin of safety wide enough to render unintended loss of consciousness unlikely." "Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the	Moderate sedation (old terminology conscious sedation or sedation/analgesia): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands (eg, *open your eyes* either alone or accompanied by light tactile stimulation—a light tap on the shoulder or face, not a sternal rub). For older patients, this level of sedation implies an interactive state; for younger patients,age-appropriate behaviors (eg, crying) occur and are expected. Reflex withdrawal, although a normal response to a painful stimulus, is not considered as the only age-appropriate purposeful response (eg, it must be accompanied by another response, such as pushing away the painful stimulus so as to confirm a higher cognitive function).With moderate sedation, no intervention is

For the very young or handicapped, incapable of the usual verbal response, a minimally depressed level of consciousness should be maintained. Further, patients whose only response is reflex withdrawal from painful stimuli shall not be considered to be in a state of conscious sedation.	intent of the dentist." "A patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation. The ADA Guidelines also include the following cautionary statement: "Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended." For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.	required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. However, in the case of procedures that may themselves cause airway obstruction (eg, dental or endoscopic), the practitioner must recognize an obstruction and assist the patient in opening the airway. If the patient is not making spontaneous efforts to open his/her airway so as to relieve the obstruction, then the patient should be considered to be deeply sedated.
	Deep sedation	
Deep Sedation in California is described in BPC 1647 (c) as part of a continuum for which the educational standards for general anesthesia should be applied. Deep sedation is not otherwise defined in the California law.	The ADA defines deep sedation as "a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.	• *Deep sedation* (deep sedation/analgesia): a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (see discussion of reflex withdrawal above) after repeated verbal or painful stimulation (eg, purposefully pushing away the noxious stimuli). The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be

		inadequate. Cardiovascular function is usually maintained. A state of deep sedation may be accompanied by partial or complete loss of protective airway reflexes.
	General Anesthesia	
Defined as a "controlled state of depressed consciousness or unconsciousness, accompanied by a partial or complete loss of protective reflexes, produced by pharmacologic or non-pharmacologic method, or a combination thereof." (BPC 1646)	A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.	*General anesthesia*: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
CA requires a pediatric oral (moderate) conscious sedation permit for children 13 or under	Pediatrics For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.	

[i] American Dental Association. (2012). Guidelines for the Use of Sedation and General Anesthesia by Dentists. In *Society* (Vol. 80, pp. 75–106). http://doi.org/10.1112/S0024611500012132

[ii] Coté, C. J., & Wilson, S. (2016). Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016. *Pediatrics*, *138*(1), 1–87. http://doi.org/10.1542/peds.2016-1212

Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

California requirements for moderate sedation and general anesthesia	ADA Guidelines for use of sedation and general anesthesia by dentists[1]	AAP-AAPD Guidelines for monitoring and management of pediatric patients[2]
	Educational Requirements	
	Minimal Sedation	
Minimal Sedation is not specifically defined in California sedation laws. Training in minimal sedation, including the administration of a mixture of nitrous oxide and oxygen, either alone or in combination with minimal oral sedation, may be taught to the level of basic competency at the predoctoral (dental school) level. (see ADA Educational Guidelines)	The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for including a "hands on" component. Such courses should be AHA or ARC approved. Minimal sedation requires a. training to the level of competency in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, or a comprehensive training program in moderate sedation that satisfies the	No specific educational requirements are provided in these guidelines, however personnel qualifications are described. "The practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). Because the level of intended sedation may be exceeded, the practitioner must be sufficiently skilled to provide rescue should the child progress to a level of deep sedation. The practitioner must be trained in, and capable of providing, at the minimum, bag-valve-mask ventilation so as to be able to oxygenate a child who

[1] American Dental Association. (2012). Guidelines for the Use of Sedation and General Anesthesia by Dentists. In *Society* (Vol. 80, pp. 75–106). http://doi.org/10.1112/S0024611500012132

[2] Coté, C. J., & Wilson, S. (2016). Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016. *Pediatrics*, *138*(1), 1–87. http://doi.org/10.1542/peds.2016-1212

Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

	requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced, or b. an equivalent advanced education program accredited by the ADA Commission on Dental Accreditation. **Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration:** Current certification in Basic Life Support for Healthcare Providers 1. Completion of a nitrous oxide competency course. 2. While length of a course is only one of many factors, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if	develops airway obstruction or apnea. Training in, and maintenance of, advanced pediatric airway skills is required; regular skills reinforcement is strongly encouraged." The practitioner is responsible for life- support measures while awaiting EMS arrival. Rescue techniques require specific training and skills. The maintenance of the skills needed to rescue a child with apnea, laryngospasm, and/or airway obstruction include the ability to open the airway, suction secretions, provide continuous positive airway pressure (CPAP), perform successful bag-valve-mask ventilation, insert an oral airway,a nasopharyngeal airway, or a laryngeal mask airway (LMA), and, rarely, perform tracheal intubation. These skills are likely best maintained with frequent simulation and team training for the management of rare events. Competency with emergency airway management procedure algorithms is fundamental for safe sedation practice and successful patient rescue. Practitioners should have an in-depth knowledge of the agents they intend to use and their potential complications.

Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

	competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course. Not intended for the management of sedation in children, which requires additional course content and clinical learning experience.	
	Moderate Sedation	
California Moderate enteral sedation courses for adults and minors	**Moderate Enteral Sedation**	
Completion of approved post doctoral or residency training; or, a board approved course that includes 25 hours of instruction including a clinical component utilizing at least one age-appropriate patient; training for either adult patients or minor patients (13 or younger); training requirements reference ADA, AAPD definitions of levels of sedation.(See BPC 1647.12; CCR 1044-1044.5.)	A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation. Participants combining enteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult	No specific educational requirements are provided in these guidelines, however personnel qualifications are described. See description below. High-fidelity patient simulators are now available that allow physicians, dentists, and other health care providers to practice managing a variety of programmed adverse events, such as apnea, bronchospasm, and laryngospasm. The use of such devices is encouraged to better train medical professionals and teams to respond more effectively to rare events. One study that simulated the quality of cardiopulmonary resuscitation compared

Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

	patients; **this course in moderate enteral sedation is not designed for the management of children (aged 12 and under).** Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted.	standard management of ventricular fibrillation versus rescue with the EZ-IO for the rapid establishment of intravenous access and placement of an LMA for establishing a patent airway in adults; the use of these devices resulted in more rapid establishment of vascular access and securing of the airway.
Conscious Sedation (moderate IV sedation)	**Moderate Parenteral Sedation**	**Moderate Sedation**
At least 60 hours of instruction; Satisfactory completion of at least 20 cases of administration of conscious sedation for a variety of dental procedures. Course must comply with the requirements of the *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry* of the American Dental Association (see BPC 1647.3)	A minimum of 60 hours of instruction plus management of at least 20 patients using the intravenous route; clinical experience in managing a compromised airway is critical to prevention of emergencies; Management of children and medically compromised adults requires additional experience; course completion does not result in clinical competency	The practitioner must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). (ed. Specific educational requirements are not described.) The use of moderate sedation shall include the provision of a person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required.

Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

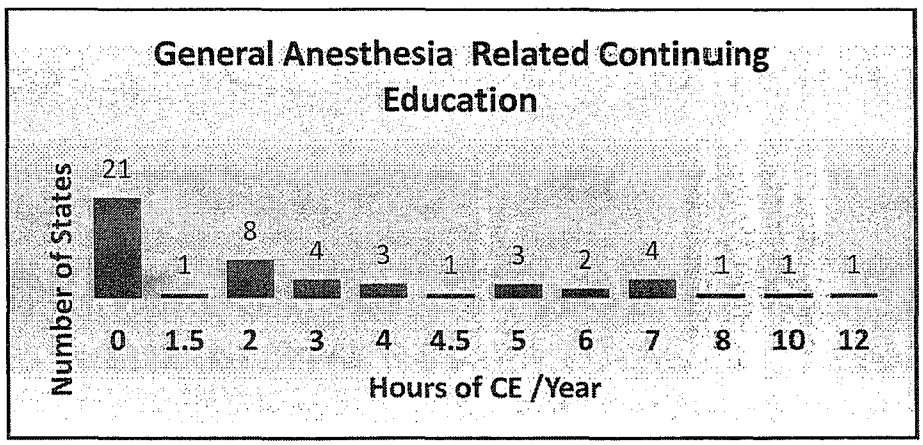
		This individual may also be responsible for assisting with interruptible patient-related tasks of short duration, such as holding an instrument or troubleshooting equipment. This individual should be trained in and capable of providing advanced airway skills (eg, PALS). The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews, simulation of rare emergencies, and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies. It is recommended that at least 1 practitioner be skilled in obtaining vascular access in children.
General Anesthesia	**Deep Sedation or General Anesthesia**	**Deep Sedation**
Completion of a residency program in general anesthesia of not less than one calendar year, that is approved by the board; or a graduate program in oral and maxillofacial surgery which has been approved by the Commission on Dental Accreditation. (CCR 1043)	**C. Deep Sedation or General Anesthesia** 1.Completion of an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or	Ed. Specific educational requirements are not addressed in this document During deep sedation, there must be 1 person whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or

Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

dentist who orders administration of anesthesia by a nurse anesthetist must meet the requirements for California general anesthesia permit.(BPC 2827).	general anesthesia, commensurate with these guidelines; and 2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.	direct their administration. This individual must, at a minimum,be trained in PALS and capable of assisting with any emergency event. At least 1 individual must be present who is trained in and capable of providing advanced pediatric life support and who is skilled to rescue a child with apnea, laryngospasm, and/or airway obstruction. Required skills include the ability to open the airway,suction secretions, provide CPAP, insert supraglottic devices (oral airway, nasal trumpet, LMA), and perform successful bag-valve-mask ventilation, tracheal intubation, and cardiopulmonary resuscitation.

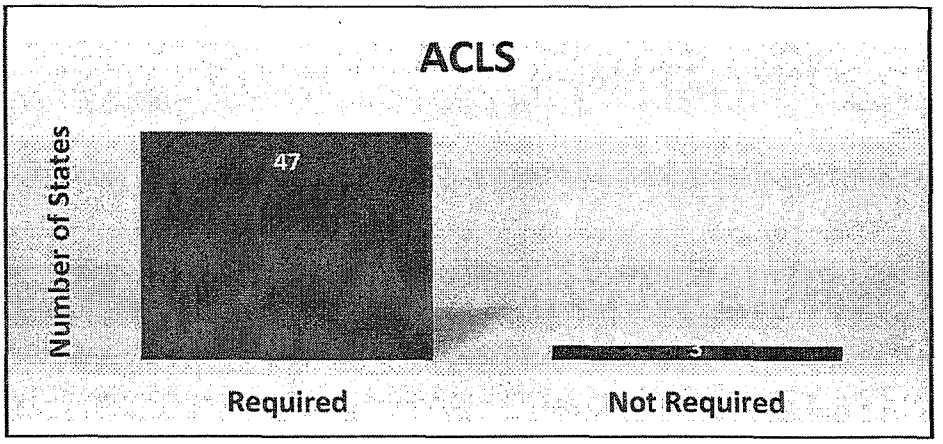
Continuing Education – State Requirements



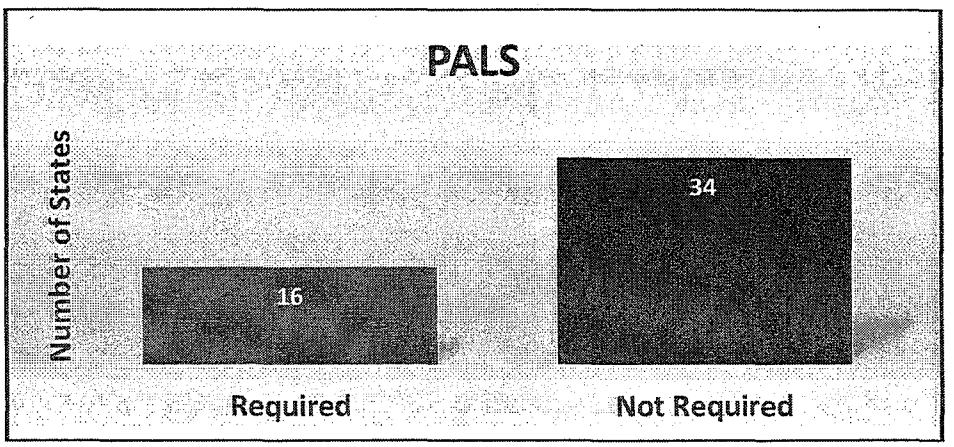
ACLS for General Anesthesia Permits

Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia



Pediatric Advanced Life Support for General Anesthesia Permit Holders



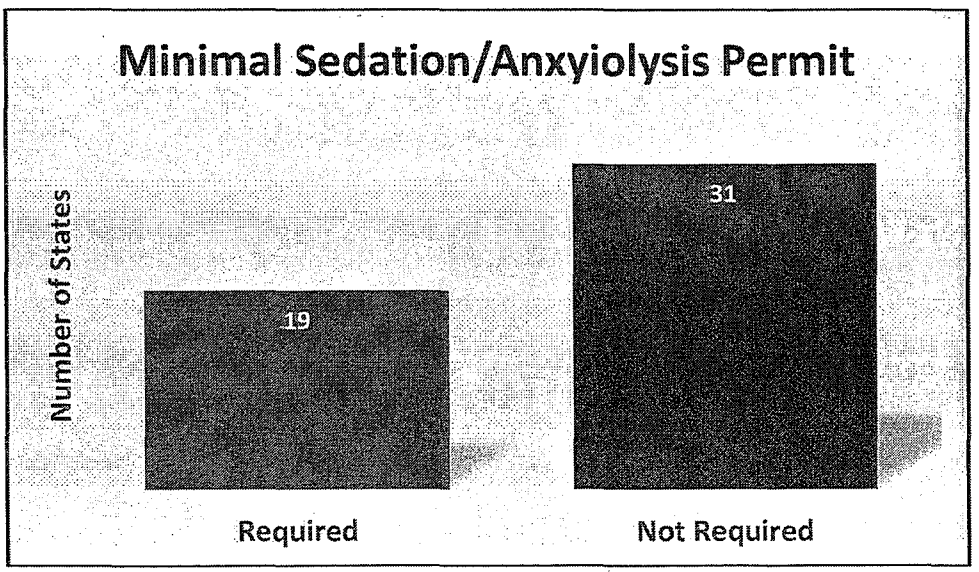
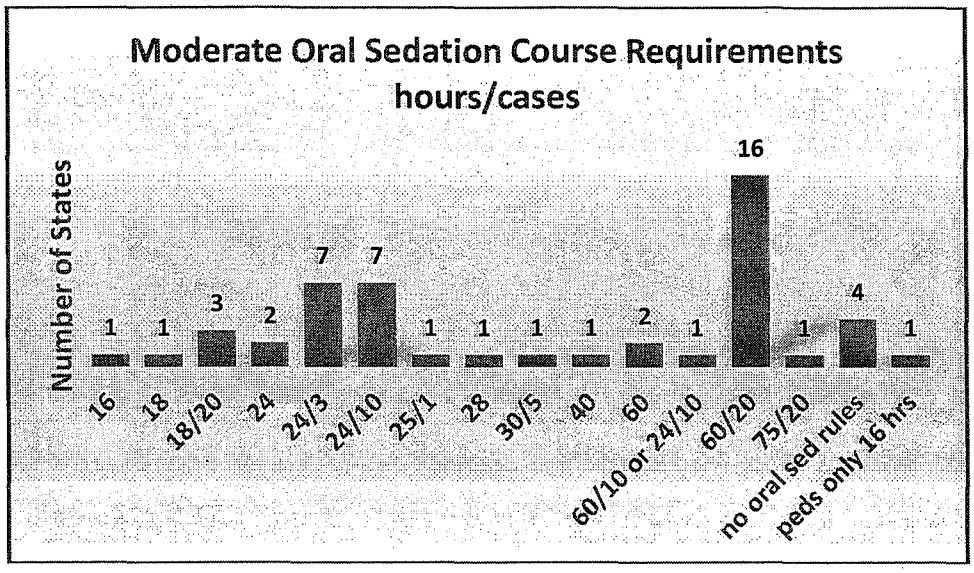


Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia



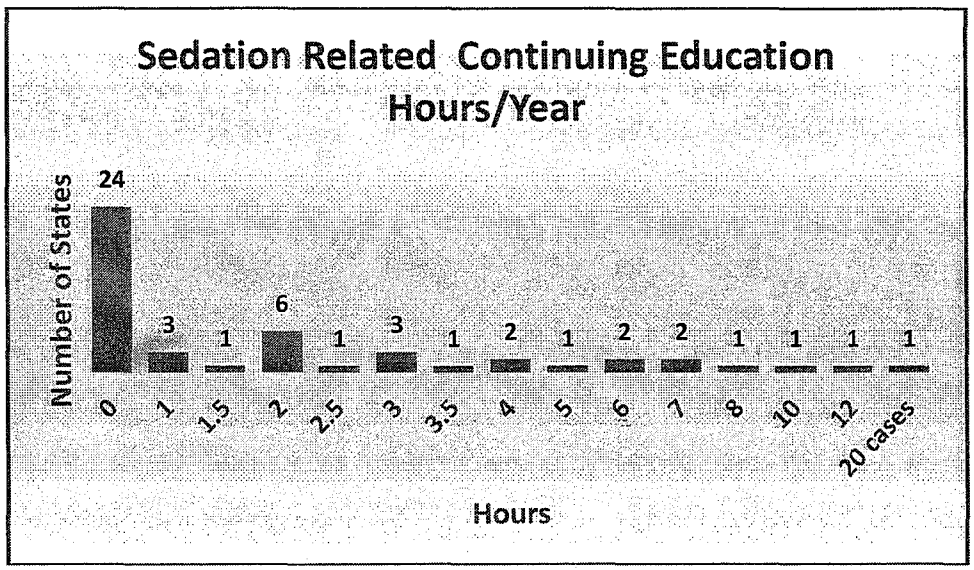


Table 2.

Educational Requirements for Minimal, Moderate, Deep Sedation and General Anesthesia

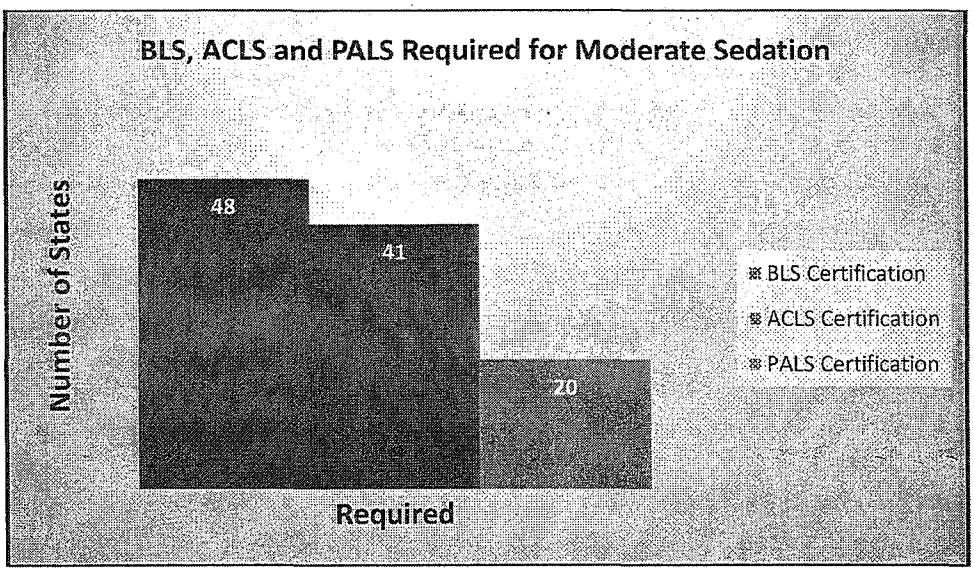


Table 3.

Clinical Requirements for minimal sedation, moderate sedation deep sedation and general anesthesia

California Requirements	ADA Guidelines	AAP-AAPD Guidelines
The term Minimal sedation is not used in CA. Laws related to oral moderate sedation apply (CCR sec. 1044)	**Minimal sedation**	General Guidelines are provided for all levels of sedation
Preoperative evaluation Adequate medical history and physical evaluation records updated prior to each administration of oral conscious sedation. Such records shall include, but are not limited to an assessment including at least visual examination of the airway, the age, sex, weight, physical status (American Society of Anesthesiologists Classification), and rationale for sedation of the minor or adult patient. (CCR 1043.3 (i)) Written informed consent must be obtained for all patients undergoing general anesthesia or conscious sedation, or as appropriate, from the parent or legal guardian of the patient. (BPC 1682 (d)) **There is no specific requirement for preoperative dietary precautions.**	Preoperative evaluation and preparation 1. In healthy or medically stable individuals (ASA I, II) a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist. 2. Pre-Operative Preparation • The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained. • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed. • Baseline vital signs must be obtained unless the patient's behavior prohibits such determination. • A focused physical evaluation must be performed as deemed appropriate. • Preoperative dietary restrictions must be	**Health evaluation** Age and weight. • Health history, including: 1) allergies and previous allergic or adverse drug reactions, 2) medication/drug history. 3) relevant diseases, physical abnormalities, and neurologic impairment that might increase the potential for airway obstruction, such as a history of snoring or obstructive sleep apnea,4) pregnancy status, 5) a summary of previous relevant hospitalizations, 6) history of sedation or general anesthesia and any complications or unexpected responses, and 7) relevant family history, particularly related to anesthesia. • Review of systems with a special focus on abnormalities of cardiac, pulmonary, renal, or hepatic function. Vital signs, including heart rate, blood pressure, respiratory rate, and temperature • Physical examination, including a focused evaluation of the airway (tonsillar hypertrophy,abnormal anatomy• Physical status evaluation [ASA classification • Name, address, and telephone number of the

Table 3.

Clinical Requirements for minimal sedation, moderate sedation deep sedation and general anesthesia

	considered based on the sedative technique prescribed. • Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.	child's medical home. Dietary precautions **Dietary precautions** Before sedation, the practitioner should evaluate preceding food and fluid intake. It is likely that the risk of aspiration during procedural sedation differs from that during general anesthesia involving tracheal intubation or other airway manipulation. However, because the absolute risk of aspiration during procedural sedation is not yet known, guidelines for fasting periods before elective sedation generally should follow those used for elective general anesthesia. For emergency procedures in children who have not fasted, the risks of sedation and the possibility of aspiration must be balanced against the benefits of performing the procedure promptly Further research is needed to better elucidate the relationships between various fasting intervals and sedation complications
Conscious (Moderate) Sedation	**Moderate Sedation**	**Moderate Sedation** See above section
Adequate medical history and physical evaluation records updated prior to each administration of general anesthesia or conscious sedation. Such records shall include, but are not limited to the recording of the age, sex, weight, physical status	Patient Evaluation In healthy or medically stable individuals (ASA I, II) evaluation should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g.,	

Table 3.

Clinical Requirements for minimal sedation, moderate sedation deep sedation and general anesthesia

(American Society of Anesthesiologists Classification), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required.(CCR 1043.3 (i)) **There are no specific requirements for preoperative dietary restrictions.** A written informed consent must be signed by the patient or guardian, see BPC 1682 (d)	ASA III, IV) may require consultation with their primary care physician or consulting medical specialist. 2. Pre-operative Preparation • The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained. • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed. • Baseline vital signs must be obtained unless the patient's behavior prohibits such determination. • A focused physical evaluation must be performed as deemed appropriate. • Preoperative dietary restrictions must be considered based on the sedative technique prescribed. • Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver.	
General Anesthesia	**Deep Sedation or General Anesthesia**	**Deep Sedation**
no specific dietary restrictions Equipment for an IV must be available, but does not	1. Patient Evaluation In healthy or medically stable individuals (ASA I, II) at least a review of their current medical history and medication use and NPO status. However, patients with	Ed. See above section for health evaluation. This applies to all levels of sedation.

Table 3.

Clinical Requirements for minimal sedation, moderate sedation deep sedation and general anesthesia

need to be established. Dentist discretion advised for cases where it may be difficult or impossible to establish IV access.	significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist. 2. Pre-operative Preparation • The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained. • Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed. • Baseline vital signs must be obtained unless the patient's behavior prohibits such determination. • A focused physical evaluation must be performed as deemed appropriate. • Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed. • Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver. • An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.	

Table 4.

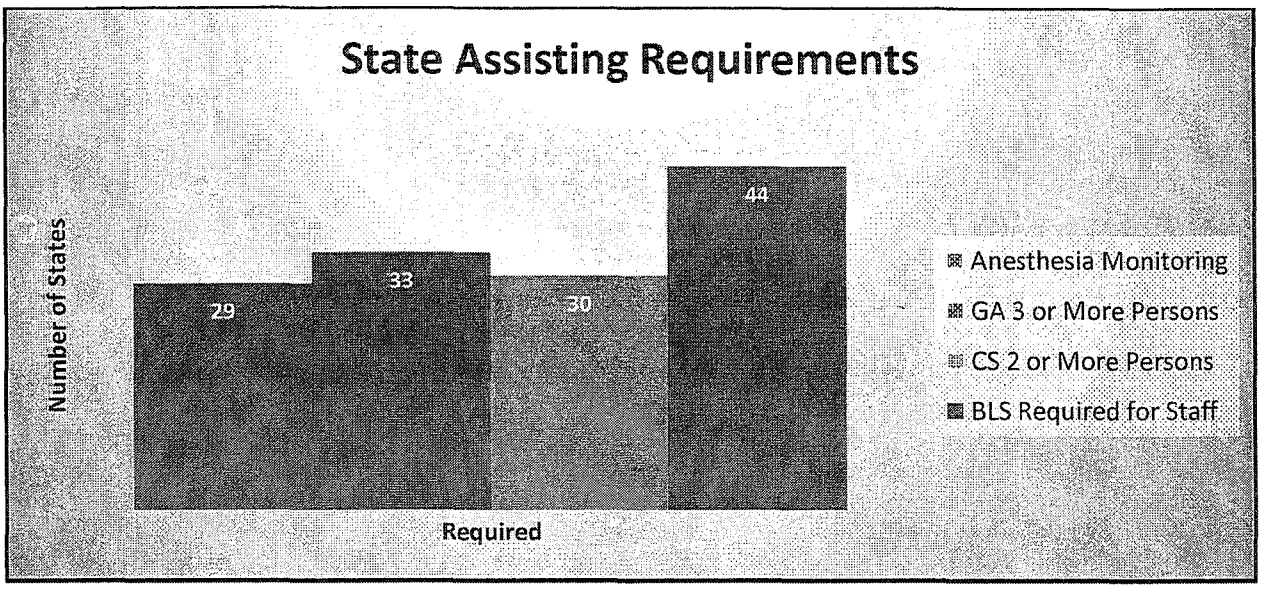
Personnel Requirements – Clinical Guidelines - Comparison of CA, ADA, and AAP-AAPD Guidelines (updated Sept. 2016)

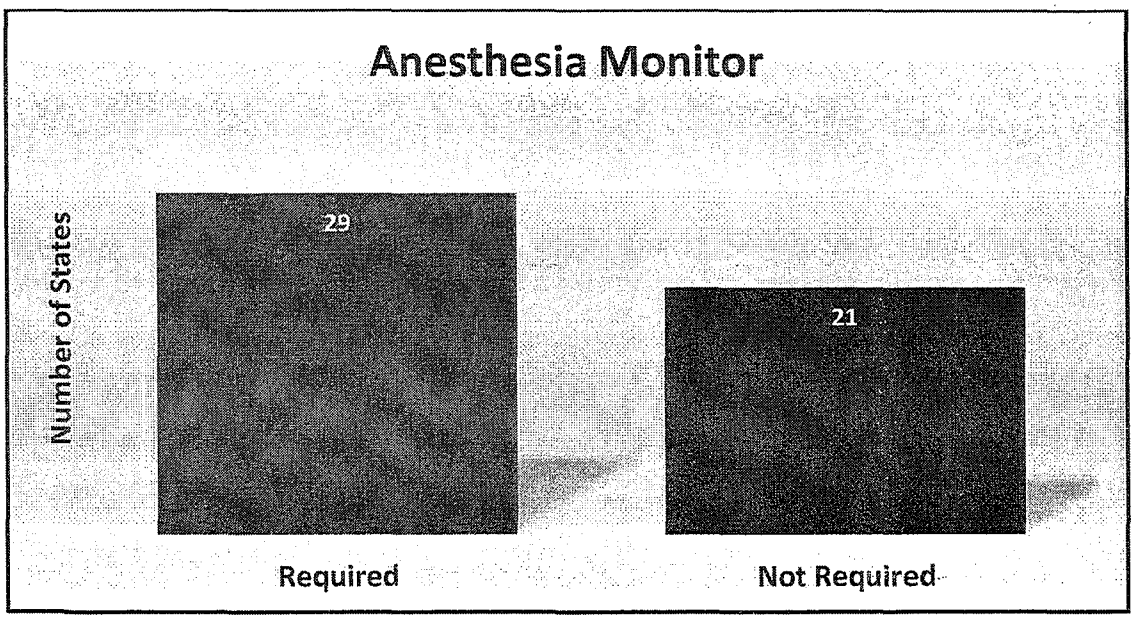
California	ADA Guidelines	AAP-AAPD Guidelines
Minimal sedation	**Minimal sedation**	**Minimal sedation**
	At least one additional person trained in BLS + dentist	Children who have received minimal sedation generally will not require more than observation and intermittent assessment of their level of sedation. Some children will become moderately sedated despite the intended level of minimal sedation; should this occur, then the guidelines for moderate sedation apply.
Moderate sedation	**Moderate sedation**	**Moderate sedation**
BPC 1682 Each patient is continuously monitored on a one-to-one ratio while sedated by either the dentist or another licensed health professional authorized by law to administer conscious sedation or general anesthesia. The patient must be closely monitored by licensed health professionals experienced in the care and resuscitation of patients recovering from conscious sedation or general anesthesia. If one licensed professional is responsible for the recovery care of more than one patient at a time, all of the patients shall be physically in the same room to allow continuous visual contact with all patients and the patient to recovery staff ratio should not exceed three to one. Staff must be certified in basic cardiac life support (CPR) and recertified	At least one person trained in BLS for providers+dentist	The use of moderate sedation shall include provision of a person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration, such as holding an instrument or troubleshooting equipment. This individual should be trained in and capable of providing advanced airway skills (eg, PALS). The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews, simulation of rare emergencies, and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies.

		It is recommended that at least 1 practitioner be skilled in obtaining vascular access in children.
	A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.	A dedicated and properly equipped recovery area is recommended (see Appendices 3 and 4). The time and condition of the child at discharge from the treatment area or facility shall be documented, which should include documentation that the child's level of consciousness and oxygen saturation in room air have returned to a state that is safe for discharge by recognized criteria (see Appendix 1). Patients receiving supplemental oxygen before the procedure should have a similar oxygen need after the procedure. Because some sedation medications are known to have a long half-life and may delay a patient's complete return to baseline or pose the risk of re-sedation[62,104,256,349,350] and because some patients will have complex multiorgan medical conditions, a longer period of observation in a less intense observation area (eg, a step-down observation area) before discharge from medical/dental supervision may be indicated.[239] Several scales to evaluate recovery have been devised and validated.[212,346-348,351,352] A simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet environment.
Deep sedation/general anesthesia	**Deep sedation/general anesthesia**	**Deep sedation/GA**
Same as moderate sedation	A minimum of three (3) individuals must be present. • A dentist qualified in accordance with Part III. C. of these Guidelines to administer the deep sedation or general anesthesia. • Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for	During deep sedation, there must be 1 person whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration. This individual must, at a minimum, be trained in PALS and capable of assisting with any emergency event. At least 1 individual must be present who is

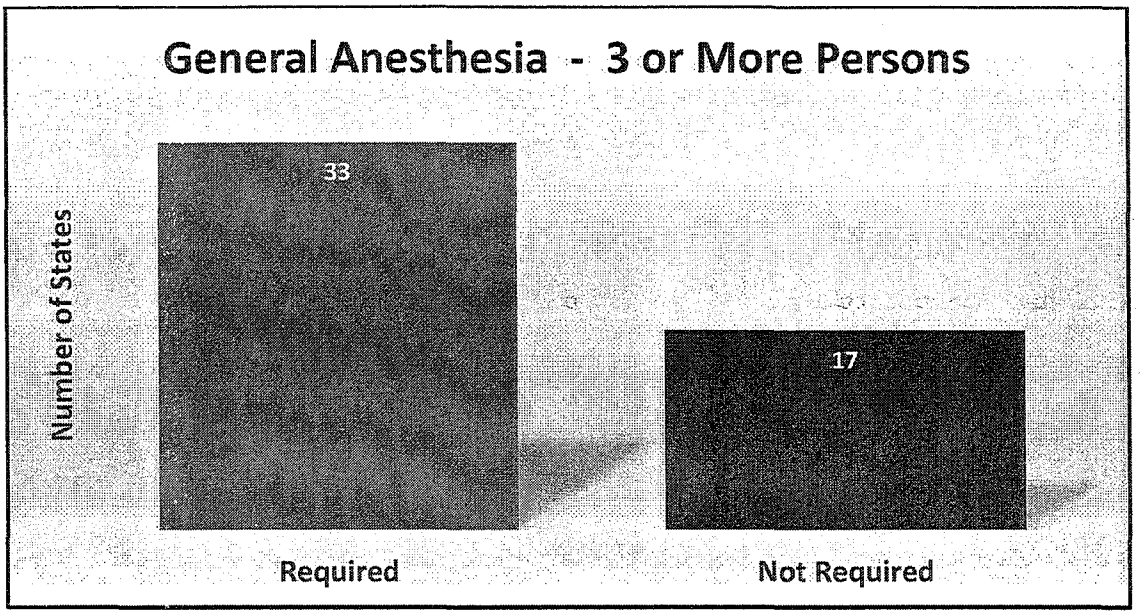
	the Healthcare Provider. • When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring. A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.	trained in and capable of providing advanced pediatric life support and who is skilled to rescue a child with apnea, laryngospasm, and/or airway obstruction. Required skills include the ability to open the airway, suction secretions, provide CPAP, insert supraglottic devices (oral airway, nasal trumpet, LMA), and perform successful bag-valve-mask ventilation, tracheal intubation, and cardiopulmonary resuscitation. (updated to 2016 Guidelines)

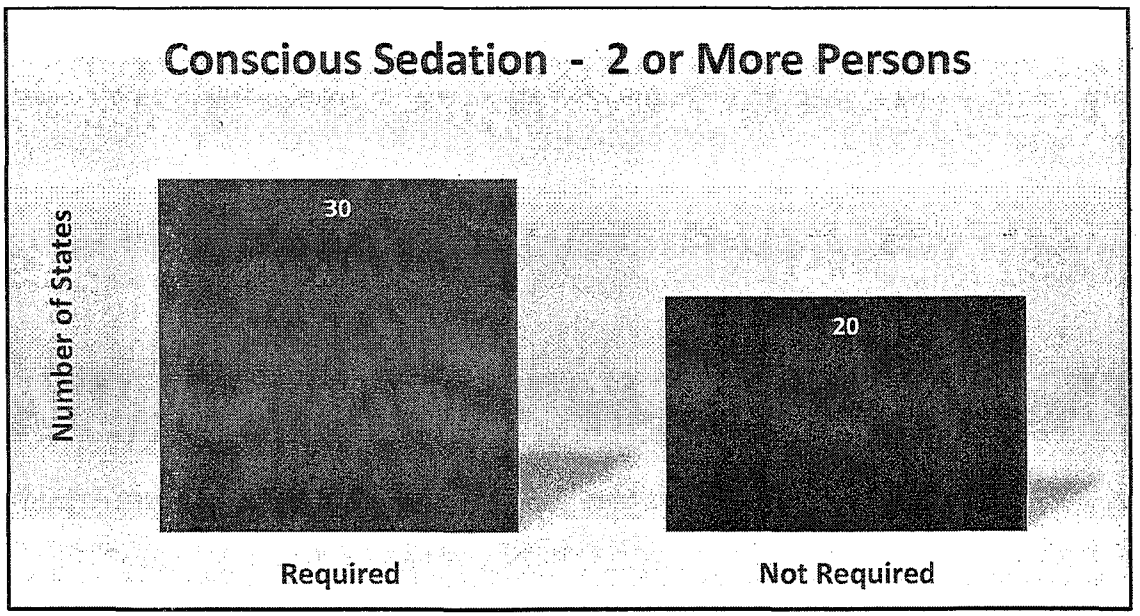
Sedation and Anesthesia Assisting Requirements in the 50 States





Sedation and Anesthesia Assisting Requirements in the 50 States





Sedation and Anesthesia Assisting Requirements in the 50 States

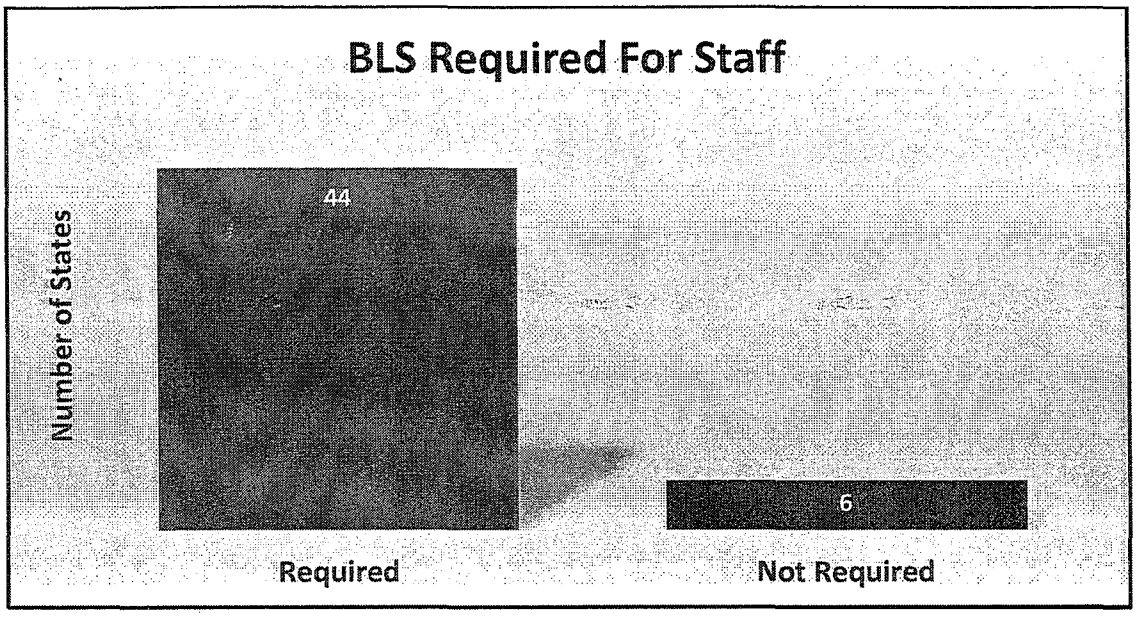


Table 5.

Facility Requirements - Clinical Guidelines – Comparison of California, ADA and AAP-AAPD Guidelines

California Requirements	ADA Guidelines	AAP-AAPD Guidelines
Facilities **See CCR 1044.5 Facility and Equipment Standards – these are the same for all levels of sedation and anesthesia** (a) Office Facilities and Equipment. The following office facilities and equipment shall be available and shall be maintained in good operating condition: (1) An operating theater large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient. (2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation. (3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and	Facility requirements not specifically stated, except as listed under equipment requirements below. A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. • When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm. • An appropriate scavenging system must be available if gases other than oxygen or air are used.	**Facilities** The practitioner who uses sedation must have immediately available facilities, personnel, and equipment to manage emergency and rescue situations. The most common serious complications of sedation involve compromise of the airway or depressed respirations resulting in airway obstruction, hypoventilation, hypoxemia, and apnea. Hypotension and cardiopulmonary arrest may occur, usually from inadequate recognition and treatment of respiratory compromise. Other rare complications may also include seizures and allergic re-actions. Facilities providing pediatric sedation should monitor for, and be prepared to treat, such complications.

a backup lighting system which is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure. (4) Suction equipment which permits aspiration of the oral and pharyngeal cavities. A backup suction device which can operate at the time of general power failure must also be available. (5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of allowing the administering of greater than 90% oxygen at a 10 liter/minute flow at least sixty minutes (650 liter "E" cylinder) to the patient under positive pressure, together with an adequate backup system which can operate at the time of general power failure. (6) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theater.		

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

California Requirements	ADA Guidelines	AAP-AAPD Guidelines
Oral Conscious Sedation	Minimal Sedation	All Levels of Sedation
CCR 1044: An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Ancillary equipment, which must include the following, and be maintained in good operating condition: (1) Age-appropriate oral airways capable of accommodating patients of all sizes. (2) An age-appropriate sphygmomanometer with cuffs of appropriate size for patients of all sizes. (3) A precordial/pretracheal stethoscope. (4) A pulse oximeter	Monitoring: A dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include: Oxygenation: • Color of mucosa, skin or blood must be evaluated continually. • Oxygen saturation by pulse oximetry may be clinically useful and should be considered. Ventilation: • The dentist and/or appropriately trained individual must observe chest excursions continually. • The dentist and/or appropriately trained individual must verify respirations continually. Circulation: • Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).	**On-site monitoring and rescue equipment** An emergency cart or kit must be immediately accessible. This cart or kit must contain equipment to provide the necessary age- and size-appropriate drugs and equipment to resuscitate a non breathing and unconscious child. The contents of the kit must allow for the provision of continuous life support while the patient is being transported to a medical facility or to an-other area within a medical facility. All equipment and drugs must be checked and maintained on a scheduled basis (see Appendices C and D for suggested drugs and emergency life support equipment to consider before the need for rescue occurs). Monitoring devices, such as electrocardiography (**ECG**) machines, pulse oximeters (with size-appropriate oximeter probes), end-tidal carbon dioxide monitors, and defibrillators (with size-appropriate defibrillator paddles), must have a safety and function check on a regular basis as required by local or state

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

		regulation.
Conscious Sedation	Moderate sedation	
1682 (c) Acts constituting unprofessional conduct: Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior equipment required by the board. BPC 1043.3 (7) Ancillary equipment, which must include the following maintained in good operating condition: (A) Laryngoscope complete with adequate selection of blades and spare batteries and bulb. (This equipment is not required for conscious sedation.) (B) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.) (C) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device). (D) Tonsillar or pharyngeal type suction tip adaptable to all office outlets. (E) Endotracheal tube forcep . (This equipment is not required for conscious sedation.) (F) Sphygmomanometer and stethoscope. (G) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.) (H) Adequate equipment for the establishment of an intravenous infusion. (I) Precordial/pretracheal stethoscope. (J) Pulse oximeter. (K) Capnograph and temperature device. A	Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include: Consciousness: • Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed. Oxygenation: • Color of mucosa, skin or blood must be evaluated continually. • Oxygen saturation must be evaluated by pulse oximetry continuously. Ventilation: • The dentist must observe chest excursions continually. • The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO2 or by verbal communication with the patient. Circulation: • The dentist must continually evaluate blood pressure and heart	There shall be continuous monitoring of oxygen saturation and heart rate; when bidirectional verbal communication between the provider and patient is appropriate and possible (ie, patient is developmentally able and purposefully communicates), monitoring of ventilation by (1) capnography (preferred) or (2) amplified, audible pretracheal stethoscope (eg,Bluetooth technology) or precordial stethoscope is strongly recommended. If bidirectional verbal communication is not appropriate or not possible, monitoring of ventilation by capnography (preferred), amplified, audible pretracheal stethoscope, or precordial stethoscope is required. S =Size-appropriate suction catheters and a functioning suction apparatus (eg, Yankauer-type suction) O = An adequate oxygen supply and

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)	rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record). • Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.	functioning flow meters/other devices to allow its delivery **A = Airway:** size-appropriate airway equipment [nasopha-ryngeal and oropharyngeal airways, LMA, laryngoscope blades (checked and functioning), endotracheal tubes, stylets, face mask, bag-valve-mask or equivalent device (functioning)] **P = Pharmacy:** all the basic drugs needed to support life during an emergency, including antagonists as indicated **M = Monitors:** functioning pulse oximeter with size-appropriate oximeter probes and other monitors as appropriate for the procedure (eg, noninvasive blood pressure, end-tidal carbon dioxide, ECG, stethoscope) **E** = Special **equipment or drugs** for a particular case (eg, defibrillator) Appendix D includes a list of suggested drugs and equipment that MAY be needed to rescue a sedated patient. Appendix D. Emergency Equipment† That May Be Needed to Rescue a Sedated Patient ‡

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

		Intravenous Equipment Assorted IV catheters (eg, 24-, 22-, 20-, 18-, 16-gauge) Tourniquets Alcohol wipes Adhesive tape Assorted syringes (eg, 1-, 3-, 5-, 10-mL) IV tubing Pediatric drip (60 drops/mL) Pediatric burette Adult drip (10 drops/mL) Extension tubing 3-way stopcocks IV fluid Lactated Ringer solution Normal saline solution D_5 0.25 normal saline solution Pediatric IV boards Assorted IV needles (eg, 25-, 22-, 20-, and 18-gauge) Intraosseous bone marrow needle Sterile gauze pads **Airway Management Equipment** Face masks (infant, child, small adult, medium adult, large adult) Breathing bag and valve set Oropharyngeal airways (infant, child, small adult, medium

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

		adult, large adult) Nasopharyngeal airways (small, medium, large) Laryngeal mask airways (1, 1.5, 2, 2.5, 3, 4, and 5) Laryngoscope handles (with extra batteries) Laryngoscope blades (with extra light bulbs) Straight (Miller) No. 1, 2, and 3 Curved (Macintosh) No. 2 and 3 Endotracheal tubes (2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, and 6.0 uncuffed and 6.0, 7.0, and 8.0 cuffed) Stylettes (appropriate sizes for endotracheal tubes) Surgical lubricant Suction catheters (appropriate sizes for endotracheal tubes) Yankauer-type suction Nasogastric tubes Nebulizer with medication kits Gloves (sterile and nonsterile, latex free) † The choice of emergency equipment may vary according to individual or procedural needs. ‡ The practitioner is referred to the

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

		SOAPME acronym describe
Conscious (Moderate) Sedation and General Anesthesia	Deep Sedation or General Anesthesia	Deep Sedation
1682 (c) Acts constituting unprofessional conduct: Any dentist with patients who are undergoing conscious sedation to fail to have these patients continuously monitored during the dental procedure with a pulse oximeter or similar or superior equipment required by the board. 1043.3 Onsite inspections The following office facilities and equipment shall be available and shall be maintained in good operating condition: Ancillary equipment, which must include the following maintained in good operating condition: Ancillary Equipment: (K) Laryngoscope complete with adequate selection of blades and spare batteries and bulb. (This equipment is not required for conscious sedation.) (L) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.) (M) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device). (N) Tonsillar or pharyngeal type suction tip adaptable to all office outlets. (O) Endotracheal tube forcep . (This equipment is not required for conscious sedation.)	Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include: Oxygenation: • Color of mucosa, skin or blood must be continually evaluated. • Oxygenation saturation must be evaluated continuously by pulse oximetry. Ventilation: • Intubated patient: End-tidal CO2 must be continuously monitored and evaluated. • Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO2 must be continually monitored and evaluated. • Respiration rate must be continually monitored and evaluated. Circulation: • The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry. • The dentist must continually evaluate blood pressure. Temperature: • A device capable of measuring body temperature must be readily	Equipment In addition to the equipment previously cited for moderate sedation, an electrocardiographic monitor and a defibrillator for use in pediatric patients should be readily available. Monitoring shall include all parameters described for moderate sedation. Vital signs, including heart rate, respiratory rate, blood pressure, oxygen saturation, and expired carbon dioxide, must be documented at least every 5 minutes in a time-based record. Capnography should be used for almost all deeply sedated children because of the increased risk of airway/ventilation compromise. Capnography may not be feasible if the patient is agitated or uncooperative during the initial phases of sedation or during certain procedures, such as bronchoscopy or repair of facial lacerations, and this circumstance should be documented. For

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

(P) Sphygmomanometer and stethoscope. (Q) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.) (R) Adequate equipment for the establishment of an intravenous infusion. (S) Precordial/pretracheal stethoscope. (T) Pulse oximeter. (K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)	available during the administration of deep sedation or general anesthesia. • The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.	uncooperative children, the capnography monitor may be placed once the child becomes sedated. Note that if supplemental oxygen is administered, the capnograph may underestimate the true expired carbon dioxide value; of more importance than the numeric reading of exhaled carbon dioxide is the assurance of continuous respiratory gas exchange (ie, continuous waveform). Patients should have intravenous access established at the begining of the procedure or have someone available who can do this.

Table 6.
Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

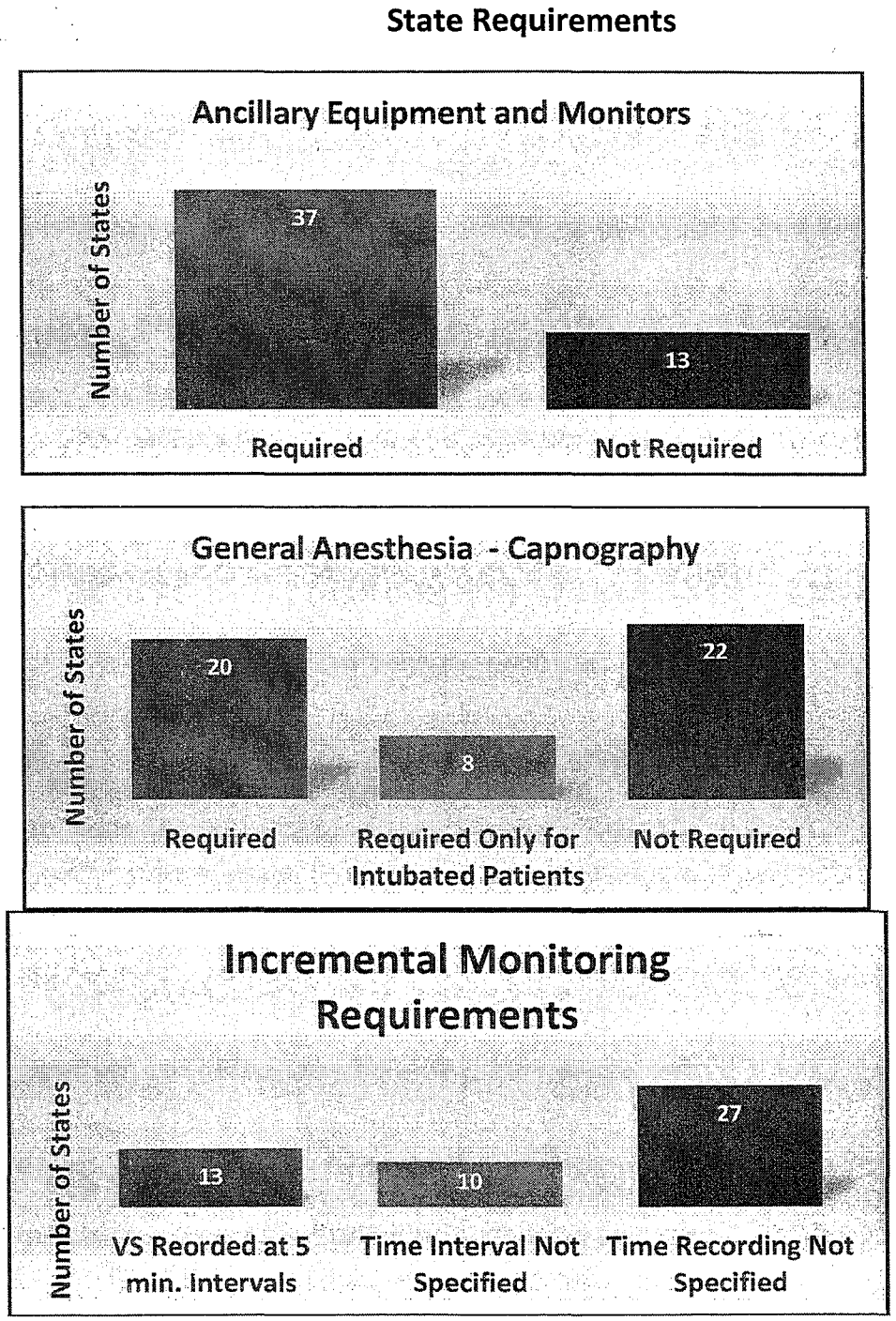


Table 6.

Monitoring and Equipment - Clinical Guidelines For Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia

Table 7.
Record Requirements - Clinical Guidelines for Minimal sedation, Moderate sedation, Deep Sedation, and General Anesthesia

California Record Requirements	ADA Guidelines	AAP-AAPD Guidelines
Oral (Moderate) Conscious Sedation	Minimal Sedation	All levels of Sedation
Oral conscious sedation records shall include baseline vital signs. If obtaining baseline vital signs is prevented by the patient's physical resistance or emotional condition, the reason or reasons must be documented. The records shall also include intermittent quantitative monitoring and recording of oxygen saturation, heart and respiratory rates, blood pressure as appropriate for specific techniques, the name, dose and time of administration of all drugs administered including local and inhalation anesthetics, the length of the procedure, any complications of oral sedation, and a statement of the patient's condition at the time of discharge. (CCR 1044.5)	Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored physiological parameters.	**Documentation prior to treatment – see preoperative evaluation** **Documentation during treatment** The patient's chart shall contain a time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs. Before sedation, a "time out" should be performed to confirm the patient's name, procedure to be per-formed, and site of the procedure. During administration, the inspired concentrations of oxygen and inhalation sedation agents and the duration of their administration shall be documented. Before drug administrations, special attention must be paid to calculation of dosage (ie, mg/kg). The patient's chart shall contain documentation at the time of treatment that the patient's level of consciousness and responsiveness, heart rate, blood pressure, respiratory rate, and oxygen saturation were

Table 7.
Record Requirements - Clinical Guidelines for Minimal sedation, Moderate sedation, Deep Sedation, and General Anesthesia

		monitored until the patient attained predetermined discharge criteria. A variety of sedation scoring systems are available and may aid this process. Adverse events and their treatment shall be documented. **Documentation after treatment** The time and condition of the child at discharge from the treatment area or facility shall be documented; this should include documentation that the child's level of consciousness and oxygen saturation in room air have returned to a state that is safe for discharge by recognized criteria Patients receiving supplemental oxygen before the procedure should have a similar oxygen need after the procedure. Because some sedation medications are known to have a long half-life and may delay the patient's complete return to baseline of pose the risk of resedation some patients might benefit from a longer period of less-intense observation (eg, a step-down observation area) before discharge from medical super-vision.133 Several scales to evaluate recovery have been devised and validated. A recently described and simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet

Table 8.

Emergency drugs - California sedation laws compared to ADA and ADA-AAPD Guidelines

California - required emergency drugs	ADA Guidelines	AAP-AAPD Guidelines
Pediatric and Adult Oral Conscious Sedation (CCR 1044.5)	Minimal Sedation	All Levels of Sedation
An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Emergency drugs of the following types shall be available: (1) Epinephrine (2) Bronchodilator (3) Appropriate drug antagonists (4) Antihistaminic (5) Anticholinergic (6) Anticonvulsant (7) Oxygen (8) Dextrose or other antihypoglycemic	The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.	Appendix C. Drugs That May Be Needed to Rescue a Sedated Patient Albuterol for inhalation Ammonia spirits Atropine Diphenhydramine Diazepam Epinephrine (1:1000, 1:10 000) Flumazenil Glucose (25 percent or 50 percent) Lidocaine (cardiac lidocaine, local infiltration) Lorazepam Methylprednisolone Naloxone Oxygen Fosphenytoin Racemic epinephrine Rocuronium Sodium bicarbonate Succinylcholine * The choice of emergency drugs may vary according to individual or procedural needs
Conscious Sedation and General Anesthesia CCR 1043.3	Moderate Sedation	
Drugs: Emergency drugs of the following types shall be available: (1) Epinephrine (2)Vasopressor(other than epinephrine) (3) Bronchodilator	•The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate	

Table 8.

Emergency drugs - California sedation laws compared to ADA and ADA-AAPD Guidelines

(4) Muscle relaxant (This is not required for conscious sedation.) (5) Intravenous medication for treatment of cardiopulmonary arrest (This is not required for conscious sedation.) (6) Appropriate drug antagonist (7) Antihistaminic (8) Anticholinergic (9) Antiarrhythmic (This is not required for conscious sedation.) (10) Coronary artery vasodilator (11) Antihypertensive (This is not required for conscious sedation.) (12) Anticonvulsant(13) Oxygen (14)50% dextrose or other antihypoglycemic	sedation and providing the equipment, drugs and protocol for patient rescue.	
	Deep Sedation General Anesthesia	
	• The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.	

Table 9.

State Mandated Office Inspection Requirement

California laws related to office inspections

Tables summarizing requirements in 50 states

California office inspection laws

General Anesthesia

1646.4. (a) Prior to the issuance or renewal of a permit for the use of general anesthesia, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure, unless within that time period the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once every five years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) The board may contract with public or private organizations or individuals expert in dental outpatient general anesthesia to perform onsite inspections and evaluations. The board may not, however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

Conscious Sedation

1647.7. (a) Prior to the issuance or renewal of a permit to administer conscious sedation, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure unless, within that time period, the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once in every six years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) An applicant who has successfully completed the course required by Section 1647.3 may be granted a one-year temporary permit

by the board prior to the onsite inspection and evaluation. Failure to pass the inspection and evaluation shall result in the immediate and automatic termination of the temporary permit.

(c) The board may contract with public or private organizations or individuals expert in dental outpatient conscious sedation to perform onsite inspections and evaluations. The board may not, however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

16 CCR § 1043.3

§ 1043.3. Onsite Inspections.

Also see CCR 1043, 1043.2, 1043.4, 1043.5, 1043.6, 1043.7, 1043.8

All offices in which general anesthesia or conscious sedation is conducted under the terms of this article shall, unless otherwise indicated, meet the standards set forth below. In addition, an office may in the discretion of the board be required to undergo an onsite inspection. For the applicant who administers in both an outpatient setting and at an accredited facility, the onsite must be conducted in an outpatient setting. The evaluation of an office shall consist of three parts:

(a) Office Facilities and Equipment. The following office facilities and equipment shall be available and shall be maintained in good operating condition:

(1) An operating theatre large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient.

(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.

(3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure.

(4) Suction equipment which permits aspiration of the oral and pharyngeal cavities. A backup suction device which can operate at the time of general power failure must also be available.

(5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of allowing the administering of greater than 90% oxygen at a 10 liter/minute flow at least sixty minutes (650 liter "E" cylinder) to the patient under positive pressure, together with an adequate backup system which can operate at the time of general power failure.

(6) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theatre.

(7) Ancillary equipment:

(A) Laryngoscope complete with adequate selection of blades and spare batteries and bulb. (This equipment is not required for conscious sedation.)

(B) Endotracheal tubes and appropriate connectors. (This equipment is not required for conscious sedation.)

(C) Emergency airway equipment (oral airways, laryngeal mask airways or combitubes, cricothyrotomy device).

(D) Tonsillar or pharyngeal type suction tip adaptable to all office outlets.

(E) Endotracheal tube forcep. (This equipment is not required for conscious sedation.)

(F) Sphygmomanometer and stethoscope.

(G) Electrocardioscope and defibrillator. (This equipment is not required for conscious sedation.)

(H) Adequate equipment for the establishment of an intravenous infusion.

(I) Precordial/pretracheal stethoscope.

(J) Pulse oximeter.

(K) Capnograph and temperature device. A capnograph and temperature measuring device are required for the intubated patient receiving general anesthesia. (This equipment is not required for conscious sedation.)

(b) Records. The following records shall be maintained:

(1) Adequate medical history and physical evaluation records updated prior to each administration of general anesthesia or conscious sedation. Such records shall include, but are not limited to the recording of the age, sex, weight, physical status (American Society of Anesthesiologists Classification), medication use, any known or suspected medically compromising conditions, rationale for sedation of the patient, and visual examination of the airway, and for general anesthesia only, auscultation of the heart and lungs as medically required.

(2) General Anesthesia and/or conscious sedation records, which shall include a time-oriented record with preoperative, multiple interaoperative, and postoperative pulse oximetry (every 5 minutes intraoperatively and every 15 minutes postoperatively for general anesthesia) and blood pressure and pulse readings, (both every 5 minutes intraoperatively for general anesthesia) drugs, amounts administered and time administered, length of the procedure, any complications of anesthesia or sedation and a statement of the patient's condition at time of discharge.

(3) Written informed consent of the patient or if the patient is a minor, his or her parent or guardian.

(c) Drugs. Emergency drugs of the following types shall be available:

(1) Epinephrine

(2) Vasopressor (other than epinephrine)
(3) Bronchodilator
(4) Muscle relaxant (This is not required for conscious sedation.)
(5) Intravenous medication for treatment of cardiopulmonary arrest (This is not required for conscious sedation.)
(6) Appropriate drug antagonist
(7) Antihistaminic
(8) Anticholinergic
(9) Antiarrhythmic (This is not required for conscious sedation.)
(10) Coronary artery vasodilator
(11) Antihypertensive (This is not required for conscious sedation.)
(12) Anticonvulsant
(13) Oxygen
(14) 50% dextrose or other antihypoglycemic
(d) Prior to an onsite inspection and evaluation, the dentist shall provide a complete list of his/her emergency medications to the evaluator.
Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1646.2, 1646.3, 1647.3 and 1647.6, Business and Professions Code.

HISTORY

1. Amendment filed 4-1-91; operative 5-1-91 (Register 91, No. 18).
2. Editorial correction of subsection (a)(4) (Register 95, No. 16).
3. Amendment filed 2-27-2006; operative 3-29-2006 (Register 2006, No. 9).
This database is current through 7/1/16 Register 2016, No. 27
16 CCR § 1043.3, 16 CA ADC § 1043.3

Oral Conscious Sedation

16 CCR § 1044.5

See also CCR sections 1044, 1044.1, 1044.2, 1043.3, 1044.4

§ 1044.5. Facility and Equipment Standards.

A facility in which oral conscious sedation is administered to patients pursuant to this article shall meet the standards set forth below.
(a) Facility and Equipment.
(1) An operatory large enough to adequately accommodate the patient and permit a team consisting of at least three individuals to freely move about the patient.
(2) A table or dental chair which permits the patient to be positioned so the attending team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.
(3) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system which is battery powered and of sufficient intensity to permit completion of any treatment which may be underway at the time of a general power failure.
(4) An appropriate functional suctioning device that permits aspiration of the oral and pharyngeal cavities. A backup suction device that can function at the time of general power failure must also be available.
(5) A positive-pressure oxygen delivery system capable of administering greater than 90% oxygen at a 10 liter/minute flow for at least sixty minutes (650 liter "E" cylinder), even in the event of a general power failure. All equipment must be age-appropriate and capable of accommodating the patients being seen at the permit-holder's office.
(6) Inhalation sedation equipment, if used in conjunction with oral sedation, must have the capacity for delivering 100%, and never less than 25%, oxygen concentration at a flow rate appropriate for an age appropriate patient's size, and have a fail-safe system. The equipment must be maintained and checked for accuracy at least annually.
(b) Ancillary equipment, which must include the following, and be maintained in good operating condition:
(1) Age-appropriate oral airways capable of accommodating patients of all sizes.
(2) An age-appropriate sphygmomanometer with cuffs of appropriate size for patients of all sizes.
(3) A precordial/pretracheal stethoscope.
(4) A pulse oximeter.
(c) The following records shall be maintained:
(1) An adequate medical history and physical evaluation, updated prior to each administration of oral conscious sedation. Such records shall include, but are not limited to, an assessment including at least visual examination of the airway, the age, sex, weight, physical status (American Society of Anesthesiologists Classification), and rationale for sedation of the minor patient as well as written informed consent of the patient or, as appropriate, parent or legal guardian of the patient.

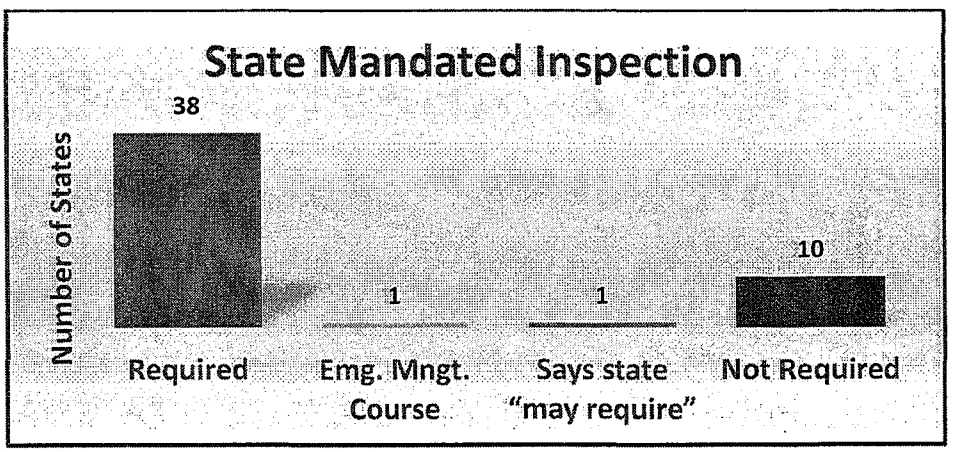
(2) Oral conscious sedation records shall include baseline vital signs. If obtaining baseline vital signs is prevented by the patient's physical resistance or emotional condition, the reason or reasons must be documented. The records shall also include intermittent quantitative monitoring and recording of oxygen saturation, heart and respiratory rates, blood pressure as appropriate for specific techniques, the name, dose and time of administration of all drugs administered including local and inhalation anesthetics, the length of the procedure, any complications of oral sedation, and a statement of the patient's condition at the time of discharge.
(d) An emergency cart or kit shall be available and readily accessible and shall include the necessary and appropriate drugs and age- and size-appropriate equipment to resuscitate a nonbreathing and unconscious patient and provide continuous support while the patient is transported to a medical facility. There must be documentation that all emergency equipment and drugs are checked and maintained on a prudent and regularly scheduled basis. Emergency drugs of the following types shall be available:
(1) Epinephrine
(2) Bronchodilator
(3) Appropriate drug antagonists
(4) Antihistaminic
(5) Anticholinergic
(6) Anticonvulsant
(7) Oxygen
(8) Dextrose or other antihypoglycemic
Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1647.10, 1647.16, 1647.22 and 1647.24, Business and Professions Code.

HISTORY

1. New section and new forms OCS-5 and OCS-3 filed 3-14-2000; operative 4-13-2000 (Register 2000, No. 11).
2. Amendment of section and Note and repealer of printed forms (this action incorporates applicable forms within article 5.5 by reference) filed 12-13-2007; operative 12-13-2007 pursuant to Government Code section 11343.4 (Register 2007, No. 50).
This database is current through 7/1/16 Register 2016, No. 27
16 CCR § 1044.5, 16 CA ADC § 1044.5

Summary of Requirements in 50 states

General Anesthesia Permits



Moderate (Parenteral) Sedation Permit

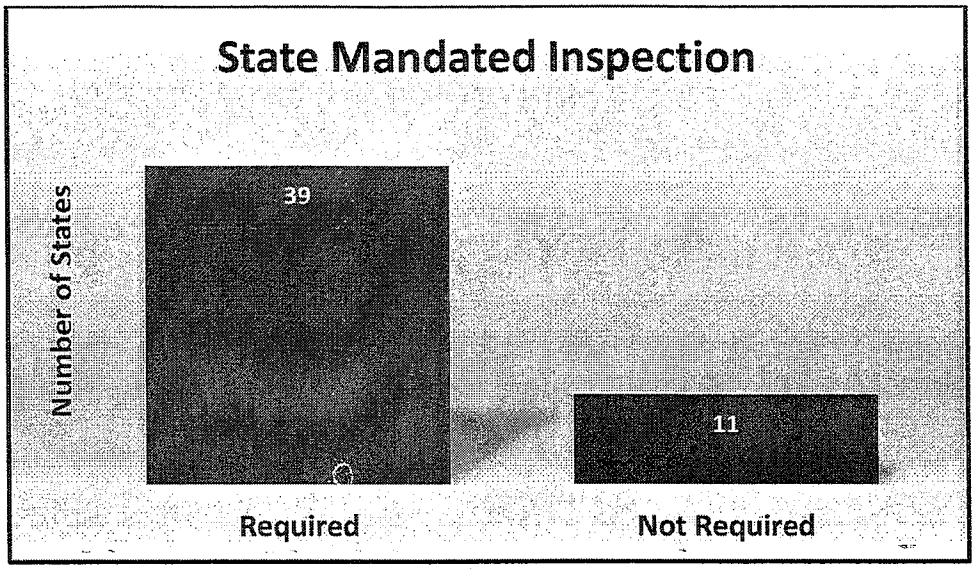

State Mandated Inspection
Number of States
39
11
Required
Not Required

Table 10.

Pediatric Sedation Laws for the 50 States – Summary

Pediatric sedation requirements

Individual states have taken different approaches to the regulation of pediatric sedation. Twenty five states, including California have special requirements for young patients. California requirements apply to patients age 13 or under. An increasing number of states have adopted pediatric sedation educational requirements, equipment requirements, and permits over the past 10 years. All states regulate moderate sedation and deep sedation/GA , regardless of route of administration.

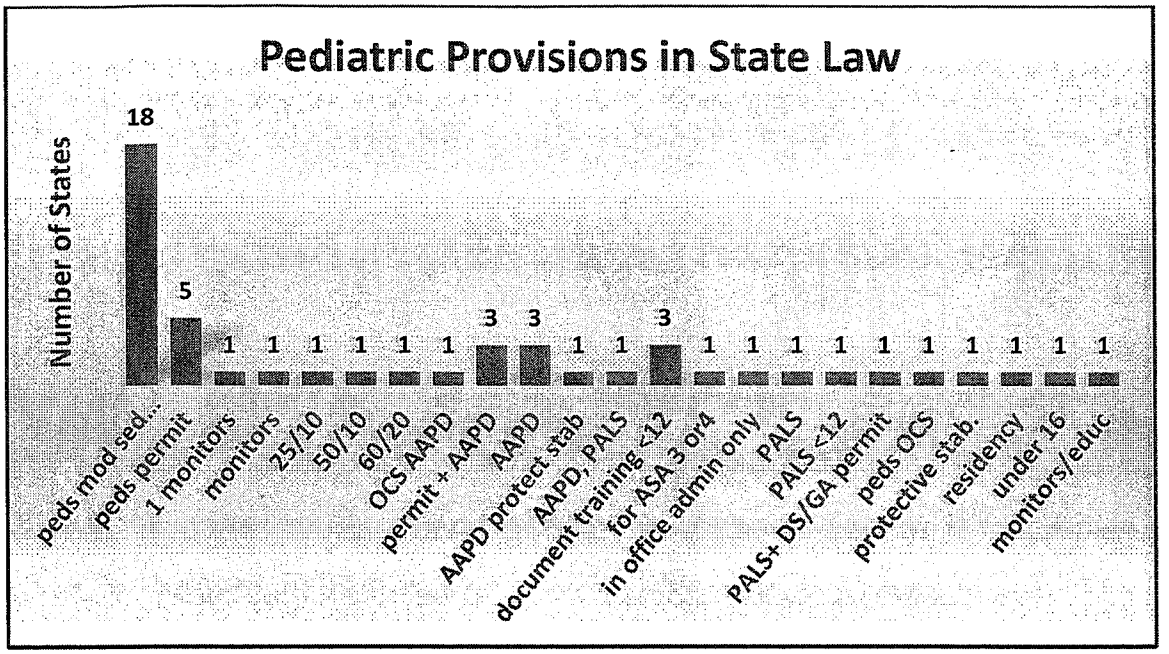
Ten states (California, Colorado, Florida, Georgia, Kentucky, Louisiana, Missouri, Mississippi, North Carolina and Oklahoma) require permits for sedating pediatric patients.

Sixteen states require specific training, some in addition to adult sedation training, to administer moderate/conscious sedation to pediatric patients.

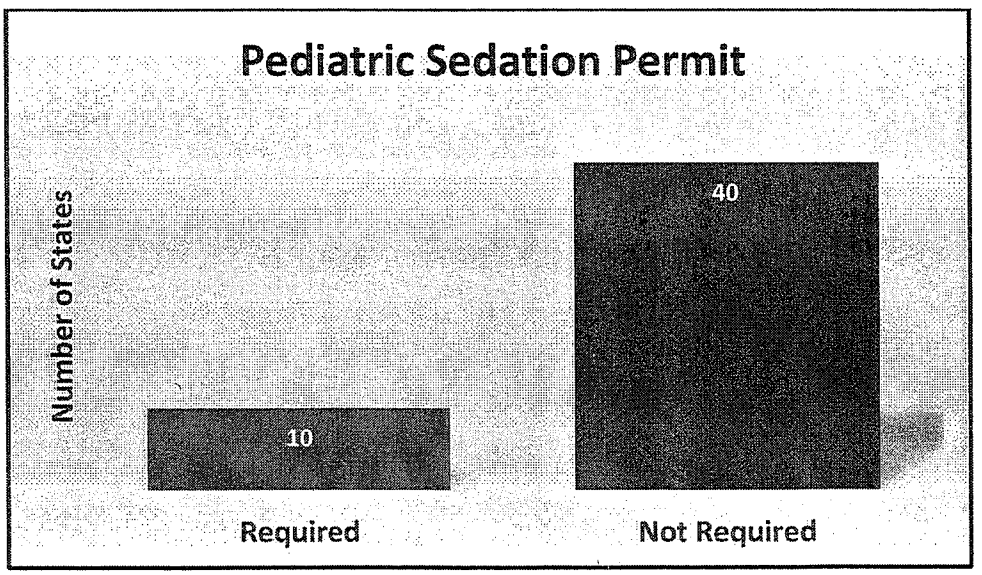
Approximately twenty nine states have specific requirements for pediatric sedation administered by the oral route.

States differ in their definition of the pediatric patient. Several states define the pediatric patient as being under the age of 12 consistent with ADA Guidelines; however other states use 13, 14, 16 and 18 years of age. Most states, including California, specify that the practitioner must have appropriately sized equipment for pediatric patients. In some states ACLS certification is deemed sufficient for treating pediatric patients; Twenty states currently require PALS certification. California does not presently require certification in PALS.

Although ten states have adopted the AAP-AAPD Guidelines, these usually apply to minimal and moderate sedation. Most states do not have specific requirements for the administration of deep sedation/general anesthesia to children.



OCS = oral conscious sedation; 25/10 etc. = classroom hours/supervised cases; PALS= pediatric advanced life support course; all numbers are approximate.



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MEMORANDUM

DATE	December 1, 2016
TO	Dental Board of California
FROM	Karen Fischer, Executive Officer
SUBJECT	**Agenda Item 11:** Update Regarding California Society of Periodontists' Request for the Dental Board of California's Endorsement of their Efforts in the Creation of a Periodontal Awareness Month.

In February 2016, the Dental Board of California received a letter from Mark Fagan, DDS, MS, Immediate Past President of the California Society of Periodontists (CSP) requesting the Dental Board of California's endorsement of their efforts in the creation of a periodontal disease awareness month.

Their goal is to raise awareness of the prevalence and significance of periodontal disease and to provide education on how best to prevent, recognize, and appropriately treat this disease that affects the majority of the adult population.

This issue was discussed at the May 2016 meeting. Dr. Nicholas Caplanis, incoming president of CSP presented information to the Board for discussion. Many board members expressed support for increasing public awareness of the health issues surrounding gum disease including recognizing the signs and symptoms of the disease and treatment options. However the board did not come to a consensus on endorsing CSP's efforts to designate a "Gum Disease Awareness" month at this time. One of the main concerns expressed by members was that an endorsement by the Dental Board would be used by "for-profit" organizations/private companies for personal gain.

The Board asked me to continue to work with CSP on this issue. CSP representatives will give a verbal update on their efforts since the May meeting.

CALIFORNIA SOCIETY OF PERIODONTISTS

California Society of Periodontists

August 10, 2016

Karen M. Fischer, MPA
Executive Officer
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

Dear Ms. Fischer,

In a recent report from the CDC, it is estimated that about half of U.S. adults over the age of 30 have some form of periodontal disease. In California, this number is estimated to range from 46-47.8%, with 58.7% of those affected to be of Hispanic/Latino ethnicity, 59.7% non-Hispanic black, 39.1% non-Hispanic white, and 51% non-Hispanic "other". Additionally, it is estimated that 60.6% of U.S. adults with periodontal disease are below the poverty level. These estimates, based on a recent article in the Journal of Dental Research, further predict that the highest prevalence of periodontal disease is in the southeastern and southwestern states, particularly those along the US-Mexico border. Additionally, the CDC report reiterates that periodontitis disproportionally affects ethnic minorities, those of lower socio-economic status, and those in areas with sparse access to dental care; of which California has many.

These findings should be of particular concern for California, especially given the fact that periodontal disease has also been found to be significantly correlated with an increased risk and/or worsening of many serious medical conditions including, but not limited to, cardiovascular disease, diabetes, pregnancy complications, metabolic syndrome, Alzheimer's, dementia, and even certain cancers. It should also be of particular interest to our state representatives not to ignore the fact that the management of these chronic diseases poses a real burden to our state healthcare programs on which many of those afflicted with periodontal disease are largely dependent on. To ignore an opportunity to reduce the incidence and severity of these conditions by educating our public about significant risk factors such as untreated periodontal disease, would be a great disservice to our community. Proclaiming an official Periodontal Disease Awareness Month would be a positive step towards improving the overall well being and quality of life of all Californians.

Many other states have already recognized this opportunity to improve the life of its citizens, and reduce the long-term economic burden of the state to provide healthcare for highly prevalent chronic diseases like cardiovascular disease and diabetes, by simply proclaiming an official Periodontal/Gum Disease Awareness month. Recognizing this opportunity to make a difference in the lives of their citizens, the states of Illinois, Tennessee, Virginia, North Dakota, Georgia, Mississippi, Vermont, and Arizona, to name a few, have already made such proclamations. This suggestion is in line with other such motions made by our state in the recent past including proclaiming official awareness months for the following diseases and conditions: Asthma, SIDS, Neurofibromatosis, Childhood Cancer, Ovarian Cancer, Breast Cancer, Alzheimer's, and Prostate Cancer. Furthermore, this request is in line with the California Department of Public Health Oral Health Program, established in 2014. In summary, the affirmation of the importance of public awareness of this chronic disease would be a simple, cost-effective method to potentially improve the lives of millions of Californians, as well as reducing the future economic burdens on state healthcare programs.

Sincerely,

Laura Purcell

Laura Purcell
Executive Director

California Society of Periodontists
P.O. Box 7875
Norco, CA 92860

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JOINT MEETING OF THE DENTAL BOARD AND DENTAL ASSISTING COUNCIL

Thursday, December 1, 2016

Upon Conclusion of Agenda Item 11

Embassy Suites San Francisco Airport Waterfront
150 Anza Boulevard, Burlingame, CA 94010
(650) 342-4600 (Hotel) or (916) 263-2300 (Board Office)

Members of the Board

Steven Morrow, DDS, MS, President
*Judith Forsythe, RDA, Vice President (Also a Council member)
Steven Afriat, Public Member, Secretary

Fran Burton, MSW, Public Member
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDH
Kathleen King, Public Member
Ross Lai, DDS
Huong Le, DDS, MA
Meredith McKenzie, Public Member
Thomas Stewart, DDS
*Bruce Whitcher, DDS, (Also a Council member)
Debra Woo, DDS

Members of the Dental Assisting Council

Chair – Anne Contreras, RDA
Vice Chair – Emma Ramos, RDA

Pamela Davis-Washington, RDA
Tamara McNealy, RDA
Judith Forsythe, RDA
Bruce Whitcher, DDS

Public comments will be taken on agenda items at the time the specific item is raised. Action may be taken on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the Council Chair. For verification of the meeting, call (916) 263-2300 or access the Board's website at www.dbc.ca.gov. This Council meeting is open to the public and is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Karen M. Fischer, MPA, Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five business days before the meeting will help to ensure availability of the requested accommodation.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources or technical difficulties that may arise.

JNT 1 - Call to Order/Roll Call/Establishment of Quorum

**The Board meeting is still in progress. Therefore, it is necessary to take roll call of the Dental Assisting Council members only, for the purpose of joining the Board meeting.*

**The Board may take action on any Council recommendations during this joint meeting.*

JNT 2 - Approval of the August 18, 2016 Joint Dental Board and Dental Assisting Council Meeting Minutes

JNT 3 – Update on Dental Assisting Program and Course Application Statistics

JNT 4 - Update on Dental Assisting Examinations Statistics

- Practical
- Written
- Orthodontic Assistant (OA)
- Dental Sedation Assistant (DSA)

JNT 5 – Update on Dental Assisting Licensing Statistics

- Registered Dental Assistant (RDA)
- Registered Dental Assistant in Extended Functions (RDAEF)
- Orthodontic Assistant (OA)
- Dental Sedation Assistant (DSA)

JNT 6 - Discussion and Possible Action Regarding the Update and Possible Combining of the Registered Dental Assistant (RDA) Law & Ethics and Written Examinations in Accordance with Business and Professions Code Section 139 Requirements.

JNT 7 – Update Regarding the 2017 Examination Schedule

JNT 8 – Discussion and Possible Action Regarding the Location of the July 2017 Registered Dental Assistant (RDA) Practical Examination

JNT 9 – Update Regarding the Review of the Registered Dental Assistant (RDA) Practical Examination

JNT 10 – Update Regarding the Registered Dental Assistant (RDA) Candidate Guide

JNT 11 – Update on Dental Assisting Council Regulatory Workshops.

JNT 12 - Discussion and Possible Action Regarding Review of Draft Regulatory Language Relating to the Implementation of the Additional Duties of Registered Dental Assistant in Extended Functions (RDAEF) as Specified in Business and Professions Code Section 1753.55 (Determination of Radiographs and Placement of Interim Therapeutic Restorations)

JNT 13 – Discussion and Possible Action Regarding the Following Items Requested by Joan Greenfield, RDAEF, OAP, MS:

- Placement of Gingival Retraction Cord
- Removal of the Placement of Gingival Retraction Cord from the RDAEF Clinical Examination as a Separate Graded Item
- Amending the Regulatory Language for the RDAEF Restorative Examination
- Add the Administration of Nitrous Oxide to the Scope of Practice for the RDAEF Licensed on or after January 1, 2010
- Add the Administration of Local Anesthesia to the Scope of Practice for the RDAEF Licensed on or after January 1, 2010

JNT 14 – Election of 2017 Dental Assisting Council Officers

JNT 15 – Public Comment on Items Not on the Agenda

The Board may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

JNT 16 - Adjourn Joint Meeting of the Dental Board and the Dental Assisting Council.

DENTAL BOARD AND DENTAL ASSISTING COUNCIL MEETING MINUTES
Thursday, August 18, 2016

Hilton Sacramento Arden West
2200 Harvard Street, Sacramento, CA 95815

Members of the Board Present
Steven Morrow, DDS, MS, President
*Judith Forsythe, RDA, Vice President (Also a Council member)
Fran Burton, MSW, Public Member
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDH
Kathleen King, Public Member
Ross Lai, DDS
Huong Le, DDS, MA
Meredith McKenzie, Public Member
Thomas Stewart, DDS
*Bruce Whitcher, DDS, (Also a Council member)
Debra Woo, DDS

Members of the Board Absent
Steven Afriat, Public Member, Secretary

Members of the Dental Assisting Council Present
Chair – Anne Contreras, RDA
Vice Chair – Emma Ramos, RDA
Pamela Davis-Washington, RDA
Tamara McNealy, RDA
Judith Forsythe, RDA
Bruce Whitcher, DDS

JNT 1 - Call to Order/Roll Call/Establishment of Quorum.
President Steven Morrow called the meeting to order at 2:42 p.m. Anne Contreras, Dental Assisting Council Chair, called the roll and a quorum was established.

JNT 2 - Approval of the May 11, 2016 Joint Dental Board and Dental Assisting Council Meeting Minutes.
Ms. McKenzie asked for an amendment to be made to the minutes, due to her name being left out.

President Morrow asked if there were any other reccomendations or edits needed to be made to the May 11, 2016 minutes.

Ms. Contreras brought up a question regarding the dental assisting fee increases mentioned in agenda item JNT 12. She asked if there is a seperate fee amount for permits such as an orthodontic assistant permit and dental sedation assistant permit. She went on to point out that these are permits and not licenses, such as an RDA and an RDAEF license, and wanted to know if the permit holders are assessed a seperate fee amount for their permits.

Ms. Wallace responded there are separate fees for orthodontic assistant and dental sedation permits.

Ms. Contreras asked if the fees for both permits will increase to $100 each. She mentioned there are a lot of registered dental assistants that also hold either an orthodontic assistant permit or a dental sedation permit and went on to ask if the Board will consider having a reduced or discounted fee amount for RDAs that hold a permit in addition to their RDA license.

Ms. Wallace mentioned she wasn't sure if it was the appropriate time to bring this discussion up and deferred it to legal council Mr. Walker.

Ms. Contreras mentioned that since she wasn't at the previous Board meeting she wanted to bring this up now. She asked if this matter could be discussed at a future Board meeting.

Ms. Wallace responded that as a standard practice across all boards, if one has a permit and a license, that individual pays a separate renewal fee for both the license and permit and that at this point in time that's how the fee regulations would be structured.

Mr. Walker asked if this subject should be discussed at a future Regulatory Workshop.

Ms. Wallace answered no.

Ms. Fischer suggested that if there are further questions on this matter, Ms. Contreras can talk to staff about it and possibly add this as a future agenda item for discussion.

Ms. Contreras agreed.

President Morrow asked if there were any additional comments or edits, other than Ms. McKenzie's attendance edit, that needed to be made to the minutes. Hearing none, President Morrow asked that the motion be ammended to approve the corrected minutes.

The motioner (Meredith McKenzie) and seconder (Tamara McNealy) agreed.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Le, Lai, McKenzie, Stewart, Whitcher, Woo, Ramos, Davis-Washington, McNealy.
Oppose: 0 **Abstain:** 1

The motion passes.

JNT 3 - Overview of the Dental Assisting Educational Program, Course Curriculum Requirements and the Application Process.

Sarah Wallace, Assistant Executive Officer gave an overview of the information provided. Ms. Wallace mentioned that at the last Board meeting, questions were brought up regarding the approval process for programs and courses, curriculum requirements and the application process. Therefore for informational purposes, staff put together this memo. She added that for best practices, staff will continue to include this information at every meeting moving forward, in case any questions on the matter should arise.

Ms. Wallace moved on to discuss the amount of programs and courses approved and the amount of applications pending approval since the last meeting.

Ms. Wallace also pointed out as noteworthy that the Board has recently received 3 RDAEF Program applications. She mentioned these types of programs approved in CA have been the same ones for a very long time, and that a sudden interest in opening new RDAEF programs has taken place. Therefore the board will need to keep an eye on that in the future as it relates to examination availability.

Board comment:
Ms. McNealy asked what the specific amount of clinical hours are for RDA Programs that have been approved since the last board meeting.

Ms. Wallace responded that we do not have that information at hand.

Ms. McNealy responded that the current regulatory language for programs and courses regarding extramural clinical hours is being misinterpreted, since there isn't a specific stipulated amount. She proceeded to mention that any given program can interpret the language in a manner that was never the intent, and that the clinical hours should be discussed at the regulatory workshops.

Ms. Wallace responded that staff has made a note of the discussion on extramural clinical hours and will be working on the final draft language to bring to the board council in 2017.

JNT 4 – Update on Dental Assisting Examinations Statistics.

Ms. Adams gave an overview of the information provided. She clarified that the statistics provided do not include the practical exam that was held in Fresno in mid-July, and added that staff are currently working on entering grades to enable us to send results to candidates.

Ms. Adams proceeded to give preliminary information of the July Fresno exam. She mentioned there were 454 candidates that attended, 210 candidates failed, 244 passed, which gave us a 46% failure rate and a 54% pass rate. She went on to mention that

staff is currently working on the 2017 RDA and RDAEF examination schedule and the aim is to have it posted on the Boards website by October 2016.

Ms. Wallace mentioned that this is the last Board meeting Ms. Adams will be attending due to moving on to work for another state agency and thanked her for her work and dedication to the examination process and to the dental assisting council.

JNT 5 - Dental Assisting Program Licensing Statistics.

- RDA
- RDAEF
- Orthodontic Assistant Permit(OA)
- Dental Sedation Assistant Permit(DSA)

Ms. Adams gave an overview of the information provided.

Ms. Wallace commented on the 3rd table provided and said that staff had been asked at the March board meeting to pull statistics for licensees who possess both an RDA and RDH license. She pointed out that although the table's information may look somewhat strange, the grand total for both columns come to be the same amount.

JNT 6 – Report on the Results of the Department of Consumer Affairs (DCA) Office of Professional Examination Services (OPES) Occupational Analysis of the Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEF) Practical Examinations.

Ms. Wallace pointed out that this report only in relation to the RDAEF Occupational Analysis and not the RDA findings discussed at the previous board meeting, and also pointed out a calculation error regarding the response rate found on page 6 of the report. She then passed the presentation over to Dr. Lincer.

Dr. Heidi Lincer, Chief of OPES, provided a PowerPoint presentation report on the findings of the (OPES) Occupational Analysis of the Registered Dental Assistant in Extended Functions (RDAEF) Practical Examinations.

Board comment:

Dr. Whitcher commented it was interesting that the dominant tasks are mostly performed at the RDA level. There are a few RDAEF 1s and of course numerically there aren't that many EF 2s. He mentioned that it was also interesting how many of them had received on the job training and that he's aware that a lot of the EF 1s were originally brought with their dentists to the program and somewhat trained with them. He added that it's always been a curiosity as to how many of the EF 2 duties were actually being utilized, and mentioned that they are being done enough and actually being utilized in the workplace.

Ms. McNealy asked how does one utilize the EFs when there's a limited number that the overseeing dentist can have. How does this statute apply to an associate dentist?

Dr. Morrow asked if Ms. McNealy wants to know how many RDAEFs can be working for a dentist at the same time.

Ms. McNealy responded that statute says 3 RDAEFs. But she wanted to know how many EFs can work in a dental office if there's an associate dentist working there as well. Can the associate dentist have 3 RDAEFs as well?

Ms. Forsythe commented that she has always interpreted statute to state it is 3 RDAEFs per dentist not per office.

Mr. Walker confirmed Ms. Forsythe's interpretation to be correct. He stated it is 3 RDAEFs per dentist.

Dr. Le commented that it is 3 per dentist.

Dr. Morrow thanked Dr. Lincer for taking the time to present the Occupational Analysis for Registered Dental Assistant in Extended Functions (RDAEF) Practical Examinations report.

JNT 7 – Discussion and Possible Action Regarding the Update of the Registered Dental Assistant in Extended Functions (RDAEF) Written Examination in Accordance with Business and Professions Code Section 139 Requirements.

Ms. Wallace discussed that as is standard practice, after an occupational analysis is completed, it's usually then time to work on the examination development to update our current examinations to link it to the findings of the occupational analysis. She moved to ask the Board and the Dental Assisting council to consider and possibly direct staff to work with DCA's Office of Professional Examinations and Services to update the Board's RDAEF written examination based on the findings of the recently conducted occupational analysis of the RDAEF profession. She clarified that at this point we are asking for permission to direct staff to initiate the contract agreement with OPES that would be followed up with a series of workshops and examination developments with a potential new examination to be released in 2018.

Dr. Morrow asked if there is a Board member interested in stepping up to the plate on this project.

Dr. Morrow moved the motion; Yvette Chappell-Ingram seconded the motion.

Support: Morrow, Forsythe, Burton, Chappell-Ingram, Dawson, King, Le, Lai, McKenzie, Stewart, Whitcher, Woo, Contreras, Ramos, Davis-Washington, McNealy.
Oppose: 0 **Abstain:** 0

The motion passes.

JNT 8 – Update on Dental Assisting Council Regulatory Workshops.
Ms. Wallace introduced Ms. Campaz as one of the AGPAs in the dental assisting unit tasked with running and coordinating all of the Dental Assisting Regulatory Workshops.

Ms. Campaz gave a summary of the Regulatory Workshops scheduled throughout the remainder of 2016 and their topics of discussion.

JNT 9 - Public Comment on Items Not on the Agenda.
None.

JNT 10 - Adjourn Joint Meeting of the Dental Board and the Dental Assisting Council.
President Morrow adjourned the council meeting at 3:30p.m.

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MEMORANDUM

DATE	November 15, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Leslie Campaz, Educational Program Analyst
SUBJECT	**Agenda Item JNT 3:** Update on Dental Assisting Program and Course Application Statistics

In an effort to meet the requirements of CCR, Title 16, Section 1070(a)(2), the Board has approved DA program and course curriculum applications and has conducted site visits throughout 2016. The re-evaluation of programs and courses may include a site visit or may require written documentation that ensures compliance with all regulations. Additionally, the Board will soon begin recruiting and training additional subject matter experts (SME's) in the dental assisting program and course evaluation process.

Table 1 identifies the total number of DA Program/Course curriculum applications that have been approved in 2016 to date. Table 2 lists the number of DA Programs and Course site visits conducted in 2016 to date. Table 3 lists the DA Program and Course applications that are currently being reviewed or have been approved since the last board meeting. Table 4 identifies approved DA program or course providers by name and type of program.

Table 1
Total DA Program and Course Applications Approved in 2016 to date

	RDA Programs	RDAEF Programs	Radiation Safety Course	Coronal Polish Course	Pit and Fissure Sealants	Ultrasonic Scaler	Infection Control	Orthodontic Assistant	Dental Sedation Assistant	**Grand Total**
Course Totals	**6**	**4**	**8**	**10**	**8**	**2**	**4**	**8**	**1**	**51**

Table 2
Total DA Program and Course Site Visits/Re-evaluations conducted in 2016

	RDA Programs		RDAEF	Radiation Safety	Coronal Polish	Pit and Fissure Sealants	Ultrasonic Scaler	Infection Control	Orthodontic Assistant	Dental Sedation Assistant	**Grand Total**
	Provisional	Full									
Site Visit Totals	**5**	**1**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10**

Table 3 DA Program & Course Applications Approved and Received Since Last Board Meeting				
Program or Course Title	**Approved**	**Denied**	**Received/ Currently Processing**	**Incomplete Application Received**
RDA Program/Curriculum	3	0	1	0
RDAEF/Program/Curriculum	3	0	0	0
Radiation Safety	3	0	1	0
Coronal Polish	3	0	0	0
Pit and Fissure	1	0	0	0
Ultrasonic Scaler	1	0	1	0
Infection Control	2	0	0	0
OA Permit	4	0	3	1
DSA Permit	0	0	0	0
Total Applications	**20**	**0**	**6**	**1**

Table 4

Dental Assisting Programs/Courses Approved Since Last Board Meeting

Provider	Approval Date	RDA Program	RDAEF Program	X-Ray	CP	P/F	US	IC	DSA	OA
Academy of Evolution in Dental Assisting	10/18/16				X					
American Career College - Long Beach	9/28/16	X								
C&G Orthodontics	9/22/2016									X
Dental Assisting School of San Pablo - Vacaville	8/31/2016							X		
Dental Career Institute	10/2/2016		X							
Expanded Functions Dental Assistant Association	10/8/2016				X					
Expanded Functions Dental Assistant Association	10/8/2016			X						
The FADE Institute, Inc.	10/31/2016		X							
Howard Healthcare Academy	10/20/2016	X								
Howard Healthcare Academy	10/20/2016		X							
InfoTech Career College	10/2/16				X					
InfoTech Career College	10/1/2016					X				
InfoTech Career College	10/3/2016			X						
Jimmy Vu Ngo	10/6/16									X
Kenneth P. Brown	10/6/2016			X						
Los Angeles School of Dental Assisting	10/4/2016							X		
Milde Family Orthodontics	10/6/2016									X

Netra V. Dudhbhate	10/17/2016						X			
Susan S. So	10/14/2016									X
Unitek College - San Jose	10/13/2016	X								
INDIVIDUAL PROGRAM/COURSE TOTALS		**3**	**3**	**3**	**3**	**1**	**1**	**2**	**0**	**4**
TOTAL APPROVALS = 20										

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MEMORANDUM

DATE	November 15, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**AGENDA ITEM JNT 4:** Update on Dental Assisting Examination Statistics

This agenda item will be hand-carried to the meeting. The statistical information will be posted on the Board's web site immediately following the Board meeting.

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MEMORANDUM

DATE	November 15, 2016
TO	Dental Assisting Council Members, Dental Board of California
FROM	Jorrelle Abutin, Staff Services Analyst
SUBJECT	**Agenda Item JNT 5:** Update on Dental Assisting Licensing Statistics

A: The following table provides current license status statistics by license type as of

November 14, 2016

License Type	Registered Dental Assistant (RDA)	Registered Dental Assistant in Extended Functions (RDAEF)
Current & Active	28,641	1,359
Current & Inactive	4,611	76
Delinquent	11,168	214
Total Population (Current & Delinquent)	**44,420**	**1,649**
Total Cancelled Since Implementation	40,950	251

The following table provides current permit status statistics by permit type as of **November 14, 2016**

Permit Type	Orthodontic Assistant (OA)	Dental Sedation Assistant (DSA)	Total Permits
Current & Active	523	27	550
Current & Inactive	6	1	7
Delinquent	41	9	58
Total Population (Current & Delinquent)	**570**	**37**	**607**
Total Cancelled Since Implementation	0	0	1

Definitions

Current & Active	An individual who has an active status and has completed all renewal requirements receives this status.
Current & Inactive	An individual who has an inactive status and has completed all renewal requirements receives this status.
Delinquent	An individual who does not comply with renewal requirements receives this status until renewal requirements are met.
Cancelled	An individual who fails to comply with renewal requirements by a set deadline will receive this status.
Voluntary Surrendered	An individual who surrenders his or her license as part of a disciplinary action would receive this status.
Revoked	An individual who receives a disciplinary action of revoked would receive this status.
Deceased	After the Board/Bureau receives proof of death, a license would be set to this status.

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MEMORANDUM

DATE	November 16, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**AGENDA ITEM JNT 6:** Discussion and Possible Action Regarding the Update and Possible Combining of the Registered Dental Assistant (RDA) Law & Ethics and Written Examination in Accordance with Business and Professions Code Section 139 Requirements

Background:
Executive Officer, Karen Fischer, received the attached memorandum from the Office of Professional Examination Services (OPES) at the Department of Consumer Affairs (DCA) recommending that the Registered Dental Assistant (RDA) Written and the Law and Ethics examinations be combined into one 100-item written examination.

Heidi Lincer, Ph.D., Chief of OPES will be in attendance at the Board meeting to speak to the OPES recommendation and answer questions.

Action Requested:
Board staff requests the Board and Council consider and possibly direct staff to work with the Department of Consumer Affairs' Office of Professional Examination Services to update and combine the Registered Dental Assistant (RDA) Written and the Law and Ethics examinations into one 100-item written examination based on the findings of the recently completed *Occupational Analysis of the Registered Dental Assistant Profession*.

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OFFICE OF PROFESSIONAL EXAMINATION SERVICES
2420 Del Paso Road, Suite 265, Sacramento, CA 95834
P (916) 575-7240 F (916) 575-7291

MEMORANDUM

DATE	October 4, 2016
TO	Karen Fischer, Executive Officer Dental Board of California
FROM	Heidi Lincer, Ph.D., Chief Office of Professional Examination Services
SUBJECT	**2016 RDA OA Results and Recommendations for RDA Written and Law and Ethics Licensure Examinations**

In March 2015, the Office of Professional Examination Services (OPES) initiated an occupational analysis (OA) of the Registered Dental Assistant (RDA) profession at the request of the Dental Board of California (Board). California Business and Professions Code section 139 requires that the boards and bureaus of the Department of Consumer Affairs conduct an OA for each license classification every five to seven years.

One purpose of the OA is to develop a description of current practice in terms of the actual job tasks that entry-level licensees must be able to perform safely and competently. The results of OAs are also used to develop updated test plans for licensing examinations. The current RDA Written examination focuses on general entry-level practice issues, whereas the Law and Ethics examination focuses on California laws and ethical issues. Based on the results of the 2016 RDA OA, new test plans were developed for both examinations.

Given the OA results, OPES strongly recommends that the RDA Written and the Law and Ethics examinations be combined into one 100-item written examination.

A comparison between the current RDA Law and Ethics test plan and the new 2016 OA Law and Ethics test plan reveals major changes in content. The current test plan takes a broad view of the laws and ethical responsibilities relevant to RDA licensure, whereas the new plan focuses on the depth of RDA practice. The licensees participating in the OA workshops evaluated the current test plan and identified and eliminated areas not closely related to RDA duties and responsibilities. This was done to develop a stronger focus on assessing candidates' readiness for RDA practice.

After discussion, the licensees in the OA workshops also determined that it was critical to include laws in the test plan that were related to the scope of practice for both RDAs and Registered Dental Assistants in Extended Functions (RDAEF). The licensees believed that it was important for RDA candidates to know what the RDA scope enabled them to do, as well as to be aware of the limits of the RDA scope of practice (RDAEF duties). The new test plan also incorporates California laws related to infection control, hazardous waste, mandated reporting, and patient confidentiality, which were either not included in the current test plan or included but in a more general way.

The primary impact of this update in content is that the examination items of the RDA Law and Ethics examination will more strongly focus on the relationship between RDA-related laws and ethical responsibilities and critical areas of RDA entry-level practice. Another impact of this update is that, because of the changes in the test plan, over 35% of the current examination items in the item bank will no longer be viable for inclusion on examinations based on the new test plan.

In summary, with the test content changes, OPES recommends combining the RDA Written and Law and Ethics examinations into a single examination. The RDA Written and the Law and Ethics examinations are currently administered as two separate 50-item examinations. Combining the two examinations into one 100-item examination will improve test reliability since measurement error tends to decrease as test length increases. Improving the reliability of the examinations will lead to a more valid assessment and thus strengthen the decisions about competency to practice.

In addition, combining the two examinations into one examination better reflects the integration of the laws and ethical principles RDAs must know upon licensure with the duties RDAs perform in their scope of practice. The results of the 2016 RDA OA support a test plan where content based on RDA-related laws and ethical responsibilities is developed within the context of RDA duties. A single examination based on the 2016 RDA OA results will provide a better measure of the RDA candidate's readiness to practice as the content will be more focused on entry-level RDA practice requirements.

Finally, combining the RDA Written and Law and Ethics examinations will bring the licensure requirements for RDAs into alignment with the licensing requirements of the other professions overseen by the Board by requiring RDAs to only pass a single, written state examination for licensure. RDAEF and Dentist candidates are required to pass a single, written state examination to become licensed. In addition, Registered Dental Hygienist and Registered Dental Hygienist in Alternative Practice candidates are also required to pass a single, written state examination to become licensed.

Conclusion

The 2016 RDA OA results indicate that the RDA Written and Law and Ethics examinations should be combined into one examination. Making this change will remove barriers to licensure for RDA candidates. Candidates will only have to schedule

and pay for one written examination instead of scheduling and paying for two examinations.

OPES can assist the Board with drafting the regulatory language required to implement these changes to current procedures. OPES can also assist in developing a plan for implementing the combined test plan based on the results of the 2016 RDA OA to ensure that the combined examination is legally defensible and meets the requirements of Business and Professions Code section 139.

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MEMORANDUM

DATE	November 16, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**AGENDA ITEM JNT 7:** Update Regarding the 2017 Examination Schedule

Background:
The Dental Board of California has posted to its web site the confirmed dates and locations for the RDA and RDAEF examinations to be held during 2017. Additional examination dates may be added. The examination schedules are attached for informational purposes.

Action Requested:
No action necessary.

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2017 REGISTERED DENTAL ASSISTANT (RDA) PRACTICAL EXAMINATION SCHEDULE

The following are the confirmed dates for the RDA Practical Examination in California for 2017. All examination dates and locations are subject to change and cancellation. Applicants may be reassigned by the Dental Board to an alternate location based on space availability. Applications will not be accepted before the filing period opens.

NOTE: Applications must be received at the Board office no later than 5:00 on the last day of the filing period.

Applicants will be provided specific information regarding the content of the examination and directions for scheduling the written examinations upon being notified that their applications are deemed complete and approved.

Additional 2017 examination dates may be added. Please check back frequently for information regarding examination dates, locations, and filing period.

Examination Date	Examination Location	Filing Period
February 4 February 5	Carrington College, Pomona 901 Corporate Center Drive, Ste 300 Pomona, CA 91768	November 14, 2016 to December 9, 2016
February 11 February 12	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143	
April 29 April 30	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143	January 17, 2017 to February 17, 2017
May 20 May 21	Carrington College, Pomona 901 Corporate Center Drive, Ste 300 Pomona, CA 91768	

August 5 August 6	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143	May 1, 2017 to May 26, 2017
August 19 August 20	Carrington College, Pomona 901 Corporate Center Drive, Ste 300 Pomona, CA 91768	
November 4 November 5	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143	August 7, 2017 to September 1, 2017
November 18 November 19	Carrington College, Pomona 901 Corporate Center Drive, Ste 300 Pomona, CA 91768	

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2017 REGISTERED DENTAL ASSISTANT IN EXTENDED FUNCTIONS (RDAEF) EXAMINATION SCHEDULE

The following are the confirmed dates for the RDAEF Examination in California for 2017. All examination dates and locations are subject to change and cancellation. Applicants may be reassigned by the Dental Board to an alternate location based on space availability. Applications will not be accepted before the filing period opens.

NOTE: Applications must be received at the Board office no later than 5:00 on the last day of the filing period.

Applicants will be provided specific information regarding the content of the examination and directions for scheduling the written examinations upon being notified that their applications are deemed complete and approved.

Additional 2017 examination dates may be added. Please check back frequently for information regarding examination dates, locations, and filing period.

Examination Date	Examination Location	Filing Period
January 28 January 29	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143	November 14, 2016 to December 9, 2016
June 10	University of California, Los Angeles School of Dentistry 10833 Le Conte Avenue Los Angeles, CA 90095	March 20, 2017 To April 7, 2017
October 7	University of California, Los Angeles School of Dentistry 10833 Le Conte Avenue Los Angeles, CA 90095	July 3, 2017 to July 28, 2017
October 14 October 15	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143	July 3, 2017 to July 28, 2017

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MEMORANDUM

DATE	November 17, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**Agenda Item JNT 8:** Discussion and Possible Action Regarding the Location of the July 2017 Registered Dental Assistant (RDA) Practical Examination

Background:
The 2017 examination schedule for the Board's RDA practical examination was recently posted to the Board's web site. This schedule includes eight (8) weekends of testing with confirmed locations throughout the year. For each weekend of examinations, the Board can test approximately 540 candidates.

For the past several years, the Board has been administering a RDA practical examination during one weekend during the month of July. Prior to 2016, this examination was administered at Allan Hancock College in Santa Maria, California. In July 2016, the Board administered the examination at San Joaquin Valley College in Fresno, California.

The Board has the capacity to administer one more examination in 2017, for a total of nine (9) weekends of RDA practical examination administration during the year. Board staff has received interest from both the facilities located in Fresno and Santa Maria. Board staff has also received emails from dentists local to Santa Maria expressing the need to keep the testing at the Santa Maria site as testing in other locations creates a burden upon the students of that school to have to travel.

Both locations have the capacity to accommodate approximately 540 candidates for a weekend of testing. However, for the past few years the Board administered the examination at the Santa Maria site, only 150-250 candidates attended the examination offered at that location. In July 2016, the Board tested approximately 540 candidates at the Fresno location as the Board received a greater number of applicants interested in taking the examination at that location.

The fees for facility rental of the Santa Maria location are approximately $1,700 more than the fees for the facility rental of the Fresno location. Additionally, travel related

expenses for staff, examiners, and proctors are greater when testing at the Santa Maria location than when we tested at the Fresno location.

Action Requested:
With the understanding that the Board can accommodate only one more weekend of testing in July 2017 and due to the interest of both locations, Board staff is requesting the Board and the Dental Assisting Council determine which location at which the RDA practical examination should be administered in July 2017.

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MEMORANDUM

DATE	November 17, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**Agenda Item JNT 9:** Update the Review of the Registered Dental Assistant (RDA) Practical Examination

Background:
At the Dental Board of California's May 2016 Board meeting, the Board requested the Department of Consumer Affairs' (DCA) Office of Professional Examination Services (OPES) review the Registered Dental Assistant (RDA) practical examination and determine what modifications may need to be made.

The OPES has initiated its review and update of the RDA practical exam and anticipates is completion of the project by the end of Fiscal Year 2016-2017. This review and update will include reviewing the recently completed RDA Occupational Analysis and examination materials, observation of the examination, evaluation of the psychometric quality of the examination, coordination of a stakeholder meeting and workshops to review the practical examination.

Board staff anticipates the stakeholder meeting and workshops to be held during the beginning of 2017. Board staff will continue to report on the progress of the OPES review of the RDA practical examination.

Action Requested:
No action necessary.

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MEMORANDUM

DATE	November 17, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**Agenda Item JNT 10:** Update Regarding the Registered Dental Assistant (RDA) Candidate Guide

Background:

At the Dental Board of California's May 2016 Board meeting, the Board requested the Department of Consumer Affairs' (DCA) Office of Professional Examination Services (OPES) determine what additional information could be provided to Registered Dental Assistant (RDA) educational programs and candidates regarding the scoring of the RDA practical examination.

In making this determination, OPES reviewed the scoring materials used in training and scoring the RDA practical examination. In addition, OPES reviewed the information provided to candidates by the Board, as well as the candidate preparation materials.

The Candidate Guide for the RDA Practical Examination, New August 2016, covers information regarding the RDA application requirements, administration procedures for the practical examination, and the general procedures used for testing and scoring candidate performance. This latter section contains the rating scale and scoring criteria for the temporary crown and cementation portion of the examination, and it also has the rating scale and scoring criteria for the Class II temporary restoration portion of the examination.

The Dental Board of California Candidate Guide for the RDA Practical Examination, New August 2016, is was made available on the Board's web site on August 15, 2016 at: http://www.dbc.ca.gov/applicants/rda/rda_exam_guide.pdf.

Candidates for the September and November 2016 practical examinations received copies of this new Candidate Guide with their examination scheduling letters.

Board staff has received feedback and recommended modifications to the candidate guide from educators and stakeholders. Staff has been gathering this information and meeting with the OPES to discussed which modifications, if any, can be made to the

candidate guide. Should a revised candidate guide be released, it will be made publically available on the Board's web site and distributed to educators and candidates.

Action Requested:
No action necessary.

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MEMORANDUM

DATE	November 15, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Leslie Campaz, Educational Program Analyst
SUBJECT	**Agenda Item JNT 11:** Update on Dental Assisting Council Regulatory Workshops.

2016 Regulatory Development Workshops

In an effort to initiate the development of the dental assisting comprehensive rulemaking package, a total of 6 Regulatory Workshops have been successfully held throughout 2016, with only one remaining in December. The topics of discussion at the December regulatory workshop will be General Provisions (CCR § 1070.), Dental Sedation Assistant Permit Courses (CCR § 1070.8), General Provisions Definitions (CCR § 1067), and Educational Program and Course Definitions and Instructor Ratios (CCR § 1070.1).The development of the language for all topics has begun in collaboration with the department's Legal Counsel.

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MEMORANDUM

DATE	November 17, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**Agenda Item JNT 12:** Discussion and Possible Action Regarding Review of Draft Regulatory Language Relating to the Implementation of the Additional Duties of Registered Dental Assistant in Extended Functions (RDAEF) as Specified in Business and Professions Code Section 1753.55 (Determination of Radiographs and Placement of Interim Therapeutic Restorations)

Background:
Assembly Bill 1174 (Bocanegra, Chapter 662, Statutes of 2014) added specified duties to registered dental assistants in extended functions. This bill required the Dental Board of California (Board) to adopt regulations to establish requirements for courses of instruction for procedures authorized to be performed by a registered dental assistant in extended functions using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Health Planning and Development. Additionally, the bill required the Board to propose regulatory language for the Interim Therapeutic Restoration (ITR) for registered dental hygienists (RDH) and registered dental hygienists in alternative practice (RDHAP).

Board staff has developed the attached draft regulatory language and application form as a starting point to implement the provisions of AB 1174. The Dental Hygiene Committee of California (DHCC) is also required to develop regulatory language relative to the duties for RDHs and RDHAPs. As such, Board staff will need to work with the DHCC to further develop this proposed language to bring back to the Board at a future meeting to initiate as a rulemaking package.

Action Requested:
Board staff requests the Board and Council members review the preliminary draft regulatory language and provide comments and feedback to further develop this regulatory proposal; and, direct staff to work with the DHCC to further develop this proposed language to bring back to the Board at a future meeting to initiate as a rulemaking package.

CCR §1071.1: ***Radiographic Decision-Making and Interim Therapeutic Restoration Permit Course for the RDAEF - Approval; Curriculum Requirements; Issuance of Permit***

In addition to the requirements of Sections 1070 and 1070.1, the following criteria shall be met by a course in Radiographic Decision-Making and Interim Therapeutic Restorations to secure and maintain approval by the Board.

a) In accordance with B&P Section 1753.55, a Registered Dental Assistant in Extended Functions, licensed on or after January 1, 2010, is authorized to 1) determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist, following the protocols established by the dentist and, 2) place protective restorations, herein referred to as Interim Therapeutic Restorations (ITR), consisting of removal of soft material from the tooth using only hand instrumentation and subsequent placement of an adhesive restorative material. The functions described herein may only be performed by a Registered Dental Assistant in Extended Functions upon completion of a program that includes didactic, lab and clinical education in the performance of these functions, or after having provided evidence, satisfactory to the board, of having completed a board-approved course in radiographic decision-making and ITR. At the time of course registration, participants shall provide evidence of the following requirements:
    1) Possess a current, active license as a Registered Dental Assistant in Extended Functions issued on or after January 1, 2010; and
    2) Possess current certification in Basic Life Support (CPR) from the American Heart Association or the American Red Cross.

b) With respect to radiographic decision-making, the course shall be sufficient in length for the students to develop competency in making decisions about which radiographs to expose to facilitate diagnosis and treatment planning by a dentist but shall be, at a minimum, four (4) hours in length and include didactic, laboratory and simulated clinical experiences. As it relates to ITR, the course shall be sufficient in length for the students to develop competency in placement of protective restorations but shall be, at a minimum, 16 hours in length, including four (4) hours of didactic training, four (4) hours of laboratory training, and eight (8) hours of clinical training. Such course content may be incorporated into a current RDAEF program. New or existing programs seeking to incorporate or offer a stand-alone permit course in radiographic decision-making and ITR shall submit an application and all related fees to the Board prior to instruction.

c) In addition to the instructional components described in this subdivision, a program or course shall be established at the postsecondary educational level. The program or course director shall:
    1) ensure all faculty involved in clinical evaluation of students maintain currency in evaluation protocols for radiographic decision-making and ITR placement, and,
    2) shall ensure that all faculty responsible for clinical evaluation have completed a one-hour methodology course in clinical evaluation for radiographic decision-making and ITR placement prior to instruction.

d) With respect to radiographic decision-making, didactic instruction shall include:
    1) CAMBRA "Caries Management by Risk Assessment" concept;
    2) Guidelines for Radiographic decision-making to include but not limited to the following concepts of;
        i. The American Dental Association's Dental Radiographic Examinations: Recommendations for patient selection and limiting radiation (revised 2012); and
        ii. The American Academy of Pediatric Dentistry's Guidelines on Prescribing Dental Radiographs.
    3) The guidelines developed by Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry (Pacific) for use in training for HWPP #172 including:
        i. instruction on specific decision making guidelines that incorporate information about the patient's health, radiographic history, time span since previous radiographs were taken, and availability of previous radiographs; and
        ii. instruction pertaining to the general condition of the mouth including extent of dental restorations present, visible signs of abnormalities, including broken teeth, dark areas, holes in teeth, demineralization, visible carious lesions, and remineralization.

e) With respect to radiographic decision-making, laboratory instruction shall include case-based examination with various clinical situations where trainees make decisions about which radiographs to expose and demonstrate competency to faculty based on these case studies.

f) With respect to radiographic decision-making, simulated-clinical instruction shall consist of a review of various clinical cases with instructor-led discussion about radiographic decision-making in these clinical situations.

g) With respect to ITR placement, didactic instruction shall include:
    1) Review of pulpal anatomy;
    2) Protocols for adverse outcomes after ITR placement including, but not limited to; exposed pulp, tooth fracture, gingival tissue injury, high occlusion, open margins, tooth sensitivity, rough surface;
    3) Theory of protocols to deal with adverse outcomes used in the placement of adhesive protective restorations including mechanisms of bonding to tooth structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques;
    4) Criteria used in clinical dentistry pertaining to the use and placement of adhesive protective restorations;
    5) Criteria for evaluating successful completion of adhesive protective restorations;
    6) Protocols for handling sensitivity, complications, or unsuccessful completion of adhesive protective restorations including situations requiring immediate referral to a dentist; and
    7) Protocols for follow-up of adhesive protective restorations.

h) With respect to ITR placement, laboratory instruction shall include placement of adhesive protective restorations where trainees demonstrate competency in this technique on typodont teeth.

i) With respect to for ITR placement, clinical instruction shall include experiences where students demonstrate, at a minimum, the placement of four (4) interim therapeutic restorations that shall be evaluated by the program faculty to criteria-referenced standards.

Satisfactory completion of a course in radiographic decision-making and interim therapeutic restoration placement is determined using criteria-referenced completion standards, where the instructor determines when the trainee has achieved competency based on these standards, but trainees take varying amounts of time to achieve competency. Any student who does not achieve competency in this duty in the specified period of instruction could receive additional training and evaluation. In cases where, in the judgment of the faculty, students are not making adequate progress, they would be discontinued from the program.

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APPLICATION FOR COURSE APPROVAL
RADIOGRAPHIC DECISION-MAKING AND PLACEMENT OF INTERIM THERAPEUTIC RESTORATIONS FOR THE RDAEF

Date of Application: _____

Name of Applicant: _____

Business Name: _____

Address: _____

City, State, Zip: _____ Telephone: _____

Type of Program: ☐ Community College ☐ Vocational Program ☐ Dental School ☐ Private

☐ Other – Specify: _____

Name of Program Director: _____

Telephone: _____ Email Address: _____

Name of Owner *(if other than Program Director):* _____

Telephone: _____ Email Address: _____

I certify under penalty of perjury under the laws of the State of California that the data contained in this application and all associated attachments are true and correct.

_____ _____
Signature of Program Director *Date*

I certify that I will be responsible for the compliance of the program director who shall act in accordance with the laws governing Registered Dental Assistant in Extended Functions programs. I certify under penalty of perjury under the laws of the State of California that this application and all associated attachments are true and correct.

_____ _____
Signature of Owner *Date*

Educational Setting/Student Prerequisite

CCR 1070 (a)(5) and B&P Code 1753.55: All programs and courses shall be established at the post-secondary educational level or deemed equivalent thereto by the Board. In order to be admitted into the program, each student shall possess a valid, active, and current license as a Registered Dental Assistant in Extended Functions, issued by the Board on or after January 1, 2010.

1. Is the program established at the post-secondary educational level?

☐ Yes ☐ No

2. In order to be admitted into the program, will each student be required to possess a valid, active and current license as a RDAEF issued on or after January 1, 2010?

☐ Yes ☐ No

3. As a provider, identify how the permit course will be offered through your institution:

☐ A stand-alone permit course ☐ Integrated into an Existing RDAEF program ☐ Both

(b) Program Director

CCR 1070 (b)(1-3): The program or course director shall possess a valid, active, and current license issued by the Board or the dental hygiene committee. The program or course director shall actively participate in and be responsible for the administration of the program or course. Specifically, the program or course director shall be responsible for the following requirements:
(1) Maintaining for a period of not less than five years copies of curricula, program outlines, objectives, and grading criteria, and copies of faculty credentials, licenses, and certifications, and individual student records, including those necessary to establish satisfactory completion of the program or course.
(2) Informing the Board of any major change to the program or course content, physical facilities, or faculty, within 10 days of the change.
(3) Ensuring that all staff and faculty involved in clinical instruction meet the requirements set forth in this Article.

4. Does the program director possess a valid, active, and current dentist or RDAEF license issued by the Board?

☐ Yes ☐ No

Attach as ***Question 4 Attachment*** the name and license number of the proposed program director.

5. Will the program director actively participate in and be responsible for the administration of the program?

☐ Yes ☐ No

(c) Faculty

CCR 1070 (c - d): (c) Course faculty and instructional staff shall be authorized to provide instruction by the program or course director and the educational facility in which instruction is provided. (d) No faculty or instructional staff member

shall instruct in any procedure that he or she does not hold a license or permit in California to perform. Each faculty or instructional staff member shall possess a valid, active, and current license issued by the Board or the Dental Hygiene Committee of California, shall have been licensed or permitted for a minimum of two years and possess experience in the subject matter he or she is teaching.

B&P Code 1753.55 (4)(B) and 1910.5 (c)(4)(B): All faculty responsible for clinical evaluation shall have completed a one-hour methodology course in clinical evaluation or have a faculty appointment at an accredited dental education program prior to conducting evaluations of students.

6. Has each faculty member been licensed by the Board as a dentist or RDAEF or by the Dental Hygiene Committee of California as a RDH for at least two years, and possess experience in the subject matter he or she is teaching?

☐ Yes ☐ No

Attach as ***Question 6 Attachment*** a table containing the name(s) and license number(s) of each faculty member.

7. Has each faculty member responsible for clinical evaluation completed a one-hour methodology course in clinical evaluation?

☐ Yes ☐ No

Attach as ***Question 7 Attachment*** a copy of the certificate of completion of a one-hour methodology course in clinical evaluation for each faculty member.

8. Is each faculty and staff member certified in basic life support?

☐ Yes ☐ No

Attach as ***Question 8 Attachment*** a copy of each faculty and staff member's current CPR card.

(e) Student Certificate of Completion

CCR 1070 (e): A certificate, diploma, or other evidence of completion shall be issued to each student who successfully completes the program or course and shall include the following: the student's name, the name of the program or course, the date of completion, and the signature of the program or course director or his or her designee.

9. Will a certificate or other evidence of completion be issued to each student who successfully completes the program as specified above?

☐ Yes ☐ No

Attach as ***Question 9 Attachment*** a copy of the certificate of completion.

(f) Emergency Management

CCR 1070 (h): A written policy on managing emergency situations shall be made available to all students, faculty, and instructional staff.

10. Does the program have a written policy on managing emergency situations, and will it be made available to all students, faculty, and staff?

☐ Yes ☐ No

Attach as ***Question 10a Attachment*** a copy of the written policy.

Attach as ***Question 10b Attachment*** a document describing the location of the eye wash station(s), oxygen tank, and the contents of the first aid kit.

(g) Infection Control and Hazardous Waste Disposal Protocols

CCR 1070 (g): The program or course shall establish written clinical and laboratory protocols that comply with the Board's Minimum Standards for Infection Control (Cal. Code of Regs., Title 16, Section 1005) and other federal, state, and local requirements governing infection control. The program or course shall provide these protocols to all students, faculty, and instructional staff to ensure compliance. Adequate space shall be provided for handling, processing and sterilizing all armamentarium.

11. Will OSHA-required attire and protective eyewear be required for each student to wear?

☐ Yes ☐ No

12. Does the course have written clinical and laboratory protocols to ensure adequate asepsis, infection and hazard control, and disposal of hazardous wastes, that comply with the Board's regulations and other Federal, State, and local requirements, and will such protocols be provided to all students, faculty and appropriate staff?

☐ Yes ☐ No

Attach as ***Question 12 Attachment*** a copy of such protocols.

13. Is adequate space provided for preparing and sterilizing all armamentarium?

☐ Yes ☐ No

Attach as ***Question 13 Attachment*** a description of how reusable instruments are properly sterilized before use on patients.

(h) Length of Program

In addition to the requirements of CCR 1070 and 1070.1, the following criteria shall be met by a course provider in the subject area to secure and maintain approval by the Board:

As it relates to radiographic decision-making, the course shall be sufficient in length for the students to develop competency in making decisions about which radiographs to take to facilitate diagnosis and treatment planning by a dentist but shall be, ***at a minimum, four hours in length and include didactic, laboratory and simulated-clinical experiences.*** *As it relates to Interim Therapeutic Restorations (ITR), the course shall be sufficient in length for the students to develop competency in ITR placement and shall be,* ***at a minimum 16 hours in length, including four hours of didactic training, four hours of laboratory training, and eight hours of clinical training.***

14. Will the course, as it relates to radiographic decision-making, be sufficient in length for the students to develop competency in making decisions about which radiographs to take to facilitate diagnosis and

treatment planning by a dentist but be, at a minimum, four hours in length and include didactic, laboratory and simulated-clinical experiences?

☐ Yes ☐ No

15. Will the course, as it relates to Interim Therapeutic Restorations (ITR), be sufficient in length for the students to develop competency in ITR placement and be, at a minimum, 16 hours in length, including four hours of didactic training, four hours of laboratory training, and eight hours of clinical training?

☐ Yes ☐ No

(i) Faculty/Student Ratios

Facilities and class scheduling shall provide each student with sufficient opportunity, with instructor supervision, to develop minimum competency in all duties for which the program or course is approved to instruct (CCR 1070 (f)).

All laboratory and simulated-clinical instruction shall be provided under the direct supervision of program staff. Clinical instruction shall be provided under the direct supervision of a licensed dentist and may be completed in an extramural dental facility as defined in Section 1070.1(c) - (Excerpt CCR 1071(e).

(CCR 1070.1(a)) "Clinical instruction" means instruction in which students receive supervised experience in performing procedures in a clinical setting on patients. Clinical procedures shall only be allowed upon successful demonstration and evaluation of laboratory and preclinical skills. There shall be at least one instructor for every six students who are simultaneously engaged in clinical instruction.

(CCR 1070.1(b)) "Didactic instruction" means lectures, demonstrations, and other instruction involving theory that may or may not involve active participation by students. The faculty or instructional staff of an educational institution or approved provider may provide didactic instruction via electronic media, home study materials, or live lecture modality.

(CCR 1070.1(c)) "Extramural dental facility" means any clinical facility utilized by a Board-approved dental assisting educational program for instruction in dental assisting that exists outside or beyond the walls, boundaries or precincts of the primary location of the Board-approved program and in which dental treatment is rendered.

(CCR 1070.1(d)) "Laboratory instruction" means instruction in which students receive supervised experience performing procedures using study models, mannequins, or other simulation methods. There shall be at least one instructor for every 14 students who are simultaneously engaged in instruction.

(CCR 1070.1(e)) "Preclinical instruction" means instruction in which students receive supervised experience within the educational facilities performing procedures on simulation devices or patients, which are limited to students, faculty, or instructional staff members. There shall be at least one instructor for every six students who are simultaneously engaged in instruction.

(CCR 1070.1(f)) "Simulated-clinical instruction" means instruction in which students receive supervised experience performing procedures using simulated patient heads mounted in appropriate position and accommodating an articulated typodont in an enclosed intraoral environment, or mounted on a dental chair in a dental operatory. Clinical simulation spaces shall be sufficient to permit one simulation space for each two students at any one time.

16. Will all instruction be provided under the direct supervision of program faculty?

☐ Yes ☐ No

17. Will there be at least the following number of instructors per student who are simultaneously engaged in the following instruction: 1:14 students in laboratory instruction, 1:6 students in preclinical instruction, 1:6 students engaged in clinical instruction and 1:2 engaged in simulated-clinical instruction?

☐ Yes ☐ No

Attach as ***Question 17 Attachment*** the following information in a table or chart in the following format for those sessions applicable to the program (do not complete these charts):

Maximum students enrolled per session:		Number of operatories:	
Faculty/Student Ratios	Didactic:	Laboratory:	Clinical:

Class Session *	Hours **	Total # of Students	Total # of Faculty Providing Instruction (include program director)	Names of Faculty providing instruction (include program director)

*Class Session – describe the day or days the class(es) meet(s) – (ex: Monday and Wednesday evenings).

**Hours – provide the hours per day for each session

(j) Facilities and Resources

CCR 1070 (f)(1): The location and number of general use equipment and armamentaria shall ensure that each student has the access necessary to develop minimum competency in all of the duties for which the program or course is approved to instruct. The program or course provider may either provide the specified equipment and supplies or require that the student provide them.

The following requirements are in addition to the requirements of Sections 1070 and 1070.1:
(A) Laboratory facilities with individual seating stations for each student and equipped with air, gas and air, or electric driven rotary instrumentation capability. Each station or operatory shall allow an articulated typodont to be mounted in a simulated head position.
(B) Clinical simulation facilities that provide simulated patient heads mounted in appropriate position and accommodating an articulated typodont in an enclosed intraoral environment, or mounted on a dental chair in a dental operatory.
(C) Articulated typodonts of both deciduous and permanent dentitions with flexible gingival tissues and with prepared teeth for each procedure to be performed in the laboratory and clinical simulation settings. One of each type of typodont is required for each student.
(D) A selection of restorative instruments and adjunct materials for all procedures that RDAEFs are authorized to perform.

18. Do the facilities and class scheduling provide each student with sufficient opportunity, with instructor supervision, to develop minimal competency in all duties that RDAEFs are authorized to perform pertaining to this permit?

☐ Yes ☐ No

Attach as ***Question 18 Attachment*** a description of the entire facility, identifying the location of the following major areas of instruction: lecture areas, laboratory, dental operatories, and sterilization area.

19. Do the location and number of general use equipment and armamentaria ensure that each student has the access necessary to develop minimal competency in all of the duties for which the program is approved to instruct?

☐ Yes ☐ No

Attach as ***Question 19 Attachment*** a list of the types, location and number of the required equipment and armamentarium.

20. Will protective eyewear, masks, and gloves be required or provided for each student and faculty member, and will appropriate eye protection be provided for each piece of equipment?

☐ Yes ☐ No

(k) Operatories

Excerpt CCR 1070.1(f): Operatories shall be sufficient in number to allow a ratio of at least one operatory for every two students who are simultaneously engaged in simulated clinical instruction ()).
Clinical simulation spaces shall be sufficient to permit one simulation space for each two students at any one time.
Each operatory shall contain functional equipment, including a power-operated chair for patient or simulation-based instruction in a supine position, operator and assistant stools, air-water syringe, adjustable light, oral evacuation equipment, work surface, handpiece connection, and adjacent hand-washing sink. Each operatory shall be of sufficient size to simultaneously accommodate one student, one instructor, and one patient or student partner (CCR 1070 (f)(2)(A-B)).

21. Are operatories sufficient in number to allow for a ratio of at least one operatory for every two students who are simultaneously engaged in simulated-clinical instruction? Are they of sufficient size to simultaneously accommodate one student, one instructor, and one patient? Do they contain functional equipment, including a power-operated chair for patient or simulation-based instruction in a supine position, operator and assistant stools, air-water syringe, adjustable light, oral evacuation equipment, work surface, handpiece connection, and adjacent hand-washing sink?

☐ Yes ☐ No

Attach as ***Question 21 Attachment*** a description of the operatories, their number, and a list of the equipment and supplies that are housed in the operatory area.

(l) Program Content

CCR 1070(i)(1-3): A detailed program or course outline shall clearly state, in writing, the curriculum subject matter, hours of didactic, laboratory, and clinical instruction, general program or course objectives, instructional objectives, theoretical content of each subject, and, where applicable, the use of practical application. Objective evaluation criteria shall be used for measuring student progress toward attainment of specific program or course objectives. Students shall be provided with all of the following:

(1) Specific performance objectives and the evaluation criteria used for measuring levels of competence for each component of a given procedure including those used for examinations.

(2) Standards of performance that state the minimum number of satisfactory performances that are required for

each performance-evaluated procedure.

(3) Standards of performance for laboratory, preclinical, and clinical functions, those steps that would cause the student to fail the task being evaluated, a description of each of the grades that may be utilized during evaluation procedures, and a defined standard of performance.

(CCR 1070(f)(2)(c): Prior to clinical assignments, students must demonstrate minimum competence in laboratory or preclinical performance of the procedures they will be expected to perform in their clinical experiences.

In accordance with proposed regulations and the statutory provisions of B&P Code 1753.55 and 1910.5:

(a) General areas of instruction shall include, at a minimum, the topics specified herein:

(1) Restorative treatment review; charting; patient education; legal requirements; indications and contraindications; consent; problem solving techniques; laboratory, simulated-clinical, and clinical criteria and evaluation; and infection control protocol implementation.

(2) Dental science, including dental and oral anatomy, caries process, tooth morphology, basic microbiology relating to infection control, and occlusion.

(3) Characteristics and manipulation of dental materials related to Placement of Interim Therapeutic Restorations.

(4) Armamentaria for Placement of Interim Therapeutic Restorations.

(5) Principles, techniques, criteria, and evaluation for performing each procedure, including implementation of infection control protocols.

(6) Occlusion: the review of articulation of maxillary and mandibular arches in maximum intercuspation.

(7) Tooth isolation review.

(b) General laboratory instruction shall include reviewing cases with various situations with instructor-led discussion about radiographic decision-making in these situations.

(c) With respect to Radiographic Decision Making, didactic instruction shall include the following:

(1) CAMBRA "Caries Management by Risk Assessment" concept

(2) Guidelines for Radiographic decision-making to include but not limited to the following concepts of;

i. The American Dental Association's Dental Radiographic Examinations: Recommendations for patient selection and limiting radiation (revised 2012); and

ii. The American Academy of Pediatric Dentistry's Guidelines on Prescribing Dental Radiographs.

(3) The guidelines developed by Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry (Pacific) for use in training for HWPP #172 including:

i. instruction on specific decision making guidelines that incorporate information about the patient's health, radiographic history, time span since previous radiographs were taken, and availability of previous radiographs; and

ii. instruction pertaining to the general condition of the mouth including extent of dental restorations present, visible signs of abnormalities, including broken teeth, dark areas, holes in teeth, demineralization, visible carious lesions, and remineralization.

(d) Laboratory instruction shall include a review of cases with various clinical situations with instructor-led discussion about radiographic decision-making in these situations.

(e) Simulated-Clinical instruction shall include case-based examination with various clinical situations where trainees

make decisions about which radiographs to take and demonstrate competency to faculty based on these case studies.

(f) With respect to Placement of Interim Therapeutic Restorations, didactic instruction shall include, but not limited to:

(1) Pulpal anatomy.

(2) Theory of adhesive protective restorations including mechanisms of bonding to tooth structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques.

(3) Criteria that dentists use to make decisions about placement of adhesive protective restorations

(4) Criteria for evaluating successful completion of adhesive protective restorations.

(5) Protocols for handling sensitivity, complications, or unsuccessful completion of adhesive protective restorations including situations requiring immediate referral to a dentist.

(6) Protocols for follow-up of adhesive protective restorations.

(g) Laboratory instruction shall include the following:

(1) Placement of a minimum of four (4) adhesive protective restorations where students demonstrate competency in this technique on typodont teeth that shall be evaluated by the program faculty to criteria-referenced standards.

(h) Clinical instruction shall include the following:

(1) The placement of five (5) ITRS on patients that shall be evaluated by the program faculty to criteria-referenced standards.

(i) Each student shall pass a written examination that reflects the curriculum content, which may be administered at intervals throughout the course as determined by the course director.

22. Will clinical instruction only be performed by students upon the successful demonstration and evaluation of their preclinical skills?

☐ Yes ☐ No

23. Will instruction include all content described in Business and Professions Code 1753.55 (above) governing the approval of a permit course in Radiographic Decision-Making and Placement of Interim Therapeutic Restorations?

☐ Yes ☐ No

Attach as ***Question 23 Attachment*** the following course documentation:

- Detailed program outline including subsections that clearly state curricula subject areas and specifies instructional hours for each topic in the individual areas of didactic, lab, and clinical instruction (externship).
- General program objectives
- Specific didactic and performance-based learning objectives
- Criteria for all performance evaluations
- Minimum number of satisfactory performances for all (evaluated) skills
- Practical and clinical evaluation sheets

Regulations and Statutes Pertaining to Radiographic Decision-Making and the Placement of Interim Therapeutic Restorations for the RDAEF and the Approval of a Permit Course

CCR Section 1070 - General Provisions Governing All Dental Assistant Educational Programs and Courses

(a) (1) The criteria in subdivisions (b) to (j), inclusive, shall be met by a dental assisting program or course and all orthodontic assisting and dental sedation assisting permit programs or courses to secure and maintain approval by the Board as provided in this Article.

(2) The Board may approve, provisionally approve, or deny approval of any program or course for which an application to the Board for approval is required. All Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEF) programs and dental assisting educational courses shall be re-evaluated approximately every seven years, but may be subject to re-evaluation and inspection by the Board at any time to review and investigate compliance with this Article and the Dental Practice Act (Act). Re-evaluation may include a site visit or written documentation that ensures compliance with all regulations. Results of re-evaluation shall be reported to the Board or its designee for final consideration and continuance of program or course approval, provisional approval or denial of approval.

(3) Program and course records shall be subject to inspection by the Board at any time.

(4) The Board may withdraw approval at any time that it determines that a program or course does not meet the requirements of this Article or any other requirement in the Act.

(5) All programs and courses shall be established at the postsecondary educational level or deemed equivalent thereto by the Board.

(6) The Board or its designee may approve, provisionally approve, or deny approval to any such program. Provisional approval shall not be granted for a period which exceeds the length of the program. When the Board provisionally approves a program, it shall state the reasons therefore. Provisional approval shall be limited to those programs which substantially comply with all existing standards for full approval. A program given provisional approval shall immediately notify each student of such status. If the Board denies approval of a program, the specific reasons therefore shall be provided to the program by the Board in writing within 90 days after such action.

(b) The program or course director shall possess a valid, active, and current license issued by the Board or the dental hygiene committee. The program or course director shall actively participate in and be responsible for the administration of the program or course. Specifically, the program or course director shall be responsible for the following requirements:

(1) Maintaining for a period of not less than five years copies of curricula, program outlines, objectives, and grading criteria, and copies of faculty credentials, licenses, and certifications, and individual student records, including those necessary to establish satisfactory completion of the program or course.

(2) Informing the Board of any major change to the program or course content, physical facilities, or faculty, within 10 days of the change.

(3) Ensuring that all staff and faculty involved in clinical instruction meet the requirements set forth in this Article.

(c) Course faculty and instructional staff shall be authorized to provide instruction by the program or course director at the educational facility in which instruction is provided.

(d) No faculty or instructional staff member shall instruct in any procedure that he or she does not hold a license or

permit in California to perform. Each faculty or instructional staff member shall possess a valid, active, and current license issued by the Board or the Dental Hygiene Committee of California, shall have been licensed or permitted for a minimum of two years, and possess experience in the subject matter he or she is teaching. An instructor who has held a license as a registered dental assistant or registered dental assistant in extended functions for at least two years, who then becomes a permit holder as an Orthodontic Assistant on or after January 1, 2010, shall not be required to have held such a permit for two years in order to instruct in the subject area.

(e) A certificate, diploma, or other evidence of completion shall be issued to each student who successfully completes the program or course and shall include the following: the student's name, the name of the program or course, the date of completion, and the signature of the program or course director or his or her designee.

(f) Facilities and class scheduling shall provide each student with sufficient opportunity, with instructor supervision, to develop minimum competency in all duties for which the program or course is approved to instruct.

(1) The location and number of general use equipment and armamentaria shall ensure that each student has the access necessary to develop minimum competency in all of the duties for which the program or course is approved to instruct. The program or course provider may either provide the specified equipment and supplies or require that the student provide them. Nothing in this Section shall preclude a dental office that contains the equipment required by this Section from serving as a location for laboratory instruction.

(2) Clinical instruction shall be of sufficient duration to allow the procedures to be performed to clinical proficiency. Operatories shall be sufficient in number to allow a ratio of at least one operatory for every five students who are simultaneously engaged in clinical instruction.

(A) Each operatory shall contain functional equipment, including a power-operated chair for patient or simulation-based instruction in a supine position, operator and assistant stools, air-water syringe, adjustable light, oral evacuation equipment, work surface, handpiece connection, and adjacent hand-washing sink.

(B) Each operatory shall be of sufficient size to simultaneously accommodate one student, one instructor, and one patient or student partner.

(C) Prior to clinical assignments, students must demonstrate minimum competence in laboratory or preclinical performance of the procedures they will be expected to perform in their clinical experiences.

(g) The program or course shall establish written clinical and laboratory protocols that comply with the Board's Minimum Standards for Infection Control (Cal. Code Regs., Title 16, Section 1005) and other federal, state, and local requirements governing infection control. The program or course shall provide these protocols to all students, faculty, and instructional staff to ensure compliance. Adequate space shall be provided for handling, processing, and sterilizing all armamentarium.

(h) A written policy on managing emergency situations shall be made available to all students, faculty, and instructional staff. All faculty and staff involved in the direct oversight of patient care activities shall be certified in basic life support procedures, including cardiopulmonary resuscitation. Recertification intervals may not exceed two years. The program or course director shall ensure and document compliance by faculty and instructional staff. A program or course shall sequence curriculum in such a manner so as to ensure that students complete instruction in basic life support prior to performing procedures on patients used for clinical instruction and evaluation.

(i) A detailed program or course outline shall clearly state, in writing, the curriculum subject matter, hours of didactic, laboratory, and clinical instruction, general program or course objectives, instructional objectives, theoretical content of each subject, and, where applicable, the use of practical application. Objective evaluation criteria shall be used for measuring student progress toward attainment of specific program or course objectives. Students shall be provided with all of the following:

(1) Specific performance objectives and the evaluation criteria used for measuring levels of competence for each component of a given procedure including those used for examinations.

(2) Standards of performance that state the minimum number of satisfactory performances that are required for each performance-evaluated procedure.

(3) Standards of performance for laboratory, preclinical, and clinical functions, those steps that would cause the student to fail the task being evaluated, and a description of each of the grades that may be assigned during evaluation procedures.

(j) (1) If an extramural dental facility is utilized, students shall, as part of an extramural organized program of instruction, be provided with planned, supervised clinical instruction. Laboratory and preclinical instruction shall be performed under the direct supervision of program or course faculty or instructional staff and shall not be provided in an extramural dental facility.

(2) The program or course director, or a designated faculty member, shall be responsible for selecting extramural dental facility and evaluating student competence before and after the clinical assignment.

(3) Prior to student assignment in an extramural dental facility, the program or course director, or a designated faculty or instructional staff member, shall orient dentists and all licensed dental healthcare workers who may provide instruction, evaluation, and oversight of the student in the clinical setting. Orientation shall include, at a minimum, the objectives of the program or course, the student's preparation for the clinical assignment, and a review of procedures and criteria to be used by the dentist or the licensed personnel in the extramural dental facility in evaluating the student during the assignment, which shall be the same as the evaluation criteria used within the program or course.

(4) There shall be a written contract of affiliation between the program and each extramural dental facility that includes written affirmation of compliance with the regulations of this Article.

CCR Section 1070.1 – Educational Program and Course Definitions and Instructor Ratios

As used in this article, the following definitions shall apply:

(a) "Clinical instruction" means instruction in which students receive supervised experience in performing procedures in a clinical setting on patients. Clinical procedures shall only be allowed upon successful demonstration and evaluation of laboratory and preclinical skills. There shall be at least one instructor for every six students who are simultaneously engaged in clinical instruction.

(b) "Didactic instruction" means lectures, demonstrations, and other instruction involving theory that may or may not involve active participation by students. The faculty or instructional staff of an educational institution or approved provider may provide didactic instruction via electronic media, home study materials, or live lecture modality.

(c) “Extramural dental facility” means any clinical facility utilized by a Board-approved dental assisting educational program for instruction in dental assisting that exists outside or beyond the walls, boundaries or precincts of the primary location of the Board-approved program and in which dental treatment is rendered.

(d) "Laboratory instruction" means instruction in which students receive supervised experience performing procedures using study models, mannequins, or other simulation methods. There shall be at least one instructor for every 14 students who are simultaneously engaged in instruction.

(e) "Preclinical instruction" means instruction in which students receive supervised experience within the educational facilities performing procedures on simulation devices or patients which are limited to students, faculty, or instructional staff members. There shall be at least one instructor for every six students who are

simultaneously engaged in instruction.

(f) "Simulated clinical instruction" means instruction in which students receive supervised experience performing procedures using simulated patient heads mounted in appropriate position and accommodating an articulated typodont in an enclosed intraoral environment, or mounted on a dental chair in a dental operatory. Clinical simulation spaces shall be sufficient to permit one simulation space for each two students at any one time.

CCR Section 1071.1 - Radiographic Decision-Making and Interim Therapeutic Restoration Permit Course for the RDAEF - Approval; Curriculum Requirements; Issuance of Permit

In addition to the requirements of Sections 1070 and 1070.1, the following criteria shall be met by a course in Radiographic Decision-Making and Interim Therapeutic Restorations to secure and maintain approval by the Board.

(a) In accordance with B&P Section 1753.55, a Registered Dental Assistant in Extended Functions, licensed on or after January 1, 2010, is authorized to 1) determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist, following the protocols established by the dentist and, 2) place protective restorations, herein referred to as Interim Therapeutic Restorations (ITR), consisting of removal of soft material from the tooth using only hand instrumentation and subsequent placement of an adhesive restorative material. The functions described herein may only be performed by a Registered Dental Assistant in Extended Functions upon completion of a program that includes didactic, lab and clinical education in the performance of these functions, or after having provided evidence, satisfactory to the board, of having completed a board-approved course in radiographic decision-making and ITR. At the time of course registration, participants shall provide evidence of the following requirements:

1) Possess a current, active license as a Registered Dental Assistant in Extended Functions issued on or after January 1, 2010; and
2) Possess current certification in Basic Life Support (CPR) from the American Heart Association or the American Red Cross.

(b) With respect to radiographic decision-making, the course shall be sufficient in length for the students to develop competency in making decisions about which radiographs to expose to facilitate diagnosis and treatment planning by a dentist but shall be, at a minimum, four (4) hours in length and include didactic, laboratory and simulated clinical experiences. As it relates to ITR, the course shall be sufficient in length for the students to develop competency in placement of protective restorations but shall be, at a minimum, 16 hours in length, including four (4) hours of didactic training, four (4) hours of laboratory training, and eight (8) hours of clinical training. Such course content may be incorporated into a current RDAEF program. New or existing programs seeking to incorporate or offer a stand-alone permit course in radiographic decision-making and ITR shall submit an application and all related fees to the Board prior to instruction.

(c) In addition to the instructional components described in this subdivision, a program or course shall be established at the postsecondary educational level. The program or course director shall:

1) ensure all faculty involved in clinical evaluation of students maintain currency in evaluation protocols for radiographic decision-making and ITR placement, and,
2) shall ensure that all faculty responsible for clinical evaluation have completed a one-hour methodology course in clinical evaluation for radiographic decision-making and ITR placement prior to instruction.

(d) With respect to radiographic decision-making, didactic instruction shall include:

1) CAMBRA "Caries Management by Risk Assessment" concept;
2) Guidelines for Radiographic decision-making to include but not limited to the following concepts of;
    i. The American Dental Association's Dental Radiographic Examinations: Recommendations for patient selection and limiting radiation (revised 2012); and
    ii. The American Academy of Pediatric Dentistry's Guidelines on Prescribing Dental Radiographs.
3) The guidelines developed by Pacific Center for Special Care at the University of the Pacific Arthur A.

Dugoni School of Dentistry (Pacific) for use in training for HWPP #172 including:

i. instruction on specific decision making guidelines that incorporate information about the patient's health, radiographic history, time span since previous radiographs were taken, and availability of previous radiographs; and

ii. instruction pertaining to the general condition of the mouth including extent of dental restorations present, visible signs of abnormalities, including broken teeth, dark areas, holes in teeth, demineralization, visible carious lesions, and remineralization.

(e) With respect to radiographic decision-making, laboratory instruction shall include case-based examination with various clinical situations where trainees make decisions about which radiographs to expose and demonstrate competency to faculty based on these case studies.

(f) With respect to radiographic decision-making, simulated-clinical instruction shall consist of a review of various clinical cases with instructor-led discussion about radiographic decision-making in these clinical situations.

(g) With respect to ITR placement, didactic instruction shall include:

1) Review of pulpal anatomy;
2) Protocols for adverse outcomes after ITR placement including, but not limited to; exposed pulp, tooth fracture, gingival tissue injury, high occlusion, open margins, tooth sensitivity, rough surface;
3) Theory of protocols to deal with adverse outcomes used in the placement of adhesive protective restorations including mechanisms of bonding to tooth structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques;
4) Criteria used in clinical dentistry pertaining to the use and placement of adhesive protective restorations;
5) Criteria for evaluating successful completion of adhesive protective restorations;
6) Protocols for handling sensitivity, complications, or unsuccessful completion of adhesive protective restorations including situations requiring immediate referral to a dentist; and
7) Protocols for follow-up of adhesive protective restorations.

(h) With respect to ITR placement, laboratory instruction shall include placement of adhesive protective restorations where trainees demonstrate competency in this technique on typodont teeth.

(i) With respect to for ITR placement, clinical instruction shall include experiences where students demonstrate, at a minimum, the placement of four (4) interim therapeutic restorations that shall be evaluated by the program faculty to criteria-referenced standards.

Satisfactory completion of a course in radiographic decision-making and interim therapeutic restoration placement is determined using criteria-referenced completion standards, where the instructor determines when the trainee has achieved competency based on these standards, but trainees take varying amounts of time to achieve competency. Any student who does not achieve competency in this duty in the specified period of instruction could receive additional training and evaluation. In cases where, in the judgment of the faculty, students are not making adequate progress, they would be discontinued from the program.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	November 15, 2016
TO	Members of the Dental Board of California Members of the Dental Assisting Council
FROM	Sarah E. Wallace, Assistant Executive Officer
SUBJECT	**AGENDA ITEM JNT 13:** Discussion and Possible Action Regarding Items Requested by Joan Greenfield, RDAEF, OAP, MS

Background:
The Board received a request from Ms. Joan Greenfield, RDAEF, OAP, MS, that the following items be considered by the Board and the Dental Assisting Council at the December meeting:

- Placement of Gingival Retraction Cord
- Removal of the Placement of Gingival Retraction Cord from the RDAEF Clinical Examination as a Separate Graded Item
- Amending the Regulatory Language for the RDAEF Restorative Examination
- Add the Administration of Nitrous Oxide to the Scope of Practice for the RDAEF Licensed on or after January 1, 2010
- Add the Administration of Local Anesthesia to the Scope of Practice for the RDAEF Licensed on or after January 1, 2010

Ms. Greenfield will be presenting these items to the Board and Council for consideration and will provide additional information.

Action Requested:
Board staff requests the Board and the Council consider Ms. Greenfield's requested items and prioritize and agendize futher discussion regarding these items for future meetings.

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DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
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MEMORANDUM

DATE	December 1, 2016
TO	Dental Assisting Council, Dental Board of California
FROM	Karen Fischer, Executive Officer
SUBJECT	**JNT 14:** Dental Assisting Council Elections

The Dental Assisting Council members will elect a Chairperson and a Vice-Chairperson for 2017. The Board's Legal Counsel, Mr. Spencer Walker, will preside over the election.

Roles and Responsibilities

Chair

- In consultation with the Executive Officer and the Board President, develops the Dental Assisting Council agenda.
- Calls the Council meeting to order, takes roll and establishes a quorum.
- Facilitates Council meetings.
- Recommends to the Board President, Council subcommittees to work on issues as appropriate.
- Reports activities of the Council to the full Board.

Vice-Chair

- In the absence of the presiding Chair, fulfills the Chairs responsibilities.

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NOTICE OF PRESCRIPTION DRUG ABUSE COMMITTEE MEETING

Thursday, December 1, 2016

Upon Conclusion of the Joint Meeting of the Dental Board and Dental Assisting Council
Embassy Suites San Francisco Airport Waterfront
150 Anza Boulevard, Burlingame, CA 94010
(650) 342-4600 (Hotel) or (916) 263-2300 (Board Office)

MEMBERS OF THE PRESCRIPTION DRUG ABUSE COMMITTEE

Chair – Thomas Stewart, DDS
Vice Chair – Steve Afriat
Yvette Chappell-Ingram, Public Member
Huong Le, DDS, MA
Meredith McKenzie, Public Member
Bruce Whitcher, DDS
Debra Woo, DDS, MA

Public comments will be taken on agenda items at the time the specific item is raised. The Committee may take action on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the Committee Chair. For verification of the meeting, call (916) 263-2300 or access the Board's website at www.dbc.ca.gov. This Committee meeting is open to the public and is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Karen M. Fischer, MPA, Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five business days before the meeting will help to ensure availability of the requested accommodation.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

1. Call to Order/Roll Call/Establishment of Quorum

2. Approval of the December 3, 2015 Prescription Drug Abuse Committee Meeting Minutes

3. Discussion and Possible Action to Approve the Communication Plan Regarding Opioid Prescription Abuse and Misuse for Posting on the Board's Web Site

4. Public Comment of Items Not on the Agenda
   The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

5. Future Agenda Items
   Stakeholders are encouraged to propose items for possible consideration by the Committee at a future meeting.

6. Committee Member Comments for Items Not on the Agenda
   The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

7. Adjournment

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PRESCRIPTION DRUG ABUSE COMMITTEE MINUTES

December 3, 2015
Marriott LAX
5855 West Century Blvd.
Los Angeles, CA 90045
DRAFT

MEMBERS PRESENT

Chair – Thomas Stewart, DDS
Vice Chair – Fran Burton
Huong Le, DDS, MA
Steven Morrow, DDS
Bruce Whitcher, DDS
Debra Woo, DDS, MA

PDA 1 - Call to Order/Roll Call/Establishment of Quorum

Dr. Thomas Stewart, Chair, called the meeting to order at 3:57 p.m. Roll was called and a quorum established.

PDA 2 - Approval of the February 26, 2015 Prescription Drug Abuse Committee Meeting Minutes

M/S/C (Burton/Morrow) to approve the minutes.

Support: Stewart, Burton, Le, Morrow, Whitcher, Woo **Oppose:** 0 **Abstain:** 0

The motion passed.

PDA 3 - Subcommittee Update on Opioid Prescription Abuse and Misuse

Dr. Stewart gave an overview of the information provided. There was discussion regarding how best to disseminate information and whether or not education should be part of the continuing education requirements.

PDA 4 - Public Comment of Items Not on the Agenda

There was no public comment.

PDA 5 - Future Agenda Items

There were no future agenda Item requests.

PDA 6 - Committee Member Comments for Items Not on the Agenda

There were no committee member comments.

PDA 7 - Adjournment

The meeting was adjourned at 4:20 p.m.

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MEMORANDUM

DATE	December 1, 2016
TO	Prescription Drug Abuse Committee Members Dental Board of California
FROM	Carlos Alvarez, Acting Enforcement Chief
SUBJECT	**PDA #3:** Discussion and Possible Action to Approve the Communication Plan Regarding Opioid Prescription Abuse and Misuse for Posting on the Board's Web Site

At the December 3, 2015 meeting of the Board's Prescription Drug Abuse Committee (PDA Committee), a subcommittee was appointed to work with staff to develop draft prescription guidelines for dental practitioners.

Since that time and during 2016, the subcommittee has continued to meet periodically. On Saturday, September 9, 2016, in conjunction with CDA Presents in San Francisco, Thomas Stewart, DDS, Huong Le, DDS, California Dental Association (CDA) representatives - Mary McCune and Megan Allred, and I met to discuss the ideas moving forward for the education of dentists, patients, parents, and healthcare providers about the devastating impact that prescription drug abuse is having in our communities.

At this time, the subcommittee recommends having a communication plan which initially includes a webpage dedicated to prescription drug resources. The idea behind the webpage is to not only provide dentists with the information regarding the epidemic of the abuse and misuse of opioid products, but also to provide resources to the dispensing dental practitioners to educate them on the new paradigm of educating the patient on opioid prescription use and the meticulous monitoring of the individual. The dentist is the ultimate decision maker in determining the best course of pain management treatment for his/her patient. However, the Board should consider offering tools to educate dentists in the public health trends and how this may impact the way they prescribe.

The webpage should be continually updated when new material is available making it a valuable contemporary resource for the Boards licensees.

This website will also provide dentists with links to the Medical and Pharmacy Boards prescription guidelines and the Drug Enforcement Administration (DEA). These guidelines provide clear expectations to prescribers regarding their role in deciding to

prescribe opioids for pain control to their patients as well as follow-up after treatment has been provided.

It was also discussed that many dental practitioners may not recognize the red flags of substance abuse or know what to do. Experts in substance abuse as well as other support services (such as local Mental Health counselors/public health officials) can provide places to refer the patients who are in need of services. Having a link to these local resources may be of a great benefit to the practitioner.

Other resources that the subcommittee proposes are links to the American Dental Association and California Dental Association and articles specifically relating to prescription drugs as well as the American Association of Oral and Maxillofacial Surgeons article on Prescription Drug Abuse and Prevention,

Lastly, the California Prescription Drug Monitoring Program (PDMP) also known as CURES has a mission to reduce pharmaceutical drug diversion while promoting legitimate medical and patient care. The PDMP collects Schedule II through IV controlled substance prescription and dispensation information for facilitating diversion awareness and intervention.

The proposal is to have the webpage contain detailed educational information about the CURES system, including the mandatory registration for all California-licensed dentists authorized to prescribe, order, administer, furnish, or dispense controlled substances. The CURES system will allow access to the dentist to look up a patient's controlled substance usage and history before prescribing controlled substances.

Action Requested

That the Prescription Drug Abuse Committee approve the Subcommittee's recommendation to establish a communication plan relating to opioid abuse and misuse which initially includes a webpage dedicated to prescription drug resources; and to recommend the Board approve the posting of these resource links to its website beginning January 1, 2017.