Oral and maxillofacial surgeons:
The experts in face, mouth and jaw surgery®

American Association of Oral and Maxillofacial Surgeons

9700 W. Bryn Mawr Ave.
Rosemont, IL 60018-5701

847-678-6200
800-822-6637
fax 847-678-6286

AAOMS.org

J. David Johnson Jr., DDS
President

Karin Wittich, CAE
Executive Director

VIA EMAIL: Karen.Fischer@dca.ca.gov

November 17, 2021

Joanne Pacheco, RDH, MAOB
Board President
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

Karen M. Fischer, MPA
Executive Officer
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

Dear Mses. Pacheco and Fischer:

On behalf of the 9,000 members of the American Association of Oral and Maxillofacial Surgeons (AAOMS) – and the 747 members practicing in California – we thank you for the opportunity to provide comment to the committee on the *Report to the California State Legislature Regarding Finding Relevant to Inform Dental Anesthesia and Sedation Standards* as required by SB 501.

Anesthesia is at the core of OMS training and practice. OMS residency education standards require a dedicated 32-week resident rotation on medical and anesthesia service as well as an ongoing outpatient experience in all forms of anesthesia throughout four- to six-years of residency training. OMSs are trained in medical assessment and emergency management on par with our medical colleagues. Our training and ability to deliver treatment safely and affordably to patients via our team model of practice in our offices is unparalleled.

A review of claims data provided by FAIR Health for 2018, 2019 and 2020[1] show that OMSs are the dental specialists providing the overwhelming majority of deep sedation/general anesthesia and IV sedation services in the U.S. to patients who have private dental insurance. Because OMSs provide the majority of dental office-based anesthetic care in the country, we are uniquely qualified to offer informed opinion on this report.

We are gravely concerned by the omission of key data points necessary for any meaningful analysis and urge immediate revision. Failure to do so will lead to inaccurate conjecture on the state of dental anesthesia delivery and relative safety among provider classes. We are most concerned with the following points.

[1] Statistics calculated by AAOMS using data from the U.S. Census Bureau and information provided by FAIR Health based on its privately insured dental claims data for calendar years 2018, 2019 and 2020. Of the total 6,240,366 moderate and deep sedation/general anesthesia (DS/GA) cases performed in this period, 79 percent – or 4.911.840 – were delivered by OMSs. In the 1- to 7-year-old age group, OMSs provided 44 percent (16,707) of the total DS/GA cases (38,257). In the 8- to 12-year-old age group, OMSs provided 81 percent (85,919) or the total DS/GA cases (105,791). For moderate sedation, in the 1- to 7-year-old age group, OMSs provided 34 percent (1,439) of the total moderate IV sedation procedures (4,244) and in the 8- to 12-year-old age group, provided 76 percent (10,378) of the total moderate IV sedation services (13,698).

Lack of provider type specificity

While we appreciate the Board's efforts to delineate the data based on patient age group, ASA status and practice site, the report fails to properly identify the provider type of the individual delivering the sedation/anesthesia. While the level of permit held by the provider is quantified, it fails to delve further into the education and training received by the individual.

For example, although a general dentist, dentist anesthesiologist and oral and maxillofacial surgeon all may hold a deep sedation/general anesthesia permit, they practice in very different settings and have divergent educational backgrounds. Additionally, patients may be treated by the operator-anesthetist model or utilize a separate anesthesia provider. This information is critical in any after-action evaluation and certainly required by the state during investigations into adverse events.

Disclosing the type of provider involved in each incident will allow the state to accurately identify any repeat event and pinpoint areas for legislative or regulatory action. Without this information, the state will only be guessing at the root cause and possibly make decisions that negatively impact patient care without ample justification.

Absence of information on patient sedation level

Similarly, the report fails to identify the intended level of sedation/anesthesia for each patient, focusing instead on only the level of permit held by the provider. A deep sedation/general anesthesia permit holder may choose to administer moderate sedation to a patient. A moderate sedation provider may provide inhalation analgesia.

In each incident – and based on our understanding of the data presented in this report – the matters would be reported under deep sedation/general anesthesia and moderate sedation, respectively, despite the incident actually involving an entirely different level of sedation on the continuum. This information must be included in any report to accurately determine and quantify how many incidents were associated with what levels of sedation.

Omission of AAOMS anesthesia standards

As previously mentioned, OMSs deliver the majority of dental anesthetics in the nation, yet surprisingly AAOMS guidelines were conspicuously omitted from the list of "relevant professional guidelines, recommendations or best practices for the provision of dental anesthesia and sedation care."

The AAOMS Parameters of Care[2] reflect the guidelines for treatment and outcome expectations for 11 designated areas of oral and maxillofacial surgery, including Anesthesia in Outpatient Facilities. It is updated regularly to reflect the latest scientific research, surgical technique and policy positions.

In addition, the AAOMS Office Anesthesia Evaluation[3] was designed to assure that each practicing AAOMS member maintained a properly equipped office and was prepared to use accepted techniques for managing emergencies and complications of anesthesia in the treatment of the OMS patient in the

[2] https://members.aaoms.org/PersonifyEbusiness/AAOMSStore/Product-Details/productId/1518255.
[3] https://members.aaoms.org/PersonifyEbusiness/AAOMSStore/Product-Details/productId/2076557.

office or outpatient setting. This evaluation has long served as the gold standard model for state anesthesia evaluations.

Any discussion on anesthesia in the dental outpatient setting must include reference to these documents.

Recommendation

These omissions must be rectified in any report forwarded to the legislature or released to the public. We urge the Board to revisit this report and include the aforementioned data points. There is precedent for this information as this same information was gathered and released via the 2016 Pediatric Anesthesia Study compiled by the Board (see Part 3).

We thank you for the opportunity to submit these thoughts and look forward to our continued collaboration on this and other issues affecting dentistry. Please contact Ms. Sandy Guenther of the AAOMS Governmental Affairs Department at 847-678-6200 or sguenther@aaoms.org for questions or additional information.

J. David Johnson, Jr., DDS

CC: Shama Currimbhoy, DDS, President, CALAOMS
Pamela Congdon, CAE, IOM, Executive Director, CALAOMS
Gary Cooper, Lobbyist, CALAOMS
Karin K. Wittich, CAE, Executive Director, AAOMS
Srini Varadarajan, Associate Executive Director, AAOMS