STATE OF IOWA
IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

Revised 4/26/13

IOWA DENTAL BOARD
AGENDA
May 9-10, 2013

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa

Board Members: *Steve Bradley, D.D.S., Board Secretary; Steven Fuller, D.D.S.; Matthew McCullough, D.D.S.; Kaaren Vargas, D.D.S.; Tom Jeneary, D.D.S.; Mary Kelly, R.D.H.; Nancy Slach, R.D.H.; Diane Meier, Public Member; Lori Elmitt, Public Member*

* New material in red

THURSDAY, May 9, 2013

Committee Meetings:

9:00 a.m.	**EXECUTIVE COMMITTEE** *(Bradley, Kelly)*		
10:00 a.m.	**DENTAL HYGIENE COMMITTEE** *(See Separate Committee Agenda)*	**Open**	*Kelly, Slach, Bradley*

Board Meeting:

11:15 a.m.	**OPEN SESSION**	**Open**	*Full Board*

I. CALL MEETING TO ORDER – ROLL CALL *Steve Bradley*

II. ELECTION OF OFFICERS

1. Board Chair
2. Board Vice Chair
3. Board Secretary

III. 2013-2014 COMMTTEE APPOINTMENTS

a. Elected by Vote of Full Board:

1. Dental Hygiene Committee (Board appoints 1 dentist)
2. Iowa Practitioner Review Committee (appoint/reappoint members)
3. Anesthesia Credentials Committee (appoint/reappoint members)
4. Continuing Education Advisory Committee (appoint/reappoint members)

5. Central Regional Dental Testing Service, Inc. (CRDTS)

   - *Steering Committee* (appoint IDB representative)

   - *Examination Review Committee* (appoint IDB representative)

b. Appointed by <u>Board Chair</u>:

1. Continuing Education Advisory Committee
   (appoint Committee Chair)
2. Licensure/Registration Committee
   (appoint members; appoint Committee Chair)
3. Dental Assistant Registration Committee
   (appoint members; appoint Committee Chair)

IV. 1ST OPPORTUNITY FOR PUBLIC COMMENT

V. APPROVAL OF OPEN SESSION MINUTES

a. January 31 – February 1, 2013 Quarterly Meeting
Added draft minutes 4/26/13

b. February 11, 2013 Telephonic Meeting
Added draft minutes 4/26/13

VI. REPORTS

a. EXECUTIVE DIRECTOR'S REPORT *Melanie Johnson*

b. LEGAL REPORT *Theresa Weeg*

c. ANESTHESIA CREDENTIALS COMMITTEE REPORT

1. Recommendations re: <u>Moderate Sedation Permit</u> Applications *(See Separate Committee Agenda)*
2. Recommendations re: <u>General Anesthesia Permit</u> Applications *(See Separate Committee Agenda)*
3. Other Committee Recommendations, If Any

d. CONTINUING EDUCATION ADVISORY COMMITTEE REPORT

1. Recommendations re: Continuing Education <u>Course Applications</u> *(See Separate Committee Agenda)*
2. Recommendations re: Continuing Education <u>Sponsor Applications</u> *(See Separate Committee Agenda)*
3. Other Committee Recommendations, If Any

e. BUDGET REVIEW COMMITTEE REPORT *Steven Fuller, Matt McCullough*

1. Review of Quarterly IDB Financial Report
   Added 3/31/13 financials 4/26/13
2. FY'14 Projected Budget

3. Other Committee Recommendations, if any

f. EXECUTIVE COMMITTEE REPORT *Steve Bradley*

g. LICENSURE/REGISTRATION COMMITTEE REPORT *Matt McCullough*

1. Actions Taken by Committee on Applications
2. Pending Licensure/Registration Applications, If Any – Will Be Discussed Under Agenda Item X
3. Other Committee Recommendations, If Any

h. DENTAL HYGIENE COMMITTEE REPORT *Mary Kelly*

1. Pending Dental Hygiene Applications, If Any – Will Be Discussed Under Agenda Item X
2. Report RE: Actions Taken at Dental Hygiene Committee Meeting
3. Committee Recommendations, If Any

i. DENTAL ASSISTANT REGISTRATION COMMITTEE REPORT

j. EXAMINATIONS REPORT

1. CRDTS (Central Regional Dental Testing Service) - *Dental Steering Committee Report* *Steve Bradley*
2. CRDTS - *Dental Hygiene Examination Review Committee Report* *Mary Kelly*
3. CRDTS - *Dental Examination Review Committee Report* *Steve Bradley*

k. AD HOC EXPANDED FUNCTIONS COMMITTEE REPORT *Mike Kanellis*

l. IOWA PRACTITIONERS REVIEW COMMITTEE REPORT

1. Quarterly IPRC report Added Report 4/26/13 *Brian Sedars*

VII. ADMINISTRATIVE RULES *Melanie Johnson*

VIII. LEGISLATIVE UPDATE *Melanie Johnson*

IX. OTHER BUSINESS *Steve Bradley*

a. Update re: Dental Asst. Trainees and Trainee Status Expiration Date Extensions Added Report 4/26/13 *Melanie Johnson*

b. Review of FAQs for Website Added Report and FAQS 4/26/13

c. Letter from RMBF re: Pediatric Dental Patients Added copy of letter 4/26/13

d. AADB Chicago Mid-Year Meeting Report *Mary Kelly*

e. Update on AMANDA Database Project *Phil McCollum*

f. 2014 Quarterly Board Meeting Schedule

X. APPLICATIONS FOR LICENSURE /REGISTRATION & OTHER REQUESTS * *Steve Bradley*

a. Ratification of Actions Taken by Executive Director on Applications Since Last Meeting *Melanie Johnson*

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members, presenters or attendees or to facilitate meeting efficiency.

b. Pending Licensure/Registration Applications*

XI. 2nd OPPORTUNITY FOR PUBLIC COMMENT *Steve Bradley*

XII. DISCIPLINARY HEARINGS**

2:00 p.m. 1. In the Matter of Angel King, R.D.A. (#12-181) **TBD**

XIII. *CLOSED SESSION **Closed**

XIV. ACTION, IF ANY, ON CLOSED SESSION ITEMS

1. Licensure/Registration Applications
2. Statement of Charges
3. Combined Statement of Charges, Settlement Agreement and Final Order
4. Settlement Agreements
5. Final Hearing Decisions
6. Final Action on Non-Public Cases Left Open
7. Final Action on Non-Public Cases Closed
8. Other Closed Session Items

FRIDAY, MAY 10, 2013

8:30 a.m. **XV. BOARD RECONVENES** **Closed** *Steve Bradley*

XVI. DISCIPLINARY HEARINGS**

8:30 a.m. **a.** In the Matter of Jay Buckley, D.D.S. (#12-104) **TBD**

XVII. CONTINUE WITH ANY CLOSED SESSION AGENDA ITEMS **Closed**

XVIII. OPEN SESSION **Open**

a. ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS

1. Licensure/Registration Applications
2. Statement of Charges
3. Combined Statement of Charges, Settlement Agreement and Final Order
4. Settlement Agreements
5. Final Hearing Decisions
6. Final Action on Non-Public Cases Left Open
7. Final Action on Non-Public Cases Closed
8. Other Closed Session Items

b. OTHER OPEN SESSION ITEMS, IF ANY

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members, presenters or attendees or to facilitate meeting efficiency.

XIX. ADJOURN

- NEW BOARD MEMBER ORIENTATION SESSION-

Next Quarterly Meeting: August 1-2, 2013

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515/281-5157.

* These matters constitute a sufficient basis for the board to consider a closed session under the provisions of section 21.5(1), (a), (c), (d), (f), (g), and (h) of the 2011 Code of Iowa. These sections provide that a governmental body may hold a closed session only by affirmative public vote of either two-thirds of the members of the body or all of the members present at the meeting to review or discuss records which are required or authorized by state or federal law to be kept confidential, to discuss whether to initiate licensee disciplinary investigations or proceedings, and to discuss the decision to be rendered in a contested case conducted according to the provisions of Iowa Code chapter 17A.

**Pursuant to Iowa Code section 272C.6(1) a licensee may request that their disciplinary hearing be held in closed session.

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members, presenters or attendees or to facilitate meeting efficiency.

REPORT TO THE IOWA DENTAL BOARD

ACTION REQUIRED

DATE OF MEETING: May 9-10, 2013

RE: **2013-2014 Election of Officers & Committee Appointments**

SUBMITTED BY: Melanie Johnson, Executive Director

ACTION REQUESTED: Election of Officers and Committee Appointments

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Annually, the Board elects its officers (Chair, Vice Chair and Secretary) and makes appointments/reappointments to its committees.

Some committee appointments are required by statute or rule to be made by action of the full Board and some are required to be made by the Board Chair. Included with this Report is information about each committee (e.g., roles and responsibilities; whether it is created by rule, statute, or appointed by the Board Chair; and any specific composition or eligibility requirements).

Also included is a listing of the current committees with vacancies identified.

Attached for Review:

- 2012-2013 Committees with Vacancies Highlighted
- 2012-2013 Board Members' Committee Assignments
- Individual Committee summaries

yellow highlight = Vacancies on May 1, 2013
green = Board Chair appoints/reappoints committee members
blue = Board votes to appoint/reappoint committee members

2012-2013 IOWA DENTAL BOARD OFFICERS:

Board Officers

- Elected by Board

Michael Rovner, D.D.S., *Chair* (Board Chair)
Lynn Curry, D.D.S. (Board Vice Chair)
Steve Bradley, D.D.S. (Board Secretary)

STATUTE & RULE:

Statute requires annual selection of a chairperson and vice chairperson.

Board rules require an annual election of a chairperson, vice chairperson and secretary.

Officers assume their duties immediately following their election at the annual meeting.

2012- 2013 IOWA DENTAL BOARD COMMITTEES:

Dental Hygiene Committee

- DDS Member Elected by Board vote

1. Mary Kelly, R.D.H, *Chair* (Board Member)
2. Nancy Slach, R.D.H., Vice Chair (Board Member)
3. Steve Bradley, D.D.S, Secretary (Board Secretary)

STATUTE & RULE

Composition is set by statute: 3 members

2 dental hygienist members of the Board

1 dentist member of the board.

- The dentist member of the committee must have supervised and worked in collaboration with a dental hygienist for a period of at least three years (3) immediately preceding election to the committee.
- DDS must be elected by majority of the Board

By Board rule, the Committee elects its own officers (Chair, Vice Chair, Secretary)

Continuing Education Advisory Committee

- Board appoints/reappoints members; vote required
- Board Chair appoints Committee Chair

1. *Lynn Curry, D.D.S., Chair* (Board Vice Chair)
2. Lori Elmitt (Board Member)
3. George North, D.D.S. (Private Sector Member)
4. Eileen Cacioppo, R.D.H. (Private Sector Member)
5. Marijo Beasler, R.D.H. (Private Sector Member)
6. Jane Slach, R.D.A (Private Sector Member)
7. Kristee Malmberg, R.D.A. (Private Sector Member)

RULE:

Composition is set by rule: 7 members

1 member of the Iowa Dental Board

2 licensed dentists with expertise in the area of professional continuing education

2 licensed dental hygienists with expertise in the area of professional continuing education

2 registered dental assistants with expertise in the area of professional continuing education

Anesthesia Credentials Committee

- Board appoints/reappoints 6 members; vote required
- Board Chair appoints Committee Chair

1. *Lynn Curry, D.D.S., Chair* (Board Vice Chair)
2. Richard Burton, D.D.S. (Private Sector Member)
3. Kurt Westlund, D.D.S. (Private Sector Member)
4. Douglas Horton, D.D.S. (Private Sector Member)
5. Steven Clark, D.D.S. (Private Sector Member)
6. Kaaren Vargas, D.D.S. (Private Sector Member)
7. Gary Roth, D.D.S. (Private Sector Member)

RULE:

Composition is set by rule: 7 members, minimum (can appoint more)

1 Member of the Iowa Dental Board

6 At least 6 additional members who are licensed to practice dentistry in Iowa
- At least 4 of the 6 must hold deep sedation/general anesthesia or conscious sedation permits

- Brd. rule requires Committee Chair to be a Board member

yellow highlight = Vacancies on May 1, 2013
green = Board Chair appoints/reappoints committee members
blue = Board votes to appoint/reappoint committee members

Iowa Practitioners Review Committee

- Board appoints/reappoints members; vote required

1. *Jerome Greenfield, M.D., Chair*
2. Gordon Anderson, II, IADC, *Vice Chair*
3. Kathy Stone, L.M.S.W., M.B.A
4. Richard A. Rips, D.D.S.
5. Melanie Johnson, J.D., IDB Executive Director

STATUTE & RULE:

Composition is set by rule: 5 members, minimum (can appoint more)

1 Executive director of the Board or the director's designee from the Board's staff
1 Practitioner who has remained free of addiction for a period of no less than 2 years following successful completion of a board-approved recovery program, a board-ordered probation for drug or alcohol dependency, addiction, or abuse, or an IPRC contract.
1 Physician/counselor with expertise in substance abuse/addiction treatment programs.
1 Psychiatrist or one psychologist
1 Public member

By Board rule, the Committee elects its own officers (Chair, Vice Chair, Secretary)

Executive Committee

- Board Chair appoints members
- Board Chair appoints Committee Chair

1. Michael Rovner, D.D.S., *Chair* (Board Chair)
2. Lynn Curry, D.D.S. (Board Vice Chair)
3. Steve Bradley, D.D.S. (Board Secretary)
4. Mary Kelly, R.D.H. (Board Member)

APPOINTED BY BOARD CHAIR

By rule, the Board Chair has authority to appoint committees.
Membership must be less than a quorum of the Board (5 members).
This is a Committee appointed by the Board Chair.
No set number of members or eligibility requirements.

Current Composition: 4
The membership has historically been the elected officers of the Board (Chair, Vice-Chair, and Secretary).
In May, 2012, the Board Chair appointed a RDH Board Member to the Committee.

Licensure/Registration Committee

- Board Chair appoints/reappoints members
- Board Chair appoints Committee Chair

1. *Michael Rovner, D.D.S., Chair* (Board Chair)
2. Diane Meier (Board Member)
3. Matthew McCullough, D.D.S. (Board Member)

APPOINTED BY BOARD CHAIR

By rule, the Board Chair has authority to appoint committees.
Membership must be less than a quorum of the Board (5 members).
This is a Committee appointed by the Board Chair.
No set number of members or eligibility requirements.
Current composition: 3 members
2 dentist members of the Board
1 public member of the Board

Dental Assistant Registration Committee

- Board Chair appoints/reappoints members
- Board Chair appoints Committee Chair

1. *George North, D.D.S., Chair* (Private Sector Member)
2. Steven Bradley, D.D.S. (Board Member)
3. Michael Rovner, D.D.S. (Board Chair)
4. Steven Fuller, D.D.S., (Board Member)
5. Diane Meier (Board Member)
6. Denise Bell, R.D.A. (Private Sector Member)

APPOINTED BY BOARD CHAIR

By rule, the Board Chair has authority to appoint committees.
Membership must be less than a quorum of the Board (5 members).
This is a Committee appointed by the Board Chair.
No set number of members or eligibility requirements.

Current composition: 4 Brd members, 2 private sector
4 dentists: - 1 private sector dentist
- 3 dentist Board members
1 public member of the Board
1 dental assistant, private sector

yellow highlight = Vacancies on May 1, 2013
green = Board Chair appoints/reappoints committee members
blue = Board votes to appoint/reappoint committee members

Budget Review Committee

- Board Chair appoints/reappoints members
- Board Chair appoints Committee Chair

1. *Lynn Curry, D.D.S., Chair* (Board Vice Chair)
2. Matthew McCullough, D.D.S. (Board Member)
3. Steven Fuller, D.D.S., (Board Member)

APPOINTED BY BOARD CHAIR

By rule, the Board Chair has authority to appoint committees.
Membership must be less than a quorum of the Board (5 members).
This is a Committee appointed by the Board Chair.
No set number of members or eligibility requirements.
This Committee was established by the Board Chair in October, 2012.

Ad Hoc Examination Committee

- Board Chair appoints/reappoints members
- Board Chair appoints Committee Chair

1. *P.T. Grimes, D.D.S., Chair* (Private Sector Member)
2. David Holmes, D.D.S. (U. of I. College of Dentistry)
3. Michael Kanellis, D.D.S. (U. of I. College of Dentistry)
4. Lynn Curry, D.D.S. (Board Member)
5. Steven Fuller, D.D.S. (Board Member)
6. Deena Kuempel, D.D.S. (Private Sector Member)

APPOINTED BY BOARD CHAIR

By rule, the Board Chair has authority to appoint committees.
Membership must be less than a quorum of the Board (5 members).
This is a Committee appointed by the Board Chair; originally intended to address the topic of clinical examinations.
No set number of members or eligibility requirements.

Ad Hoc Committee - Expanded Functions

- Board Chair appoints/reappoints members
- Board Chair appoints Committee Chair

1. *Michael Kanellis, D.D.S., Committee Chair* (UICD)
2. George North, D.D.S. (Dental Assist. Regis. Comm. Chair)
3. Eileen Cacioppo, R.D.H. (IDHA)
4. Jane Slach, R.D.A (IDAA)
5. Mary Mariani, D.D.S. (IDA)
6. Lori Elmitt (IA Dental Board, Public Member)
7. Steve Bradley, D.D.S. (IA Dental Board, Dentist)
8. Mary Kelly, R.D.H. (IA Dental Board, Dental Hygienist)

APPOINTED BY BOARD CHAIR

By rule, the Board Chair has authority to appoint committees.
Membership must be less than a quorum of the Board (5 members).
This is a Committee appointed by the Board Chair; assigned a specific, limited task of making recommendations to the Board about possible rule amendments related to expanded functions for RDAs and RDHs.
No set number of members or eligibility requirements.

Central Regional Dental Testing Service, Inc. (CRDTS)

- Board Chair appoints/reappoints members

1. *Steering Committee:* Steve Bradley, D.D.S. (Brd Vice Chair)
2. *Examination Review Committees:*
   a. *Dental:* P.T. Grimes, D.D.S. (Private Sector Member)
   b. *Dental Hygiene:* Mary Kelly, R.D.H. (Board Member)

These appointments are made pursuant to an agreement with CRDTS.

BOARD MEMBERS AND CURRENT COMMITTEE ASSIGNMENTS

Mike Rovner, Chair:	1. Executive Committee 2. Licensure/Registration Committee 3. Dental Asst. Registration Committee
Lynn Curry, Vice Chair:	1. Executive Committee 2. Anesthesia Credentials Committee 3. Continuing Education Advisory Committee 4. Ad Hoc Examination Committee
Steve Bradley, Secretary:	1. Executive Committee 2. Dental Hygiene Committee 3. Dental Asst. Registration Committee 4. CRDTS Steering Committee 5. Ad Hoc Examination Committee 6. Ad Hoc Expanded Functions Committee
Steven Fuller:	1. Dental Asst. Registration 2. Budget Review Committee 3. Ad Hoc Examination Committee
Matthew McCullough:	1. Licensure/Registration Committee 2. Budget Review Committee
Mary Kelly:	1. Executive Committee 2. Dental Hygiene Committee 3. CRDTS Examination Review Committee – Dental Hygiene 4. Ad Hoc Expanded Functions Committee
Nancy Slach:	1. Dental Hygiene Committee
Diane Meier:	1. Licensure/Registration Committee 2. Dental Asst. Registration Committee
Lori Elmitt	1. Continuing Education Advisory Committee 2. Ad Hoc Expanded Functions Committee
Kaaren Vargas:	Term begins: May 1, 2013 (new appointee, not assigned to committees yet)
Tom Jeneary:	Term begins: May 1, 2013 (new appointee, not assigned to committees yet)

FOR 2013-2014 APPOINTMENTS

STATUTORY COMMITTEES:

1. Dental Hygiene Committee (Iowa Code §153.33A)
2. Iowa Practitioner Review Committee (Iowa Code §272C.3)

COMMITTEES ESTABLISHED BY BOARD RULE:

1. Continuing Education Advisory Committee (Rule: 650 IAC 25.1)
2. Anesthesia Credentials Committee (Rule: 650 IAC 29.10)

COMMITTEES APPOINTED BY BOARD CHAIR:

1. Executive Committee (Rule: 650 IAC 1.3(5))
2. Licensure/Registration Committee (Rule: 650 IAC 1.3(5))
3. Dental Assistant Registration Committee (Rule: 650 IAC 1.3(5))
4. Budget Review Committee (Rule: 650 IAC 1.3(5))
5. Ad Hoc Examination Committee (Rule: 650 IAC 1.3(5))
6. Ad Hoc Expanded Functions Committee (Rule: 650 IAC 1.3(5))

IDB REPRESENTATIVES ON CRDTS COMMITTEES:

Appointments to CRDTS committees are made pursuant to an agreement between the Iowa Dental Board and CRDTS.

CREATED BY STATUTE:

COMMITTEE:	***Dental Hygiene Committee***
# OF MEMBERS:	3
COMPOSITION:	Composition established in statute (153.33A); full Board elects dentist Board member to serve on the Committee. The two dental hygiene Board members are members of the Committee. *Composition:* The 2 dental hygienist members of the Board 1 dentist member of the board. - The dentist member of the committee must have supervised and worked in collaboration with a dental hygienist for a period of at least three years (3) immediately preceding election to the committee.
TERM:	1 year, May 1 – April 30 Board reviews annually; can reappoint current dentist member or elect new dentist to serve
VACANCY:	(Annually, Board elects 1 DDS member)
RESPONSIBILITIES:	The committee shall have the authority to adopt recommendations regarding the practice, discipline, education, examination, and licensure of dental hygienists, subject to subsection 3, and shall carry out duties as assigned by the board. (*See* Iowa Code 153.33A(2))
SUBJECT TO OPEN MEETINGS LAW?	Yes
ESTABLISHED BY RULE, STATUTE?	- Established by statute, Iowa Code section 153.33A **Iowa Code (2013)** **153.33A Dental hygiene committee.** 1. A three-member dental hygiene committee of the board is created, consisting of the two dental hygienist members of the board and one dentist member of the board. The dentist member of the committee must have supervised and worked in collaboration with a dental hygienist for a period of at least three years immediately preceding election to the committee. The dentist member shall be elected to the committee annually by a majority vote of board members. 2. The committee shall have the authority to adopt recommendations regarding the practice, discipline, education, examination, and licensure of dental hygienists, subject to subsection 3, and shall carry out duties as assigned by the board. The committee shall have no regulatory or disciplinary authority with regard to dentists, dental assistants, dental lab technicians, or any other auxiliary dental personnel. 3. The board shall ratify recommendations of the committee at the first meeting of the board following adoption of the recommendations by the committee, or at a meeting of the board specifically called for the purpose of board review and ratification of committee recommendations. The board shall decline to ratify committee recommendations only if the board makes a specific finding that a recommendation exceeds the jurisdiction or expands the scope of the committee beyond the authority granted in subsection 2, creates an undue financial impact on the board, or is not supported by the record. The board shall pay the necessary expenses of the committee and of the board in implementing committee recommendations ratified by the board. 4. This section shall not be construed as impacting or changing the scope of practice of the profession of dental hygiene or authorizing the independent practice of dental hygiene. The Committee's composition is set by statute – 2 dental hygienists, 1 dentist. All are Board members.

COMMITTEE:	***Dental Hygiene Committee***
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	The dentist member is elected by the full Board.
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	The Committee elects its officers, pursuant to Board rule. **650—1.6(17A,147,153) Meetings**. **-------** 1.6(3) The dental hygiene committee shall hold an annual meeting each year in Des Moines, Iowa, to elect officers and conduct other business. Officers of the committee shall consist of a chairperson, vice chairperson, and secretary. Officers shall assume their duties immediately following their election at the annual meeting.

CREATED BY STATUTE:

COMMITTEE:	***Iowa Practitioner Review Committee***
# OF MEMBERS:	5
COMPOSITION:	Authorized by statute, composition set by rule, committee members appointed by the full Board, IPRC elects their Chair and Vice Chair. Minimum of 5 members, but Board may appoint more members. The membership of the IPRC may include, but is not limited to: 1 Executive director of the Board or the director's designee from the Board's staff 1 Practitioner who has remained free of addiction for a period of no less than 2 years following successful completion of a board-approved recovery program, a board-ordered probation for drug or alcohol dependency, addiction, or abuse, or an IPRC contract. 1 Physician/counselor with expertise in substance abuse/addiction treatment programs. 1 Psychiatrist or one psychologist 1 Public member
TERM:	3 year terms, May 1 – April 30 * Terms changed by rule, effective April 10, 2013 Board reviews vacancies; may reappoint current members or appoint new members
VACANCY:	0
RESPONSIBILITIES:	**35.1(2)** *Purpose.* The IPRC evaluates, assists, and monitors the recovery, rehabilitation, or maintenance of dentists, hygienists, or assistants who self-report impairments. As necessary, the committee notifies the board in the event of noncompliance with contract provisions. The IPRC is both an advocate for the health of a practitioner and a means to protect the health and safety of the public. Reports on the activities of the IPRC shall be made to the board on a quarterly basis.
SUBJECT TO OPEN MEETINGS LAW?	Yes
ESTABLISHED BY RULE, STATUTE?	- Authorized by statute, Iowa Code 272C.3(1)"k" - Implemented by rule 650 IAC Chapter 35 *Statute: Iowa Code (2013)* **272C.3 Authority of licensing boards.** 1. Notwithstanding any other provision of this chapter, each licensing board shall have the powers to: ------ *k.* Establish a licensee review committee for the purpose of evaluating and monitoring licensees who are impaired as a result of alcohol or drug abuse, dependency, or addiction, or by any mental or physical disorder or disability, and who self-report the impairment to the committee, or who are referred by the board to the committee. Members of the committee shall receive actual expenses for the performance of their duties and shall be eligible to receive per diem compensation pursuant to section 7E.6. The board shall adopt rules for the establishment and administration of the committee, including but not limited to establishment of the criteria for eligibility for referral to the committee and the grounds for disciplinary action for noncompliance with committee decisions. Information in the possession of the board or the licensee review committee, under this paragraph, shall be subject to the confidentiality requirements of section 272C.6. Referral of a licensee by the board to a licensee review committee shall not relieve the board of any duties of the board and shall not divest the board of any authority or jurisdiction otherwise provided. A licensee who violates section 272C.10 or the rules of the board while under review by the licensee review committee shall be referred to the board for appropriate action.

COMMITTEE:	***Iowa Practitioner Review Committee***
	*Board Rule: *Rule amended. Effective April 10, 2013* **35.1(3)** *Composition of the committee.* The chairperson of the board shall appoint the members of the IPRC. Committee members, except the executive director, shall be appointed for three-year terms which begin on May 1 and terminate on April 30. The committee shall elect a chairperson and vice chairperson annually at the last meeting closest to April 30. The chairperson and vice chairperson will serve one-year terms beginning on May 1. The membership of the IPRC may include, but is not limited to: *a.* Executive director of the board or the director's designee from the board's staff; *b.* One practitioner who has remained free of addiction for a period of no less than two years following successful completion of a board-approved recovery program, a board-ordered probation for drug or alcohol dependency, addiction, or abuse, or an IPRC contract; *c.* One physician/counselor with expertise in substance abuse/addiction treatment programs; *d.* One psychiatrist or one psychologist; and *e.* One public member.
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Committee members are appointed by the Board Chair
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	IPRC elects a chairperson and vice chairperson annually

CREATED BY RULE:

COMMITTEE:	***Continuing Education Advisory Committee***
# OF MEMBERS:	7
COMPOSITION:	Committee established by rule, composition set by rule, committee members appointed by the full Board and Committee Chair is appointed by Board Chair: *Composition:* 1 member of the Iowa Dental Board 2 licensed dentists with expertise in the area of professional continuing education 2 licensed dental hygienists with expertise in the area of professional continuing education 2 registered dental assistants with expertise in the area of professional continuing education.
TERM:	1 year, May 1 – April 30 Board reviews annually; may reappoint current members or appoint new members
VACANCY:	1 dentist member w/con. ed. expertise; Chair must be a Board member
RESPONSIBILITIES:	Review and advise the Board with respect to: - Applications for approval of sponsors - Applications for approval of activities - Requests for post approval of activities
SUBJECT TO OPEN MEETINGS LAW?	Yes
ESTABLISHED BY RULE, STATUTE?	By rule: **650—25.1(153) Definitions**. For the purpose of these rules on continuing education, definitions shall apply: *"Advisory committee."* An advisory committee on continuing education shall be formed to review and advise the board with respect to applications for approval of sponsors or activities and requests for post approval of activities. Its members shall be appointed by the board and consist of a member of the board, two licensed dentists with expertise in the area of professional continuing education, two licensed dental hygienists with expertise in the area of professional continuing education, and two registered dental assistants with expertise in the area of professional continuing education. The advisory committee on continuing education may tentatively approve or deny applications or requests submitted to it pending final approval or disapproval of the board at its next meeting.
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Full Board appoints the Committee members
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	Committee Chair is appointed by the Board Chair, per rule: **1.3(5)** Committees of the board may be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include the executive committee, licensure committee, grievance committee, continuing education advisory committee, and dental assistant committee.

CREATED BY RULE:

COMMITTEE:	***Anesthesia Credentials Committee***
# OF MEMBERS:	7
COMPOSITION:	Established in rule, composition set by rule, Committee Chair must be a Board member, Committee members appointed by the full Board. Must be 7 members, but Board may appoint more members. *Current composition:* 1 member of the Iowa Dental Board 6 At least 6 additional members who are licensed to practice dentistry in Iowa - At least 4 of the 6 must hold deep sedation/general anesthesia or conscious sedation permits
TERM:	1 year, May 1 – April 30 Board reviews annually; may reappoint current members or appoint new members
VACANCY:	1 Board member
RESPONSIBILITIES:	- Review all permit applications and make recommendations to the Board regarding • Applications for moderate sedation • Applications for general anesthesia • Applications for deep sedation - Conduct site visits at facilities and report the results of those site visits to the Board. The anesthesia credentials committee may submit recommendations to the Board regarding the appropriate nature and frequency of site visits. - Perform professional evaluations and report the results of those evaluations to the Board. - Other duties as delegated by the Board or Board chairperson.
SUBJECT TO OPEN MEETINGS LAW?	Yes
ESTABLISHED BY RULE, STATUTE?	By rule: **29.10(153) Anesthesia credentials committee**. 29.10(1) The anesthesia credentials committee is a peer review committee appointed by the board to assist the board in the administration of this chapter. This committee shall be chaired by a member of the board and shall include at least six additional members who are licensed to practice dentistry in Iowa. At least four members of the committee shall hold deep sedation/general anesthesia or conscious sedation permits issued under this chapter.
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Members are appointed by the full Board
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	The Committee Chair must be a Board member

APPOINTED BY BOARD CHAIR:

COMMITTEE:	***Executive Committee***
# OF MEMBERS:	4
COMPOSITION:	The membership has historically been the elected officers of the Board (Chair, Vice-Chair, and Secretary). In May, 2012, the Board Chair appointed a RDH Board Member to the Committee.
TERM:	1 year, May 1 – April 30 Composition changes as Board officers are elected
VACANCY:	4
RESPONSIBILITIES:	Include, but are not limited to: - Meeting with the executive director. - Review of personnel matters. - Budgetary review and recommendations to the Board. - Review and recommendations to the Board re: rules and legislative proposals. - Study and recommendations to the Board on practice issues and policy.
SUBJECT TO OPEN MEETINGS LAW?	No
ESTABLISHED BY RULE, STATUTE?	By rule: **1.3(5)** Committees of the board may be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include the executive committee, licensure committee, grievance committee, continuing education advisory committee, and dental assistant committee.
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Committee Members appointed by the Board Chair
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	Committee Chair appointed by the Board Chair

APPOINTED BY BOARD CHAIR:

COMMITTEE:	***Licensure/Registration Committee***
# OF MEMBERS:	3
COMPOSITION:	No set number of members or eligibility requirements, but total number must be less than quorum (5) of Board; Board Chair appoints Committee members & Committee Chair. *Current composition:* 2 dentist members of the Board 1 public member of the Board
TERM:	1 year, May 1 – April 30 Board reviews annually; may reappoint current members or appoint new members
VACANCY:	1 Board member
RESPONSIBILITIES:	Reviewing and recommending appropriate action concerning applications for: - Permanent licensure as a dentist; - Dentists seeking permission to practice as a resident, intern or graduate student; - Dentists requesting authorization to practice dentistry as a faculty member; - Dentists requesting temporary permits to practice dentistry on a short-term basis, to fulfill an urgent need, or to serve an educational purpose; - Dental assistant registration, radiography qualification, trainee status
SUBJECT TO OPEN MEETINGS LAW?	No
ESTABLISHED BY RULE, STATUTE?	By rule: **1.3(5)** Committees of the board may be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include the executive committee, licensure committee, grievance committee, continuing education advisory committee, and dental assistant committee.
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Committee members appointed by the Board Chair
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	Board Chair appoints the Committee Chair

APPOINTED BY BOARD CHAIR:

COMMITTEE:	***Dental Assistant Registration Committee***
# OF MEMBERS:	6
COMPOSITION:	No set number of members or eligibility requirements, but total number must be less than quorum (5) of Board; Board Chair appoints Committee members & Committee Chair. *Current composition: 4 Brd members, 2 private sector* 4 dentists: - 1 private sector dentist - 3 dentist Board members 1 public member of the Board 1 dental assistant, private sector
TERM:	1 year, May 1 – April 30 Board reviews annually; may reappoint current members or appoint new members
VACANCY:	1
RESPONSIBILITIES:	Provide recommendations to the Board regarding: - Dental assistant program policies - Dental assistant procedures - Rules applicable to dental assisting - Other dental assistant matters referred by the Board to the Committee
SUBJECT TO OPEN MEETINGS LAW?	No
ESTABLISHED BY RULE, STATUTE?	By rule: **1.3(5)** Committees of the board may be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include the executive committee, licensure committee, grievance committee, continuing education advisory committee, and dental assistant committee.
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Committee members appointed by the Board Chair
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	Board Chair appoints the Committee Chair

IDB REPRESENTATIVE ON CRDTS COMMITTEE:

COMMITTEE:	***Central Regional Dental Testing Service, Inc. (CRDTS)*** *Steering Committee*
# OF MEMBERS:	1
COMPOSITION:	Historically, 1 Board member
TERM:	1 year, May 1 – April 30 Board reviews annually and elects IDB representative to serve on CRDTS Committee
VACANCY:	1 Board Member
RESPONSIBILITIES:	- Attend CRDTS meetings - Present report to Iowa Dental Board at quarterly meeting re: CRDTS activities
SUBJECT TO OPEN MEETINGS LAW?	No
ESTABLISHED BY RULE, STATUTE?	By agreement with CRDTS
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Historically, members have been appointed by the full Board
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	(Not applicable)

IDB REPRESENTATIVES ON CRDTS COMMITTEES:

COMMITTEE:	***Central Regional Dental Testing Service, Inc. (CRDTS)*** *Examination Review Committee*
# OF MEMBERS:	2
COMPOSITION:	Historically, 1-2 Board members Private Sector (former Board member) appointed for May 1, 2011 – April 30, 2012
TERM:	1 year, May 1 – April 30 Board reviews annually and elects IDB representative to serve on CRDTS Committee
VACANCY:	1 Board Member
RESPONSIBILITIES:	- Attend CRDTS examination review committee meetings - Present report to Iowa Dental Board at quarterly meeting re: CRDTS activities
SUBJECT TO OPEN MEETINGS LAW?	No
ESTABLISHED BY RULE, STATUTE?	By agreement with CRDTS
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR *OR* FULL BOARD?	Historically, members have been appointed by the full Board
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR *OR* DOES THE COMMITTEE ELECT A CHAIR?	(Not applicable)

MJ edits 4/26/13

IOWA DENTAL BOARD
MINUTES
January 31-February 1, 2013
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members	**January 31, 2013**
Michael J. Rovner, D.D.S., Chairperson	Present
Lynn D. Curry, D.D.S., Vice Chairperson	Present
Steven P. Bradley, R.D.H., Secretary	Present
Steven C. Fuller, D.D.S.	Present
Matthew J. McCullough, D.D.S.	Present
Mary C. Kelly, R.D.H.	Present
Nancy A. Slach, R.D.H.	Present
Diane Meier, Public Member	Present
Lori Elmitt, Public Member	Present

Staff Members
Melanie Johnson, Christel Braness, Phil McCollum, Brian Sedars, Dee Ann Argo, Janet Arjes

Attorney General's Office
Theresa Weeg, Assistant Attorney General

Other Attendees
Tom Cope, Iowa Dental Hygienists' Association
Lori Brown, Iowa Dental Hygienists' Association
Ashley Bixler, Iowa Dental Hygienists' Association, DMACC student
Myrima Imsirovic, Iowa Dental Hygienists' Association, DMACC student
Carol Van Aernam, Iowa Dental Hygienists' Association
Tracy Rodgers, R.D.H., Iowa Department of Public Health
Jeannene Veenstra, R.D.A., Iowa Dental Assistant Association
Larry Carl, Iowa Dental Association
Stephen Thies, D.D.S., Iowa Academy of General Dentistry

I. CALL TO ORDER FOR JANUARY 31, 2013

Chairman Rovner called the open session meeting of the Iowa Dental Board to order at 12:12 p.m. on Thursday, January 31, 2013. A quorum was established with all members present.

Roll Call:

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Slach	Rovner
Present	x	x	x	x	x	x	x	x	x
Absent									

II. 1st OPPORTUNITY FOR PUBLIC COMMENT

Dr. Rover asked the non-Board members in the audience to introduce themselves.

Chairman Rovner allowed time for public comment.

Larry Carl, Iowa Dental Association (IDA) indicated that he provided information about the legislative initiatives of the Iowa Dental Association for the current legislative session. Mr. Carl also provided information on the 2012 Iowa Mission of Mercy (IMOM). In 2013, IMOM is scheduled to be held in Des Moines.

III. APPROVAL OF OPEN SESSION MINUTES

- *October 25-26, 2012 Minutes*

Ms. Kelly reported that she had provided proposed language to the Dental Hygiene Committee report section of the minutes for the October 2012 meeting of the Board. In Ms. Kelly's opinion, the proposed language better reflected the discussion, which occurred.

❖ MOVED by SLACH, SECONDED by BRADLEY, to approve the minutes of the October 25-26, 2012 meeting, with a correction under the Dental Hygiene Committee report to better reflect the discussion, which occurred. Motion APPROVED unanimously.

IV. REPORTS

EXECUTIVE DIRECTOR'S REPORT

Ms. Johnson reported that the Board members received a copy of her report.

EXPLORING A DENTAL HEALTH PROFESSIONS DATA COLLECTION PROJECT

Ms. Johnson reported that she met with members of Delta Dental of Iowa and the Iowa Workforce Development to discuss the proposed project. This project is in the early stages; however, Iowa Workforce Development reported that they have a division devoted to this kind of information. The next step is to determine what information, specifically, that organizations are interested in collecting.

PRACTICE OF DENTAL HYGIENE

Ms. Johnson reported that the Des Moines Register had provided information in a recent issue of the newspaper concerning the practice of dental hygiene and potential employment prospects

HAGEN PETITION FOR JUDICIAL REVIEW: DISTRICT COURT DECISION
Ms. Johnson reported that the District Court review Dr. Hagen's Petition for Judicial Review. The District Court upheld the Board's decision in this matter.

AMANDA LICENSING DATABASE
Ms. Johnson reported that the database project is scheduled to go live around June 1, 2013 provided that there are no further delays. The project is currently on track. The Iowa Board of Nursing has already launched their version of the database. To date, few problems have been reported.

2013 QUARTERLY MEETINGS
Ms. Johnson provided the remaining 2013 meeting dates scheduled to date: May 9-10, 2013; August 1-2, 2013; October 31-November 1, 2013.

AMERICAN ASSOCIATION OF DENTAL BOARDS (AADB) MID-YEAR MEETINGS
Ms. Johnson reported that the Board has been forwarded information about the mid-year meetings scheduled in Chicago, IL later this spring. The information was placed in the Board folders.

LEGAL REPORT

UPDATE RE: REVIEW OF STATUTORY AUTHORITY OF DENTAL HYGIENE COMMITTEE AND DENTAL BOARD
Ms. Weeg reported that there has been some discussion on the statutory authority of the Dental Hygiene Committee, and what role the Board plays in that. Ms. Weeg provided some historical perspective on this issue.

The Dental Hygiene Committee is made up of two dental hygienists and a dentist, who employs a dental hygienist.

Iowa Code 153.33A, subsection 2 discusses the authority of the Dental Hygiene Committee to make recommendations concerning the practice of dental hygiene. Iowa Code 153.33A, subsection 3 addresses the Board's adoption of Dental Hygiene Committee recommendations. The Board is required to adopt the Committee's recommendations unless it meets certain criteria established in the statute. They are as follows:

- A recommendation exceeds the jurisdiction or expands the scope of the Committee beyond the authority granted in subsection 2;
- Creates an undue financial impact on the board;
- Or is not supported by the record.

Ms. Weeg feels that these criteria are subject to subsection 4, which states that recommendations shall not impact or change the scope of practice of dental hygiene.

Ms. Weeg reported that when the Dental Hygiene Committee was created, there was quite a lot of discussion about how to implement these regulations. Ms. Weeg interpreted Iowa Code 153.33A, subsection 4 to mean that the Dental Hygiene Committee is prohibited from putting forward recommendations, which would expand or change the scope of practice of dental hygiene. Administrative processes were established to comply with the law. If a proposal does not address the jurisdiction/scope issues, the Dental Hygiene Committee's proposal would come forward as a recommendation. If the proposal addressed jurisdiction or scope of practice, it would be presented to the Board as a suggestion.

Typically, the Board has accepted the Committee's recommendations. As far as Ms. Weeg is aware, the Board has never needed to determine if a proposal from the Dental Hygiene Committee was a recommendation or a suggestion.

This discussion arose due to ongoing discussions regarding public health supervision. Prior to this time establishment of public health supervision, supervision levels were limited to general, direct or personal. When the Board considered the request for rulemaking, which added another level of supervision: public health supervision, Ms. Weeg, Board staff, and the Committee agreed that the proposal was a suggestion from the Committee as it expanded the scope of practice.

The Iowa Dental Hygienists' Association (IDHA) has challenged this interpretation of Iowa Code section 153.33A. The IDHA feels that the reference to "regarding the practice" covers all matters concerning the practice of dental hygiene, unless the proposal meets one of the three exceptions. Ms. Weeg disagrees since subsection 4 limits the authority of the Dental Hygiene Committee to change the scope of practice.

Ms. Weeg noted that the other issue with this is that there is no established process in writing to address the administrative procedures for compliance with the law in this respect. This administrative process was established in conjunction with Ms. Weeg, Board staff and the Committee at the time the Dental Hygiene Committee was established.

Ms. Weeg reported that two of the current Dental Hygiene Committee members disagree with her interpretation of the law. The proposal that will be brought before the Board at this meeting is being sent as a recommendation by the Dental Hygiene Committee against the advice of Ms. Weeg. Ms. Weeg stated that, in her legal opinion, the proposed rule change for Iowa Administrative Code 650—Chapter 10 expands the scope of the practice of dental hygiene.

If the Board were to agree with Ms. Weeg on the legal interpretation of Iowa Code section 153.33A, she would advise the Board to put forward a motion to decide whether this should be a treated as recommendation or a suggestion from the Dental Hygiene Committee.

UPDATE RE: EXECUTIVE ORDER 80

MS. Weeg reported that the governor issued this executive order, which addresses the rulemaking process. Agencies have been directed to establish stakeholder groups, which are to be more

directly involved in the rulemaking process. The hope is to make government more efficient and effective. The stakeholder groups would study the matter and report to the Board.

Ms. Weeg stated that, historically, "agency" would refer to a state agency with rulemaking authority. Initially, it was unclear who would have the authority to establish the stakeholders group(s). In conjunction with the governor's office, the Assistant Attorney General, Julie Pottorf, issued a letter clarifying that, for these purposes, the department directors would determine how, when or with whom the stakeholder groups would be established.

SUBSEQUENT EXAMINATIONS & RDH UNDER A PUBLIC HEALTH AGREEMENT
Ms. Weeg indicated that this this agenda item will be discussed later in the meeting.

UPDATE RE: DENTAL LICENSURE EXAMINATION & USE OF PATIENTS IN EXAMS
Ms. Weeg reported that Dean Johnson, University of Iowa College of Dentistry (UIA COD), has expressed some concerns about how patients are selected for clinical examinations. There are some opinions that would suggest that clinical examination patients could be equal to, and therefore, subject to, requirements related to clinical trials. After speaking with CRDTS and the UIA COD, it was determined that patients for clinical examinations *are* different from clinical trial patients, and should, therefore, be treated differently.

REPORT RE: PATIENT REFERRAL RULES & MARKETING PROMOTIONS
Ms. Weeg reported that there has been some ongoing discussion about patient referrals and marketing promotions. Ms. Weeg indicated that the laws in place are older and have not been updated or reviewed recently. Ms. Weeg, stated, however, there have been no recent cases of disciplinary actions against licensees for violations of this nature.

Nationally, this has become a more prevalent topic. Ms. Weeg indicated that this matter may need to be reviewed and discussed further. If it is determined that changes should be made, this may require changes to the Iowa Code. Staff will continue to look at this matter and report back to the Board. In the absence of a problem, it may not be worth devoting resources to.

Dr. Rovner asked about the question of using live patients for clinical examinations. Ms. Weeg stated that since these patients are asked to sign waivers, there should not be a problem.

COMMITTEES

ANESTHESIA CREDENTIALS COMMITTEE REPORT

Dr. Curry reported that Committee met on January 24, 2013 by teleconference. The Committee has recommendations regarding applications for moderate sedation application and request for course approval. A list of the recommendations has been provided to the Board.

Dr. Curry provided an overview of the Committee's recommendations.

- ❖ MOVED by CURRY, SECONDED by BRADLEY, to approve the Committee's recommendations as submitted. Motion APPROVED unanimously.

CONTINUING EDUCATION ADVISORY COMMITTEE

Dr. Curry reported that the Committee met on January 18, 2013 by teleconference. Dr. Curry provided an overview of the Committee recommendations.

- ❖ MOVED by CURRY, SECONDED by BRADLEY, to approve the Committee's recommendations as submitted.

Dr. Rovner questioned the decision for credit as it related to the request for continuing education credit for the DANB course and the recommendation by the Committee. Dr. Curry indicated that the course does not always completely fit the Board's guidelines for credit. Ms. Braness reported that the Committee referred to information from national organizations, including DANB, relating to how credit is awarded within their organizations.

Ms. Slach asked about the expanded functions courses and why they were reviewed by the Continuing Education advisory Committee. Dr. Curry, Ms. Braness and Ms. Kelly reminded the Board that they had requested that the Continuing Education Advisory Committee make an initial review and recommendation concerning approval and possible credit.

- ❖ Motion APPROVED unanimously.

BUDGET REVIEW COMMITTEE REPORT

<u>REVIEW OF QUARTERLY FINANCIAL REPORT; ANNUAL FEE REVIEW RECOMMENDATION</u>

Dr. Curry reported that Budget Review Committee met prior to that meeting of the Board. The Committee will continue to meet and address other items.

Iowa Code section147.80 requires the Board to review their fees annually. The Committee completed the annual fee review. The Committee has determined that the current fees are sufficient to cover Board expenses through June 30, 2013. It was determined that fee increases will not be necessary in FY2013.

Dr. Curry reported, however, that the Committee and the Board may need to look at fee increases in the future as costs and needs change.

- ❖ MOVED by CURRY, SECONDED by MCCULLOUGH, to approve the recommendation of the Committee that current fees are sufficient through June 30, 2013 and fee increases will not be necessary in FY2013. Motion APPROVED unanimously.

Ms. Johnson reported that the Committee did not have time this morning to thoroughly look at the budget information for FY2014. This will be discussed at a later meeting.

EXECUTIVE COMMITTEE REPORT

Dr. Rovner reported that Ms. Kelly and Ms. Weeg attended AADA/AADB the mid-year meetings in October 2012. Dr. Rovner proposed that Ms. Weeg attend the spring meeting. Ms. Weeg indicated that that the Board may be better served by Ms. Johnson attending. Ms. Johnson indicated that she would be open to it, but would need to look at her schedule more closely prior to making a final decision.

Dr. Rovner asked if any of the other Board members were interested in attending. Dr. Curry indicated that he may be able to attend; however, he would need to check his schedule prior to committing to this.

- MOVED by ROVNER, SECONDED by KELLY, to recommend sending Ms. Johnson and Dr. Curry to the mid-year AADA/AADB meetings. Motion APPROVED unanimously.

Dr. Curry provided an overview of the meeting with Delta Dental and Iowa Workforce Development. Dr. Curry provided some information about the kind of information that became available after a similar project was completed about licensed nurses. It appears that this project could yield some very useful data to a number of organizations interested in dentistry.

The decision was made to meet again at a later date. The interested parties will need to make decisions about the information: is it useful, accurate, and pertinent.

Ms. Kelly indicated that the nursing report provides a better overview of the information available. The project would be an ongoing partnership.

Dr. Curry stated that the AMANDA database will be a great way to gather this information and share it more quickly.

WEBSITE

Dr. Rovner indicated that Ms. Johnson proposed putting a list of Frequently Asked Questions (FAQs) on the website. Ms. Johnson stated that the Board may want to look at collecting frequently asked questions, reviewing proposed responses and posting them on the Board's website.

LICENSURE/REGISTRATION COMMITTEE REPORT

- *ACTIONS TAKEN BY COMMITTEE ON APPLICATIONS*

Dr. Rovner reported that the Board was provided with a listing of applications reviewed by the Licensure/Registration Committee for their information. Dr. Rovner indicated that the Board had been provided with a list of actions taken by the Committee regarding applications for licensure, registration and permit.

DENTAL HYGIENE COMMITTEE REPORT
Ms. Kelly reported that the Committee met earlier in the morning prior to the meeting of the Board. The Committee has recommended changing the use of "daycare" to "childcare", to conform to other code references. The Committee has recommended adoption of the proposed changes to IAC 650-Chapter 10 regarding the proposed changes to public health supervision.

Ms. Kelly indicated that there was some discussion about the Dental Hygiene Committee meetings on different dates than the quarterly Board meeting dates to better accommodate scheduling, preparation, and review.

DENTAL ASSISTANT REGISTRATION COMMITTEE REPORT
Dr. Rovner reported that there was nothing to report.

EXAMINATION REPORTS

CRDTS STEERING COMMITTEE
Dr. Bradley reported that there was a meeting of the Steering Committee scheduled in the near future.

CRDTS DENTAL HYGIENE EXAMINATION REVIEW COMMITTEE
Ms. Kelly reported that there was nothing to report.

CRDTS DENTAL EXAMINATION REVIEW COMMITTEE
Dr. Bradley indicated that there was discussion about the examinations for the upcoming year.

AD HOC EXPANDED FUNCTIONS COMMITTEE REPORT
Dr. Kanellis provided an overview of the meetings of the Ad Hoc Expanded Functions Committee to date. Dr. Kanellis reported there are two more meetings of the committee scheduled.

Dr. Kanellis reported that the Committee agreed that there should be an expansion of the list, and that they should be open to dental assistants and dental hygienists. Dr. Kanellis stated that procedures that can be reversed should be considered. The primary concern is developing adequate training for the proposed services.

Dr. Kanellis reported that since sealants are already addressed in Iowa law, the Committee is leaving this issue alone and will not be considering this as part of this discussion.

Dr. Pete Damiano, University of Iowa College of Dentistry, is putting together a survey, which may help the Committee determine what procedures would be most useful to licensees. Dr. Kanellis believed that the survey would go out in the mail to licensees in the very near future.

Dr. Kanellis reported that the Committee will begin to put a list of proposals together which will be brought back to the Board for further consideration.

Dr. Rovner inquired about the upcoming meetings. Dr. Kanellis stated that they are scheduled over the next two months.

Dr. Rovner thanked Dr. Kanellis for his time and service by chairing this Committee.

IOWA PRACTITIONER REVIEW COMMITTEE REPORT

Mr. Sedars provided the Board with updated statistics for the IPRC. There was two (2) self-report. There are currently seven (7) participants. There are two (2) contracts under review; and one (1) participant was discharged from the program.

- Chairman Rovner announced that several items on the agenda would be taken up out of order to accommodate schedules of presenters.

VI. LEGISLATIVE UPDATE

Ms. Johnson stated that Ms. Witkowski, Iowa Board of Pharmacy, was here to provide some information about the legislative proposal regarding the Prescription Monitoring Program (PMP).

Ms. Witkowski reported that she had some updated information regarding the proposal. Rather than go through the full PowerPoint presentation, Ms. Witkowski provided an overview.

Ms. Witkowski provided an overview of the proposal by the Iowa Board of Medicine. An agreement would be created to allow the exchange of PMP between states. This end report would also be available to PMP users. It would help practitioners have more information when treating patients, as well as identifying prescription drug “shoppers”. This information may also allow some type of intervention for those that may be developing a dependency.

Under certain circumstances, practitioners would be required to query the PMP. The specific circumstances and processes addressing required queries would be established by individual licensing boards. Some of the proposed queries may focus on when a practitioner suspects a patient is developing dependency or using prescription drugs inappropriately.

Ms. Witkowski indicated that there has been some reluctance by some about the portion of the proposal, which addresses the inter-state sharing of PMP information. Ms. Witkowski indicated that they will work with this legislature to work out some of these concerns and issues.

Ms. Witkowksi indicated that the PowerPoint provided to the Board has data through the end of 2012.

BOARD OF MEDICINE – LEGISLATIVE INITIATIVES
Ms. Johnson reported that the Iowa Board of Medicine (IBM) has proposed legislation concerning the process by which hearings are handled. The IBM is proposing increasing the maximum civil penalty from $10,000 to $20,000.

- The Board took a brief recess at 1:31 p.m.

- The Board reconvened at 1:45 p.m.

VII. PRESENTATION: PUBLIC HEALTH SUPERVISION

Ms. Johnson introduced Dr. Bobby Russell and Ms. Tracy Rodgers, R.D.H. They are with the Oral Health Bureau of the Iowa Department of Public Health.

Ms. Rodgers provided an overview of some of the IDPH programs. A lot of their funding is from Title V – Maternal Child Health programs. Smaller public health agencies (e.g. county public health departments) and other state agencies, as appropriate, work with the IDPH to implement these services.

The contract agencies assist families in obtaining medical and dental care. In some cases, this may involve transportation and contacting other organizations and agencies.

In the late 1990s, IDPH found that it was more difficult to get children dental care as opposed to medical care. At that time, it was determined that it might be helpful to employ public health hygienists to screen the children initially and refer them to dental offices for further care and treatment. The IDPH found that this increased the access to dental care.

At the time, these services were provided under general supervision. These services, in part, prompted the public health supervision rules. The language in the rules was based, in part, on other states who had similar programs.

There are more dental hygienists working in public health today. Quite a number of them are working in WIC clinics. All public health patients are referred for dental examination and treatment, where appropriate.

Dr. Russell reported that in the last seven years or so, there has been a big push to increase services and access. There are now regulations in place requiring more services than previously existed. The key issue, as Dr. Russell sees it, is getting children into a dental visit, where a dentist is present. Dr. Russell stated that Iowa is nearing the threshold where public health access is matching the private sector. If Iowa can do this, it would be the only state in the nation to do so. Dr. Russell stated that current programs were built on previously-existing programs and local culture.

Dr. Russell provided some clarification about the oversight that IDPH has over dental hygienists, as opposed to regulatory oversight by the Board. IDPH reminds public health hygienists that they must comply with the public health supervision agreements on file. Dr. Russell provided some information to the Board showing the data sets that public health hygienists must report to IDPH as a part of their annual reports required by the public health supervision rules. IDPH provides feedback to the dental hygienists based on the information reported.

The number of Medicaid-registered dentists seem to be fairly level. However, data suggest that these dentists are seeing more patients as a result of the public health supervision referrals. Dr. Russell believes that these programs benefit everyone: dentists, hygienists, and Iowan families.

I-SMILE, through outreach programs, is a catalyst for increased access to care, particularly for those who may not otherwise know how to access these programs.

Dr. Bradley asked Dr. Russell the percentage of dentists who accept Medicaid. Dr. Russell stated that it is not a clear-cut answer. Only a small number of enrolled dentists are accepting new Title XIX patients. Dr. Bradley asked why this may be. Dr. Russell stated that the reasons could vary, but indicated that a large part of this decision may have to do with the current business model with regards to distribution and economic impact. Reimbursement varies depending upon the case. The average is around $0.61 for every dollar in the UCI.

Dr. Fuller stated that data shows that fewer dentists are accepting Title XIX. Dr. Fuller stated that the primary reason has to do with reimbursement since reimbursement levels have been reduced. Dr. Fuller states that this makes it very difficult to fit them into the business model for most dental practices.

Dr. Fuller asked about the follow-up on the referrals. Ms. Rodgers indicated that IDPH does not check on the referrals. Ms. Rodgers reported that is the job of the public health contractors.

Dr. Russell clarified that I-SMILE prioritizes the urgency of the referral; however, the referral is not necessarily with the dentist who signed the public health supervision agreement. Patients are referred to a licensed dentist. The data provided today relates to a specific population, it is not the totality of the data available to IDPH.

Dr. Russell stated that across the board, data tends to be quantitative, *not qualitative*. Dr. Fuller inquired about the data provided. Ms. Rodgers indicated that it is data from 2011. January 31, 2013 is the last day for the public health hygienists to submit their annual report for 2012.

Dr. Fuller asked how often the agreements are updated. Ms. Rodgers is not aware of anything in rule that requires that the agreement be updated. Dr. Fuller asked about what happens if someone passes away. Ms. Rodgers replied by stating that the public health hygienist(s) would need to obtain a new agreement.

Dr. Curry asked Ms. Rodgers about the frequency of agreements being updated. Ms. Rodgers indicated that there is no set guideline for resubmission. The rule simply requires that the dentist and the dental hygienist review the agreement periodically; however, this does not require resubmission. Ms. Rodgers reported that it is not uncommon for agreements to be updated, however.

Dr. Curry indicated that he read through the agreements to get a better understanding of the program. Dr. Curry stated that the hardest thing to grasp was that some dentists had signed multiple agreement with several hygienists. In some cases, Dr. Curry noted that some hygienists may "cover" quite a few schools. Dr. Curry indicated that he thought the program is good, and appears to have improved within the last two years.

Dr. Rovner inquired as to whether it would be better to have a contract with an end-date. Ms. Rodgers' reported that her recollection was that the intent was to give the supervising dentist greater control over the agreements. Ms. Rodgers indicated that they would ensure compliance with whatever regulations the Board sets.

Ms. Weeg stated that she doesn't view these as formal contracts. Ms. Weeg reported that when the rules were drafted that the Board did not want to be overly-involved in the writing of these agreements. It was established consistent with all other aspects of practice in so far as you trust that licensees are complying with regulations until information would suggest otherwise.

Mr. Carl stated that as a representative for the IDA, there are concerns about patients being treated without a dentist not actively being involved. Mr. Carl feels that there are concerns that require further attention. Until such time as a more thorough review can be completed, Mr. Carl feels that the program should not be expanded.

Dr. Curry stated that these programs will not solve all of the problems; however, the data coming from this can be a stepping stone to further accomplishment. Dr. Curry thinks that the program has proven itself and feels that it is a strong program. Dr. Curry agreed that dentists need to be more involved. Dr. Curry agreed that reimbursement levels should increase to give an incentive for more dentists to participate.

Dr. Curry reported that approximately 65% of people with dental insurance actively use it. Not everyone with insurance uses it. Dr. Russell said the IDPH data show an activity rate of 61% for children ages 3-12. Dr. Curry indicated that adjustments should be made to the program; however, he thinks that the program is showing success.

Ms. Kelly stated that the I-SMILE coordinators would probably be willing to meet with anyone with questions. Dr. Russell indicated that they are willing to mediate between the programs and people with problems. Dr. Russell indicated that they cannot intercede unless they are made aware of these problems.

Dr. Curry reported that he has heard complaints that in some cases the 'public health' clinics are seeing paying patients to help cover costs. This sometimes results in people who truly need these services not being seen. Dr. Russell pointed out that most of these clinics are federally-funded. To be eligible for federal funds, they must accept all patients, regardless of ability to pay. There are federal guidelines addressing some of the billing and service issues. Grants pay for portions of the services, the remainder of the revenue must come from elsewhere.

Dr. Russell reported that he has put a lot of work into addressing the reimbursement issue. Unfortunately, due to economic and political changes, his proposals have not moved forward as previously anticipated.

- The Board took a brief recess at 2:55 p.m.
- The Board reconvened at 3:04 p.m.
- Chairman Rovner returned to agenda item V – Administrative Rules/Rule Waivers.

V. ADMINISTRATIVE RULES/ RULES WAIVERS

FINAL ADOPTION

- *Amendments to Chpt. 10, "General Requirements"(ARC #0471C – Notice of Intended Action (NOIA), Adoption of Final Rule Amendments)*

Ms. Johnson provided an overview of the proposed rule amendments. The amendment would add programs affiliated with the Early Childhood Iowa initiative and child care centers, with the exception of in-home daycares. Written comments were provided with the Board materials.

Ms. Johnson reported that the Code editor suggested the use of "childcare" as opposed to "daycare" to conform to other references within the administrative code.

Ms. Slach offered to move for acceptance; however, Dr. Curry wished to discuss this a little further to better understand the proposed changes.

Prior to the vote, Ms. Kelly asked for clarification of the motion. Ms. Braness stated that the motion was made by Ms. Slach, seconded by Ms. Kelly, to accept the amendment with the addition of the proposed changes.

- MOVED by SLACH, SECONDED by KELLY, to adopt the amendment with the changes as noted. Motion APPROVED unanimously.

- *Amendments to Chpt. 11, "Licensure to Practice Dentistry or Dental Hygiene" and Chpt. 15, "Fees" (ARC #0473C – Notice of Intended Action (NOIA), Adoption of Final Rule Amendments)*

Ms. Johnson provided an overview of the changes. The proposed changes were, in part, corrections to incorrect changes made previously. These provisions also extend the joint renewal/new registration issuance to dental assistants.

- ❖ MOVED by DIANE, SECONDED by CURRY, to adopt the amendments as submitted. Motion APPROVED unanimously.

Amendments to Chpt. 35, "Iowa Practitioner Review Committee" (ARC #0472C – Notice of Intended Action (NOIA), Adoption of Final Rule Amendments)

Ms. Johnson provided an overview of the proposed changes. The changes would remove the term limit, Committee appointments would align with Board appointments, and it would change eligibility requirements.

- ❖ MOVED by CURRY, SECONDED by ROVNER, to adopt the amendments as submitted. Motion APPROVED unanimously.

NOTICE OF INTENDED ACTION

- *Proposed Amendments to Chpt. 20, "Dental Assistants" (Proposed rules re: exams, length of validity)*

Ms. Johnson reported these amendments resulted from the Board's recommendations at the October 2012 Board meeting. At that time, the Board directed staff to draft rules amending expanded functions requirements for dental assistants who have dental assistant experience from another state, which does not required registration.

Ms. Johnson reported that the Licensure/Registration Committee chose not to recommend rule changes related to examinations required for registration and reinstatement and will review these cases individually.

- *Proposed Notice of Intended Action to Chpt. 13 "Special Licenses" (Removal of fee for volunteer temporary permit)*

Ms. Johnson reported that this agenda items was proposed at the October 2012 Board meeting. A draft of these proposed changes will be submitted to a future meeting.

- ➢ Agenda Item VI – Legislative Update and Agenda Item VII – Presentation: Public Health Supervision was discussed earlier. The Board moved on to Other Business.

VIII. OTHER BUSINESS

- **REVIEW OF LETTER FROM AMERICAN ACADEMY OF SLEEP MEDICINE (RE: SCOPE OF PRACTICE)**

Ms. Johnson reported that the Board addressed this matter at the October 2012 meeting. Shortly after that meeting, a second letter from the American Academy of Sleep Medicine was received. This was brought back prior to moving forward on the direction from October 2012 Board meeting to review the additional letter.

Ms. Weeg indicated that the Board may choose not to respond to this request.

Dr. Curry believes that this is becoming a more relevant issue in that some people want to treat sleep apnea; however, there is a point at which this would be outside the scope of dentistry. Dr. Curry believes that the patient would need to be seen by a medical doctor prior to providing any services. The work would be in conjunction with a medical doctor.

Ms. Weeg is reluctant to respond to this in case the response could be used for a purpose other than what the Board intended.

❖ MOVED by ROVNER, SECONDED by FULLER, to send a letter acknowledging receipt of the letter and thank them for the information. Motion APPROVED unanimously.

- **UPDATE RE: DENTAL ASSISTANT TRAINEES AND TRAINEE STATUS EXPIRATION DATE EXTENSIONS**

Ms. Johnson indicated that this is the quarterly update on extensions granted to dental assistant trainees. There are no changes from October 2012.

IX. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS

- **RATIFICATION OF ACTIONS TAKEN BY EXECUTIVE DIRECTOR SINCE LAST MEETING ON APPLICATIONS**

Ms. Johnson reported that the Board was provided a list of licenses, registrations, and permits issued since the last meeting.

❖ MOVED by BRADLEY, SECONDED by MCCULLOUGH, to ratify the actions taken on licenses, registrations and permits. Motion APPROVED unanimously.

- **PENDING LICENSURE/REGISTRATION APPLICATIONS**

▪ *April Strong – Application for Dental Assistant Registration and Radiography Qualification*

Dr. Rovner provided an overview of this case. The Committee is recommending issuance of a stipulated registration.

❖ MOVED by KELLY, SECONDED by BRADLEY, to approve the Committee's recommendation for a stipulated registration. Motion APPROVED unanimously.

▪ *Jessica M. Koster, R.D.H. – Application for Dental Hygiene License*

This agenda item was discussed in closed session.

- *Tracy A. Lawler – Application for Dental Assistant Registration and Reinstatement of Radiography Qualification*

This agenda item was discussed in closed session.

X. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Chairman Rovner allowed time for public comment.

Mr. Carl would suggest that the Board take a greater role in the oversight and regulation of public health supervision agreements.

Ms. Brown asked that the Board remember that these agreements are signed by Iowa-licensed dentists and should be treated much like other levels of supervision.

Ms. Brown thanked the Board members for their time and service.

CLOSED SESSION

❖ MOVED by MEIER, SECONDED by BRADLEY, to go into closed session pursuant to Iowa Code Section 21.5(1)(d) to discuss and review complaints and investigative reports which are required by state law to be kept confidential.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Yes	x	x	x	x	x	x	x	x	x
No									

Motion APPROVED by ROLL CALL

- ➢ The Board went into closed session at 3:23 p.m.
- ➢ The Board reconvened in open session on Friday, February 1 at 11:40 a.m.

XI. OPEN SESSION

OPEN SESSION ACTION ON CLOSED SESSION AGENDA ITEMS

❖ MOVED by KELLY, SECONDED by MEIER, to keep the following cases open:

#12-102
#12-126
#11-106
#12-059
#12-091
#12-159
#12-136
#12-173
#12-140
#12-141
#12-177
#12-178
#12-175
#06-055
#06-069
#06-075
#06-094
#06-095
#06-102
#12-135
#13-013

Motion APPROVED unanimously.

❖ MOVED by MEIER, SECONDED by ELMITT, to close the following cases:

#10-057
#11-056
#11-115
#12-124
#12-134
#12-137
#12-118
#12-154
#12-151
#12-149
#12-133
#12-138
#12-143
#12-148
#12-146
#12-161
#12-171
#12-163
#12-169
#12-170
#12-164
#12-167
#12-160
#12-166
#12-150
#12-165
#12-168
#12-162
#12-042
#12-182
#12-176
#12-179
#13-003
#13-002
#12-061
#09-211
#12-046
#12-070
#12-071
#12-072
#12-073
#12-112
#12-158
#13-012

Motion APPROVED unanimously.

- *In the Matter of Erna M. McSwain, D.A.(#12-007)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by MEIER, to approve the proposed Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									
Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Robert A. Benson, D.D.S. (#11-156)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by MEIER, to approve the proposed Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									
Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Marion J. Blount, D.D.S. (#12-044)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by MEIER, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									
Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Amanda M. Smithart, D.A. (#12-045)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by MEIER, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									
Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Scott B. Clemons, D.D.S. (#12-060)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by MEIER, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									
Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Robert S. Bates, D.D.S. (#11-214)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by MEIER, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									

Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Steven C. Fuller, D.D.S. (#12-017)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by MEIER, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									
Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Jay R. Buckley, D.D.S.(#12-104)*

Dr. Rovner disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by ELMITT, to approve the proposed Notice of Hearing and Statement of Charges regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x	x	x		x	x	x		x
Nay									
Abstain								x	
Absent				x					

Motion APPROVED by ROLL CALL.

- *In the Matter of Justin E. Hillock, D.D.S.(#09-136)(#09-137)*

❖ MOVED by KELLY, SECONDED by ELMITT, to grant this licensee's request to discontinue the requirement that female patients complete satisfaction surveys. Motion APPROVED unanimously.

- *In the Matter of Gary L. Jacobsen, D.D.S. (#08-120)*

Dr. Curry disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by ELMITT, to grant this licensee's request for early termination of his probation.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye	x		x		x	x	x	x	x
Nay									
Abstain		x							
Absent				x					

Motion APPROVED by ROLL CALL.

▪ *In the Matter of Dennis J. Schuller, D.D.S. (#09-151)*

❖ MOVED by KELLY, SECONDED by ELMITT, to modify this licensee's Board Order to allow him to take benzodiazepines as long as he is being monitored by his psychologist and allow him to utilize a Board approved practice monitor to review his patient records for compliance. Motion APPROVED unanimously.

▪ *In the Matter of Sara J. Lambert, R.D.H.(#12-132)*

❖ MOVED by SLACH, SECONDED by MEIER, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter and approve the local anesthesia course this licensee submitted for Board approval. Motion APPROVED unanimously.

NEXT MEETING OF THE BOARD

The next meeting of the Board is scheduled for May 9-10, 2013, in Des Moines, Iowa.

ADJOURNMENT

Chairman Rovner adjourned the meeting at 11:50 a.m. on February 1, 2013.

Respectfully submitted,

Melanie Johnson, J.D.
Executive Director

MJ/cb

MJ edits 4/24/13

IOWA DENTAL BOARD
- TELEPHONIC MEETING -

OPEN SESSION MINUTES
February 11, 2012
Origination from IDB Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members	**February 11, 2013**
Michael J. Rovner, D.D.S., Chairperson	Present
Lynn D. Curry, D.D.S., Vice Chairperson	Present
Steven P. Bradley, R.D.H., Secretary	Present
Steven C. Fuller, D.D.S.	Present
Matthew J. McCullough, D.D.S.	Present
Mary C. Kelly, R.D.H.	Present
Nancy A. Slach, R.D.H.	Present
Diane Meier, Public Member	Present
Lori Elmitt, Public Member	Present

Staff Members
Melanie Johnson, Christel Braness, Phil McCollum, Brian Sedars, Janet Arjes

Attorney General's Office
Theresa Weeg, Assistant Attorney General

Other Attendees
Lori Brown, Des Moines Area Community College
Larry Carl, Iowa Dental Association
Tom Cope, Iowa Dental Hygienists' Association
Ed Schooley, D.D.S., Delta Dental of Iowa
Tracy Rodgers, R.D.H., Iowa Department of Public Health

I. CALL TO ORDER FOR FEBRUARY 11, 2013

Chairman Rovner called the open session meeting of the Iowa Dental Board to order at 12:11 p.m. on Monday, February 11, 2013. A quorum was established with all members present.

ROLL CALL:

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Slach	Rovner
Present	x	x	x	x	x	x	x	x	x
Absent									

II. 1ST OPPORTUNITY FOR PUBLIC COMMENT

Chairman Rovner allowed time for public comment.

No comments were received.

III. ADMINISTRATIVE RULES/ RULES WAIVERS

FINAL ADOPTION

- *Re-vote: Amendments to Chpt. 10, "General Requirements"(ARC #0471C – Notice of Intended Action (NOIA), Adoption of Final Rule Amendments*

Dr. Rovner reported that this matter is being revisited as there was confusion, on the part of some of the Board members, at the time of the original vote at the January 31, 2013 Board meeting about what the motion was.

Ms. Johnson and Ms. Weeg recommended addressing the two issues separately so as to avoid any further confusion on the matter.

Ms. Slach stated that she believed that the motion was clear. Ms. Slach stated that the recommendation from the Dental Hygiene Committee clearly included both the change in language as well as adoption of the amendment.

Board staff indicated that given the confusion for some of the Board members on the prior vote, it would be best to address the change in language and the question of adopting the proposed amendment as separate motions.

- MOVED by KELLY, SECONDED by SLACH, to change the language from "daycare" to "childcare".

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Slach	Rovner
Yes	x	x	x	x	x	x	x	x	x
No									
Absent									

Motion APPROVED by ROLL CALL.

- MOVED by KELLY, SECONDED by SLACH, to adopt the proposed rule amendment to also include the change in language from "daycare" to "childcare" as approved by the Board in the previous motion.

The Board members discussed the motion.

Dr. Fuller stated that he was not opposed to extending this provision. However, his biggest reservations deal with how the public health supervision program is run. Dr. Fuller expressed his concerns with the regulation and oversight of the current agreements. Dr. Fuller stated that he was aware of a case where a public health agreement existed with a dentist who was deceased.

Ms. Kelly reported that in the case of the deceased dentist, the dental hygienist entered into a new agreement with another licensed dentist.

Dr. Bradley expressed his agreement with Dr. Fuller's comments concerning the oversight of the agreements. Dr. Bradley is concerned about the fact that there are no expiration dates on any of the agreements.

Dr. Rovner stated that he served on the Board at the time when the Board voted on the amendment that ultimately removed the requirement of an examination by a dentist within 12 months for dental hygiene services to continue under these agreements. The rule change allowed the supervising dentist to set the time frame for a required examination for hygiene services to continue under these agreements. Dr. Rovner indicated that he might vote differently now that he better understands the program.

Dr. Bradley asked if the current rule amendment could be changed to include a 12-month limitation.

In response to Dr. Bradley's proposal, Ms. Weeg advised the Board that they cannot make that kind of substantive change to the proposed rule amendment at this time. The Board members, however, can propose rulemaking in the future if they feel that the rule needs to be addressed.

Dr. Rovner asked to clarify whether the Board could address the issue pertaining to the examination timelines. Ms. Weeg clarified that the Board could address this through the standard rulemaking process.

Ms. Slach asked if the Dental Hygiene Committee should review the agreements and see if there are any other changes that should be addressed. Ms. Weeg stated that this would be appropriate if the committee members chose to do so.

Dr. Bradley expressed concerns about being outvoted on the Dental Hygiene Committee. Ms. Kelly ensured that the discussion would be an open one.

Dr. Curry stated that the Board should look at the issue of advanced access to care for the elderly in nursing homes. Dr. Curry reported that many of these patients are seen under these agreements. Ms. Slach agreed.

Chairman Rovner called for a roll call vote.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Slach	Rovner
Yes		x	x		x	x	x	x	
No	x			x					
Abstain									x

Motion APPROVED, 6 in favor, 2 opposed and 1 abstention.

- MOVED by ROVNER, seconded by KELLY, to solicit information from interested parties for ideas on the future oversight of the public health supervision program for inclusion on the agenda of the next meeting of the Board.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Slach	Rovner
Yes	x	x	x	x	x	x	x	x	x
No									

Motion APPROVED by ROLL CALL.

IV. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Chairman Rovner allowed time for public comment.

No comments were received.

V. CLOSED SESSION

- MOVED by BRADLEY, SECONDED by ROVNER, to go into closed session pursuant to Iowa Code Section 21.5(1)(d) to discuss and review complaints and investigative reports which are required by state law to be kept confidential.

  - 12:29 pm Ms. Meier left the call.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Yes	x	x	x	x	x	x		x	x
No									
Absent							x		

Motion APPROVED by ROLL CALL.

- The Board went into closed session at 12:30 p.m.

VI. RETURN TO OPEN SESSION

- The Board returned to open session at 12:31 p.m.

VII. OPEN SESSION ACTION ON CLOSED SESSION AGENDA ITEMS

- *In the Matter of Lance P. Forbes, D.D.S. (#12-059, #12-091)*

  - MOVED by BRADLEY, SECONDED by FULLER, to approve the Notice of Hearing, Statement of Charges and Emergency Adjudicate Order as drafted.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Slach	Rovner
Yes	x	x	x	x	x	x		x	x
No									
Absent							x		

Motion APPROVED by ROLL CALL.

ADJOURNMENT

- MOVED by BRADLEY, SECONDED by MCCOLLOUGH to adjourn. Motion APPROVED unanimously.

Chairman Rovner adjourned the meeting at 12:33 p.m. on February 11, 2013.

NEXT MEETING OF THE BOARD

The next meeting of the Board is scheduled for May 9-10, 2013, in Des Moines, Iowa.

Respectfully submitted,

Melanie Johnson, J.D.
Executive Director

MJ/cb

Dental Board Financial Report (As of March 31, 2013)

	REVENUES	FY13 Estimated Budget Revised 02.07.13	FY13 Actual as of 03.31.13	FY13 % Spent (Actual/Budget)
	Prior FY Carryover of fees	300,644.61	300,644.61	100%
204	Intra-State Transfers	95,520.00	-	0%
401	Licensing Fees (new and renewal)(0521,0529,0530)	767,797.39	706,934.00	92%
401	§8.2 reimbursement receipts (0512,0570,0578)	72,500.00	54,041.18	75%
	Revenue Total	**1,236,462.00**	**1,061,619.79**	86%
Class	**EXPENDITURES**			
101	Personnel	626,540.00	432,673.47	69%
202	In-State Travel	9,500.00	6,353.58	67%
203	State Vehicle Operation	2,500.00	1,427.81	57%
204	State Vehicle Depreciation	2,160.00	-	0%
205	Out-of-State Travel	6,000.00	1,543.45	0%
301	Office Supplies	8,000.00	6,906.30	86%
309	Printing and Binding	10,000.00	7,813.52	78%
313	Postage	9,500.00	5,243.12	55%
401	Communications	12,250.00	6,619.19	54%
402	Rentals	50,200.00	41,504.52	83%
405	Professional & Scientific Services	4,000.00	1,282.62	32%
406	Outside Services	13,750.00	18,592.53	135%
407	Intra-State Transfers	2,500.00	981.00	39%
409	Outside Repairs	1,000.00	-	0%
411	Attorney General Reimbursement	-	-	0%
412	Auditor of State Reimburseement	-	-	0%
414	Reimbursement to other Agencies	21,000.00	12,680.59	60%
416	ITD Reimbursements	23,310.00	11,280.71	48%
432	Gov Transfer Attorney General	20,500.00	15,161.96	74%
433	Gov Transfer Auditor of State	2,000.00	418.27	21%
434	Gov Transfer Other Agencies	3,100.00	215.12	0%
501	Equipment/Non-Inventory	17,000.00	19,490.60	115%
502	Office Equipment	500.00	-	0%
503	Equipment/Non-Inventory	50.00	-	0%
510	IT Equipment	196,446.00	25,255.15	13%
601	Claims	-	-	0%
602	Other Expenses & Obligations	123,656.00	-	0%
701	Licenses	-	-	0%
705	Refund	-	-	0%
	Expenditure Total	**1,165,462.00**	**615,443.51**	53%

RECAP	FY13 Budget	FY13 TO DATE	FY13 %
Total Revenue	**1,236,462.00**	**1,061,619.79**	86%
Total Expenditures	**1,165,462.00**	**615,443.51**	53%
Balance	**71,000.00**	**446,176.28**	
Approp Close Out &/or Appeal Boards		**-**	
Estimated Carry Forward to next Fiscal Year	**71,000.00**	**446,176.28**	

REPORT TO THE IOWA DENTAL BOARD

FYI ONLY

DATE OF MEETING: May 9-10, 2013

RE: **Quarterly Report on IPRC Activities**

SUBMITTED BY: Brian Sedars, Health Professions Investigator

ACTION REQUESTED: None.

The Iowa Practitioner Review Committee evaluates, assists, and monitors the recovery, rehabilitation, or maintenance of dentists, hygienists, or assistants who self-report impairments. As necessary, the Committee notifies the Board in the event of noncompliance with contract provisions.

The IPRC is both an advocate for the health of a practitioner and a means to protect the health and safety of the public.

The Board's administrative rules require the Committee to submit a quarterly report to the Board on the activities of the IPRC. Below is the quarterly report.

Iowa Dental Board

Iowa Practitioner Review Committee

Current Numbers (as of 1/17/13)	2013 Totals
Self Reports	4
Current Participants	8
Contracts under Review	1
Discharged Participants	1

REPORT TO THE IOWA DENTAL BOARD

FYI ONLY

DATE OF MEETING: May 9, 2013

RE: **List of Registrations Issued Based on Approved Extensions**

SUBMITTED BY: Melanie Johnson, Executive Director

ACTION REQUESTED: None

At the **May 18, 2012** telephonic Board meeting the Board adopted a process for handling future requests for registration in which there is evidence that the applicant believed he/she had been granted an extension of the Trainee Status Expiration Date.

The Board voted to grant authority to issue dental assistant registrations after review by Board staff, the executive director, and the Board's Assistant Attorney(s) General. The Board office was directed to maintain a listing of all applications that have been issued under these circumstances and provide the list to the Board at each regularly scheduled meeting until such time there are no longer any applications involving extensions.

No new applications that involve an extension of the Trainee Status Expiration Date have been processed since the January 31, 2013 Report to the Board. Attached for review is the list of applications that involved extensions.

DENTAL ASSISTANT APPLICATIONS & EXTENSIONS

AS OF: March 18, 2013

No additional applications & extensions since the January 31, 2013 report at the quarterly Board meeting.

Board action at 4/24-4/25, 2012 meeting:

1. Nicole McGhghy	Application for registration & radiography qualification	Board approved issuance
2. Ashley Backes	Application for registration & radiography qualification	Board approved issuance
3. Katherine Callan	Application for registration & radiography qualification	Board approved issuance
4. Martha Miller	Request for extension of trainee status expiration date	Board denied request; applicant can start over as a trainee
5. Alisha Linville	Request for extension of trainee status expiration date	Board denied request; applicant can start over as a trainee

Action after review by Executive Director, IDB staff, Asst. Attorney General:

6. Hillary Dalton	Application for registration	Issuance approved on 5/4/12

REPORT TO THE IOWA DENTAL BOARD

ACTION

DATE OF MEETING: May 9-10, 2013

RE: **Frequently Asked Question (FAQs)**

SUBMITTED BY: Melanie Johnson, Executive Director

ACTION REQUESTED: Review of FAQs and Proposed Answers

FAQs for IDB Website

The Board office receives questions on a regular basis from licensees, registrants, permit holders and members of the public about the Board, its rules and procedures. We would like to use the Board's recently updated website as a means to share answers to commonly asked questions.

Background

Attached for your review and consideration are FAQs and responses. At the March 28, 2013 telephonic meeting of the Dental Hygiene Committee, members requested that action on the draft FAQS involving dental hygiene be postponed until the May 9-10, 2013 quarterly meeting. At the March 28, 2013 telephonic Board meeting, members did not have sufficient time to review and discuss each of the FAQS. The Board voted to approve the first four FAQs and postpone action on the rest until the May 9-10, 2013 quarterly meeting.

Questions and responses that are still undergoing legal, policy, Board or Committee review have been identified and marked as "Review of Answer Pending."

Reconsideration of One Previously Approved FAQ

One FAQ approved by the Board at the March 28, 2013 meeting needs to be reconsidered due to important information received after the meeting. It is the FAQ that deals with whether or not oral maxillofacial surgeons are allowed to perform pre-surgical history and physicals. The Board office has received information concerning this topic from:

- Dr. John Frank, D.D.S., President of the Iowa Society of Oral and Maxillofacial Surgeons
- The American Association of Oral and Maxillofacial Surgeons (AAOMS)
- Dr. Jonathan DeJong, D.D.S., Ft. Dodge Oral and Maxillofacial Surgery
- Dr. Steven Fletcher, D.D.S., Asst. Professor, Graduate Program Director, OMFS, U.I.

Attached for Review

- Draft FAQs
- 4/1/13 Email from Dr. Jonathan DeJong, D.D.S.
- 4/4/13 Email from AAOMS
- 4/12/13 Letter from Dr. Steven Fletcher, D.D.S.

FAQs – Revised Draft 4/18/13

IOWA DENTAL BOARD

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About the Board

The Iowa Dental Board is a state agency charged with the overall responsibility for regulating the professions of dentistry, dental hygiene, and dental assisting in the state of Iowa.

The Board consists of nine members appointed by the Governor, and confirmed by the Iowa Senate, to serve three-year terms. Five members are licensed dentists, two members are licensed dental hygienists, and two members represent the public.

Our Mission

The Board's mission is to ensure that all Iowans receive professional, competent, and safe dental health care of the highest quality. In pursuit of this mission, the Iowa Dental Board performs these primary functions:

- Administers examinations for the testing of dentists, dental hygienists and dental assistants;
- Issues licenses, registrations, and permits to qualified practitioners;
- Sets standards for license, registration, and permit renewal and continuing education;
- Enforces Iowa laws, which regulate the practice of dentistry, dental hygiene and dental assisting and investigates complaints concerning violations of the dental practice act and Board rules;
- Conducts disciplinary hearings and actively monitors the compliance of licensees with Board orders; and
- Adopts rules and establishes standards for practitioners pursuant to its authority under Iowa Code.

Learn about the Iowa Dental Board and read about the Board's recent and future activity:

- Board Overview
- Board Members & Staff
- Agendas & Minutes
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FAQS

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Medicaid Patients Answer approved by Board at 3/28/13 mtg.

Q: I feel that seeing Medicaid patients is very important so I would like to continue doing so. However, I would like to be able to limit the amount of Medicaid patients I see and focus down to what I see as "core groups" of Medicaid patients. For example, accepting all children on Medicaid, but only accept "selected" individuals over 18 years of age (referrals from existing patients within the practice, referrals from select organizations that I have relationships with, etc.). I have talked with multiple other dentists regarding this issue and I keep getting different answers. It is getting to the point where I cannot accept all Medicaid patients but would only like to see children and select adults.

A: The Dental Board's administrative rules do not address your questions. Your questions require someone with Medicaid expertise. We contacted Iowa Medicaid Enterprise (IME) for answers to the specific questions you posed. IME's Policy Specialist indicated that the Attorney General's office advised on your questions as follows:

> "The law generally allows or even provides for "discrimination" in favor of children in all kinds of ways—free schooling, limited exposure to the criminal justice system, requirements that their parents keep a roof over their heads and food in their mouths, etc.—they get all the breaks. So I'd say that everything the dentist proposes is permissible."

Recordkeeping Answer approved by Board at 3/28/13 mtg.

Q: We have a question about orthodontic models and record keeping requirements. We have an abundance of Ortho boxes filled with patient models from impression casts. We are running out of space in our basement to put more recent models. Some of our models are 7 years old or more. My question is how long do we need to keep these? And how do we go about destroying them? Each model is labeled with patient's name, date they were in, and patient number.

A: The Board has always interpreted that models are part of the patient record, which means that they are required to be retained for either 6 years or until a minor reaches age 19, whichever is longer. When the Board reviews cases, we regularly ask for the models as part of the review. In regards to the disposal question, it should be done in a manner that protects the confidentiality of the patient's information. Some offices remove all identifying information and then destroy them.

Oral Maxillofacial Surgeons ~~Answer approved by Board at 3/28/13 mtg.,~~

**Requesting additional Board review at May 9-10, 2013 mtg. due to new information **

Q: Could you please advise if the State of Iowa allows Oral Maxillofacial Surgeons to perform Pre-surgical History & Physicals? Is yes, where in the Iowa Code is this addressed?

A: Pre surgical screenings (oral) for surgeries they are conducting would be fine, but they could not provide a physical, as it is not "incident or common to the practice of dentistry. (See Iowa Code 153.13)

Disaster-Related Events Answer approved by Board at 3/28/13 mtg.

Q: You wanted to know under what authority dentists licensed in other states, but unlicensed in Iowa, are permitted to assist here in Iowa during a disaster-related event. The short answer is that Iowa is a party to an Emergency Management Assistance Compact (EMAC) that has a provision which allows Iowa to request the assistance of health care or other licensed professionals from other states. Under the terms of the EMAC these individuals are deemed licensed in Iowa to render such assistance for the duration of a disaster.

A: Below is an excerpt from some guidance this office has previously received on the subject from the Attorney General's Office:

> "As many of you know, Iowa is a member of the Emergency Management Assistance Compact (EMAC), which is contained at Iowa Code section 29C.21. All of the states are now parties to this agreement. EMAC contains the following provision related to licensure:
>
> > Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting such assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise. (Article V)
>
> In practical terms, this means the state of Iowa can request the assistance of health care or other licensed professionals (such as engineers or plumbers) from other states and such persons will be deemed licensed in Iowa to render such assistance during the duration of the disaster. The request must come through the State Emergency Operations Center (SEOC). SEOC has procedures in place for communities to make requests and to facilitate the deployment of these resources to affected communities. This process must be utilized for the "deemed licensed" provision to apply. (There are also liability protections and reimbursement provisions in EMAC which also require formal state request and approval to attach)."

- Link to Iowa Homeland Security re: the Emergency Management Assistance Compact (EMAC): www.iowahomelandsecurity.org/ProgramsIMAC_EMAC.html

Scope of Practice – Dental Hygienist

REVIEW OF ANSWER PENDING

Q: Can a RDH perform dental assistant duties?

A: Yes, a RDH can do everything a RDA can do except perform RDA "expanded functions" duties, as defined in Board rule 650--20.15.

REVIEW OF ANSWER PENDING

Q: What is the scope of practice of an Iowa-licensed RDH?

A: The "practice of dental hygiene" as defined in Iowa Code 153.15 means the performance of the following *educational, therapeutic, preventive, and diagnostic* dental hygiene procedures which are delegated by and under the supervision of a licensed Iowa dentist. These services are performed under the general, direct or public health supervision of a dentist. Board rules, 650—Chapter 10, further define the scope of practice for an Iowa licensed dental hygienist.

General supervision

REVIEW OF ANSWER PENDING

Q: What are the requirements for a RDH working under "general supervision"?

A: For a RDH to work under the "general supervision" of a dentist, both of the following requirements must be met: (1) The patient must be examined by a dentist, and
(2) Be a patient of record for that dentist.

Therefore, "general supervision" most often applies to work environments where a RDH is working in the same place as the supervising dentist (e.g., private practice dental office, nursing home where the dentist and RDH travel together to provide services). "General supervision of a dental hygienist" is defined in Board rule.

REVIEW OF ANSWER PENDING

Q: Can a RDH work under the "general supervision" of a dentist and provide services to individuals in a nursing home?

A: Yes, provided each of the following requirements are met:
(1) Patient must be examined by a dentist, and
(2) The individual must be a patient of record for that dentist.

If a RDH travels with a dentist to a nursing home where the dentist provides services then the RDH can provide services to those individuals. A RDH cannot independently provide services; only those services allowed under the "general supervision" of a dentist. Under Board rules "general supervision of a dental hygienist" means that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided.

REVIEW OF ANSWER PENDING

Q: What level of supervision is required for a RDH?

A: The authorized practice of dental hygiene as defined in Iowa law means the performance of: (1) educational, (2) therapeutic, (3) preventive, and (4) diagnostic dental hygiene procedures which are delegated by and under the supervision of a licensed dentist. The level of required supervision varies depending on the type of services performed. Supervision levels are: *Direct, General, Personal and Public Health*.

- *General – All.* For a hygienist to provide all possible services (educational, therapeutic, preventive, and diagnostic) under **"general supervision**," the patient must be examined by a dentist, be a patient of record for that dentist and the services to be performed must be prescribed by the dentist.

- *General – Some*. Board rules also specifically spell out that hygienists can perform some functions under the "**general supervision"** of a dentist, even if the patient has not been examined by the dentist. These services are limited to: educational, assessments, screenings, and data collection for the evaluation by a licensed dentist. This rule does NOT list therapeutic or preventive.

- *Direct or PHS.* Board rules then state that all other authorized services (referring to therapeutic (e.g., prophys), or preventive (e.g.sealants)) to new patients shall be provided under the "**direct supervision"** or "**public health supervision"** and it requires that an exam be completed during the initial visit by a new patient, except under PH supervision.

REVIEW OF ANSWER PENDING

Q: Can dental hygienists provide services in a medical office or wellness center?

A: Yes, a RDH can work at a medical center or wellness center, but only if he/she is under the general supervision of a dentist OR has a public health supervision agreement. (*See Iowa Code Section 153.15; 650 Iowa Administrative Code 10.3-10.5.*)

Public health supervision

REVIEW OF ANSWER PENDING

Q: Under a public health supervision agreement, after the initial examination by a dentist, how much time can elapse before another examination by a dentist is required before additional dental hygiene services can be provided?

Example:

- DDS performs initial examination of a patient. RDH provides therapeutic services based on DDS's diagnosis (e.g., professional cleaning of teeth (*prophylaxis* or "*prophy"* for short*)*. RDH also provides patient with "educational services, assessments, screenings and fluoride if specified in the supervision agreement," as allowed by Board rule xx.
- Subsequent visit by patient 6 months later – RDH performs another prophy; no DDS examination.
- Subsequent visit by patient 1 year later – RDH performs another prophy; no DDS examination. Subsequent visit by patient 2 years later – RDH performs another prophy; no DDS examination.

The first prophy performed by the RDH is based on the DDS's diagnosis after the initial examination. What about the subsequent visits? Is this allowable or must a DDS examination occur at the 6 month, 1 year and 2 year visits prior to the dental hygienist "providing further hygiene services" (i.e., the prophies in this example) [see Board rule 10.5(3)"a"(3)]?

A: Answer, Option 1

No examination is required at the 6 month, 1 year or 2 year visits if the terms of the public health supervision agreement allow that period of time before another examination by the supervising dentist must occur. Current Board rules do not establish a maximum amount of time before another examination by a dentist is required. The rules were amended in 2009 to rescind the 12 month requirement for a subsequent examination. In lieu of establishing a set time, current Board rules require that time period to be included in the PHS agreement between a RDH and the supervising DDS.

Answer, Option 2

Yes, an examination by a dentist must occur at the 6 month, 1 year or 2 year visits before the dental hygienist can perform "further hygiene services." In the example above, the RDH cannot legally provide additional hygiene services (i.e. prophies) without a subsequent examination by a DDS.

Board subrule 10.3(3) states that a RDH may provide *"educational, assessment, screening, or data collection for the preparation of preliminary written records for evaluation by a dentist."* The same subrule indicates that *"a dentist is not required to examine a patient prior to the provision of these dental hygiene services."* This subrule does NOT list "therapeutic," "preventative," or "diagnostic" services. Each of these categories are part of a RDH's scope of practice [see rule 10.3(1)]. The exclusion of these categories from the list in 10.3(3) means that a dentist would be

required to examine a patient prior to the provision of "further dental hygiene services" [the phrase used in rule xx regarding required terms in a public health supervision agreement].

REVIEW OF ANSWER PENDING

Q: Can a dental assistant work under a "public health supervision agreement"?

A: No, a dental assistant cannot work under "public health supervision." A public health supervision agreement is between a dentist and a dental hygienist. Chapter 20 of the Board's administrative rules states that dental assistants must work under the supervision of a dentist, and defines (3) levels of supervision: Personal, Direct, or General supervision. The Board has not adopted rules to allow dental assistants to work under Public Health Supervision. Further, the rules governing Public Health Supervision are located in Chapter 10 and only make reference to "dentist" and "hygienist".

REVIEW OF ANSWER PENDING

Q: Can a RDH place dental sealants as part of a sealant program in a "public health setting" pursuant to a public health supervision agreement? Or does the placement of sealants by a RDH require the RDH to be under the "general supervision" of a dentist?

A: A RDH cannot apply sealants under "general supervision" unless the patient is a patient of record.
A RDH can apply sealants under "public health supervision."

REVIEW OF ANSWER PENDING

Q: Can a registered dental assistant provide assistance to a registered dental hygienist working under a public health supervision agreement?

A: No, a registered dental assistant cannot assist a RDH working under public health supervision, because they are seeing patients who are not patients of record for their employing dentist.

REVIEW OF ANSWER PENDING

Q: Can a registered dental assistant provide services outside of a dental office? For example, could a dental assistant employed by a radiography company travel around and to mobile x-rays?

A: A dental assistant is required by Board rule 650 IAC 20.13 to work under the supervision of a dentist in a dental office. If the dental assistant in this question is not accompanied by a supervising dentist then the dental assistant would not be permitted to perform these services.

REVIEW OF ANSWER PENDING

Q: Can a dental assistant provide services anywhere a dentist practices or must a dental assistant only provide services in a dental office?

A: A dental assistant can work under the "direct" or "personal" supervision of a dentist anywhere that dentist practices. But under "general supervision," the individual must be a patient of record, and the dental assisting services must be provided in a dental office (or place the dentist practices)

Consumers

REVIEW OF ANSWER PENDING

Q: I would like to know what my patient rights are regarding requesting electronic copies of my digital x-ray from my dentist. Does this fall under HIPPA?

A: If you have not already done so, we would recommend that you call your dentist first to request the records. Board rules require a dentist to furnish dental records upon the request of a patient. If no response, then you could file a complaint with the Board. A complaint form is available on our website {link to complaint form}. If you want additional information, the Iowa Dental Association is another good resource to help. The Iowa State Bar Association (ISBA) would be another option if you need to consult an attorney. The ISBA has a lawyer referral service that offers an initial consultation for a small fee.

Tooth Whitening Services

REVIEW OF ANSWER PENDING

General

Q: I am planning on starting a tooth whitening service. Someone told me that I can't do that unless I'm a dentist. Is that true?

A: Yes. Tooth whitening is considered the practice of dentistry. Under Iowa law, a person is not allowed to practice dentistry without an Iowa dental license. Only dentists who hold a valid Iowa dental license are permitted to provide tooth whitening services in the state. Iowa law provides for criminal penalties for the practicing of dentistry without a license.

REVIEW OF ANSWER PENDING

Teeth Whitening Services at Tanning Salons

Q: I own a tanning salon and I want to sell tooth whitening gel to my customers. Can I do that?

A: Yes, provided the customer is only buying the product and then leaving the salon.

REVIEW OF ANSWER PENDING

Q: What if the customer buys the whitening gel and takes it with them to use while in the tanning bed or elsewhere in the salon? Is that a violation?

A: The selling of the product alone is not the practice of dentistry. It is the selling of the product in conjunction with providing the tanning bed (or any other equipment) that is considered a violation of the part of the law that prohibits individuals from assisting with "any phase of any operation incident to tooth whitening."

REVIEW OF ANSWER PENDING

Q: We don't want anyone to apply the whitening gel wrong so our staff has been told to give the customers some instructions about how to use it properly. Is that okay?

A: No. Providing instructions to customers about how to apply the gel is not allowed under Iowa law.

REVIEW OF ANSWER PENDING

Tooth Whitening at Home and Garden Shows, Fairs, Malls, etc.

Q: I want to set up a tooth whitening booth in our local mall. I plan on selling whitening gel and having my staff apply the gel and the light to the customer's teeth for the whitening process. For extra safety, my staff has been trained in how to apply the gel and use the equipment. Any problems?

A: Yes. Unless the staff person applying the gel and using the light is a dentist with an Iowa dental license, he/she is prohibited from providing the services you described.

- For more information, refer to the Iowa Dental Board's 2008 statement on tooth whitening {add link here}
- Iowa's law re: practice of dentistry, including tooth whitening services. (Iowa Code 153.13)

153.13 "Practice of dentistry" defined.
For the purpose of this subtitle the following classes of persons shall be deemed to be engaged in the practice of dentistry:

1. Persons publicly professing to be dentists, dental surgeons, or skilled in the science of dentistry, or publicly professing to assume the duties incident to the practice of dentistry.

2. Persons who perform examination, diagnosis, treatment, and attempted correction by any medicine, appliance, surgery, or other appropriate method of any disease, condition, disorder, lesion, injury, deformity, or defect of the oral cavity and maxillofacial area, including teeth, gums, jaws, and associated structures and tissue, which methods by education, background experience, and expertise are common to the practice of dentistry.

3. Persons who offer to perform, perform, or assist with any phase of any operation incident to tooth whitening, including the instruction or application of tooth whitening materials or procedures at any geographic location. For purposes of this subsection, *"tooth whitening"* means any process to whiten or lighten the appearance of human teeth by the application of chemicals, whether or not in conjunction with a light source.

About the Board

REVIEW OF ANSWER PENDING

Q: How often and where does the Board meet?

A: The Board holds regular quarterly two day meetings, most often in Des Moines, IA at the Board office. The Board also conducts special meetings telephonically in between the quarterly meetings, as needed.

REVIEW OF ANSWER PENDING

Q: How do I become a Board member?

A: The Dental Board is composed of nine members: 5 dentists, 2 dental hygienists and 2 members of the public. Members are appointed by the governor and confirmed by the Iowa Senate. For more information on how to seek appointment, address your questions to the governor's office at 515-281-0215 or visit their website at {add address}

REVIEW OF ANSWER PENDING

Q: How can I get on the Board's email list to receive meeting notices?

A: Send an email to {add address} you would like to receive agendas for all board meetings via email and free of charge.

REVIEW OF ANSWER PENDING

Q: Where can I get copies of the meeting agendas and materials?

A: Agendas and meeting materials are available on the Board's website. Go to "Agendas & Minutes" to access the information: http://www.state.ia.us/dentalboard/board/meetings/index.html

Enforcement

REVIEW OF ANSWER PENDING

Restitution to patients

Q: I'm wondering if the Board has authority/jurisdiction to order restitution from the dentist to the patient?

A: The answer is "yes" - the Iowa Dental Board does have statutory authority to order restitution to patients. See Iowa Code section 153.33:

> **153.33 Powers of board.**
> Subject to the provisions of this chapter, any provision of this subtitle to the contrary notwithstanding, the board shall exercise the following powers:
> 1. *a*. To initiate investigations of and conduct hearings on all matters or complaints relating to the practice of dentistry, dental hygiene, or dental assisting or pertaining to the enforcement of any provision of this chapter, to provide for mediation of disputes between licensees or registrants and their patients when specifically recommended by the board, to revoke or suspend licenses or registrations, or the renewal thereof, issued under this or any prior chapter, to provide for restitution to patients, and to otherwise discipline licensees and registrants.

Services

[Under development]

Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Monday, April 01, 2013 1:19 PM
To: Johnson, Melanie [IDB]; McCollum, Phil [IDB]
Subject: FW: regarding proposed FAQ to be place on Iowa Dental Board Website

Please see below.

Christel Braness, Program Planner
Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

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From: Jonathan R. DeJong [mailto:facefixer@mchsi.com]
Sent: Monday, April 01, 2013 11:48 AM
To: Iowa Dental Board [IDB]
Cc: info@iowadental.org
Subject: regarding proposed FAQ to be place on Iowa Dental Board Website

To Whom it Concerns:

I am board certified oral and maxillofacial surgeon in Fort Dodge. I reviewed your only question pertaining to OMFS on your proposed FAQ that is to be placed on your website and am extremely concerned about your answer. It appears to me that the Iowa Dental Board's opinion is that an Oral and Maxillofacial Surgeon should not perform a History and Physical examination.

H&Ps are part of OMFS core services and education. I have full admission privileges at the University of Iowa and Trinity Regional Medical Center. Most all oral surgeons are active in hospital settings, and actually to be Board Certified, we have to maintain hospital privileges (which include admission H&P privileges).

Oral and Maxillofacial surgeons routinely perform H&Ps for our patients undergoing osteotomies, infection treatment, dentoalveolar surgery, and trauma. OMFS' routinely manage all aspects of a patient's medical conditions while they are hospitalized. The medical community is well-aware of our abilities to manage inpatients. While I agree that H&Ps are not part of the "general practice of dentistry" they are definitely part of the general practice of oral and maxillofacial surgery.

Please respond at your earliest convenience to this most important matter.

Jonathan R. DeJong, DDS
Fort Dodge Oral and Maxillofacial Surgery

Jonathan R. DeJong, DDS
facefixer@mchsi.com
Cell: 515-408-1657
Office: 515-576-8727

Johnson, Melanie [IDB]

From: Randi Andresen [randresen@aaoms.org]
Sent: Thursday, April 04, 2013 12:01 PM
To: Johnson, Melanie [IDB]
Cc: Mark Adams
Subject: FW: Histories and Physicals
Attachments: Patient Assessment.pdf

Dear Ms. Johnson: Dr. John Frank, President of the Iowa Society of Oral and Maxillofacial Surgeons contacted this office in reference to a proposed FAQ for inclusion on the Iowa Dental Board website relative to oral and maxillofacial surgeons performing a history and physical examination on their patients. The proposed response may have been taken out of context as that essentially describes H/Ps by general dentists. The proposed FAQ response could be detrimental to the patient care provided by oral and maxillofacial surgeons as it is critical that they be able to evaluate their patients before they undergo a medical, surgical, and anesthetic risk of the proposed operative and other procedures. The Joint Commission included specific language when this was approved from 1986 through 1999 which has since been broadened to allow everyone who has the qualifications to perform this. You may wish to change the FAQ to the 1999 JC specific language which still serves as the guideline for OMS in spite of the need to change specific language making all eligible. It is stated as:

> Qualified oral and maxillofacial surgeons* may perform the medical history and physical examination in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s).
>
> *Oral and maxillofacial surgeon, qualified was defined: an individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the US Department of Education. As determined by the medical staff, the individual is also currently competent to perform a complete history and physical examination in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s).
>
> For general dentists, The JC stated in a subsequent standard:
> Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.

The oral and maxillofacial surgeons complete four years of dental school followed with a postgraduate surgical residency of a minimum of four years based in a hospital. Some residencies also offer a medical education which results in a 6-year program. The Standards for Advanced Specialty Education in Oral and Maxillofacial Surgery must be met by residents in both types of programs. As you will note in the linked Standards, http://www.ada.org/sections/educationAndCareers/pdfs/oms.pdf, requires that patient evaluation occurs early in the postgraduate curriculum and that there must be attestation to competence in this area. Often the residents complete this course alongside medical students. This early knowledge and skills of patient assessment can then be applied throughout the four-year residency.

In addition, the American Association of Oral and Maxillofacial Surgeons has had Parameters of Care in place since the process was initiated in 1986. These Parameters of Care serve as guidelines for the oral and maxillofacial surgery practice. A copy of the Patient Assessment chapter of the recently (2012) revised Parameters of Care has been attached for your information.

The Joint Commission which bases its Standards on the CMS states in the Provision of Care, Treatment, and Services Chapter that there are four core components of the care process, the first of which is to assess the patients needs. It is stated:

> The goal of assessment is to determine the care, treatment, and services that will meet the patient's initial and continuing needs. Patient needs must be reassessed throughout the course of care, treatment and services.

Identifying and delivering the right care, treatment, and services depends on the following:

1. Collecting information about the patient's health history as well as physical, functional, and psychosocial status
2. Analyzing the information in order to understand the patient's needs for care, treatment and services.
3. Making care, treatment, and services decisions based on the analysis of information collected.

I hope you concur with this long-standing understanding of the performance of history and physicals and would be willing to change the proposed Iowa Dental Board FAQ to reflect a change in historical and physical examination on patients. It is critical that oral and maxillofacial surgeons who provide moderate sedation, deep sedation and general anesthesia in their offices as well as perform surgery on their patients are able to assess their patients. These clinical components are all included in the oral and maxillofacial surgeon's scope of practice.

The AAOMS forwarded to you the 2012 Parameters of Care when mailed to all state dental licensing boards to assist in understanding the oral and maxillofacial surgery guidelines for practice and their scope of practice. This document includes eleven areas of practice, including various subareas and the diagnostic and therapeutic goals for each area.

Please let me know if you have any questions regarding the information provided. Thank you so much for your consideration.

Randi

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

PATIENT ASSESSMENT

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THIS SECTION IS 1 OF 11 CLINICAL SECTIONS INCLUDED IN *AAOMS, PARCARE 2012,* WHICH IS VIEWED AS A LIVING DOCUMENT APPLICABLE TO THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY. IT WILL BE UPDATED AT DESIGNATED INTERVALS TO REFLECT NEW INFORMATION CONCERNING THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY.

INTRODUCTION

An appropriate preoperative patient assessment is a critical component of an Oral and Maxillofacial Surgery practice. The proper method of obtaining and documenting a patient's medical history and physical examination findings, as well as appropriate diagnostic tests (laboratory and radiologic), is essential to ascertaining an accurate diagnosis and differential diagnosis and developing an effective treatment plan algorithm. In addition, a thorough patient evaluation provides the basis for determining the surgical and anesthetic risk of each patient, minimizing morbidity and complications associated with concomitant systemic conditions, and evaluating the effectiveness of treatment. Several specific comorbid conditions require consideration by the Oral and Maxillofacial Surgeon (OMS).

The OMS has been trained during his/her surgical residency to complete a thorough patient assessment. Therefore, this section will not describe how to perform an assessment but will attempt to organize the assessment process. The assessment process has been divided into five phases: indications for patient assessment, specific goals for patient assessment, specific factors affecting risk for patient assessment, indicated therapeutic parameters for patient assessment, and outcome assessment indices for patient assessment. The patient assessment process described in this section establishes a foundation for patient assessment and management as described in subsequent sections of *ParCare 2012*.

Specific diagnostic techniques and physical assessment protocols are purposely not defined. It is not the intent of this document to dictate the exact methods for performing a patient assessment. The OMS has the latitude to complete a patient assessment based on the clinical circumstances of the patient and/or institutional standards.

PREAMBLE

The OMS is responsible for an initial history and physical evaluation necessary to determine the risk factors associated with management of each patient. In some circumstances, the patient's primary care physician may perform the history and physical examination, but it is the responsibility of the OMS to review such information and ascertain whether it is complete to his/her level of satisfaction or whether further assessment is indicated based on the specific patient and planned procedure.

GENERAL CRITERIA, PARAMETERS, AND CONSIDERATIONS FOR PATIENT ASSESSMENT

INFORMED CONSENT PROCESS: All elective surgery must be preceded by documentation of the patient's or legal guardian's informed consent. The informed consent process occurs when the OMS initiates a discussion with the patient and/or legal guardian and reviews the indications for the procedure(s), goals of treatment, factors that may affect the risk, alternative treatment options, and known risks and complications of the procedure(s). In some cases, videotapes may be used to introduce the informed consent process before a discussion between the OMS and each patient. In life-threatening emergency situations, consent may be deferred, but such clinical circumstances must be documented adequately. Results of the informed consent process, indicating that the patient (and/or his/her guardian) understands all components of the informed consent process and consents to treatment, must be documented in the patient medical record. In general, an informed consent document is signed by the patient or guardian, but the OMS is well advised to document in the medical record that the informed consent process occurred and that the patient/guardian provided both verbal and written consent that they understand and are willing to proceed with treatment. The OMS should consider the use of individualized informed consent forms for specific surgical procedures (eg, cosmetic facial surgery, orthognathic surgery).

PERIOPERATIVE ANTIBIOTIC THERAPY: In certain circumstances, the use of antimicrobial rinses and systemic antibiotics may be indicated to prevent infections related to surgery. The decision to employ prophylactic perioperative antibiotics is at the discretion of the treating surgeon and should be based on the patient's clinical condition as well as other comorbidities which may be present.

DOCUMENTATION: The *AAOMS ParCare 2012* includes documentation of objective findings, diagnoses, and patient management interventions. If the patient refuses a portion of a history or physical examination, the OMS should document that the examination was not performed and state the reasons for the omissions. *The final judgment regarding the appropriateness of any specific diagnostic method or adjunctive test or the need for medical consultation must be made by the individual OMS according to circumstances presented by each patient. Understandably, there may be sound clinical reason to deviate from these parameters. When an OMS chooses to deviate from an applicable parameter based on specific circumstances, he/she is well advised to enter a note in the patient's record stating the reason for the*

course of action. Moreover, it should be understood that adherence to the parameters does not guarantee a favorable outcome.

Documentation in a patient's medical record contains critical information and is governed by Health Insurance Portability and Accountability Act regulations. The OMS is responsible for ensuring that all information contained in the medical record is complete. Any errors should be deleted with a single line accompanied by the initials of the OMS with the date of the deletion. Any additions or deletions to the medical record must be made clearly and dated to ensure accuracy. Changes to the medical record are subject to medicolegal scrutiny and, therefore, should be made cautiously and carefully, with great attention to detail. It is advisable never to alter the medical record; an additional note with a more recent date is preferable.

The use of templates (eg, "cookie-cutter") should be discouraged because each patient should be treated as an individual. A note or dictation from the OMS for that patient should be included for each specific date of service. If templates are used to document patient care, the OMS should ensure the accuracy of each entry for the individual patient.

In instances when another health care provider assesses the patient preoperatively, such as a primary care physician, cardiologist, or pediatrician, the OMS must ensure that the documented assessment meets the parameters set forth in the *AAOMS ParCare 2012*. Additionally, the OMS is responsible for the risk assessment of the patient and, ultimately, the decision to perform the surgical procedure. No other provider may assume this responsibility.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PHYSICAL STATUS CLASSIFICATION SYSTEM: On the basis of a thorough patient assessment, an ASA physical status should be assigned to all surgical patients according to the most recent guidelines set forth by the ASA (*Appendix 1*).

PREOPERATIVE FASTING GUIDELINES: All healthy patients without a risk of gastroparesis who will undergo a sedation or general anesthetic procedure should maintain a "nothing per mouth" (NPO) status (*Appendix 2*). The ASA recommends a 2-hour fasting period of clear liquids for all patients. The ASA recommends a fasting period for breast milk of 4 hours and infant formula or non-human milk of 6 hours for neonates and infants. For solid foods in most adult patients, the ASA recommends fasting periods of at least 6 hours (light meal such as toast and clear liquid) and 8 hours (fatty or fried foods or meat). For infants and children, the fasting period for solids should be at least 6 hours.
The preoperative use of gastric stimulants, gastric acid secretion blockers (histamine$_2$ receptor antagonist agents), antacids, antiemetic agents, and/or anticholinergic medications (to decrease the risk of pulmonary aspiration) is not routinely recommended. Their use should be based on the individual patient assessment.

DISCHARGE CRITERIA: All patients who have had outpatient surgery using sedation or general anesthesia must meet minimal criteria to permit safe discharge from the office or outpatient surgical facility. Such criteria may include either the use of an Aldrete Score, Post-Anesthesia Discharge Scoring System (PADSS or modified PADSS), or equivalent. (Also see the *Anesthesia in Outpatient Facilities* chapter.) The patient must arrive at the office or surgical facility with a responsible adult escort for discharge after surgery and anesthesia.

SPECIAL CONSIDERATIONS FOR PEDIATRIC PATIENT ASSESSMENT

As for the adult patient, initial assessment of the child begins with a careful history, followed by physical examination and radiographic and laboratory evaluation. However, the information may, of necessity, be provided by the parents (for infants and toddlers) or by both the patient and the parents (older children and teenagers). Informed consent for all children, who are considered minors, must be obtained from the parents, although it is advisable to have the child assent if he/she is old enough to understand the risks and complications of the procedure. Furthermore, it is critical to ascertain that the parent or adult giving the consent is the legal guardian and has the legal authority to do so. This is especially critical when the parents are divorced or when the child is living with guardians other than the biologic parents. Special conditions when a minor may have legal autonomy (liberated) are state or province specific and should be determined before treatment.

Several important aspects of the initial patient assessment are unique to children. The OMS must deal with both the parent(s) and the patient. The parent may have different goals for treatment and may not appreciate or accept any psychological or physical barriers to treatment. The surgeon must be the advocate for the minor patient and ensure that all concerned parties understand the procedure, the risks, the benefits, and alternative treatment options.

Indicated therapeutic parameters are affected by the patient's chronologic age and stage of psychological, physical, and dental development. These factors affect not only the indications for therapy but also the timing of treatment and must be considered in the final assessment of the pediatric patient. A history of continued growth (height); change in shoe size; status on standardized growth charts; studies such as the hand-wrist radiograph, cervical vertebral maturation, and technetium bone scan of the condyles and mandible; and a careful menstrual history for female patients are helpful

in evaluating growth. Perhaps the simplest and most reproducible method of ascertaining growth cessation is the use of serial cephalometric radiographs performed semiannually. In some cases, serum hormone markers may be helpful in determining the stage of maturation.

The family history, particularly the mother's obstetric history and the existence of similar conditions in other relatives or siblings, is important when evaluating pediatric patients who have congenital or developmental anomalies. Exposure to known teratogens during pregnancy or in the early developmental years is a key component in the initial evaluation of children who exhibit growth abnormalities.

When performing the physical examination, it is critical to remember the differences between children at various ages and adults with regard to anatomy (eg, airway), vital signs (eg, heart and respiratory rates), and physiology (greater body surface area or mass and cardiac output). For example, cardiac output is more heart rate dependent in the child than in the adult.

When assessing the child for anesthesia, the surgeon must pay particular attention to the patient's allergy history for the common childhood precipitants of asthmatic attacks: pollen, other indoor or outdoor airborne irritants, animal hair, physical exercise, and/or anxiety. Upper respiratory tract infections that produce airway irritability are exceedingly common in young children. Specific reactions to suspected drug allergens should be ascertained through allergy testing with, for example, an anergy panel.

Outcomes assessment indices in children must include not only those surrounding the procedure but also those related to future growth and development. The surgeon must consider the effects of the child's growth on the ultimate outcome of treatment.

PATIENT ASSESSMENT

This section addresses the assessment of the patient's medical history and physical status in all patient care settings, including the documentation of examination findings. The results of the patient assessment are used as a foundation for subsequent clinical sections throughout the remainder of this book.

I. Indications for Patient Assessment

A. Presentation of a patient to an OMS for evaluation, diagnosis, continuing care, and/or treatment
B. Referral to an OMS for a second opinion regarding diagnosis and management
C. Planning for inpatient or outpatient surgery or procedure
D. Scheduled follow-up visit for assessment of outcomes resulting from a treatment, surgery, or procedure
E. Return of patient for new condition, evolving condition, and continuing evaluation

II. Specific Goals for Patient Assessment

A. Perform a problem-focused, age-appropriate, ASA-appropriate medical history and physical examination
B. Establish an accurate diagnosis
C. Determine the need for care or treatment
D. Identify factors affecting risk to determine patient ability to undergo safe treatment, surgery, and/or anesthesia
E. Establish the rationale for care, treatment, or surgery of diagnosed conditions
F. Develop care or treatment recommendations and alternative treatment options
G. Document findings and recommendations and assign an ASA physical status (*Appendix 1*)
H. Provide preoperative patient instructions for planned surgery
I. Identify new or previously unrecognized conditions and determine the need for further assessment (eg, laboratory or radiographic) or consultation (eg, with primary care physician or specialist), treatment, surgery, or procedure and perioperative management (eg, autologous blood products)
J. Document outcomes and recommendations for further care or treatment
K. Confirm or refute an established diagnosis as a second opinion
L. Confirm appropriateness of a planned operation or procedure
M. Perform an informed consent discussion
N. Psychologically prepare the patient for surgery by providing reassurance and review of perioperative expectations
O. Inform the patient of the findings, diagnosis, treatment options, and risks and benefits of surgery
P. Obtain documentation for predetermination of insurance coverage benefits

III. Specific Factors Affecting Risk for Patient Assessment

Factors that increase the potential for inadequate assessment:

PATIENT ASSESSMENT (continued)

A. Incomplete initial assessment
B. Patient's failure to return for scheduled follow-up assessment
C. Communication barriers (eg, language or cultural barriers, communication disorders, altered mental status, or level of consciousness)
D. Psychological barriers
E. Patient's, legal guardian's, or responsible party's failure to disclose information regarding patient history
F. Degree of patient's and/or family's cooperation and/or compliance
G. Physical barriers (eg, obesity, trismus, trauma)
H. Situational barriers (eg, life-threatening emergency, pending litigation)
I. Regulatory and/or third-party decisions concerning access to care, indicated therapy, drugs, devices, and/or materials

IV. Indicated Therapeutic Parameters for Patient Assessment

Patient assessment may be categorized into many different forms of encounter. Please refer to the current Current Procedural Terminology (CPT) *coding manual, as necessary. These encounters may be either initial or subsequent and may include but are not limited to the following:*

The level of patient assessment is determined by the severity of the problem or complexity of the disease entity and may include any or all of the components of a comprehensive history and physical examination. According to CPT criteria, the levels of evaluation and management services are determined by multiple components of the patient encounter, including the history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time. History, examination, and medical decision-making are considered the key components in determining the level of evaluation and management services provided. Each of the components is composed of differing levels of significance and/or complexity. The CPT published by the American Medical Association should be referred to for details of those factors required when determining the level of evaluation and management services.

Patient assessment should be documented in the medical record. The medical history (obtained from the patient, legal guardian, or responsible party) and the physical examination findings form the basis of this document. Documentation of a patient's condition and planned surgery or procedure includes the following elements of information, as indicated by the patient's presentation or form of encounter. A comprehensive history and physical examination may not be appropriate for all patients, and the components of the history and physical examination should be individualized for each patient's specific needs.

A. Office or other outpatient services
    1. New patient
    2. Established patient
B. Hospital observation services
C. Hospital inpatient services (eg, admission)
D. Consultations
    1. Office or other outpatient consultations
    2. Initial inpatient consultations
    3. Confirmatory consultation (eg, second opinion)
E. Preoperative assessment for outpatient surgery
F. Emergency department services
G. Other: nursing home
H. Medical and dental history
    1. Chief complaint
    2. History of present illness
    3. Past medical history, with elaboration of positive and significant negative findings
        a. Medical, dental, and psychological conditions and/or illnesses
        b. Hospitalizations
        c. Anesthesia experience (adverse reactions or complications, eg, personal or family history of malignant hyperthermia)
        d. Past surgical history (operations: major and minor)
        e. Past dental history

PATIENT ASSESSMENT *(continued)*

f. Medications and dosages (past and present, including herbal medicines and nonprescription drugs)
g. Allergies and reactions (including latex allergy)

4. Review of systems (general and pertinent)
   a. General
   b. HEENT (head, ears, eyes, nose, and throat, including oral cavity)
   c. Cardiovascular (including exercise tolerance quantified by Metabolic Equivalent of Tasks [METs] activity [see *Appendix 3*])
   d. Respiratory
   e. Gastrointestinal
   f. Genitourinary (including date of last menstrual period)
   g. Musculoskeletal
   h. Integumentary
   i. Neurologic
   j. Psychiatric
   k. Endocrine
   l. Hematologic/lymphatic
   m. Allergic/immunologic
5. Family history
6. Social history
   a. Occupation
   b. Substance use (eg, tobacco [pack-years], alcohol [daily amount], illicit or recreational drugs [specific drugs and frequency of use])
   c. Other issues, as indicated by the patient's presentation (eg, religious or philosophical objections to care or treatment), infectious disease risk factors (eg, multiple sexual partners, multiple transfusions, human immunodeficiency virus disease, hepatitis, methicillin-resistant Staphylococcus aureus [MRSA])

I. Physical examination

The surgeon is responsible for documenting the performance of an appropriate history and physical examination, although the patient may be referred to another qualified professional for an examination. In general, the physical examination may be focused for the OMS patient, and several areas may be deferred, but such deferrals should be documented in the medical record. For most ASA class I and II patients undergoing outpatient surgery, the history and physical examination may be focused. For the surgical inpatient (depending on individual institutional requirements) and/or patients of advanced ASA status, a more comprehensive history and physical examination may be necessary. A patient's refusal to consent to a medical history and physical examination must be documented in the medical record.

1. General examination (Alert and Oriented [AO] x 3; well developed, well nourished [WDWN])
2. Vital signs (heart rate, blood pressure [minimum for patient who will undergo anesthesia], temperature, respiratory rate)
3. HEENT (head, ears, eyes, nose, and throat, including oral cavity)
4. Neck, including lymph nodes
5. Chest and lungs (inspection, palpation, percussion, auscultation)
6. Heart and great vessels
7. Breast (deferred, in most cases)
8. Abdomen
9. Pelvic/rectal (deferred, in most cases)
10. Musculoskeletal
11. Neurologic
12. Skin
13. Extremities

J. Adjunctive studies

The decision to obtain any adjunctive studies must be based on results of the preoperative patient assessment data, ASA physical status, and surgical risk classification. Laboratory or radiologic testing without specific clinical indications is not medically necessary, clinically beneficial, or cost-effective. In determining studies

PATIENT ASSESSMENT (continued)

to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable) should be followed. For women of child bearing age, the decision to perform urine or blood pregnancy testing prior to surgery and anesthesia should be based on an equivocal history of sexual activity and the possibility of pregnancy and an uncertainty regarding the date of the last menstrual period. Routine preoperative assessment in the pediatric patient undergoing outpatient or noninvasive surgery is not clinically warranted without a specific indication. Adjunctive studies, when indicated, may include but are not limited to:

1. Complete blood count (CBC), white blood cell count (WBC), hemoglobin, hematocrit
2. Chemistry-7 (sodium, potassium, chloride, serum bicarbonate, blood urea nitrogen, creatinine, and glucose)
3. Chest radiograph (CXR)
4. Panoramic radiograph
5. Periapical and/or occlusal radiographs
6. Maxillary and/or mandibular radiographs
7. Computed tomography
8. Cone beam computed tomography
9. Positron emission tomography
10. Positron emission tomography/computed tomography
11. Magnetic resonance imaging
12. Electrocardiogram (12-lead ECG)
13. Prothrombin time (PT), partial thromboplastin time (PTT), and international normalized ratio (INR)
14. Platelet count
15. Bleeding time
16. Type and screen, type and cross-sensitivity
17. Arterial blood gas
18. Fasting blood glucose, random blood glucose, glucose tolerance test, hemoglobin A_{1c}
19. Pregnancy testing, serum or urine
20. Pulmonary function tests
21. Liver function tests
22. Urinalysis
23. Blood cultures

K. Assessment

The OMS should compile all of the information related to the results of the patient assessment, ASA status, surgical risk classification, and planned surgical procedure to determine an appropriate differential diagnosis and alternative treatment options. The decisions made at this point in the patient assessment may include a review of the literature and/or consultations with other professionals, such as physicians, dentists, and specialists.

L. Treatment plan

The OMS may make treatment recommendations based on his/her assessment of the patient's needs and ability to undergo surgery. In general, there are several options for management, including no treatment, and these should be presented to the patient and discussed in terms of risks and benefits of treatment and nontreatment, material risks of the procedures, possible complications, risk of recurrence, and possibly the need for additional procedures. The treatment plan may involve the need to submit a letter to a third-party company for predetermination of benefits for each patient before surgery.

V. Outcome Assessment Indices for Patient Assessment

Outcomes indices are used by the OMS and Oral and Maxillofacial Surgery specialty to assess aggregate outcomes of care. Outcomes are assessed through clinical functional evaluation of patients and laboratory and radiographic measures.

A. General favorable outcomes associated with patient assessment

1. Determination of accurate diagnoses
2. Documentation of care or treatment recommendations based on an evidence-based rationale, when feasible
3. Identification and documentation of risk factors associated with the patient assessment and recommended care or treatment vs nontreatment

PATIENT ASSESSMENT *(continued)*

4. Successful achievement of assessment goals

B. General unfavorable outcomes associated with patient assessment
1. Failure of patient to disclose adequate information contributing to incomplete obtainment of a medical history
2. Failure of patient to disclose information contributing to an incomplete physical examination
3. Patient-related factors contributing to incomplete or inaccurate diagnoses
4. Patient-related factors contributing to incomplete or inaccurate treatment recommendations and/or treatment
5. Complications resulting from inadequate assessment (eg, unrecognized risk factors, such as immunocompromised patient status)
6. Failure of patient to obtain the necessary informed consent information that a prudent patient would want to know before any surgical procedure
7. Failure of the patient to disclose a new or evolving condition
8. Failure of patient to return for scheduled follow-up assessment and management
9. Failure to obtain appropriate consultation, when indicated
10. Failure to recognize the need for adjunctive studies based on patient history, physical examination, or ASA status
11. Failure to adhere to American Heart Association (AHA) guidelines regarding subacute bacterial endocarditis (*Appendix 4*) and American Dental Association (ADA) guidelines for total joint replacement (*Appendix 5*) prophylaxis regimens in at-risk patients undergoing at-risk procedures
12. Inappropriate medication prescribing (eg, allergy, drug interaction)
13. Iatrogenic patient injury due to inadequate patient assessment

SPECIFIC CLINICAL SCENARIOS

On occasion, the OMS must perform an assessment of patients of advanced ASA status. The following clinical scenarios represent several of the more commonly seen disease processes organized by system and provide recommendations for assessment and management. These are only recommendations, and definitive patient assessment and management must be correlated clinically for each patient. In all cases of ASA class II or greater patients, consideration should be given to consultation with a physician for medical clarification of the patient's physiologic condition clearance to assist the OMS in determining the appropriateness for outpatient OMS procedures that may include sedation or general anesthesia. The following guidelines are recommendations ONLY and should be individualized for each specific surgical patient at the discretion of the OMS.

I. Cardiovascular System

A. Rheumatic heart disease, valvular heart disease, heart murmurs, congenital heart disease
1. Consider cardiology consultation, if indicated
2. Consider ultrasonography or echocardiography for documentation of cardiac valvular function
3. Follow AHA subacute bacterial endocarditis prophylaxis regimens for the at-risk patients undergoing at-risk procedures (*Appendix 4*)

B. Ischemic heart disease, hypertension, angina pectoris, myocardial infarction (MI)
1. Determine current level of control (eg, exercise-tolerance, METs, stable vs unstable angina)
2. Consider consultation with physician
3. Consider *Cardiac Risk Stratification for Noncardiac Surgical Procedures* (*Appendix 6*)
4. Use stress reduction techniques
5. Consider deferring elective treatment for 1 month, and ideally 3 months, following MI
6. Consider discontinuation of antiplatelet therapy only with a cardiology consultation. For bare metal stents, the period of antiplatelet therapy is typically 6 months, while drug-eluting stents require 1 year of antiplatelet therapy after MI
7. Consider limitation of epinephrine dosage contained in local anesthetic solution
8. Be prepared for Basic Life Support (BLS)/Advanced Cardiac Life Support (ACLS) in emergency situation

C. Congestive heart failure
1. Determine level of control by history and physical examination (eg, shortness of breath, dyspnea on exertion, paroxysmal nocturnal dyspnea, orthopnea, jugular venous distention, ankle edema)

SPECIFIC CLINICAL SCENARIOS *(continued)*

2. Consider consultation with physician
3. Consider ECG, CXR
4. Consider oxygen supplementation

II. Respiratory System

A. Chronic obstructive pulmonary disease, emphysema
1. Consider consultation with physician
2. Use supplementary steroids when indicated
3. Use supplemental oxygen cautiously, since that may inhibit respiratory drive
4. Consider pulmonary function testing to determine the extent of the disease and degree of respiratory reserve

B. Asthma
1. Consider consultation with physician
2. Determine severity based on history (eg, frequency of inhaler use, respiratory-related hospitalizations) and examination (wheezing)
3. Consider prophylactic use of inhaler
4. Use stress reduction techniques
5. Consider pulmonary function testing

III. Endocrine System

A. Diabetes mellitus
1. Determine level of diabetic control (based upon history, fasting blood glucose analysis, glucose tolerance test, hemoglobin A_{1c})
   Note: The decision to obtain a finger stick glucose level depends on many variables, including patient factors and surgical factors, such as clinical signs and symptoms of hypoglycemia or hyperglycemia, whether the patient is taking insulin or oral hypoglycemic agents only, presurgical NPO status, plan for local vs intravenous sedation, general anesthesia, length of planned surgery, and patient's self-reporting of level of glucose control.
2. Avoid hypoglycemia
3. Consider hypoglycemic agent scheduling adjustment
4. Consider insulin reduction, as necessary (see *Appendix 7*)
5. Consider discontinuation or reduction of oral hypoglycemic agents before surgery, although second generation sulfonylureas may be continued. Metformin should be discontinued 48 hours before surgery only in patients with compromised renal function or those having IV contrast due to the risk of lactic acidosis.
6. Consider rescheduling surgery if blood glucose level is significantly elevated, but this decision should be based on other factors as well
7. Consider prophylactic antibiotics
8. Consider H_2 blockers and prokinetic agents to reduce aspiration risks
9. Consider an extended period of NPO status due to gastroparesis
10. Use stress reduction techniques

B. Adrenal insufficiency due to exogenous steroid use
1. Use stress reduction techniques
2. Consider steroid supplementation

IV. Hematologic Disorders

A. Coagulopathy, bleeding disorders (von Willebrand disease, hemophilia), therapeutic anticoagulation
1. Determine pertinent laboratory values (eg, CBC with platelets, PT, PTT, INR)
2. Consider temporary discontinuation of anticoagulation therapy (with physician consultation) to achieve a reasonable INR for surgical hemostasis based on specific procedures performed
3. Consider adjustment of medication(s) for the patient on multiple anticoagulants
4. Determine factor level or platelet count, if indicated, and supplement as necessary (with hematologist consultation, if indicated)
5. For extended length cases or for patients at increased risk, deep vein thrombosis prophylaxis may be considered using compression stockings or subcutaneous medications (eg, heparin, enoxaparin)

B. Anemia
1. Consider a CBC with platelet count

SPECIFIC CLINICAL SCENARIOS *(continued)*

2. Consider autodonation of blood or blood products if a large percentage of blood volume loss during surgery is anticipated

V. Gastrointestinal Disorders

A. Hepatitis
1. Avoid medications with hepatic metabolism
2. Consider liver function tests, PT/PTT, INR, platelet count, bleeding time
3. Consider hepatitis B surface antigen screening

VI. Renal Disease

A. Renal Failure
1. Consider avoidance of drugs with renal metabolism
2. Consider hemodialysis or peritoneal dialysis regimen and schedule surgery accordingly
3. Consider the impact of medications removed by hemodialysis

VII. Neurologic Disorders

Some neurologic disorders, such as intellectual disability, attention-deficit/hyperactivity disorder, and autism, and their associated medical treatments may affect the ability of an OMS to perform an adequate patient assessment and subsequent management. Consideration should be given to comprehensive dental and oral surgical management in an operating facility under sedation or general anesthesia.

VIII. Musculoskeletal System

A. Total joint replacement
1. Follow ADA recommendations regarding prophylaxis with antibiotics (*Appendix 5*)

IX. Miscellaneous

A. Obesity
1. Consider Body Mass Index (BMI) calculation
2. Consider altered airway anatomy
3. Consider decreased respiratory reserve
4. Consider medication dosage adjustment
5. Consider an extended period of NPO status

B. Pregnancy
1. Consider elective surgery in second trimester
2. Consider drug safety pregnancy profiles (*Appendix 8*)

C. Bisphosphonate-related osteonecrosis of the jaws (Also see *Diagnosis and Management of Pathological Conditions* chapter)
1. Consider consultation with prescribing physician
2. Consider discontinuation of oral bisphosphonate medication (based upon consultation) for a brief period before surgery
3. Consider debridement of necrotic bone to reduce the associated soft tissue trauma or inflammation
4. Consider prophylactic antibiotics and antimicrobial rinses

D. Malignant hyperthermia
1. Recognize risk factors, signs, and symptoms
2. Be prepared to manage/transfer patient for treatment

E. Radiation therapy
1. Ascertain total dosage, field of involvement, use of jaw shields, and timing of radiation therapy
2. Consider prophylactic hyperbaric oxygen to possibly decrease the incidence of osteoradionecrosis

APPENDICES

APPENDIX 1

American Society of Anesthesiologists Physical Status Patient Classification System

ASA Class I A normal healthy patient

ASA Class II A patient with mild systemic disease

ASA Class III A patient with severe systemic disease

ASA Class IV A patient with severe systemic disease that is a constant threat to life

ASA Class V A moribund patient who is not expected to survive without an operation

ASA Class VI A declared brain-dead patient whose organs are being removed for donor purposes

Note: If a surgical procedure is performed emergently, an "E" is added to the previously defined ASA classification

American Society of Anesthesiologists. http://www.asahq.org/For-Members/Clinical-Information/ASA-Physical-Status-Classification-System.aspx. Accessed April 4, 2011. Reprinted with permission.

APPENDIX 2

American Society of Anesthesiologists Fasting Guidelines

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

American Society of Anesthesiologists: 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. *Anesthesiology* 114:495, 2011. Reprinted with permission.

APPENDIX 3

Estimated Energy Requirements for Various Activities

	Can you		Can you
1 MET	Take care of yourself?	4 METs	Climb a flight of stairs or walk up a hill?
↓	Eat, dress, or use the toilet?	↓	Walk on level ground at 4 mph?
	Walk indoors around the house?	↓	Run a short distance?
↓		↓	
	Walk a block or 2 on level	↓	Do heavy work around the house like scrubbing floors
↓	ground at 2-3 mph?	↓	or lifting or moving heavy furniture?
4 METs	Do light work around the house	↓	Participate in moderate recreational activities like golf,
	like dusting or washing dishes?	↓	bowling, dancing, doubles tennis or throwing a
		↓	baseball or football?
		>10 METs	Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?

ACC/AHA 2007 guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery. *Circulation* 116:1971, 2007

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APPENDIX 4

American Heart Association Prevention of Infective Endocarditis

Table 3. Cardiac Conditions Associated With the Highest Risk of Adverse Outcome From Endocarditis for Which Prophylaxis With Dental Procedures Is Recommended

Prosthetic cardiac valve
Previous IE
Congenital heart disease (CHD)*
- Unrepaired cyanotic CHD, including palliative shunts and conduits
- Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure†
- Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)

Cardiac transplantation recipients who develop cardiac valvulopathy

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

†Prophylaxis is recommended because endothelialization of prosthetic material occurs within 6 months after the procedure.

Prevention of infective endocarditis: guidelines from the American Heart Association. *Circulation* 116:1736, 2007

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Table 4. Dental Procedures for Which Endocarditis Prophylaxis Is Recommended for Patients in Table 3

All dental procedures that involve manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa*

*The following procedures and events do not need prophylaxis: routine anesthetic injections through noninfected tissue, taking dental radiographs, placement of removable prosthodontic or orthodontic appliances, adjustment of orthodontic appliances, placement of orthodontic brackets, shedding of deciduous teeth, and bleeding from trauma to the lips or oral mucosa.

Prevention of infective endocarditis: guidelines from the American Heart Association. *Circulation* 116:1736, 2007

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Table 5. Regimens for a Dental Procedure

Situation	Agent	Regimen: Single Dose 30 to 60 min Before Procedure	
		Adults	Children
Oral	Amoxicillin	2 g	50 mg/kg
Unable to take oral medication	Ampicillin	2 g IM or IV	50 mg/kg IM or IV
	OR		
	Cefazolin or ceftriaxone	1 g IM or IV	50 mg/kg IM or IV
Allergic to penicillins or ampicillin—oral	Cephalexin*†	2 g	50 mg/kg
	OR		
	Clindamycin	600 mg	20 mg/kg
	OR		
	Azithromycin or clarithromycin	500 mg	15 mg/kg
Allergic to penicillins or ampicillin and unable to take oral medication	Cefazolin or ceftriaxone†	1 g IM or IV	50 mg/kg IM or IV
	OR		
	Clindamycin	600 mg IM or IV	20 mg/kg IM or IV

IM indicates intramuscular; IV, intravenous.

*Or other first- or second-generation oral cephalosporin in equivalent adult or pediatric dosage.

†Cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema, or urticaria with penicillins or ampicillin.

Prevention of infective endocarditis: guidelines from the American Heart Association. *Circulation* 116:1736, 2007

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APPENDIX 5

American Dental Association Antibiotic Prophylaxis for Dental Patients With Total Joint Replacements

PATIENTS AT POTENTIAL INCREASED RISK OF HEMATOGENOUS TOTAL JOINT INFECTION[a]

All Patients During the First Two Years Following Joint Replacement

Immunocompromised/Immunosuppressed Patients

- ☐ Inflammatory arthropathies such as rheumatoid arthritis, systemic lupus erythematosus
- ☐ Drug- or radiation-induced immunosuppression

Patients with Comorbidities[b]

- ☐ Previous prosthetic joint infections
- ☐ Malnourishment
- ☐ Hemophilia
- ☐ HIV infection
- ☐ Insulin-dependent (Type I) diabetes
- ☐ Malignancy

[a]Based on Ching et al, Brause, Murray et al, Poss et al, Jacobson, Millard et al, Johnson and Bannister; Jacobson, Patel et al, and Berbari et al.

[b]Conditions shown for patients in this category are examples only; there may be additional conditions that place such patients at risk of experiencing hematogenous total joint infection.

SUGGESTED ANTIBIOTIC PROPHYLAXIS REGIMENS[a]

Patients not allergic to penicillin:	**Cephalexin, cephradine, or amoxicillin** 2 grams orally 1 hour prior to the dental procedure
Patients not allergic to penicillin and unable to take oral medications:	**Cefazolin or ampicillin** Cefazolin 1 g or ampicillin 2 g intramuscularly or intravenously 1 hour prior to the dental procedure
Patients allergic to penicillin:	**Clindamycin** 600 mg orally 1 hour prior to the dental procedure
Patients allergic to penicillin and unable to take oral medications:	**Clindamycin** 600 mg IV 1 hour prior to the dental procedure

[a]No second doses are recommended for any of these dosing regimens.

ADA Total Joint Replacements (cont.)

INCIDENCE STRATIFICATION OF BACTEREMIC DENTAL PROCEDURES[a]

HIGHER INCIDENCE[b]

- ☐ Dental extractions
- ☐ Periodontal procedures, including surgery, subgingival placement of antibiotic fibers or strips, scaling and root planing, probing, recall maintenance
- ☐ Dental implant placement and replantation of avulsed teeth
- ☐ Endodontic (root canal) instrumentation or surgery only beyond the apex
- ☐ Initial placement of orthodontic bands but not brackets
- ☐ Intraligamentary and intraosseous local anesthetic injections
- ☐ Prophylactic cleaning of teeth or implants where bleeding is anticipated

LOWER INCIDENCE[c,d]

- ☐ Restorative dentistry (operative and prosthodontic) with or without retraction cord[e]
- ☐ Local anesthetic injections (nonintraligamentary and nonintraosseous)
- ☐ Intracanal endodontic treatment; post placement and buildup
- ☐ Placement of rubber dam
- ☐ Postoperative suture removal
- ☐ Placement of removable prosthodontic or orthodontic appliances
- ☐ Taking of oral impressions
- ☐ Fluoride treatments
- ☐ Taking of oral radiographs
- ☐ Orthodontic appliance adjustment

[a]Adapted with permission from the publisher from Dajani, et al.

[b]Prophylaxis should be considered for patients with total joint replacement who meet the criteria in Table 1. No other patients with orthopedic implants should be considered for antibiotic prophylaxis prior to dental treatment/procedures.

[c]Prophylaxis not indicated.

[d]Clinical judgment may indicate antibiotic use in selected circumstances that may create significant bleeding.

[e]This includes restoration of carious (decayed) or missing teeth.

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Based on the association report entitled Antibiotic Prophylaxis for Dental Patients With Total Joint Replacements. J Am Dent Assoc 134:895-898, 2003. Reprinted with permission.

Please note that this report was retired by the American Academy of Orthopedic Surgeons (AAOS), effective December 5, 2008. As a result of this action, the report has been removed from the AAOS Web site and is no longer supported, endorsed, or distributed by the academy. A new Information Statement (http://www.aaos.org/about/papers/advistmt/1033.asp) was issued by AAOS in February 2009.

APPENDIX 6

Cardiac Risk Stratification for Noncardiac Surgical Procedures

Risk Stratification	Procedure Examples
Vascular (reported cardiac risk often more than 5%)	Aortic and other major vascular surgery Peripheral vascular surgery
Intermediate (reported cardiac risk generally 1% to 5%)	Intraperitoneal and intrathoracic surgery Carotid endarterectomy Head and neck surgery Orthopedic surgery Prostate surgery
Low□ (reported cardiac risk generally less than 1%)	Endoscopic procedures Superficial procedure Cataract surgery Breast surgery Ambulatory surgery
□ These procedures do not generally require further preoperative cardiac monitoring	

ACC/AHA guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery. *Circulation* 116:1971, 2007
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APPENDIX 7

Perioperative Insulin Management

Insulin Regimen	Day before Surgery	Day of surgery	Comments
Insulin pump	No change	No change	Use "sick day or "sleep" basal rates
Long-acting peakless insulins	No change	75-100% of morning dose	Reduce nighttime dose if history of nocturnal or morning hypoglycemia On day of surgery, the morning dose of basal insulin may be administered on arrival to the ambulatory surgery facility
Intermediate-acting insulins	No change in daytime dose 75% of dose if taken in the evening	50-75% of morning dose	See comments for long-acting insulins
Fixed combination insulins	No change	50-75% of morning dose of intermediate-acting component	Lispro-protamine only available in combination; therefore use NPH instead on day of surgery. See the comments for long-acting insulins.
Short- and rapid-acting insulins	No change	Hold the dose	
Non-insulin injectables	No change	Hold the dose	

Joshi GP, Chung F, Vann MA, et al. Society for Ambulatory Anesthesia consensus statement on perioperative blood glucose management in diabetic patients undergoing ambulatory surgery. *Anesth Analg*. 111:1378, 2010 Reprinted with permission.

APPENDIX 8

Pregnancy Risk Categories (FDA Current Categories)

FDA Pregnancy Category Definitions

(language summarized from 21 CFR 201.57)

Category	Definition
A	Adequate and well-controlled (AWC) studies in pregnant women have failed to demonstrate a risk to the fetus in the first trimester of pregnancy (and there is no evidence of a risk in later trimesters).
B	Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no AWC studies in humans AND the benefits from the use of the drug in pregnant women may be acceptable despite its potential risks OR animal studies have not been conducted and there are no AWC studies in humans.
C	Animal reproduction studies have shown an adverse effect on the fetus, there are no AWC studies in humans, AND the benefits from the use of the drug in pregnant women may be acceptable despite its potential risks OR animal studies have not been conducted and there are no AWC in humans.

Category	Definition
D	There is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans, BUT the potential benefits from the use of the drug in pregnant women may be acceptable despite its potential risks (eg, if the drug is needed in a life-threatening situation or serious disease for which safer drugs cannot be used or are ineffective).
X	Studies in animals or humans have demonstrated fetal abnormalities OR there is positive evidence of fetal risk based on adverse reaction reports from investigational or marketing experience, or both, AND the risk of the use of the drug in a pregnant woman clearly outweighs any possible benefit (eg, safer drugs or other forms of therapy are available).

Food and Drug Association (FDA) Web site. http://www.fda.gov/Drugs/DrugSafety/ucm245470.htm Accessed April 6, 2011.

SELECTED REFERENCES – PATIENT ASSESSMENT

This list of selected references is intended only to acknowledge some of the sources of information drawn on in the preparation of this document. Citation of the reference material is not meant to imply endorsement of any statement contained in the reference material. The list is not an exhaustive compilation of information on the topic. Readers should consult other sources to obtain a complete bibliography

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IOWA DENTAL BOARD

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University of Iowa Health Care

Hospital Dentistry Institute

Division of Oral & Maxillofacial Surgery
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April 12, 2013

Melanie Johnson
Executive Director, Iowa Dental Board
400 SW 8th St. Suite D
Des Moines, IA
50309-4686

Dear Ms. Johnson,

A colleague recently brought to my attention something that was discussed at a recent telephonic meeting of the IDB (March 28, 2013). In the FAQ section, there was a question about oral and maxillofacial surgeons performing history and physicals. The notes from the meeting state:

> **"Could you please advise if the State of Iowa allows Oral Maxillofacial Surgeons to perform Pre-surgical History & Physicals? Is yes, where in the Iowa Code is this addressed?**
> Pre surgical screenings (oral) for surgeries they are conducting would be fine, but they could not provide a physical, as it is not "incident or common to the practice of dentistry." (See Iowa Code 153.13)"

This response is very concerning to us as oral and maxillofacial surgeons. Performing history and physicals is an integral part of our practice. An updated history and physical (H&P) is required prior to admitting and treating patients in a hospital setting and as such OMFS perform them on a regular basis. It is well within the scope of our practice.

All oral and maxillofacial surgeons, even those without an MD, are well trained in performing H&Ps. In order to be accredited, all OMFS programs are required to have a formal course in physical diagnosis as well as to document each resident's competency in performing H&Ps. In addition, all admissions by the OMFS team need to have an H&P done by an OMFS resident. These requirements ensure that all surgeons who complete an accredited OMFS program are well trained and have demonstrated competence in performing and documenting H&Ps.

I am requesting that the Board reconsider the response that is given here to state that oral and maxillofacial surgeons are trained and are able to perform H&Ps. As the answer is currently worded, it could significantly hinder our ability to treat our patients in an appropriate manner.

Thank you for your consideration. Please feel free to contact me with any questions.

Sincerely,

Steven L Fletcher, DDS
Assistant Professor
Graduate Program Director, OMFS
University of Iowa Hospitals and Clinics
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319-384-7215

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MAR 30 2013
IOWA DENTAL BOARD

March 22, 2013

Iowa Board of Dental Examiners
400 S.W. 8th Street
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To Whom It May Concern:

The Raven Maria Blanco Foundation (RMBF) is a 501(c) 3 charity dedicated to raising awareness in the dental profession and the public regarding the importance of emergency medical preparedness in dental offices. Our organization is named in memory of 8-year-old, Raven, who died in 2007 during a routine dental check-up.

For our 2013 project to recognize National Children's Dental Health month, RMBF conducted a national survey to determine patient expectations and knowledge regarding medical emergency preparedness by their dentist. We surveyed 591 people from across the nation.

Attached, you will find a copy of the raw data. Several key points are noteworthy:

1) Dental patients overwhelmingly expect their dentist to be prepared to manage a medical emergency occurring during dental treatment in *all* of six key areas:
   ① Ongoing training of the dentist,
   ② Regular training of the dental staff,
   ③ Periodically holding mock emergency drills,
   ④ Having a written medical emergency plan,
   ⑤ Stocking routine emergency medications, and
   ⑥ Maintaining appropriate emergency equipment such as oxygen and an automated external defibrillator.
2) Most dental patients believe their personal dentist *already has all six* of these preparations in place.
3) Nearly 80% of dental patients would take some type of action against their dentist if they learned there was a deficiency in any area of medical emergency preparation. Over one in three patients would confront their dentist on the matter. An additional 20% would quietly change dentists and nearly a quarter (24%) would report the matter to their state dental board with the expectation of punitive action.

RMBF, INC.
NICOLE CUNHA • EXECUTIVE DIRECTOR
419 S. LYNNHAVEN RD, SUITE 111, VIRGINIA BEACH, VA 23452
Phone: 757.502.8853 • **Cell:**757.222.2876 • **Web:** http://www.rmbfinc.org • **Email:** nicole@rmbfinc.org

Based on our communication with numerous dental lecturers on medical emergency preparedness, it is RMBF's position the vast majority of dental offices, including those in your state, are *seriously* lacking in *multiple* areas. However, based on the results of our survey, patients have a skewed view of the actual emergency preparedness of their dentist.

We believe medical emergencies occurring during dental treatment are increasing in frequency and severity.

① Demographically, dental patients are aging.

② Advances in healthcare mean patients with complex medical histories (e.g. elderly or homebound) now receive dental care.

③ Dental treatment is becoming more sophisticated and increasingly invasive (e.g. implants and grafts). Given these facts, the public expectations of medical emergency preparedness in the six key areas listed above are both reasonable and appropriate, and should be incorporated into training and emergency preparedness procedures.

As the governmental agency *charged solely with protection of your state's population*, you are urged to improve the quality of medical emergency preparedness provided by those you license.

Kindly, reply with your board's position on this matter.

Sincerely,

Nicole Cunha
Executive Director, RMBF

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