



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 HYGIENE COMMITTEE

AGENDA

May 9, 2013

10:00 a.m.

* **New material in red**

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

Committee Members: *Mary Kelly, R.D.H., Chair; Nancy Slach, R.D.H., Vice Chair;
Steve Bradley, Secretary*

- I. **CALL TO ORDER, ROLL CALL** *Mary Kelly*

- II. **APPROVAL OF OPEN SESSION MINUTES**
 - a. January 31, 2013 Quarterly Meeting **Added draft minutes 4/26/13**

- III. **1ST OPPORTUNITY FOR PUBLIC COMMENT** *Theresa Weeg*

- IV. **LEGAL REPORT**

- V. **ADMINISTRATIVE RULES UPDATE** *Melanie Johnson*

- VI. **OTHER BUSINESS**
 - a. Public Health Supervision
 - b. Expanded Functions Dental Assistant and Geriatric Work Group
 - c. FAQs Re: Dental Hygiene for Board Website **Added Report and FAQs 4/26/13**

- VII. ***APPLICATIONS FOR LICENSURE & OTHER REQUESTS**
 - a. Request for Continuing Education Extension*

- VIII. *** CLOSED SESSION**

- IX. **RECONVENE IN OPEN SESSION**

- X. **OPEN SESSION ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS**

XI. ELECTION OF OFFICERS

- a. Committee Chair
- b. Committee Vice Chair
- c. Committee Secretary

XII. 2ND OPPORTUNITY FOR PUBLIC COMMENT

XIII. OTHER BUSINESS

XIV. ADJOURN

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.

*This portion of the meeting may be conducted in closed session to discuss confidential matters that may concern examination information, peace officers' investigative reports, attorney records related to litigation, patient records and reports on the condition, diagnosis, care or treatment of a patient, or investigation reports and other investigative information which is privileged and confidential under the provisions of Sections 22.7(2), 22.7(4), 22.7(5), 22.7(9), 22.7(19), and 272C.6(4) of the 2011 Code of Iowa.

These matters constitute a sufficient basis for the committee 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.

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



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EXECUTIVE DIRECTOR

DENTAL HYGIENE COMMITTEE

MJ edits 4/25/13

OPEN SESSION MINUTES

January 31, 2013

10:30 A.M.

Conference Room

400 S.W. 8th St., Suite D

Des Moines, Iowa

Committee Members

Mary C. Kelly, R.D.H.

Nancy A. Slach, R.D.H.

Steven P. Bradley, D.D.S.

January 31, 2013

Present

Present

Present

Staff Members

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

Attorney General's Office

Theresa Weeg, Assistant Attorney General

I. OPEN SESSION

CALL TO ORDER FOR JANUARY 31, 2013

Ms. Kelly called the meeting of the Dental Hygiene Committee to order at 10:50 a.m. on Thursday, January 31, 2013. A quorum was established with all members present.

Roll Call:

<u>Member</u>	<u>Kelly</u>	<u>Slach</u>	<u>Bradley</u>
Present	x	x	x
Absent			

APPROVAL OF MINUTES

- *October 25, 2012 Open Session Minutes*

- ❖ MOVED by BRADLEY, SECONDED by SLACH, to approve the minutes of the October 25, 2012, Dental Hygiene Committee meeting as submitted. Motion APPROVED unanimously.

II. 1ST OPPORUNITY FOR PUBLIC COMMENT

Ms. Kelly allowed the opportunity for public comment.

Ms. Kelly asked the attendees to introduce themselves.

Ms. Brown, DMACC, asked the committee to make a recommendation regarding the addition of daycare centers to the list of allowed sites for public health supervision.

III. LEGAL REPORT

▪ FOLLOW-UP RE: REVIEW OF STATUTORY AUTHORITY OF DENTAL HYGIENE COMMITTEE AND DENTAL BOARD

Ms. Weeg provided an overview of the duties and historical perspective of the Dental Hygiene Committee and its duties. Ms. Weeg reported that, under Iowa law, the Dental Hygiene Committee is responsible for dental hygiene matters.

Ms. Weeg read the Iowa Code section which addresses the adoption by the Board of recommendations from the Dental Hygiene Committee. Ms. Weeg provided some explanation and interpretation of the statutory language.

Ms. Weeg also read the language in Iowa Code wherein the Board may decline to adopt recommendations from the Dental Hygiene Committee. The Iowa Code specifically states that the Dental Hygiene Committee cannot change the scope of practice of dental hygienists. Ms. Weeg, therefore, interpreted this to mean that the Dental Hygiene Committee could not change the scope of practice of dental hygiene without the approval of the Board.

Several years ago, a process was created whereby these considerations could be addressed. In cases where the law constrained the Dental Hygiene Committee, these matters, typically, went to the Board as suggestions, not recommendations. The Board also needs to act within the constraints of the law and approve Dental Hygiene Committee recommendations in all cases that do not change the scope of practice.

Ms. Weeg reported that the Iowa Dental Hygienists' Association (IDHA) has recently expressed disagreement with this interpretation of the law. There is ongoing research to look into this matter further.

Ms. Slach asked for clarification as to what would be considered the scope of practice and what may be considered a change to the scope of the practice. Ms. Weeg provided some clarification in that respect.

▪ FOLLOW-UP RE: SUBSEQUENT EXAMINATIONS & RDHs UNDER A PUBLIC HEALTH SUPERVISION AGREEMENT

Ms. Weeg reported that this matter will be discussed at the open meeting of the Board.

DHC – OPEN MINUTES – DRAFT – Subject to final DHC approval
January 31, 2013 (4/26/13)

IV. ADMINISTRATIVE RULES

- *COMMITTEE RECOMMENDATION – PROPOSED AMENDMENTS TO CHAPTER 10, “GENERAL REQUIREMENTS” (Amends Definition of “Public Health Setting”)*

Ms. Kelly reported that there was a suggestion received by the Board office that suggested that terminology within the proposed rule change be amended from “daycare” to “childcare”. Ms. Johnson provided some further clarification on the matter. The change was proposed by the Iowa Administrative Code editor, in addition to another organization, to match language used by other agencies when referring to the same institutions.

Dr. Bradley asked about the difference between “daycare” and “childcare”. Ms. Weeg explained that part of the reason for the change is to conform to other code references. Ms. Kelly clarified that in-home childcares would still be excluded if the proposed rulemaking is adopted.

- ❖ MOVED by KELLY, SECONDED by SLACH, to change the terminology from “daycare” to “childcare” settings. Motion APPROVED unanimously.
- ❖ MOVED by KELLY, SECONDED by SLACH, to suggest adoption of the rule amendments as proposed to include the approved change in terminology from “daycare” to “childcare”. Motion APPROVED unanimously.

There was some discussion as to whether this expands the scope of practice, as opposed to simply expanding the list of allowed locations. Ms. Weeg’s stated that since this would expand the scope of the setting it would be also expand the ability of a dental hygienist to practice. Therefore, it was in her opinion, that it would be considered a change in the scope of practice.

Ms. Weeg reported that there has not been sufficient disagreement in the past about whether a proposal is changing the scope of practice. Therefore, the Board, ultimately, will need to decide whether or not this proposal is deemed to be a change in the scope of practice.

Ms. Slach asked if there is a way to address this without having to change the rules every single time a new proposal arises. Ms. Weeg stated that this was understandable; however, an expansion of an existing list could be construed as a change in the scope of practice.

Dr. Rovner, who was sitting in on the meeting asked Ms. Weeg to clarify how the Board would address the disagreement between a recommendation by the committee and a suggestion. Ms. Weeg indicated that the Board would need to make the final decision as to whether or not to treat it as a recommendation or a suggestion based on whether or not the proposal would change the scope of practice for dental hygiene.

- ❖ MOVED by SLACH, SECONDED by KELLY, bring forward the motion as a recommendation of the Dental Hygiene Committee, and not as a suggestion.

<u>Member</u>	<u>Kelly</u>	<u>Slach</u>	<u>Bradley</u>
Aye	x	x	
Nay			x

Motion approved, 2-1.

- Chairperson Kelly announced that some items on the agenda would be taken up out of order to accommodate those who were observing the open session of the meeting.

V. APPLICATIONS FOR LICENSURE & OTHER REQUESTS

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

This matter was tabled until closed session for discussion.

X. OTHER BUSINESS

2013 MEETING SCHEDULE

Ms. Kelly reported that meeting as a committee on the same date as the Board meeting sometimes poses difficulty in a number of ways. Ms. Johnson agreed. Sometimes, this forces committee discussions to be more rushed. This can also be a bit of an issue for review of committee topics.

Dr. Bradley asked about meeting after the quarterly Board meeting. Ms. Johnson pointed out that the main problem with this suggestion is that Dental Hygiene Committee agenda items would need to wait another quarter before the Board could review these matters and act on them.

Ms. Slach indicated that she was willing to meet the evening before the quarterly Board meeting if that would work better. Ms. Braness indicated that staff may have some difficulty in accommodating requests to meet the day before a quarterly meeting since staff will be setting up and preparing for the Board meeting. Ms. Braness indicated, however, that staff would accommodate the committee's decision.

Dr. Bradley indicated that meeting on days other than quarterly Board meeting dates are difficult for him since it means that it is another day that he must be out of the office.

Ms. Johnson reported that a decision does not need to be made today.

Dr. Bradley inquired about potential new appointments in May 2013. Ms. Kelly indicated that she did not intend to meet without a full committee.

EXPANDED FUNCTIONS

Ms. Kelly reported that a former dental assistant, now a licensed dental hygienist, requested approval to perform expanded functions. The interpretation of the Iowa Administrative Code 650, as it is currently written, was that she could not perform these tasks. This prompted the discussion about adding expanded functions to the scope of practice for dental hygienists. Ms. Kelly asked that the committee review this request at the next meeting of the committee.

DHC – OPEN MINUTES – DRAFT – Subject to final DHC approval
January 31, 2013 (4/26/13)

Dr. Bradley asked if dental hygienists could perform these tasks now. Ms. Braness indicated that Board rules, currently, require registration as a dental assistant to perform expanded functions. Historically, licensees have not been allowed to hold both a license and a registration. Mr. McCollum indicated that prior to expanded functions, this was not an issue. The question now is how to address this.

Ms. Kelly indicated that this agenda item should be discussed further at the next meeting of the committee.

IX. 2ND OPPORTUNITY FOR PUBLIC COMMENT

Ms. Kelly allowed the opportunity for public comment.

Tom Cope expressed his disagreement with the interpretation of the Iowa law concerning the authority of the Dental Hygiene Committee. Mr. Cope has concerns about Iowa Dental Association attempting to undermine the Iowa Dental Hygienists' Association.

Ms. Brown asked about the scope of practice and how adding childcare settings is different than head start settings. If head start programs are allowed under current rule, why would childcare settings change the scope of practice? Ms. Weeg stated that head start does not include all childcare settings. Ms. Brown indicated that it seems to be a scope of settings issue, not a scope of practice issue.

Ms. Weeg stated that when a list exists, and if the list is expanded, the scope of practice is being expanded.

Ms. Slach expressed her agreement with Ms. Brown's comments.

Ms. Veenstra stated her agreement with Ms. Weeg's interpretation since the proposal is expanding the group of children, which can be seen by dental hygienists without the direct supervision of a licensed dentist. Therefore, Ms. Veenstra believed that this is expanding the scope of practice. In her opinion, it is broadening the practice.

Mr. Cope read a section of the Iowa Code. Mr. Cope feels that this section clearly gives the Dental Hygiene Committee authority over the "practice" of dental hygiene. Mr. McCollum asked if this would grant authority to the dental hygiene members to dictate all dental hygiene decisions. Mr. Cope stated that the law still grants the Board authorities to handle this.

VI. CLOSED SESSION

- ❖ MOVED by SLACH, SECONDED by KELLY, to go into closed session pursuant to Iowa Code 21.5(d) to discuss and review complaints and other information required by state law to be kept confidential.

Roll Call:

<u>Member</u>	<u>Kelly</u>	<u>Slach</u>	<u>Bradley</u>
Yes	x	x	x
No			
Absent			

Motion APPROVED by ROLL CALL.

- The Dental Hygiene Committee convened in closed session at 11:33 a.m.

VII. RECONVENE IN OPEN SESSION

- The Committee reconvened in open session at 12:02 pm.

VIII. OPEN SESSION ACTION ON CLOSED SESSION AGENDA ITEMS

- *In the Matter of Sara J. Lambert, R.D.H. (#12-132) Consideration of Combined Statement of Charges, Settlement Agreement & Final Order*
- ❖ MOVED by BRADLEY, SECONDED by SLACH, to recommend approval of the Combined Statement of Charges, Settlement Agreement & Final Order as submitted. Motion APPROVED unanimously.
- *Request for Approval of Local Anesthesia Course Offered at the University of Minnesota School of Dentistry*
- ❖ MOVED by BRADLEY, SECONDED by SLACH, to recommend approval of the local anesthesia course as submitted. Motion APPROVED unanimously.

XI. ADJOURNMENT

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

The meeting of the Dental Hygiene Committee was adjourned at approximately 12:02 p.m. on January 31, 2013.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Dental Hygiene Committee is scheduled for May 9, 2013, in Des Moines, Iowa.

Respectfully submitted,

Melanie Johnson, J.D.
Executive Director

MJ/cb

REPORT TO THE DENTAL HYGIENE COMMITTEE

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.



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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:

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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 prophylaxis; no DDS examination.
- Subsequent visit by patient 1 year later – RDH performs another prophylaxis; no DDS examination. Subsequent visit by patient 2 years later – RDH performs another prophylaxis; no DDS examination.

The first prophylaxis 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 prophylaxes 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. prophylaxes) 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

FAQs – Revised Draft 4/18/13

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.

Chrstel 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

Randi V. Andresen
Associate Executive Director
Advanced Education and Professional Affairs
American Association of Oral and Maxillofacial Surgeons
1.800.822.6162; 1.847.233.4337; randresen@aaoms.org

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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 (histamine₂ 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 H₂ 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 ground at 2-3 mph?	↓	Do heavy work around the house like scrubbing floors or lifting or moving heavy furniture?
4 METs	Do light work around the house like dusting or washing dishes?	↓	Participate in moderate recreational activities like golf, bowling, dancing, doubles tennis or throwing a baseball or football?
		↓	Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?
		>10 METs	

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 Unable to take oral medication	Amoxicillin	2 g	50 mg/kg
	Ampicillin	2 g IM or IV	50 mg/kg IM or IV
Allergic to penicillins or ampicillin—oral	OR		
	Cefazolin or ceftriaxone	1 g IM or IV	50 mg/kg IM or IV
	Cephalexin*†	2 g	50 mg/kg
	OR		
Allergic to penicillins or ampicillin and unable to take oral medication	Clindamycin	600 mg	20 mg/kg
	OR		
	Azithromycin or clarithromycin	500 mg	15 mg/kg
	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

^aBased 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.

^bConditions 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

^aNo 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 (nonintraaligamentary 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
-

^aAdapted with permission from the publisher from Dajani, et al.

^bProphylaxis 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.

^cProphylaxis not indicated.

^dClinical judgment may indicate antibiotic use in selected circumstances that may create significant bleeding.

^eThis 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
Intermediate (reported cardiac risk generally 1% to 5%)	Peripheral vascular surgery Intraperitoneal and intrathoracic surgery Carotid endarterectomy Head and neck surgery Orthopedic surgery Prostate surgery
Low <input type="checkbox"/> (reported cardiac risk generally less than 1%)	Endoscopic procedures Superficial procedure Cataract surgery Breast surgery Ambulatory surgery
<input type="checkbox"/> 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 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 See comments for long-acting insulins
Long-acting peakless insulins	No change	75-100% of morning dose	
Intermediate-acting insulins	No change in daytime dose 75% of dose if taken in the evening	50-75% of morning dose	Lispro-protamine only available in combination; therefore use NPH instead on day of surgery. See the comments for long-acting insulins.
Fixed combination insulins	No change	50-75% of morning dose of intermediate-acting component	
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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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,

A handwritten signature in black ink, appearing to read 'S. L. Fletcher', followed by a long horizontal line extending to the right.

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