The mission of the Iowa Dental Board is to ensure that all Iowans receive professional, competent, and safe dental care of the highest quality.

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


COMMITTEE MEETINGS:

8:15 A.M. DENTAL HYGIENE COMMITTEE  
(See separate agenda)

9:15 A.M. EXECUTIVE COMMITTEE

10:00 A.M. BOARD MEETING:

OPEN SESSION:

I. CALL MEETING TO ORDER – ROLL CALL  
Steven Bradley

II. 1st OPPORTUNITY FOR PUBLIC COMMENT  
Steven Bradley

III. APPROVAL OF OPEN SESSION MINUTES  
Steven Bradley
   a. July 13-14, 2017 – Quarterly Meeting
   b. August 30, 2017 – Teleconference
   c. September 26, 2017 – Teleconference

IV. REPORTS

A. EXECUTIVE DIRECTOR’S REPORT  
Jill Stuecker

B. BUDGET REPORT  
Jill Stuecker
a. Overview of FY18 Budget to Date

C. LEGAL REPORT

D. ANESTHESIA CREDENTIALS COMMITTEE REPORT

a. Actions Taken by the Committee on General Anesthesia & Moderate Sedation Permit Applications
b. Other Committee Recommendations, if any

E. CONTINUING EDUCATION COMMITTEE REPORT

a. Vote on Recommendations: Continuing Education Course Applications
b. Vote on Recommendations: Continuing Education Sponsor Applications
c. Other Committee Recommendations, if any

F. LICENSURE/REGISTRATION COMMITTEE REPORT

(Pursuant to Iowa Code § 21.5(1)(a) some licensure/registration information is required by state or federal law to be kept confidential).

a. Recommendations by the Committee on Applications
b. Lindsey Paris

G. DENTAL HYGIENE COMMITTEE REPORT

a. Vote on Actions Taken at the Dental Hygiene Committee Meeting for Board Ratification
   i. Vote on Dental Hygiene Nitrous Oxide Course
b. Other Committee Recommendations, if any
   i. Vote on Adopted and File: Iowa Administrative Code 650 - Chapter 10, General Requirements
   ii. Rule Waiver Request: Danielle Pettit-Majewski on behalf of Martha Hernandez Lopez, R.D.H., Iowa Administrative Code 650 - Chapter 10.5(2), Public health supervision allowed

H. EXAMINATION REPORTS

a. CRDTS – Dental Steering Committee
b. CRDTS – Dental Hygiene Examination Review Committee
   Nancy Slach
   Will McBride

I. IOWA PRACTITIONER PROGRAM REPORT

a. Quarterly Update

V. ADMINISTRATIVE RULES

a. Review of 2017 Regulatory Plan
b. Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 29, Sedation and Nitrous Oxide Inhalation Analgesia
   Iowa Administrative Code 650 – Chapter 10, General Requirements (Educational Services Provided by a Hygienist)

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

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.
d. Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 11, *Licensure to Practice Dentistry or Dental Hygiene* (Portfolio Exam)
e. Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 12, *Dental and Dental Hygiene Examinations* (Portfolio Exam)
f. Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 25, *Continuing Education*
g. Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 14, *Renewal and Reinstatement*
h. Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 20, *Dental Assistants*
i. Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 15, *Fees*
j. Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 26, *Advertising*
k. Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 28, *Designation of Specialty*
m. Discussion on Draft Revisions to Expanded Function Rules
n. Discussion on Draft Revisions to Change of Address Rules
o. Discussion on Draft Revisions to Public Health Supervision Rules
p. Discussion on Resident License Rules
q. Discussion on Exam Requirements for Licensure

### VI. ADMINISTRATIVE RULE WAIVERS

*Jill Stuecker*


### VII. LEGISLATIVE UPDATES

*Jill Stuecker*

a. IDA Legislative Priorities
b. IDHA Legislative Priorities

### VIII. OTHER BUSINESS

*Jill Stuecker*

a. Vote on Nitrous Oxide Course Submitted by Dr. Stecklein
b. Discussion and Vote on Opioid Task Force
c. Committee Appointments
   a. Opioid Task Force
   b. Executive Committee
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c. Licensure and Registration Committee
d. Discussion and Vote on Becoming Members of WREB
e. Review of Strategic Plan
f. Approve 2019 Board Meeting Dates

IX. APPLICATIONS FOR LICENSURE/REGISTRATION
& OTHER REQUESTS (Pursuant to Iowa Code § 21.5(1)(a) some licensure/registration information is required by state or federal law to be kept confidential).

a. Quarterly Ratification of Applications Issued

X. 2nd OPPORTUNITY FOR PUBLIC COMMENT

CLOSED SESSION:

I. ITEMS FOR REVIEW AND DISCUSSION

a. Closed Session Minutes (Closed session pursuant to Iowa Code § 21.5(1)(a) “to review or discuss records which are required or authorized by state or federal law to be kept confidential…”, specifically to review or discuss information that is confidential under Iowa Code § 21.5(4)).

b. Compliance with Board Orders (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept confidential, specifically Iowa Code § 272C.6(4) and Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).

c. Investigative Reports (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

d. New Complaints (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

e. Additional Information on Previous Complaints (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

f. Malpractice Reports Section 21.5(1)(d) for agenda item 2l to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).
g. **Combined Statement of Charges, Settlement Agreement and Final Order** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings, and Iowa code § 21.5(1)(f) to discuss the decision to be rendered in a contested case).

h. **Application for Licensure/Registration** (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept confidential).

**OPEN SESSION**

II. **ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS**

a. Closed Session Minutes  
b. Compliance with Board Orders  
c. Investigative Reports  
d. New Complaints  
e. Additional Information on Previous Complaints  
f. Malpractice Reports  
g. Notice of Hearing and Statement of Charges  
h. Combined Statement of Charges, Settlement Agreement and Final Order  
i. Application for Licensure/Registration

III. **ADJOURN**

**NEXT QUARTERLY MEETING: January 27, 2018**

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

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IOWA DENTAL BOARD

MINUTES
July 13-14, 2017
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members
Steven Bradley, D.D.S., Present July 13, 2017 Present July 14, 2017
Michael Davidson, D.D.S. Present Present
Thomas Jenairy, D.D.S. Present Present
Monica Foley, D.D.S. Present Present
William McBride, D.D.S. Present Present
Mary Kelly, R.D.H. Present Present
Nancy Slach, R.D.H. Present Present
Bruce Thorsen, Public Member Present Present
Lori Elmitt, Public Member Present Present

Staff Members
Jill Stuecker, Phil McCollum, Christel Braness, David Schultz, Dee Ann Argo

Attorney General’s Office
Sara Scott, Assistant Attorney General

Other Attendees
Jeannene Veenstra, Iowa Dental Assistants Association
Larry Carl, Iowa Dental Association
Rich Bokemper, D.D.S., Iowa Dental Association
Francisco Olalde, University of Iowa College of Medicine
Jane Slach, Iowa Dental Assistants Association
Charlotte Eby, LS2 Group
Dennis LaGanca, ADSO
Carol Van Aernam, Iowa Dental Hygienists' Association
Bob Russell, D.D.S., Iowa Department of Public Health
Katy McBurney, R.D.H., Iowa Department of Public Health
Tracy Rodgers, R.D.H., Iowa Department of Public Health
Stephanie Chickering, R.D.H., Iowa Department of Public Health
Tom Cope, Iowa Dental Hygienists' Association
Molly Driscoll, Brown Winnick
John Frank, D.D.S., Anesthesia Credentials Committee  
Lynh Patterson, Delta Dental of Iowa  
Stephen Thies, D.D.S., Iowa Academy of General Dentistry  
Becki Brommel, Brown Winnick  
Patty Meredith, D.D.S., University of Iowa College of Dentistry  
Sabrina Johnson

I. CALL TO ORDER FOR JULY 13-14, 2017

Dr. Bradley thanked the new board members for their service, and asked Dr. Davidson and Mr. Thorsen to introduce themselves.

Dr. Bradley called the meeting of the Iowa Dental Board to order at 12:02 p.m., Thursday, July 13-14, 2017.

Roll Call:

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A quorum was established with all members present.

II. DISCUSSION WITH ANESTHESIA CREDENTIALS COMMITTEE ON GUIDELINES FOR THE USE OF SEDATION AND GENERAL ANESTHESIA

- Vote on Notice of Intended Action: Iowa Administrative Code 650 - Chapter 29, Sedation and Nitrous Oxide Inhalation Analgesia

Mr. McCollum provided an overview of the proposed rule changes. Dr. John Frank and Dr. Kaaren Vargas, members of the Anesthesia Credentials Committee, were also in attendance to address questions.

Ms. Stuecker asked Dr. Frank to speak about the proposed changes, and to explain why the Anesthesia Credentials Committee recommended adoption of these changes. Dr. Frank noted that there is a reduction of hypoxic incidents with early detection. Dr. Vargas agreed with Dr. Frank, and stated that these issues are of particular concern with pediatric patients, who are at higher risk for complications.

Dr. Davidson indicated that he was opposed to the proposed requirement for capnography for moderate sedation permit holders. Dr. Davidson stated that he was in favor of the requirement for deep sedation and general anesthesia; however, he raised concerns about the matter false alarms. Dr. Davidson believed that a pretracheal stethoscope should be sufficient since it monitored the breathing of the patient.

Dr. Vargas and Dr. Frank addressed the concerns raised by Dr. Davidson. In particular, there was discussion about the transitional nature of sedation and the matter of false alarms. Dr. Frank stated
that the doctor can tell the patient to breathe through the nose to reset the capture of data. If the patient cannot follow the command, it would suggest that they are in a deeper level of sedation than moderate sedation.

- **MOVED by SLACH, SECONDED by MCBRIDE, to APPROVE the Notice of Intended Action as drafted. Motion APPROVED, 8-1. Dr. Davidson dissented.**

**III. 1st OPPORTUNITY FOR PUBLIC COMMENT**

Dr. Bradley reported that this was the last Board meeting for Mr. Carl, Iowa Dental Association, as he would be retiring at the end of July 2017.

Dr. Bradley asked everyone to introduce themselves and allowed the opportunity for public comment.

**IV. APPROVAL OF OPEN SESSION MINUTES**

- **April 27, 2017 – Quarterly Meeting**

- **MOVED by ELMITT, SECONDED by JENEARY, to APPROVE the meeting minutes as submitted. Motion APPROVED unanimously.**

- **May 18, 2017 – Teleconference**

- **MOVED by JENEARY, SECONDED by ELMITT, to APPROVE the meeting minutes as submitted. Motion APPROVED unanimously.**

**V. ADMINISTRATIVE RULES/ADMINISTRATIVE RULE WAIVERS**

- **Review of 2017 Regulatory Plan**

Mr. McCollum provided an overview of the current regulatory plan.

Mr. McCollum reported that the changes to chapter 22, “Dental Radiography” would become effective July 26, 2017.

- **Vote on Adopted and Filed: Iowa Administrative Code 650 – Chapter 27, Standards of Practice and Principles of Professional Ethics**

Mr. McCollum provided an overview of the proposed changes. Mr. McCollum recommended that the Board table these amendments until they can be further reviewed. The intent was to make sure that patients are not abandoned and that records may be located. The Board may want to reconsider a number of changes in practice structure prior to moving forward on this rulemaking.
MOVED by ELMITT SECONDED by MCBRIDE, to allow the Notice of Intended Action to expire, and come back with a new draft of rules at a later date. Motion APPROVED unanimously.

- **Discussion on Portfolio Exam**

Ms. Stuecker asked Dr. Kanellis to speak on this matter to discuss this further.

Dr. Kanellis thanked the Board for their work on the portfolio exam. The university will work with Penni Ryan to provide calibration training online, for portfolio examiners, through the university’s website at no cost. The school will provide a list of faculty members eligible to assist with examination. The university recommended that specialists examine the specialty areas of treatment. They will work with IT staff to develop an online calendar to schedule competency challenges.

Dr. Kanellis stated that there may be times when the 7-days’ notice may not be possible. In those cases, the university will notify the Board as soon as possible.

- **Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 11, Licensure to Practice Dentistry or Dental Hygiene**
- **Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 12, Dental and Dental Hygiene Examinations**
- **Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 15, Fees**

Ms. Stuecker reported that the proposed rules limit the option of becoming licensed by portfolio exam to students at the University of Iowa College of Dentistry only. Ms. Stuecker stated that the rules would give priority to Board members or their designees as examiners.

Ms. Stuecker discussed the fee associated with the exam and provided an overview of the calculations.

Dr. Kanellis believed that most students would likely continue to take CRDTS or other regional examination as those have greater portability to other states.

MOVED by DAVIDSON, SECONDED by ELMITT, to APPROVE the Notice of Intended Action as drafted. Motion APPROVED unanimously.

- **Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 10, General Requirements**

Mr. McCollum provided an overview. Senate File 479 was signed into law, and became effective July 1, 2017. The change in law allows dental hygienists to provide educational services without the supervision of a dentist. The proposed changes are intended to implement the change in Iowa law.
Ms. Kelly reported the Dental Hygiene Committee recommended approval of the proposed Notice of Intended Action.

- **MOVED by KELLY, SECONDED by ELMITT, to APPROVE** the Notice of Intended Action as drafted. Motion APPROVED unanimously.
  - **Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 26, Advertising**
  - **Vote on Notice of Intended Action: Iowa Administrative Code 650 – Chapter 28, Designation of Specialty**

Ms. Stuecker reported that the proposed changes were being initiated due to a number of issues related to specialty practice on the national level. Ms. Stuecker noted that the state dental board of Texas recently lost an appeal related to their specialty regulations.

Ms. Stuecker reported that this was a first draft. The Board did not have to vote on this today. The Board may want to table a vote on this to incorporate some of the recently received feedback about the proposed rules. Ms. Stuecker asked for an indication from the Board that they were supportive of changes to these rules. The Board indicated they were supportive and understood the need for changes.

- **MOVED by JENEARY, SECONDED by ELMITT, to TABLE** this discussion until October 2017, with a new draft. Motion APPROVED unanimously.
  - **Rule Waiver Request: Danielle Pettit-Majewski on behalf of Martha Hernandez Lopez, R.D.H., Iowa Administrative Code 650 – Chapter 10.5(2), Public health supervision allowed**

Ms. Braness provided an overview of the request. Ms. Kelly reported that the Dental Hygiene Committee recommended approval of the request with a few reservations. The committee believed that it would be useful to further discuss some of the reservations with the full Board.

The Board members discussed some of the pros and cons of approving the waiver. Mr. Thorsen, who also serves on the Dallas County of Public Health, stated that he was aware of the problems attracting help given the salaries.

- **MOVED by FOLEY, SECONDED by KELLY, to REQUEST ADDITIONAL information regarding** Ms. Hernandez Lopez’s clinical practice and placement of sealants. Motion APPROVED unanimously.
  - **Rule Waiver Request: Scott Kalniz, D.D.S., Iowa Administrative Code 650 – Chapter 11.3(2)(e), Dental licensure by credentials**

Ms. Stuecker reported that after further discussions with Dr. Kalniz, it appeared that he met the requirements of the rule, and would not need to seek a rule waiver. The Board members agreed.
VI. EXPANDED FUNCTIONS, LEVEL 2 UPDATE

Dr. Meredith presented information about the level 2 expanded functions course offered by the University of Iowa College of Dentistry. Dr. Meredith answered questions about the program, and discussed some of the changes made to the course based on the first round of training.

- The Board took a brief recess at 1:37 p.m.
- The Board reconvened at 1:50 p.m.

VII. INFORMATION SESSION

- Overview of 2016 Public Health Supervision Reports

Ms. Stuecker reported that the Iowa Department of Public Health (IDPH) submitted the annual reports regarding public health supervision and I-Smile.

Ms. Chickering focused her remarks primarily on the public health supervision agreements, which the IDPH maintains. Most of the agreements are for providers who are not with IDPH or I-Smile.

Public health supervision providers are required to submit annual reports. Reminders to submit the data are sent around mid-December. Ms. Chickering provided a brief summary of the data collected.

- Overview of 2016 I-SMILE Report

Ms. Rodgers provided an overview of the 2016 I-SMILE report. Ms. Rodgers summarized some of the programs provided by the I-SMILE coordinators. The primary goal is to encourage early and regular dental care. Ms. Rodgers provided a brief overview of the data.

Ms. Rodgers reported that children under the age of 3 need more assistance in getting them into dental offices. Ms. Rodgers believes that the children of Iowa are well served by these programs.

Mr. Thorsen asked about the strategies to reach the children 0-3. Ms. Rodgers stated that WIC, Medicaid enrollment, or head start programs are good avenues for program outreach.

VIII. REPORTS

EXECUTIVE DIRECTOR’S REPORT

Ms. Stuecker reported that renewal season started approximately two weeks prior. Board staff was cautiously optimistic about increases in the number of online applications. Ms. Stuecker reported on some of the strategies to encourage the completion of renewal online.

Ms. Stuecker stated that she was trying to better utilize social media to interact with licensees and members of the public. Facebook was one of the platforms that was being utilized to better share information.
Ms. Stuecker reported that the new website has been handed off to OCIO for implementation.

Ms. Stuecker reported briefly on the issuance of new licenses, registrations, and permits. Ms. Stuecker addressed the issue of work volume, staffing and overall process for processing applications.

Ms. Stuecker thanked the staff for all of the work that they do.

Ms. Stuecker provided some additional information about the ongoing opioid crisis. Increasingly, Ms. Stuecker was being included in these discussions to find better ways of communicating these issues, and educating licensees about the Prescription Monitoring Program (PMP). Awareness of this program may help determine cases of possible abuse.

Ms. Stuecker asked Mr. McCollum to provide some brief updates on the licensing database. Mr. McCollum addressed some of the changes to the public side in order to streamline and make those processes more efficient. The Board will try to streamline the renewal of a license and anesthesia permit – hopefully, be available next week.

**BUDGET REPORT**

- Overview of FY17 Budget to Date
- Vote on FY18 Budget

Ms. Stuecker reported that FY2017 has ended. Some ongoing expenditures will continue to be processed prior to the final closeout, but a year end budget was presented.

Ms. Stuecker provided an overview of the proposed FY2018 budget, and explained some of the data provided on the overview.

Ms. Stuecker stated that staff continued to monitor the financial stability of the Board. Costs have increased over previous fiscal years, and fees have not been increased since 2007. Based on current data, staff believed that there would be sufficient funding under the current fee structure for an addition one to two fiscal years. A fee increase would be needed to sustain Board operations beyond that time period.

Mr. Thorsen asked about potential hiring needs in the future, and whether staff would need to be added given the reference to a small staff. Ms. Stuecker stated that there was a need for additional staff; however, efforts would continue to work towards making processes more efficient. The question that remained, however, was how to balance future deficits with the potential addition of staff. Mr. Thorsen was in favor of considering these scenarios.

- **MOVED** by JENEARY, **SECONDED** by KELLY, to APPROVE the FY2018 budget as submitted. Motion APPROVED unanimously.

**LEGAL REPORT**
Ms. Scott stated that she had nothing to report.

ANESTHESIA CREDENTIALS COMMITTEE REPORT
- Actions Taken by the Committee on General Anesthesia & Moderate Sedation Permit Applications
- Other Committee Recommendations, if any

Ms. Braness provided a brief overview of the committee’s recent meetings and recommendations.

CONTINUING EDUCATION COMMITTEE REPORT
- Vote on Recommendations: Continuing Education Course Applications
- Vote on Recommendations: Continuing Education Sponsor Applications
- Other Committee Recommendations, if any

Ms. Elmitt provided an overview of the committee’s recommendations.

- MOVED by ELMITT, SECONDED by MCBRIDE, to APPROVE the recommendations as submitted. Motion APPROVED unanimously.

LICENSURE/REGISTRATION COMMITTEE REPORT
- Recommendations by the Committee on Applications

Dr. Jeneary reported that the committee had reviewed a number of applications for issuance of licenses and registrations.

- MOVED by JENEARY, SECONDED by KELLY, to APPROVE the recommendations as submitted. Motion APPROVED unanimously.

Dr. Jeneary recommended that the Board consider reviewing the requirements for foreign-trained dentists in the future.

DENTAL HYGIENE COMMITTEE REPORT
- Vote on Actions Taken at the Dental Hygiene Committee Meeting for Board Ratification
- Vote on Notice of Intended Action: Iowa Administrative Code 650 - Chapter 10, General Requirements
- Other Committee Recommendations, if any
- Rule Waiver Request: Danielle Pettit-Majewski on behalf of Martha Hernandez Lopez, R.D.H., Iowa Administrative Code 650 - Chapter 10.5(2), Public health supervision allowed

Ms. Kelly noted these items were discussed earlier in the meeting.

- Discussion on Silver Diamine Fluoride with Arwa Owais, D.D.S.

Ms. Kelly stated that Dr. Kanellis would report on the use of silver diamine fluoride.
Ms. Kelly reported that silver diamine fluoride may be used by dental hygienists under general supervision. Currently, however, this was not allowed under public health supervision.

Dr. Kanellis provided a brief overview of the use of silver diamine fluoride. Dr. Kanellis believed that there may be situations where it might be appropriate to allow dental hygienists to provide this service.

Ms. Kelly reported that the Iowa Department of Public Health assisted the University of Iowa College of Dentistry in developing silver diamine fluoride protocols.

Dr. Kanellis provided a brief overview of current and intended insurance reimbursement rates related to the application of silver diamine fluoride on teeth.

Ms. Kelly reported that, anecdotally, the primary negative issue was the darkening of the tooth. Dr. Kanellis reported that some people indicated that it tastes bad. The biggest adverse issue remains the discoloration of teeth and other objects that it touches.

Dr. Kanellis believed that there may be a good application of this service in nursing facilities. Ms. Slach stated that with proper protocols it may be advantageous in public health supervision.

There was a question about its use by dental hygienists to treat caries since they cannot diagnose caries. Ms. Stuecker clarified that currently, the use of silver diamine fluoride would only be permitted as prescribed by a dentist, under general supervision. Nursing homes are supposed to ensure that a dental examination is completed within 30 days of admittance. Rules are in place by the Department of Inspections and Appeals, and are infrequently enforced.

Dr. Kanellis believed that this may also be utilized in cooperation with teledentistry.

Dr. Russell and Ms. Kelly stated that public health supervision requires referral to dentists for examinations, and treatment. The public health supervision agreements are required to provide a period of time after which further treatment must end prior to continuing treatment.

Dr. McBride’s expressed concern regarding informed consent, primarily in pediatric cases. Dr. Kanellis was more inclined to recommend usage with geriatric patients, and understood the need for further education prior to consent regarding pediatric patients.

Ms. Veenstra asked about the use of silver diamine fluoride by dental assistants. Staff believed that this was allowed under direct supervision, and will continue to look into this matter further.

**DENTAL ASSISTANT REGISTRATION COMMITTEE**

- Committee Update
- Other Committee Recommendations, if any

Dr. Bradley reported that the committee has not met recently.
EXAMINATION REPORTS

- **CRDTS – Dental Steering Committee**

Dr. Bradley reported that the majority of the discussion at the last meeting was the proposed ADA-OSCE examination. Many of the state licensing boards are opposed to this idea.

- **CRDTS – Dental Hygiene Examination Review Committee**

Ms. Slach reported that the committee recently. CRDTS has developed an auxiliary restorative examination. Washington state has also requested a local anesthesia examination; that will be offered beginning in March 2018.

The committee also discussed some sensitivity prototypes for tactile sensitivity. For the most part, there have been minimal changes to the examination over the last few years; though, the committees are open to feedback.

The fee will remain the same for the dental hygiene examination.

- **CRDTS – Dental Examination Review Committee**

Dr. McBride reported that he was unable to attend this meeting.

IOWA PRACTITIONER PROGRAM REPORT

- **Quarterly Update**

Ms. Stuecker provided an update on the committee.

IX. LEGISLATIVE UPDATES

Ms. Stuecker stated that there was not anything to report at this time.

OTHER BUSINESS

- **Discussion on Licensee Failure to Comply with Change of Address Requirements, Pursuant to 10.6(1) and 30.4(31)**

Ms. Stuecker reported that this was intended to be an informational discussion. There was an ongoing issue with licensees not reporting changes of addresses, which causes delays in possible contact. The Board may continue to look into ways to better address this.

- **Discussion and Vote on Tiffany Otto Complaint Against Lilly White Smiles**
- **Discussion on IDA Tooth Whitening Letter**

Ms. Stuecker reported that, based on the Board’s previous discussions, letters of information have been sent. Ms. Stuecker reported that the Iowa Dental Association sent a follow up letter in regards to these matters.
Ms. Slach asked about over-the-counter products versus prescribed products. Dr. McBride stated that these are all available for purchase over the counter.

Ms. Scott provided another overview of the options, and the history of the recent cases. The subsequent response from the Iowa Dental Association was that they are displeased with these options.

There is a difference between complaints against licensees and complaints against non-licensed individuals. Ms. Scott stated that this method of addressing these complaints was not new. Before any action can be taken, an investigation must be completed.

Ms. Scott stated that a cease and desist letter was not appropriate. Ms. Scott provided an overview of the options available to the Board.

- Continue sending letters of information;
- Investigate all complaints received; the Board could not choose to investigate some and ignore others;
- Refer cases, as appropriate, to county attorneys or other equivalent agency; the Board would be unable to dictate the outcome of these referrals;
- The Board could seek injunctive relief; though, the decision would be made by the court, not the Board.

Ms. Scott believed that there was concern for potential anti-trust claims despite the definition of the practice of dentistry within the Iowa Code. Board members and staff discussed their concerns, and the historical response to such requests. Dr. Davidson was in favor of investigating these complaints.

Ms. Slach asked if the Iowa Dental Association has tried to advertise or otherwise promote the advantages of going to a dentist for these services. Ms. Slach questioned the motive of the complaint if there have not been any complaints made by members of the public, particularly, given the Dental Board’s limited resources.

❖ MOVED by DAVIDSON, SECONDED by KELLY, to REFER cases to the respective county attorney offices.

Ms. Scott asked for clarification of the motion. The Board members stated that all of the current cases should be referred for further consideration.

❖ Vote taken. Motion APPROVED. Ms. Slach abstained.

❖ Discussion on American Association of Orthodontists Complaint

Ms. Stuecker provided an overview of the complaint. Many states have received similar complaints; however, the Board cannot act without an allegation against a specific license. Ms. Stuecker send a letter to Smile Direct and was awaiting a response. Ms. Stuecker will forward any information received to a future meeting of the Board.
Ms. Stuecker reported that in recent weeks that she received three separate requests for information about teledentistry in Iowa. Ms. Stuecker believed that some of the requests may be related.

Mr. Thorsen recommended working with Iowa Board of Medicine to develop more specific protocols related to the practice of teledentistry in Iowa.

- **Impact Dental Expanded Functions Request Regarding Online Courses**

Ms. Braness provided an overview of the request.

- MOVED by SLACH, SECONDED by KELLY, to ALLOW the didactic portions of the expanded functions to be offered and completed online.
- Motion APPROVED unanimously. Dr. Davidson and Ms. Elmitt abstained.

- **Vote on Patterson Dental Radiography Training and Exam**

Ms. Braness provided an overview of the request.

- MOVED by DAVIDSON, SECONDED by JENEARY, to APPROVE the course and examination as submitted. Motion APPROVED unanimously.

- **Vote on Vatterott College Radiography Exam**

Ms. Braness provided an overview of the request.

- MOVED by KELLY, SECONDED by THORSEN, to APPROVE the examination as submitted. Motion APPROVED unanimously.

- **Vote on Officers**

Ms. Stuecker provided an overview of the role of officers and explained the voting process.

- MOVED by JENEARY, SECONDED by MCBRIDE, to NOMINATE Dr. Bradley as the chairman. Ms. Stuecker asked if there were any other nominations. There were none. Motion APPROVED unanimously.

- MOVED by BRADLEY, SECONDED by FOLEY, to NOMINATE Dr. Jeneary as the vice-chairman. Ms. Stuecker asked if there were any other nominations. There were none. Motion APPROVED unanimously.

- MOVED by BRADLEY, SECONDED by DAVIDSON, to NOMINATE Dr. McBride as the secretary. Ms. Stuecker asked if there were any other nominations.
MOVED by SLACH, SECONDED by THORSEN, to NOMINATE Ms. Kelly as secretary.

A roll call vote was taken.

Roll Call:

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Motion APPROVED 6-3 in favor of Dr. McBride serving as secretary.

- Discussion and Vote on Committees and Committee Appointments

- Dental Hygiene Committee

MOVED by KELLY, SECONDED by JENEARY, to APPOINT Dr. Foley as the dental member to the Dental Hygiene Committee. Motion APPROVED unanimously.

- Anesthesia Credentials Committee

MOVED by BRADLEY, SECONDED by JENEARY, to APPOINT Dr. Davidson as the chairperson of the Anesthesia Credentials Committee. Motion APPROVED unanimously.

Ms. Stuecker reported that the Dr. DeJong requested to serve as a full member of the committee in lieu of serving as an alternate. This would require another committee member to be appointed as the interim member in his place.

MOVED by BRADLEY, SECONDED by JENEARY, to APPOINT Dr. DeJong as a full member of the Anesthesia Credentials Committee, and ask Dr. Vargas to serve as the alternate member. Motion APPROVED unanimously.

- Continuing Education Advisory Committee

MOVED by BRADLEY, SECONDED by JENEARY, to APPOINT Dr. Foley to serve as a dental member on the committee, replacing Dr. Fuller. Motion APPROVED unanimously.

- Iowa Practitioner Review Committee

Ms. Stuecker reported that Dr. Rips was up reappointment. Ms. Stuecker recommended that Dr. Rips be reappointed. The committee is going through a period of transition, and this would allow for continuity.
MOVED by JENEARY, SECONDED by ELMITT, to REAPPOINT Dr. Rips to the IPRC. Motion APPROVED unanimously.

- Licensure/Registration Committee

Ms. Stuecker recommended tabling the discussion of this committee until October 2017.

- Dental Assistant Registration Committee

Ms. Stuecker proposed disbanding the committee due to its underutilization. Ms. Stuecker proposed creating temporary ad-hoc committees to address specific topics as needed.

MOVED by BRADLEY, SECONDED by JENEARY, to disband the Dental Assistant Registration Committee.

Ms. Veenstra spoke out in favor of keeping the committee. Ms. Stuecker reported that the committee only has two dental assistant members and has not met in several years. Ms. Stuecker is always open to communication and input from interested parties on any number of issues.

Vote taken. Motion APPROVED unanimously.

- The Executive Committee

Ms. Slach asked if a dental hygienist could be appointed to serve on this committee. Dr. Thorsen expressed some concern about the lack of a dental hygienist on the committee. Dr. Bradley stated that he preferred limiting the committee to the elected officers. Dr. Bradley indicated that he may reconsider the formation of the committee at a later date.

- Review of Strategic Plan

Ms. Stuecker recommended that the Board continue to discuss the implementation of its strategic plans. Ms. Stuecker addressed how some of these items have been implemented to date.

X. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS

- Quarterly Ratification of Applications Issued

Ms. Braness reported that the Board had been provided a list of licenses, registrations, qualifications and permits issued in the last quarter.

MOVED by JENEARY, SECONDED by DAVIDSON, to APPROVE the list as submitted. Motion APPROVED unanimously.

XI. 2nd OPPORTUNITY FOR PUBLIC COMMENT
Dr. Bradley allowed the opportunity for public comment.

Ms. Brommel, spoke on behalf of the Iowa Dental Association, and thanked the Board for their decision making on the tooth whitening matters. Ms. Brommel stated that the Board’s job is to protect the public, and therefore, these cases must be enforced in spite of limited resources. Ms. Brommel believed that the information that they provided was sufficient to determine the illegal practice of dentistry.

Mr. Carl, Iowa Dental Association, reiterated what Ms. Brommel. Mr. Carl appreciated the chance to work with the Board in spite of occasional disagreements.

**XII. SECURE THE HUMAN TRAINING**

Ms. Stuecker recommended tabling this discussion given the length of the meeting; and go into the performance review.

- The Board took a brief recess at 4:30 p.m.
- The Board reconvened at 4:35 p.m.

MOVED by BRADLEY, SECONDED by JENEARY, to go into closed session at 4:35 p.m., on Thursday, July 13, 2017 pursuant to the following:

**I. Executive Director Annual Performance Evaluation** (Closed session pursuant to Iowa Code Section 21.5(1)(i) to evaluate the professional competency of an individual whose performance is being considered when necessary to prevent needless and irreparable injury to that individual’s reputation and that individual requests a closed session).

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MOVED by JENEARY, SECONDED by FOLEY, to RETURN into OPEN session at 5:33 p.m., on Thursday, July 13, 2017. The meeting was recessed until Friday, July 14.

MOVED by BRADLEY, SECONDED by ELMITT, to go into closed session at 4:35 p.m., on Friday, July 14, 2017 pursuant to the following:

**II. ITEMS FOR REVIEW AND DISCUSSION**

- **Closed Session Minutes** (Closed session pursuant to Iowa Code § 21.5(1)(a) “to review or discuss records which are required or authorized by state or federal law to be kept confidential…””, specifically to review or discuss information that is confidential under Iowa Code § 21.5(4)).

- **Compliance with Board Orders** (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept
c. **Investigative Reports** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

d. **New Complaints** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

e. **Additional Information on Previous Complaints** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

f. **Malpractice Reports** Section 21.5(1)(d) for agenda item 2l to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

g. **Notice of Hearing and Statement of Charges** (Closed session pursuant to Iowa Code §21.5(1)(d) for to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

h. **Combined Statement of Charges, Settlement Agreement and Final Order** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings, and Iowa code § 21.5(1)(f) to discuss the decision to be rendered in a contested case).

i. **Hygiene Committee (Disciplinary Only)** (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept confidential, specifically Iowa Code § 272C.6(4) and Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).

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**OPEN SESSION**

- MOVED by ELMITT, SECONDED by JENEARY to RETURN to open session. Motion APPROVED unanimously.

- The Board reconvened in open session at 12:17 p.m. on July 14, 2017.

**III. ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS**
a. Closed Session Minutes

- MOVED by ELMITT, SECONDED by JENEARY, to APPROVE the closed session minutes for the April 27, 2017 quarterly meeting. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to APPROVE the closed session minutes for the May 18, 2017 teleconference meeting. Motion APPROVED unanimously.

b. Compliance with Board Orders


c. Disciplinary Orders


- MOVED by KELLY, SECONDED by MCBRIDE, to APPROVE the Combined Statement of Charges, Settlement Agreement, and Final Order as proposed in the Matter of Sara J. Ernst, Q.D.A., file numbers 16-0131. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MCBRIDE, to APPROVE the Combined Statement of Charges, Settlement Agreement, and Final Order as proposed in the Matter of Joyce M. Nieland, Q.D.A., file numbers 16-0132. Motion APPROVED unanimously.


d. Final Action on Cases
MOVED by SLACH, SECONDED by FOLEY, to CLOSE file number 14-0010. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to CLOSE file number 14-0017. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to CLOSE file number 14-0068. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 15-0146. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 16-0046. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 16-0084. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 15-0111. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 15-0118. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 17-0016. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 15-0174. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to CLOSE file number 16-0113. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 16-0059. Motion APPROVED unanimously. Dr. Bradley recused himself.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 16-0033. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by FOLEY, to KEEP OPEN file number 16-0094. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to CLOSE file number 16-0101. Motion APPROVED unanimously. Dr. Bradley, Ms. Slach, and Dr. McBride recused themselves.
moved by slach, seconded by foley, to keep open file number 16-0153. motion approved unanimously.

moved by slach, seconded by foley, to keep open file number 17-0006. motion approved unanimously.

moved by slach, seconded by foley, to keep open file number 17-0051. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0013. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0036. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0037. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0038. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0039. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0040. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0044. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0046. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0047. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0048. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0049. motion approved unanimously.

moved by mcbride, seconded by elmitt, to close file number 17-0050. motion approved unanimously.
MOVED by MCBRIDE, SECONDED by ELMITT, to CLOSE file number 17-0052. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by ELMITT, to CLOSE file number 17-0066. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by ELMITT, to KEEP OPEN file number 17-0067. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by ELMITT, to CLOSE file number 17-0071. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by ELMITT, to CLOSE file number 17-0072. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file numbers 13-061, 14-0166, and 16-0035. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file number 13-0086. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file number 14-0125. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file number 15-0027. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file number 16-0001. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file number 16-0123. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file number 17-0068. Motion APPROVED unanimously.

MOVED by JENEARY, SECONDED by KELLY, to CLOSE file number 17-0069. Motion APPROVED unanimously.

MOVED by KELLY, SECONDED by MCBRIDE, to CLOSE file number 14-0176. Motion APPROVED unanimously.

MOVED by KELLY, SECONDED by MCBRIDE, to CLOSE file number 14-0177. Motion APPROVED unanimously.
MOVED by KELLY, SECONDED by MCBRIDE, to CLOSE file number 15-0101. Motion APPROVED unanimously.

MOVED by KELLY, SECONDED by MCBRIDE, to KEEP OPEN file number 16-0093. Motion APPROVED unanimously.

e. Additional Information on Previous Complaints
f. Malpractice Reports
g. Notice of Hearing and Statement of Charges
h. Combined Statement of Charges, Settlement Agreement and Final Order
i. Hygiene Committee Recommendations (Disciplinary Only)

IV. ADJOURN

MOVED by JENEARY, SECONDED by FOLEY, to ADJOURN the meeting. Motion APPROVED unanimously.

The Board adjourned its meeting at 12:27 p.m. on July 13, 2017.

NEXT MEETING OF THE BOARD

The next quarterly meeting of the Board is scheduled for October 13, 2017, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.
IOWA DENTAL BOARD

OPEN SESSION MINUTES
August 30, 2017
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members
Steven Bradley, D.D.S., Present
Lori Elmitt, Public Member Present
Thomas Jeneary, D.D.S. Present
Mary Kelly, R.D.H. Present
William McBride, D.D.S. Present
Michael Davidson, D.D.S. Present
Bruce Thorsen, Public Member Present
Nancy Slach, R.D.H. Present
Monica Foley, D.D.S. Present

Staff Members
Jill Stuecker, Phil McCollum, David Schultz, Dee Ann Argo

Attorney General’s Office
Sara Scott, Assistant Attorney General

I. CALL TO ORDER

Ms. Stuecker called the open session meeting of the Iowa Dental Board to order at 7:17 a.m. on Wednesday, August 30, 2017. The meeting was held by electronic means in compliance with Iowa Code Section 21.8. The purpose of the meeting was to conduct time-sensitive Board business. It was impractical to meet in person with such a short agenda. A quorum was established with nine (9) members present.

Roll Call:

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II. OPPORTUNITY FOR PUBLIC COMMENT
There were no members of the public present and no public comments made.

III. OTHER BUSINESS
   a. MOVED by BRADLEY, SECONDED by JENEARY, to approve the Kirkwood Community College Radiography exam. Motion APPROVED unanimously.
   b. MOVED by JENEARY, SECONDED by BRADLEY, to approve the Hawkeye Community College Radiography exam. Motion APPROVED unanimously.

IV. DENTAL HYGIENE COMMITTEE REPORT
   Will be discussed in closed session pursuant to 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

CLOSED SESSION
   I. ITEM FOR REVIEW AND DISCUSSION
      ❖ MOVED by JENEARY, SECONDED by BRADLEY, to go into CLOSED SESSION pursuant to Iowa Code § 21.5(1)(d) for items I.a., I.b., and I.c., to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

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Motion APPROVED by roll call vote.

❖ The Board convened in CLOSED session at 7:20 a.m.

❖ MOVED by KELLY, SECONDED by ELMITT, to return to OPEN session. Motion APPROVED unanimously.

❖ The Board reconvened in OPEN session at 8:00 a.m.

III. ACTION ON CLOSED SESSION AGENDA ITEM
MOVED by THORSON, SECONDED by JENEARY, to KEEP OPEN case #15-0146 and #16-0084. Motion APROVED unanimously.

MOVED by THORSON, SECONDED by ELMITT, to KEEP OPEN case #17-0075. Motion APROVED unanimously.

MOVED by THORSON, SECONDED by ELMITT, to APPROVE the request in the matter of case #11-190, #16-0005, and #16-0098. Motion APROVED unanimously.

MOVED by KELLY, SECONDED by SLACH, to CLOSE case #04-061 and reinstate the license. Motion APROVED unanimously. JENEARY dissented.

IV. ADJOURN

MOVED by BRADLEY, SECONDED by JENEARY, to ADJOURN. Motion APROVED unanimously.

The meeting was adjourned at 8:02 a.m. on Wednesday, August 30, 2017.

NEXT MEETING OF THE BOARD

The next quarterly meeting of the Board is scheduled for October 12-13, 2017, in Des Moines, Iowa.

These minutes are respectfully submitted by Jill Stuecker, Iowa Dental Board.
OPEN SESSION MINUTES
September 26, 2017
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

IOWA DENTAL BOARD

I. CALL TO ORDER

The meeting of the Iowa Dental Board was called to order at 7:00 a.m. on Wednesday, September 26, 2017. The meeting was held by electronic means in compliance with Iowa Code Section 21.8. The purpose of the meeting was to conduct time-sensitive Board business. It was impractical to meet in person on such short notice with such a short agenda.

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A quorum was established with eight (8) members present.

CLOSED SESSION
I. ITEMS FOR REVIEW AND DISCUSSION

❖ MOVED by ELMITT, SECONDED by BRADLEY, to go into closed session pursuant to the following:
   a. Review of Board Order (Closed session pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential).
   b. Review of a New Complaint (Closed session pursuant to Iowa Code § 21.5(1)(d) discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).

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Motion APPROVED by roll call vote.

➢ The Board convened in CLOSED session.

❖ MOVED by BRADLEY, SECONDED by ELMITT, to return to OPEN session. Motion APPROVED unanimously.

➢ The Board reconvened in OPEN session.

III. ACTION ON CLOSED SESSION AGENDA ITEM

❖ MOVED by ELMITT, SECONDED by MCBRIDE, to APPROVE the Reinstatement Order as drafted in the Matter of Chad A. King, D.D.S. Motion APPROVED unanimously.

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<th>Bradley</th>
<th>Elmitt</th>
<th>Jeneary</th>
<th>Kelly</th>
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<th>Davidson</th>
<th>Thorsen</th>
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Motion APPROVED by roll call vote.

❖ MOVED by ELMITT, SECONDED by SLACH, to APPROVE the Stipulated Order – Agreement to Not Practice in the Matter of James A. Knight, D.D.S. Motion APPROVED unanimously.

Roll Call:
Motion APPROVED by roll call vote.

IV. ADJOURN

MOVED by KELLY, SECONDED by BRADLEY, to ADJOURN. Motion APPROVED unanimously.

NEXT MEETING OF THE BOARD

The next quarterly meeting of the Board is scheduled for October 13, 2017, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness and Phil McCollum, Iowa Dental Board.
DATE OF MEETING: October 13, 2017
RE: Recommendations: Course, Sponsor & Requests
SUBMITTED BY: Continuing Education Advisory Committee
ACTION REQUESTED: Board Action on Committee Recommendation

COMMITTEE RECOMMENDATIONS
The committee requests that the Board accept the following recommendations:

CONTINUING EDUCATION COURSE REVIEW
- Henry Schein – “Double Your Production Tomorrow” – Requested 4 hours – Recommended DENIAL due to focus on business aspects of practice.
- AppleWhite Dental Partners – “A Presentation by Dr. Michael Abernathy” – Requested 4 hours for the team, 6.5 hours for the doctors – Recommended DENIAL due to focus on business aspects of practice.
- Metro West Seminars – “Botulinum Toxins and Dermal Fillers for Aesthetic and Therapeutic Use in the Dental Practice” – Requested 2 hours – Recommended APPROVAL as submitted.
- Impact Dental Training – “Iowa Dental Jurisprudence” – Requested 2 hours – Recommended APPROVAL as submitted.

CONTINUING EDUCATION COURSE APPLICATIONS REVIEWED BY BOARD STAFF
The Continuing Education Advisory Committee recommended APPROVAL for the staff recommendations as follows:
- Eastern Iowa Community Colleges – “Infection Control and Dental Radiography” – Requested 4 hours (2 hours for each portion).
• Henry Schein Dental – “HIPAA Compliance: Understanding HIPAA for Dentistry” – Requested 3 hours.
• Iowa Lakes Community College – “Infection Control for Dental Assistants” – Requested 2 hours.
• Alpha Orthodontics – “5th Annual Meeting: ‘Connecting the Dots Between Cancer, Chronic Illness and Periodontal Disease’ and ‘America’s Sweet Tooth Obsession and It’s Impact on Oral & Systemic Health’” – Requested 6 hours (3 hours for each portion).
• Omni Dental Centres, LLC – “Non-Surgical Perio Therapy With Laser” – Requested 8 hours.
• Northwest Component Iowa Dental Hygienists' Association – “Gums and Roses: The Role of the Dental Hygienist from Tooth Preservation to Tooth Replacement” – Requested 6 hours.
• Mercy Cedar Rapids, Hall-Perrine Cancer Center – “2017 Fall Cancer Care Update for Dental Health Professionals” – Requested 2 hours.
• Metro West Seminars – “Management of Dry Mouth and Sjorgen’s Syndrome in the Dental Practice” – Requested 2 hours.
• Metro West Seminars – “Periodontal Maintenance of Dental Implants” – Requested 2 hours.
• Impact Dental Training, LLC – “Integrating CAD/CAM Dentistry into Your Practice” – Requested 4 hours (2 hours for lecture, 2 hours for workshop).

* Iowa Administrative Code 650—25.3(7)b. “Acceptable subject matter includes courses in patient treatment record keeping, risk management, sexual boundaries, communication, and OSHA regulations, and courses related to clinical practice. A course on Iowa jurisprudence that has been prior-approved by the board is also acceptable subject matter.”

CONTINUING EDUCATION SPONSOR APPLICATIONS FOR REVIEW

The Continuing Education Advisory Committee recommended APPROVAL of the following sponsor applications:
• Midwest Dental
• Digital Aspects

OTHER RECOMMENDATIONS

The Continuing Education Advisory Committee recommended APPROVAL of the following, with clarifications as noted:

• Nitrous Oxide Administration Course Request – Oklahoma Dental Foundation – with a clarification regarding the current regulations regarding the monitoring of nitrous oxide by dental assistants as an expanded function. Current regulations do not allow dental assistants to administer nitrous oxide pursuant to IAC 650—Chapter 29.

• Expanded Functions Online Course Request – Impact Dental Training – with a clarification that there is a limit of 12 hours of self-study courses that may be applied towards the renewal of a license or registration pursuant to IAC 650—Chapter 25.
<table>
<thead>
<tr>
<th>Chapter # and Title</th>
<th>Description of Action, Reason, &amp; Alternatives</th>
<th>Legal Basis for Action</th>
<th>Schedule for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAC 650-Chapter 11 “Licensure to Practice Dentistry or Dental Hygiene” and Chapter 12 “Dental and Dental Hygiene Examinations”</td>
<td>Amending licensure by examination to include all regional testing agencies for licensure. This will ensure uniformity in the testing process.</td>
<td>Iowa Code Chapter 147.34</td>
<td>ADOPTED</td>
</tr>
<tr>
<td>IAC 650-Chapter 11 “Licensure to Practice Dentistry or Dental Hygiene” and Chapter 12 “Dental and Dental Hygiene Examinations”</td>
<td>Per legislative mandate the Board is required to offer an alternate examination for licensure of dentists. These rules implement the Portfolio Exam.</td>
<td>Iowa Code Chapter 147.34</td>
<td>IN PROGRESS</td>
</tr>
<tr>
<td>IAC 650—Chapter 25 “Continuing Education”</td>
<td>These rules update and simplify continuing education requirements.</td>
<td>Iowa Code Chapter 272C.2</td>
<td>IN PROGRESS</td>
</tr>
<tr>
<td>IAC 650 – Chapter 14, “Renewal and Reinstatement”</td>
<td>These rules have not been reviewed for several years. They simply the process for reinstatement of a dental assisting application.</td>
<td>Iowa Code Chapter 147.34</td>
<td>IN PROGRESS</td>
</tr>
<tr>
<td>IAC 650—Chapter 20 “Dental Assistants”</td>
<td>These rules have not been reviewed for several years. They provide clarification on trainee status and simplify requirements.</td>
<td>Iowa Code Chapter 153.39 and 147.11</td>
<td>IN PROGRESS</td>
</tr>
<tr>
<td>IAC 650—Chapter 15 “Fees”</td>
<td>Due to database updates some mailing lists and subscription services are now automated. Revisions reflect these changes.</td>
<td>Iowa Code Chapter 147.80</td>
<td>IN PROGRESS</td>
</tr>
<tr>
<td>IAC 650—Chapter 10 “General Requirements”</td>
<td>Per a bill signed into law, these revisions add language allowing RDH to provide educational services without supervision.</td>
<td>Iowa Code Chapter 153.15</td>
<td>IN PROGRESS</td>
</tr>
<tr>
<td>IAC 650-Chapter 29 “Sedation and Nitrous Oxide Inhalation Analgesia”</td>
<td>These rules reflect recent ADA recommendations, add definition of “hospitalization” and clarify ACLS/PALS requirements.</td>
<td>Iowa Code Chapter 153.33 and 153.34</td>
<td>IN PROGRESS</td>
</tr>
<tr>
<td>IAC 650 – Chapter 11 “Licensure to Practice Dentistry or Dental Hygiene”</td>
<td>The role of the licensure and registration committee needs to be clarified.</td>
<td>Iowa Code Chapter 147.2 and 147.4</td>
<td>Scheduled for October 2017</td>
</tr>
<tr>
<td>IAC 650-Chapter 28 “Designation of Specialties”</td>
<td>The Board needs to discuss new legal concerns with ADA approved specialties, and determine whether changes need to be made to this chapter.</td>
<td>Iowa Code Chapter 153.13</td>
<td>Scheduled for October 2017</td>
</tr>
<tr>
<td>IAC 650-Chapter 26 “Advertising”</td>
<td>The Board needs to discuss new legal concerns with ADA approved specialties, and determine whether changes need to be made to this chapter.</td>
<td>Iowa Code Chapter 153.33 and 153.34</td>
<td>Scheduled for October 2017</td>
</tr>
<tr>
<td>IAC 650—Chapter 10 “General Requirements”</td>
<td>The address type a licensee must submit to the board needs to be specified.</td>
<td>Iowa Code Chapter 147.8 and 147.9</td>
<td>Discussion scheduled for October 2017</td>
</tr>
<tr>
<td>IAC 650—Chapter 20 “Dental Assistants” and Chapter 10 “General Requirements”</td>
<td>Expanded function rules in these 2 chapters need to be revisited to provide clarity on some functions. Language may need to be added regarding minimum requirements for training and resubmission of courses.</td>
<td>Iowa Code Chapter 153.15 and 153.38</td>
<td>Discussion scheduled for October 2017</td>
</tr>
<tr>
<td>IAC 650—Chapter 10 “General Requirements”</td>
<td>Chapter 10 currently prohibits a hygienist from owning a dental practice. This is the only prohibition on ownership and the Board has approved 2 waivers. It needs to revisited.</td>
<td>Iowa Code Chapter 153.15</td>
<td>Discussion scheduled for October 2017</td>
</tr>
<tr>
<td>IAC 650—Chapter 16 “Prescribing, Administering and Dispensing Drugs”</td>
<td>Update rules to match requirements by the DEA and the Iowa Board of Pharmacy.</td>
<td>Iowa Code Chapter 153.20</td>
<td>Discussion scheduled for January 2018</td>
</tr>
<tr>
<td>IAC 650—Chapter 1 “Administration” and Chapter 11 “Licensure to Practice Dentistry or Dental Hygiene”</td>
<td>Updates to committees to reflect current needs of the Board.</td>
<td>Iowa Code Chapter 17A.3, 147.3, 147.4, 147.9, 147.14(4), 147.22, and 15.33A(1)</td>
<td>Discussion scheduled for January 2018</td>
</tr>
<tr>
<td>IAC 650—Chapter 27 “Discontinuation of Practice”</td>
<td>These rules need to be updated to reflect new practice structures.</td>
<td>Iowa Code Chapter 153.33(8), 153.34 and 147.76</td>
<td>NOTICE TABLED – WILL REVISIT IN JANUARY</td>
</tr>
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</table>
Pursuant to the authority of Iowa Code sections 147.76 and 153.33, the Dental Board hereby amends Chapter 29, “Sedation and Nitrous Oxide Inhalation Analgesia,” Iowa Administrative Code.

These amendments define “hospitalization” for the purpose of reporting an adverse occurrence, update requirements for the use of moderate sedation and deep sedation/general anesthesia in accordance with newly issued American Dental Association (ADA) guidelines for the use of sedation, and clarify the type of Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certification courses allowed for the purposes of application and renewal of a sedation permit.

These amendments clarify situations wherein a licensee would be required to report an adverse occurrence. The current rules require a report in the case of hospitalization, but hospitalization is not currently defined in the Board’s rules; this has led to some uncertainty about requirements for reporting of adverse occurrences.

The amendments update sedation guidelines to match the new guidelines issued by the ADA. Comments received during past rule making related to this chapter urged the Board to wait for guidelines to be issued by the ADA prior to implementing changes. In the fall of 2016, the ADA issued new guidelines recommended for use in moderate sedation and deep sedation/general anesthesia. The Anesthesia Credentials Committee, a committee of the Board, reviewed the recommendations and advocated their adoption in order to have additional safeguards in place during the administration of moderate sedation or deep sedation/general anesthesia. The amendments require general anesthesia permit holders to maintain and be trained on equipment that monitors end-tidal CO₂ and on a pretracheal or precordial stethoscope during the use of deep sedation/general anesthesia in order to monitor auscultation of breath sounds.
These amendments update the requirements for certification in ACLS and PALS, which is a requirement for moderate sedation and general anesthesia permits. The amendments would require acceptable certification courses to include a clinical component wherein the practitioner must demonstrate competency in life support services. Online-only certification courses would not be accepted. These amendments would make the ACLS and PALS certification requirements consistent with the requirements for CPR certification for licensure and registration.

These amendments update the requirements for moderate sedation training. The ADA has recommended that moderate sedation training courses include training on rescuing a patient from a deeper level of sedation than intended, including training in airway management and the use of reversal medications.

These amendments require moderate sedation permit holders to maintain and be trained on equipment that monitors end-tidal CO₂ and on a pretracheal or precordial stethoscope unless precluded or invalidated by the nature of the patient, procedure or equipment.

Notice of Intended Action was published in the Iowa Administrative Bulletin on August 15, 2017 as ARC 3261C. A public hearing was held on September 12, 2017, at 2 p.m. at the office of the Iowa Dental Board. There were not any attendees at the public hearing, nor were any written comments received.

The Board reviewed and discussed the amendments during their October 13, 2017, open session board meeting and allowed additional comments from the public.

The amendments are subject to waiver or variance pursuant to 650-chapter 7.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 153.20.

These amendments are identical to those published under Notice.

The following amendments are adopted.
ITEM 1. Adopt the following **new** definition of “Hospitalization” in rule 650—29.1(153):

“Hospitalization” means in-patient treatment at a hospital or clinic. Out-patient treatment at an emergency room or clinic is not considered to be hospitalization for the purposes of reporting adverse occurrences.

ITEM 2. Amend subrule 29.3(2) as follows:

29.3(2) A dentist using deep sedation/general anesthesia shall maintain a properly equipped facility at each facility where sedation is administered. The dentist shall maintain and be trained on the following equipment at each facility where sedation is provided: capnography to monitor end-tidal CO2, pretracheal or precordial stethoscope to continually monitor auscultation of breath sounds, EKG monitor, positive pressure oxygen, suction, laryngoscope and blades, endotracheal tubes, magill forceps, oral airways, stethoscope, blood pressure monitoring device, pulse oximeter, emergency drugs, defibrillator. A licensee may submit a request to the board for an exemption from any of the provisions of this subrule. Exemption requests will be considered by the board on an individual basis and shall be granted only if the board determines that there is a reasonable basis for the exemption.

ITEM 3. Amend subrule 29.3(4) as follows:

29.3(4) A dentist administering deep sedation/general anesthesia must document and maintain current, successful completion of an **certification in** Advanced Cardiac Life Support (ACLS) course. **Current certification means certification by an organization on an annual basis or, if that certifying organization requires certification on a less frequent basis, evidence that the permit holder has been properly certified for each year covered by the renewal period. In addition, the course must include a clinical component.**

ITEM 4. Amend subrule 29.4(1) as follows:

29.4(1) A permit may be issued to a licensed dentist to use moderate sedation for dental patients provided the dentist meets the following requirements:
ITEM 5. Amend subrule 29.4(2) as follows:

29.4(2) A dentist utilizing moderate sedation shall maintain a properly equipped facility. The dentist shall maintain and be trained on the following equipment at each facility where sedation is provided: capnography to monitor end-tidal CO₂ unless precluded or invalidated by the nature of the patient, procedure or equipment, pretracheal or precordial stethoscope, EKG monitor, positive pressure oxygen, suction, laryngoscope and blades, endotracheal tubes, magill forceps, oral airways, stethoscope, blood pressure monitoring device, pulse oximeter, emergency drugs, defibrillator. A licensee may submit a request to the board for an exemption from any of the provisions of this subrule. Exemption requests will be considered by the board on an individual basis and shall be granted only if the board determines that there is a reasonable basis for the exemption.

ITEM 6. Amend subrule 29.4(4) as follows:

29.4(4) A dentist administering moderate sedation must document and maintain current,
successful completion of an certification in Advanced Cardiac Life Support (ACLS) course. A dentist administering moderate sedation to pediatric patients may maintain current certification in Pediatric Advanced Life Support (PALS) in lieu of ACLS. Current certification means certification by an organization on an annual basis or, if that certifying organization requires certification on a less frequent basis, evidence that the permit holder has been properly certified for each year covered by the renewal period. In addition, the course must include a clinical component.

ITEM 7. Amend subrule 29.5(11) as follows:

29.5(11) Use of capnography required beginning January 1, 2014. Use of capnography and pretracheal or precordial stethoscope.

a. Consistent with the practices of the American Association of Oral and Maxillofacial Surgeons (AAOMS), all general anesthesia/deep sedation permit holders shall use capnography at all facilities where they provide sedation beginning January 1, 2014.

b. All general anesthesia/deep sedation permit holders shall use a pretracheal or precordial stethoscope to continually monitor auscultation of breath sounds beginning January 1, 2018.

ITEM 8. Amend subrule 29.5(12) as follows:

29.5(12) Use of capnography or pretracheal/precordial stethoscope required for moderate sedation permit holders. Beginning January 1, 2015, all moderate sedation permit holders shall use capnography or a pretracheal/precordial to monitor end-tidal CO₂ unless precluded or invalidated by the nature of the patient, procedure or equipment. In cases where the use of capnography is precluded or invalidated for the reasons listed previously, a pretracheal or precordial stethoscope must be used to continually monitor the auscultation of breath sounds at all facilities where they permit holders provide sedation.
SENT VIA EMAIL TO THE STATE DENTAL BOARD DIRECTORS

July 28, 2017

Dear Colleagues:

The American Dental Association (ADA) is aware of a recent letter sent by the Academy of General Dentistry (AGD) to members of State Dental Boards and their Executive Directors in apparent response to a NBC news story about the tragic deaths in California of two children while undergoing in-office sedation and dental procedures. We are concerned that the letter contains a number of misstatements and, most importantly, improperly suggests a relationship between the tragedies described in that story and the recent revisions to the adult Guidelines for the Use of Sedation and General Anesthesia by Dentists (Appendix 1) and Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Appendix 2). The AGD letter also creates the misconception that the ADA Guidelines run contrary to the AAP/AAPD Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures for care and management of pediatric patients. These misstatements and mischaracterizations are very disturbing.

At a time when the dental profession should be united in working toward the goal that such events never happen again, and in assuring the public that guidelines are in place to prevent such tragedies, the ADA does not understand the AGD’s purpose in disparaging the adult sedation guidelines and falsely suggesting that they create a risk of harm to the public. We are concerned this might lead to confusion and distrust among our patients and public officials, the opposite of what is needed when these events occur.

The ADA stands behind the efficacy of its adult sedation guidelines. The revision of those guidelines was a process that occurred over more than two years, and was based on the most current peer-reviewed literature. Input was solicited from all communities of interest, including a special meeting at the ADA Building in June 2016; town hall meetings at the ADA Annual Meeting; calls for written testimony throughout the process; and utilization of the expertise of the members of the ADA Council on Scientific Affairs. The authors of the revision, the Council on Dental Education and Licensure’s (CDEL) Anesthesia Committee, are undisputed experts in the field of sedation and anesthesia who all have impeccable credentials. They carefully and thoughtfully reviewed all comments submitted by all of the communities of interest, including the AGD. In the end, the revision process was centered around utilizing the best, most relevant scientific evidence available for the benefit to, and safety of, the patients we serve.

In particular, the ADA takes strong exception to three AGD statements. First, it is a mischaracterization to suggest that the American Dental Association is at odds in any way with the AAP/AAPD Guidelines, whether in regard to the use of capnography or in any other detail. The AAPD has expressly stated, in both written and verbal testimony, that this revision is aligned with their own guidelines. Further, the ADA is not alone in its conclusion about the importance of
including capnographic measure in the monitoring of the moderately sedated dental patient. The American Association of Oral and Maxillofacial Surgeons (AAOMS) has required capnography for the monitoring of moderately sedated patients in outpatient facilities since January 1, 2014 (Appendix 3).

Second, it is a mischaracterization for AGD to suggest that “the revisions...mandate a capnograph (with no other options) for moderate sedation...” and that “...use of a capnograph can produce false-positives and endanger the patient in an open-airway environment.” The revised guidelines are quite clear that the clinician has the option to utilize other methods of monitoring respiration based on his/her clinical judgment:

“The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO2 unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation should be monitored by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.”

(Guidelines for the Use of Sedation and General Anesthesia by Dentists, p. 11, 13.)

In addition, while agreeing that the use of a capnography can, like all methods of monitoring respiration, produce false-positives, the ADA conducted a meta-analysis evaluating ability of capnography to detect respiratory complications, most commonly reported as apnea or altered ventilation, during moderate procedural sedation and analgesia. Using a random-effects model of ten studies (Appendix 4) involving 839 adults receiving procedural sedation and anesthesia, the ADA found that the weighted odds ratio of adverse respiratory events was 10.48 (95% CI: 3.64, 30.23), indicating that the odds of correctly detecting adverse respiratory events in patients undergoing moderate procedural sedation may be 10.48 greater if monitoring included capnography than if it did not. The ADA suggests that this improvement in patient safety outweighs the inconvenience of taking the time to check a patient subsequently determined to have a false-positive event.

Finally, although the guidelines have revised the training requirements, it is false to state that the ADA has “relaxed” the intravenous training requirement. In fact the training requirements were not reduced. The number of training hours for moderate sedation, regardless of agent, is 60 hours in the 2016 Guidelines. The ADA Guidelines include a new statement to support this: “Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.”

Further the 2016 Guidelines reinforced training by requiring that courses include:
- A minimum of 60 hours of instruction plus administration of sedation for at least 20 individually managed patients.
- Certification of competence [emphasis added] in moderate sedation technique(s).
- Certification of competence [emphasis added] in rescuing patients from a deeper level of sedation than intended including managing the airway, intravascular or intraosseous access, and reversal medications.
• Provision by course director or faculty of additional clinical experience if participant competency has not been achieved in time allotted.
• Records of instruction and clinical experiences (i.e., number of patients managed by each participant in each modality/route) that are maintained and available for participant review.

To the extent that AGD is suggesting that these training requirements are deficient, we note "competent" is defined in the 2016 ADA Guidelines as follows: "competent – displaying special skill or knowledge derived from training and experience." Demonstration of competence is certainly more rigorous than simply mandating a random number of procedures performed without any evaluation of whether the clinician is actually performing to an acceptable level. In other words, under the old guidelines, a clinician could complete administration of sedation for at least 20 individually managed patients very poorly, and yet still meet the training requirements.

In conclusion, let us reiterate that the issues raised by the AGD have nothing to do with the tragic deaths of children reported in the media. The ADA is very disappointed that the AGD has chosen to utilize the deaths of two children to highlight its continued disagreement with the ADA revised adult sedation guidelines, especially in light of the fact it was afforded ample opportunity at several levels of review to make a scientific-based argument in its favor. As noted, it is much more important to provide assurance to the public that the adherence to the guidelines adopted by the AAPD and by the ADA, respectively, will result in minimizing these unfortunate events.

Sincerely,

Gary L. Roberts, D.D.S.
President

Kathleen T. O’Loughlin, D.M.D., M.P.H.
Executive Director

GLR/KTO/AZ:ns
Enclosures
cc: Officers and Members of the ADA Board of Trustees
American Association of Dental Boards
State Dental Association Executive Directors
Dr. Maria A. Smith, president, Academy of General Dentistry
Mr. Daniel Buksa, associate executive director of public affairs, Academy of General Dentistry
GUIDELINES
for the Use of Sedation and General Anesthesia by Dentists

Adopted by the ADA House of Delegates, October 2016

I. INTRODUCTION
The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists must comply with their state laws, rules and/or regulations when providing sedation and anesthesia and will only be subject to Section III. Educational Requirements as required by those state laws, rules and/or regulations.

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

For children, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

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  ➤ DEEP SEDATION OR GENERAL ANESTHESIA 12
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II. DEFINITIONS
METHODS OF ANXIETY AND PAIN CONTROL

MINIMAL SEDATION (previously known as anxiolysis) – a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.¹

Patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

The following definitions apply to administration of minimal sedation:

**maximum recommended dose (MRD)** – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

**dosing for minimal sedation via the enteral route** – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

The administration of enteral drugs exceeding the maximum recommended dose during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

If more than one enteral drug is administered to achieve the desired sedation effect, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.
MODERATE SEDATION – a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.¹

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

titration – administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug’s time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

DEEP SEDATION AND GENERAL ANESTHESIA

deep sedation – a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.¹

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.¹

For all levels of sedation, the qualified dentist must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.
ROUTES OF ADMINISTRATION

enteral – any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral – a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal – a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation – a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

TERMS

analgesia – the diminution or elimination of pain.

local anesthesia – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.

qualified dentist – a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.

operating dentist – dentist with primary responsibility for providing operative dental care while a qualified dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or deep sedation or general anesthesia.

competency – displaying special skill or knowledge derived from training and experience.

must/shall – indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should – indicates the recommended manner to obtain the standard; highly desirable.

may – indicates freedom or liberty to follow a reasonable alternative.

continual – repeated regularly and frequently in a steady succession.

continuous – prolonged without any interruption at any time.

time-oriented anesthesia record – documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.
### AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PATIENT PHYSICAL STATUS CLASSIFICATION²

<table>
<thead>
<tr>
<th>Classification</th>
<th>Definition</th>
<th>Examples, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA I</td>
<td>A normal healthy patient</td>
<td>Healthy, non-smoking, no or minimal alcohol use</td>
</tr>
<tr>
<td>ASA II</td>
<td>A patient with mild systemic disease</td>
<td>Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 &lt; BMI &lt; 40), well-controlled DM/HTN, mild lung disease</td>
</tr>
<tr>
<td>ASA III</td>
<td>A patient with severe systemic disease</td>
<td>Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, *ESRD undergoing regularly scheduled dialysis, premature infant PCA &lt; 60 weeks, history (&gt;3 months) of MI, CVA, TIA, or CAD/stents.</td>
</tr>
<tr>
<td>ASA IV</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Examples include (but not limited to): recent (&lt; 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or *ESRD not undergoing regularly scheduled dialysis</td>
</tr>
<tr>
<td>ASA V</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction</td>
</tr>
<tr>
<td>ASA VI</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td></td>
</tr>
</tbody>
</table>

*The addition of “E” denotes emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)*

### AMERICAN SOCIETY OF ANESTHESIOLOGISTS' FASTING GUIDELINES²

<table>
<thead>
<tr>
<th>Ingested Material</th>
<th>Minimum Fasting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear liquids</td>
<td>2 hours</td>
</tr>
<tr>
<td>Breast milk</td>
<td>4 hours</td>
</tr>
<tr>
<td>Infant formula</td>
<td>6 hours</td>
</tr>
<tr>
<td>Nonhuman milk</td>
<td>6 hours</td>
</tr>
<tr>
<td>Light meal</td>
<td>6 hours</td>
</tr>
<tr>
<td>Fatty meal</td>
<td>8 hours</td>
</tr>
</tbody>
</table>
III. EDUCATIONAL REQUIREMENTS

A. Minimal Sedation

1. To administer minimal sedation the dentist must demonstrate competency by having successfully completed:
   a. training in minimal sedation consistent with that prescribed in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or
   b. comprehensive training in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced; or
   c. an advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines; and
   d. a current certification in Basic Life Support for Healthcare Providers.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must demonstrate competency by having successfully completed:
   a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced; or
   b. an advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines; and
   c. 1) A current certification in Basic Life Support for Healthcare Providers and
      2) Either current certification in Advanced Cardiac Life Support (ACLS or equivalent) or completion of an appropriate dental sedation/anesthesia emergency management course on the same recertification cycle that is required for ACLS.
2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must demonstrate competency by having completed:

   a. An advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines; and

   b. 1) A current certification in Basic Life Support for Healthcare Providers and

   2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent) or completion of an appropriate dental sedation/anesthesia emergency management course on the same re-certification cycle that is required for ACLS.

2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.
IV. CLINICAL GUIDELINES

A. Minimal sedation

1. Patient History and Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of a review of their current medical history and medication use. In addition, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-Operative Evaluation and Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- An appropriate focused physical evaluation should be performed.
- Baseline vital signs including body weight, height, blood pressure, pulse rate, and respiration rate must be obtained unless invalidated by the nature of the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver.

3. Personnel and Equipment Requirements

Personnel: At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- Documentation of compliance with manufacturers’ recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
4. Monitoring and Documentation

Monitoring: A dentist, or at the dentist’s direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

Consciousness: Level of sedation (e.g., responsiveness to verbal commands) must be continually assessed.

Oxygenation: Oxygen saturation by pulse oximetry may be clinically useful and should be considered.

Ventilation:
- The dentist and/or appropriately trained individual must observe chest excursions.
- The dentist and/or appropriately trained individual must verify respirations.

Circulation: Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, time administered and route of administration, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns is returned to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.
B. Moderate Sedation

1. Patient History and Evaluation

Patients considered for moderate sedation must undergo an evaluation prior to the admin-
istration of any sedative. This should consist of at least a review at an appropriate time of
their medical history and medication use and NPO (nothing by mouth) status. In addition,
patients with significant medical considerations (e.g., ASA III, IV) should also require
consultation with their primary care physician or consulting medical specialist. Assessment
of Body Mass Index (BMI)\(^4\) should be considered part of a pre-procedural workup. Patients
with elevated BMI may be at increased risk for airway associated morbidity, particularly if in
association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure
  associated with the delivery of any sedative agents and informed consent for the
  proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen
  under positive pressure must be completed.
- An appropriate focused physical evaluation must be performed.
- Baseline vital signs including body weight, height, blood pressure, pulse rate, respiration
  rate, and blood oxygen saturation by pulse oximetry must be obtained unless precluded
  by the nature of the patient, procedure or equipment. Body temperature should be
  measured when clinically indicated.
- Pre-operative verbal or written instructions must be given to the patient, parent,
  escort, legal guardian or care giver, including pre-operative fasting instructions based
  on the ASA Summary of Fasting and Pharmacologic Recommendations.

3. Personnel and Equipment Requirements

Personnel: At least one additional person trained in Basic Life Support for Healthcare
Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must
  be immediately available.
- Documentation of compliance with manufacturers’ recommended maintenance of
  monitors, anesthesia delivery systems, and other anesthesia-related equipment should
  be maintained. A pre-procedural check of equipment for each administration of sedation
  must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately
  checked and calibrated. The equipment must also have either (1) a functioning device
  that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated
  and functioning in-line oxygen analyzer with audible alarm.
- The equipment necessary for monitoring end-tidal CO\(_2\) and auscultation of breath sounds
  must be immediately available.
4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Consciousness: Level of sedation (e.g., responsiveness to verbal command) must be continually assessed.

Oxygenation: Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:
- The dentist must observe chest excursions continually.
- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO₂ unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation should be monitored by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.

Circulation:
- The dentist must continually evaluate blood pressure and heart rate unless invalidated by the nature of the patient, procedure or equipment and this is noted in the time-oriented anesthesia record.
- Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:
- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters.
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must continually monitor the patient’s blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
• Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver.
• If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management
• If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient is returned to the intended level of sedation.
• The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

C. Deep Sedation or General Anesthesia

1. Patient History and Evaluation
Patients considered for deep sedation or general anesthesia must undergo an evaluation prior to the administration of any sedative. This must consist of at least a review of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) should also require consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI) should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation
• The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
• Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
• A focused physical evaluation must be performed as deemed appropriate.
• Baseline vital signs including body weight, height, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless invalidated by the patient, procedure or equipment. In addition, body temperature should be measured when clinically appropriate.
• Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.
• An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6., Special Needs Patients.
3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- Documentation of compliance with manufacturers’ recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- The equipment necessary for monitoring end-tidal CO₂ and auscultation of breath sounds must be immediately available.
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Oxygenation: Oxygenation saturation must be evaluated continuously by pulse oximetry.
- Ventilation:
  - Intubated patient: End-tidal CO₂ must be continuously monitored and evaluated.
  - Non-intubated patient: End-tidal CO₂ must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation should be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
  - Respiration rate must be continually monitored and evaluated.
Circulation:

- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:

- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters.
- Pulse oximetry and end-tidal CO₂ measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient’s blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, and parent, escort, guardian or care giver.

6. Special Needs Patients

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.
ENDNOTES

1 Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at www.asahq.org.

2 Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at www.asahq.org.

3 Excerpted from 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, 2011. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at www.asahq.org.

4 Standardized BMI category definitions can be obtained from the Centers for Disease Control and Prevention or the American Society of Anesthesiologists.
GUIDELINES
for Teaching Pain Control and Sedation to Dentists and Dental Students

Adopted by the ADA House of Delegates, October 2016

I. INTRODUCTION

The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of dentistry. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists.

Anxiety and pain control can be defined as the application of various physical, chemical and psychological modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as such, is one of the most important aspects of dental education. The intent of these Guidelines is to provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental education from predoctoral through continuing education. They are designed to teach initial competency in pain control and minimal and moderate sedation techniques.

These Guidelines recognize that many dentists have acquired a high degree of competency in the use of anxiety and pain control techniques through a combination of instruction and experience. It is assumed that this has enabled these teachers and practitioners to meet the educational criteria described in this document.

It is not the intent of the Guidelines to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education.

The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these Guidelines.
Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and techniques for administering these drugs enterally, parenterally and by inhalation as supplements to local anesthesia.

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for the Healthcare Provider. Though Basic Life Support courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents.

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

For children, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.
II. DEFINITIONS

METHODS OF ANXIETY AND PAIN CONTROL

**MINIMAL SEDATION** (previously known as anxiolyis) – a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.

Patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

The following definitions apply to administration of minimal sedation:

**maximum recommended dose (MRD)** – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

**dosing for minimal sedation via the enteral route** – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

The administration of enteral drugs exceeding the maximum recommended dose during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

If more than one enteral drug is administered to achieve the desired sedation effect, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

*Note:* In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.
**MODERATE SEDATION** — a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.¹

*Note:* In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

**titration** — administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug’s time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intended effect is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

**deep sedation** — a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.¹

**general anesthesia** — a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.¹

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.¹

For all levels of sedation, the qualified dentist must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.
ROUTES OF ADMINISTRATION

enteral — any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral — a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal — a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal — a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation — a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

TERMS

analgesia — the diminution or elimination of pain.

local anesthesia — the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.

qualified dentist — a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.

must/shall — indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should — indicates the recommended manner to obtain the standard; highly desirable.

may — indicates freedom or liberty to follow a reasonable alternative.

continual — repeated regularly and frequently in a steady succession.

continuous — prolonged without any interruption at any time.

time-oriented anesthesia record — documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available — on site in the facility and available for immediate use.
LEVELS OF KNOWLEDGE

**familiarity** – a simplified knowledge for the purpose of orientation and recognition of general principles.

**in-depth** – a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

LEVELS OF SKILL

**exposed** – the level of skill attained by observation of or participation in a particular activity.

**competent** – displaying special skill or knowledge derived from training and experience.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PATIENT PHYSICAL STATUS CLASSIFICATION

<table>
<thead>
<tr>
<th>Classification</th>
<th>Definition</th>
<th>Examples, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA I</td>
<td>A normal healthy patient</td>
<td>Healthy, non-smoking, no or minimal alcohol use</td>
</tr>
<tr>
<td>ASA II</td>
<td>A patient with mild systemic disease</td>
<td>Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 &lt; BMI &lt; 40), well-controlled DM/HTN, mild lung disease</td>
</tr>
<tr>
<td>ASA III</td>
<td>A patient with severe systemic disease</td>
<td>Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, *ESRD undergoing regularly scheduled dialysis, premature infant PCA &lt; 60 weeks, history (&gt;3 months) of MI, CVA, TIA, or CAD/stents.</td>
</tr>
<tr>
<td>ASA IV</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Examples include (but not limited to): recent (&lt; 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or *ESRD not undergoing regularly scheduled dialysis</td>
</tr>
<tr>
<td>ASA V</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction</td>
</tr>
<tr>
<td>ASA VI</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td></td>
</tr>
</tbody>
</table>

*The addition of “E” denotes emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)
AMERICAN SOCIETY OF ANESTHESIOLOGISTS’ FASTING GUIDELINES

<table>
<thead>
<tr>
<th>Ingested Material</th>
<th>Minimum Fasting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear liquids</td>
<td>2 hours</td>
</tr>
<tr>
<td>Breast milk</td>
<td>4 hours</td>
</tr>
<tr>
<td>Infant formula</td>
<td>6 hours</td>
</tr>
<tr>
<td>Nonhuman milk</td>
<td>6 hours</td>
</tr>
<tr>
<td>Light meal</td>
<td>6 hours</td>
</tr>
<tr>
<td>Fatty meal</td>
<td>8 hours</td>
</tr>
</tbody>
</table>

EDUCATION COURSES

Education may be offered at different levels (competency, update, survey courses and advanced education programs). A description of these different levels follows:

1. **Competency Courses** are designed to meet the needs of dentists who wish to become competent in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist’s competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. **Update Courses** are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. **Survey Courses** are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. **Advanced Education Courses** are a component of an advanced dental education program, accredited by the Commission on Dental Accreditation in accord with the Accreditation Standards for advanced dental education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be competent in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.
III. TEACHING PAIN CONTROL

These Guidelines present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predental curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;

2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;

3. be competent in monitoring vital functions;

4. be competent in prevention, recognition and management of related complications;

5. have in-depth knowledge of the appropriateness of and the indications for medical consultation or referral; and

6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain

2. Review of physiologic and psychologic aspects of anxiety and pain

3. Review of airway anatomy and physiology

4. Physiologic monitoring
   a. Observation
      (1) Central nervous system
      (2) Respiratory system
         (a) Oxygenation
         (b) Ventilation
      (3) Cardiovascular system
   b. Monitoring equipment

5. Pharmacologic aspects of anxiety and pain control
   a. Routes of drug administration
   b. Sedatives and anxiolytics
   c. Local anesthetics
   d. Analgesics and antagonists
   e. Adverse side effects
   f. Drug interactions
   g. Drug abuse

6. Control of preoperative and operative anxiety and pain
a. Patient evaluation
   (1) Psychological status
   (2) ASA physical status
   (3) Type and extent of operative procedure

b. Nonpharmacologic methods
   (1) Psychological and behavioral methods
      (a) Anxiety management
      (b) Relaxation techniques
      (c) Systematic desensitization
   (2) Interpersonal strategies of patient management
   (3) Hypnosis
   (4) Electronic dental anesthesia
   (5) Acupuncture/Acupressure
   (6) Other

c. Local anesthesia
   (1) Review of related anatomy, and physiology
   (2) Pharmacology
      (i) Dosing
      (ii) Toxicity
      (iii) Selection of agents
   (3) Techniques of administration
      (i) Topical
      (ii) Infiltration (supraperiosteal)
      (iii) Nerve block – maxilla – to include:
         (aa) Posterior superior alveolar
         (bb) Infraorbital
         (cc) Nasopalatine
         (dd) Greater palatine
         (ee) Maxillary (2nd division)
         (ff) Other blocks
      (iv) Nerve block – mandible – to include:
         (aa) Inferior alveolar-lingual
         (bb) Mental-incisive
         (cc) Buccal
         (dd) Gow-Gates
         (ee) Closed mouth
      (v) Alternative injections – to include:
         (aa) Periodontal ligament
         (bb) Intraosseous

d. Prevention, recognition and management of complications and emergencies
C. **Sequence of Pain Control Didactic and Clinical Instruction:** Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient’s level of anxiety, cooperation, medical condition and the planned procedures.

D. **Faculty:** Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. **Facilities:** Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.
IV. TEACHING ADMINISTRATION OF MINIMAL SEDATION

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: Guidelines for the Use of Sedation and General Anesthesia by Dentists, and the Commission on Dental Accreditation’s Accreditation Standards for dental education programs.

These Guidelines present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

**General Objectives:** Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification risk assessment and pre-procedure fasting instructions.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.
10. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

**INHALATION SEDATION (NITROUS OXIDE/OXYGEN)**

**A. Inhalation Sedation Course Objectives:** Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.
B. Inhalation Sedation Course Content:
1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment (i.e., pulse oximetry), with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of 14 hours plus management of clinical dental cases, during which clinical competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should possess an active permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual’s formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be encouraged.
A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

ENTERAL AND/OR COMBINATION INHALATION-ENTERAL MINIMAL SEDATION

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives:
   Upon completion of a competency course in enteral and/or combination inhalation-ental minimal sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-ental minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-ental minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-ental minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-ental minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support for Healthcare Providers.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.
B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in enteral and/or combination inhalation-ental minimal sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of enteral and/or combination inhalation-ental minimal sedation (combined minimal sedation).
8. Review of dental procedures possible under enteral and/or combination inhalation-ental minimal sedation).
9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-ental minimal sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration: Participants must be able to document current certification in Basic Life Support for Healthcare Providers and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include a minimum of 16 hours, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-ental minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-ental minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.
D. **Participant Evaluation and Documentation of Instruction:** Competency courses in combination inhalation-enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them to achieve competency. The course director must certify the competency of participants upon satisfactory completion of the course. Records of the course instruction must be maintained and available.

E. **Faculty:** The course should be directed by a dentist or physician qualified by experience and training. This individual should possess a current permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual’s formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, and cardiologists and psychologists, should be encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. **Facilities:** Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

V. **TEACHING ADMINISTRATION OF MODERATE SEDATION**

These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation. These include courses in enteral and parenteral moderate sedation. The teaching guidelines contained in this section on moderate sedation differ slightly from documents in medicine to reflect the differences in delivery methodologies and practice environment in dentistry.

Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining moderate sedation with nitrous oxide-oxygen.

A. **Course Objectives:** Upon completion of a course in moderate sedation, the dentist must be able to:

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.
3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.
9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.
13. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions.
5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
8. Indications and contraindications for use of moderate sedation.
10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs, ventilation/breathing and reflexes related to consciousness.
11. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
13. Description, maintenance and use of moderate sedation monitors and equipment.
15. Intravenous access: anatomy, equipment and technique.
16. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
17. Description and rationale for the technique to be employed.
18. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.
C. **Moderate Sedation Course Duration and Documentation:** The course must include:

- A minimum of 60 hours of instruction plus administration of sedation for at least 20 individually managed patients.

- Certification of competence in moderate sedation technique(s).

- Certification of competence in rescuing patients from a deeper level of sedation than intended including managing the airway, intravascular or intraosseous access, and reversal medications.

- Provision by course director or faculty of additional clinical experience if participant competency has not been achieved in time allotted.

- Records of instruction and clinical experiences (i.e., number of patients managed by each participant in each modality/route) that are maintained and available for participant review.

D. **Documentation of Instruction:** The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience, managing the airway, intravascular/intraosseous access, and reversal medications.

E. **Faculty:** The course should be directed by a dentist or physician qualified by experience and training. This individual should possess a current permit or license to administer moderate or deep sedation and general anesthesia in at least one state, have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than four-to-one when moderate sedation is being taught allows for adequate supervision during the clinical phase of instruction. A one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. **Facilities:** Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.
ENDNOTES

1 Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173–4973 or online at www.asahq.org.

2 Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173–4973 or online at www.asahq.org.

3 Excerpted from ASA Task Force on Practice Guidelines for Sedation and Analgesia by non-Anesthesiologists; Anesthesiology, 2005–2006. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173–4973 or online at www.asahq.org.
Capnography is coming to the OMS office in 2014¹

In recent years, capnography monitoring equipment, long a standard of care in the hospital OR, has been improved and now offers real benefits in such outpatient surgery sites as the OMS office. Following the lead of the American Society of Anesthesiologists (ASA), the American Heart Association and other organizations that develop parameters of care and practice guidelines for their dental and medical surgical specialists, the AAOMS Board of Trustees approved the following revised guidelines requiring capnography equipment in the OMS office beginning in 2014:

During moderate or deep sedation and general anesthesia the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure or equipment; and

Improvements in monitoring exhaled CO₂ during anesthesia continue to evolve. Beginning in 2014, AAOMS Office Anesthesia Evaluations will require capnography for moderate sedation, deep sedation and general anesthesia unless precluded or invalidated by the nature of the patient, procedure or equipment.

The statements appear in the 2012 Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 12), version 5.0, which is also a component of the revised Office Anesthesia Evaluation Manual, 8th edition. Additional information about the new capnography guidelines will be provided in the July/August issue of AAOMS Today.

¹ June 2012 American Association of Oral and Maxillofacial Surgeons Message from the President (http://www.aaos.org/president/062012.html#2)
Benefits and Harms of Capnography During Procedural Sedation: Rapid Review and Meta-

Analysis

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Introduction
Capnography provides a continuous measure and display of the partial pressure of exhaled carbon dioxide (CO₂). Monitoring carbon dioxide provides confirmation of ventilation and airway patency.

Although capnographic monitoring is required with deep sedation unless precluded by the nature of the patient, procedure or equipment,¹ there is contention about the need to mandate its use in monitoring during moderate sedation of dental patients.² ³ There is, however, recognition that sedated patients have potential to progress to deeper levels of sedation and it has been suggested that the ability to recognize early warning signs may provide critical opportunity to intervene and prevent sedation-related morbidity and mortality.⁴ The Oral and Maxillofacial Surgery National Insurance Company closed-claims data has been reported to indicate that the most frequent reason for transfer of a patient who had been under anesthesia to an Emergency Department was respiratory distress.⁵ Early detection of respiratory events increases the likelihood of halting progression to hypoxemia, and more severe adverse outcomes such as cardiac arrest or death.⁶ The utility of capnography to improve detection of hypoventilation in moderately sedated patients before changes in vital signs or clinician observations has been documented, but whether such episodes are clinically significant or if earlier detection with capnography has an effect on patient outcomes is unclear.⁷ A systematic review and meta-analysis was undertaken to facilitate decision-making about the need to routinely use capnography during moderate sedation of adults in dental practice. The aim was to determine whether adding capnography to standard monitoring influences hypoxemia, adverse respiratory events, serious adverse events, quality of sedation, and patient satisfaction. Data available from clinical trials involving dental patients is limited. However, anesthesia-related complications during dental care are similar to those reported for the hospital operating system environment.⁸ Therefore, we chose to use all data evaluating the impact of capnography for individuals undergoing a procedure under sedation.

Methods
Search strategies
A rapid review⁹ was used to evaluate the benefits and harms of capnography monitoring for adults undergoing procedures under moderate sedation. A search conducted in PubMed in February 2016 for the terms “capnography” AND “systematic review,” limited to English-language manuscripts published after 2011, identified 53 papers. Of these, two were relevant systematic reviews and meta-analyses.¹⁰ ¹¹
The search strategies in these two papers were similar, excepting that Conway\textsuperscript{10} was less restrictive in regard to patient population and publication language.

To update the existing systematic reviews\textsuperscript{10,11} in February 2016 we conducted systematic searches in PubMed and Google Scholar for clinical trials involving adult humans, limited to English language published in the prior 10 years. This search strategy combined keywords, synonyms, and subject headings for the concept “capnography” with keywords, synonyms, and index terms for each of the following two concepts: (procedural sedation and analgesia or patient controlled analgesia) or (ambulatory surgical procedures or biopsies or refractive surgical procedures or tracheostomy or tracheotomy or paracentesis or surgical procedures, minimally invasive or endoscopy or electroconvulsive therapy or electric countershock or debridement or ablation techniques or induced abortion or dental). The reference lists of studies selected for inclusion were scanned for additional relevant studies.

**Study Selection**

Randomized controlled trials or observational studies that enrolled adult (≥18 years) patients who received procedural sedation, and reported respiratory events by capnography and standard monitoring were included. Standard monitoring may have included visual assessment of skin color, airway patency and chest movements, pulse oximetry, or auscultation of breath and heart sounds using a pretracheal stethoscope. All types of medication used for procedural sedation and anesthesia in adults were included. For inclusion in the meta-analysis for risk of hypoxemia, studies had to be randomized controlled trials with parallel group or crossover design. After the removal of duplicates, titles and abstracts that met the inclusion criteria were downloaded into an EndNote® database and reviewed for eligibility.

**Data extraction**

Three investigators independently extracted data to a standardized form, and disagreements were resolved through discussion and consensus. The form included the main characteristics of the studies, including the study design, population, medical procedure, whether routine supplemental oxygen was
used, sedation agents, and study’s definition of hypoxemia. The outcomes extracted were: hypoxemia, adverse respiratory events, serious adverse events, and the quality, duration, and satisfaction with sedation. Studies used varying definitions of hypoxemia, from $\text{SpO}_2<90\%$ to $\text{SpO}_2<93\%$. Adverse respiratory events were defined as an incident of respiratory depression, apnea, oxygen desaturation, airway obstruction, or the need for oxygen supplementation. Serious adverse events were defined as: death, permanent disability, respiratory failure, orotracheal intubation, cardiopulmonary resuscitation, or use of reversal agents. Procedure time was measured in minutes from start of procedure to end. Sedation quality and satisfaction were defined by the authors. Authors were contacted in cases of missing or unclear data. Raw data from each individual study was extracted based on intention to treat, except where imputation was used for missing data,\textsuperscript{12} in which case per-protocol data was extracted instead.

**Data analysis**

Two meta-analyses were conducted: one to update the meta-analysis in Waugh\textsuperscript{11} evaluating detection of adverse respiratory events, and one to update the meta-analysis in Conway\textsuperscript{10} evaluating risk of hypoxemia. Fixed-effects models would assume that the “true” effect of capnographic monitoring is the same in every study, and that differences between study results are due solely to chance, whereas random-effects models relax this assumption, and instead assume that the effect of capnographic monitoring for individual studies varies around some overall average effect.\textsuperscript{13} Given the variety of subjects and study characteristics, DerSimonian-Laird random effects models\textsuperscript{14} were used to calculate the odds of detecting adverse respiratory events and the risk of hypoxemia. Confidence intervals were calculated using the modified Wald method in the presence of empty cells, as previously reported,\textsuperscript{11} and each study’s effect size was given weight using the formula $w_i' = \frac{1}{\text*SE(\theta_i)^2+t^2}$. Bivariate models calculated the pooled sensitivity and specificity based on the numbers of true negatives, false negatives, true positives, and false positives. Statistical heterogeneity of included studies was evaluated using an $I^2$ statistic and Chi-square test for each meta-analysis. Where possible, subgroup analyses were performed to investigate significant heterogeneity. Funnel plots were used to assess publication bias.
Statistical analysis were conducted using Stata (Version 14.1, StataCorp LP), risk of bias and flow charts were constructed in Review Manager (Version 5.3.5, Cochrane Community), and quality of evidence tables were created in GRADEpro Guideline Development Tool (McMaster University, developed by Evidence Prime Inc.).

**Subgroup and sensitivity analyses**

Subgroup analysis was conducted to determine whether differences in oxygen supplementation or sedative and analgesic agents used during sedation had different treatment effects. The detection of apnea or airway obstruction by arterial oxygen saturation monitoring may be delayed when patients receive supplemental oxygen.\(^\text{15,16}\) Distinguishing the effects of sedative and analgesic agents was considered important because agents differ in their respiratory and hemodynamic effects.\(^\text{17}\) To investigate the extent to which statistical heterogeneity between study outcomes related to differences in sedation agents or routine oxygen supplementation, random-effects meta-regression with restricted maximum likelihood and Knapp-Hartung variance was used.\(^\text{18}\) Finally, a sensitivity analysis was conducted, eliminating those studies that included deeply sedated patients. Moderate sedation (also referred to as conscious sedation or procedural sedation and analgesia) was defined as "a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation."\(^\text{19}\)

**Assessment of the quality of evidence**

Quality of evidence was assessed separately for each outcome using the GRADE approach.\(^\text{20}\) In GRADE, the body of evidence for an outcome without any serious limitations is rated as high quality; however, if the body of evidence has serious or very serious issues of risk of bias (as assessed by the Cochrane Collaboration Risk of Bias tool), indirectness, imprecision, inconsistency or publication bias that reduces confidence in the evidence, it is downgraded to moderate, low, or very low. The quality of the evidence may be upgraded if there is a large effect, a dose response relationship, or if all plausible residual confounding and bias would be expected to reduce the demonstrated effect, or suggest a spurious effect if no effect was observed.
Results

Study selection

Of the 119 studies identified by the systematic search, 25 met the inclusion criteria based on their title and abstract and were reviewed as full-text articles. Of these, 16 articles were included in the qualitative analysis and 15 in the quantitative analysis (Figure 1). A single study was included in the qualitative analysis but excluded from the meta-analyses because the data was reported differently than the other included studies. 21 Of the eight excluded articles, one was excluded because it was only available in Spanish,22 three were excluded because they compared capnography to a nonstandard comparison group,23-25 two were excluded because they were not clinical studies,26 27 and two were excluded because they enrolled pediatric patients.28 29 The single study involving dental treatment25 was among those excluded due to a nonstandard comparison group.

Included Studies

Sixteen studies were eligible for qualitative analysis (Table 1). The majority of studies concerned either gastrointestinal endoscopic procedures12, 30-36 or were set in emergency departments.15, 37-40 Propofol was the most common sedation medication, used in eleven of the studies. Standard monitoring in all studies included pulse oximetry and visual assessment, and the majority of studies also included non-invasive blood pressure monitoring. A single study compared capnographic monitoring to monitoring via pretracheal stethoscope.36 There was also variety in whether patients received supplemental oxygen via cannula throughout the procedure. Eleven studies15, 16, 31, 32, 34, 36-42 compared surveillance of respiratory events between capnography in addition to standard monitoring and standard monitoring alone; these studies were used to calculate sensitivity, specificity, and odds of adverse respiratory events. Eight studies30, 32, 33, 35, 38, 43-45 compared outcomes among groups with standard monitoring and groups with standard monitoring and capnography; these studies were used to estimate the risk of hypoxemia. Five studies12, 30, 32, 35, 45 evaluated the quality of sedation, patient satisfaction, or sedation duration. Six studies15, 31, 32, 39, 40, 45 reported measures of depth of sedation.
The risk of bias present in each study was rated (Figure 2). Fourteen of the sixteen studies were judged to have high potential for performance or detection bias, and the majority of included studies were found to have low risk of selection, attrition, reporting, or other bias. Three studies alerted the capnography-blinded group to apnea that was undetected after 20 seconds\textsuperscript{16} or 30 seconds,\textsuperscript{12,33} potentially biasing these studies toward conclusions of no difference between groups; this is reflected in the ratings for “other bias.”

**Diagnostic test accuracy for adverse respiratory events**

Data from ten studies\textsuperscript{15, 16, 31, 32, 34, 36-38, 40, 46} was used to calculate the numbers of patients with adverse respiratory events detected, along with the sensitivity and the specificity of their detection (Table 2). The summary estimate of capnography sensitivity was 0.91 (95% CI: 0.64, 0.98), and its specificity was 0.79 (95% CI: 0.56, 0.91). Excluding studies that explicitly included deeply sedated patients,\textsuperscript{15, 31, 32} the pooled sensitivity is 0.90 (95% CI: 0.42, 0.99) and the specificity is 0.88 (95% CI: 0.57, 0.97).

A meta-analysis evaluating ability of capnography to detect respiratory complications, most commonly reported as apnea or altered ventilation, during moderate procedural sedation and analgesia was also conducted. This random-effects model of ten studies\textsuperscript{15, 16, 31, 32, 34, 36-38, 40, 46} involved 839 adults receiving procedural sedation and anesthesia (Figure 3). The weighted odds ratio of adverse respiratory events was 10.48 (95% CI: 3.64, 30.23), indicating that the odds of correctly detecting adverse respiratory events in patients undergoing moderate procedural sedation may be 10.48 greater if monitoring included capnography than if it did not. Excluding studies that included deeply sedated patients,\textsuperscript{15, 31, 32} the odds ratio of adverse respiratory events was 11.63 (95% CI: 2.55, 52.98).

Subgroup analysis was conducted to investigate whether supplemental oxygen and sedation agents were potential sources of the high statistical heterogeneity detected ($I^2=76.6\%$, $X^2$ p-value <0.001) (Figure 3). Heterogeneity between studies remained considerable: 69.9\% (p =0.003) among studies where the sedative was propofol and patients were provided with routine supplemental oxygen, 64.5\% (p =0.06) among those studies where the sedative was propofol and patients received room air only (Supplemental
Figure 1). Only one study used neither propofol nor routine supplemental oxygen,\textsuperscript{36} and in no study were patients provided with supplemental oxygen when they were sedated with something other than propofol. The direction of effects was similar in all groups: the odds of adverse respiratory events was 9.56 (95% CI: 2.81, 32.60) for studies with supplemental oxygen and propofol, 3.81 (95% CI: 0.80, 18.13) with propofol and room air, and 580.0 (95% CI: 34.2, 9825.86) for the one study with room air and non-propofol sedation. (Supplemental Figure 1). Based on the meta-regression of these studies, 99.97% of the residual variation is attributable to between-study heterogeneity, of which 79.6% is explained by the covariates of sedative or oxygen supplementation. The effect of the covariates was statistically different from zero (joint F test p-value=0.0007), largely driven by the significant effect of sedation agent (t test p-value: <0.001) rather than oxygen supplementation (t test p-value: 0.39).

The quality of the evidence was evaluated using GRADE criteria. Funnel plots did not demonstrate the presence of publication bias, the study evidence is generalizable and applicable, and the results are precise. We downgraded the quality of the evidence because there is a serious risk of bias in the studies, mainly due to lack of blinding of outcome assessment, and there is serious inconsistency in the studies’ estimates of effect. Taken together, this means the quality of the evidence for this outcome was low, meaning that the true effect of capnography on adverse respiratory events may be substantially different from the estimate of effect from this meta-analysis (Table 3).

**Risk of hypoxemia under sedation**

Estimating the relative risk of hypoxemia for patients monitored with and without capnography included seven studies\textsuperscript{12, 30, 32, 33, 35, 38, 45} involving a total of 3,351 patients. To account for the two levels of peripheral capillary oxygen saturation used to define hypoxemia in the literature, the meta-analysis was stratified by hypoxemia definition.

For studies that defined hypoxemia as SpO\textsubscript{2} less than 90%, the relative risk of hypoxemia was 0.68 (95% CI: 0.55, 0.85) (Figure 4). For studies that defined hypoxemia as SpO\textsubscript{2} less than 93%, the relative risk of hypoxemia was 0.67 (95% CI: 0.44, 1.01). Combining outcomes without respect to definition of
hypoxemia used, the relative risk of hypoxemia was 0.69 (95% CI: 0.57, 0.82). This represents a potential 31% reduction in risk of hypoxemia for adult patients under moderate sedation when monitoring included capnography. Excluding studies that included patients that experienced deep sedation encounters\textsuperscript{32, 35, 45}, the relative risk of hypoxemia was 0.72 (95% CI: 0.57, 0.91).

As was done for the adverse respiratory events analysis, a high level of statistical heterogeneity was detected among the studies ($I^2=56.1\%, X^2$ p-value $=0.03$) and therefore subgroup analysis was undertaken to evaluate whether the risk of hypoxemia varied by sedation agent or use of supplemental oxygen (Supplemental Figure 2). Patients in five studies\textsuperscript{30, 32, 35, 38, 45} received propofol sedation and supplemental oxygen (RR: 0.61, 95% CI: 0.51, 0.73); as in the Conway et al. meta-analysis, the protective effect of capnography was strongest in this group. Patients in two studies\textsuperscript{12, 33} were sedated with something other than propofol and did not receive routine supplemental oxygen (RR: 0.79, 95% CI: 0.57, 1.09), however, these results should be interpreted in the context of their potential bias toward the null, since in these two studies patients were monitored using capnography in both study arms, and if capnography detected apnea that remained unrecognized for 30 seconds or longer, the team in the “capnography-blinded” arm was alerted. No study provided patients with propofol without also giving them routine supplemental oxygen, and no study gave patients routine supplemental oxygen without also giving them propofol. In a meta-regression of these studies, oxygen supplementation was collinear with sedation agent and was therefore dropped from the model. Differences between studies in sedation agent used explained 56.9% of the between-study variance, but this was not significant (covariate t test p-value 0.2).

The relative risk of the meta-analysis is statistically significant, but it is calculated from studies with a high risk of bias, and there is serious inconsistency between studies’ estimates of effect. Therefore the rating for quality of the evidence was downgraded to moderate, indicating moderate confidence in the effect estimate of this meta-analysis (Table 4). The true effect is likely to be close to the estimate of the effect, but there remains the possibility that it is substantially different.

**Harm associated with additional monitoring**
Among the 3,866 patients studied, no serious adverse events related to sedation (e.g. death, permanent disability, respiratory failure, orotracheal intubation, cardiopulmonary resuscitation, or use of reversal agents) were reported. One potential harm associated with increased monitoring is alarm overload or fatigue, however none of the included studies reported frequency of these. Another potential harm is that changes in the capnographic waveform could lead to unnecessary premature stimulation of patients,\textsuperscript{10} conceivably affecting duration and quality of sedation. However, of the 5 studies\textsuperscript{12, 30, 32, 35, 45} that compared patient satisfaction, recovery post sedation, or the quality and duration of sedation, none found a significant difference between groups monitored with or without capnography.

**Discussion**

**Summary of Results**

While not all professional organizations mandate capnography during moderate sedation,\textsuperscript{47, 48} the ADA has recently revised its guidance to require end-tidal CO\textsubscript{2} monitoring unless precluded or invalidated by the nature of the patient, procedure, or equipment.\textsuperscript{49} In such cases, digital transcutaneous PCO\textsubscript{2} may serve as an alternate technique to continuously measure blood gases.\textsuperscript{50} There is low quality evidence suggesting that including capnography in the monitoring of moderately sedated patients may significantly improve detection of respiratory adverse events (OR 10.49, 95\% CI: 3.64, 30.23) (Table 3). The sensitivity (0.91) and specificity (0.79) of capnography for identification of adverse respiratory events is reasonable for a prognostic indicator test, erring on the side of improved patient management. We identified moderate quality evidence that capnographic monitoring would reduce the risk of hypoxemia during moderate sedation during dental procedures. Regarding potential harms of capnography, no serious adverse events were reported in the included studies, and there were no significant differences between groups with and without capnography with respect to assisted ventilation, patient satisfaction, recovery time, or the quality and duration of sedation. We conclude that the potential ability to increase detection of adverse respiratory events and reducing hypoxemia events outweighs the hypothesized harms.

**Strengths and limitations of current review**
The GRADE approach transparently conveys the level of confidence that the estimates of effect are correct. This review is the first to meta-analyze the sensitivity and specificity of capnographic monitoring for detecting adverse respiratory events during sedation. We investigated sources of heterogeneity, which indicated that sedation agents significantly affect the effect of capnography on adverse respiratory events. However, post hoc conclusions from subgroup analyses should not be considered tests of the hypothesis that sedation agents and routine oxygen supplementation affect monitoring, but rather as encouragement to further investigate these questions. Our ability to distinguish the effects of sedation agents and supplemental oxygen combined was limited by the lack of studies that sedated patients without propofol or routine supplemental oxygen. The literature search strategy was systematic, but searching more databases and removing the English-only language exclusion criteria may have identified additional studies. Study design issues, reliance upon study authors’ definitions of outcomes, and the paucity of studies that measured or reported on factors that could be used to ascertain potential harms associated with additional monitoring during moderate sedation may also have affected the calculated estimates. Patients may attain varying levels of sedation during a single procedure and propofol commonly induces deep sedation. Since patients’ level of consciousness was not assessed in all studies, some of the studies likely included patients whose sedation level was deeper than that typically used in dentistry. Nonetheless, these results can be interpreted to suggest that inclusion of capnography when monitoring patients having dental procedures under moderate sedation can improve early pick-up of respiratory events. Future research should include double-blinded studies to reduce the risk of bias and improve confidence in the findings. Lastly, the effect of capnography in dental practice, especially in patients with asthma, chronic obstructive pulmonary disease, and other conditions where exhalation may be compromised, was not examined in this review but warrants study.

**Conclusion**

Early identification of adverse respiratory events and hypoxemia enables rapid interventions and prevents hypoxic brain damage, cardiac arrest, or death. Adding capnography to standard monitoring of adult patients under moderate sedation improves sensitivity to detect adverse respiratory events and reduces
risk of hypoxemia where supplemental oxygen is routine. Inclusion of capnography is not associated with increased harm, such as decreased sedation quality. Balancing these potential benefits and harms, these findings suggest that capnography is an important addition to standard monitoring during procedural sedation. We conclude that adult patients undergoing dental procedures with moderate sedation should be monitored with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment.

**Acknowledgements:**
This work was derived from a report requested by the 2015 ADA House of Delegates for use by the ADA Council for Dental Education and Licensure in their deliberation process resulting in the revision of the “Guidelines for the Use of Sedation and General Anesthesia by Dentists.” The revised guidelines were adopted by the ADA House of Delegates in 2016.49
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SENT VIA EMAIL

August 15, 2017

Dear Colleagues:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) and its fellows and members are dedicated to provide safe and accessible anesthesia services for our adult and pediatric patients. We have provided cost-effective anesthesia in the outpatient setting with an unparalleled safety record for more than 60 years.

AAOMS and its Board of Trustees have embraced a multifaceted approach to support our strong and long-held beliefs in a culture of safety and, especially, anesthesia patient safety. These efforts include a wide scope of initiatives that exemplify our level of ongoing commitment to a culture of anesthesia safety in the practice of oral and maxillofacial surgery, including:

- Stewardship of OMS residency education standards that require a five-month rotation on the medical anesthesia service as well as a continuous outpatient experience, whereby OMS residents participate in the delivery of all levels of anesthesia through their four to six years of training.
- A self-imposed mandatory Office Anesthesia Evaluation program, in place for more than 25 years.
- Development of the Dental Anesthesia Assistant National Certification Examination (DAANCE), which strengthens our anesthesia team model and augments our multiple educational programs for anesthesia assistants.
- Our recently developed anesthesia emergency management simulation training modules in cooperation with the Medical University of South Carolina Simulation Center. These courses will maintain critical skills as well as further enhance and promote patient safety and excellence for the OMS anesthesia team.
- AAOMS being the first dental specialty to embrace the mandatory requirement of end-tidal carbon dioxide monitoring in the delivery of outpatient anesthesia.
- Active support of the recent revisions of the American Dental Association’s Council on Dental Education and Licensure’s anesthesia guidelines.

Oral and maxillofacial surgeons perform millions of outpatient anesthetic procedures throughout the United States every year. Despite the highest levels of quality care and a continuous focus on patient safety, a small number of adverse events still occur — not unlike
any specialty that delivers anesthesia. These rare events create negative publicity, which can have devastating consequences to all dentists who deliver anesthesia and the overall profession of dentistry. Recently, pediatric sedation/anesthesia has become a particular focus of the news media. Adverse events in this age group are understandably disturbing. With the intense media focus, emotions – instead of science and evidence-based medicine – are being used to enact changes to state anesthesia rules.

Responses to these unfortunate events have promulgated communications from various groups (e.g., AGD) that, in many cases, are less familiar with sedation and anesthesia in general. More significantly, these groups appear to be unaware of the unparalleled safety record of the oral and maxillofacial surgeon and our team model of anesthesia delivery. These same groups also suggest or demand changes without having scientific or evidence-based studies to support such actions. An example of this is the fallout from Caleb’s Law in California. The related legislation that followed – had it passed without modification – would have done significant harm by reducing access to care and limiting resources available to the most at-risk populations, with no evidence there would be improved outcomes.

All stakeholders, including state dental boards, should recognize the long-standing commitment that AAOMS and its fellows and members have made to ensure the continued safe delivery of office-based anesthesia. AAOMS strives to achieve visionary education and training for our members and future members. It is our hope that our dental colleagues would embrace rather than challenge this commitment. Sending out unfounded critical communiqués is not productive nor collaborative. Instead, we welcome all areas of dentistry to join us in our pursuit to improve the safety record for all patients.

Sincerely,

[Signature]

Douglas W. Fain, DDS, MD, FACS
President
American Association of Oral and Maxillofacial Surgeons
Pursuant to the authority of Iowa Code sections 147.76, 153.15 and 153.33, the Dental Board hereby amends Chapter 10, “General Requirements,” Iowa Administrative Code.

2017 Iowa Acts, Senate File 479, was signed into law by the Governor during the recent 2017 Legislative Session. The law, which went into effect on July 1, 2017, allows dental hygienists to provide educational services without the supervision of a licensed dentist.

These amendments change the scope of practice of dental hygienists to include the provision of educational services without the supervision of a licensed dentist.

Notice of Intended Action was published in Iowa Administrative Bulletin on August 15, 2017, as ARC 3253C. A public hearing was held on September 12, 2017 at 2:00 p.m. at the office of the Iowa Dental Board. There were not any attendees at the public hearing, nor were any written comments received.

The board reviewed and discussed the amendments during their October 13, 2017, open session board meeting and allowed additional comments from the public.

The amendments are not subject to waiver or variance pursuant to 650-chapter 7.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 153.15 as amended by 2017 Iowa Acts, Senate File 479.

This amendment is identical to the one published under Notice.

ITEM 1. Amend subrule 650—10.3(1) as follows:

650—10.3 (153) Authorized practice of a dental hygienist.

10.3(1) “Practice of dental hygiene” as defined in Iowa Code section 153.15 means the performance of the following educational, therapeutic, preventive and diagnostic dental hygiene
ITEM 2. Amend subrule 650—10.3(2) as follows:

10.3(2) All authorized services provided by a dental hygienist, except educational services, shall be performed under the general, direct, or public health supervision of a dentist currently licensed in the state of Iowa in accordance with 650—1.1(153) and 650—10.5(153).

ITEM 3. Amend subrule 650—10.4 as follows:

650—10.4 (153) Unauthorized practice of a dental hygienist. A dental hygienist who assists a dentist in practicing dentistry in any capacity other than as an employee or independent contractor supervised by a licensed dentist or who directly or indirectly procures a licensed dentist to act as nominal owner, proprietor, director, or supervisor of a practice as a guise or subterfuge to enable such dental hygienist to engage in the practice of dentistry or dental hygiene or who renders dental service(s), except educational services, directly or indirectly on or for members of the public other than as an employee or independent contractor supervised by a licensed dentist shall be deemed to be practicing illegally.

ITEM 4. Amend subrule 650—10.4(3) as follows:

10.4(3) A dental hygienist shall not provide services, except for educational services, practice independent from the supervision of a dentist nor shall a dental hygienist establish or maintain an office or other workplace separate or independent from the office or other workplace in which the supervision of a dentist is provided.
Pursuant to the authority of Iowa Code sections 147.34 and 153.21, the Dental Board hereby amends Chapter 11, “Licensure to Practice Dentistry or Dental Hygiene,” Chapter 12, “Dental and Dental Hygiene Examinations,” and Chapter 15, “Fees,” Iowa Administrative Code.

The purpose of the amendments is to implement an alternative examination for licensure pursuant to 2016 Iowa Acts, House File 2387, signed by the Governor on March 31, 2016.

The amendments to Chapter 11 add an alternative examination for students at the University of Iowa College of Dentistry. These amendments allow students or graduates of the University of Iowa to complete a portfolio examination and submit it for the purposes of licensure on the basis of examination. These amendments also establish the time period during which an application on the basis of portfolio examination would be accepted.

The amendments to Chapter 12 establish the basis of the portfolio examination, the criteria for administering the portfolio examination and related procedures, and the scoring requirements for successful completion of the portfolio examination.

The amendments to Chapter 15 establish the fee for examination for licensure by portfolio. The fee is intended to cover the anticipated costs of proctoring the examination. These amendments also update several cross references within Chapter 15.

Notice of Intended Action was published in Iowa Administrative Bulletin on August 15, 2017, as ARC 3252C. A public hearing was held on September 12, 2017 at 2:00 p.m. at the office of the Iowa Dental Board. There were not any attendees at the public hearing, nor were any written comments received.

The board reviewed and discussed the amendments during their October 13, 2017, open session board meeting and allowed additional comments from the public.

The amendments to Chapters 11 and 12 are subject to waiver or variance pursuant to 650—
Chapter 7. The amendments to Chapter 15 are not subject to waiver or variance pursuant to 650—Chapter 7.

After analysis and review of this rule making, no impact on jobs has been found. These amendments are intended to implement 2016 Iowa Acts, House File 2387. These amendments are identical to those published under Notice.

ITEM 1. Amend subrule 11.2(2) as follows:

11.2(2) Applications for licensure must be filed with the board along with:

a. to c. No change.

d. Documentation of passage of a regional clinical examination.

(1) Successful passage of a regional board-approved clinical examination within the previous five-year period with a grade of at least 75 percent.

(2) The following regional clinical examinations are approved by the board for purposes of licensure by examination: the Central Regional Dental Testing Service, Inc. examination as administered by the Central Regional Dental Testing Service, Inc. (CRDTS), the Western Regional Examining Board examination as administered by the Western Regional Examining Board (WREB), the Southern Regional Testing Agency, Inc. examination as administered by the Southern Regional Testing Agency, Inc. (SRTA), and the American Board of Dental Examiners, Inc. examination as administered by the Commission on Dental Competency Assessments (CDCA) and the Council of Interstate Testing Agencies, Inc. (CITA).

(3) Beginning January 1, 2018, the 2014 California portfolio examination is approved by the board for the purposes of licensure by examination. To be eligible for licensure on the basis of portfolio examination, an applicant must be a student at the University of Iowa College of Dentistry or have graduated from the University of Iowa College of Dentistry within one year of
the date of application.

e. to i. No change.

ITEM 2. Amend subrule 11.3(2) as follows:

11.3(2) Applications must be filed with the board along with:

a. Satisfactory evidence of graduation with a DDS or DMD from an accredited dental college approved by the board or satisfactory evidence of meeting the requirements specified in rule 650—11.4(153).

b. Evidence of attaining a grade of at least 75 percent on the examination of the Joint Commission on National Dental Examinations or evidence of attaining a grade of at least 75 percent on a written examination during the last ten years that is comparable to the examination given by the Joint Commission on National Dental Examinations. Any dentist who has lawfully practiced dentistry in another state or territory for five years may be exempted from presenting this evidence.

c. A statement of any dental examinations taken by the applicant, with indication of pass/fail for each examination taken. Any dentist who has lawfully practiced dentistry in another state or territory for five or more years may be exempted from presenting this evidence.

d. Evidence of a current, valid license to practice dentistry in another state, territory or district of the United States issued under requirements equivalent or substantially equivalent to those of this state.

e. Evidence that the applicant has met at least one of the following:

(1) Has less than three consecutive years of practice immediately prior to the filing of the application and evidence of attaining a grade of at least 75 percent on a regional board-approved clinical examination within the previous five-year period. The following regional examinations are approved by the board for purposes of licensure by credentials: the Central Regional Dental Testing Service, Inc. examination as administered by the Central Regional Dental
Testing Service, Inc. (CRDTS), the Western Regional Examining Board examination as administered by the Western Regional Examining Board (WREB), the Southern Regional Testing Agency, Inc. examination as administered by the Southern Regional Testing Agency, Inc. (SRTA), and the American Board of Dental Examiners, Inc. examination as administered by the Commission on Dental Competency Assessments (CDCA) and the Council of Interstate Testing Agencies, Inc. (CITA), and the 2014 California portfolio examination; or

(2) Has for three consecutive years immediately prior to the filing of the application been in the lawful practice of dentistry in such other state, territory or district of the United States.

f. Evidence from the state board of dentistry, or equivalent authority, from each state in which applicant has been licensed to practice dentistry, that the applicant has not been the subject of final or pending disciplinary action.

g. A statement disclosing and explaining any disciplinary actions, investigations, malpractice claims, complaints, judgments, settlements, or criminal charges, including the results of a self-query of the National Practitioner Data Bank (NPDB).

h. The nonrefundable application fee for licensure by credentials, plus the fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), as specified in 650—Chapter 15.

i. Current CPR certification. A statement:

(1) Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a “hands-on” clinical component;

(2) Providing the expiration date of the CPR certificate; and

(3) Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.
j. Evidence of successful completion of a board-approved jurisprudence examination with a grade of at least 75 percent.

k. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.

ITEM 3. Renumber rules 650—12.3(147,153) and 650—12.4(147,153) as 650—12.4(147,153) and 650—12.5(147,153).

ITEM 4. Adopt the following new rule 650—12.3(147,153):

650—12.3(147,153) Portfolio examination procedure for dentistry.

12.3(1) Completion of a portfolio examination. The 2014 California portfolio examination is accepted for licensure by examination for University of Iowa graduates. To meet the requirements for dental licensure and portfolio examination, applicants shall complete the portfolio examination as administered at the University of Iowa College of Dentistry.

12.3(2) Compliance with testing requirements and procedures.

a. The board shall oversee all aspects of the portfolio examination process but shall not interfere with the College of Dentistry’s authority to establish and deliver an accredited curriculum. The board shall determine an end-of-year deadline, in consultation with the College of Dentistry, to determine when the portfolio examinations shall be completed and submitted to the board for review by the board’s examiners.

b. The portfolio examination shall be conducted while the applicant is actively enrolled as a student at the University of Iowa College of Dentistry. This examination shall utilize uniform standards of clinical experiences and competencies as outlined in the 2014 California portfolio examination. The applicant shall pass a final assessment of the submitted portfolio at the end of the applicant’s dental school education at the University of Iowa College of Dentistry.

c. Before any portfolio examination may be submitted to the board, the applicant shall remit to the board the required portfolio examination fee as specified in 650—Chapter 15 and a
pending approval by the Iowa Dental Board

letter of good standing signed by the dean of the College of Dentistry stating that the applicant has graduated or will graduate with no pending ethical issues.

12.3(3) Scoring requirements.

a. Final clinical competencies performed by the applicant must be evaluated by two examiners who have participated in standardization, calibration and training. The examiners shall be approved by the board and may include faculty, board members or board member designees. Board members or board member designees shall have priority as examiners at all times. The College of Dentistry shall submit to the board the names of the portfolio examiners for consideration by January 1 of each calendar year.

b. The College of Dentistry shall provide a minimum of a seven-day notice for all final competencies. In the event that a seven-day notice cannot be provided, the College of Dentistry must notify the board immediately. In the event that no board members or designees are available to participate in an evaluation, the College of Dentistry may use two board-approved portfolio examiners.

c. Successful completion of each competency shall result in a score that meets minimum competence-level performance. Scoring criteria for each competency is outlined in the 2014/2015 California Examiner Training Manual.

d. The board shall monitor and audit the standardization and calibration of examiners at least biennially to ensure standardization and an acceptable level of calibration in the grading of the examination. The College of Dentistry’s competency examinations with regard to the portfolio examination shall be audited annually by the board.

12.3(4) Compliance with clinical operation requirements.

a. The board shall require and verify the successful completion of a minimum number of clinical experiences for the portfolio examination.

b. The board shall require and verify the successful completion of a set number of
competency examinations performed on a patient of record. The clinical experiences include, but are not limited to, the following:

- (1) Comprehensive oral diagnosis and treatment planning;
- (2) Periodontics;
- (3) Direct restorations;
- (4) Indirect restorations;
- (5) Removable prosthodontics; and
- (6) Endodontics.

ITEM 5. Amend renumbered subrule 12.5(1) as follows:

12.5(1) Method of counting failures.

- a. No change.
- b. A dental hygiene examinee who has two examination failures will be required to complete the remedial education requirements set forth in subrule 12.4(2) 12.5(2).


ITEM 7. Adopt the following new rule 650—15.3(153):

650—15.3(153) Examination fees. All fees are nonrefundable. In addition to the fees specified in this rule, an applicant will pay a service charge for filing online.

- 15.3(1) Portfolio dental examination fee. The fee for dental examination on the basis of portfolio is $1500.

- 15.3(2) Reserved.

ITEM 8. Amend renumbered rule 650—15.4(153) as follows:

650—15.4(153) Application fees. All fees are nonrefundable. In addition to the fees specified in this rule, an applicant will pay a service charge for filing online.
15.4(1) Dental licensure on the basis of examination. The fees for a dental license issued on the basis of examination include an application fee, a fee for evaluation of a fingerprint packet and criminal background check and, if the applicant is applying within three months or less of a biennial renewal due date, the renewal fee.

a. No change.

b. Initial licensure period and renewal period. If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in 650—15.4(153) rule 650—15.5(153).

c. Fingerprint packet and criminal history check. The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.7(4) 15.8(4).

15.4(2) Dental hygiene licensure on the basis of examination. The fees for a dental hygiene license issued on the basis of examination include an application fee, an initial licensure fee, and a fee for evaluation of a fingerprint packet and criminal background check.

a. No change.

b. Initial licensure period and renewal period. If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in 650—15.4(153) rule 650—15.5(153).

c. Fingerprint packet and criminal history check. The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.7(4) 15.8(4).

15.4(3) and 15.4(4) No change.

15.4(5) Dental licensure on the basis of credentials. The fees for a dental license issued on
the basis of credentials include an application fee, an initial licensure fee, and a fee for evaluation of a fingerprint packet and criminal background check.

a. No change.

b. *Initial licensure period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in 650—15.4(153) rule 650—15.5(153).

c. *Fingerprint packet and criminal history check.* The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.7(4) 15.8(4).

15.4(6) *Dental hygiene licensure on the basis of credentials.* The fees for a dental hygiene license issued on the basis of credentials include an application fee, an initial licensure fee, and a fee for evaluation of a fingerprint packet and criminal background check.

a. No change.

b. *Initial licensure period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in 650—15.4(153) rule 650—15.5(153).

c. *Fingerprint packet and criminal history check.* The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.7(4) 15.8(4).

15.4(7) to 15.4(12) No change.

15.4(13) *Dental assistant registration only application.*

a. No change.

b. *Initial registration period and renewal period.* If an applicant applies within three
months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the registration application fee. A dental assistant registration shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a registrant shall pay the renewal fee as specified in 650—15.4(153) rule 650—15.5(153).

15.4(14) Combined application—dental assistant registration and qualification in radiography.

a. No change.

b. Initial combined registration and radiography qualification period and renewal period. If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the combined registration/radiography qualification application fee. A dental assistant registration and radiography qualification shall not be issued for a period less than three months or longer than two years and three months. Thereafter, the applicant shall pay the renewal fee as specified in 650—15.4(153) rule 650—15.5(153).

15.4(15) to 15.4(17) No change.

Item 9. Amend renumbered rule 650—15.7(147,153) as follows:

650—15.7(147,153) Reinstatement fees. If a license, registration or permit lapses or is inactive, a licensee, registrant or permit holder may submit an application for reinstatement. Licensees, registrants or permit holders are subject to reinstatement fees as described in this rule.

15.7(1) Reinstatement of a dental license. In addition to the reinstatement application fee specified in 15.3(8) subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed $750) and the fee for evaluation of a fingerprint packet and criminal background check as specified in 15.7(4) subrule 15.8(4).

15.7(2) Reinstatement of a dental hygiene license. In addition to the reinstatement application fee specified in 15.3(8) subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed $750) and the fee for evaluation of a fingerprint packet and criminal background

Pending approval by the Iowa Dental Board
check as specified in §15.7(4) subrule 15.8(4).

15.7(3) Reinstatement of a dental assistant registration. In addition to the reinstatement application fee specified in §15.3(8) subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed $750).

15.7(4) Combined reinstatement application—dental assistant registration and qualification in radiography. The fee for a combined application to reinstate both a registration as a registered dental assistant and a radiography qualification is specified in §15.3(8) subrule 15.4(8).

15.7(5) Reinstatement of qualification in radiography. In addition to the reinstatement application fee specified in §15.3(8) subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed $750).
Pursuant to the authority of Iowa Code sections 147.10, 147.11, 153.15A, 153.39 and 272C.2, the Dental Board hereby amends Chapter 14, “Renewal and Reinstatement,” and Chapter 20, “Dental Assistants,” and to rescind Chapter 25, “Continuing Education,” Iowa Administrative Code, and to adopt a new Chapter 25 with the same title.

These amendments rescind Chapter 25 and replace it with a new Chapter 25 pertaining to updated continuing education requirements and standards. The purpose of the registrations and to simplify requirements for continuing education course and sponsor review.

These amendments will place all continuing education requirements for the purposes of renewal in a single chapter. Currently, continuing education requirements for dental assistants are found in Chapter 20. The continuing education requirements for dental assistants will be stricken from Chapter 20 and moved to Chapter 25.

These amendments update and add definitions to the chapter to clarify intent and to allow the approval of programs and activities when content clearly meets established requirements for approval.

The amendments will clarify when proof of continuing education shall be submitted, as the result of a registrant’s or licensee’s being selected for an audit.

These amendments will update and clarify the list of acceptable and unacceptable topics for continuing education credit and add a provision to allow credit for those who complete the Dental Assisting National Board (DANB) examination during the current reporting period.

These amendments will establish a new rule 650—25.9(153), “Designation of continuing education hours,” which sets forth the number of continuing education hours that will be awarded for certain specific activities.

These amendments will establish new requirements for continuing education in the areas of
infection control and jurisprudence for all Iowa licensees and registrants.

These amendments will put a limit on the length of time for which continuing education courses would be eligible for credit following review and approval by the Board. This provision will ensure that courses for which credit is awarded are current and include relevant concepts and information.

These amendments will update the notification requirement following the Board’s decision regarding continuing education requests. Current requirements require notification by ordinary mail. The new rule will require written notification by e-mail.

The purposes of the amendments to Chapter 14 are to clarify the provisions for placing a license or registration on inactive status and to update provisions regarding the reactivation or reinstatement of an inactive or lapsed license or registration.

These amendments will move the rules relating to reinstatement of an inactive practitioner from Chapter 25 to Chapter 14 to allow renewal and reinstatement requirements to be addressed in a single chapter.

The amendments to Chapter 14 add a provision that a practitioner who has not actively practiced clinically for a period of five years or more may be required to complete an examination or assessment to prove competency.

The amendments to Chapter 14 lower from 50 hours to 30 hours the cap on the number of continuing education hours that a dental assistant is required to submit for reinstatement or reactivation.

The amendments eliminate the need for submission of a separate signed form in cases where a license or registrant renews on inactive status. The amendments to Chapter 20 add definitions to refine the roles of dental assistants in the dental office. The amendments will also clarify the procedures that may be completed under general supervision and the requirements of personal supervision.
The amendments to Chapter 20 clarify the timeline for dental assistant trainee status and application for dental assistant registration. These amendments would add a rule to Chapter 20 for applicant responsibilities regarding the submission of applications, the time period for applications, and the information being submitted, using language currently in Chapter 11, “Licensure to Practice Dentistry or Dental Hygiene.”

Notice of Intended Action was published in the Iowa Administrative Bulletin on July 3, 2017, as ARC 3157C. A public hearing was held on July 27, 2017 at 2:00 p.m. at the office of the Iowa Dental Board. There were not any attendees at the public hearing, nor were any written comments received.

The Board reviewed and discussed the amendments during their October 13, 2017, open session board meeting and allowed additional comments from the public.

The amendments are subject to waiver or variance pursuant to 650-chapter 7.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code chapters 153 and 272C.

These amendments are the same as those published under Notice.

ITEM 1. Amend rule 650—14.1(147,153,272C), introductory paragraph, as follows:

650—14.1(147,153,272C) Renewal of license to practice dentistry or dental hygiene. A license to practice dentistry or a license to practice dental hygiene must be renewed prior to the expiration date of the license. Dental hygiene licenses expire on August 31 of every odd-numbered year. Dental licenses expire August 31 of every even-numbered year. A licensee who is not engaged in practice in the state of Iowa may place the license on inactive status by submitting a renewal form and paying the required renewal fee. No continuing education hours are required to renew a license on inactive status until application for reactivation is made. A request to place a license on inactive status shall also contain a statement that the applicant will not engage in the
practice of the applicant’s profession in Iowa without first complying with all rules governing reactivation of inactive licenses.

**ITEM 2.** Amend subrule 14.1(1) as follows:

**14.1(1) Application renewal procedures.**

a. **Renewal notice.** The board office will send a renewal notice by regular mail or e-mail to each licensee at the licensee’s last-known mailing or e-mail address.

b. **Licensee and permit holder obligation.** The licensee or permit holder is responsible for renewing the license or permit prior to its expiration. Failure of the licensee or permit holder to receive the notice does not relieve the licensee or permit holder of the responsibility for renewing that license or permit in order to continue practicing in the state of Iowa.

c. **Renewal application form.** Application for renewal must be made on forms provided by the board office. Licensees and permit holders may renew their licenses and permits online or via paper application.

d. **Complete and timely filed application.** No renewal application shall be considered timely and sufficient until received by the board office and accompanied by all material required for renewal and all applicable renewal and late fees. Incomplete applications will not be accepted. For purposes of establishing timely filing, the postmark on a paper submittal will be used, and for renewals submitted online, the electronic timestamp will be deemed the date of filing.

**ITEM 3.** Amend rule 650—14.2(153), introductory paragraph, as follows:

**650—14.2(153) Renewal of registration as a dental assistant.** A certificate of registration as a registered dental assistant must be renewed biennially. Registration certificates shall expire on August 31 of every odd-numbered year. A registrant who is not engaged in practice in the state of Iowa may place the registration on inactive status by submitting a renewal form and paying the required renewal fee. No continuing education hours are required to renew a registration on inactive status until application for reactivation is made. A request to place a registration on
inactive status shall also contain a statement that the applicant will not engage in the practice of the applicant’s profession in Iowa without first complying with all rules governing reactivation of inactive registrations.

**ITEM 4.** Amend paragraph 14.2(1)“a” as follows:

a. **Renewal notice.** The board office will send a renewal notice by regular mail or e-mail to each registrant at the registrant’s last-known mailing address or e-mail address. The board will notify each registrant by mail or e-mail of the expiration of the registration certificate.

**ITEM 5.** Amend subrule 14.2(3) as follows:

14.2(3) **Continuing education requirements.** Completion of continuing education as specified in rule 650—20.11(153) and 650—Chapter 25 is required for renewal of an active registration. Failure to meet the requirements of renewal in the time specified by rule will automatically result in a lapsed registration.

**ITEM 6.** Amend rule 650—14.6(147,153,272C) as follows:

650—14.6(147,153,272C) **Reinstatement of a lapsed license or registration.**

14.6(1) A licensee or a registrant who allows a license or registration to lapse by failing to renew may have the license or registration reinstated at the discretion of the board by submitting the following:

a. A completed application for reinstatement of a lapsed license or registration to practice dentistry, or dental hygiene, or dental assisting, on forms provided by the board, in addition to the required fee or application for reinstatement of a lapsed registration on the form provided by the board.

b. Dates and places of practice.

c. A list of other states in which licensed or registered and the identifying number of each license or registration.

d. Reasons for seeking reinstatement and why the license or registration was not
e. Payment of all renewal fees past due, as specified in 650—Chapter 15, plus the reinstatement fee as specified in 650—Chapter 15.

f. Evidence of completion of a total of 15 hours of continuing education for each lapsed year or part thereof in accordance with 650—Chapter 25, up to a maximum of 75 hours. Dental assistants shall be required to submit evidence of completion of a total of 10 hours of continuing education for each lapsed year or part thereof in accordance with 650—20.12(153), 650—Chapter 25, up to a maximum of 30 hours, or evidence of the full-time or part-time practice of the profession in another state of the United States or the District of Columbia, for a minimum of two years within the previous five-year period, and a statement verifying that continuing education requirements in that state of practice have been met;

g. If licensed or registered in another state, the licensee or registrant shall provide certification by the state board of dentistry or equivalent authority of such state that the licensee or registrant has not been the subject of final or pending disciplinary action.

h. A statement disclosing and explaining any disciplinary actions, investigations, claims, complaints, judgments, settlements, or criminal charges.

i. Evidence that the applicant possesses a current certificate in a nationally recognized course in cardiopulmonary resuscitation. The course must include a clinical component.

j. For reinstatement of a lapsed license, a completed fingerprint packet to facilitate a criminal history background check by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), including the fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and FBI, as specified in 650—Chapter 15.

14.6(2) The board may require a licensee or registrant who is applying for reinstatement, and has not actively practiced clinically within the previous five years, to successfully complete an examination designated by the board prior to reinstatement if necessary to ensure the licensee...
or registrant is able to practice the licensee’s or registrant’s respective profession with reasonable skill and safety a regional clinical examination, or other board-approved examination or assessment, for the purpose of ensuring that the applicant possesses sufficient knowledge and skill to practice safely.

**14.6(3)** When the board finds that a practitioner applying for reinstatement is or has been subject to disciplinary action taken against a license or registration held by the applicant in another state of the United States, District of Columbia, or territory, and the violations which resulted in such actions would also be grounds for discipline in Iowa in accordance with rule 650—30.4(153), the board may deny reinstatement of a license or registration to practice dentistry, dental hygiene, or dental assisting in Iowa or may impose any applicable disciplinary sanctions as specified in rule 650—30.2(153) as a condition of reinstatement.

**14.6(4)** The dental hygiene committee may, in its discretion, review any applications for reinstatement of a lapsed dental hygiene license and make recommendations to the board. The board’s review of the dental hygiene committee recommendation is subject to 650—Chapter 1.

This rule is intended to implement Iowa Code sections 147.10, 147.11, and 272C.2.

**ITEM 7.** Adopt the following new rule 650—14.8(153):

**650—14.8(153) Reactivation of an inactive license or registration.**

**14.8(1)** Inactive practitioners shall, prior to engaging in the practice of dentistry, dental hygiene, or dental assisting in the state of Iowa, satisfy all of the following requirements for reactivation:

a. Submit application for reactivation to the board upon forms provided by the board, in addition to the required fee.

b. Provide evidence of one of the following:

1. The full-time or part-time practice of the profession in another state of the United States or the District of Columbia for a minimum of two years within the previous five-year period;
(2) Completion of a total number of hours of approved continuing education computed by multiplying 15 by the number of years the license has been on inactive status for a dentist or dental hygienist, up to a maximum of 75 hours for a dentist or dental hygienist, or by multiplying 10 by the number of years the registration has been on inactive status for a dental assistant, up to a maximum of 30 hours for a dental assistant.

c. Submit evidence that the applicant possesses a current certificate in a nationally recognized course in cardiopulmonary resuscitation (CPR). The course must include a clinical component.

14.8(2) The board may require a licensee or registrant who is applying for reactivation and has not actively practiced clinically in the previous five years to successfully complete a regional clinical examination, or other board-approved examination or assessment, to ensure the licensee or registrant is able to practice with reasonable skill and safety.

14.8(3) Applications must be filed with the board along with the following:

a. Certification by the state board of dentistry or equivalent authority of the state in which the applicant has been licensed or has engaged in the practice of the applicant’s profession that the applicant has not been the subject of final or pending disciplinary action.

b. Statement as to any claims, complaints, judgments or settlements made with respect to the applicant arising out of the alleged negligence or malpractice in rendering professional services as a dentist, dental hygienist, or dental assistant.

Item 8. Amend rule 650—20.2(153) as follows:

650—20.2(153) Definitions. As used in this chapter:

“Dental assistant trainee” means any person who is engaging in on-the-job training to meet the requirements for registration and who is learning the necessary skills under the personal supervision of a licensed dentist. Trainees may also engage in on-the-job training in dental
radiography pursuant to 650—22.3(136C,153).

“Dental assistant” means any person who, under the supervision of a dentist, performs any extraoral services including infection control or the use of hazardous materials or performs any intraoral services on patients. The term “dental assistant” does not include persons otherwise actively licensed in Iowa to practice dental hygiene or nursing who are engaged in the practice of said profession.

“Direct supervision” means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room while the registered dental assistant is performing acts assigned by the dentist.

“General supervision” means that a dentist has examined the patient and has delegated the services to be provided by a registered dental assistant, which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light, intraoral digital imaging and intraoral camera. The dentist need not be present in the facility while these services are being provided.

“Personal supervision” for intraoral procedures means the dentist is physically present in the treatment room to oversee and direct all intraoral or chairside services of the dental assistant and trainee. “Personal supervision” for extraoral procedures means a licensee or registrant is physically present in the treatment room to oversee and direct all extraoral services of the dental assistant trainee.

“Public health supervision” means all of the following:

1. The dentist authorizes and delegates the services provided by a registered dental assistant to a patient in a public health setting, with the exception that services may be rendered without the patient’s first being examined by a licensed dentist;

2. The dentist is not required to provide future dental treatment to patients served under public health supervision;
3. The dentist and the registered dental assistant have entered into a written supervision agreement that details the responsibilities of each licensee/registrant, as specified in subrule 20.16(2); and

4. The registered dental assistant has an active Iowa registration and a minimum of one year of clinical practice experience.

“Registered dental assistant” means any person who has met the requirements for registration and has been issued a certificate of registration.

“Trainee status expiration date” means the date established by the board office which is 12 months from a person’s first date of employment as a dental assistant. The trainee status expiration date is the date by which a trainee must successfully complete requirements and become registered as a dental assistant, pursuant to Iowa Code section 153.39 12 months from the date of issuance.


ITEM 10. Adopt the following new rule 650—20.3(153):

650—20.3(153) Applicant responsibilities. An applicant for dental assistant trainee status or dental assistant registration bears full responsibility for each of the following:

20.3(1) Providing accurate, up-to-date, and truthful information on the application including, but not limited to, prior professional experiences, education, training, examination scores, and disciplinary history.

20.3(2) Submitting complete application materials. An application for trainee status will be considered active for 90 days from the date the application is received. An application for dental assistant registration, reactivation, or reinstatement will be considered valid for 180 days from the date the application is received. If the applicant does not submit all materials within this time period, or if the applicant does not meet the requirements for trainee status, dental assistant registration, or reinstatement, the application shall be considered incomplete and the applicant
must submit a new application and application fee.

ITEM 11. Amend renumbered subparagraph 20.4(4)“e”(3) as follows:

(3) Notwithstanding 650—paragraph 10.3(1)“e” and paragraph 20.3(2)“e,” 20.4(2)“e.” for the purposes of this chapter, the removal of adhesives by hand instrumentation does not constitute the removal of “hard natural or synthetic material.”

ITEM 12. Rescind existing rule 650—20.6(153).

ITEM 13. Amend renumbered rule 650—20.6(153) as follows:

650—20.6(153) Categories of dental assistants: dental assistant trainee, registered dental assistant. There are two categories of dental assistants. Both the supervising dentist and the registered dental assistant or dental assistant trainee are responsible for maintaining documentation of training. Such documentation must be maintained in the office of practice and shall be provided to the board upon request.

20.6(1) Registered dental assistant. Registered dental assistants are individuals who have met the requirements for registration and have been issued a certificate of registration. A registered dental assistant may, under general supervision, perform dental radiography, intraoral suctioning, use of a curing light and intraoral camera, and all extraoral duties that are assigned by the dentist and are consistent with these rules. During intraoral procedures, the registered dental assistant may, under direct supervision, assist the dentist in performing duties assigned by the dentist that are consistent with these rules. The registered dental assistant may take radiographs if qualified pursuant to 650—Chapter 22.

20.6(1) 20.6(2) Dental assistant trainee. Dental assistant trainees are all individuals who are engaging in on-the-job training to meet the requirements for registration and who are learning the necessary skills under the personal supervision of a licensed dentist. Trainees may also engage in on-the-job training in dental radiography pursuant to 650—22.3(136C,153).

a. General requirements. The dental assistant trainee shall meet the following
requirements:

1. Prior to the trainee status expiration date, the dental assistant trainee shall successfully complete a course of study and examination in the areas of infection control, hazardous materials, and jurisprudence. The course of study shall be prior approved by the board and sponsored by a board-approved postsecondary school.

2. Prior to the trainee status expiration date, the trainee must apply to the board office to be reclassified as a registered dental assistant.

3. If a trainee fails to become registered by the trainee status expiration date, the trainee must stop work as a dental assistant trainee. If the trainee has not yet met the requirements for registration, the trainee may reapply for trainee status but may not work until a new dental assistant trainee status certificate has been issued by the board.

b. New trainee application required if trainee not registered prior to trainee status expiration date. Pursuant to Iowa Code section 153.39, a person employed as a dental assistant has a 12-month period following the person’s first date of employment to become registered. If not registered by the trainee status expiration date, the trainee must stop work as a dental assistant and reapply for trainee status.

1. Reapplying for trainee status. A trainee may “start over” as a dental assistant trainee provided the trainee submits an application in compliance with subrule 20.7(1).

2. Examination scores valid for three years. A “repeat” trainee is not required to retake an examination (jurisprudence, infection control/hazardous materials, radiography) if the trainee has successfully passed the examination within three years of the date of application. If a trainee has failed two or more examinations, the trainee must satisfy the remedial education requirements in subrule 20.11(1). The trainee status application will not be approved until the trainee successfully completes any required remedial education.

3. New trainee status expiration date issued. If the repeat trainee application is
approved, the board office will establish a new trainee status expiration date by which registration must be completed.

(4) Maximum of two “start over” periods allowed. In addition to the initial 12-month trainee status period, a dental assistant is permitted up to two start over periods as a trainee. If a trainee seeks an additional start over period beyond two, the trainee shall submit a petition for rule waiver under 650—Chapter 7.

c. Trainees enrolled in cooperative education or work study programs. The requirements stated in this subrule apply to all dental assistant trainees, including a person enrolled in a cooperative education or work-study program through an Iowa high school. In addition, a trainee under 18 years of age shall not participate in dental radiography.

20.6(2) Registered dental assistant. A registered dental assistant may perform under general supervision dental radiography, intraoral suctioning, use of a curing light and intraoral camera, and all extraoral duties that are assigned by the dentist and are consistent with these rules. During intraoral procedures, the registered dental assistant may, under direct supervision, assist the dentist in performing duties assigned by the dentist that are consistent with these rules. The registered dental assistant may take radiographs if qualified pursuant to 650—Chapter 22.

ITEM 14. Amend subrule 20.7(1) as follows:

20.7(1) Dental assistant trainee.

a. On or after May 1, 2013, a dentist supervising a person performing dental assistant duties must ensure that the person has been issued a trainee status certificate from the board office prior to the person’s first date of employment as a dental assistant. A dentist who has been granted a temporary permit to provide volunteer services for a qualifying event of limited duration pursuant to 650—subrule 13.3(3), or an Iowa-licensed dentist who is volunteering at such qualifying event, is exempt from this requirement for a dental assistant who is working under the dentist’s supervision at the qualifying event.
b. Applications for registration as a dental assistant trainee must be filed on official board forms and include the following:

1. The fee as specified in 650—Chapter 15.
2. Evidence of high school graduation or equivalent.
3. Evidence the applicant is 17 years of age or older.
4. Any additional information required by the board relating to the character and experience of the applicant as may be necessary to evaluate the applicant’s qualifications.
5. If the applicant does not meet the requirements of (2) and (3) above, evidence that the applicant is enrolled in a cooperative education or work-study program through an Iowa high school.

c. Prior to the trainee status expiration date, the dental assistant trainee is required to successfully complete a board-approved course of study and examination in the areas of infection control, hazardous materials, and jurisprudence. The course of study may be taken at a board-approved postsecondary school or on the job using curriculum approved by the board for such purpose. Evidence of meeting this requirement prior to the trainee status expiration date shall be submitted by the employer dentist.

d. Prior to the trainee status expiration date, the dental assistant trainee’s supervising dentist must ensure that the trainee has received a certificate of registration or has been issued start-over trainee status in accordance with rule 650—20.6(153) before performing any further dental assisting duties.

ITEM 15. Amend rule 650—20.12(153) as follows:

650—20.12(153) Continuing education. Beginning July 1, 2001, each person registered as a dental assistant shall complete 20 hours of continuing education approved by the board during the biennium period as a condition of registration renewal requirements as specified in 650—Chapter 25.
20.12(1) At least two continuing education hours must be in the subject area of infection control.

20.12(2) A maximum of three hours may be in cardiopulmonary resuscitation.

20.12(3) For dental assistants who have radiography qualification, at least two hours of continuing education must be obtained in the subject area of radiography.

20.12(4) For the renewal period July 1, 2001, to June 30, 2003, at least one hour of continuing education must be obtained in the subject area of jurisprudence.

ITEM 16. Rescind 650—Chapter 25 and adopt the following new chapter in lieu thereof:

CHAPTER 25
CONTINUING EDUCATION

650—25.1(153) Definitions. For the purpose of this chapter, these definitions shall apply:

“Advisory committee” means a committee on continuing education formed to review and advise the board with respect to applications for approval of sponsors or activities. The committee’s members shall be appointed by the board and consist of at least one member of the board, two licensed dentists with expertise in the area of professional continuing education, two licensed dental hygienists with expertise in the area of professional continuing education, and two registered dental assistants with expertise in the area of professional continuing education. The advisory committee on continuing education may recommend approval or denial of applications or requests submitted to it pending final approval or disapproval of the board at its next meeting.

“Board” means the dental board.

“Continuing dental education” consists of education activities designed to review existing concepts and techniques and to update knowledge on advances in dental and medical sciences. The objective of continuing dental education is to improve the knowledge, skills, and ability of the individual to deliver the highest quality of service to the public and professions.

Continuing dental education should favorably enrich past dental education experiences.
Programs should make it possible for practitioners to attune dental practice to new knowledge as it becomes available. All continuing dental education should strengthen the skills of critical inquiry, balanced judgment and professional technique.

“Dental public health” is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice in which the community serves as the patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, with the administration of group dental care programs, and with the prevention and control of dental diseases on a community basis.

“Hour of continuing education” means one unit of credit which shall be granted for each hour of contact instruction and shall be designated as a “clock hour.” This credit shall apply to either academic or clinical instruction.

“Licensee” means any person who has been issued a certificate to practice dentistry or dental hygiene in the state of Iowa.

“Registrant” means any person registered to practice as a dental assistant in the state of Iowa.

“Self-study activities” means the study of something by oneself, without direct supervision or attendance in a class. “Self-study activities” may include Internet-based coursework, television viewing, video programs, correspondence work or research, or computer programs that are interactive and require branching, navigation, participation and decision making on the part of the viewer. Internet-based webinars which include the involvement of an instructor and participants in real time and which allow for communication with the instructor through messaging, telephone or other means shall not be construed to be self-study activities.

“Sponsor” means a person, educational institution, or organization sponsoring continuing education activities which has been approved by the board as a sponsor pursuant to these rules. During the time a person, educational institution, or organization is an approved sponsor, all continuing education activities of such person or organization may be deemed automatically
approved provided the continuing education activities meet the continuing education guidelines of
the board.

650—25.2(153) Continuing education administrative requirements.

25.2(1) Each person licensed to practice dentistry or dental hygiene in this state shall
complete during the biennium renewal period a minimum of 30 hours of continuing education
approved by the board.

25.2(2) Each person registered to practice dental assisting in this state shall complete
during the biennium renewal period a minimum of 20 hours of continuing education approved by
the board.

25.2(3) Each person who holds a qualification in dental radiography in this state shall
complete during the biennium renewal period a minimum of two hours of continuing education in
the area of dental radiography.

25.2(4) The continuing education compliance period shall be the 24-month period
commencing September 1 and ending on August 31 of the renewal cycle.

25.2(5) Hours of continuing education credit may be obtained by attending and
participating in a continuing education activity either previously approved by the board or which
otherwise meets the requirements herein and is approved by the board pursuant to rule 650—
25.5(153).

25.2(6) It is the responsibility of each licensee or registrant to finance the costs of
continuing education.

650—25.3(153) Documentation of continuing education hours.

25.3(1) Every licensee or registrant shall maintain a record of all courses attended by
keeping the certificates of attendance for four years. The board reserves the right to require any
licensee or registrant to submit the certificates of attendance for the continuing education courses
attended. If selected for continuing education audit, the licensee or registrant shall file a signed
pending approval by the iowa dental board

25.3(2) licensees and registrants are responsible for obtaining proof of attendance forms when attending courses. clock hours must be verified by the sponsor with the issuance of proof of attendance forms to the licensee or registrant.

25.3(3) each licensee or registrant shall report the number of continuing education credit hours completed during the current renewal cycle in compliance with this chapter. such report shall be filed with the board at the time of application for renewal of a dental or dental hygiene license or renewal of dental assistant registration.

25.3(4) no carryover of credits from one biennial period to the next will be allowed.

650—25.4(153) required continuing education courses.

25.4(1) the following courses are required for licensees and registrants:

a. mandatory reporter training for child abuse and dependent adult abuse.

b. cardiopulmonary resuscitation.

c. infection control.

d. jurisprudence.

25.4(2) mandatory reporter training for child abuse and dependent adult abuse.

a. licensees or registrants who regularly examine, attend, counsel or treat children in iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or conditions for exemptions as identified in paragraph “f” of this subrule, pursuant to iowa code chapter 232. completion of training in this course shall result in two hours of continuing education credit.

b. licensees or registrants who regularly examine, attend, counsel or treat adults in iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or conditions for exemptions as identified in paragraph “f” of this subrule, pursuant to iowa code chapter 235b.
c. Licensees or registrants who regularly examine, attend, counsel or treat both children and adults in Iowa shall indicate on the renewal application completion of at least two hours of training on the identification and reporting of abuse in children and dependent adults in the previous five years or conditions for exemptions as identified in paragraph “f” of this subrule, pursuant to Iowa Code chapters 232 and 235B. Training may be completed through separate courses or in one combined course that includes curricula for identifying and reporting child abuse and dependent adult abuse. Completion of training in this combined course shall result in three hours of continuing education credit.

d. The licensee or registrant shall maintain written documentation for five years after completion of the mandatory training, including program date(s), content, duration, and proof of participation. The board may audit this information at any time within the five-year period.

e. Training programs in child and dependent adult abuse identification and reporting that are approved by the board are those that use a curriculum approved by the abuse education review panel of the department of public health or a training program offered by the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

f. Exemptions. Licensees and registrants shall be exempt from the requirement for mandatory training for identifying and reporting child and dependent adult abuse if the board determines that it is in the public interest or that at the time of the renewal the licensee or registrant is issued an extension or exemption pursuant to rule 650—25.10(153).

25.4(3) Cardiopulmonary resuscitation (CPR). Licensees and registrants shall furnish evidence of valid certification for CPR, which shall be credited toward the continuing education requirement for renewal of the license, faculty permit or registration. Such evidence shall be filed at the time of renewal of the license, faculty permit or registration. Valid certification means certification by an organization on an annual basis or, if that certifying organization requires
certification on a less frequent basis, evidence that the licensee or registrant has been properly
certified for each year covered by the renewal period. In addition, the course must include a clinical
component. Credit hours awarded for certification in CPR shall not exceed three hours of required
continuing education hours per biennium.

25.4(4) Infection control. Beginning July 1, 2018, licensees and registrants shall complete
continuing education in the area of infection control. Licensees and registrants shall furnish
evidence of continuing education completed within the previous biennium in the area of infection
control standards, as required by the Centers for Disease Control and Prevention of the United
States Department of Health and Human Services. Completion of continuing education in the area
of infection control shall be credited toward the required continuing education requirement in the
renewal period during which it was completed. A minimum of one hour shall be submitted.

25.4(5) Jurisprudence. Beginning July 1, 2018, licensees and registrants shall complete
continuing education in the area of jurisprudence related to the practice of dentistry, dental hygiene
and dental assisting. Licensees and registrants shall furnish evidence of continuing education
completed within the previous biennium in the area of jurisprudence. Completion of continuing
education in the area of jurisprudence shall be credited toward the required continuing education
requirement in the renewal period during which it was completed. A minimum of one hour shall
be submitted.

650—25.5(153) Acceptable programs and activities.

25.5(1) A continuing education activity shall be acceptable and not require board approval
if it meets the following criteria:

a. It constitutes an organized program of learning (including a workshop or
symposium) which contributes directly to the professional competency of the licensee or registrant
and is of value to dentistry and applicable to oral health care; and

b. It pertains to common subjects or other subject matters which relate to the practice
of dentistry, dental hygiene, or dental assisting which are intended to refresh and review, or update knowledge of new or existing concepts and techniques, and enhance the dental health of the public; and

    c. It is conducted by individuals who have sufficient special education, training and experience to be considered experts concerning the subject matter of the program. The program must include a written outline or manual that substantively pertains to the subject matter of the program.

25.5(2) Types of activities acceptable for continuing dental education credit may include:

    a. A dental science course that includes topics which address the clinical practice of dentistry, dental hygiene, dental assisting and dental public health.

    b. Courses in record keeping, medical conditions which may have an effect on oral health, ergonomics related to clinical practice, HIPAA, risk management, sexual boundaries, communication with patients, OSHA regulations, and the discontinuation of practice related to the transition of patient care and patient records.

    c. Sessions attended at a multiday convention-type meeting. A multiday convention-type meeting is held at a national, state, or regional level and involves a variety of concurrent educational experiences directly related to the practice of dentistry.

    d. Postgraduate study relating to health sciences.

    e. Successful completion of a recognized specialty examination or the Dental Assisting National Board (DANB) examination.

    f. Self-study activities.

    g. Original presentation of continuing dental education courses.

    h. Publication of scientific articles in professional journals related to dentistry, dental hygiene, or dental assisting.

25.5(3) Credit may be given for other continuing education activities upon request and
650—25.6(153) Unacceptable programs and activities.

25.6(1) Unacceptable subject matter and activity types include, but are not limited to, personal development, business aspects of practice, business strategy, financial management, marketing, sales, practice growth, personnel management, insurance, collective bargaining, and events where volunteer services are provided. While desirable, those subjects and activities are not applicable to dental skills, knowledge, and competence. Therefore, such courses will receive no credit toward renewal. The board may deny credit for any course.

25.6(2) Inquiries relating to acceptability of continuing dental education activities, approval of sponsors, or exemptions should be directed to Advisory Committee on Continuing Dental Education, Iowa Dental Board, 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687.

650—25.7(153) Prior approval of activities. A person or organization, other than an approved sponsor, that desires prior approval for a course, program or other continuing education activity or that desires to establish approval of the activity prior to attendance may apply for approval to the board, using board-approved forms, at least 90 days in advance of the commencement of the activity. Within 90 days after receipt of such application, the board shall advise the licensee or registrant in writing whether the activity is approved and the number of hours allowed. All requests may be reviewed by the advisory committee on continuing education prior to final approval or denial by the board. An application fee as specified in 650—Chapter 15 is required. Continuing education course approval shall be valid for a period of five years following the date of board approval. Thereafter, courses may be resubmitted for approval. Courses which clearly meet the criteria listed under acceptable programs and activities are not required to be submitted for approval.

650—25.8(153) Postapproval of activities. A licensee or registrant seeking credit for
attendance and participation in an educational activity which was not conducted by an approved sponsor or otherwise approved and which does not clearly meet the acceptable programs and activities listed in rule 650—25.5(153) may apply for approval to the board using board-approved forms. Within 90 days after receipt of such application, the board shall advise the licensee or registrant in writing whether the activity is approved and the number of hours allowed. All requests may be reviewed by the advisory committee on continuing education prior to final approval or denial by the board. An application fee as specified in 650—Chapter 15 is required.

650—25.9(153) Designation of continuing education hours. Continuing education hours shall be determined by the length of a continuing education course in clock hours. For the purpose of calculating continuing education hours for renewal of a license or registration, the following rules shall apply:

25.9(1) Attendance at a multiday convention.
   a. Attendees at a multiday convention may receive a maximum of 1.5 hours of credit per day with the maximum of six hours of credit allowed per biennium.
   b. Sponsors of multiday conventions shall submit to the board for review and prior approval guidelines for awarding credit for convention attendance.

25.9(2) Presenters or attendees of table clinics at a meeting.
   a. Four hours of credit shall be allowed for presentation of an original table clinic at a meeting as verified by the sponsor when the subject matter conforms with rule 650—25.5(153).
   b. Attendees at the table clinic session of a dental, dental hygiene, or dental assisting meeting shall receive two hours of credit as verified by the sponsor when the subject matter conforms with rule 650—25.5(153).

25.9(3) Postgraduate study relating to health sciences shall receive 15 credits per semester.

25.9(4) Successful completion of a specialty examination or the Dental Assisting National Board (DANB) shall result in 15 hours of credit.
25.9(5) Self-study activities shall result in a maximum of 12 hours of continuing education credit per biennium.

25.9(6) An original presentation of continuing education dental education shall result in credit double that which the participants receive. Additional credit will not be granted for the repeating of presentations within the biennium. Credit is not given for teaching that represents part of the licensee’s or registrant’s normal academic duties as a full-time or part-time faculty member or consultant.

25.9(7) Publication of scientific articles in professional journals related to dentistry, dental hygiene, or dental assisting shall result in 5 hours of credit per article with the maximum of 20 hours allowed per biennium.

650—25.10(153) Extensions and exemptions.

25.10(1) Illness or disability. The board may, in individual cases involving physical disability or illness, grant an exemption of the continuing education requirements or an extension of time within which to fulfill the same or make the required reports. No exemption or extension of time shall be granted unless written application is made on forms provided by the board and signed by the licensee or registrant and a licensed health care professional. Extensions or exemptions of the continuing education requirements may be granted by the board for any period of time not to exceed one calendar year. In the event that the physical disability or illness upon which an exemption has been granted continues beyond the period granted, the licensee or registrant must apply for an extension of the exemption. The board may, as a condition of the exemption, require the applicant to make up a certain portion or all of the continuing education requirements.

25.10(2) Other extensions or exemptions. Extensions or exemptions of continuing education requirements will be considered by the board on an individual basis. Licensees or registrants will be exempt from the continuing education requirements for:
a. Periods that the person serves honorably on active duty in the military services;

b. Periods that the person practices the person’s profession in another state or district having a continuing education requirement and the licensee or registrant meets all requirements of that state or district for practice therein;

c. Periods that the person is a government employee working in the person’s licensed or registered specialty and assigned to duty outside the United States;

d. Other periods of active practice and absence from the state approved by the board;

e. The current biennium renewal period, or portion thereof, following original issuance of the license;

f. For dental assistants registered pursuant to rule 650—20.7(153), the current biennium renewal period, or portion thereof, following original issuance of the registration.

650—25.11(153) Exemptions for inactive practitioners. No continuing education hours are required to renew a license or registration on inactive status until application for reactivation is made. A licensee or registrant with a license or registration on inactive status is prohibited from practicing unless and until the license or registration is restored to active status.

650—25.12(153) Approval of sponsors.

25.12(1) An organization or person which desires approval as a sponsor of courses, programs, or other continuing education activities shall apply for approval to the board stating its education history, including approximate dates, subjects offered, total hours of instruction presented, and names and qualifications of instructors. All applications shall be reviewed by the advisory committee on continuing education prior to final approval or denial by the board.

25.12(2) Prospective sponsors must apply to the board using approved forms in order to obtain approved sponsor status. An application fee as specified in 650—Chapter 15 is required. Sponsors must pay the biennial renewal fee as specified in 650—Chapter 15 and file a sponsor recertification record report biennially.
25.12(3) The person or organization sponsoring continuing education activities shall make a written record of the Iowa licensees or registrants in attendance, maintain the written record for a minimum of five years, and submit the record upon the request of the board. The sponsor of the continuing education activity shall also provide proof of attendance and the number of credit hours awarded to the licensee or registrant who participates in the continuing education activity.

25.12(4) Sponsors must be formally organized and adhere to board rules for planning and providing continuing dental education activities. Programs sponsored by individuals or institutions for commercial or proprietary purposes, especially programs in which the speaker advertises or urges the use of any particular dental product or appliance, may be recognized for credit on a prior-approval basis only. When courses are promoted as approved continuing education courses which do not meet the requirements as defined by the board, the sponsor will be required to refund the registration fee to the participants. Approved sponsors may offer noncredit courses provided the participants have been informed that no credit will be given. Failure to meet this requirement may result in loss of approved sponsor status.

650—25.13(153) Review of programs or sponsors. The board on its own motion or at the recommendation of the advisory committee on continuing education may monitor or review any continuing education program or sponsors already approved by the board. Upon evidence of a failure to meet the requirements of rule 650—25.12(153), the board may revoke the approval status of the sponsor. Upon evidence of significant variation in the program presented from the program approved, the board may deny all or any part of the approved hours granted to the program. A provider that wishes to appeal the board’s decision regarding revocation of approval status or denial of continuing education credit shall file an appeal within 30 days of the board’s decision. A timely appeal shall initiate a contested case proceeding. The contested case shall be conducted pursuant to Iowa Code chapter 17A and 650—Chapter 51. The written decision issued at the conclusion of a contested case hearing shall be considered final agency action.
650—25.14(153) Noncompliance with continuing dental education requirements. It is the licensee’s or registrant’s personal responsibility to comply with these rules. The license or registration of individuals not complying with the continuing dental education rules may be subject to disciplinary action by the board or nonrenewal of the license or registration.

650—25.15(153) Dental hygiene continuing education. The dental hygiene committee, in its discretion, shall make recommendations to the board for approval or denial of requests pertaining to dental hygiene education. The dental hygiene committee may utilize the continuing education advisory committee as needed. The board’s review of the dental hygiene committee recommendation is subject to 650—Chapter 1. The following items pertaining to dental hygiene shall be forwarded to the dental hygiene committee for review.

1. Dental hygiene continuing education requirements and requests for approval of programs, activities and sponsors.

2. Requests by dental hygienists for waivers, extensions and exemptions of the continuing education requirements.

3. Requests for exemptions from inactive dental hygiene practitioners.

4. Requests for reinstatement from inactive dental hygiene practitioners.

5. Appeals of denial of dental hygiene continuing education and conduct hearings as necessary.

These rules are intended to implement Iowa Code sections 147.10, 153.15A, and 153.39 and chapter 272C.
Pursuant to the authority of Iowa Code sections 147.80 and 272C.6, the Dental Board hereby amends Chapter 15, “Fees,” Iowa Administrative Code.

The amendments update the definition of “fee” to reflect the definition of “overpayment” provided in Chapter 1.

These amendments would reduce the total back renewal fees owed for the reinstatement of a lapsed dental assistant registration, and eliminate the fee for notification of public orders if provided via e-mail.

These amendments clarify the types of items available for purchase and the formats in which the items may be provided. These amendments update the types of data provided in the standard mailing and data lists. These amendments also seek to clarify the types of costs that may be recovered following a disciplinary hearing.

Notice of Intended Action was published in Iowa Administrative Bulletin on July 3, 2017, as ARC 3156C. A public hearing was held on July 27, 2017 at 2:00 p.m. at the office of the Iowa Dental Board. There were not any attendees at the public hearing, nor were any written comments received. Due to further discussion by staff, a change has been proposed to the definition of “overpayment” to better address the issue of overpayment.

The board reviewed and discussed the amendments during their October 13, 2017, open session board meeting and allowed additional comments from the public.

The amendments are not subject to waiver or variance pursuant to 650—Chapter 7.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code sections 147.80 and 272C.6.

These amendments include a modification from those published under Notice to change the definition of “overpayment” following further discussion.
ITEM 1. Amend rule 650—15.2(147,153) as follows:

650—15.2(147,153) Definitions. The following definitions apply to this chapter:

“Fee” means the amount charged for the services described in this chapter. All fees are nonrefundable. The board office will refund any overpayment of fees $10 or more. Overpayment of the fee will result in the original request and payment being returned, prior to processing, with a clarification of the total amount due.

“Service charge” means the amount charged for making a service available online and is in addition to the actual fee for a service itself. For example, a licensee who renews a license online will pay the license renewal fee and a service charge.

ITEM 2. Amend subrule 15.3(8) as follows:

15.3(8) Reinstatement of an inactive lapsed license or registration. The fee for a reinstatement application for a lapsed license or registration is $150.

ITEM 3. Amend rule 650—15.6(147,153) as follows:

650—15.6(147,153) Reinstatement fees. If a license, registration or permit lapses or is inactive, a licensee, registrant or permit holder may submit an application for reinstatement. Licensees, registrants or permit holders are subject to reinstatement fees as described in this rule.

15.6(1) Reinstatement of a dental license. In addition to the reinstatement application fee specified in 15.3(8), the applicant must pay all back renewal fees (not to exceed $750) and the fee for evaluation of a fingerprint packet and criminal background check as specified in 15.7(4).

15.6(2) Reinstatement of a dental hygiene license. In addition to the reinstatement application fee specified in 15.3(8), the applicant must pay all back renewal fees (not to exceed $750) and the fee for evaluation of a fingerprint packet and criminal background check as specified in 15.7(4).

15.6(3) Reinstatement of a dental assistant registration. In addition to the reinstatement application fee specified in 15.3(8), the applicant must pay all back renewal fees (not to exceed
$750 $115) to reinstate a registration as a registered dental assistant.

15.6(4) Combined reinstatement application—dental assistant registration and qualification in radiography. The fee In addition to the reinstatement application fee specified in 15.3(8), the applicant must pay all back renewal fees (not to exceed $175) for a combined application to reinstate both a registration as a registered dental assistant and a radiography qualification is specified in 15.3(8).

15.6(5) Reinstatement of qualification in radiography. In addition to the reinstatement application fee specified in 15.3(8) of $40, the applicant must pay all back renewal fees (not to exceed $750 $60) to reinstate a qualification in dental radiography without registration as a dental assistant.

ITEM 4. Amend subrule 15.7(2) as follows:

15.7(2) Certification or verification. The fee for a written certification or written verification of an Iowa license, permit or registration is $25.

ITEM 5. Amend subrule 15.7(7) as follows:

15.7(7) Disciplinary hearings—fees and costs.

a. No change.

b. The board may charge a fee not to exceed $75 for conducting a disciplinary hearing which results in disciplinary action taken against the licensee by the board. In addition to the fee, the board may recover from the licensee costs for the following procedures and personnel:

(1) Transcript Court reporter and transcript.

(2) Witness fees and expenses. The parties in a contested case shall be responsible for any witness fees and expenses incurred by witnesses appearing at the contested case hearing. In addition, the board may assess a licensee the witness fees and expenses incurred by witnesses called to testify on behalf of the state of Iowa.

(3) Depositions. Deposition costs for the purposes of allocating costs against a licensee.
include only those deposition costs incurred by the state of Iowa. The licensee is directly responsible for the payment of deposition costs incurred by the licensee.

(4) Medical examination fees incurred relating to a person licensed under Iowa Code chapter 147. All costs of physical or mental examinations or substance abuse evaluations or drug screening or clinical competency evaluations ordered by the board pursuant to Iowa Code section 272C.9(1) as part of an investigation or pending complaint or as a sanction following a contested case shall be paid directly by the licensee.

ITEM 6. Adopt the following new subrules 15.7(8) to 15.7(11):

15.7(8) Certification of reimbursable costs. The executive director or designee shall certify any reimbursable costs incurred by the board. The executive director shall calculate the specific costs, certify the cost calculated, and file the certification as part of the record in the contested case. A copy of the certification shall be served on the party responsible for payment of the certified costs at the time of the filing.

15.7(9) Assessment of fees and costs. A final decision of the board imposing disciplinary action against a licensee shall include the amount of any disciplinary hearing fee assessed, which shall not exceed $75. If the board also assesses reimbursable costs against the licensee, the board shall file a Certification of Reimbursable Costs which includes a statement of costs delineating each category of costs and the amount assessed. Fees and costs that cannot be calculated at the time of the issuance of the board’s final disciplinary order may be invoiced to the licensee at a later time, provided the board’s final disciplinary order states that the fees and costs will be invoiced at a later date. The board shall specify the time period in which the fees and costs must be paid by the licensee.

15.7(10) Board treatment of collected fees, costs. Fees and costs collected by the board shall be considered repayment receipts as defined in Iowa Code section 8.2.

15.7(11) Failure to pay assessed fees, costs. Failure of a licensee to pay the fees and costs
assessed herein within the time period specified in the board’s final disciplinary order shall constitute a violation of an order of the board and shall be grounds for disciplinary action.

ITEM 7. Amend subrule 15.10(3) as follows:

15.10(3) Electronic files of statements of charges, final orders and consent agreements from each board meeting delivered via e-mail may be available for an annual subscription fee of $24 delivered via e-mail, upon written request, at no cost.

ITEM 8. Amend rule 650—15.11(22,147,153) as follows:

650—15.11(22,147,153) Purchase of a mailing list or data list. Payment made to the Iowa Dental Board, which shall be considered a repayment receipt as defined in Iowa Code section 8.2, shall be received in the board office prior to the release of a list.

15.11(1) Mailing list for dentists, hygienists or assistants. The standard mailing list for all active licensees and registrants includes the full name, address, city, state, and ZIP code, and Iowa county. The standard mailing list of dentists or dental hygienists does not include resident licensees or faculty permit holders.

a. Printed mailing list, $65 per profession requested.

b. Mailing list on disc or DVD, $45 per profession requested.

c. Mailing list in an electronic file, $35 per profession requested.

15.11(2) Data list for dentists, hygienists, or assistants. The standard data list for active licensees or registrants includes full name, address, Iowa county (if applicable), original issue date, expiration date, license or registration number, and license or registration status, specialty (if applicable), and whether public disciplinary action has been taken. The standard data list includes resident licensees and faculty permit holders. Additional data elements, programming or sorting increases the following fees by $25.

a. Printed standard data list, $75 per profession requested.
b. Standard data list on disc or DVD, $55 per profession requested.

c. Standard data list in an electronic file, $45 per profession requested.
Pursuant to the authority of Iowa Code 153.33 and 153.34, the Dental Board hereby gives Notice of Intended Action to amend Chapter 26, “Advertising”, and to rescind and reserve Chapter 28, “Designation of Specialty” Iowa Administrative Code.

The amendments clarify the requirements to advertise a specialty in the practice of dentistry to permit dentists to advertise as a specialist if they are a diplomate of, or board eligible for, a national certifying board of a specialty recognized by the American Dental Association or a diplomate of a board recognized by the American Board of Dental Specialties. In addition, the rules permit dentists a third option for advertising as a specialist if they are a diplomate of a national certifying board that meets established criteria. The American Dental Association has recently addressed the changing scope of specialization and recent court cases have highlighted the constitutional rights of licensees to advertise the services they provide. Chapter 28 currently sets forth in detail the specialties that may be advertised and the requirements for those specialties. Because the proposed amendments to chapter 26 set forth the criteria for advertising specialties, the Board is also seeking to rescind chapter 28 at this time.

Any interested person may make written comments on the proposed amendments on or before September 12, 2017. Such written materials should be directed to Phil McCollum, Associate Director, Iowa Dental Board, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa 50309 or sent by email to phil.mccollum@iowa.gov.

There will be a public hearing on September 12, 2017 at 2:00 pm in the Board office, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa, 50309 at which time persons may present their views orally or in writing.

The proposed amendments are subject to waiver or variance pursuant to 650-chapter 7.

After analysis and review of this rule making, there is no impact on jobs.
ITEM 1. Amend subrule 650—26.4 as follows:

650—26.4(153) Public representation. All advertisements and public representations shall contain the name and address or telephone number of the practitioner who placed the ad.

26.4(1) If one’s practice is referred to in an advertisement or representation, it may state either “general/family practice” or “specialist,” “specializes,” or “specializing.” For those dentists advertising or representing themselves as a specialist, they must comply with the other provisions of this rule. The American Dental Association recognized specialty that the practitioner practices.

26.4(2) No dentist may state or imply that the dentist is certified as a specialist when that is not the case. Use of the terms “specialist,” “specializing in” or other similar terms in connection with areas that are not recognized as specialties pursuant to 650—Chapter 28 is not permitted. A dentist may only advertise as a specialist if the dentist meets the standards set forth in this rule.

a. The dentist wishing to advertise as a specialist must be a Diplomate of, or board eligible for, a national certifying board of a specialty recognized by the American Dental Association (ADA), or a Diplomate of a board recognized by the American Board of Dental Specialties (ABDS), and:

b. The indicated area of specialty must be Board approved. Board approved ADA specialties are as follows: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics and oral and maxillofacial radiology. Board approved ABDS specialties are as follows: oral implantology/implant dentistry, oral medicine, orofacial pain, and anesthesiology.

26.4(3) Any certifying board may apply for a new area of specialty to become Board approved by submitting information regarding the area of specialty, including an explanation of how it is within the scope of practice of dentistry in Iowa, and proof of all of the following:

a. ADA or ABDS recognition;

b. that the ADA or ABDS has not already recognized a certifying board for that specialty;

c. that the proposed specialty is a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates;

d. that the proposed area of specialty is separate and distinct from any pre-existing specialty already recognized by the Board or combination of Board recognized dental specialties;

e. the certifying board is an independent entity comprised of licensed dentists whose membership is reflective of the proposed specialty and is incorporated and governed solely by the licensed dentists/board members;

f. the certifying board has a permanent headquarters and staff;

g. the certifying board has issued Diplomate certificates to licensed dentists for at least five years;

h. the certifying board requires passing an oral and written examination based on psychometric principles that tests the applicant’s knowledge and skills in the proposed specialty;
i. the certifying board requires all dentists who seek certification in the proposed specialty to have successfully completed a specified, objectively verifiable amount of post DDS or DMD education and experience that is appropriate for the proposed specialty area, as determined by the Board;

j. information regarding the certifying board’s website, that includes online resources for the consumer to verify the certifying board’s certification requirements and a listing of the names and addresses of the dentists who have been awarded its board certification.

26.4(4) The use of the terms "specialist", "specializes", "orthodontist", "oral and maxillofacial surgeon", "oral and maxillofacial radiologist", "periodontist", "pediatric dentist", "prosthodontist", "endodontist", "oral pathologist", "public health dentist", “dental anesthesiologist”, or other similar terms which imply that the dentist is a specialist or specializes in a Board approved area may only be used by licensed dentists meeting all of the requirements of this rule for their respective specialty. A dentist who advertises as a specialist must avoid any implication that other dentists associated with him or her in practice are specialists.

26.4(5) The term "diplomate" or “board certified” may only be used by a dentist who has successfully completed the qualifying examination of the appropriate certifying board of one or more of the specialties recognized by the American Dental Association or the American Board of Dental Specialties, or otherwise permitted pursuant to these rules.

26.4(6) A dentist advertising as a specialist pursuant to these rules shall include the name of the national certifying board and the name of the entity which recognizes the board in the advertisement.

26.4(37) Dentists A dentist may advertise the areas in which they practice, including, but not limited to, specialty services, using other descriptive terms such as “emphasis on ________________” or other similar terms, as long as all other provisions of these rules are met.

ITEM 2. Rescind and reserve 650—Chapter 28.
Jill Stuecker
Iowa Dental Board, Executive Director
400 SW 8th Street, Suite D
Des Moines, IA 50309

Dear Ms. Stuecker and Members of the Iowa Dental Board,

This letter is sent on behalf of the American Association of Orthodontists ("AAO") to provide further feedback on the proposed revisions to Iowa’s Chapter 26, Specialty Advertising and Chapter 28, Designation of Specialty (hereinafter referred to as “specialty laws”). Again, we appreciate the opportunity to provide this feedback and participate in the regulatory process.

As a preliminary matter, and as set forth in the AAO’s July 12, 2017 comments, the AAO does not believe now is the proper time to revise Iowa’s specialty laws and supports Iowa’s Chapters 26 and 28 as currently written. Under the current laws, only those dentists who have successfully completed a formal advanced educational program accredited by the Commission on Dental Accreditation (“CODA”) of two or more years in length are able to advertise and represent themselves as “specialists.” These educational requirements properly equip graduates of CODA accredited, specialty programs to diagnose, treat, and ensure the health of Iowa patients for each graduate’s respective specialty, and they also provide a validated basis for the graduates to advertise and represent themselves as “specialists” to the public. If a dentist was able to advertise as a “specialist” without completing a multi-year CODA accredited program, it would dilute the “specialty” designation and allow providers, who do not have years of supervised clinical and didactic training and/or who have not satisfied extensive criterion, to advertise on par with those providers who have long-term, comprehensive education and training through CODA accredited programs. Such dilution would threaten the health and safety of Iowa patients by obscuring important distinctions between dental professionals as well as their respective educational and training backgrounds.

As far as timing, as detailed in the AAO’s July 12 correspondence, an ADA Task Force on Specialty and Specialty Certifying Board Recognition (“Task Force”) has been formed, and that Task Force is considering whether to establish the National Commission on Recognition of Dental Specialties and Certifying Boards (“Commission”). That Commission alone would be deciding whether a new specialty should be recognized or not, without requiring final approval from the ADA’s House of Delegates. The Task Force has already identified guiding principles for the Commission, including a proposed specialty and specialty certifying board recognition process that would: be grounded in objective standards, serve to reduce potential bias or conflicts of interest, and include multiple steps (such as provisions for appeal). As it stands now, the Task Force has finalized a recommendation to the ADA’s Board of Trustees and that recommendation will go to the ADA’s House of Delegates for approval at the ADA’s October 2017 meeting. Given this possibility of a new Commission that may address the very issues resulting in the proposed revisions to Chapters 26 and 28, the AAO requests that the Iowa Dental Board stay any action regarding Iowa’s specialty laws until after the ADA’s October 2017 meeting, which is next month.
To the extent the Iowa Dental Board still wishes to move forward with the proposed revisions (which are in red font) to Iowa’s specialty laws submitted on August 15, 2017 (hereinafter “August 15 proposal”), the AAO has attached additional revisions (in blue font), which it believes should be incorporated. Some of the revisions are self-explanatory and the basis for the AAO’s more substantive revisions are set forth below:

<table>
<thead>
<tr>
<th>Section</th>
<th>Proposed Revision</th>
<th>Basis for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.4(1)</td>
<td>For those dentists advertising or representing themselves as a specialist, they must comply with the other provisions of this rule. the American Dental Association recognized specialty that the practitioner practices. No dentist, who is not a specialist pursuant to this rule, may state or imply that the dentist is certified as a specialist or specializes in a dental area.</td>
<td>Provides clarification and further explanation.</td>
</tr>
<tr>
<td>26.4(2)(a)</td>
<td>The dentist wishing to advertise as a specialist must have completed a post DDS or DMD advanced specialty education program, which is accredited by the Commission on Dental Accreditation of the American Dental Association, for the specialty in which they wish to advertise</td>
<td>Provides clarification.</td>
</tr>
<tr>
<td>26.4(2)(b)</td>
<td>Board approved ADA specialties are as follows: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics and oral, maxillofacial radiology, and any other ADA specialties that meet the requirements set forth within this rule and which are thereafter approved by the Board. Board</td>
<td>Allows for additional ADA and ABDS specialties that may be recognized in the future. It makes sure all specialties comply with all the rule’s requirements.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Why this prevents confusion</td>
</tr>
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</tr>
<tr>
<td>26.4(3)(b)</td>
<td>that the ADA or ABDS has not already recognized a certifying board for that specialty;</td>
<td>Prevents consumer confusion and avoids numerous certifying boards for each specialty, all with varying requirements.</td>
</tr>
<tr>
<td>26.4(3)(c)</td>
<td>that the proposed specialty is a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates;</td>
<td>Prevents consumer confusion by preventing non-specialized areas from becoming specialized areas. For example, recognized teeth cleaning as a “specialty” would not seem to make sense.</td>
</tr>
<tr>
<td>26.4(3)(d)</td>
<td>that the proposed area of specialty is separate and distinct from any pre-existing specialty already recognized by the Board or combination of Board recognized dental specialties, and unable to be accommodated by pre-existing specialties already recognized by the Board;</td>
<td>Prevents consumer confusion and duplicative specialties.</td>
</tr>
<tr>
<td>26.4(3)(e)</td>
<td>the certifying board is an independent entity comprised of licensed dentists whose membership is reflective of the proposed specialty and is incorporated and governed solely by the licensed dentists/board members</td>
<td>The dentists of a certifying board under Section 26.4(3) should be members of the proposed specialty, so they know how to run and govern that specialty.</td>
</tr>
<tr>
<td>26.4(3)(i)(iii)</td>
<td>a formal advanced education program of at least two (2) years beyond the doctoral dental curriculum as defined by the Commission on Dental Accreditation (CODA);</td>
<td>Setting the educational standard at at least two (2) years beyond the doctoral dental curriculum, as defined by CODA, is most in line with the Iowa Dental Board’s mission to “ensure that all Iowans receive professional, competent, and safe dental health care of the highest quality.” Taking the current two year educational requirement and reducing it to only 670 (less than 17 weeks for a 40 hour a week program) does not benefit Iowa patients seeking specialty dental care. Rather, it</td>
</tr>
</tbody>
</table>
allows a situation in which Iowa dentists can now call themselves “specialists” with far less training and education. How does that benefit and protect Iowa patients? Moreover, it would seem misleading and confusing to Iowa consumers if a dentist completing only 670 hours of specialty training was able to advertise as a “specialist,” and on par, with those dentists who have completed multi-year, formal education and training from CODA accredited programs.

| 26.4(4) | The use of the terms "specialist", "specializes", "orthodontist", "oral and maxillofacial surgeon", "oral and maxillofacial radiologist", "periodontist", "pediatric dentist", "prosthodontist", "endodontist", "oral pathologist", "public health dentist," “dental anesthesiologist”, any variations thereof, or other similar terms which imply that the dentist is a specialist or specializes in a Board approved area may only be used by licensed dentists meeting all the requirements of this rule for their respective specialty. A dentist who advertises as a specialist must avoid any implication that other dentists associated with him or her in practice are specialists. | Provides clarification and further explanation. |

| 26.4(7) | **A dentist** may advertise the areas in which they practice, including, but not limited to, specialty services, using other descriptive terms such as “practices in _____” or other similar terms, as long as all other provisions of these rules are met. | “Emphasis on ________” seems too analogous to “Specializes in _____,” which seems contradictory to the rule’s intended purpose. |

Overall, the AAO believes that those dentists who identify and advertise as “specialists” should have an advanced level of training and education, which is what Iowa’s laws currently
require and which benefits Iowa patients. As such, the AAO believes Iowa’s current specialty laws under Chapter 26 and Chapter 28 should be affirmed. Should the Iowa Dental Board still choose to revise its specialty laws and not wait until after the ADA’s October 2017 meeting, then the AAO believes the only viable option is to revise the specialty laws so they require, among other things, the “completion of at least 2-years of post-doctoral residency education at a CODA-accredited school” for any new specialty. Under this approach, CODA’s rigorous education requirements are maintained and a dentist completing only a few hundred hours of specialty training cannot advertise on par with those providers who have long-term, comprehensive education and training.

In closing, the AAO respectfully requests that the Iowa Dental Board consider these comments during its review. The AAO also looks forward to further involvement and additional comments should the specialty law discussion continue into the formal comment period. If the Board needs any further information or has questions for the AAO, please feel free to contact our Associate General Counsel, Sean Murphy, at smurphy@aaortho.org and phone - 314-292-6523.

Thank you for your time and attention to this matter.

Sincerely,

Mike

Dr. Michael G. Durbin
AAO Trustee for the Midwestern Society of Orthodontists
ITEM 1. Amend subrule 650—26.4 as follows:

650—26.4(153) Public representation. All advertisements and public representations shall contain the name and address or telephone number of the practitioner who placed the ad.

26.4(1) If one’s practice is referred to in the advertisement or representation, the ad may state either “general/family practice” or “specialist,” “specializes,” or “specializing.” For those dentists advertising or representing themselves as a specialist, they must comply with the other provisions of this rule. The American Dental Association recognized specialty that the practitioner practices. No dentist, who is not a specialist pursuant to this rule, may state or imply that the dentist is certified as a specialist or specializes in a dental area.

26.4(2) No dentist may state or imply that the dentist is certified as a specialist when that is not the case. Use of the terms “specialist,” “specializing in” or other similar terms in connection with areas that are not recognized as specialties pursuant to 650—Chapter 28 is not permitted.

A dentist may only advertise as a specialist if the dentist meets the standards set forth in this rule.

a. The dentist wishing to advertise as a specialist must have completed a post DDS or DMD advanced specialty education program, which is accredited by the Commission on Dental Accreditation of the American Dental Association, for the specialty in which they wish to advertise be a Diplomate of, or board eligible for a national certifying board of a specialty recognized by the American Dental Association (ADA), or a Diplomate of a board recognized by the American Board of Dental Specialties (ABDS), and;

b. The indicated area of specialty must be Board approved by the Iowa Dental Board (Board). Board approved ADA specialties are as follows: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics and oral, and maxillofacial radiology, and any other ADA specialties that meet the requirements set forth within this rule and which are thereafter approved by the Board. Board approved ABDS specialties are as follows: oral implantology/implant dentistry, oral medicine, orofacial pain, and anesthesiology any ABDS specialties that meet the requirements set forth within this rule and which are thereafter approved by the Board.

26.4(3) A certifying board may apply for a new area of specialty to become Board approved by submitting information regarding the area of specialty, including an explanation of how it is within the scope of practice of dentistry in Iowa, and proof of all of the following:

a. ADA or ABDS recognition;

b. that the ADA or ABDS has not already recognized a certifying board for that specialty;

c. that the proposed specialty is a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates;

d. that the proposed area of specialty is separate and distinct from any pre-existing specialty already recognized by the Board or combination of Board recognized dental specialties, and unable to be accommodated by pre-existing specialties already recognized by the Board;

e. the certifying board is an independent entity comprised of licensed dentists whose membership is reflective of the proposed specialty and is incorporated and governed solely by the licensed dentists/board members;

f. the certifying board has a permanent headquarters and staff;

g. the certifying board has issued Diplomate certificates or similar certification to licensed dentists for at least five years;

h. the certifying board requires passing an oral and written examination based on psychometric principles that tests the applicant’s knowledge and skills in the proposed specialty specific area of dentistry;

i. the certifying board requires all dentists who seek certification in the proposed specialty to have successfully completed a specified, objectively verifiable amount of post DDS or DMD education through a formal postgraduate program; or an organized continuing education program of comprehensive scope that requires a minimum of all of the following:

i. 5 years of experience in the area of specialty;

ii. 75 completed cases in the area of specialty; and
iii. 670 hours of educational formal advanced education program of at least two (2) years beyond the doctoral dental curriculum as defined by the Commission on Dental Accreditation (CODA) in the area of specialty; 50% of those hours must be obtained from a single sponsor who provides a continuum of training in the area of specialty.

g-i. information regarding the certifying board’s website, that includes an—online resources for the consumer to verify its the certifying board’s certification requirements and a listing of the names and addresses of the dentists who have been awarded its board certification.

26.4(4) The use of the terms "specialist", "specializes", "orthodontist", "oral and maxillofacial surgeon", "oral and maxillofacial radiologist", "periodontist", "pediatric dentist", "prosthodontist", "endodontist", "oral pathologist", "public health dentist," "dental anesthesiologist", any variations thereof, or other similar terms which imply that the dentist is a specialist or specializes in a Board approved area may only be used by licensed dentists meeting all the requirements of this rule for their respective specialty. A dentist who advertises as a specialist must avoid any implication that other dentists associated with him or her in practice are specialists.

26.4(5) The term "diplomate" or "board certified" may only be used by a dentist who has successfully completed the qualifying examination of the appropriate certifying board of one or more of the specialties recognized by the ADA or the ABDS or otherwise permitted pursuant to these rules.

26.4(6) A dentist advertising as a specialist pursuant to these rules shall include the name of the national certifying board and the name of the entity which recognizes the board in the advertisement.

26.4(7) Dentists—A dentist may advertise the areas in which they practice, including, but not limited to, specialty services, using other descriptive terms such as “emphasis on practice in _________” or other similar terms, as long as all other provisions of these rules regarding advertising are met.

ITEM 2. Rescind and reserve 650—Chapter 28.
Pursuant to the authority of Iowa Code 147.2, 153.15A, 153.21, 153.33B, and 153.39 the Dental Board hereby gives Notice of Intended Action to amend Chapter 11, “Licensure to Practice Dentistry or Dental Hygiene,” and Chapter 20, “Dental Assistants.”

The purpose of the proposed amendments is to clarify when the executive director can administratively issue a license, permit or registration, and the role of the licensure and registration committee in reviewing license, permit and registration applications.

Any interested person may make written comments on the proposed amendments on or before December 12, 2017. Such written materials should be directed to Phil McCollum, Associate Director, Iowa Dental Board, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa 50309 or sent by email to phil.mccollum@iowa.gov.

There will be a public hearing on December 12, 2017 at 2:00 pm in the Board office, 400 S.W. Eighth Street, Suite D, Des Moines, Iowa, 50309 at which time persons may present their views orally or in writing.

The proposed amendments in Chapter 11 and 20 are not subject to waiver or variance pursuant to 650-chapter 7.

After analysis and review of this rule making, there is no impact on jobs.

The proposed amendments are intended to implement Iowa Code 147.2, 153.15A, 153.21, 153.33B, and 153.39.

ITEM 1. Amend subrule 650—11.8 as follows:

650—11.8(147,153) Review of applications. Upon receipt of a completed application, the executive director as authorized by the board has discretion to:

1. Authorize the issuance of the license, permit, or registration.
2. Refer the license, permit, or registration application to the license and registration committee for review and consideration when the executive director determines that matters including, but not limited to, prior criminal history, chemical dependence, competency, physical or psychological illness, malpractice claims or settlements, or professional disciplinary history are relevant in determining the applicants’ qualifications for license, permit, or registration.

11.8(1) Following review and consideration of a license, permit, or registration application referred by the executive director, the license and registration committee may at its discretion:
   
a. Recommend to the board issuance of the license, permit, or registration. Authorize the executive director to issue the license, registration or permit.

   b. Recommend to the board denial of the license, permit, or registration. Send to the board for further review and consideration.

   c. Recommend to the board issuance of the license, permit, or registration under certain terms and conditions or with certain restrictions.

   d. Refer the license, permit, or registration application to the board for review and consideration without recommendation.

11.8(2) Following review and consideration of a license, registration or permit application referred by the license and registration committee, the board shall:

   a. Authorize the issuance of the license, permit, or registration,

   b. Deny the issuance of the license, permit, or registration, or

   c. Authorize the issuance of the license, permit, or registration under certain terms and conditions or with certain restrictions.

11.8(3) The license and registration committee or board may require an applicant to appear for an interview before the committee or the full board as part of the application process.

11.8(4) The license and registration committee or board may defer final action on an application if there is an investigation or disciplinary action pending against an applicant, who may
otherwise meet the requirements for license, permit, or registration, until such time as the committee or board is satisfied that licensure or registration of the applicant poses no risk to the health and safety of Iowans.

11.8(5) The dental hygiene committee shall be responsible for reviewing any applications submitted by a dental hygienist that require review in accordance with this rule. Following review by the dental hygiene committee, the committee shall make a recommendation to the board regarding issuance of the license or permit. The board’s review of the dental hygiene committee’s recommendation is subject to 650—Chapter 1.

11.8(6) An application for a license, permit, or reinstatement of a license will be considered complete prior to receipt of the criminal history background check on the applicant by the FBI for purposes of review and consideration by the executive director, the license committee, or the board. However, an applicant is required to submit an additional completed fingerprint packet and fee within 30 days of a request by the board if an earlier fingerprint submission has been determined to be unacceptable by the DCI or FBI.

ITEM 2. Add subrule 650—20.7(5) as follows:

20.7(5). Review of applications. The board shall follow the procedures specified in 650—11.8 in reviewing applications for registration and qualification.
BEFORE THE IOWA DENTAL BOARD

Petition by Danielle Pettit-Majewski for the waiver of 650 IAC sub rule 10.5 (2) d relating to the years of clinical experience defined under a Public Health Supervision agreement.

PETITION FOR WAIVER

1. Petitioner’s name, address, and telephone number. All communications concerning the petition can be directed to the address, phone, and e-mail address listed below.
   Danielle Pettit-Majewski, BS, MPH
   Executive Director, Washington County Public Health
   110 N Iowa Ave, Suite 300
   Washington, IA 52353
   Work Telephone: 319-653-7758
   Home Phone: 641-330-2148
   Email: dpettitmajewski@washph.com

2. I am requesting a waiver of 650 Iowa Administrative Code sub rule 10.5 (2) d which requires the dental hygienist to have an active Iowa license with a minimum of three years of clinical practice experience. In lieu of three years clinical dental hygiene experience, I would like the board to accept the following: 2 years clinical dental hygiene experience and eight months clinical experience as a dental assistant.

3. Describe the specific waiver requested, including the precise scope and time period for which the waiver will extend: I am requesting a waiver, on behalf of Martha Hernandez Lopez of 650 Iowa Administrative Code sub rule 10.5 (2) d which requires a dental hygienist to have an active Iowa license with a minimum of three years of clinical practice experience. In lieu of three years clinical dental hygiene experience, I would like the board to accept the following: 2 years clinical dental hygiene experience and eight months clinical experience as a dental assistant.
   • (List specific training at accredited schools or other relevant information).

Martha Hernandez Lopez’s Employment History:
   1. Gentle Family Dentist, West Liberty and Muscatine, Iowa, June 2015-Current; Registered Dental Hygienist
   2. Gentle Family Dentists, West Liberty, IA January 2012-August 2012; Registered Dental Assistant

Martha Hernandez Lopez’s Educational History:
   1. Kirkwood Community College Dental Hygiene Diploma, May 2014
   2. Kirkwood Community College Dental Assistant Diploma, 2011

Martha Hernandez Lopez’s Volunteer History:
   1. Dental Assistant – His Hands Free Clinic, Cedar Rapids, IA 1/2012-2015
   2. Dental Hygiene Student – His Hands Free Clinic, Cedar Rapids, IA 2013-2014
3. Dental Hygiene Student – Manor Care, West Ridge Care Facilities, Cedar Rapids, IA 2013-2014
4. Dental Hygiene Student – My Iman Montessori, Cedar Rapids, IA 2013-2014
5. Dental Hygiene Student – Iowa City Free Clinic, Iowa City, IA 2013-2014

In addition, I would like to express our current situation:

- Washington County Public Health (serving Henry and Washington Counties) has been without a public health dental hygienist for more than 6 months. This public health dental hygienist serves as an I-Smile Coordinator, a valuable community resource who ensures that all children have access to dental care by providing referrals to dentists, care coordination and some gap-filling services. Due to a dental provider shortage designation and proximity to Iowa City, Washington County Public Health has been unable to attract and hire a qualified applicant.

- Washington County Public Health has identified Martha Hernandez Lopez as a qualified candidate for our agency’s public health dental hygienist position, with the exception of the required experience for a Public Health Supervision agreement. If this waiver is approved, Martha Hernandez Lopez will have a Public Health Supervision agreement which will clearly outline more frequent dentist and dental hygienist meetings and discussions than required in Chapter 650 of the Iowa Administrative Code, as well as standing orders for all gap-filling services to be provided.

- Martha Hernandez Lopez will provide dental screenings, fluoride varnish and education at community-based events (health fairs, etc.), Head Start programs, child care centers, schools and WIC clinics. Dental sealants may be provided in schools through the I-Smile @ School dental sealant and education program; however, this will be done as a partnership with local dentists, as dentists will provide exams to all participating students and provide standing orders for all teeth needing sealants and fluoride varnish applications.

Add any additional detail regarding examinations completed, etc:

- According to our FFY2017 I-Smile Needs Assessment, we determined that there is a lack of providers seeing children under the age of 3, so Washington County Public Health provides critical gap-filling services for this population. Additionally, we determined zero out of eight dental offices in Washington County accept Medicaid clients, while only three out of nine dental offices in Henry County accept Medicaid clients. This is a large barrier in our community.

- Another barrier in our service area is the number of communities that don’t have optimal community water fluoridation. There are six communities in Washington County that don’t meet the optimal level of fluoridation, and this is a priority activity for our new I-Smile Coordinator in our FY18 activities for the I-Smile program.

4. Explain the relevant facts and reasons that the petitioner believes justify a waiver. Include in your answer all of the following:

   a. Undue Hardship. Compliance with the rule would impose an undue hardship in hiring a public health dental hygienist/I-Smile Coordinator for our Maternal Child and Adolescent Health program, which is a requirement for Title V funding. As a Public Health agency in a rural
County within a dental shortage service area, we have difficulty finding and attracting dental hygienist to our program as we cannot compete with a private practice salary, while finding a qualified applicant to serve the needs of the at-risk children and pregnant women in our service area.

b. Why Waiving the Rule Would Not Prejudice the Substantial Legal Rights of Any Person. Waiver of the rule would not prejudice the substantial legal rights of any person because allowing this waiver will ensure and protect public health, safety, and welfare.

c. The Provisions of the Rule Subject to the Waiver are NOT Specifically Mandated by Statute or Another Provision of Law. Iowa Code Chapter 153 does not mandate the requirements of rule 650.

d. Substantially Equal Protection of the Public Health, Safety, and Welfare has been Afforded by: The sub rule that I am requesting a waiver from helps to ensure that the at-risk children and pregnant women in our service area receive dental referrals, care coordination and gap-filling care from a knowledgeable and qualified dental hygienist. We are currently providing dental screenings, fluoride varnish and education through a trained agency Registered Nurse, who is licensed to provide these services through her scope of practice, but is not as familiar with the dental services and conditions. A dental hygienist with two years clinical experience and eight months clinical experience as a dental assistant, as well as training and graduation from two accredited dental programs, would be very experienced, knowledgeable and qualified to provide dental services under public health supervision.

5. A history of prior contacts between the board and petitioner related to the regulated activity is as follows.
   • None

6. Information related to the board’s action in similar cases:
   • I am not aware of any waiver requests of a similar nature to mine that the Board has granted in the past.

7. There is no political subdivision that regulates dentistry in Iowa. The Iowa Department of Public Health is charged with maintaining all Public Health Supervision Agreements. They will need to be aware of the waiver, if approved.

8. I am not aware of any person or entity that would be adversely affected by the granting of a waiver in this case.

9. Provide the name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver:
   Stephanie Chickering, BA, RDH
   Oral Health Consultant, Iowa Department of Public Health
   321 E/ 12th Street, Des Moines, IA 50319
   515-240-9819
10. I hereby authorize the Board to obtain any information relating to this waiver request from the individuals named herein. I will provide signed releases of information if necessary.

I hereby attest to the accuracy and truthfulness of the above information.

[Signature]

Petitioner’s signature

5/26/17

Date
10.5(1) Public health settings defined. For the purposes of this rule, public health settings are limited to schools; Head Start programs; programs affiliated with the early childhood Iowa (ECI) initiative authorized by Iowa Code chapter 256I; child care centers (excluding home-based child care centers); federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.

10.5(2) Public health supervision defined. “Public health supervision” means all of the following:

a. The dentist authorizes and delegates the services provided by a dental hygienist to a patient in a public health setting, with the exception that hygiene services may be rendered without the patient’s first being examined by a licensed dentist;

b. The dentist is not required to provide future dental treatment to patients served under public health supervision;

c. The dentist and the dental hygienist have entered into a written supervision agreement that details the responsibilities of each licensee, as specified in subrule 10.5(3); and

d. The dental hygienist has an active Iowa license with a minimum of three years of clinical practice experience.

10.5(3) Licensee responsibilities. When working together in a public health supervision relationship, a dentist and dental hygienist shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

   1) Be available to provide communication and consultation with the dental hygienist;

   2) Have age- and procedure-specific standing orders for the performance of dental hygiene services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of dental hygiene services;

   3) Specify a period of time in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

   4) Specify the location or locations where the hygiene services will be provided under public health supervision.

b. A dental hygienist providing services under public health supervision may provide assessments; screenings; data collection; and educational, therapeutic, preventive, and diagnostic services as defined in rule 10.3(153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must:

   1) Maintain contact and communication with the dentist providing public health supervision;

   2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

   3) Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs;

   4) Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and

   5) Specify a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the dental hygienist and must be made available to the board upon request. The dentist and dental hygienist must review the agreement at least biennially.
d. A copy of the written agreement for public health supervision shall be filed with the Bureau of Oral and Health Delivery Systems, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

10.5(4) Reporting requirements. Each dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the bureau of oral and health delivery systems of the Iowa department of public health on forms provided by the department and shall include information related to the number of patients seen and services provided so that the department may assess the impact of the program. The department will provide summary reports to the board on an annual basis.

This rule is intended to implement Iowa Code section 153.15.

[ARC 7767B, IAB 5/20/09, effective 6/24/09; ARC 0629C, IAB 3/6/13, effective 4/10/13; ARC 2141C, IAB 9/16/15, effective 10/21/15]
Dear Board Members -

Thank you for your consideration of my Petition of Waiver to allow Martha Hernandez Lopez to use public health supervision in her work as our I-Smile™ Coordinator for Washington and Henry Counties. Ms. Braness has shared with me that you would like additional information prior to making your decision and I am happy to share that with you.

Miss Hernandez Lopez’s main role as the I-Smile™ coordinator for Washington County Public Health will be to improve the dental support system for families, as this is the basis for the I-Smile™ program. Miss Hernandez Lopez will help children establish dental homes and achieve optimal oral health, particularly children on Medicaid. Her job duties will also include a focus on pregnant women to assure good oral health during pregnancy and optimal birth outcomes and oral health for infants. She will develop referral relationships with dental offices, provide care coordination services for families to help them access dental appointments, represent oral health on community workgroups, provide trainings for health care providers, and promote oral health by educating the public about the importance of oral health and participating in community events.

Although the majority of Miss Hernandez Lopez’s time will be spent on infrastructure and outreach activities just described, she will also be expected to provide some gap-filling dental services – oral screenings, fluoride varnish applications, oral health education – for children in WIC clinics, Head Start/Early Head Start classrooms, child care sites (excluding in-home) and preschools. The screenings she would provide are visual assessments to identify oral health anomalies, dental decay, or inflammation. Dental explorers are not used and
diagnoses are not made. All clients are referred to a dentist, and follow-up is provided to ensure client's oral health needs have been met.

Henry and Washington counties are currently designated as dental professional shortage areas by the Health Resources and Services Administration (HRSA). Since there are too few dental providers and a high poverty population in our service area, it is essential for our I-Smile™ program to ensure that children and pregnant women receive age-appropriate comprehensive dental care in our service area. Using a team approach (which utilizes I-Smile™ to provide preventive dental services and anticipatory guidance and dentists to provide treatment and definitive evaluations) to manage and prevent dental care, dental disease identification and risk are determined early, enhanced prevention services are provided and improved care coordination and data tracking are anticipated.

Miss Hernandez Lopez has been practicing as a dental hygienist since May 2015. During the course of her career as a dental hygienist, she has seen about ten patients per day and estimated 50% of those clients being under age 21 or pregnant. As a dental hygienist, Miss Hernandez Lopez has provided various dental services such as: sealants, varnish fluoride, screenings for oral health conditions, prophylaxis, periodontal maintenance, scaling and root planing, radiographs, nutritional counseling, oral hygiene instructions, office documentation, local anesthesia and scheduling patient re-care on a regular basis.

Thank you for your consideration.

Sincerely,

[Signature]

Danielle Pettit-Majewski, MPH
Administrator
Washington County Public Health
Dear Danielle,

Since May 2015, I’ve been working as a full time dental hygienist at a very busy dental office, Gentle Family dentists of West Liberty and Muscatine, Iowa. I was previously a Dental Assistant for this same office from 2012-2013 prior to attending Dental Hygiene School at Kirkwood Community College class of 2014.

As a dental hygiene student, I was exposed to many community services and outreach programs such as My Iman Montessori to provided oral hygiene instruction for kids ages 3-8, His Hands Free Clinic, Manor Care and West Ridge Care facilities in Cedar Rapids, IA. Services provided at these clinics included prophy cleanings and oral hygiene instructions. As a dental hygiene student, I provided sealants to Kids at the Cedar Valley Townhomes which is a low-income apartment complex with a summer program for kids that lived there. These kids were pre-screened by a dentist.

During my two years as a dental hygienist I’ve seen patients of all ages and conditions. My daily duties include assessing patients for any oral health conditions and anomalies, prophy cleanings, Scaling and Root Planning, periodontal maintenance, take radiographs, applying sealants, fluoride varnish, providing nutritional counseling and oral hygiene instructions. On top of my daily patient’s schedule, I also help our two doctors with providing anesthetic to their patients. In daily basis, I see about nine patients per day (or more with assisted hygiene) and about 50% are kids and young adults, including pregnant woman. Pregnant woman, I make sure they are receiving appropriate nutrition, healthy oral care and instruction necessary for a healthy pregnancy.

At Gentle Family Dentists, we provide service to patient with Medicaid and Iowa Wellness insurance every Tuesday mornings as a first come first serve. During this time, our goal is to provide service to as many patients as we can because most aren’t able to find a dental home elsewhere. Some cases are more severe than what we can handle as a team, so we refer patients to an appropriate oral health care provider to treat properly. We follow-up to make sure service was provided. Most of my patients are children. It is my responsibility to inform my patients and parents of the importance of oral health and receiving regular dental visits. I am also responsible for completing Dental Screening forms for kids returning to school.

With my two years of dental experience, I consider myself well informed and feel confident of my duties as a dental hygienist. I’m well organized and have had about 10 years of customer service at previous jobs that has helped me to develop my skill working with the public. I hope
I've answered most of your questions. I appreciate you considering me for the I-Smile™ position.

Sincerely,

Martha Hernandez Lopez, RDH
August 11, 2017
I-Smile Coordinator, Washington County Public Health
Attn: Danielle Pettit-Majewski

I am writing this letter of recommendation for Martha Hernandez Lopez. Martha graduated from the Kirkwood Community College Dental Hygiene Program in 2014. As a fulltime faculty professor, and the clinical coordinator for the dental hygiene program, I worked closely with Martha in both clinical and didactic courses. During her education and throughout the curriculum, Martha had the opportunity to work in several community adult and child outreach programs and nursing homes. During our child outreach program, Martha had the opportunity to place sealants, I however, cannot attest to the number of sealants she placed. In her last three semesters of the program, students are required to place a minimum of 4 sealants each semester.

I believe that Martha is competent in placing fluoride varnish. Her bilingual language skills will also be a positive asset.

She was a team player in and outside of the classroom. She attended all clinics and didactic courses.

Lisa M. Hebl, RDH, BS, MEd
Kirkwood Community College
Dental Hygiene Program
Cedar Rapids, Iowa 52406
Response to Petition for Rule Waiver

Christel-

Good afternoon. I’ve attached additional information that I feel would be helpful to the Iowa Dental Board in their consideration of my waiver regarding a Public Health Supervision Agreement for Martha Hernandez Lopez.

During our phone conversation on July 17th, you shared the board would be meeting in August or September. Would you please let me know the date of the meeting? Thank you so much for your help. If there’s anything else you feel would benefit the board, please don’t hesitate to let me know.

Thanks!

Danielle Pettit-Majewski BS, MPH
Administrator
Washington County Public Health & Home Care
110 North Iowa Avenue, Suite 300
Washington, IA 52353
p) 319-653-7758 f)319-653-6870

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“Public health is filled with heroes, both well known and unknown. They are visible on the national or international stage or they work quietly in communities with families and individuals. When they do their job, they often become invisible.” ~Dr. Harrison Spencer
I will save this out to the network for the October meeting.

Christel Braness | Program Planner
Iowa Dental Board | 400 SW 8th St. Suite D | Des Moines, IA 50309

Ensuring that Iowans receive professional, competent, and safe dental care of the highest quality.

We value your feedback! Click here to tell us how we’re doing.

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Response to Petition for Rule Waiver.pdf
675K
September 19, 2017

VIA HAND-DELIVERY

Iowa Dental Board
Attn: Christel Branness
400 S.W. 8th Street, Suite B
Des Moines, IA 50309

Re: Petition for Waiver/Variance by Daniel J. Binkowski, DDS

Dear Christel:

Enclosed please find an original Petition for Waiver/Variance, which I discussed briefly with you via email last week. I am submitting this on behalf of my client, Daniel J. Binkowski, DDS, for review at the next Anesthesia Credentials Committee meeting. If it is not necessary for it to be reviewed by the Anesthesia Credentials Committee, we request that it be placed on the next Board meeting agenda. It is our understanding that the next Anesthesia Credentials Committee meeting is October 5, 2017, and the Board meeting is scheduled for October 12-13, 2017.

If you have any questions, please do not hesitate to contact me. Thank you.

Very truly yours,

Rebecca A. Brommel

RAB:tns

Enclosure
BEFORE THE IOWA DENTAL BOARD

PETITION BY
Daniel J. Binkowski, D.D.S.,
for the waiver of certain requirements under Iowa Admin. Code Ch. 650-29

PETITION FOR WAIVER/VARIANCE

COMES NOW the above-named Petitioner, Daniel J. Binkowski, D.D.S., and hereby submits the following Petition for Waiver/Variance pursuant to Iowa Administrative Code section 650-7.4 and 7.5.

1. Petitioner Daniel J. Binkowski, D.D.S. practices dentistry at Story City Dental, which is located at 525 Timberland Drive, Story City, Iowa. Petitioner is licensed and in good standing with the Iowa Dental Board. The phone number for Story City Dental is (515)733-0112 and the email is storycitydental@gmail.com. Petitioner's legal representative is Rebecca A. Brommel of Brown, Winick, Graves, Gross, Baskerville & Schoenebaum, P.L.C., which is located at 666 Grand Avenue, Suite 2000, Des Moines, Iowa 50309. Ms. Brommel's phone number is (515)242-2452 and her email address is brommel@brownwinick.com. Communications regarding this Petition should be addressed to Ms. Brommel.

2. Petitioner seeks waiver of a portion of Iowa Administrative Code section 650-29.5(1), which states in relevant part as follows: "No dentist shall use or permit the use of deep sedation/general anesthesia or moderate sedation for dental patients, unless the dentist possesses a current permit issued by the board."

3. More specifically, Petitioner seeks a permanent waiver of the portion of the rule that requires him to individually hold a deep sedation/general anesthesia permit. Petitioner
intends to have the sedation or anesthesia services performed in his office by a Certified Registered Nurse Anesthetist ("CRNA"). Although Petitioner currently only intends to have CRNAs perform the sedation or anesthesia services, he requests that the waiver allow him to also have anesthesiologists perform such service should he decide to use anesthesiologists instead of or in addition to CRNAs. Petitioner is not requesting waiver of the requirements related to the equipment that must be present at the facility in which the sedation or anesthesia is being provided.

4. Petitioner’s requested waiver is justified for the following reasons:

a. Application of the rule would result in undue hardship to Petitioner. Petitioner would incur significant expense – both related to the costs of the training itself and related to time away from the office – to obtain the training necessary to meet the permit requirements.

b. Waiver of this rule would not substantially prejudice the rights of any person. Under Petitioner’s proposal, the sedation and anesthesia services will be performed by a CRNA or an anesthesiologist who is properly trained and licensed to perform such services. Accordingly, there would be no prejudice to the rights of any other person, because the Board would not be decreasing the requirements for the administration of sedation in a dentist office. Furthermore, the Board has granted similar waivers in the past. See Petition for Waiver by Gregory Ceraso, DMD, granted by Board at October 22-23, 2015 Meeting; Petition for Waiver by Ryan Hussong, D.D.S., granted by Board at July 31-August 1, 2014 Meeting; Petition for Waiver by Robert Hurley, D.D.S., David Jones, D.D.S. and Melissa Nensel, D.D.S., granted by Board at July 21-22, 2016
Meeting; and Petition for Waiver by Samuel L. Koth, D.D.S., granted by Board at January 26, 2017 Meeting.

c. The provisions of Iowa Administrative Code section 650-29.5 are not mandated by Iowa Code chapter 153 or any other statute or provision of law.

d. Utilizing a CRNA or anesthesiologist to perform the sedation or anesthesia services at Petitioner’s dental office actually ensures a higher level of public protection, health and safety, because these practitioners have the specific and advanced training to provide these services. Additionally, the CRNA that Petitioner intends to utilize has experience with various levels of sedation in an in-office setting and provides a full scope of anesthesia services in a variety of facilities across Iowa.

5. Petitioner has had prior contact with Board staff Phil McCollum and Christel Braness related to procedure and requirements for filing this Petition. Petitioner currently has a moderate sedation permit, which was originally issued September 17, 2015. This is, however, Petitioner’s first Petition for Waiver/Variance of the rule at issue.

6. As stated above, the Board has granted similar waiver requests on at least four occasions: (1) Gregory Ceraso, DMD, which was granted at the Board’s meetings on October 22-23, 2015 (allowing Dr. Ceraso to use CRNAs), and May 8, 2009 (allowing Dr. Cerasco to use anesthesiologists); (2) Ryan Hussong, D.D.S., which was granted at the Board’s meeting on July 31-August 1, 2014; (3) Robert Hurley, D.D.S., David Jones, D.D.S. and Melissa Nensel, D.D.S., which was granted at the Board’s meeting on July 21-22, 2016; and (4) Samuel L. Koth, D.D.S., which was granted at the Board’s meeting on January 26, 2017.

7. No other public agency or political subdivision regulates the provision of sedation
or anesthesia in dental offices. The CRNAs or anesthesiologists would be subject to any statutes and regulations pertinent to their profession and in particular, the Iowa Board of Nursing and the Iowa Board of Medicine, respectively.

8. Petitioner is not aware of any person who would be adversely affected by the grant of this Petition for Waiver/Variance.

9. The following individuals will provide the sedation and anesthesia services should this waiver be granted and thus, will have knowledge of relevant facts related to this requested waiver:

M & M Anesthesia, L.L.C. d/b/a Heartland Anesthesia & Consulting
Mindy Miller, MSN, CRNA, ARNP
2014 SW Sage Circle
Ankeny, Iowa 50023
Phone: (515)988-1564
Email: mindy@heartlandanes.com

10. Through the signature of his legal representative below, Petitioner authorizes the persons with knowledge identified in paragraph 9 to provide the Board with any information relevant to this Petition for Waiver/Variance.

Rebecca A. Brommel, AT0001235

BROWN, WINICK, GRAVES, GROSS,
BASKERVILLE AND SCHOENEBAUM, P.L.C.
666 Grand Avenue, Suite 2000
Des Moines, IA 50309-2510
Telephone: 515-242-2452
Facsimile: 515-323-8552
E-mail: brommel@brownwinick.com

ATTORNEY FOR PETITIONER
Original hand-delivered on September 19, 2017 to:

Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Rule/Subrule</th>
<th>Topic</th>
<th>Decision</th>
<th>Date of Ruling</th>
<th>Background Information</th>
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<tbody>
<tr>
<td>Ceraso</td>
<td>Gregory</td>
<td>29.5(1)</td>
<td>Moderate Sedation Permit</td>
<td>Approved</td>
<td>10/22/2015</td>
<td>Asked for permission to allow a CRNA to provide sedation services when the anesthesiologist would not be available. This is a clarification from the previous waiver, which was addressed only the issue of an anesthesiologist to provide the sedation.</td>
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<td>Hurley, Jones, Nensel</td>
<td>Robert, David</td>
<td>29.5(1)</td>
<td>Moderate Sedation Permit</td>
<td>Approved</td>
<td>7/21/2016</td>
<td>Intend to have sedation services provided by a registered CRNA and/or anesthesiologists due to hardship in meeting the other requirements.</td>
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<td>Ceraso</td>
<td>Gregory</td>
<td>29.5(1)</td>
<td>Moderate Sedation Permit, Facility Requirements</td>
<td>Approved</td>
<td>5/8/2009</td>
<td>Intend to have sedation services provided by a registered CRNA and/or anesthesiologists due to hardship in meeting the other requirements.</td>
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<td>Hussong</td>
<td>Ryan</td>
<td>29.5(1)</td>
<td>Moderate Sedation Permit, Facility Requirements</td>
<td>Approved</td>
<td>7/31/2014</td>
<td>Intend to have sedation services provided by a registered CRNA and/or anesthesiologists due to hardship in meeting the other requirements.</td>
</tr>
<tr>
<td>Koth</td>
<td>Samuel</td>
<td>29.5(1)</td>
<td>Moderate Sedation Permit</td>
<td>Approved</td>
<td>1/26/2017</td>
<td>Intend to have sedation services provided by a registered CRNA and/or anesthesiologists due to hardship in meeting the other requirements.</td>
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</table>
BEFORE THE IOWA DENTAL BOARD

Petition by Joseph Kunnel for the Waiver of IAC 650-11.4 relating to educational requirement } } PETITION FOR WAIVER

1. Petitioner’s name, address, and telephone number. All communications concerning the petition can be directed to the address, phone, and e-mail address listed below.

Joseph Kunnel
2328 Phillips Dr
Glenview, IL 60026

Work Telephone: 847 675 7090
Home Phone: 847 498 5747 ; cell phone : 312 317 5647
Email: jkunnel05@gmail.com

2. I am requesting a waiver of IAC 650-11.4 Iowa Administrative Code subrule, which requires a DDS or DMD training from the United States. In lieu of additional training in the USA I would like the board to accept the following: 1) A two year program in clinical general dentistry with a Master’s degree from Northwestern University Dental school, Chicago from September 1993 to August 1995 and 2) Specialty training in Orthodontics with a Master’s degree from the University of Illinois Dental school, Chicago from August 1999 to May 2002.

3. I am requesting a waiver to obtain a permanent license in the State of Iowa, to practice dentistry and specifically the specialty of Orthodontics. I am requesting a waiver of 650 Iowa Administrative Code 11.4, which requires a dental degree from the USA In lieu of additional training in accredited dental schools in the USA. I would like the board to accept the following: 1) A two year program in general dentistry with a Master’s degree from Northwestern University Dental School, Chicago from September 1993 to August 1995 and 2) Specialty training in Orthodontics with a Master’s degree from the University of Illinois Dental School, Chicago from August 1999 to May 2002.

In addition, I

- I have practiced general dentistry from 1996 to 2002 and as an orthodontic specialist from 2002 till today.
- I have a PhD in bone biology from Northwestern University Medical School and was a research associate professor at Northwestern till 2005.
- Please see attached CV for additional education, research and teaching experience.

Add any additional detail regarding examinations completed, etc.

1. Completed Part I, II of the National Boards and Northeast Regional Clinical Board (NERB)
2. Licensed in the State of Illinois since 1996.
4. Explain the relevant facts and reasons that the petitioner believes justify a waiver. Include in your answer all of the following:

a. **Undue Hardship.** Compliance with the rule would impose an undue hardship caused by the untimely death of Dr. Mike Hollen. He has many patients currently under orthodontic treatment. The family has not been able to find an orthodontist to continue the treatment for these patients.

b. **Why Waiving the Rule Would Not Prejudice the Substantial Legal Rights of Any Person.** Waiver of the rule would not prejudice the substantial legal rights of any person because the clinic has not been able to find a replacement for him since his death 6 month ago. This ensures and protects public health, safety, and welfare.

c. **The Provisions of the Rule Subject to the Waiver are NOT Specifically Mandated by Statute or Another Provision of Law.** Iowa Code Chapter 153 does not mandate the requirements of rule 650-11.4 if the candidate has additional training in an accredited Dental School in the USA.

d. **Substantially Equal Protection of the Public Health, Safety, and Welfare has been Afforded by.** The subrule that I am requesting a waiver from helps to ensure that adequate care be provided for the patients who are undergoing active orthodontic retreatment.

5. A history of prior contacts between the board and petitioner related to the regulated activity is as follows.
   - Obtained a temporary license to practice in State of IOWA

6. Information related to the board’s action in similar cases: Candidates with similar training in the USA has been given the waiver.

7. There is no other public agency or political subdivision that regulates dentistry in Iowa. No any public agency or political subdivision will be affected by the grant of the petition

8. I am not aware of any person or entity that would be adversely affected by the granting of a waiver in this case.

9. Provide the name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver 1. Northwestern University dental school is closed. Dr. Frank Perry the program director is now a faculty at Midwestern University dental school, Downers Grove. His email is: fperry@midwestern.edu 2. Dr. Budi Kusnoto is head of department of Orthodontics at University of Illinois orthodontic program. His email is: bkusno1@uic.edu

10. I hereby authorize the Board to obtain any information relating to this waiver request from the individuals named herein. I will provide signed releases of information if necessary.
I hereby attest to the accuracy and truthfulness of the above information.

Joseph Kunnel  
Petitioner’s signature  

9/19/2017  
Date
**BIOGRAPHICAL SKETCH**

Give the following information for all new key personnel.

Copy this page for each person.

---

**NAME**

Joseph George Kunnel  
2328 Phillips Dr.  
Glenview, IL-60026  
Phone: Cell: 312 317 5647  
Email: j-kunnel@northwestern.edu

**POSITION TITLE**

Assistant Professor  
Molecular Pharmacology and Biological Chemistry  
Northwestern University Medical School  
Private Practice. Orthodontic Specialist.  
Former Chief Orthodontist and  
Associate Professor, Midwestern University

---

**EDUCATION/TRAINING** *(Begin with baccalaureate or other initial professional education, such as nursing. Include postdoctoral training.)*

<table>
<thead>
<tr>
<th>INSTITUTION AND LOCATION</th>
<th>DEGREE</th>
<th>YEAR(s)</th>
<th>FIELD OF STUDY</th>
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<tr>
<td>Baselius College, University of Kerala</td>
<td>BS</td>
<td>1982-85</td>
<td>Cost Accounting</td>
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<td>College of Dental Surgery, Manipal</td>
<td>DDS</td>
<td>1985-90</td>
<td>Dentistry</td>
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<tr>
<td>Northwestern University, Chicago</td>
<td>MS</td>
<td>1993-95</td>
<td>Advanced Dentistry</td>
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<tr>
<td>University of Illinois, Chicago</td>
<td>MS</td>
<td>1999-2002</td>
<td>Orthodontics</td>
</tr>
<tr>
<td>Northwestern University Medical School, Chicago</td>
<td>Ph.D.</td>
<td>1996-2001</td>
<td>Bone Biology</td>
</tr>
</tbody>
</table>

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**RESEARCH AND PROFESSIONAL EXPERIENCE:** Concluding with present position, list, in chronological order, previous employment, experience, and honors. Include present membership on any Federal Government public advisory committee. List, in chronological order, the titles, all authors, and complete references to all publications during the past three years and to representative earlier publications pertinent to this application. If the list of publications in the last three years exceeds two pages, select the most pertinent publications. DO NOT EXCEED TWO PAGES.

**Research and Professional Experience:**

Associate Professor and Chief Orthodontist, College of Dental Medicine, Midwestern University, IL. 2012 to June 2016.

Private Practice: Orthodontic Specialist; 2002 to date

Associate Professor, Marquette University Dental School, 2003 to 2004

Assistant Professor, Northwestern University Medical School. 1999 to date.

Resident, Dept. of Orthodontics, University of Illinois. 1999 to 2002

Clinical Assistant Professor, Northwestern University Dental School. 1995-1999.

Post-doctoral Fellow, Dept. of Biomaterials, Northwestern University Dental School, Chicago, IL. 1995-96

Resident, Dept. of Orthodontics, Bapuji Dental College, Davangere. 1991-92

Senior Resident, Dept. of Oral and Maxillofacial Surgery, Medical College, Kottayam. 1991

General Practice Residency, College of Dental Surgery, Manipal. 1989-91

**Honors:**

Recipient NIH LRP Award 2002

First Place, University of Illinois Research Presentations. February 2002

Recipient ‘Teaching Fellowship Award’ American Association of Orthodontists Foundation. (4/01/01 through 4/01/02)

Recipient ‘Clinical Investigator Award’, National Institute of Dental and Craniofacial Research (Grant Number: 1 K08 DE00446-01; Issue Date: 04/29/1999 through 04/29/04)

Recipient ‘Institutional Training Grant’, NIDCR (Grant Number: 5-T32 DE07042-19, 1995 to 1999)

Third Rank, Graduating Class of 1989, College of Dental Surgery, Manipal. 1989

First Rank, Graduating Class of 1980, Rex Higher Secondary School. 1980


**Research Funding:**

NIH Grant. K08 DE00446-01; ‘Mechanotransduction in Bone”. PI Joseph Kunnel. (04/29/1999 through 04/29/04)

American Association of Orthodontists Foundation Grant. Micromechanical Testing of Viable Bone. PI Joseph Kunnel (4/01/01 through 4/01/02)

Howard Hughes Grant: Gene array expression of bone during mechanical stimulation. (2003)

---

**Refereed Manuscripts:**


**Abstracts:**


Northwestern University

ON RECOMMENDATION OF THE FACULTY OF THE GRADUATE SCHOOL
NORTHWESTERN UNIVERSITY HAS CONFERRED THE DEGREE OF MASTER OF SCIENCE UPON JOSEPH GEORGE KUNNEL WHO HAS HONORABLY FULFILLED ALL THE REQUIREMENTS PRESCRIBED BY THE UNIVERSITY FOR THAT DEGREE DONE AT EVANSTON ILLINOIS THIS THIRTIETH DAY OF DECEMBER IN THE YEAR ONE THOUSAND NINE HUNDRED AND NINETY-SIX A.D.

Chairman of the Board of Trustees

President of the University

Secretary of the Board of Trustees

Dean
Northwestern University
Dental School

Upon the recommendation of its Faculty Awards this Certificate of Achievement to

Joseph George Kunnel

Who has honorably completed a Program of Advanced Studies and who has demonstrated proficiency in the Theory and Practice of Advanced General Dentistry from September 20, 1993 to August 25, 1995

[Signatures]

Michael A. [Signature]
Dean of the Dental School
CHICAGO, ILLINOIS

[Signature]
Director Advanced Education

[Signature]
Program Director

[Signature]
Director Advanced Education

August 25, 1995

https://mail.google.com/mail/u/0/#inbox?projector=1
ON RECOMMENDATION OF THE FACULTY OF
THE GRADUATE SCHOOL
NORTHWESTERN UNIVERSITY HAS CONFERRED THE DEGREE OF
DOCTOR OF PHILOSOPHY
UPON
JOSEPH GEORGE KUNNEL
WHO HAS HONORABLY FULFILLED ALL THE REQUIREMENTS PRESCRIBED
BY THE UNIVERSITY FOR THAT DEGREE
DONE AT EVANSTON ILLINOIS THIS TWENTY-EIGHTH DAY OF DECEMBER
IN THE YEAR TWO THOUSAND AND ONE A.D.
By authority of the Board of Trustees of the
UNIVERSITY OF ILLINOIS
and upon recommendation of the Senate
at Chicago
Joseph George Kunnel
has been admitted to the Degree of
Master of Science
and is entitled to all rights and honors thereunto appertaining
Witness the Seal of the University and the Signatures of its Officers
this fifth day of May, two thousand and two.

George W. Shea
Chair of the Board of Trustees

James G. Atchel
President of the University

Michele M. Thompson
Secretary of the Board of Trustees

Sylvia Manning
Chancellor
University of Illinois
at Chicago

College of Dentistry
certifies that

Joseph George Kunnel
has completed a program of postdoctoral study in
the Specialty of
Orthodontics
August 24, 1999 to May 5, 2002

Carla A. Evans
Program Director

Carla A. Evans
Head of Department

Harry Abraham
Dean, College of Dentistry

Ben F. Veltri
Associate Dean for Academic Affairs
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<tr>
<th>Last Name</th>
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<tr>
<td>Chowdhury</td>
<td>Jyoti</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>6/17/2004</td>
<td>MS in dental public health from University of Iowa College of Dentistry; Advanced clinical training in general practice residency program (1 year); pediatric residency program (2 years); also references education completed in India.</td>
</tr>
<tr>
<td>Karunagaran</td>
<td>Saravana</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>10/24/2008</td>
<td>Training in dental materials, MS in biomaterials - State University of New York at Buffalo, School of Dental Medicine Sept 2005; 2 years advanced clinical training in general dentistry, LSU Health Sciences Center School of Dentistry, Medical Center of Louisiana, New Orleans; Training in conscious sedation, LSU Health Sciences Center School of Dentistry, Medical Center of Louisiana, New Orleans; Compulsory Rotatory Internship 2001 - India; 2000 Bachelor of Dental Surgery, India.</td>
</tr>
<tr>
<td>Vargas</td>
<td>Kaaren</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>10/24/2006</td>
<td>Board determined that a waiver could be granted following completion of a 1-1 year general practice residency (GPR), in addition to the previously-completed postgraduate training in pediatrics and PhD in oral sciences</td>
</tr>
<tr>
<td>Mahajan</td>
<td>Shrirang</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>DENIED</td>
<td>1/18/2007</td>
<td>Graduated from dental school in India; 1 year general practice residency (GPR) in India; 1 year private practice in India; 2 year research-oriented masters program at the State University of New York, Buffalo, School of Dentistry - focus of studies was TMJ and materials science; completed national board examination in 2002, and WREB in 2004; ongoing CE.</td>
</tr>
<tr>
<td>Vargas</td>
<td>Marco</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>9/4/2007</td>
<td>2 years of Advanced Education in General Dentistry (AEGD) at Eastman Dental Center, Rochester, NY; completed 2 year master’s program in operative dentistry at University of Iowa College of Dentistry; full time faculty in operative dentistry 1994-2006; full time faculty in dept. of family dentistry &quot;From 2006-present.&quot;</td>
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<tr>
<td>Uribe</td>
<td>Juan M.</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>10/2/2007</td>
<td>2 years of Advanced Education in General Dentistry (AEGD) at the Univ. of Missouri - KC, served as chief resident;</td>
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<tr>
<td>Rouman</td>
<td>Marco</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>DENIED</td>
<td>11/20/2008</td>
<td>1 year general practice residency (GPR) in Egypt; 30 months Oral/Maxillo surgery residency in Egypt; Diploma of the faculty of dental surgery of the Royal College of Surgeons of Edinburgh; 2 academic years geriatric dentistry residency training at Univ. of Minnesota School of Dentistry; Master of Science in dentistry degree in progress at the Univ. of MN School of Dentistry; 5 months oral pathology director for RDH students at MN State University - Mankato.</td>
</tr>
<tr>
<td>Bansal</td>
<td>Ritu</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>10/15/2007</td>
<td>2005 - entered master’s program in public health at the University of Texas Health Science Center at Houston; during program, completed internship with Baylor College of Dentistry in the dept. of Oral Diagnosis (April 2005-Oct 2005); graduated with Master of Public Health degree in December 2006; enrolled in a dental public health residency at Baylor College of Dentistry (Jan 2007- May 2008); accepted faculty position, Baylor College of Dentistry, November 2007; private practice (general practice) since December 2008.</td>
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<tr>
<td>Fatah</td>
<td>Walid</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>3/2/2012</td>
<td>1 year externship at the Quality Surgery Center in Clinton, IA (2006-2007); 6 months preceptorship training program in Advanced Education in General Dentistry (AEGD) at UCLA (2007); 1 year AEGD at Nova Southeastern University (2008-2009); 2nd year AEGD at the University of Texas Dental Branch in Houston (2008-2009); 400 credit hours of CE in general dentistry within previous 5 years.</td>
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<td>Oestervemb</td>
<td>Niels</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>7/12/2011</td>
<td>Completed 5 months in his senior year as part of an exchange program in family dentistry at University of Iowa College of Dentistry; General practice residency (GPR) from 2010-2011 at UIA Hospitals/Clinics - certificate granted; Fellowship 2011-2012 at UIA COD - certificate granted.</td>
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<tr>
<td>Khan</td>
<td>Shiza</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>10/25/2011</td>
<td>1 year general practice residency (GPR) at St. Mary's Hospital, Waterbury, CT; Second year of GPR from Carolin Medical Center, Charlotte, NC, chief resident; 3 years of advanced specialty training in periodontology from Univ. of CT; Masters degree in dental science from Univ. of CT, Storrs, CT.</td>
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<tr>
<td>Habib</td>
<td>Amr</td>
<td>11.4(1)</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>5/9/2014</td>
<td>2 years of Advanced Education in General Dentistry (AEGD) at Eastman Dental Center, Rochester, NY (December 2008-March 2011); Completed the national boards, and WREB; also references education and experience in Egypt.</td>
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<tr>
<td>Zitouni</td>
<td>Sima</td>
<td>11.4(1), 11.4(3)e</td>
<td>Foreign Graduate</td>
<td>Approved</td>
<td>7/21/2016</td>
<td>Dr. Zitouni completed dental school in Syria. States that Course-by-Course Evaluation Report from the Educational Credential Evaluators compare how the curriculum compares to ADA-accredited programs. 2009-2010: completed one year of study in general dentistry along with a restorative fellowship at Case Western University. 2010-2014 completed a 3-year program in periodontics at Case Western University. Also completed a post-doctoral training course in sedation while at Case Western University. Has completed the National Board, WREB, TOEFL and Iowa juris exams. Political climate in Syria makes it difficult for Dr. Zitouni to obtain documentation regarding her education and licensing there.</td>
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A National Dental and Dental Hygiene Testing Agency

Mission of WREB

The Mission of WREB is to develop and administer competency assessments for state agencies that license dental professionals.

Vision Statement

WREB maintains our internal focus on providing the highest quality examinations. This leads to WREB being the best developer and leading administrator in this field.

Values

1. Commitment to quality
2. Consistently valid and reliable examinations
3. Administered with honesty, integrity, and fairness
4. Effective, appropriate technology
5. Use of patients
6. Examiners & committee members
7. Constructive collaboration
8. Fiscal responsibility, nonprofit stewardship of candidate resources
9. Universal acceptance
10. Respectful disagreement, then joining together
11. Care for the patient
The concept of a regional testing service originated with Dr. Martin Kolstoe of Oregon. Dr. Kolstoe was the prime organizer who worked diligently to assure the success of the regional testing concept. His original idea was to have a Northwest Regional testing service, and he gathered testing information from a variety of sources. As time went by, his horizons broadened, and the idea of a Western Regional Examining Board was born.

The idea was further explored in 1975 at a joint meeting of the American Association of Dental Examiners and the Western Conference of Dental Examiners and Dental School Deans. The idea of a Western Regional Examining Board was discussed among the thirteen states of the Western Conference. Utah was looking for an affiliation of this type, since they did not have a proper facility for conducting examinations, and was forced to use hotels, prisons, etc. as examination sites. During the meeting, Utah made an arrangement with Oregon to have a simultaneous examination.

In November of 1976, the states formally incorporated WREB (Western Regional Examining Board) and in June of 1977, the first exam was given under the auspices of the WREB in Oregon. Oregon withdrew from WREB in 1981, but rejoined in January 1992.
• Arizona became a member in 1978, and in June 1978, the first exam was given with the three-state membership. The first Dental Hygiene exam was given in 1979.
• In April of 1979, Montana became a member of WREB. It participated in its first WREB exam in June 1979.
• In January of 1980, Colorado became a member of WREB. Colorado withdrew from WREB in 1983.
• In March of 1985, Idaho became a member of WREB.
• In July of 1987, Alaska became a member of WREB.
• In January of 1988, New Mexico became a member of WREB.
• In 1994, Texas and Oklahoma became members of WREB.
• In 1995, Washington became a member of WREB.
• In 2000, Wyoming became a member of WREB.
• In 2006, California became a member of WREB (Dental Only).
• In 2007, Missouri became a member of WREB.
• In 2008, Kansas became a member of WREB.
• In 2009, North Dakota became a member of WREB.
• In 2010, California accepts Dental Hygiene WREB results.
• In 2011, Illinois became a member of WREB.
• In 2013, Nevada became a member of WREB.
• In 2014, Hawaii became a member of WREB (Hygiene Only)
WREB offers potential member states two levels of membership, *active* or *affiliate* with different levels of commitment and responsibility. There is not a fee associated with either level of membership. Both levels of membership require that the potential member state accept WREB dental and dental hygiene exams as constructed and administered.
Roles and Responsibilities of Active Member States

Dental Representation

Each active member state must provide a minimum of two dental examiners who are willing to do a minimum of two dental exams each year. Participation in dental hygiene exams is also encouraged. At least one of the two must be a sitting dental State Dental Board member, the other one can be either current or past State Dental Board members or they may be designated representatives chosen by the State Board to represent them in the WREB examiner pool. They must all be currently licensed. WREB recognizes that it may take time to identify these individuals and get them onto the WREB schedule, therefore the expected time frame to get two examiners actively engaged is 12 months.

Each active member state will identify a current sitting board member that will act as their representative to the WREB Dental Exam Review Board (DERB). This person must make a commitment to attend one meeting each year of the Dental Examination Review Board.

Dental Hygiene Representation

In addition, each active member state is required to provide two dental hygiene examiners. One must be a sitting State Dental Board or hygiene committee member and one can be either a current or past State Dental Board representative designated by the State Board or hygiene committee or WREB committee member.

Each active member state will identify a current sitting dental hygiene board/hygiene committee member that will be an active examiner and act as their representative to the WREB Hygiene Exam Review Board.
For states with only one sitting dental hygiene representative, it is preferred that this person be the representative to the Hygiene Exam Review Board. If this is not possible, a state may designate a currently licensed hygienist to serve in this capacity. The second examiner could be either a past state board/hygiene committee member or an examiner designated by that state board or hygiene committee.

It is requested that all state representatives serving on the Dental and Dental Hygiene Exam Review Boards, be able to complete at least one consecutive 2-year term.

Each Examination Review Board meets twice per year, usually in the summer and winter months. Attendance at these meetings is funded by WREB. In addition, all examiners participation at WREB exams is funded by WREB.

All active membership applications must be approved by the WREB Board of Directors.
Roles and Responsibilities of Affiliate Member States

Affiliate membership also requires the acceptance of WREB examination results as constructed. By design this category has fewer responsibilities and also therefore, more limited opportunities for input. It is designed to accommodate those with interest but limited resources to dedicate to participation on WREB committees and in providing examiners to examine for dental and dental hygiene. Affiliates will receive updates and communication from WREB.

Affiliate memberships may be approved by the Officers of the Board of Directors.
2019 Proposed Board Meeting Dates

January 24 & 25
April 5
June 7
August 1 & 2
September 27
November 15

*January 24 and August 1 reserved for hearings. All regularly scheduled board meetings to be held on Fridays.