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

DENTAL HYGIENE COMMITTEE: 8:30 AM
(See separate agenda)

EXECUTIVE COMMITTEE: 9:15 AM

BOARD MEETING

OPEN SESSION: 10:00 AM

I. CALL MEETING TO ORDER – ROLL CALL

II. 1st OPPORTUNITY FOR PUBLIC COMMENT

III. APPROVAL OF OPEN SESSION MINUTES
   a. September 28, 2018
   b. October 10, 2018 Teleconference

IV. REPORTS

   A. EXECUTIVE DIRECTOR’S REPORT
      Jill Stuecker

   B. BUDGET REPORT
      Jill Stuecker
C. ANESTHESIA CREDENTIALS COMMITTEE REPORT  Christel Braness
   a. Actions Taken by the Committee on General Anesthesia &
      Moderate Sedation Permit Applications
   b. Other Committee Recommendations, if any

D. CONTINUING EDUCATION COMMITTEE REPORT  Lori Elmitt
   a. Vote on Recommendations: Continuing Education Course Applications
   b. Vote on Recommendations: Continuing Education Sponsor Applications
   c. Other Committee Recommendations, if any

E. LICENSURE/REGISTRATION COMMITTEE REPORT  Tom Jeneary
   (Pursuant to Iowa Code § 21.5(1)(a) some licensure/registration
   information is required by state or federal law to be kept confidential
   and may be discussed in closed session).
   a. Vote on Recommendations by the Committee on Applications
   b. Vote on Ronald Moon, D.D.S., Application for Dental License

F. DENTAL HYGIENE COMMITTEE REPORT  Mary Kelly
   a. Committee Meeting Overview
   b. Recommendations for Board Discussion and Vote

G. EXAMINATION REPORTS
   a. CRDTS - Dental Steering Committee  Steven Bradley
   b. CRDTS - Dental Hygiene Examination Review Committee  Nancy Slach
   c. CRDTS - Dental Examination Review Committee  Will McBride
   d. WREB - Dental Committee  Monica Foley
   e. WREB - Dental Hygiene Committee  Mary Kelly

H. IOWA PRACTITIONER PROGRAM REPORT  Steve Garrison
   a. Quarterly Update

V. ADMINISTRATIVE RULES  Steve Garrison
   b. Vote on ARC 4005C, Proposed Adoption and Filing:
      Amendments to Iowa Administrative Code 650 - Chapter 11, “Licensure
      to Practice Dentistry or Dental Hygiene” and Iowa Administrative Code
      650 - Chapter 20, “Dental Assistants”
   c. Vote on Proposed Notice of Intended Action:
      Amendments to Iowa Administrative Code 650 - Chapter 16, “Prescribing,
      Administering and Dispensing Drugs”, Iowa Administrative Code 650 -
      Chapter 25 “Continuing Education”, and Iowa Administrative Code 650 -
      Chapter 30, “Discipline”
   d. Vote on Proposed Notice of Intended Action: Addition to Iowa Administrative Code
      650 - Chapter 23, “Expanded Functions”, Amendments to Iowa Administrative Code

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members,
apresenters 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.
VI. LEGISLATIVE UPDATES

Jill Stuecker

a. Vote to Propose Amendment to Iowa Code Section 153.33 to Authorize Administrative Penalties
b. Discussion on Settings for Services Provided as Outlined in Iowa Code 153.15

VII. OTHER BUSINESS

Jill Stuecker

a. Vote on American Dental Association/Centers for Disease Control Opioid Course
b. Update on IDB Strategic Plan
c. Vote on Mary Kelly, LLC Silver Diamine Fluoride Course

VIII. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS

Christel Braness

(Pursuant to Iowa Code § 21.5(1)(a) some licensure/registration information is required by state or federal law to be kept confidential and may be discussed in closed session).
a. Quarterly Ratification of Applications Issued

IX. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Steven Bradley

CLOSED SESSION: Motion to go into closed session pursuant to Iowa Code section 21.5(1)(a), to review or discuss records which are required or authorized by state or federal law to be kept confidential; pursuant to Iowa Code section 21.5(1)(d), to discuss whether to initiate licensee disciplinary investigations or proceedings; pursuant to Iowa Code section 21.5(1)(f), to discuss the decision to be rendered in a contested case conducted according to the provisions of chapter 17A; and pursuant to Iowa Code section 21.5(1)(h), to avoid disclosure of specific law enforcement matters, such as allowable tolerances or criteria for the selection, prosecution, or settlement of cases, which if disclosed would facilitate disregard of requirements imposed by law.

I. ITEMS FOR REVIEW AND DISCUSSION

a. Closed Session Minutes, September 28, 2018 and October 5, 2018 (21.5(1)(a))
b. Discussion of Enforcement Criteria (21.5(1)(h))
c. Compliance with Board Orders (21.5(1)(d))
d. Complaints and Investigative Reports (21.5(1)(d))
e. Combined Statement of Charges, Settlement Agreement and Final Order (21.5(1)(d) (21.5(1)(f))
f. Hygiene Committee Complaints (21.5(1)(d))

OPEN SESSION

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

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.
II. ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS
   a. Closed Session Minutes: September 28, 2018 and October 5, 2018
   b. Compliance with Board Orders
   c. Complaints and Investigative Reports
   d. Combined Statement of Charges, Settlement Agreement and Final Order
   e. Hygiene Committee Complaints

III. ADJOURN

NEXT REGULARLY-SCHEDULED MEETING: JANUARY 24-25, 2019
IOWA DENTAL BOARD

MINUTES
September 28, 2018
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members
September 28, 2018
Steven Bradley, D.D.S., Present
Michael Davidson, D.D.S. Present
Thomas Jeneary, D.D.S. Absent
Monica Foley, D.D.S. Present
William McBride, D.D.S. Present
Mary Kelly, R.D.H. Present
Nancy Slach, R.D.H. Present
Bruce Thorsen, Public Member Present
Lori Elmitt, Public Member Present

Staff Members
Jill Stuecker, Christel Braness, Dee Ann Argo, Steven Garrison, David Schultz

Attorney General’s Office
Laura Steffensmeier, Assistant Attorney General

Other Attendees
Jane Slach; Iowa Dental Assistants Association, Dental Educators Council
Francisco Olalde, University of Iowa Carver College of Medicine
Bob Russell, D.D.S., Iowa Department of Public Health
Nancy Miller, R.D.H., Iowa Dental Hygienists' Association
Tom Cope, Iowa Dental Hygienists' Association
Lea Albaugh, R.D.H.
Chris Albaugh
Jeff Chaffin, D.D.S., Delta Dental of Iowa
Lori Pelke, Midwest Dental
Sean Murphy, American Association of Orthodontists
Tom Stark, D.D.S., Iowa Society of Orthodontists
Laurie Traetow, Iowa Dental Association
Katie Cownie, Brown Winnick, Iowa Dental Association
Stephen Thies, D.D.S, Iowa Academy of General Dentistry
I. CALL TO ORDER FOR AUGUST 3, 2018

Dr. Bradley called the meeting of the Iowa Dental Board to order at 10:00 a.m., on Friday, September 28, 2018.

Roll Call:

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<th>Elmitt</th>
<th>Foley</th>
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A quorum was established with eight (8) members present.

II. 1st OPPORTUNITY FOR PUBLIC COMMENT

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

Mr. Cope, Iowa Dental Hygienists' Association (IDHA), called attention to the agenda item listed under Legislative Updates regarding Iowa Code Section 153.15. The IDHA would like to add to the current list of allowed practice settings to make the Iowa Code language consistent with Iowa Administrative Code 650 and current practice. The IDHA has discussed this issue with the Iowa Dental Association (IDA). In particular, they have agreed on the need to add nursing facilities to the list of approved facilities.

Dr. Stark, orthodontist, spoke about the proposed rules before the Board regarding the designation of specialties. Dr. Stark reported that he’d recently attended a meeting in Minneapolis, Minnesota where this matter was discussed. Dr. Stark thanked the Board for continuing to recognize specialties; though, orthodontists recommended a requirement for CODA-approved training to claim a specialty.

Mr. Murphy spoke on behalf of the American Association of Orthodontists (AAO). Mr. Murphy reported that they prefer a requirement of CODA-accredited residency training to qualify for specialty status. Mr. Murphy reported that other states are moving in that direction. Mr. Murphy recommended that the Board consider this in the future.

Mr. Murphy reported on the complaints that he previously submitted regarding Smile Direct Club. Mr. Murphy indicated that Smile Direct Club now claims to be a dental support organization (DSO), and choose to direct advertising and other matters without the consultation of a licensed
Mr. Murphy referenced complaints submitted online by Iowans. One of the complaints referenced dialogue with Smile Direct Club, which discouraged that person from seeing a licensed dentist.

Mr. Murphy stated that Smile Direct Club also claims they are providing care via teledentistry, which the Board does not currently address in rules. Mr. Murphy urged the Board to look into these matters further.

III. APPROVAL OF OPEN SESSION MINUTES

- August 3, 2018 – Quarterly Meeting
- MOVED by ELMITT, SECONDED by FOLEY to APPROVE the meeting minutes as submitted. Motion APPROVED unanimously.

Mr. Thorsen asked to update the Board about some recent discussions he has had regarding oral health. Mr. Thorsen comes from a hospital administration background, and is interested in furthering discussions regarding the issue of access to oral healthcare. Mr. Thorsen has held discussions with individuals at the Harkin Institute at Drake University about holding an oral health conference in October 2019. The IDPH Bureau of Oral & Health Delivery Systems will assist with this. The intention would be to hold a forum to further address concerns related to oral health.

IV. PANEL DISCUSSION ON DRAFT EXPANDED FUNCTIONS RULES


Ms. Stuecker provided an overview of the intended format for the discussion.

Dr. Foley provided an overview of the proposed changes and additions to the expanded functions, and the suggestion to move a few of the current Level 1 expanded functions to the scope of practice for dental assistants and dental hygienists.

Ms. Stuecker asked Dr. Meredith to address some of the comments, which she recently submitted regarding the current draft. Dr. Meredith noted that there should be some consideration given to the use of terms such as “aesthetic restorations” and “adhesive restorations” as they relate to procedures of different natures.

Ms. Jane (J.) Slach asked about the addition of “observational supervision” to the definitions in the draft. Ms. J. Slach recommended changing the clinical practice requirements for training in expanded functions to one year of clinical experience for graduates of ADA-accredited dental assisting programs, and two years of clinical experience for those who trained on the job.
Board staff later commented on the addition of “observational supervision”. Staff suggested the addition of this terminology to distinguish it from “personal supervision”, which only applies to dental assistant trainees. Dental assistant trainees are prohibited from training in expanded functions, and the hope is to avoid any confusion that might result from using the same terminology for substantially different situations.

Ms. J. Slach also noted that the addition of placement of intermediate restorative material (IRM) was not included in the rule 23.5, which is the list of Level 1 expanded functions for dental hygienists. Ms. J. Slach wondered if the language needed to be cleaned up. Board staff stated that they would correct this.

Dr. Meredith recommended limiting the type of material that expanded functions dental assistants and dental hygienists could use when placing IRMs. Dr. Meredith recommended limiting Level 1 expanded functions to the use of class one IRMs. Dr. Mabry stated the committee recommended that IRM should only remain in the tooth, following placement, for up to 12 months.

Ms. Stuecker asked the panel and the Board to further discuss the proposal to allow the recementation of a provisional restoration by a Level 2 expanded functions dental assistant or dental hygienist under general supervision. Ms. Stuecker noted that this would be a substantial change from current supervision requirements.

Dr. Davidson was in favor of allowing this, since leaving the restoration off could do greater harm. Dr. Holst agreed with Dr. Davidson’s comments. Dr. Holst is from a small town and has concerns related to the access of care in situations where the dentist may not be readily available. Dr. McBride stated that the worst case scenario would be the removal and replacement of the provisional restoration if something went wrong. The Board members indicated that they were in favor of allowing this under general supervision.

Dr. Mabry addressed the proposed change in language related to provisional crowns. Dr. Mabry stated that the recommendation to limit the expanded functions procedures to stainless steel crowns was that they are easier to place. Zirconia crowns require more training and skill to prepare the tooth for correct placement.

Dr. Mabry also recommended updating language in rule 23.6 from “final occlusal adjustment” to “fit verification by the dentist” since those procedures would not change the occlusion.

Dr. Davidson asked about the exclusion of taking final impressions for upper and lower dentures in Level 1 expanded functions. Dr. Davidson believed that crown impressions can sometimes be harder to take. Dr. Meredith reported that the prosthodontists at the university believed that poorly made upper and lower dentures can have a profound impact if done incorrectly. Dr. Davidson appreciated the limitations on irreversible procedures; however, dentures can be remade. Ms. Kelly stated that the number of complaints to the Board regarding dentures affected some of the recommendations made by the committee.

Ms. Nancy Slach stated that, having worked in education, she had concerns about people teaching without a preceptorship. Dr. Meredith clarified that training in Level 2 expanded functions
requires dental assistants and dental hygienists to complete training in all Level 1 expanded functions, thereby providing clinical experience. Additionally, all candidates must pass a pre-test prior to beginning training in Level 2 expanded functions.

Dr. Mabry addressed the proposed changes regarding nitrous oxide, acknowledging that there has been some serious discussion about how to mediate the differences in opinion. Ms. Braness stated the Iowa Administrative Code 650-Chapter 29 allows dental assistants to monitor nitrous oxide, whereas dental hygienists may monitor or administer. Ms. Braness stated that she has asked on a number of occasions where monitoring ends and administration begins, and has not received a clear answer. Most of the Board members were inclined to allow a dental assistant turn down, or turn off, the nitrous oxide as part of monitoring a patient.

Ms. Elmitt believed that the committee has done a good job establishing clearer requirements for didactic and clinical training for greater consistency. Ms. Stuecker led the discussion on the proposed training standards. In some cases, there are noticeable increases over the current requirements.

There was some additional discussion pertaining to the proposed training requirements in the draft, including the reference to clinical experience and patient experiences. The panel members agreed that tracking time is not always easy. In most cases, patient experiences would be more important to document the clinical experience; though, Dr. Holst stated that for monitoring nitrous oxide, it may make more sense to require a minimum amount of time versus quantity of patient experiences.

Ms. Stuecker asked the Board to weigh in on the matter of certification for expanded functions. Dr. Mabry stated that it was currently challenging for those enrolling in the Level 2 expanded functions course since the documentation is inconsistent between Level 1 training providers. The panelists discussed the matter further. Dr. Holst emphasized the importance of a certification particularly for Level 2, because patients may have questions regarding the ability of their assistant or hygienist to do procedures they did not previously perform. Ultimately, the panelists and the Board were in favor of establishing a method of certification as follows:

- Certified Level 1: Optional for those who wish to document their training in all Level 1 procedures, and required for those who want to train in Level 2 expanded functions;
- Certified Level 2: Required.

Ms. Nancy Slach asked about a CRDTS-type examination for Level 2 expanded functions similar to what other states require. Dr. Meredith reported that assessments are completed at each point of the Level 2 training. Dr. Meredith stated that it would only be essential if the Board believed that independent testing was necessary. Dr. Mabry also noted that they have required remediation within the Level 2 training course. The course is rigorous and successful completion is not guaranteed.

Ms. Stuecker asked to discuss the minimum level of clinical experience needed to train in expanded functions. Dr. McBride believed that it should be up to the dentist to determine which staff members should receive expanded functions training. Dr. McBride wanted objective evidence showing a need before to increasing the minimum clinical practice requirements.
Ms. J. Slach stated that Iowa Western Community College has expressed some concerns with the clinical skills of those who have enrolled in their training courses. Dr. Meredith indicated that she understood the concern since the Level 2 training program does not include re-training the Level 1 procedures.

Ms. J. Slach asked whether there has been discussion about the minimum number of questions that should be included in the post-course assessment. Ms. Stuecker indicated that this had not been discussed in depth.

- Ms. Stuecker changed the agenda order slightly to discuss the sealant issue while the expanded functions committee members were in attendance.

LEGISLATIVE UPDATES

a. Discussion and Vote on Proposed Bill to Amend Iowa Code Section 153.38 Regarding Dental Assisting Scope of Practice

Ms. Stuecker reported that the Expanded Functions Committee members proposed a legislative change to allow Level 2 dental assistants to place sealants. 2000 Iowa Acts, chapter 1002, section 7 currently prohibits dental assistants from placing sealants, among the other activities listed.

Ms. Kelly stated that the Dental Hygiene Committee has discussed this issue as well. Ms. Kelly expressed concern about the removal of language with respect to the types of instruments that may be used. Ms. Kelly preferred that this language would be added back in.

- MOVED by DAVIDSON, SECONDED by FOLEY, to SUBMIT the proposed language as drafted for the upcoming legislative session.

Prior to the vote, Ms. N. Slach recommended adding a prohibition on the administration of nitrous oxide by dental assistants.

- Vote taken. Motion APPROVED unanimously.
  - The Board took a brief recess at 11:06 a.m.
  - The Board reconvened at 11:14 a.m.

V. REPORTS

EXECUTIVE DIRECTOR’S REPORT

Ms. Stuecker reported that, to date, 89% of dentists have been renewed. Ms. Stuecker noted that every renewal, approximately 10% of the licensees will allow their licenses to lapse.
Ms. Stuecker stated that the Board had received positive feedback about the online jurisprudence webinar. If the Board continues to offer courses such as this in the future, they will likely be offered in the same format.

Ms. Stuecker reported that infection control complaints are on the rise. The CDC has a number of good infection control resources available. The Board may send another notice regarding these resources as a way of making sure the information is readily available to everyone.

Ms. Stuecker reported on some of the upcoming IT projects the Board is considering. The database needs to be upgraded, and the overall costs could reach $100,000 or more for the Dental Board’s portion. This may affect fee increases in the future. Mr. McCollum will present more information about the statuses of these projects at the November 2018 meeting.

**BUDGET REPORT**

Ms. Stuecker reported that the Board was provided copies of the FY2018 and FY2019 budgets.

The first quarter of FY2019 was almost complete. Approximately 90% of revenue for the fiscal year has been received. Ms. Stuecker briefly commented on the increased IT costs as noted in the director’s report.

**ANESTHESIA CREDENTIALS COMMITTEE REPORT**

- *Actions Taken by the Committee on General Anesthesia & Moderate Sedation Permit Applications*
- *Other Committee Recommendations, if any*

Ms. Braness reported that the committee had not recently met. The committee was scheduled to meet again in November; though this date may be rescheduled to a date in October, as needed, to allow sufficient time to review the additional information related to the proposed rulemaking.

**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 THORSEN, to **APPROVE** the recommendations as submitted. Motion **APPROVED** unanimously.

Ms. Stuecker discussed the recommendation to add language to letters of continuing education approval notices, in order to distinguish between approval for continuing education credit, and Board approval for specific procedures as relates to scope of practice. Ms. Stuecker feels the Board
needs to emphasize that approving a continuing education course is separate and distinct from the assessing whether a specific procedures falls within a specific scope of practice.

- **MOVED by ELMITT, SECONDED by THORSEN, to APPROVE the recommendations for sponsor approvals as submitted. Motion APPROVED unanimously.**

**LICENSURE/REGISTRATION COMMITTEE REPORT**

- **Recommendations by the Committee on Applications**

Ms. Braness reported that the Board was provided a list of applications reviewed by the committee, and its recommendations.

- **MOVED by MCBRIDE, SECONDED by KELLY, to APPROVE the committee’s recommendations. Motion APPROVED unanimously.**

- **Review and Recommendation of Eligibility of Residency Program for Application by a Foreign-Trained Dentist**

Ms. Braness provided an overview of the information before the Board. Dr. Karem Hamid is a foreign-trained dentist, who has applied for an Iowa dental license. The information provided to date does not clearly indicate whether he meets the requirements for an Iowa dental license.

Ms. Braness forwarded the information provided by Dr. Karem Hamid to the License/Registration Committee for a recommendation concerning his training, and whether it met the requirements established in rule. The committee referred the request to the Board without a recommendation.

Ms. Braness noted that she has requested additional information from Dr. Karem Hamid in order to better determine whether his education met the requirements for license. To date, Dr. Karem Hamid has not supplied additional information.

The Board members discussed the information submitted to date. It was unclear to the Board members whether Dr. Karem Hamid’s education met the requirements established in Iowa Administrative Code 650-11.4. The Board recommended sending a letter requesting more information demonstrating that he qualified for a license in Iowa if he wished to continue with his application.

**DENTAL HYGIENE COMMITTEE REPORT**

- **Committee Meeting Overview**

- **Recommendations for Board Discussion and Vote**

Ms. Kelly reported that the committee discussed the request regarding myofunctional therapy. Ms. Kelly provided an overview of the information discussed during the committee meeting.
Ms. Kelly reported that the committee believed that this fell within the scope of practice of dental hygiene.

Dr. Foley asked where the services would be provided. Ms. Kelly stated that in this case, the services would be rendered within the dental office, following referral by a licensed dentist.

Ms. Steffensmeier clarified that the Board would be issuing an informal opinion since rules would not be written, and training and other standards would not be established.

The Board members agreed.

EXAMINATION REPORTS

- **CRDTS – Dental Steering Committee**

Dr. Bradley reported that the committee met in August 2018. The committee discussed several items including the OSCE examination, Botox, and differences in renewal among states.

Dr. Bradley noted that a number of states are on three-year renewal cycles. The Board briefly discussed the impact that might have on fees.

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

Ms. Slach reported that the committee had not recently met.

- **CRDTS – Dental Examination Review Committee**

Dr. McBride reported that the committee will meet again in January 2019.

- **WREB – Dental Examination Review Committee**

Dr. Foley stated that she had nothing to report.

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

Ms. Kelly reported that she observed her first WREB exam a few weeks ago. A meeting of the committee is scheduled for November 1, 2018. Ms. Kelly commented briefly on the differences she noticed between the CRDTS and WREB examinations.

IOWA PRACTITIONER PROGRAM REPORT

- **Quarterly Update**

Mr. Garrison provided an update on the committee. There were currently twelve active participants. The committee had received two new self-reports, which were under review.

VI. ADMINISTRATIVE RULES

Iowa Dental Board Meeting – OPEN SESSION – Subject to final approval
September 28, 2018 (Draft: 10/8/2018)
**Review of 2018-2019 Regulatory Plan**

Ms. Stuecker provided an overview of the updated regulatory plan.

- **Vote on ARC 3901C, Proposed Adoption and Filing: Amendments to Iowa Administrative Code 650 - Chapter 28, “Advertising” and Iowa Administrative Code 650 - Chapter 28, “Designation of Specialty”**

Ms. Stuecker reported that these rules were eligible for a vote to adopt and file. Ms. Stuecker briefly discussed the written comments received to date.

Ms. Braness reported that a minor correction would need to be made to the preamble if the rules were adopted. Ms. Braness reported that the correction was in regards to Dr. Krell, and the organization on whose behalf he had been commenting.

Mr. Murphy discussed the comments that the AAO submitted. As to the current draft, he recommended consideration of a few changes. Mr. Murphy recommended that “expert” be added to the rule.

- **MOVED by ELMITT, SECONDED by KELLY, to ADOPT and FILE the amendments with the correction to the preamble as noted previously regarding Dr. Krell’s organization affiliation. Motion APPROVED unanimously.**

- **Discussion on Draft Revisions Pursuant to HF2377:**
  1. *Iowa Administrative Code 650 - Chapter 25 “Continuing Education”*
  2. *Iowa Administrative Code 650 - Chapter 16 “Prescribing, Administering, and Dispensing Drugs”*
  3. *Iowa Administrative Code 650 - Chapter 30 “Discipline”*

Ms. Stuecker stated that the Board needed to implement these requirements into rule. All licensees who prescribe opioids would be required to complete a minimum of one hour of continuing education in the area of opioids every two years. The Board members agreed with the proposed requirement.

Ms. Stuecker advised the Board that she had been meeting with Mr. Funk, the director of the Iowa Board of Pharmacy, to ensure the Board’s prescribing rules were consistent with the Iowa Board of Pharmacy. Portions of the proposed changes to chapter 16 will refer licensees to Iowa Administrative Code 657, Pharmacy Board.

Ms. Stuecker reported that there was a new requirement to use the Prescription Monitoring Program (PMP) when prescribing opioids. The provisions of HF2377 would also require registration with the PMP. E-prescribing would be required starting January 2020.

Dr. Davidson asked about the proposed penalties. Ms. Steffensmeier clarified that Iowa Code established the specific basis for fees as penalties in lieu of discipline.
HF2377 also requires the Board to establish grounds for discipline. In the draft, this was addressed in item 28 of chapter 30. Ms. Stuecker also suggested reorganizing chapter 30 while incorporating these changes to make it more user friendly. The Board members were in agreement with that proposal.

Dr. Davidson asked about the current language in chapter 30 that requires compliance with CDC guidelines for infection control in dental offices. Dr. Davidson asked if it would be better to incorporate more of the requirements into rule for clarification. Following discussion about this, most of the Board members were inclined to keep the language as currently established.

Ms. Stuecker stated that she would continue accepting input about these drafts; though, Ms. Stuecker intended for the Board to vote on a Notice of Intended Action at the November 2018 meeting to ensure compliance with HF2377.

- **Discussion on Draft Revisions to Iowa Administrative Code 650 – Chapter 27, “Standards of Practice and Principles of Professional Ethics”**

Ms. Stuecker provided an update on the draft. Discussions related to the discontinuation of practice rules has resulted in an attempt to review and update the chapter in its entirety.

Ms. Stuecker pointed out that rule 27.7 required a thorough review. Ms. Stuecker recommended focusing on issues of importance to the Board, and getting away from addressing matters related to insurance and other matters.

Ms. Stuecker indicated that sub rules 27.7(9) and (10) are confusing to licensees. Ms. Kelly noted that these were newer provisions made in response to reported complaints about offices, in the past, having charged the entirety of a treatment plan to lines of credit prior to treatment having started. The Board members agreed that more information needed to be obtained about billing procedures before exploring this further.

The Board members discussed the matter related to discontinuation of practice. The discussion focused on whether individual licensees or practices had the greater responsibility to the patient. The Board members were split on this issue. Some of the Board members believed that licensees, individually, had a responsibility to notify patients of the discontinuation of practice in an area; whereas others believed that it was sufficient to allow the practice to determine what was appropriate. Staff will continue to look into this issue.

- **Update on Draft Revisions to Iowa Administrative Code 650 – Chapter 29, “Sedation”**

Ms. Stuecker updated the Board on the status of the draft. Following the August Board meeting, a letter was sent out to a number of national organizations requesting information related to the rulemaking. Staff has started receiving responses, and will forward that information to the November 2018 meeting for further consideration.

**VII. LEGISLATIVE UPDATES**
- **Discussion and Vote on Proposed Bill to Amend Iowa Code Section 153.38 regarding Dental Assisting Scope of Practice**

Ms. Stuecker noted that this agenda item was discussed earlier in the meeting, during the panel discussion of the expanded functions review.

- **Discussion on Proposed Bill to Amend Iowa Code Section 153.33 to Authorize Administrative Penalties**

Ms. Stuecker proposed this in response to the increased number of complaints regarding practitioners working on an expired trainee status, or a lapsed license or registration. The proposal was based on the option for fines in lieu of discipline as established in HF2377. This would be a compromise to deal with those simple disciplinary issues without resorting to formal discipline.

There was some discussion as to whether the penalty would be confidential, or subject to public requests for information. Since this was proposed as an alternative to formal action, some of the details would still need to be discussed. The Board members were in favor of the proposal overall.

Dr. Davidson asked if this could be opened up to administrative/clerical type issues. Most of the Board members were in favor of keeping it straightforward. Ms. Braness noted that the Board has not typically taken action over small things such as a current renewal card not being posted. Historically in those cases, the Board has sent a letter citing the requirement, and asking the licensee/registrant to come into compliance.

Ms. Stuecker will bring this back for a vote at the November 2018 meeting. Ms. Stuecker has currently proposed that the Board be allowed to retain these fees; however, this will likely be subject to discussion at the state house.

- **Discussion on Settings for Services Provided as Outlined in Iowa Code 153.15**

Ms. Stuecker stated that this issue was brought to the Board for review as it has been noted that the current language restricts where dental services may be provided.

The IDHA recommended adding nursing facilities to the list of approved service locations. Ms. Kelly believed that it may be advantageous to give the Board greater discretion in determining appropriate dental settings. For example, Ms. Kelly would also like to see medical offices and clinics included provided that the dental work is still supervised by a licensed dentist.

The Board discussed how to proceed. It was clear that there was support to add nursing facilities; however, the Board discussed whether it would make sense to support broader changes.

Mr. Beltram stated that the IDA was in support of adding nursing facilities to the Iowa Code; however, there weren’t any other agreements, currently, about other changes. The IDA and IDHA will continue to discuss this and share their feedback with the Board.
VIII. OTHER BUSINESS

- **Vote on Silver Diamine Fluoride Course, Submitted by U of I**

Ms. Stuecker reported that the changes to Iowa Administrative Code 650-chapters 10 and 16 go into effect on October 3, 2018. The rules require licensees who want to administer silver diamine fluoride in public health settings to complete Board-approved training. This course has been submitted to meet that requirement.

- MOVED by KELLY, SECONDED by MCBRIDE, to APPROVE the course for training in the use of silver diamine fluoride in public health settings. Motion APPROVED unanimously.

- **Vote on Silver Diamine Fluoride Protocol, Submitted by IDPH**

Ms. Stuecker reported that the new rules also require that silver diamine fluoride administered in public health settings needs to be done in accordance with Board-approved protocols.

- MOVED by KELLY, SECONDED by SLACH, to APPROVE the protocols for use of silver diamine fluoride in public health settings as submitted. Motion APPROVED unanimously.

- **Discussion on Myofunctional Therapy**

Ms. Stuecker noted that this agenda item was discussed earlier in the meeting during the report of the Dental Hygiene Committee.

- **Discussion on Botox**

Ms. Stuecker provided an overview of the discussion of this issue. In the past, the Board has elected against regulating the use of Botox and dermal fillers within the practice of dentistry. Ms. Stuecker reported that she regularly receives questions about this, more specifically asking what specific treatments are allowed. If the Board continues to choose not to regulate the application of these services within dentistry, Ms. Stuecker will continue referring licensees to Iowa Code Section 153 where the practice of dentistry is defined.

A couple of the Board members weighed in on this, and they were in favor of not regulating these services within the practice of dentistry.

Ms. Stuecker reported that Dr. Malcmacher, with the American Academy of Facial Esthetics, is reporting to licensees that the Iowa Dental Board has granted broad approval of the procedures he teaches through his course. Ms. Stuecker clarified that the Board has not approved the procedures he teaches as being within the scope of practice of dentistry, because the Board has not evaluated this. Dr. Malchmacher’s course was submitted as a continuing education program and was approved only for the purposes of continuing education.
The Board members discussed this matter further. Board staff noted that this was a principle reason behind the recommendation to include additional language in the continuing education approval notification.

- **Update on IDB Strategic Plan**

Ms. Stuecker stated that there weren’t any significant updates. Ms. Stuecker stated that the Board may want to review this further to make updates to reflect the progress made to date.

**IX. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS**

- **Quarterly Ratification of Applications Issued**

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

- **MOVED by ELMITT, SECONDED by KELLY, to APPROVE the list as submitted. Motion APPROVED unanimously.**

**X. 2nd OPPORTUNITY FOR PUBLIC COMMENT**

Dr. Bradley allowed the opportunity for public comment.

Dr. Russell commented on the discussion about the list of approved locations within Iowa Code 153.15 wherein dental services may be provided. The current restrictions have been a burden, particularly with respect to providing basic dental care to children. It may be valuable to partner with other health care providers to determine what is appropriate. The IDPH was in favor of focusing on supervision as opposed to approving specific locations.

Mr. Murphy recommended that the Board continue to discuss the issue of teledentistry. Smile Direct Club increasingly was using teledentistry as the basis for treatment. Teledentistry is not defined or regulated in Iowa. Additionally, Smile Direct Club claims that they are a DSO, and therefore, not subject to all regulations regarding the practice of dentistry.

Mr. Murphy noted that the Board has referred non-licensees for investigation over teeth whitening; and yet, the Board argues that they can only regulate licensees. Mr. Murphy encouraged the Board to proceed with the investigations of these complaints.

Dr. Thies commented on the proposed requirements for a dental assistant to monitor nitrous oxide. Dr. Thies felt strongly that a dental assistant should be allowed to turn the nitrous oxide off in the event of an adverse reaction.

- The Board took a brief recess at 12:36 p.m.
- The Board reconvened at 1:10 p.m.

**CLOSED SESSION**
MOVED by BRADLEY, SECONDED by ELMITT, to go into CLOSED session pursuant to the following:

- **Closed Session Minutes, August 3, 2018** (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.)
- **Discussion of Enforcement Criteria** (Closed session pursuant to Iowa Code § 21.5(1)(h) to avoid disclosure of specific law enforcement matters, such as allowable tolerances or criteria for the selection, prosecution, or settlement of cases, which if disclosed would facilitate disregard of requirements imposed by law).
- **Compliance with Board Orders** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).
- **Board Appearances** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).
- **Complaints and Investigative Reports** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).
- **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).
- **Settlement Agreement** (Closed session pursuant to Iowa Code § 21.5(1)(f) to discuss the decision to be rendered in a contested case).
  1. In the Matter of James A. Knight, D.D.S – Case No. 17-0104
- **Hygiene Committee Complaints** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).

**Roll Call:**

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<tr>
<th>Member</th>
<th>Bradley</th>
<th>Davidson</th>
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The motion was APPROVED by roll call.

- The Board reconvened in closed session at 1:13 p.m.

MOVED by ELMITT, SECONDED by DAVIDSON, to RETURN to OPEN session. Motion APPROVED unanimously.

- The Board reconvened unanimously in open session at 3:35 p.m.

**OPEN SESSION**

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

Iowa Dental Board Meeting – OPEN SESSION – Subject to final approval
September 28, 2018 (Draft: 10/8/2018)
a. Closed Session Minutes

- MOVED by SLACH, SECONDED by THORSEN, to APPROVE the closed session minutes for the August 3, 2018 quarterly meeting. Motion APPROVED unanimously.

b. Compliance with Board Orders


- MOVED by SLACH, SECONDED by THORSEN, to APPROVE the proposed worksite monitor and ethics course however the Board feels the infection control course should be more comprehensive in the Matter of Sara A. Anderson, D.D.S., file numbers 15-0156, 17-0128. Motion APPROVED unanimously.

c. Disciplinary Orders

- MOVED by MCBRIDE, SECONDED by KELLY, to APPROVE the Combined Statement of Charges, Settlement Agreement and Final Order as proposed in the Matter of Shawn M. Kerby, D.D.S., file number 15-0080. Motion APPROVED unanimously.


- MOVED by MCBRIDE, SECONDED by KELLY, to APPROVE the Combined Statement of Charges, Settlement Agreement and Final Order as proposed in the Matter of Michael J. Lattner, D.D.S., file number 17-0080. Motion APPROVED unanimously.

- MOVED by MCBRIDE, SECONDED by KELLY, to APPROVE the Combined Statement of Charges, Settlement Agreement and Final Order as proposed in the Matter of Kari J. Goodwin, R.D.A, file number 17-0134. Motion APPROVED unanimously.
MOVED by MCBRIDE, SECONDED by KELLY, to APPROVE the Settlement Agreement and Final Order as proposed in the Matter of James A. Knight, D.D.S., file number 17-0104. Motion APPROVED unanimously.

d. Action on Cases

MOVED by SLACH, SECONDED by THORSEN, to CLOSE file number 18-0047. Motion APPROVED unanimously.

MOVED by SLACH, SECONDED by THORSEN, to CLOSE file numbers 18-0034, 18-0052. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to CLOSE file number 17-0127. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to CLOSE file numbers 17-0168, 17-0174. Motion APPROVED unanimously.

MOVED by DAVIDSON, SECONDED by KELLY, to CLOSE file number 17-0177. Motion APPROVED unanimously. Dr. Foley recused herself.

MOVED by DAVIDSON, SECONDED by KELLY, to CLOSE file number 18-0098. Motion APPROVED unanimously. Dr. Foley recused herself.

MOVED by DAVIDSON, SECONDED by KELLY, to CLOSE file number 18-0099. Motion APPROVED unanimously. Dr. Foley recused herself.

MOVED by FOLEY, SECONDED by KELLY, to CLOSE file number 18-0020. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to CLOSE file number 18-0072. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to CLOSE number 18-0052. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to CLOSE file number 18-0097. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to issue a confidential evaluation order file number 18-0134. Motion APPROVED unanimously.

MOVED by FOLEY, SECONDED by KELLY, to KEEP OPEN number 18-0116. Motion APPROVED unanimously.
MOVED by FOLEY, SECONDED by KELLY, to KEEP OPEN file number 18-0135. Motion APPROVED unanimously. Ms. Kelly recused herself.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 14-0148. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 15-0098. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 15-0130. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 15-0177. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 16-0002. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 16-0104. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 17-0169. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 17-0056. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 17-0151. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to KEEP OPEN number 18-0013. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to KEEP OPEN number 18-0014. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 18-0067. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 18-0075. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to KEEP OPEN number 18-0087. Motion APPROVED unanimously.
MOVED by ELMITT, SECONDED by DAVIDSON, to KEEP OPEN number 18-0089. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to KEEP OPEN number 18-0114. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 18-0130. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 18-0131. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 18-0127. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 18-0132. Motion APPROVED unanimously.

MOVED by ELMITT, SECONDED by DAVIDSON, to CLOSE number 18-0140. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by KELLY, to KEEP OPEN number 16-0046. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by DAVIDSON, to CLOSE number 16-0134. Motion APPROVED unanimously. Ms. Kelly recused herself.

MOVED by MCBRIDE, SECONDED by DAVIDSON, to KEEP OPEN number 16-0135. Motion APPROVED unanimously. Ms. Kelly recused herself.

MOVED by MCBRIDE, SECONDED by KELLY, to KEEP OPEN number 17-0015. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by KELLY, to CLOSE number 17-0111. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by KELLY, to CLOSE number 17-0146. Motion APPROVED unanimously.

MOVED by MCBRIDE, SECONDED by KELLY, to KEEP OPEN number 18-0076. Motion APPROVED unanimously.

e. Hygiene Committee Complaints

MOVED by KELLY, SECONDED by SLACH, to CLOSE number 17-0100. Motion APPROVED unanimously.
ADJOURN

❖ MOVED by KELLY, SECONDED by SLACH, to ADJOURN the meeting. Motion APPROVED unanimously.

The Board adjourned its meeting at 3:41 p.m. on September 28, 2018.

NEXT MEETING OF THE BOARD

The next quarterly meeting of the Board is scheduled for November 16, 2018, in Des Moines, Iowa.

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

MINUTES
October 12, 2018
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members

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<tr>
<th>Member</th>
<th>October 12, 2018</th>
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<tr>
<td>Steven Bradley, D.D.S.</td>
<td>Present</td>
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<td>Michael Davidson, D.D.S.</td>
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<td>Thomas Jeneary, D.D.S.</td>
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<td>Monica Foley, D.D.S.</td>
<td>Present</td>
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<td>William McBride, D.D.S.</td>
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<td>Mary Kelly, R.D.H.</td>
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<td>Nancy Slach, R.D.H.</td>
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<td>Bruce Thorsen, Public Member</td>
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<td>Lori Elmitt, Public Member</td>
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Staff Member(s)
Jill Stuecker

Attorney General’s Office
Laura Steffensmeier, Assistant Attorney General

I. CALL TO ORDER FOR OCTOBER 12, 2018

Dr. Bradley called the meeting of the Iowa Dental Board to order at 7:00 a.m., on Friday, October 12, 2018.

Roll Call:

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<tr>
<th>Member</th>
<th>Bradley</th>
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A quorum was established with eight (8) members present.

CLOSED SESSION:

❖ MOVED by BRADLEY, SECONDED by KELLY, to go into CLOSED session pursuant to the following:
a. **Notice of Hearing and Statement of Charges** (Closed session pursuant to Iowa Code Section 21.5(1)(d) discuss whether to initiate licensee disciplinary investigations or proceedings).

Roll Call:

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<th>Member</th>
<th>Bradley</th>
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The motion was APPROVED by roll call.

- The Board reconvened in closed session.
- MOVED by JENEARY, SECONDED by KELLY, to RETURN to OPEN session. Motion APPROVED unanimously.
- The Board reconvened in open session.

**OPEN SESSION**

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

1. **Disciplinary Orders**


**ADJOURN**

- MOVED by THORSEN, SECONDED by KELLY, to ADJOURN the meeting. Motion APPROVED unanimously.

The Board adjourned its meeting at 7:18 a.m. on October 12, 2018.

**NEXT MEETING OF THE BOARD**

The next quarterly meeting of the Board is scheduled for November 16, 2018, in Des Moines, Iowa.

These minutes are respectfully submitted by Jill Stuecker, Executive Director, Iowa Dental Board.
COMMITTEE ACTIONS TAKEN ON APPLICATIONS
The committee voted to take action on the applications as indicated below:

APPLICATION(S) FOR GENERAL ANESTHESIA PERMIT:

➤ No applications received.

APPLICATION(S) FOR MODERATE SEDATION PERMITS:

• Megumi Williamson, D.D.S. – Approved.
• Zachary Stecklein, D.D.S. – Approved pending successful facility inspection.

OTHER BUSINESS:

• For Review and Recommendations —IAC 650—Ch. 29, “Sedation and Nitrous Oxide Inhalation Analgesia”
  ○ Regarding the ‘delegation’ of sedation, the committee was evenly split (3-3) between the following options:
    ▪ Require an active moderate sedation permit to request/allow an anesthesia provider to administer moderate sedation, deep sedation or general anesthesia in a dental office/facility.
    ▪ Permit holders may request/allow an anesthesia provider to administer the sedation level that the sedation permit allows. (A moderate sedation permit holder could only delegate moderate sedation; a general anesthesia permit holder could delegate moderate sedation, deep sedation or general anesthesia.)
  ○ The anesthesia provider would make the final decision about the suitability of a candidate for sedation.
  ○ Require both the dentist and the anesthesia provider to provide post-operative instructions.
    ▪ The dentist would provide post-operative instructions for the dental work completed; and
    ▪ The anesthesia provider would provide post-operative instructions for the sedation. Anesthesia provider should be available post-operatively in the event of sedation-related complications.
  ○ Recommended that offices where sedation is performed periodically train on their emergency protocols and procedures.
The committee requests that the Board accept the following recommendations:

CONTINUING EDUCATION COURSE REVIEW*

RECOMMENDED APPROVAL AS FOLLOWS:

2. Hu-Friedy Mfg: “OSHA and Infection Control” – Requested 2 hours.
5. ADA: “Improving Opioid Prescribing (Webinar) – Requested 1 hour.
6. Iowa Academy of General Dentistry: “How to Achieve Predictable Excellence in Cosmetic Dentistry” – Requested 8 hours for lecture, or 24 hours for clinical participation.
7. Iowa Academy of General Dentistry: “Incorporating Quality Periodontics into Comprehensive Restorative Dentistry” – Requested 8 hours for lecture, or 24 hours for clinical participation.
8. Iowa Academy of General Dentistry: “Utilize Today’s Dental Lasers in Managing Periodontal/Soft Tissue Conditions in the Dental Practice” – Requested 8 hours for lecture, or 24 hours for clinical participation.
10. Des Moines District Dental Society: “Dealing with Hypoplastic First Molars and Effectively Treating Dental Trauma” – Requested 3 hours. **
11. Des Moines District Dental Society: “Radiology Update” – Requested 3 hours. **

**Staff recommended APPROVAL pursuant to IAC 650—25.5(2)

REQUESTED ADDITIONAL INFORMATION AS FOLLOWS:

1. Southeast Iowa District Dental Society: “Advanced Imaging in Dentistry/Jurisprudence/Infection Control” – Requested 5.5 hours.
3. University District Dental Society: “University District Fall 2018 Meeting” – Requested 5 hours.

CONTINUING EDUCATION SPONSOR APPLICATIONS FOR REVIEW

RECOMMENDED APPROVAL OF SPONSOR RECERTIFICATIONS:

1. Creighton University School of Dentistry
2. Parks & Schmit Orthodontics
3. Eastern Iowa Community College
OTHER RECOMMENDATIONS

- **Dr. Arcuri, Expanded Functions Course Request**: The committee recommended approval of the expanded functions training with a clarification that the expanded functions training rules are being reviewed for update and that when the new rules become effective, Dr. Arcuri would need to maintain compliance with the rules to include modification of training and patient experiences if necessary pursuant to Iowa Administrative Code 650.
<table>
<thead>
<tr>
<th>IAC 650</th>
<th>Chapter Title</th>
<th>Description of Proposed Action, Reason</th>
<th>Legal Basis for Proposed Action</th>
<th>Schedule for Action</th>
<th>Date of NoIA</th>
<th>NOIA ARC #</th>
<th>Public Hearing Date</th>
<th>Date Board Vote</th>
<th>Final Outcome</th>
<th>AF ARC #</th>
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<tr>
<td>1</td>
<td>&quot;Administration&quot;</td>
<td>Update definition of &quot;overpayment&quot; to coincide with definition of &quot;fee&quot; in ch. 15.</td>
<td>147.2, 147.13, 147.30, 147.76, 147.80, 153.13, 153.15, 272C</td>
<td>Adopted</td>
<td>1/26/2018</td>
<td>ARC 3703C</td>
<td>4/24/2018</td>
<td>6/8/2018</td>
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<td>ARC 3963C</td>
<td>9/19/2018</td>
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<td>&quot;Licensure to Practice Dentistry or Dental Hygiene&quot;</td>
<td>Update requirements for application by foreign-trained dentists to match previously-approved rule waivers</td>
<td>147.2, 147.33, 153.13, 153.21, 153.33A</td>
<td>Adopted</td>
<td>1/26/2018</td>
<td>ARC 3705C</td>
<td>4/24/2018</td>
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<td>ADOPTED</td>
<td>ARC 3961C</td>
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<td>&quot;Standards of Practice and Principles of Professional Ethics&quot;</td>
<td>Create teledentistry rules</td>
<td>153.13, 153.15, 153.33, 153.38</td>
<td>Ongoing Discussion</td>
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<td>&quot;Sedation and Nitrous Oxide Inhalation Analgesia&quot;</td>
<td>Review requirements for allowing sedation in dental offices by CRNAs or MDs, and related requirements.</td>
<td>147.76, 153.33</td>
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<td>&quot;Prescribing, Administering and Dispensing Drugs&quot;</td>
<td>Update rules to match requirements of 2018 legislation, DEA and Iowa Board of Pharmacy</td>
<td>153.2</td>
<td>November 2018*</td>
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<td>&quot;General Requirements&quot;</td>
<td>Review and update expanded function rules</td>
<td>153.15</td>
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<td>22</td>
<td>&quot;Dental Assistant Radiography Qualification&quot;</td>
<td>Discussion/update regarding the use of lasers by dental hygienists. Currently, the board references a position statement issued in the past. Due to ongoing questions, the rules ought to be updated to clarify use and requirements.</td>
<td>153.38, 153.39, 147.10, 147.11, 272C.2</td>
<td>January 2019*</td>
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<td>10</td>
<td>&quot;General Requirements&quot;</td>
<td>Review, update expanded functions rules</td>
<td>153.15, 153.33A</td>
<td>November 2018*</td>
<td></td>
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<td>27</td>
<td>&quot;Discontinuation of Practice&quot;</td>
<td>Update to eliminate confusing language</td>
<td>153.33B, 153.34, 147.76</td>
<td>September 2018*</td>
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<td>13</td>
<td>&quot;Special Licenses&quot;</td>
<td>Update requirements for resident/Faculty</td>
<td>153.22, 153.37</td>
<td>November 2018*</td>
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<td>35</td>
<td>&quot;Iowa Practitioner Review Committee&quot;</td>
<td>Update program eligibility</td>
<td>153, 272C</td>
<td>November 2018*</td>
<td></td>
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* Tentative Date Scheduled
Pursuant to the authority of Iowa Code 147.2, 153.15A, 153.21, 153.33B, and 153.39 the Dental Board hereby adopts and filed amendments to Chapter 11, “Licensure to Practice Dentistry or Dental Hygiene,” and Chapter 20, “Dental Assistants.”

The proposed amendments 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.

A public hearing was held on July 13, 2018. No comments were received on these amendments.

The proposed amendments in Chapter 11 and 20 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.

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 an 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.
DENTAL BOARD [650]

Notice of Intended Action


Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 147.76, 153.33, and 272C.3.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code sections 147.10, 147.11, 153.15A, 153.33(8), 153.39 and 272C.2.

Purpose and Summary

The primary purpose of these amendments is to make updates as required by House File 2377. Additional amendments make updates and points of clarification to existing rules.

These amendments rescind Chapter 30 and replace it with a new Chapter 30 pertaining to updated disciplinary standards. The purpose of the proposed amendments is to clarify and reorganize disciplinary standards, add an opioid related disciplinary standard as required by House File 2377, and to reduce duplicative disciplinary standards.

The purpose of the proposed amendments to Chapter 16 is to update requirements for prescribing controlled substances as required by House File 2377, and to update prescribing standards in general.

The amendments to Chapter 25 add a requirement for continuing education on opioids, pursuant House File 2377. An amendment is also made relating to the number of hours permissible to claim for an advanced cardiac life support course.

Fiscal Impact

This rule making has no fiscal impact to the state of Iowa.

Jobs Impact

After analysis and review of this rule making, there is no impact on jobs.

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

Public Comment

Any interested person may submit written comments on this proposed rulemaking. Written comments in response to this rule making must be received by the Board no later than 4:30 p.m. on January 10, 2019. Comments should be directed to:

Steve Garrison, Program Officer
Iowa Dental Board
400 S.W. Eighth Street, Suite D
Des Moines, Iowa 50309
Email: steven.garrison@iowa.gov
Fax: 515-281-7969

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)”b,” an oral presentation regarding this rule may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by the Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee’s meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

ITEM 1. Amend rule 650–16.1 as follows:

CHAPTER 16
PREScribing, ADMINISTERing, AND DISPEnSing DRuGS

[Prior to 5/18/88, Dental Examiners, Board of[320]]


“Authorized delegate” means a licensed or registered healthcare professional such as a
dental hygienist, dental assistant or registered nurse who has obtained PMP login credentials. Dental assistant trainees may not serve as an authorized delegate.

“Controlled substance” means a drug or other substance listed in division II of Iowa Code chapter 124.

“Electronic signature” means a confidential personalized digital key, code, or number used for secure electronic data transmissions which identifies and authenticates the signatory.

“Electronic transmission” means the transmission of information in electronic form or the transmission of the exact visual image of a document by way of electronic equipment. Electronic transmission includes but is not limited to transmission by facsimile machine and transmission by computer link, modem, or other computer communication device.

“Prescription drug” means any of the following: (a) a substance for which federal or state law requires a prescription before it may be legally dispensed to the public; (b) a drug or device that under federal law is required, prior to being dispensed or delivered, to be labeled with either of the following statements: (1) Caution: Federal law prohibits dispensing without a prescription or (2) Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian; or (c) a drug or device that is required by any applicable federal or state law or regulation to be dispensed on prescription only, or is restricted to use by a practitioner only—means a drug, as classified by the United States food and drug administration, that is required to be prescribed or administered to a patient by a practitioner prior to dispensation.

“Prescription Monitoring Program” or “PMP” means the information program for
drug prescribing and dispensing, administered by the Iowa Board of Pharmacy.

“Opioid” means a drug that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

ITEM 2. Amend rule 650--16.2 as follows:

650—16.2(153) Scope of authority and prescribing requirements.

16.2(1) A license to practice dentistry issued by this board permits the licensee to prescribe, administer, or dispense prescription drugs if the use is directly related to the practice of dentistry and is within the scope of the dentist-patient relationship. Registration with the Federal Drug Enforcement Administration and the Iowa board of pharmacy further extends this privilege to controlled substances.

16.2(2) A dental examination must be conducted and a medical history taken before a dentist initially prescribes, administers, or dispenses medication to a patient, except for patients who receive fluoride dispensed under protocols approved by the dental health bureau of the department of public health. The examination must focus on the patient’s dental problems, and the resulting diagnosis must relate to the patient’s specific complaint. The patient’s dental record must contain written evidence of the examination and medical history.

Prescribing by a licensed dentist must be directly related to the practice of dentistry. A dental examination and medical history must be taken before a dentist initially prescribes, administers or dispenses a prescription drug to a patient, except for patients who receive fluoride dispensed under protocols approved by the bureau of oral and health delivery systems of the department of public health. A prescription drug prescribed, administered
or dispensed by a licensed dentist must be for a diagnosed condition and be included in a
dental treatment plan. The patient’s dental record must contain written evidence of the
examination and medical history.

16.2(3) On each occasion when a prescription drug is prescribed, administered, or
dispensed to a patient an entry must be made in the patient’s dental record containing the
following information: the name, quantity, and strength of the prescription drug; the
directions for its use; the date of issuance; and the condition for which the prescription drug
was used.

16.2(4) A patient’s dental record that contains an entry pertaining to the issuance of
medications must be retained in accordance with 650–27.11(153,272C) The prescribing,
administering, and dispensing of prescription drugs shall be done in accordance with all
applicable state and federal laws.

16.2(5) The prescribing, administering, and dispensing of prescription drugs shall be
done in accordance with all applicable state and federal laws. When controlled substances
are purchased, administered, or dispensed, a dentist shall maintain records and
accountability in accordance with 657--Chapter 10.

16.2(6) A dentist shall not self-prescribe or self-administer controlled substances.

16.2(7) Prescribing, administering, or dispensing controlled substances to members of
the licensee’s immediate family is prohibited except for an acute dental condition or on an
emergency basis for a dental condition when the licensee conducts an examination,
establishes a patient record, and maintains proper documentation.

[ARC 8369B, IAB 12/16/09, effective 1/20/10]
ITEM 3. Rescind rule 650—16.3:

650—16.3(153) Purchasing, administering, and dispensing of controlled substances.

16.3(1) When controlled substances are purchased, records must be maintained showing the date of receipt, the name and address of the supplier, the name and quantity of drugs received.

16.3(2) When controlled substances are administered or dispensed, including samples, records that are readily retrievable and separate and apart from the patient records must be maintained showing date of dispensing, name and address of person to whom the drugs were administered or dispensed, and the name, quantity, and strength of drugs administered or dispensed.

16.3(3) All controlled substance records must be retained for a period of two years from the date of the last entry. All records must be readily available for inspection by state or federal agents.

16.3(4) Every two years the dentist is required to perform a complete inventory of all controlled substances in stock.

16.3(5) Security of controlled substances must be maintained by storage in a securely locked, substantially constructed cabinet.

16.3(6) The dentist shall notify the board of pharmacy examiners of the loss or theft of controlled substances within two weeks of the discovery of the loss or theft.

16.3(7) A dentist shall not self-prescribe, self-administer, or self-dispense controlled substances or tramadol.

16.3(8) Prescribing, administering, or dispensing controlled substances or tramadol to members of the licensee’s immediate family is not allowed except for an acute dental
condition or on an emergency basis for a dental condition when the licensee conducts an examination, establishes a patient record, and maintains proper documentation.

[ARC 8369B, IAB 12/16/09, effective 1/20/10]

ITEM 4. Amend and renumber rule 650--16.4 to 16.3 as follows:

650—16.416.3(153) Dispensing—requirements for containers and labeling.

16.3(1) Containers. A prescription drug shall be dispensed in a suitable container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. §§ 1471-1476 which relates to childproof closure, unless otherwise required by the patient. Containers must also meet the requirements of Section 502G of the Federal Food Drug and Cosmetic Act, 21 U.S.C. §301 et seq. which pertains to light resistance and moisture-resistance needs of the drug being dispensed. designed to protect its integrity in accordance with all applicable federal and state laws.

16.3(2) Labeling. A label shall be affixed to the container in which a prescription drug is dispensed bearing the following information:

1. Name, telephone number, and address of the dentist.
2. Name of the patient.
3. Date dispensed.
4. Directions for use.
5. Name, quantity, and strength of medication.
6. If it is Schedule II, III, or IV controlled substance, the federal transfer warning statement must appear on the label as follows: “Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.”
7. Cautionary statements, if any.

16.4(3) Prescription sample drugs dispensed in the original container or package and provided without charge shall be deemed to conform to labeling and packaging requirements.

ITEM 5. Amend and renumber rule 650—16.5 to 16.4 as follows:

650—16.4(153) Identifying information on prescriptions—Prescription requirements.

16.4(1) Prescriptions for Schedule II, III, IV, and V controlled substances must include the name and address of the prescribing dentist and the dentist’s federal DEA number. The name and address of the prescribing dentist may be preprinted. Proper security shall be maintained if prescription forms are preprinted. Prior to January 1, 2020, a prescription drug order may be written or transmitted to a pharmacy orally, by fax or through electronic prescribing in accordance with applicable federal and state laws. A dentist shall take adequate measures to prevent prescription forgery from occurring. Beginning January 1, 2020, all prescription drug orders, including prescriptions for controlled substances, must be electronically prescribed unless otherwise exempted. Beginning January 1, 2020, a dentist who fails to comply with the electronic prescribing mandate may be subject to a non-disciplinary administrative penalty of two hundred fifty dollars per violation, up to a maximum of five thousand dollars per calendar year.

16.4(2) The dentist’s signature on a prescription must be original or an electronic signature, not a copy or stamp, except as the use of electronic signatures may be limited by federal or state law. A dentist may delegate to a licensed dental hygienist or registered
dental assistant the preparation of a prescription for the review, authorization, and manual
or electronic signature of the dentist, but the dentist is responsible for the accuracy,
completeness, and validity of the prescription.

16.4(3) On each occasion when medication is prescribed to a patient, the prescription
issued to the patient shall contain the following information: the name of the patient for
whom the prescription is intended; the name, quantity, and strength of the medication; the
directions for its use; the date of issuance; and the name, address, and signature of the
dentist issuing the prescription. A dentist shall securely maintain the unique authentication
credentials issued to the dentist for utilization of the electronic prescription application and
authentication of the dentist’s electronic signature. Unique authentication credentials
issued to any individual shall not be shared with or disclosed to any other individual.

ITEM 6. Amend and renumber rule 650--16.6 to 16.5 as follows:

16.5 Required use of the PMP Transmission of prescriptions. A prescription
drug order may be transmitted to a pharmacy in written form, orally including telephone
voice communication, or by electronic transmission in accordance with applicable federal
and state laws and rules. A dentist shall take adequate measures to guard against the
diversion of prescription drugs and controlled substances through prescription forgeries.
The dentist may authorize an employee to transmit to the pharmacy a prescription drug
order orally or by electronic transmission provided that the identity of the transmitting
employee is included in the order.

16.5(1) Computer-to-computer transmission of a prescription. Prescription drug orders,
excluding orders for controlled substances, may be communicated directly from a dentist’s computer to a pharmacy’s computer by electronic transmission.

a. Orders shall be sent only to the pharmacy of the patient’s choice with no unauthorized intervening person or other entity controlling, screening, or otherwise manipulating the prescription drug order or having access to it.

b. The electronically transmitted order shall identify the dentist’s telephone number for verbal confirmation, the time and date of transmission, and the pharmacy intended to receive the transmission as well as any other information required by federal or state law or rules.

e. Orders shall be transmitted only by the dentist or the dentist’s employee and shall include the dentist’s electronic signature.

d. The electronic transmission shall be deemed the original prescription drug order provided it meets the requirements of this rule.

Prior to issuing an opioid prescription or dispensing an opioid, a dentist or authorized delegate shall query the PMP. The query shall be performed within 48 hours of a prescription being issued or dispensed and shall be done for each patient, each time an opioid prescription is authorized or dispensed.

16.5(2) Facsimile transmission of a prescription. A dentist may request that a pharmacist dispense noncontrolled and controlled drugs, excluding Schedule II controlled substances, pursuant to a prescription transmitted to the pharmacy by the dentist or the dentist’s employee. A dentist shall maintain the original prescription, if printed, in the patient’s record. A dentist who dispenses a controlled substance is required to report the dispensing to the PMP within one business day in accordance with 657--chapter 37.
ITEM 7. Rescind rule 650--16.7:

650—16.7(153) Emergency prescriptions. If an emergency requires the issuance of a prescription, an appropriate prescription may be telephoned to a pharmacist. An emergency prescription for a Schedule II controlled substance must be covered by a written prescription within 72 hours. A dentist may not order a renewal or a refill of an emergency prescription unless the order is in writing and the dentist has given the patient a dental examination and has taken a medical history.

—16.7(1) For the purpose of authorizing an oral prescription of a controlled substance listed in Schedule II of the uniform controlled substances Act, Iowa Code chapter 124, the term “emergency situation” means those situations in which the prescribing dentist determines:

— a. That immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user;

— b. That no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II of Iowa Code chapter 124;

— c. That it is not reasonably possible for the prescribing dentist to provide a written prescription to be presented to the person dispensing the substance prior to dispensing.

16.7(2) Reserved.

These rules are intended to implement Iowa Code section 153.20.

[Filed 1/23/87, Notice 12/17/86—published 2/11/87, effective 3/18/87]


[Filed emergency 10/23/00—published 11/15/00, effective 10/23/00]
ITEM 8. Amend rule 650--25.1 as follows:

CHAPTER 25
CONTINUING EDUCATION

[Prior to 5/18/88, Dental Examiners, Board of[320]]

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
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.

“Opioid” means a drug that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

“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.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

ITEM 9. Amend rule 650—25.4 as follows:


25.4(1) The following courses are required for all 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. Credit hours awarded for certification in Pediatric Advanced Life Support (PALS) or Advanced Cardiac Life Support (ACLS) may be claimed hour for hour.

25.4(4) Infection control. Beginning September 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 September 1, 2018, licensees and registrants shall complete continuing education in the area of Iowa 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 Iowa jurisprudence. Completion of continuing education in the area of Iowa 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.

25.4(6) The following is required for dentists only.

a. A licensed dentist who has prescribed opioids to a patient during the biennium renewal period shall obtain a minimum of 1 hour of continuing education on opioids, as a condition of license renewal. This training shall include guidelines for prescribing opioids, including recommendations on limitations of dosages and the length of prescriptions, risk factors for abuse, and nonopioid and nonpharmacologic therapy options. This hour may count towards the 30 hours of continuing education required for license renewal. The licensee shall maintain documentation of this hour, which may be subject to audit. If the continuing education did not cover the United States centers for disease control and prevention guideline for prescribing opioids for chronic pain, the licensee shall read the guideline prior to license renewal.
b. A licensed dentist who did not prescribe opioids during the biennium renewal period may attest that they are not subject to this requirement due to the fact that they did not prescribe opioids during the time period.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

ITEM 10. Rescind rule 650--30.4, and replace with new rule 650--30.4 as follows:

**30.4(147,153,272C) Grounds for discipline.** The following shall constitute grounds for the imposition by the board of one or more of the disciplinary sanctions set forth in rule 650--30.2(153) specifically including the imposition of civil penalties not to exceed $10,000. This rule is not subject to waiver pursuant to 650--Chapter 7 or any other provision of law.

**30.4(1)** The board may impose discipline for the following violations related to licensure and registration:

a. Fraud or deceit in procuring or renewing any license, permit, or registration, including any false or misleading statement of a material fact or omission of information required to be disclosed;

b. Engaging in the practice of dentistry, dental hygiene, or dental assisting with a lapsed or inactive license, permit, or registration, or engaging in dental radiography with a lapsed or inactive dental radiography qualification;

c. Engaging in the practice of dentistry, dental hygiene, or dental assisting without a license, permit, or registration, or engaging in dental radiography without a dental radiography qualification;
d. **Employing** or permitting an unlicensed or unregistered person or a person with a lapsed or inactive license, permit, or registration to practice dentistry, dental hygiene, or dental assisting;

e. Encouraging, assisting or enabling the unauthorized practice of dentistry, dental hygiene, or dental assisting in any manner; or

f. Failure to prominently display the names of all persons who are practicing dentistry, dental hygiene, or dental assisting within an office.

30.4(2) The board may impose discipline for the following violations related to ethics:

a. Fraud in representation as to skill or ability, whether by words or conduct or concealment of that which should have been disclosed, including but not limited to violations of 650–Chapter 26;

b. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the licensee’s or registrant’s profession;

c. Practice harmful or detrimental to the public. Proof of actual injury need not be established;

d. Conviction of a felony or misdemeanor crime if the conviction relates to the practice of the profession;

e. Improper sexual contact with, or making suggestive, lewd, lascivious or improper remarks or advances to a patient or a coworker;

f. Actions which are abusive, coercive, intimidating, harassing, untruthful or threatening in the practice of dentistry;

g. Obtaining any fee by fraud or misrepresentation;
h. Giving or receiving cash or cash-equivalents, or giving or receiving any gifts exceeding nominal value, for referral of patients;

i. Failure to transfer patient records to another licensee upon request; or

j. Unprofessional or unethical conduct including, but not limited to, those acts defined by Iowa Code section 153.32 or any violation of 650—Chapter 27.

30.4(3) The board may impose discipline for the following violations related to the ability to practice:

a. Habitual use of drugs or intoxicants rendering the licensee or registrant unfit for practice;

b. Practicing dentistry, dental hygiene, or dental assisting while in a state of advanced physical or mental disability where such disability renders the licensee or registrant incapable of performing professional services or impairs functions of judgment necessary to the practice;

30.4(3) The board may impose discipline for the following violations related to patient care:

a. Willful and gross malpractice;

b. Willful and gross neglect;

c. Failure to maintain a satisfactory standard of competency;

d. Failure to preserve the confidentiality of patient information or accessing any confidential patient information without authorization;

e. Practicing beyond training; or

f. Delegating any acts to any licensee or registrant that are beyond the training or education of the licensee or registrant, or that are otherwise prohibited by rule.
30.4(4) The board may impose discipline for the following violations related to prescribing:

a. Violating the rules governing prescribing, including any violation of 650 Chapter 16;

b. Improperly delegating access to Iowa Prescription Monitoring Program (PMP) to an unauthorized individual;

c. Indiscriminately or promiscuously prescribing, administering, or dispensing any drug.

d. Failure to check the PMP prior to prescribing an opioid; or

e. Prescribing opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent prescribing practitioner engaged in a similar practice.

30.4(5) The board may impose discipline for the following violations related to infection control:

a. Failure to maintain adequate safety and sanitary conditions for a dental office;

or

b. Failure to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as “required” or “recommended” for dentistry by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services and the Iowa Occupational Safety and Health Administration.

30.4(6) The board may impose discipline for the following violations related to reporting, compliance and other state laws:

a. Failure to notify the board of change of address within 60 days;
b. Failure to report disciplinary action taken by a licensing authority of another state, territory or country, or another licensing authority in this state, within 30 days of the final action by the licensing authority. A stay by an appellate court shall not negate this requirement; however, if the disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board when the board is so notified;

c. Having a license or registration revoked, suspended, or otherwise disciplined by a licensing authority in any state, territory, or country;

d. Failure to report any adverse judgment in a professional malpractice action to which the licensee or registrant was a party or any settlement of a claim against the licensee or registrant alleging malpractice;

e. Failure to comply with an order of the board;

f. Violating any provision of Iowa law or rule of the board, or being a party to or assisting in any violation of any provision of Iowa law or rule of the board;

g. Failure to report any restriction of practice imposed by a hospital, clinic or other practicing setting;

h. Failure to report any misdemeanor or felony conviction within 60 days;

i. Failure to comply with an Iowa practitioner review committee (IPRC) initial agreement or contract;

j. Failure to report to the board any acts or omissions made by other licensees or registrants of the board that may constitute a basis for disciplinary action under the rules of statutory provisions governing the practice of dentistry, dental hygiene, or dental assisting in Iowa; or
k. Failure to report adverse occurrences related to sedation, nitrous oxide inhalation analgesia, and antianxiety premedication pursuant to 650 - Chapter 29.

30.4(7) The board may impose discipline for the following violations related to board investigations:

a. Knowingly providing false information to the board or an agent of the board during the course of an inspection or investigation or interfering with an inspection or investigation;

b. Failure to comply with a subpoena issued by the board;

c. Failure to fully and promptly comply with office inspections conducted at the request of the board to determine compliance with sanitation and infection control standards or sedation permit requirements;

d. Failure to cooperate with a board investigation; and

e. Retaliating against, threatening or coercing any person for filing a complaint with the board or cooperating with a board inspection or investigation.

30.4(8) The board may impose discipline for the following violations related to continuing education:

a. Failure to respond to the board during a continuing education audit, or failure to submit verification of continuing education requirements within the time period provided; or

b. Knowingly submitting a false report of continuing education.

c. Failure to meet the required continuing education hours per biennium.
Mandates Relevant to Dentistry, Pursuant to HF2377

Section 4: Mandatory registration to the PMP at the time of registration or renewal
Mandatory use of the PMP prior to prescribing an opioid
Requires prescribers who dispense a controlled substance to submit that information to the PMP
- IDB will write rules implementing this

Section 5: Requires prescribers who dispense to report information to the PMP.

Section 8: Gives the Board of Pharmacy the authority to add a surcharge of not more than 25% ($11.25/year) to the CSAR

Section 10: Mandatory electronic prescribing for all controlled substances beginning January 1, 2020 - with a section on penalties ($250 fine for for every violation for a max of $5,000 per year)

Section 11: Mandatory electronic prescribing for all prescriptions beginning January 1, 2020 - with a section on penalties ($250 fine for for every violation for a max of $5,000 per year)

Section 13: Requires the Board of Pharmacy to issue Prescriber Activity Reports which includes a summary of prescribing history as well as comparison of that data to others in the same profession

Section 17: Requires the Board of Pharmacy to implement proactive notifications to prescribers, indicating if a patient may be at risk of abusing or misusing a controlled substance

Section 21: Requires the Dental Board (along with the boards of medicine and nursing) to adopt rules establishing penalties for practitioners that prescribe opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent prescribing practitioner engaged in the same practice
- IDB will write rules implementing this

Section 22: Mandates the Boards of Medicine/Nursing/Dentistry to require continuing education hours on opioids
- IDB will write rules implementing this

Section 25: Changes the way CSAR's can be disciplined by the Board of Pharmacy (note this does not change anything about the way in which the Dental Board can discipline a licensee)
DENTAL BOARD [650]

Notice of Intended Action


Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 147.76, 153.33, and 272C.3.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code sections 153.15, 153.38, and 153.39.

Purpose and Summary

The primary purpose of these amendments is to update the requirements for expanded functions. The amendments move some procedures into the standard scope of practice for dental assistants and dental hygienists, and also allow additional procedures to be performed by dental assistants and dental assistants as new expanded functions. The amendments also include updated terminology to make the rules clearer.

These amendments would create a new Chapter 23 to place all expanded functions requirements in a single chapter. The intent is to make it easier for dental hygienists and dental assistants to locate the requirements for expanded functions by placing them all in a single chapter. The amendments would remove the expanded functions requirements currently established in Chapter 10 and Chapter 20 and move them into a single chapter.

These amendments establish clearer requirements for training in expanded functions to ensure that a minimum standard of competency is met at the conclusion of all expanded functions training courses. A review of expanded functions training courses to date has shown that there isn’t a clear minimum training standard. These amendments would resolve this concern.

These amendments also create a process whereby expanded functions dental assistants and dental hygienists may obtain a certification from the Dental Board recognizing the ability of that dental assistant or dental hygienist to perform Level 1 and Level 2 expanded functions. The certification process has been requested by dentists who have either delegated these services, and dental hygienists and dental assistants who have performed expanded functions procedures. Certification as an expanded functions dental assistant or dental hygienist would only be required for those who wish to complete training in Level 2 expanded functions. The certification would be optional for those who complete training in all Level 1 functions, and who may not opt to train in Level 2 functions.
These amendments also establish fees related to the certification of expanded function licensees and registrants, for the hard copy of a duplicate certificate or proof of renewal, and for educational services provided by the board.

_Fiscal Impact_

This rule making has no fiscal impact to the state of Iowa.

_Jobs Impact_

After analysis and review of this rule making, there is no impact on jobs.

_Waivers_

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

_Public Comment_

Any interested person may submit written comments on this proposed rulemaking. Written comments in response to this rule making must be received by the Board no later than 4:30 p.m. on January 10, 2019. Comments should be directed to:

Steve Garrison, Program Officer  
Iowa Dental Board  
400 S.W. Eighth Street, Suite D  
Des Moines, Iowa 50309  
Email: steven.garrison@iowa.gov  
Fax: 515-281-7969

_Public Hearing_

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)”b,” an oral presentation regarding this rule may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

_Review by the Administrative Rules Review Committee_

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee’s meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:
ITEM 1. Adopt the following new 650 - Chapter 23:

TITLE III
LICENSING

CHAPTER 23
EXPANDED FUNCTIONS

23.1(153) Definitions. As used in this chapter:

“Accredited school” means a dental, dental hygiene, or dental assisting education program accredited by the Commission on Dental Accreditation (CODA).

“Clinical training” means training which includes patient experiences.

“Didactic training” means educational instruction.

“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.

“Fabrication” means the construction or creation of an impression, occlusal registration or provisional restoration, as defined in this chapter.

“General supervision of a dental assistant” 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, use of a curing light and intraoral camera. The dentist need not be present in the facility while these services are being provided.

“General supervision of a dental hygienist” means that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided. If a dentist will not be present, the following requirements shall be met:
1. Patients or their legal guardians must be informed prior to the appointment that no dentist will be present and therefore no examination will be conducted at that appointment.

2. The hygienist must consent to the arrangement.

3. Basic emergency procedures must be established and in place and the hygienist must be capable of implementing these procedures.

4. The treatment to be provided must be prior prescribed by a licensed dentist and must be entered in writing in the patient record.

“Intermediate Restorative Material” means any restorative material intended to remain in place for up to one year.

“Lab training” means training that is hands-on, which may include simulation, and prepares a dental hygienist or dental assistant for patient experiences. Lab training can be done as part of an approved course, or obtained through a supervising dentist.

“Observational supervision” for expanded functions means the dentist is physically present in the treatment room to oversee and direct all services being provided as part of clinical training.

“Patient experiences” are procedures that are performed on a patient, during the course of training, under the observational supervision of a dentist.

“Prosthetic” means any provisional or permanent restoration intended to replace a tooth or teeth.

“Provisional Restoration” for the purposes of these rules means a crown or bridge placed with the intention of being replaced by a permanent crown or bridge at a later date.

23.2(153) Expanded Function Requirements and Eligibility
23.2(1) A dental hygienist or dental assistant may only perform expanded function procedures upon successful completion of Board approved training and certification by the Board. All functions must be delegated by and performed under the direct supervision of a dentist licensed pursuant to Iowa Code chapter 153 with two exceptions; the taking of occlusal registrations by a dental hygienist for purposes other than mounting study casts (Level 1) and the recementation of provisional restorations (Level 2). These exceptions may be performed under general supervision. Dental assistant trainees are not eligible to perform or receive training in expanded function procedures.

23.2(2) A dental hygienist or dental assistant shall not perform any expanded function procedures listed in this chapter unless the education and training requirements have been met and certification has been issued. This shall not preclude practicing expanded functions for training purposes while enrolled in a board-approved course of training.

23.2(3) To be eligible to train in Level 1 expanded functions, a dental hygienist or dental assistant must comply with one of the following:

a. Hold an active dental hygiene license in Iowa; or

b. Hold an active dental assistant registration, and comply with at least one of the following:

1. Be a graduate of an accredited school; or
2. Be currently certified by the Dental Assisting National Board (DANB); or
3. Have at least one year of clinical practice as a registered dental assistant; or
4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration.
23.2(4) A dentist who delegates Level 1 or Level 2 expanded functions under direct supervision to a dental hygienist or dental assistant must examine the patient to review the quality of work prior to the conclusion of the dental appointment. The following are exempt from this requirement and may be performed under general supervision:

a. Recementation of a provisional crown by Level 1 dental hygienists and dental assistants.

b. Recementation of a bridge restoration by Level 1 dental hygienists and dental assistants.

c. Taking occlusal registrations for purposes other than mounting study casts by Level 1 dental hygienists only.

23.3(153) Expanded Function Categories.

1. Basic Level 1. Dental hygienists or dental assistants who train in some, but not all, Level 1 expanded functions are deemed to be basic expanded function dental hygienists or dental assistants. A dentist may only delegate to a dental hygienist or dental assistant those Level 1 procedures for which training has been successfully completed.

2. Certified Level 1. Expanded function dental hygienists or dental assistants who have successfully completed training for all Level 1 expanded function procedures, are deemed to be Certified Level 1 dental hygienists or dental assistants.

3. Certified Level 2. Expanded function dental hygienists or dental assistants must have a minimum of one year of clinical practice as a certified Level 1 dental hygienist or dental assistant following issuance of Level 1 Certification by the board, and successfully pass a board-approved entrance examination with a score of at least 75 percent before beginning
training to become certified in Level 2. A dental hygienist or dental assistant must successfully complete training for all Level 2 expanded function procedures before becoming certified in Level 2.

a. A dentist may delegate any Level 1 or Level 2 expanded function procedures to a dental hygienist or dental assistant who is certified in Level 2.

23.4(153) Level 1 Expanded Function Procedures for Dental Assistants. Level 1 procedures for dental assistants include:

1. Taking occlusal registrations for the fabrication of dental appliances except for complete denture fabrication:

2. Placement and removal of gingival retraction cord;

3. Fabrication, temporary cementation, temporary recementation, and removal of provisional crowns or bridges placed with the intention of being replaced by a permanent crown or bridge at a later date;

4. Applying cavity liners and bases; desensitizing agents; and bonding systems, to include the placement of orthodontic brackets, following the determination of location by the supervising dentist;

5. Monitoring of patients receiving nitrous oxide inhalation analgesia, which may include increasing oxygen levels as needed, pursuant to the following:

a. A licensed dentist shall induce a patient and establish the maintenance level.

b. A dental assistant may make adjustments, which decrease the nitrous oxide concentration during the administration of nitrous oxide.
c. A dental assistant may turn off the oxygen delivery at the completion of the dental procedure.

6. Taking final impressions, except for complete upper and lower dentures;

7. Removal of any adhesives (non-motorized hand instrumentation only); and

8. Placement of class 1 intermediate restorative material, including lingual endodontic access, following preparation of a tooth by a dentist.

9. Recementation of provisional restorations. The recementation of a provisional crown or bridge restoration is the only Level 1 function, which shall be allowed under general supervision.

23.5(153) Level 1 Expanded Function Procedures for Dental Hygienists. Level 1 procedures for hygienists include:

1. Taking occlusal registrations for the fabrication of dental appliances except for complete denture fabrication, and for purposes other than mounting study casts;

2. Placement and removal of gingival retraction cord;

3. Fabrication, temporary cementation, temporary recementation, and removal of provisional crowns or bridges placed with the intention of being replaced by a permanent crown or bridge at a later date;

4. Applying cavity liners and bases; and bonding systems for restorative purposes, including the placement of orthodontic brackets, following the determination of location by the supervising dentist; and

5. Taking final impressions except for complete upper and lower dentures.

6. Placement of class 1 intermediate restorative material, including lingual endodontic access, following preparation of a tooth by a dentist.
7. Recementation of provisional restorations. The recementation of a provisional crown or bridge restoration is the only Level 1 function, which shall be allowed under general supervision.

23.6(153) Level 2 Expanded Function Procedures for Dental Hygienists and Dental Assistants.

23.6(1) Level 2 procedures for dental hygienists and dental assistants include:

a. Placement and shaping of amalgam following preparation of a tooth by a dentist;

b. Placement and shaping of adhesive restorative materials following preparation of a tooth by a dentist;

c. Polishing of adhesive restorative material using a slow-speed handpiece.

d. Fitting of stainless steel crowns on primary posterior teeth, and cementation after fit verification by the dentist;

e. Making final impressions and occlusal registrations for the fabrication of dentures and partial dentures;

f. Tissue conditioning (soft reline only);

g. Extraoral adjustment to acrylic dentures without making any adjustments to the prosthetic teeth; and

h. Placement of intracoronar temporary fillings following preparation of a tooth by a dentist.

23.6(2) These Level 2 expanded functions procedures refer to both primary and permanent teeth except as otherwise noted.

23.7(153) Expanded Function Training.
23.7(1) **Level 1 expanded function training.** Expanded function training for Level 1 procedures must be board approved. Clinical training in expanded functions must be completed under observational supervision. Training must consist of the following:

a. An initial assessment to determine the base entry level of all participants in the program;

b. Completion of a training program that meets the following minimum standards for each function:

   (1) **Taking occlusal registrations for the fabrication of dental appliances except for removable prosthetics:**

   **Goal:** To reproduce the patient’s jaw relationship accurately.

   **Standard:** Demonstrate an accurate occlusal registration confirmed by a supervising dentist.

   **Minimum Training Requirement:** 1 hour of didactic training and clinical training, which includes a minimum 5 patient experiences under observational supervision.

   (2) **Placement and removal of gingival retraction:**

   **Goal:** To expose the margins of a crown by displacing tissue from the tooth.

   **Standard:** Perform the procedural steps to place and remove retraction material and recognize oral conditions and techniques that may compromise tissue displacement or patient health.

   **Minimum Training Requirement:** 2 hours of didactic training and the equivalent of 1 hour of lab training, which includes a minimum
of 3 experiences and clinical training, which includes a minimum of 5 patient experiences under observational supervision.

(3) Fabrication, temporary cementation and removal of provisional crown and bridge restorations;

Goal: To replicate the anatomy and function of the natural tooth, prior to the final restoration.

Standard: Use various methods to fabricate and temporarily cement single-unit and multi-unit provisional restorations.

Minimum Training Requirement: 4 hours of didactic training and the equivalent of 4 hours of lab training, which includes a minimum of 5 experiences and clinical training, which includes a minimum of 10 patient experiences under observational supervision.

(4) Applying cavity liners and bases; desensitizing agents; and bonding systems, including the placement of orthodontic brackets following the determination of location by the supervising dentist;

Goal: To apply appropriate material, which protects existing tooth structure and adhere existing tooth structure to restorative materials.

Standard: Manipulate and apply appropriate material to clinical competency.

Minimum Training Requirement: 2 hours of didactic training and the equivalent of 1 hours of lab training, which includes a minimum of 2 experiences and clinical training, which includes a minimum of
5 patient experiences in each one of these areas (for a total of 15 patient experiences under observational supervision).

(5) Monitoring of nitrous oxide inhalation analgesia:

Goal: Understand the equipment, recognize the signs of patient distress or adverse reaction, and know when to call for help.

Standard: Exercise the ability to maintain patient safety while nitrous oxide is used.

Minimum Training Requirement: 2 hours of didactic training, 1 hour of lab training in the office where the dental hygienist or dental assistant is employed, and 5 patient experiences under observational supervision.

(6) Taking final impressions for the fabrication of fixed crown and bridge restorations:

Goal: Reproduce soft and hard oral issues, digitally or with impression materials.

Standard: Complete the procedural steps to obtain a clinically acceptable final impression.

Minimum Training Requirement: 3 hours of didactic training and the equivalent clinical training, which includes a minimum of 6 patient experiences under observational supervision.

(7) Removal of adhesives and restorative materials (non-motorized hand instrumentation only):
Goal: Remove excess adhesives and bonding materials to eliminate soft tissue irritation.

Standard: Identify how, when and where to remove excessive bonding or adhesive material.

Minimum Training Requirement: 1 hour of didactic training and clinical training, which includes a minimum of 5 patient experiences under observational supervision.

(8) Placement of class 1 intermediate restorative material:

Goal: Place class 1 restorative material following preparation of a tooth by a dentist.

Standard: Identify how, when and where to place class 1 intermediate restorative material;

Minimum Training Requirement: 1 hour of didactic training and clinical training, which includes a minimum of 5 patient experiences under observational supervision.

(9) Recementation of provisional restorations:

Goal: To secure the provisional restoration to a previously prepared tooth after it has become loose or dislodged.

Standard: Use various methods to fabricate and temporarily cement single-unit and multi-unit provisional restorations.

Minimum Training Requirement: If this training is completed in conjunction with training in fabrication, temporary cementation and removal of provisional crown and bridge restorations, the training...
requirements may be combined since the procedures are related. If it is being completed separately the same training requirements for fabrication, temporary cementation and removal of provisional restorations applies.

c. A postcourse written examination at the conclusion of the training program, with a minimum of 10 questions per function, must be administered. Participants must obtain a score of 75% or higher on each examination administered.

23.7(2) Level 2 Expanded function training. Expanded function training for Level 2 procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or another program accredited by the Commission on Dental Accreditation of the American Dental Association.

23.8(153) Expanded Function Certification - Level 1.

23.8(1) Dental hygienists and dental assistants who successfully complete board-approved training in all Level 1 functions, may apply for certification with the board. Dental hygienists and dental assistants who intend to train in Level 2 expanded functions must become certified.

23.8(2) Applications for Level 1 certification must be filed on official board forms and include the following:

a. The fee as specified in 650 - Chapter 15;

b. Evidence of successful completion of all Level 1 training through a board-approved training course; and

c. Evidence of successful completion of postcourse written examination for all Level 1 expanded functions.
23.8(2) Expanded function certification, when issued by the board, must be prominently displayed with the registration or license in each dental facility where expanded function services are provided.

23.9(153) Expanded Function Certification - Level 2.

23.9(1) Dental hygienists and dental assistants who successfully complete a board approved Level 2 training course must be certified by the board prior to performing these functions.

23.9(2) Applications for Level 2 certification must be filed on official board forms and include the following:

a. The fee as specified in 650 - Chapter 15;

b. Evidence of Level 1 certification;

c. Evidence of successful completion of Level 2 training through a board-approved training course; and

d. Evidence of successful completion of a postcourse written examination.

23.9(2) Expanded function Level 2 certification must be prominently displayed with the registration or license in each dental facility where expanded function services are provided.

ITEM 2. Amend subrule 650--10.3(1) as follows:

TITLE III
LICENSEING
CHAPTER 10
GENERAL REQUIREMENTS
[Prior to 5/18/88, Dental Examiners, Board of[320]]

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 as amended by 2017 Iowa Acts, Senate File 479, means the performance of the following educational, therapeutic, preventive and diagnostic dental hygiene services. Such services, except educational services, shall be delegated by and performed under the supervision of a dentist licensed pursuant to Iowa Code chapter 153.

a. Educational. Assessing the need for, planning, implementing, and evaluating oral health education programs for individual patients and community groups; conducting workshops and in-service training sessions on dental health for nurses, school personnel, institutional staff, community groups and other agencies providing consultation and technical assistance for promotional, preventive and educational services.

b. Therapeutic. Identifying and evaluating factors which indicate the need for and performing (1) oral prophylaxis, which includes supragingival and subgingival debridement of plaque, and detection and removal of calculus with instruments or any other devices; (2) periodontal scaling and root planing; (3) removing and polishing hardened excess restorative material; (4) administering local anesthesia with the proper permit; (5) administering nitrous oxide inhalation analgesia in accordance with 650—subrules 29.6(4) and 29.6(5); (6) applying or administering medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries; (7) removal of adhesives.

c. Preventive. Applying pit and fissure sealants and other medications or methods for caries and periodontal disease control; organizing and administering fluoride rinse or sealant programs.
d. Diagnostic. Reviewing medical and dental health histories; performing oral inspection; indexing dental and periodontal disease; preliminary charting of existing dental restorations and teeth; making occlusal registrations for mounting study casts; testing pulp vitality; testing glucose levels, analyzing dietary surveys.

e. The following services may only be delegated by a dentist to a dental hygienist: administration of local anesthesia, placement of sealants, and the removal of any plaque, stain, calculus, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish.

f. Expanded function procedures in accordance with 650--Chapter 23.

g. Perform phlebotomy.

ITEM 3. Rescind subrules 650--10.3(8) and 10.3(9) as follows:

10.3(8) Expanded functions requirements.
   a. Supervision requirements. A dental hygienist may only perform expanded function procedures which are delegated by and performed under the supervision of a dentist licensed pursuant to Iowa Code chapter 153. The taking of occlusal registrations for purposes other than mounting study casts may be performed under general supervision; all other expanded function procedures shall be performed under direct supervision.

       b. Expanded function training required. A dental hygienist shall not perform any expanded function procedures listed in this chapter unless the dental hygienist has successfully met the education and training requirements and is in compliance with the requirements of this chapter.

       c. Education and training requirements. All expanded function training must be prior-approved by the board. The supervising dentist and the dental hygienist shall be responsible for maintaining in each office of practice documentation of successful completion of the board-approved training.

       (1) Expanded function training for Level 1 procedures shall be eligible for board approval if the training is offered through a program accredited by the Commission on Dental Accreditation of the American Dental Association (ADA) or another program, which may include on-the-job training offered by a dentist licensed in Iowa. Training must consist of the following:

           1. An initial assessment to determine the base entry level of all participants in the program;
           2. A didactic component;
           3. A laboratory component, if necessary;
4. A clinical component, which may be obtained under the personal supervision of the participant's supervising dentist while the participant is concurrently enrolled in the training program; and
5. A postcourse competency assessment at the conclusion of the training program.

(2) Expanded function training for Level 2 procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or a program accredited by the Commission on Dental Accreditation of the American Dental Association.

10.3(9) Expanded function practitioners.

a. Basic expanded function practitioner. Dental hygienists who do not wish to become certified as a Level 1 or Level 2 practitioner may perform select Level 1 expanded function procedures provided they have met the education and training requirements for those procedures and are in compliance with the requirements of this chapter. A dentist may delegate to a dental hygienist only those Level 1 procedures for which the dental hygienist has received the required expanded function training.

b. Certified Level 1 practitioner. A dental hygienist must successfully complete training for all Level 1 expanded function procedures before becoming a certified Level 1 practitioner.

(1) A dentist may delegate any of the Level 1 expanded function procedures to a dental hygienist who is a certified Level 1 practitioner.

(2) Level 1 procedures include:

1. Taking occlusal registrations for purposes other than mounting study casts;
2. Placement and removal of gingival retraction;
3. Fabrication and removal of provisional restorations;
4. Applying cavity liners and bases and bonding systems for restorative purposes; and
5. Taking final impressions.

c. Certified Level 2 practitioner. A dental hygienist must become a certified Level 1 practitioner and successfully pass a board-approved entrance examination with a score of at least 75 percent before beginning training to become a certified Level 2 practitioner. A dental hygienist must successfully complete training for all Level 2 expanded function procedures before becoming a certified Level 2 practitioner.

(1) A dentist may delegate any of the Level 1 or Level 2 expanded function procedures to a dental hygienist who is a certified Level 2 practitioner.

(2) Level 2 procedures include:

1. Placement and shaping of amalgam following preparation of a tooth by a dentist;
2. Placement and shaping of composite following preparation of a tooth by a dentist;
3. Forming and placement of stainless steel crowns;
4. Taking records for the fabrication of dentures and partial dentures; and
5. Tissue conditioning (soft reline only).

These procedures refer to both primary and permanent teeth.

This rule is intended to implement Iowa Code section 153.15.

[ARC 2141C, IAB 9/16/15, effective 10/21/15; ARC 3487C, IAB 12/6/17, effective 1/10/18]
ITEM 4. Amend rule 650--20.4 as follows:

TITLE IV
AUXILIARY PERSONNEL
CHAPTER 20
DENTAL ASSISTANTS
[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—20.4(153) Scope of practice.

20.4(1) In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel as authorized in these rules.

20.4(2) A licensed dentist may delegate to a dental assistant those procedures for which the dental assistant has received training. This delegation shall be based on the best interests of the patient. Such services shall be delegated by and performed under the supervision of a dentist licensed and may include:

a. Placement and removal of dry socket medication;

b. Placement of periodontal dressings;

c. Testing pulp vitality;

d. Preliminary charting of existing dental restorations and teeth;

e. Performing phlebotomy;

f. Glucose testing; and

g. Expanded functions in accordance with 650--Chapter 23.

20.4(3) The dentist shall exercise supervision and shall be fully responsible for all acts performed by a dental assistant. A dentist may not delegate to a dental assistant any of the following, unless allowed pursuant to 650 -- Chapter 23:
a. Diagnosis, examination, treatment planning, or prescription, including prescription for drugs and medicaments or authorization for restorative, prosthodontic or orthodontic appliances.

b. Surgical procedures on hard and soft tissues within the oral cavity and any other intraoral procedure that contributes to or results in an irreversible alteration to the oral anatomy.

c. Administration of local anesthesia.

d. Placement of sealants.

e. Removal of any plaque, stain, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish, or removal of any calculus.

f. Dental radiography, unless the assistant is qualified pursuant to 650—Chapter 22.

g. Those procedures that require the professional judgment and skill of a dentist.

20.4(3) 20.4(4) A dental assistant may perform duties consistent with these rules under the supervision of a licensed dentist. The specific duties dental assistants may perform are based upon:

a. The education of the dental assistant.

b. The experience of the dental assistant.

[ARC 2028C, IAB 6/10/15, effective 7/15/15; ARC 3489C, IAB 12/6/17, effective 1/10/18]

ITEM 5. Rescind rule 650—20.5 as follows:

650—20.5(153) Expanded function requirements.

20.5(1) Supervision requirements. Registered dental assistants may only perform expanded function procedures which are delegated by and performed under the direct supervision of a dentist licensed pursuant to Iowa Code chapter 153. Dental assistant trainees are not eligible to perform expanded function procedures.

20.5(2) Expanded function training required. A registered dental assistant shall not perform any expanded function procedures listed in this chapter unless the assistant has successfully met the education and training requirements and is in compliance with the requirements of this chapter.

20.5(3) Education and training requirements. All expanded function training must be prior approved by the board. The supervising dentist and the registered dental assistant shall be
responsible for maintaining in each office of practice documentation of successful completion of the board-approved training.

a. Expanded function training for Level 1 procedures shall be eligible for board approval if the training is offered through a program accredited by the Commission on Dental Accreditation of the American Dental Association (ADA) or another program, which may include on-the-job training offered by a dentist licensed in Iowa. Training must consist of the following:

   (1) An initial assessment to determine the base entry level of all participants in the program. At a minimum, all participants must meet at least one of the following requirements before beginning expanded function training:

   1. Be a graduate of an ADA-accredited dental assistant program; or
   2. Be currently certified by the Dental Assisting National Board (DANB); or
   3. Have at least one year of clinical practice as a registered dental assistant; or
   4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration;

   (2) A didactic component;

   (3) A laboratory component, if necessary;

   (4) A clinical component, which may be obtained under the personal supervision of the participant’s supervising dentist while the participant is concurrently enrolled in the training program; and

   (5) A postcourse competency assessment at the conclusion of the training program.

b. Expanded function training for Level 2 procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or a program accredited by the Commission on Dental Accreditation of the American Dental Association.

20.5(4) Expanded function practitioners.

a. Basic expanded function practitioner. Registered dental assistants who do not wish to become certified as a Level 1 or Level 2 practitioner may perform select Level 1 expanded function procedures provided they have met the education and training requirements for those procedures. A dentist may delegate to a registered dental assistant only those Level 1 procedures for which the assistant has received the required expanded function training.

b. Certified Level 1 practitioner. Registered dental assistants must successfully complete training for all Level 1 expanded function procedures before becoming a certified Level 1 practitioner.

   (1) A dentist may delegate any of the Level 1 expanded function procedures to dental assistants who are certified Level 1 practitioners.

   (2) Level 1 procedures include:

   1. Taking occlusal registrations;
   2. Placement and removal of gingival retraction;
   3. Fabrication and removal of provisional restorations;
   4. Applying cavity liners and bases, desensitizing agents, and bonding systems;
   5. Placement and removal of dry socket medication;
   6. Placement of periodontal dressings;
7. Testing pulp vitality;
8. Monitoring of nitrous oxide inhalation analgesia;
9. Taking final impressions;
10. Removal of adhesives (hand instrumentation only); and
11. Preliminary charting of existing dental restorations and teeth.

e. Certified Level 2 practitioner. A registered dental assistant must become a certified Level 1 practitioner and successfully pass a board-approved entrance examination with a score of at least 75 percent before beginning training as a certified Level 2 practitioner. Registered dental assistants must successfully complete training for all Level 2 expanded function procedures before becoming certified Level 2 practitioners.

(1) A dentist may delegate any of the Level 1 or Level 2 expanded function procedures to a registered dental assistant who is a certified Level 2 practitioner.

(2) Level 2 procedures include:
1. Placement and shaping of amalgam following preparation of a tooth by a dentist;
2. Placement and shaping of composite following preparation of a tooth by a dentist;
3. Forming and placement of stainless steel crowns;
4. Taking records for the fabrication of dentures and partial dentures; and
5. Tissue conditioning (soft reline only).

These procedures refer to both primary and permanent teeth.

(3) Notwithstanding 650—paragraph 10.3(1)“e” and paragraph 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 6. Renumber rules 20.6 and 20.7 as 20.5 and 20.6.

ITEM 7. Recind subrule 650--20.7(5) as follows:

20.7(5) Review of applications. The board shall follow the procedures specified in 650—11.8(147,153) in reviewing applications for registration and qualification.

ITEM 8. Insert NEW rule 650--20.7 as follows:

20.8 Review of applications. The board shall follow the procedures specified in 650—11.8(147,153) in reviewing applications for registration and qualification.

ITEM 9. Amend rule 650--15.4 as follows:

CHAPTER 15
FEES
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. *Application fee.* The application fee for a license to practice dentistry is $200.

   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 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 15.8(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. *Application fee.* The application fee for a license to practice dental hygiene is $100.

   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 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 15.8(4).

15.4(3) *Resident dental license.* The application fee for a resident dental license is $120.

15.4(4) *Faculty permit.* The application fee for a faculty permit is $200.

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. *Application fee.* The application fee for a license to practice dentistry issued on the basis of credentials is $550.

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 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 15.8(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. *Application fee.* The application fee for a license to practice dental hygiene issued on the basis of credentials is $200.

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 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 15.8(4).

15.4(7) Reactivation of an inactive license or registration. The fee for a reactivation application for inactive practitioners is $50.

15.4(8) Reinstatement of an inactive license or registration. The fee for a reinstatement application for a lapsed license or registration is $150.

15.4(9) General anesthesia permit application. The application fee for a general anesthesia permit is $500.

15.4(10) Moderate sedation permit application. The application fee for a moderate sedation permit is $500.

15.4(11) Local anesthesia permit—initial application and reinstatement. The application or reinstatement fee for a permit to authorize a dental hygienist to administer local anesthesia is $70.

15.4(12) Dental assistant trainee application. The fee for an application for registration as a dental assistant trainee is $25.

15.4(13) Dental assistant registration only application.

a. Application fee. The application fee for dental assistant registration is $40.

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 rule 650—15.5(153).

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

   a. Application fee. The application fee for a combined application for both registration as a registered dental assistant and radiography qualification is $60.

   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 rule 650—15.5(153).

15.4(15) Dental assistant radiography qualification application fee. The fee for an application for dental assistant radiography qualification is $40.

15.4(16) Level 1 Expanded Function Certification. The fee for application to be certified as a Level 1 expanded function dental hygienist or dental assistant is $100.

15.4(17) Level 2 Expanded Function Certification. The fee for application to be certified as a Level 2 expanded function dental hygienist or dental assistant is $150.

15.4(18) Temporary permit—urgent need or educational services. The fee for an application for a temporary permit to serve an urgent need or provide educational services is $100 if an application is submitted online or $150 if submitted via paper application.

ITEM 10. Amend rule 650--15.8 as follows:

650—15.8(153) Miscellaneous fees. Payments 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 release of the requested document.

15.8(1) Duplicates. The fee for issuance of a hard copy duplicate license, permit or registration certificate or current renewal is $25.

15.8(2) Certification or verification. The fee for a written certification or written verification of an Iowa license, permit or registration is $25.

15.8(3) Trainee manual. The fee for the dental assistant trainee manual is $70.

15.8(4) Fingerprint packet and criminal history background check. The fee for evaluation of a fingerprint packet and the criminal history background checks is $46.

15.8(5) Remedial education. The cost for remedial education provided by the board for the purposes of licensing or registration is $50.

15.8(5) IPRC monitoring. The fee for monitoring for compliance with an IPRC agreement is $100 per quarter, unless otherwise stated in the Iowa practitioner program contract entered into pursuant to 650—Chapter 35.

15.8(6) Monitoring for compliance with settlement agreements. The fee for monitoring a licensee’s, registrant’s or permit holder’s compliance with a settlement agreement entered into pursuant to 650—subrule 51.19(9) is $300 per quarter, unless otherwise stated in the settlement agreement.

15.8(7) Disciplinary hearings—fees and costs.
a. Definitions. As used in this subrule in relation to fees related to a formal disciplinary action filed by the board against a licensee, registrant or permit holder:

“Deposition” means the testimony of a person pursuant to subpoena or at the request of the state of Iowa taken in a setting other than a hearing.

“Expenses” means costs incurred by persons appearing pursuant to subpoena or at the request of the state of Iowa for purposes of providing testimony on the part of the state of Iowa in a hearing or other official proceeding and shall include mileage reimbursement at the rate specified in Iowa Code section 70A.9 or, if commercial air or ground transportation is used, the actual cost of transportation to and from the proceeding. Also included are actual costs incurred for meals and necessary lodging.

“Medical examination fees” means actual costs incurred by the board in a physical, mental, chemical abuse, or other impairment-related examination or evaluation of a licensee when the examination or evaluation is conducted pursuant to an order of the board.

“Transcript” means a printed verbatim reproduction of everything said on the record during a hearing or other official proceeding.

“Witness fees” means compensation paid by the board to persons appearing pursuant to subpoena or at the request of the state of Iowa for purposes of providing testimony on the part of the state of Iowa. For the purposes of this rule, compensation shall be the same as outlined in Iowa Code section 622.69 or 622.72 as the case may be.

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) 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.

15.8(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.

15.8(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.

15.8(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.

15.8(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.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3490C, IAB 12/6/17, effective 1/10/18; ARC 3488C, IAB 12/6/17, effective 1/10/18]

ITEM 11. Amend rule 650--15.9 as follows:

650—15.9(153) Continuing education fees.

15.9(1) Application for prior approval of activities. The fee for an application for prior approval of a continuing education activity is $10.

15.9(2) Application for postapproval of activities. The fee for an application for postapproval of a continuing education activity is $10.

15.9(3) Application for approved sponsor status. The fee for an application to become an approved sponsor for a continuing education activity is $100. The biennial renewal fee is $100.

15.9(4) Continuing education training. The fee to access a continuing education course developed and presented by the board is $30.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]
DENTAL BOARD [650]

Notice of Intended Action

The Dental Board hereby proposes to rescind Chapter 29, “Sedation and Nitrous Oxide Inhalation Analgesia” and replace with a new Chapter 29, “Sedation and Nitrous Oxide” Iowa Administrative Code 650.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 147.76 and 153.33.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code sections 153.33, and 153.33B.

Purpose and Summary

The primary purpose of these amendments is to update the requirements for providing sedation and nitrous oxide inhalation analgesia in dental offices. The amendments have been drafted based on updated recommendations and input from interested parties.

These amendments would update requirements for providing moderate sedation, deep sedation and general anesthesia in dental offices. These amendments specify the conditions under which the administration of the sedation services may be delegated to another health care provider, such as an anesthesiologist or nurse anesthetist.

These amendments clarify that training in the use of nitrous oxide when enrolled in an accredited school of dentistry or dental hygiene is approved for the purposes of these rules. These amendments also clarify what a dental assistant is allowed and/or required to do while monitoring the administration of nitrous oxide.

These amendments establish a requirement for training in the monitoring of patients under moderate sedation, deep sedation, or general anesthesia. Due to the increased risk of these levels of sedation, the training could focus on additional training in observation of a patient under sedation, and prepare them for recognizing signs of an adverse reaction or occurrence.

These amendments would establish a prohibition the use of drugs intended for deeper levels of sedation from being employed for the purposes of moderate sedation. These amendments clarify the facilities and locations subject to inspection and the equipment required to maintained at each facility where moderate sedation, deep sedation and/or general anesthesia is performed.
These amendments update terminology to be more specific and to clarify the requirements for providing sedation or nitrous oxide inhalation analgesia. These amendments also reorder some of the rules for clearer understanding and reference.

**Fiscal Impact**

This rule making has no fiscal impact to the state of Iowa.

**Jobs Impact**

After analysis and review of this rule making, there is no impact on jobs.

**Waivers**

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

**Public Comment**

Any interested person may submit written comments on this proposed rulemaking. Written comments in response to this rule making must be received by the Board no later than 4:30 p.m. on XXX. Comments should be directed to:

Steve Garrison, Program Officer  
Iowa Dental Board  
400 S.W. Eighth Street, Suite D  
Des Moines, Iowa 50309  
Email: steven.garrison@iowa.gov  
Fax: 515-281-7969

**Public Hearing**

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)”b,” an oral presentation regarding this rule may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

**Review by the Administrative Rules Review Committee**

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee’s meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

CHAPTER 29
SEDATION AND NITROUS OXIDE-INHALATION ANALGESIA

650—29.1(153) Definitions. For the purpose of these rules, relative to the administration of deep sedation, general anesthesia, moderate sedation, minimal sedation, and nitrous oxide inhalation analgesia by licensed dentists, the following definitions shall apply:

“ASA” refers to the American Society of Anesthesiologists Patient Physical Status Classification System. Category 1 means normal healthy patients, and category 2 means patients with mild systemic disease. Category 3 means patients with moderate systemic disease, and category 4 means patients with severe systemic disease that is a constant threat to life.

“Board” means the Iowa dental board established in Iowa Code section 147.14(1)“d.”

“Capnography” means the monitoring of the concentration of exhaled carbon dioxide in order to assess physiologic status or determine the adequacy of ventilation during anesthesia.

“Committee” or “ACC” means the anesthesia credentials committee of the board.

“Conscious sedation” means moderate sedation.

“Deep sedation/general anesthesia” is a controlled state of unconsciousness means drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated of painful stimulation. The ability to independently maintain ventilatory function may be impaired, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
“Delegation of moderate sedation, deep sedation, or general anesthesia” means the delegation of moderate sedation, deep sedation, or general anesthesia in a dental facility by a sedation permit holder to a licensed sedation provider as permitted by state or federal law.

“Dosing for minimal sedation via enteral route” means the achievement of minimal sedation via the administration of a drug either dosed singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD). The drug(s) and/or techniques should carry a margin of safety wide enough never to render unintended loss of consciousness.

“Dosing for moderate sedation via enteral route” means the achievement of moderate sedation via the administration of enteral drugs exceeding the maximum recommended dose (MRD) during a single appointment, or the administration of more than one enteral drug, with or without the concomitant use of nitrous oxide. The drug(s) and/or techniques should carry a margin of safety wide enough never to render unintended loss of consciousness unlikely.

“Emergency management” means managing a patient that has entered a deeper level of sedation than intended. The dentist must stop the dental procedure until the patient has returned to the intended level of sedation. The dentist is responsible for the treatment of emergencies related to the administration of sedation and providing the equipment and protocols necessary for patient rescue.

“Facility” means any location where sedation is used in the practice of dentistry.

“General anesthesia” means 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.

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

“Licensed sedation provider” means a dentist sedation permit holder, a physician anesthesiologist currently licensed by the Iowa Board of Medicine or a certified registered nurse anesthetist (CRNA) currently licensed by the Iowa Board of Nursing.

“Maximum recommended dose (MRD)” means the maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

“Minimal sedation” means 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 reflex is withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation. The term “minimal sedation” also means “antianxiety premedication” or “anxiolysis.” A dentist providing minimal sedation shall meet the requirements of rule 650—29.3(153).

“Moderate sedation” means a drug-induced depression of consciousness, either by enteral or parenteral means, 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. A patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state
of moderate sedation. Prior to January 1, 2010, moderate sedation was referred to as conscious sedation.

“Monitoring nitrous oxide inhalation analgesia” means continually observing the patient receiving nitrous oxide and recognizing and notifying the dentist of any adverse reactions or complications.

“Nitrous oxide inhalation analgesia” refers to the administration by inhalation of a combination of nitrous oxide and oxygen producing an altered level of consciousness that retains the patient’s ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

“Operating dentist” means an Iowa licensed dentist with the primary responsibility for providing operative dental care while a licensed sedation provider or independently-qualified anesthesia healthcare provider administers minimal, moderate, deep sedation or general anesthesia.

“Patient monitor” for the purposes of this chapter means licensed healthcare personnel designated to continuously monitor a patient receiving moderate sedation, deep sedation or general anesthesia until the patient meets the criteria to be discharged to the recovery area.

“Pediatric” means patients aged 12 or under.

“Permit holder” for the purposes of this chapter means an Iowa licensed dentist who has been issued a moderation sedation or general anesthesia permit by the board.

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

“Titration for moderate sedation via parenteral route” means the achievement of moderate sedation via the administration of incremental doses of an intravenous or inhalation drug. The provider must know whether the previous dose has taken full effect prior to administering an
additional drug increment. The drug(s) and/or techniques should carry a margin of safety wide enough never to render unintended loss of consciousness unlikely.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13; ARC 3491C, IAB 12/6/17, effective 1/10/18]


29.2(1) A dentist may use nitrous oxide inhalation analgesia sedation on an outpatient basis for dental patients provided the dentist has completed training and complies with the following:

a. Has completed training while a student in an accredited school of dentistry; or

b. Has completed another board-approved course of training, and

a. Has adequate equipment with fail-safe features and minimum oxygen flow which meets FDA standards.

b. Has routine inspection, calibration, and maintenance on equipment performed every two years and maintains documentation of such, and provides documentation to the board upon request.

c. Ensures the patient is continually monitored by qualified personnel while receiving nitrous oxide inhalation analgesia.

29.2(2) A dentist utilizing nitrous oxide inhalation analgesia shall be trained and capable of administering basic life support, as demonstrated by current certification in a nationally recognized course in cardiopulmonary resuscitation.

29.2(2) A licensed dentist who has been utilizing nitrous oxide inhalation analgesia in a office in a competent manner for the 12-month period preceding July 9, 1986, but has not had the benefit of formal training outlined in paragraph 29.2(1)“a” or 29.2(1)“b,” may continue the use
provided the dentist fulfills the requirements of paragraphs 29.2(1)“c” and “d” and subrule 29.2(2).

29.2(2) A dental hygienist may administer and monitor nitrous oxide inhalation analgesia provided it has been delegated by a dentist, and the hygienist meets the following qualifications:

a. Has completed training while a student in an accredited school of dental hygiene; or

b. Has completed another board-approved course of training.

29.2(3) A dentist who delegates the administration of nitrous oxide inhalation analgesia shall provide direct supervision and establish a written office protocol for taking vital signs, adjusting anesthetic concentrations, and addressing emergency situations that may arise.

29.2(4) After the dentist has induced a patient and established the maintenance level, a dental assistant may monitor a patient under nitrous oxide inhalation analgesia provided all of the following requirements are met:

a. The dental assistant has completed a board-approved expanded function course;

b. The task has been delegated by a dentist and is performed under the direct supervision of a dentist;

c. Any adverse reactions are reported to the supervising dentist immediately; and

d. The dentist dismisses the patient following completion of the procedure.

29.2(5) A dental assistant may make adjustments to decrease the nitrous oxide concentration while monitoring the patient, or turn off oxygen delivery at the completion of the dental procedure.

29.2(6) If the dentist intends to achieve a state of moderate sedation from the administration of nitrous oxide inhalation analgesia, the rules for moderate sedation apply.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 8614B, IAB 3/10/10, effective 4/14/10]
Minimal Sedation Standards.

29.3(1) Patients considered for minimal sedation must be evaluated prior to the start of any sedative procedure. In healthy or medically-stable individuals this should consist of a review of a 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. Informed consent from the patient or the patient’s parent or legal guardian must be obtained prior to providing minimal sedation.

29.3(2) Minimal Sedation for Patients 13 Years of Age or Older, ASA I, II.

a. A dentist may prescribe or administer a single medication for minimal sedation via the enteral route that is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. A single supplemental dose of the same drug may be administered, provided the supplemental dose is no more than one-half of the initial dose and the dentist does not administer the supplemental dose until the dentist has determined the clinical half-life of the initial dose has passed.

b. The total aggregate dose shall not exceed 1.5 times the MRD on the day of treatment.

c. A dentist may also utilize nitrous oxide inhalation analgesia in combination with a single enteral drug.

29.3(3) Minimal sedation for ASA III, IV patients or pediatric patients.

a. A dentist may prescribe or administer a single medication for minimal sedation via the enteral route for ASA III, IV category 3 or 4 patients or pediatric patients when intended for unmonitored home use and that is no more than the maximum recommended dose.

b. A dentist may administer nitrous oxide inhalation analgesia for minimal sedation of ASA III, IV category 3 or 4 patients, or pediatric patients who is ASA I, II, provided the
concentration does not exceed 50 percent and is not used in combination with any other drug.

29.3(5–4) A dentist providing minimal sedation shall not bill for non-IV conscious or moderate sedation.

29.3(65) A dentist shall ensure that any advertisements related to the availability of antianxiety premedication, anxiolysis, or minimal sedation clearly reflect the level of sedation provided and are not misleading.

[ARC 8614B, IAB 3/10/10, effective 4/14/10]

650—29.5(153) Moderate Sedation Standards.

29.5(1) Patients considered for moderate sedation must undergo an evaluation prior to the administration of any sedative. This should consist of a review of the medical history, medication(s) use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (ASA III, IV) require consultation with their primary care physician or consulting medical specialist. Consultation of Body Mass Index (BMI) should be considered as part of the pre-procedural workup. Informed consent from the patient or the patient’s parent or legal guardian must be obtained prior to providing moderate sedation.

29.5(2) Moderate Sedation for Patients 13 Years of Age or Older, ASA I, II.

a. A dentist may prescribe or administer a single dose of an enteral drug in excess of the 1.5 MRD on the day of treatment;

b. A dentist may prescribe or administer the combination of more than one enteral drug;

c. A dentist may titrate a medication for moderate sedation via the parenteral route;

d. A dentist may administer or prescribe drugs that are not recommended for unmonitored home use; or

e. A dentist may administer nitrous oxide with more than one enteral drug.

29.5(3) Moderate Sedation for Patients Who are ASA III, IV or Pediatric Patients. The use of
one or more enteral drugs in combination with nitrous oxide, the use of more than a single enteral drug, or the administration of any intravenous drug in ASA III, IV category 3 or 4 patients or pediatric patients constitutes moderate sedation and requires that the dentist must hold a moderate sedation permit. A dentist who does not meet the requirements of this subrule is prohibited from administering moderate sedation to pediatric or ASA III, IV category 3 or 4.

A dentist utilizing moderate sedation on pediatric or ASA category 3 or 4 patients must have completed an accredited residency program that includes formal training in anesthesia and clinical experience in managing pediatric or ASA category 3 or 4 patients.

a. A dentist must establish a protocol for immediate access to back-up emergency services;
   i. A patient monitor shall employ initial life-saving measures in the event of an emergency; and
   ii. A patient monitor, in the case of an adverse occurrence, shall employ the emergency protocols and active the EMS system for life-threatening complications.

b. A dentist must have an emergency cart or kit immediately available with age- and size-appropriate equipment;

c. A dentist who administers moderate sedation to a pediatric patient shall be required to employ capnography to monitor the patient’s airway and ventilation;
   i. If a pediatric patient is agitated or uncooperative, it may be necessary to delay employing the use of capnography.
   ii. The dentist must record in the record instances wherein the patient did not
allow the use of capnography during the course of the procedure.

d. A dentist who utilizes an immobilization device must avoid chest or airway obstruction when applying the device, and shall allow a hand or foot to remain exposed;

e. A patient monitor who monitors a pediatric patient under moderate sedation must maintain current certification in Pediatric Advanced Life Support (PALS) and must be capable of responding to any emergency event;

f. The recovery room for a pediatric patient must include a functioning suction apparatus as well as the ability to provide >90% oxygen and positive-pressure ventilation, along with age- and size-appropriate rescue equipment.

29.5(4) A dentist administering moderate sedation must document and maintain current certification in Advanced Cardiac Life Support (ACLS). 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.

29.5(5) A dentist who administers moderate sedation in a facility shall ensure that each facility where sedation services are provided is staffed with trained auxiliary personnel capable of reasonably handling procedures, problems and emergencies incident to the administration of moderate sedation. The following requirements shall be met:

a. A dentist shall utilize the assistance of at least one licensed dentist, dental hygienist, nurse, or registered dental assistant qualified auxiliary personnel in the room who
is qualified under subrule 29.6(5); and

b. The patient monitor shall be present in the treatment room and continually monitor the patient for the duration of the sedation service; and

c. A licensee or registrant who monitors patients under moderate sedation shall maintain current certification in or complete one of the following:

i. Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS); or

ii. The Dental Anesthesia Assistant National Certification Examination (DAANCE) as offered by the American Association of Oral and Maxillofacial Surgeons (AAOMS) and be capable of administering basic life emergency support.

29.5(6) The dentist must not leave the facility until the patient meets the criteria for discharged and is discharged from the facility.

29.5(7) If the dentist intends to achieve a state of deep sedation or general anesthesia from the administration of moderate sedation, the rules for deep sedation or general anesthesia shall apply.

29.5(8) The decision as to whether a patient is a suitable candidate for moderate sedation must be made by a licensed sedation provider.

650—29.6(153) Facility and Equipment Requirements for Moderate Sedation, Deep Sedation or General Anesthesia.

29.6(1) A licensee may submit a request to the board for an exemption from any of the
provisions of this subrule. Change of address or addition of facility location(s).

a. A permit holder shall notify the board office in writing within 60 days of the change in location of an approved sedation facility.
b. A permit holder shall notify the board office in writing within 60 days of the addition of facility locations.

29.6(2) Equipment requirements.

a. A dentist who administers moderate sedation, deep sedation or general anesthesia in a facility is required to be trained in and maintain, at a minimum, the following equipment to be properly equipped:

(1) EKG monitor;
(2) Positive pressure oxygen;
(3) Suction;
(4) Laryngoscope and blades;
(5) Endotracheal tubes;
(6) Magill forceps;
(7) Oral airways;
(8) Stethoscope;
(9) Blood pressure monitoring device;
(10) Pulse oximeter;
(11) Emergency drugs;
(12) Defibrillator;
(13) Capnography machine to monitor end-tidal CO2;
(14) Pretracheal or precordial stethoscope, and
Any additional equipment necessary to establish intravascular or intraosseous access shall be available until the patient meets discharge criteria.

b. A dentist who administers deep sedation or general anesthesia and has a recovery area separate from the operatory must have oxygen and suction equipment in the recovery area.

29.6(4) Use of capnography or pretracheal/precordial stethoscope required for moderate sedation providers.

a. Beginning January 1, 2018, all moderate sedation permit holders licensed sedation provider shall use capnography to monitor end-tidal CO2 unless precluded or invalidated by the nature of the patient, procedure or equipment.

b. 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 permit holders licensed sedation providers provide sedation.

29.6(5) Use of capnography and pretracheal/precordial stethoscope required for deep sedation and general anesthesia providers.

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

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

29.6(6) Sedation permit providers who utilize deep sedation or general anesthesia in a dental facility shall maintain an open airway for the duration of the sedation.
650—29.7(153) Deep Sedation or General Anesthesia Standards.

29.7(1) Patients considered for deep sedation or general anesthesia must undergo an evaluation prior to the administration of any sedative. This must consist of a review of the medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g. ASA III, IV) require consultation with their primary care physician or consulting medical specialist. Assessment of BMI should be considered part of a pre-procedural workup.

29.7(2) The administration of anesthetic sedative agents intended for deep sedation or general anesthesia (e.g. Propofol, Ketamine, Dilaudid) shall constitute deep sedation or general anesthesia.

29.7(3) A dentist who administers deep sedation or general anesthesia in a facility shall ensure that each facility where sedation services are provided is staffed with trained auxiliary personnel capable of reasonably handling procedures, problems and emergencies incident to the administration of moderate sedation. The following requirements shall be met:

a. A dentist shall utilize the assistance of at least two licensed personnel (e.g. dentist, who is not the operating dentist; dental hygienist; nurse; or registered dental assistant) qualified auxiliary personnel in the room who is qualified under subrule 29.6(5); and

b. The patient monitor shall be present in the treatment room and continually monitor the patient for the duration of the sedation service; and

c. A patient monitor who monitors patients under moderate sedation shall maintain current certification in or complete one of the following:

   i. Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS); or

   ii. The Dental Anesthesia Assistant National Certification Examination
(DAANCE) as offered by the American Association of Oral and Maxillofacial Surgeons (AAOMS) and be capable of administering emergency support.

29.7(4) The dentist must provide post-operative verbal and written instructions to the patient and parent, escort, guardian or caregiver prior to discharging the patient.

29.7(4) The dentist must not leave the facility until the patient meets the criteria for discharged and is discharged from the facility.

650—29.8(153) Facility Inspections.

29.8(1) The board or designated agents of the board may conduct facility inspections, with the exception of the University of Iowa College of Dentistry, hospitals and outpatient surgical clinics.

a. The actual costs associated with the on-site evaluation of the facility shall be the primary responsibility of the licensee. The cost to the licensee shall not exceed the fee as specified in 650—Chapter 15.

b. The University of Iowa College of Dentistry shall submit written verification to the board office every five years indicating that it is properly equipped pursuant to this chapter.

650—29.9(153) Delegation of Moderate Sedation, Deep Sedation or General Anesthesia Services in a Dental Office.

29.9(1) A permit holder may have another licensed sedation provider perform the administration of sedation in a dental facility so long as the following requirements are met:

a. A licensed dentist who holds a current moderate sedation permit may have another licensed sedation provider perform the administration of moderate sedation;

b. A licensed dentist who holds a current general anesthesia permit may delegate the administration of moderate sedation, deep sedation or general anesthesia; and
c. The licensed dentist who delegates the administration of sedation services must remain present in the treatment room for the duration of the dental procedure.

29.10(2) A dentist who delegates the administration of moderate sedation, deep sedation or general anesthesia services must maintain a permanently and properly-equipped facility pursuant to subrule 29.9.

29.10(3) A licensed dentist who delegates the administration of moderate sedation, deep sedation or general anesthesia services shall comply with the rules established in this chapter.

29.10(4) A dentist who has another licensed sedation provider perform moderate sedation shall not monitor the patient without the presence and assistance of at least one patient monitor in the room who is qualified under subrule 29.6(5).

29.10(5) A dentist who has another licensed sedation provider perform deep sedation or general anesthesia shall not monitor the patient without the presence and assistance of at least two patient monitor in the room who is qualified under subrule 29.8(5).

29.10(6) A permit holder, who does not hold a current qualification to sedate pediatric and/or ASA III, IV patients as part of their moderate sedation permit, shall not delegate the administration of moderate sedation to pediatric or ASA III, IV patients.

29.10(7) Entries in the patient record shall comply with the requirements established in subrule 29.11(2).

29.10(8) Permit holders may administer sedation on behalf of another licensed dentist within the same facility, who does not hold a sedation permit, provided the licensed sedation provider complies with the following:

a. The licensed sedation provider completes a pre-operative evaluation of the patient, and determines the patient is a suitable candidate for sedation;
b. The licensed sedation provider administers the moderate sedation, deep sedation or
general anesthesia pursuant to sub rules 29.X and 29.X;

c. The sedation is provided at a facility, which has successfully passed an inspection
pursuant to the requirements of 29.9, at the University of Iowa College of Dentistry, hospital or
outpatient surgery clinic; and

d. The licensed sedation provider complies with all other rules herein.

650—29.11 (153) Record keeping.

29.11(1) Minimal sedation. A time-oriented anesthesia record must be maintained and must
contain the names of all drugs administered, including local anesthetics and nitrous oxide, dosages,
time administered, and monitored physiological parameters, including oxygenation, ventilation,
and circulation.

29.11(2) Moderate or deep sedation. A time-oriented anesthesia record must include
preoperative and postoperative vital signs, drugs administered, dosage administered, anesthesia
time in minutes, and monitors used. Pulse oximetry, heart rate, respiratory rate, and blood pressure
must be recorded continually until the patient is fully ambulatory. The chart should contain the
name of the person to whom the patient was discharged.

29.11(3) Nitrous oxide inhalation analgesia. The patient chart must include the concentration
administered and duration of administration, as well as any vital signs taken.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB
11/27/13, effective 11/4/13]

These rules are intended to implement Iowa Code sections 153.33 and 153.34.

650—29.12(153) Reporting of adverse occurrences related to sedation, nitrous oxide
inhalation analgesia, and antianxiety premedication.

29.12(1) Reporting. All licensed dentists in the practice of dentistry in this state must submit a
report within a period of seven days to the board office of any mortality or other incident which results in temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, antianxiety premedication, nitrous oxide inhalation analgesia, or sedation.

The report shall include responses to at least the following:

a. Description of dental procedure.

b. Description of preoperative physical condition of patient.

c. List of drugs and dosage administered.

d. Description, in detail, of techniques utilized in administering the drugs utilized.

e. Description of adverse occurrence:
   1. Description, in detail, of symptoms of any complications, to include but not be limited to onset, and type of symptoms in patient.
   2. Treatment instituted on the patient.

f. Description of the patient’s condition on termination of any procedures undertaken.

29.12(2) Failure to report. Failure to comply with subrule 29.12(1), when the occurrence is related to the use of sedation, nitrous oxide inhalation analgesia, or antianxiety premedication, may result in the dentist’s loss of authorization to administer sedation, nitrous oxide inhalation analgesia, or antianxiety premedication or in any other sanction provided by law.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.13(153) Requirements for issuance of a moderate sedation or general anesthesia permit.

29.13(1) No dentist shall use or permit the use of deep sedation or general anesthesia or moderate sedation for dental patients, unless the dentist possesses a current permit issued by the board.
29.13(2) An application for moderate sedation or general anesthesia permit is submitted to the board, and includes the fee as specified in 650 - Chapter 15.

29.13(3) The applicant for moderate sedation permit has completed education and training that complies with the following:

a. Successfully completed training that includes rescuing patients from a deeper level of sedation than intended, including managing the airway, intravascular or intraosseous access, and reversal medications; and

b. Successfully completed a training program that consists of a minimum of 60 hours of instruction and management of at least 20 patients; or

c. Has submitted evidence of successful completion of an accredited residency program that includes formal training and clinical experience in moderate sedation, which is approved by the board.

d. A dentist utilizing moderate sedation on pediatric or ASA III, IV category 3 or 4 patients must have completed an accredited residency program that includes formal training in anesthesia and clinical experience in managing pediatric or ASA III, IV category 3 or 4 patients;

29.13(4) The applicant for general anesthesia permit has completed education and training that complies with the following:

a. Successful completion an advanced education program accredited by the Commission on Dental Accreditation that provides training in deep sedation and general anesthesia;

b. Successful completion of a minimum of one year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental
school level in a training program approved by the anesthesia credentials committee; and

c. Completion of formal training in airway management.

29.13(5) All facilities where the applicant intends to provide sedation services have been inspected by the board or designated agent prior to the date of issuance;

29.13(6) Applicant must document and maintain current certification in Advanced Cardiac Life Support (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.

29.13(7) The applicant has completed a peer review evaluation, as may be required by the anesthesia credentials committee, prior to issuance of a permit.


29.14(1) The ACC is a peer review committee appointed by the board to assist the board in the administration of this chapter. This committee shall be chaired by a member of the board and shall include at least six additional members who are licensed to practice dentistry in Iowa. At least four members of the committee shall hold deep sedation/general anesthesia or moderate sedation permits issued under this chapter.

29.14(2) The ACC shall perform the following duties at the request of the board:

a. Review all permit applications and make recommendations to the board regarding those applications.

b. Conduct site visits at facilities under rule 650—29.9(153) and report the results of those site visits to the board. The ACC may submit recommendations to the board regarding the
appropriate nature and frequency of site visits.

c. Perform professional evaluations and report the results of those evaluations to the board.

d. Other duties as delegated by the board or board chairperson.

[ARC 1194C, IAB 11/27/13, effective 11/4/13]


29.15(1) Review by board staff. Upon receipt of a completed application, board staff will review the application for eligibility. Following staff review, a public meeting of the ACC will be scheduled.

29.15(2) Review by the ACC. Following review and consideration of an application, the ACC may at its discretion:

a. Request additional information;

b. Request an investigation;

c. Request that the applicant appear for an interview;

d. Recommend issuance of the permit;

e. Recommend issuance of the permit under certain terms and conditions or with certain restrictions;

f. Recommend denial of the permit;

g. Refer the permit application to the board for review and consideration without recommendation; or

h. Request a peer review evaluation.

29.15(3) Review by executive director. If, following review and consideration of an application, the ACC recommends issuance of the permit with no restrictions or conditions, the executive director as authorized by the board has discretion to authorize the issuance of the permit.
**29.15(4)** Review by board. The board shall consider applications and recommendations from the ACC. The board may take any of the following actions:

a. Request additional information;

b. Request an investigation;

c. Request that the applicant appear for an interview;

d. Grant the permit;

e. Grant the permit under certain terms and conditions or with certain restrictions; or

f. Deny the permit.

**29.15(5)** Right to defer final action. The ACC 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 permit until such time as the ACC or board is satisfied that issuance of a permit to the applicant poses no risk to the health and safety of Iowans.

**29.15(6)** Appeal process for denials. If a permit application is denied, an applicant may file an appeal of the final decision using the process described in rule 650—11.10(147).

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.16 (153) Renewal.** A permit to administer deep sedation/general anesthesia or moderate sedation shall be renewed biennially at the time of license renewal. Permits expire August 31 of every even-numbered year.

**29.16(1)** To renew a permit, a licensee must submit the following:

a. Evidence of renewal of ACLS certification or **PALS certification if the permit holder provides sedation services pediatric patients.**

b. A minimum of six hours of continuing education in the area of sedation. These hours may also be submitted as part of license renewal requirements.
c. The appropriate fee for renewal as specified in 650—Chapter 15.

29.16(2) Failure to renew the permit prior to November 1 following its expiration shall cause the permit to lapse and become invalid for practice.

29.16(3) A permit that has been lapsed may be reinstated upon submission of a new application for a permit in compliance with rule 650—29.13(153) and payment of the application fee as specified in 650—Chapter 15.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.17(147,153,272C) Grounds for nonrenewal. A request to renew a permit may be denied on any of the following grounds:

29.17(1) After proper notice and hearing, for a violation of these rules or Iowa Code chapter 147, 153, or 272C during the term of the last permit renewal.

29.17(2) Failure to pay required fees.

29.17(3) Failure to obtain required continuing education.

29.17(4) Failure to provide documentation of current ACLS or PALS certification.

29.17(5) Failure to provide documentation of maintaining a properly-equipped facility.

29.17(6) Receipt of a certificate of noncompliance from the college student aid commission or the child support recovery unit of the department of human services in accordance with 650—Chapter 33 or 650—Chapter 34.

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.18(153) Noncompliance. Violations of the provisions of this chapter may result in revocation or suspension of the dentist’s permit or other disciplinary measures as deemed appropriate by the board.
September 18, 2018

Dear Dr.

I am corresponding today on behalf of the Anesthesia Credentials Committee for the Iowa Dental Board (IDB). Our committee provides supporting commentary and recommendations to the IDB when the board makes decisions about sedation and anesthesia services provided by dentists in Iowa. Iowa dental providers who provide moderate sedation, deep sedation or general anesthesia services in their office must first obtain a state-issued permit under the direction of the IDB. Our committee assists in reviewing the credentials of the applicants for this process. Our guidelines typically follow the ADA guidelines for the use of sedation and general anesthesia by dentists. Permit holders are then required to document training beyond that of the baseline skills acquired in the dental school experience before receiving their permit. Iowa dentists who desire to provide deep sedation or general anesthesia services are required to demonstrate a more advanced level of training when compared to permits issued for moderate sedation.

Recently the IDB has received several requests for waivers to this process. The waivers request authorization for dental providers to delegate the provision of anesthesia related services to a second anesthesia specific provider. The waivers are for services to be provided in an office-based setting with the adjunct of a deep sedation or general anesthesia. The IDB subsequently requested input from the anesthesia committee because of the deep sedation or general anesthesia component.

Early discussions by the Anesthesia Credentials Committee recognized the benefits of a dedicated anesthesia provider. However, the committee has suggested that even if dentists are going to delegate the anesthesia specific services, the dental service provider still needs to be obligated to some minimum level of anesthesia specific training. The reasoning behind this position is that there must be a balance of understanding and a shared core of knowledge between the dental service provider and the anesthesia service provider. Providing dental procedure services with the adjunct of deep sedation or general anesthesia in a dental office setting is a completely different circumstance than managing a patient whose protective reflexes are intact. This point must be underscored when an open airway deep sedation or general anesthesia is anticipated in the office setting.

The Anesthesia Credentials Committee subsequently recommended that Iowa dental service providers who delegate anesthesia specific services in their dental offices should be required to demonstrate a minimum level of anesthesia specific training. This minimum level was determined to be the training for, and the receipt of, a moderate sedation permit in Iowa. The committee’s position has met resistance.

The focus question in this debate is: Do general dentists with no sedation or anesthesia training beyond the training that they receive in dental school have the background knowledge and experience necessary to treat patients who are receiving deep sedation or general anesthesia in an office setting? For this question we will assume that we have a well-skilled anesthesia specific provider. However, we will not necessarily assume that the anesthesia provider has knowledge of dental procedures. We will also assume that the most likely anesthesia service will be an open airway or non-intubated deep sedation or general anesthesia. This focus question is directed toward office-based procedures only, not those procedures
provided in an outpatient hospital or outpatient surgical center. The committee recognizes that those institutions are more rigorously controlled and typically have several layers of safeguards built in. Additionally, procedures are more typically completed with an intubated and protected airway in those facilities.

The IDB Anesthesia Credentials Committee is therefore reaching out to experts in the field of dental anesthesia and, in particular, those who are familiar with the provision of dental services with the adjunct of deep sedation or general anesthesia. We respectfully request your comments related to our focus question and a short series of questions along a related line of considerations. Please take the time to provide your comments.

Related questions:

1. Should the dental service provider who is delegating the deep sedation or general anesthesia service in the office setting be required to have some minimum level of actual deep sedation or general anesthesia training to better understand the interaction of anesthesia and dental services?

2. Should dental hygienists who provide hygiene services for patients receiving deep sedation or general anesthesia in an office setting be required to have some minimum level of sedation or anesthesia training to better understand the interaction of anesthesia and hygiene services?

3. Does a dental provider who is delegating both hygiene and anesthesia services need to be physically present in the treatment room while hygiene services are provided with the adjunct of deep sedation or general anesthesia in an office setting?

4. If you are involved with a residency training program, what experiences do your residents have with treating patients with deep sedation or general anesthesia (not moderate sedation)? In these circumstances are patients managed in a clinic environment or in the O.R.?

5. In your area, how are patients who require deep sedation or general anesthesia as an adjunct to general dental procedures typically managed?

6. In your area, are adjunctive deep sedation or general anesthesia services typically completed with an “open airway” technique or an “airway device” technique when completed in the office setting?

A final statement would be this: We are all too familiar with several unfortunate experiences that our colleagues in dentistry have encountered in recent years. Our committee’s concern is that if we as dentists do not act to monitor our own profession, we are failing in our obligations to the public and to other members of our profession. We may lose control of our own profession and then be subject to monitoring and regulation from outside the profession. When making our recommendations, we desire to be informed and we desire to be fair. We therefore reach out to you and our colleagues in dentistry for your expertise.

Thank you,

John Frank, DDS
On the behalf of the Anesthesia Credentials Committee for the Iowa Dental Board
August 24, 2018

John Frank, DDS and
Anesthesia Credentials Committee
Iowa Dental Board
400 SW 8th Street Suite D
Des Moines IA 50309-4687

Dear Dr. Frank and the Anesthesia Credentials Committee,

General dentists with no sedation or anesthesia training beyond the training they received in dental school do NOT have the background knowledge or experience necessary to safely treat patients receiving “non-intubated” deep sedation or general anesthesia in an office setting, even with a well-skilled anesthesia provider. Airway protection is the overriding concern: protection from secretions; irrigation; broken pieces of teeth; blood; crowns or other loose dental components; etc. The importance of airway protection cannot be overstated nor learned without formal training and experience. The skilled anesthesia provider cannot be expected to prevent inadvertent airway compromise from the general dental provider who is working in the mouth. The overseeing general dentist must be skilled in airway management and thereby understand the importance of protecting it.

Our experienced medical anesthesiologists at the University of Iowa are hesitant to provide non-intubated deep sedation or general anesthesia for general dental procedures. They were surprised to learn how many “potential airway stimulants” occur with general dental procedures. In fact, general dental patients that require more than controlled procedural sedation to provide dental care at the University of Iowa are intubated for airway protection.

Clearly we do NOT endorse this anesthesia model in the general dental office out of concern for patient safety. We do not believe the airway can be controlled adequately or protected for many if not most general dental procedures. Even one anesthesia related death in a dental office is too many. Bottom line, if a controlled, light procedural sedation is not adequate to perform dental cleanings or general dental procedures in an office setting, consideration for an operating room setting with intubation is recommended.
However, should this anesthesia model be pushed forward, the following recommendations are offered:

1. The general dentist must receive advanced anesthesia training beyond what is taught in dental school and must include live airway training. At a minimum, the general dentist MUST meet the state requirements for a moderate sedation permit.

2. The general dentist must be present in the room to perform or staff the entire dental procedure(s) for patients undergoing deep sedation or general anesthesia in conjunction with a skilled anesthesia provider.

3. The general dentist and any other dental provider must be current with BLS and ACLS or PALS.

4. The patient undergoing dental procedures with deep sedation or general anesthesia must have a formal history and physical (or equivalent document with key elements) completed within 30 days of the procedure(s) and it must be updated the day of the procedure(s) to rule out health changes, upper respiratory infection, recent drug use, pregnancy, etc. Documentation must include ASA status, BMI and METS criteria or equivalent.

5. Standardized anesthesia charting is mandatory and must be contemporaneous.

6. Only ASA 1 and 2 category patients should be considered viable for this anesthesia model. Special restrictions are needed for pediatric patients (definition?), elderly patients and those patients with elevated body mass index.

7. Recurring office anesthesia evaluations by peers or designated agencies must be done; these office evaluations must include and document consistent, comprehensive office emergency simulations.

8. Offices must be fully equipped to provide adequate monitoring including pulse oximetry, capnography, ECG tracing, precordial stethoscope, blood pressure and pulse. Additionally, offices must be fully equipped to treat all potential anesthetic emergencies (equipment and drugs).

Please do not hesitate to contact us should you have any questions.
Most sincerely,

_______________________________
Kirk Fridrich, D.D.S., M.S. F.A.C.S.

_______________________________
Richard Burton, D.D.S., M.S., F.A.C.S.

_______________________________
Steven Fletcher, D.D.S. F.A.C.S.

_______________________________
Aaron Figueroa, DDS

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Douglas Kendrick, D.D.S.

_______________________________
Kyle Stein, D.D.S., F.A.C.S.

_______________________________
William Synan, D.D.S.
September 7, 2018

John Frank, DDS
Anesthesia Credentials Committee
Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Dr. Frank,

Thank you for the opportunity to comment on the questions currently being reviewed by the Iowa Dental Board Anesthesia Credentials Committee. I agree these questions are very important and applaud your effort to gain a wide consensus from experienced providers.

Here are my thoughts on the questions you listed:

1. Should the dental service provider who is delegating the deep sedation or general anesthesia service in the office setting be required to have some minimal level of actual deep sedation or general anesthesia training to better understand the interaction of anesthesia and dental services?

Absolutely. In my career I have worked with a wide variety of dentists that ranges from dentists with no formal training beyond dental school to dual degree specialists. In more specific terms, that represents approximately 10,000 cases in a period of about 26 years. In my experience, the patient is better served when the dental provider has undergone some degree of advanced training or specific sedation training. Our scientific literature confirms that the degree of normal muscle tone that keeps an airway open during consciousness is markedly reduced, or absent during deep sedation and general anesthesia. Based on my own observations, it is extremely easy for dental operators to obstruct or compromise an airway in the anesthetized patient, even when a separate anesthesia provider is managing the airway. Advanced training provides a familiarity with and respect for the airway that is not achievable without mentored clinical instruction. This is particularly important when the anesthesia provider is using a nonintubated airway management technique, but also applies to cases with endotracheal intubation. At a minimum, I think the dentist should have moderate sedation training, since that level of training includes exposure to patients with deep sedation and general anesthesia.

2. Should dental hygienists who provide services for patients receiving deep sedation or general anesthesia in an office setting be required to have some minimum level of sedation or anesthesia training to better understand the interaction of anesthesia and hygiene services?

Yes, for the same reason stated in the question above. This is most apparent to me when I am providing general anesthesia for a dentist who employs an expanded functional dental assistant or hygienist. Very few auxiliaries and hygienists have the benefit of training to prepare them for practicing in the context of deep sedation and general anesthesia. There are certainly exceptions, but I am not aware of any
specific training requirements in their respective curricula that prepare them for this experience. Inexperienced operators are often less aware of the hazards posed by excessive traction on the mandible, excessive use of irrigation, inadequate debridement and inadvertent obstruction. Providing a basic orientation course for hygienists would increase the margin of safety for patients receiving office-based deep sedation and general anesthesia for dental hygiene services.

3. Does a dental provider who is delegating both hygiene and anesthesia services need to be physically present in the treatment room while hygiene services are provided with the adjunct of deep sedation or general anesthesia?

If the delegating dental provider is using a physician or dentist anesthesiologist, I do not believe there is a need to be in the room, since hygienists do not require the presence of a delegating dentist in the treatment room for routine services. However, I base this on my own practice of always performing office-based anesthesia with the assistance of my own nurse, independent of the office I am serving. Some physician and dentist anesthesiologists may want the delegating dentist to be available to assist in certain anesthetic urgencies or emergencies. In that case, the delegating dentist should be on the premises and immediately available.

4. If you are involved with a residency program, what experiences do your residents have with treating patients with deep sedation and general anesthesia? In these circumstances are patients managed in a clinic environment or in the OR?

Residents from the Riley Hospital Pediatric Dental Residency program shadow me in my dental anesthesia practice. I provide approximately 15-20 office-based general anesthetics per week to approximately 26 dentists in the Indianapolis area. Greater than 80% are pediatric dental practices. All anesthetics are office-based and essentially all are general anesthetics. Each resident spends a minimum of two full days as part of their scheduled offsite experiences. During that time, they gain observational experience, as well as experience in airway management and delivering intramuscular injections. The purpose of this experience is to provide practical experience that may guide them in their future practices when addressing emergencies during any form of sedation or anesthesia.

5. In your area, how are patients who require deep sedation or general anesthesia as an adjunct to general dental procedures typically managed?

Given that the patients requiring this service are most often young children or special needs patients, practices typically employ a dentist anesthesiologist to provide office-based deep sedation/general anesthesia or take their patients to a hospital or surgery center. To my knowledge, there are approximately 8-10 facilities that accommodate this service. Several of the pediatric dentists I work with report long wait times to treat patients in a hospital or surgery center (typically several months).

6. In your area, are adjunctive deep sedation or general anesthesia services typically completed with an “open airway” technique or an “airway device” technique when completed in the office setting?

The selection of an airway management technique is dependent upon the type of patient being treated and the preference of the anesthesia provider. I don’t believe there is a strong correlation between the geographic area and airway management techniques. In my own practice, we currently intubate approximately 30% to 40% of patients. Intubation is preferred for longer, more complex cases, particularly when bleeding or the use of irrigation or impressions may pose a potential threat to an open airway. I also prefer intubation when preoperative examination of the patient reveals large tonsils or other anatomic factors that increase the risk for obstruction under general anesthesia. In addition to intubation, I often use a laryngeal mask airway (LMA) for airway management. The “open airway” cases I
perform are not truly open, as I routinely place nasopharyngeal airways with the tip approximately 5mm from the arytenoid cartilage of the larynx and pack the oropharynx with a compressible throat sponge, using direct laryngoscopy. All patients receive supplemental oxygen and capnography with this technique and the head is immobilized prior to treatment. In my experience, this type of nonintubated airway management technique works well when working with experienced dental operators on short cases (less than 45 minutes).

Thank you again for the opportunity to provide comments on these important questions. In closing, I would also like to strongly recommend that all providers of office-based anesthesia log their clinical outcomes and participate in a shared database for other dental office-based anesthesia providers. This enables the development of best practices and reliable outcomes data and enhances safety. There are several models for this that allow practitioners to participate in a way that protects the individual identity of patients and practitioners while providing important safety data.

Sincerely,

Mark A. Saxen, DDS, PhD
Dear Dr. Frank,

Thank you very much for your request for my opinion regarding your questions about deep sedation and general anesthesia in the general dentistry and dental specialty environment in my area. I have given much time and consideration to your questions. I have solicited other sources to respond in a more complete fashion. I reviewed the American Dental Association Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students [adopted by the ADA House of Delegates in October 2016] and the State of Iowa, Iowa Dental Board rules and regulations pertaining to requirements for the issuance of deep sedation/general anesthesia permits (650-29.3(153) and also the form entitled Sedation Permit Renewal for biennium period September 1, 2018 to August 31, 2020.

Please allow me to give a brief history of my anesthesia experience as an oral and maxillofacial surgeon. I completed a general practice residency program in 1981 and during that time rotated on the anesthesia service in a Veteran’s Administration Hospital for one month and at the Oklahoma Children’s Memorial Hospital (OCMH) for one month. I was given the responsibilities of a first year MD anesthesia resident and administered general anesthesia with intubation under supervision from anesthesiologists. I then matriculated into my OMS training program at which time I completed 6 months of anesthesia rotation at the University of Oklahoma with three months of service at the OCMH and 3 months at the main University of Oklahoma Hospital, Oklahoma Memorial with similar responsibilities as an medical anesthesia resident for a total anesthesia residency experience of 8 months. As faculty in the Department of Oral and Maxillofacial Surgery at the University of Oklahoma for 4 years and at the University of Minnesota for 29 years, and having been the director of the OMS residency program at the University of Minnesota for two intervals, I have had an opportunity to train over 75 oral and maxillofacial surgeons. All who successfully completed both training programs were competent in office based deep sedation and general anesthesia. I currently provide deep sedation and general anesthesia services to patients that I treat in my practice of OMS at the University of Minnesota and have maintained certification for the administration of general anesthesia when I was practicing in Oklahoma, and have also obtained and
maintained certification to provide general anesthesia in the state of Minnesota for 29 years. I also provide surgical procedures in our operating rooms, usually one day per week at which time I work with anesthesiologists, anesthesia residents and certified registered nurse anesthetists (anesthesia care providers/ACPs).

I have chosen to respond to your questions directly. Your first question:

Do general dentists with no sedation or anesthesia training beyond the training that they receive in dental school have the background knowledge and experience necessary to treat patients who are receiving deep sedation or general anesthesia in an office setting?

Assumptions
1. A well skilled anesthesia provider (ACP) would be providing the anesthesia.
2. There is no assumption that the anesthesia provider has knowledge of dental procedures.
3. In most cases the most likely anesthesia service will be an open airway or non-intubated deep sedation or general anesthesia.

Answer:
In my opinion, the general dentists that have graduated from a CODA accredited dental school should have the knowledge and perhaps the experience to provide the general dental procedures required in this situation. However they would not have had any experience performing procedures on patients who not able to respond to questions or verbal commands due to the depth of the sedation or presence of the general anesthesia. A dental patient under deep sedation/dental anesthesia requires constant monitoring of vital signs and spontaneous respiration, ventilation and circulation. Dental students are not trained to monitor both the dental procedure they are performing and the patient's physiologic status under the effects of pharmaceutical agents that reduces level of consciousness and sometimes resulting in unconsciousness. In addition most dentists provide general dental procedures for a patient in a semi recumbent position in many situations. If the dental patient is supine however, in an unprotected airway situation, the risk for aspiration of foreign bodies or liquids would be much greater if the dental patient had been rendered unconscious or was sedated deeply enough that the patient could not control salivary excretions. Also it is my understanding that if deep sedation/general anesthesia is utilized for general dental procedures, many times the duration of the dental treatment may be several hours. Longer anesthesia times are associated with increased complications. Last but not least, the dentist must be able to provide a complete thorough comprehensive examination of the patient to assure that he/she is physically able to tolerate both the deep sedation/general anesthesia as well as the dental treatment procedures provided. He/she must be competent and proficient in assessing airway risk, including evaluating all parameters of assessing a difficult airway. ASA III and IV patients are not likely
candidates for deep sedation/general anesthesia for extended duration with an unprotected airway in a dental environment.

The well skilled ACP if trained in an anesthesiology program accredited by the ACGME or by becoming a certified registered nurse anesthetist would be able to provide deep sedation/general anesthesia likely with the utilization of intravenous agents. However the vast majority of anesthesia cases provided in training programs are general anesthesia/unconscious patients, positioned supine, with a protected airway. If there is an oral/dental procedure, a throat pack is used to prevent aspiration. Dental patients will tolerate an efficacious throat pack only if unconscious. A throat pack also blocks oral air exchange, which may result in airway obstruction. It has been my experience that most ACPs, when asked to provide sedation (commonly called MAC or monitored anesthesia care) the depth of the sedation rarely exceeds what is known as moderate sedation, as there is apprehension to provide general anesthesia without intubation. This does not mean that an ACP could not learn what was involved in rendering general dental care in an outpatient setting however. It must be understood that most ACPs do not have specific training or experience in providing deep sedation/GA for general dental procedures in a dental office.

In addition although not mentioned in your inquiry, our dental practice act requires dental assistants that are qualified as anesthesia assistants to be present and active during deep sedation/general anesthesia procedures for the OMS who works as an operator/anesthetist. These qualified and trained dental assistance are knowledgeable about ventilation, circulation, medication, anesthetic agents, monitor readings, and other skills and tasks. In my opinion, a third person who knows how to help manage dental patients undergoing deep sedation/general anesthesia for dental procedures would be essential to improve patient safety.

Other related questions
1. Should the dental service provider who is not acting as the anesthetist/anesthesiologist but has delegated the deep sedation/general anesthesia to an anesthesia care provider (ACP) be required to have some minimum level of deep sedation/general anesthesia training?
   
   Answer:
   Unequivocally yes. I would not choose to call it a minimum level. I would specify the skills necessary and call in proficiency in managing crises associated with the use of deep sedation/general anesthesia. The requisite techniques must be standardized, mastered and verified to protect the public. The dental service provider should be trained regarding how to perform dental treatments procedures for patients with an unprotected airway in a supine position. He/she should be trained to be able to recognize challenges with ventilation and perfusion. He/she should be aware of the monitor readings and their significance (including SpO2, end tidal CO2 and ECG). Most of all he/she must be proficient in providing respiratory assist
and bag/mask ventilation and other techniques of evaluation and management of the anesthesia emergency, including assisting the ACP with the rescue of the dental patient suffering respiratory or cardiac problems or arrest.

2. Should dental hygienists who provide hygiene services for patients receiving deep sedation/GA by an ACP have some minimum level of sedation/anesthesia training?

Answer:
Unequivocally yes.
The caution that needs to be exercised when deep sedation/general anesthesia for dental treatment procedures is no different for the dental hygienist providing hygiene procedures than it is for the general dentist providing dental treatment procedures. There is no duplicity. The risk of potential harm is the same for dental prophylaxis as it is for surgical tooth extraction. If deep sedation/general anesthesia is necessary or permitted for hygiene services, and the dental hygienist is providing the service independently of the physical presence of the dentist who has had standardized training then the dental hygienist should have the same qualification/certification as any other provider treating the patient, including a dental specialist or general dentist.

3. Does a dental provider who is delegating both hygiene and anesthesia services need to be physically present in the treatment room while the patient is under deep sedation/GA and undergoing dental hygiene procedures?

Answer:
Yes, if the dental hygienist is not certified to provide the requisite standardized monitoring and execute rescue procedures that may be necessary of anesthesia complications arise, then the certified dental provider who is delegating should be physically present at all times that the dental patient is deeply sedated or under general anesthesia. If the dental hygienist is qualified and capable to provide appropriate monitoring and possesses the requisite skills necessary to resuscitate the patient if need be, then the general dental provider need not be present (as per question 2).

4. What experiences do my OMS residents in training have with deep sedation/GA?

Answer:
As mentioned I have directed the OMS residency training program twice in my career at the University of MN serving in that role for a total of 15 years with the last term extending from July 2016 to June 1, 2018. I have also been active as a CODA site visitor during which time I evaluated more than 25 % of the US OMS training programs. Our experience at the University of Minnesota is exceptional resulting in no know serious anesthesia mishaps in the last 29 years. We have been CODA accredited for almost 3 decades. To do so we
were required to fulfill the CODA guidelines for anesthesia training. At the current time, OMS residents must spend 4 months on general anesthesia rotation, acting in the same fashion as a medical resident in anesthesia. The anesthesia rotation is provided in the first year of a four-year program, after ACLS certification and a comprehensive history and physical course. After the residents have completed their anesthesia rotation, they may provide deep sedation/general anesthesia in our OMS clinics, at three facilities under faculty supervision. OMS residents also provide deep sedation/general anesthesia for patients that I treat in my "faculty practice" clinic, at which time I am able to directly observe their skills and abilities. OMS residents must perform at least 300 deep sedations/general anesthetics in order to meet CODA guidelines and complete the program. In addition U of Minnesota residents rotate as an anesthesia resident on the pediatric anesthesia service at Masonic Children's Hospital in the third year of their residency. Our residents have also participated in the BMV (bag mask ventilation) and OBCM (Office based crisis management) national courses in our simulation center. We test on anesthesia procedures and concepts annually on our mock board exams. We evaluate anesthesia scores attained by residents on the OMSITE (oral and maxillofacial surgery in-service training examination) on an annual basis. We conduct regular conferences and seminars on anesthesia techniques and safety. All of our OMS residents attend our annual formal OMS review at which there is a comprehensive and contemporary anesthesia presentation. All of our OMS faculty have general anesthesia permits issued by the Minnesota Board of Dentistry. All of our clinical training sites have been subject to and have passed the Minnesota Board of Dentistry office anesthesia inspection. All of our dental assistants assisting with general anesthesia have passed the national DAANCE certification program (Dental Anesthesia Assistant National Certification Program). All OMS residents are required to be ACLS certified for the entire duration of their OMS training program.

5. In Minnesota how are patients who require deep sedation/GA to undergo general dental procedures managed?

*Answer:*

I cannot comment on this as I do not know the answer nor have I been exposed to this. Deep sedation/general anesthesia is not provided in any other area of the University of Minnesota of which I am aware. As far as in the practice setting, I am aware of individuals who completed certification for moderate sedation in the state of Minnesota who have used an ACP to provide perhaps a deeper sedation. At the current time, you may consult the Minnesota Board of Dentistry Rules and Regulations to determine this. I do know that there is at least one dental anesthesiologist that practices in Minnesota. I do not know if she provides deep sedation/general anesthesia for other providers.
6. In Minnesota, is deep sedation/GA provided with an “open airway” or with an “airway device” in an office setting?

Answer:

By airway device I am anticipating that you mean a laryngeal mask airway (LMA) or a King airway/Combi-tube or an I-gel supraglottic airway. To my knowledge I know of no OMS that is using such a device for routine surgical procedures. I would expect that most have an airway device in their rescue/emergency resuscitation kits to serve as a back up if a direct laryngoscopy is not achieved. Just like oral endotracheal intubation (or nasal endotracheal intubation) these devices are not well tolerated in conscious patients even with deep sedation, as they tend to cause gagging and may provoke vomiting. If one determined that they were going to provide true general anesthesia and not just a continuum of deep sedation/general anesthesia, perhaps they would resort to oral tracheal or nasotracheal intubation, which would require a direct or video laryngoscopy to accomplish. And if they wanted the patient to not respond to the stimulus of the endotracheal tube, they might use a paralytic to keep the patient still so that dental procedures may be accomplished. By open airway, I am assuming that you mean unprotected airway that requires the patient and the provider to assure that the airway remained open. I am assuming on the basis of direct contact with colleagues, the open airway concept is likely the one that they use almost exclusively. I do know that in the state of Ohio, an endotracheal intubation is more routine.

I am hopeful that my comments will be of value to you and appreciate the opportunity to offer them. If I can be of any further assistance I would be more than happy to provide service.

Thank you for your objective and fair approach to addressing these anesthesia issues.

Most sincerely,

James Q. Swift DDS FACS
Professor
Division of Oral and Maxillofacial Surgery
University of Minnesota
September 27, 2018

RE: Sedation

Members of the Iowa Dental Board,

I want to commend and thank you for your services on the board. Your efforts are appreciated!

In regard to your recent discussions on sedation in a dental ‘facility’, it is obtusely obvious that a lot of dogs have come to this fight; each senses they have something to gain or lose as a result of these hearings and your eventual vote. You have been presented with truths, bias, and hyperbole. Now you have the tough job of separating these distillates before arriving at your final decision.

Sedation has been a lifelong interest of mine, stimulated in oral surgery blocks and rotations in dental school at the University of Iowa in 1977/1978. I was encouraged and mentored by many of our fine professors and faculty to continue my learning. We had no monitors, no pulse oximeters, no short acting drugs, no reversal agents, no precordial stethoscopes, no IV catheters, less knowledge, less technology, and less safe guards. By today’s standard, we lacked much. What we did not lack was the expectation from our mentors that we could and would be of service to the people in our communities. We commenced with confidence and fortitude.

In my 40 years of general practice, I am nearing my 3,000th successful sedation as a solo provider. I say this with all humility and only to salute and honor the myriad of mentors that have made this possible. I am a product of their generous sharing of knowledge, time, and belief in me.

We are now raising the next generation of our profession. Who do we envision them to be? We need to cultivate their desire and enthusiasm and be mentors to them, but it is imperative that we have dental practice laws that facilitate this process. I was confused and flabbergasted re-reading pages 1-19 of Chapter 29 of the Iowa Code and Rules. With its tangled web of rules and regulations, it loudly shouted, “Doubt! Fear! Mistrust!” And now you appear poised to add yet additional strands to that web by “searching for the best model”, as recently referenced by a board member?

Why do we look to hang our hat on only one model? Are the resources available in the Des Moines metro the same as they are in much of rural Iowa? Absolutely not! Are the people residing in more rural areas less needful of sedation services? Emphatically no! We have taken our eye off the ball – serving the people of Iowa and their access to care – while continuing to weave this nearly impenetrable blockade for practitioners, particularly our young ones.

I think you would do well to pause, table this item for 6 months, and really listen to what the dentists and their patients in the state of Iowa are saying. Sedation can be safe, effective, available, and affordable if we are all committed to a spirit of excellence within the dental sedation community.

Sincerely,

Dean R Hussong, DDS., S.C.
10 Bradly Farm Rd 1010 S 3rd St, Suite 2A 26 S Main St
Tomahawk, WI 54487 Polk City, IA 50226 Albia, IA 52531
715.453.5321 515.984.6001 641.932.2729
September 24, 2018

Ms. Jill Stuecker
Executive Director
Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309

RE: ISA Comments Regarding Draft Proposed Dental Anesthesia Changes

Ms. Stuecker,

Thank you for the opportunity to meet with you and your staff to discuss the Iowa Dental Board’s proposed Chapter 29 rule amendments. Please note below some specific comments that we have concerning these projected changes. The page references noted below are consistent with the most recent version of the Chapter 29 draft that was distributed at the last Iowa Dental Board meeting.

1) “Delegation of deep sedation/general anesthesia or moderate sedation” – 650-29.1(153) – (page 1) – This new section refers to the delegation of deep sedation, general anesthesia, or moderate sedation to another individual classified as a “sedation provider”. This individual is then defined as being another sedation permit holder, either a physician anesthesiologist or a nurse anesthetist. We feel that the term “delegation” in this context implies that the individual delegating the anesthesia services would still be in charge of the anesthesia services. Physician anesthesiologists have an unlimited license to practice medicine and are therefore authorized by law to work independent of any supervision requirement. Therefore, any reference to the transfer of anesthesia services to a physician anesthesiologist should be defined as “refer” or “referral”.

Additionally, we are concerned about prolonged and more extensive procedures being performed in the office, necessitating longer periods of anesthesia care. We would encourage the consideration of language that requires more suitable facilities, like hospitals or ambulatory surgical centers, for these types of procedures.
2) **Minimal Sedation definition** - 29.3(3) - (Page 4) – In reviewing the definition of minimal sedation as noted in section 29.3(3), we believe this not to be consistent with either the 2016 American Dental Association sedation guidelines or the 2018 American Society of Anesthesiologists (ASA) Practice Guidelines for Moderate Procedural Sedation and Analgesia. The latter report was endorsed by the ASA Task Force on Moderate Procedural Sedation and Analgesia, the American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Dental Association, American Society of Dentist Anesthesiologists, and Society of Interventional Radiology. Rather, the current proposed rule seems to be based on the 2012 ADA guidelines and we would recommend it gets updated to reflect the most recent standards. To that end, we would recommend the following definition:

a. Minimal sedation for adults is limited to a dentist's prescribing or administering a single enteral drug (or in divided doses) that is no more than 1.0 times the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. A single supplemental dose of the same drug may be administered, provided the supplemental dose is no more than one-half of the initial dose and the dentist does not administer the supplemental dose until the dentist has determined the clinical half-life of the initial dose has passed. 

b. The total aggregate dose shall not exceed 1.5 times the MRD on the day of treatment.

3) **Moderate Sedation Definition** (Page 6) – We would advise a similar update to the definition of moderate sedation, as noted below:

29.5(3) the following shall constitute moderate sedation:

a. The prescription or administration of a single dose of a single enteral drug in excess of 1.5 the MRD on the day of treatment;

b. The combination of more than one enteral drug;

c. The administration or prescription of drugs that are not recommended for unmonitored home use;

d. The administration of nitrous oxide with more than one enteral drug; and

e. The moderate sedation of an ASA category 3-4 patient or a pediatric patient as defined pursuant to subrule 29.4(4)c.

4) **Use of Capnography** – 29.6(11) - (page 8) – We support the required use of capnography to monitor end-tidal CO2, as mandated by the most recent guidelines as referenced above.

5) **Definition of Deep sedation/general anesthesia** - 29.7(1) - (Page 9) – We recommend the addition of the word “anesthetic” to complement the word “sedative” when referring to any substance that can produce a controlled state of unconsciousness.

6) **Deep sedation/general anesthesia permit holders** – 29.9(153) - (page 9) - We would recommend the addition of language to designate a unique area in the office, appropriately
equipped, to facilitate safe recovery of patients in circumstances in which deep sedation or general anesthesia was provided.

7) **Delegation of moderate sedation and general anesthesia services** – 29.10(1) - (page 12) – Similar to our comments on item #1 above, we feel that the reference in the 2nd and 3rd lines to “an anesthesiologist currently licensed by the Iowa Board of Medicine” should be removed and replaced, in the appropriate sections, with a reference to the word, “referral” to show that an anesthesiologist works as an independent provider.

8) **Delegation of moderate sedation and general anesthesia services** – 29.10(8) - (page 13) - Section 29.10(8) should be amended to include anesthesiologists. “Permit holders and physician anesthesiologists may administer sedation on behalf of another a licensed dentist, who does not hold a sedation permit, provided the permit holder or physician anesthesiologist complies with the following:

   a. The sedation permit holder or physician anesthesiologist completes a pre-operative evaluation of the patient, and determines the patient is a suitable candidate for sedation;
   b. The sedation permit holder or physician anesthesiologist administers the administration of the moderate or deep sedation/general anesthesia;

9) **Two additional issues for the Board of Dentistry’s consideration:**
   a. In order to best assure for the safe conduct of the anesthetic, we believe that physician anesthesiologists should be able to bring in their own equipment and drugs to a permitted facility, consistent with the medical practice act. The physician anesthesiologist will assume the legal responsibility for the transport of this equipment and therapeutic agents, the selection of which is based upon the education, training, and experience of the physician as well as ASA guidelines.

   b. **Special consideration should be made for pediatric patients under the age of six years old.** The 2018 American Society of Anesthesiologists (ASA) Practice Guidelines for Moderate Procedural Sedation and Analgesia addressed this patient population in the following manner:

   “Patients age six (6) and under are unlikely to be able to cooperate with procedures under moderate sedation and may require deep sedation and/general anesthesia. They are at particular risk for respiratory or other complications and have a greater risk of sustaining life-threatening events. Therefore, ASA recommends that all training and protocols should have specific measures for this patient population, including the same standard of care and monitoring for moderate sedation as for deep sedation and general anesthesia, i.e. a distinct and separate qualified anesthesia provider not otherwise involved in the procedure.”
Thank you for the opportunity to share our written comments with you.

Sincerely,

Thomas Touney, D.O.
President
January 4, 2017

Mr. Ken Levine
Texas Sunset Advisory Commission
1501 North Congress, REJ Building, 6th Floor
PO Box 13066
Austin, TX 78711

RE: Report to the Texas Sunset Advisory Commission by the Blue Ribbon Panel on Dental Anesthesia/Sedation Safety

Dear Mr. Levine:

Enclosed please find the Blue Ribbon Panel on Dental Anesthesia/Sedation Safety's report to the Texas Sunset Advisory Commission.

If I can be of further assistance, please let me know.

Sincerely,

[Signature]
Kelly Farmer
Executive Director

cc: Texas Sunset Advisory Commission Members (w/encl.)
Report to the Texas Sunset Advisory Commission

Blue Ribbon Panel on Dental Sedation/Anesthesia Safety
of the Texas State Board of Dental Examiners

Panel Members:
Ernest B. Luce, D.D.S., Chairman
Robert G. McNeill, D.D.S., M.D.
David H. Yu, D.D.S., M.S.
Reena Kuba, D.D.S., M.S.
Bryce S. Chandler, D.D.S.
Ronald J. Redden, D.D.S.

January 2017

Agency Contact: Kelly Parker, Executive Director
333 Guadalupe, Tower 3, Suite 800
Austin, TX 78701-3942
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Report to the Texas Sunset Advisory Commission
Blue Ribbon Panel on Dental Sedation/Anesthesia Safety
of the
Texas State Board of Dental Examiners
January 2017

Summary of Recommendations

The Blue Ribbon Panel on Dental Sedation/Anesthesia Safety (BRP) reviewed de-identified data compiled during board investigations in fiscal years 2012 through 2016 involving patient mortalities and patient harm during or following dental treatment at which sedation/anesthesia was administered and evaluated the appropriate substance and application of emergency protocols related to the administration of sedation/anesthesia.

Panel members, with the assistance of SBDE staff, performed an intensive review of 78 cases. Examination of these 78 cases resulted in the determination that 19 of these events were related to mishandled sedation/anesthesia. BRP identified six of the 19 cases as major events. BRP identified 13 of the 19 cases as mishaps. The panel also reviewed other state laws/rules and scientific literature.

A summary of the BRP recommendations are as follows:

Clinical recommendations:

- SBDE shall have full authority to inspect dental offices where any level of sedation/anesthesia is provided with emphasis on assessing competency of the sedation provider;

- Texas dentists should be required to have written emergency protocols and should be required to document that they practice these protocols with office staff through exercises such as "drills" several times per year;

- The SBDE mandate that at least one support staff member assisting with a sedation procedure (level 2, 3, 4) receive training in the recognition and management of sedation/anesthesia related emergencies;

- Texas dentists providing moderate/deep/general anesthesia (levels 2, 3, 4) to children under the age of 8 be required to document to the SBDE age specific sedation training;
• Texas dentists providing moderate/deep/general anesthesia (levels 2, 3, 4) to "high risk" patients (age 75 and older, BMI greater than or equal to 30, ASA classification 3, 4) be required to document to the SBDE specific training regarding these groups of patients;

• Offices where portable providers practice be required to have basic ventilation equipment onsite; and.

• Capnography and precordial stethoscope be mandated for level 2, 3 and 4 procedures.

Administrative recommendations:

• The SBDE should establish a standing independent sedation advisory panel to continue to review and advise the SBDE regarding sedation/anesthesia issues;

• The SBDE make public de-identified sedation related major events and mishaps;

• The SBDE collect data regarding sedations performed by Texas dentists. (non-accident data);

• The SBDE create a system to evaluate and approve sedation/anesthesia continuing education;

• The SBDE mandate that the sedation record for a dental procedure be a required part of the dental record, even if the sedation provider is a non-dentist;

• The SBDE consider creation of a recurrent sedation/anesthesia written examination covering sedation/anesthesia rules; and

• The Texas Legislature make an effort to encourage other state legislatures to share de-identified sedation/anesthesia data publicly.

Administrative suggestions:

• The SBDE consider creation of a required online sedation/anesthesia rules examination;

• The SBDE consider encouraging or mandating that dentists use a preoperative sedation checklist; and

• The SBDE consider including more detail in the SBDE rules regarding appropriate pre-operative evaluation and an acceptable sedation/anesthesia record.
I. Introduction

On August 22, 2016, the Sunset Review Commission directed the Texas State Board of Dental Examiners (SBDE) to establish an independent Blue Ribbon Panel (BRP) to review dental anesthesia-related deaths and mishaps in Texas. On August 31, 2016, SBDE met to establish the BRP, charging the BRP with:

a. reviewing de-identified investigative data related to dental anesthesia-related deaths and mishaps investigated by SBDE between 2011 and 2016;

b. reporting on trends and commonalities in the de-identified data;

c. reviewing sedation/anesthesia laws, regulations, and studies from other jurisdictions and review relevant published scientific literature;

d. opining on whether present laws, regulations, and board policies are sufficient to protect patients;

e. recommending appropriate changes to the laws, regulations, and board policies related to the administration of sedation/anesthesia to dental patients in Texas; and

f. evaluating emergency protocols.

II. Blue Ribbon Panel Membership and Meetings

The members of the BRP are active sedation providers from various disciplines of dentistry. SBDE selected members of the BRP from its existing dental review panel of licensed Texas dentists who serve as expert reviewers in SBDE’s investigations.

The members of the BRP are:

- Dr. Bryce Chandler, DDS, general dentist, level 2 provider
- Dr. Rena Kuba, DDS, pediatric dentist, level 2 provider
- Dr. Ernie Luce, DDS, general dentist, level 3 provider, portable - Chairman
- Dr. Robert McNeill, MD, DDS, oral and maxillofacial surgeon, physician, level 4 provider
- Dr. Ronald Redden, DDS, dentist anesthesiologist, level 4 provider, portable
- Dr. David Yu, DDS, periodontist, level 3 provider

Three of the members, Drs. Kuba, Luce, and Redden teach sedation/anesthesia in a Texas dental school.

The BRP met in person, in meetings open to the public, on four occasions. BRP member attendance at each of the meetings was 100%.
Project Chronology:

22 August, 2016  Sunset Advisory Commission Decision Hearing
31 August, 2016  SBDE open meeting to establish BRP
15 September, 2016  BRP open meeting #1
6 October, 2016  Staff distributed Master Data Set to BRP (123 cases)
25 October, 2016  BRP open meeting #2 – selected cases (78 cases)
6 November, 2016  Staff distributed detailed data on selected cases (78 cases)
15 November, 2016  BRP open meeting #3 – identified major events/mishaps (19 cases)
7 December, 2016  BRP meeting #4 – analyzed data, identified trends and made summary recommendations
4 January, 2017  BRP submitted written report to the Sunset Advisory Commission
11 January, 2017  Sunset Advisory Commission Hearing

III. Definitions

AAOMS - American Association of Oral and Maxillofacial Surgeons

AAPD - American Academy of Pediatric Dentistry

ASDA - American Society of Dentist Anesthesiologists

ASA - American Society of Anesthesiology

ASA 1, 2, 3, 4, 5 - scale created by the American Society of Anesthesiology to make a general assessment of the physical status of a patient

BMI - body mass index, a measure of obesity based on height and weight

High risk - describes patients who are obese (BMI ≥ 30, compromised health (ASA 3 and 4) or elderly (75 years of age or older)
IV. Current Sedation Permit Levels

The SBDE formally permits Texas dentists to provide different levels of sedation/anesthesia based on educational experience.¹ The higher the level of sedation, the greater the educational requirements to obtain that permit. The levels are:

*Nitrous oxide/oxygen (laughing gas)* – typically the lightest level of sedation.

*Level 1 sedation (minimal)* – a single oral sedative, may be mixed with nitrous oxide, patients become relaxed, but will respond *normally* to gentle touch. They are very easily awakened.

*Level 2 sedation (moderate oral)* – multiple oral sedatives are allowed, patients are relaxed but respond *purposely* to gentle touch. They are easily awakened.

*Level 3 sedation (moderate parenteral)* – multiple sedatives may be administered by injection (such as an intravenous line). Patients are relaxed but respond *purposely* to gentle touch, as in level 2. They are easily awakened.

*Level 4 sedation/anesthesia (deep sedation/general anesthesia)* – multiple sedatives may be administered by any route, including injection. Patients are “asleep”. A painful stimulus must be repeatedly applied to the patient in order to elicit a response, if they respond at all. They are difficult or impossible to wake up with physical stimulation.

V. Review and Analysis of De-Identified Data – Major Events and Mishaps

The BRP made an in-depth review of 78 cases investigated by SBDE in search of evidence of mishandled sedation/anesthesia.² BRP identified six of the 78 cases as major sedation/anesthesia events. BRP identified 13 of the 78 cases as sedation/anesthesia mishaps. Findings were defined as:

a. **major events** meaning the case resulted in mortality or permanent morbidity *and* was directly related to mishandled sedation/anesthesia

b. **mishaps** meaning that an adverse event occurred without permanent injury *and* was directly related to mishandled sedation/anesthesia

¹ See Appendix 1 for SBDE Sedation/Anesthesia rules.

² Seventy-five of the 78 cases were resolved at the time of review. Three of the 78 cases were under SBDE investigation at the time of BRP review but were incorporated into the BRP review due to their high profile nature and relevance to BRP charge.
Major Events – Summary of the Six Major Sedation/Anesthesia Events

<table>
<thead>
<tr>
<th>Patient Age</th>
<th>Health Status</th>
<th>S/A Provider</th>
<th>Intended Level</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>adult under 75</td>
<td>obese, cardiac dz</td>
<td>Dentist anesth</td>
<td>4, deep IV</td>
<td>mortality</td>
</tr>
<tr>
<td>adult under 75</td>
<td>obese, DM, CV dz</td>
<td>Periodontist</td>
<td>3, moderate IV</td>
<td>mortality</td>
</tr>
<tr>
<td>child under 8</td>
<td>healthy</td>
<td>General dentist</td>
<td>2, moderate oral</td>
<td>brain damage</td>
</tr>
<tr>
<td>child under 8</td>
<td>healthy</td>
<td>Pediatric dentist</td>
<td>2, moderate oral</td>
<td>mortality</td>
</tr>
<tr>
<td>child under 8</td>
<td>cardiac disease</td>
<td>MD anesth</td>
<td>4, GA</td>
<td>mortality</td>
</tr>
<tr>
<td>child under 8</td>
<td>healthy</td>
<td>MD anesth</td>
<td>4, GA</td>
<td>mortality</td>
</tr>
</tbody>
</table>

BRP Findings Regarding the Six Major Sedation/Anesthesia Events:

a. Every event involved either young children (child under 8) or adults with high risk factors (obese/compromised health/elderly).

b. Highly trained specialists (including physicians) or a general dentist provided the sedation/anesthesia in each of the major events.

c. For the intended level 2 and 3 events, the patient almost certainly became more deeply sedated than intended. Once deeply sedated, the patient is difficult or impossible to awaken with physical stimulation. It is at this point that breathing becomes compromised. If not recognized and corrected quickly, brain damage or death ensues rapidly.

d. Poor pre-operative evaluation, drug overdose, not following current monitoring requirements and poor emergency management were also prominent in these cases.

e. Regarding portable providers, a total of four of the major events involved a provider practicing on a portable basis. Two of these four major events involved portable physician anesthesiologists. Being portable did not appear to contribute directly to these major events.

The other two of these four major events involved a portable dentist sedation/anesthesia provider, a level 3 and a level 4 provider. In these two cases, the provider appeared to not have required emergency equipment that would have been useful in the evolving emergency.

It is unknown how many sedation/anesthetics are performed in Texas on a "portable" basis vs. a "non-portable" basis.

Mishaps – Summary of the 13 Sedation/Anesthesia Mishaps

Of the 78 cases studied by BRP, BRP identified 13 cases in which a sedation/anesthesia mishap occurred. Pertinent factors in the mishaps include:
a. Eight of the 13 mishaps involved children under 8 or high-risk adults (obese, compromised health or elderly).

b. Dental specialists (oral & maxillofacial surgeons - one case, dentist anesthesiologist – one case, periodontists - two cases and pediatric dentists - three cases) as well as general dentists - six cases, provided the sedation/anesthesia in these cases.

c. The severity of the mishaps ranged from minor to serious.

d. The nature of the mishaps was also quite varied and included drug overdose, premature discharge, predictable but unanticipated drug interaction due to poor drug selection, bolus drug administration (instead of slow, careful, incremental drug administration), and poor management in the early stages of a developing urgency allowing the condition to further deteriorate to an emergent condition and delayed calls to 911.

e. Some of the mishaps occurred in the office while some developed after what was a premature or inappropriate discharge.

f. When an emergency did develop in the office, poor emergency management was present in almost all cases.

g. Every mishap involving a high risk adult patient also involved inadequate or poorly documented pre-procedural patient evaluation and some element of poor sedation technique (such as bolus drug administration, not utilizing required monitors or not being attentive to monitors that were being used while indicating a developing urgency).

VI. Summary Comments Regarding Trends in Sedation/Anesthesia

The SBDE has 16,719 dentists with an active license, and 7,502 licensees hold a Level 1-4 permit. The SBDE has not been required to collect data on each administration of sedation/anesthesia that occurs during dental procedures in Texas (estimated at 500,000 to 1,000,000 administrations per year below). Lacking this detailed information regarding all sedations done in the state limits the statistical conclusions that can be drawn.

However, the BRP was able to study case specific information of actual adverse events that occurred in Texas by reviewing de-identified data collected in board investigations that occurred between 2011 and 2016 involving patient mortalities and patient harm during or following dental treatment at which sedation/anesthesia was administered and evaluated the appropriate substance and application of emergency protocols related to the administration of sedation/anesthesia.
Many level 1, 2, and 3 sedation providers offer sedation on an episodic basis, ranging from only a few times a year to several cases per day. In contrast, most level 4 providers provide sedation/anesthesia multiple times per day. The OMS National Insurance Company (OMSNIC) estimates that the average AAOMS member in Texas performs 669 sedation/anesthetics per year. If each of the approximately 400 OMFS in Texas performs sedation/anesthesia at this rate, approximately 270,000 sedation/anesthetics are performed by Texas OMFS each year.

The American Society of Dentist Anesthesiology includes 25 members in Texas (also level 4 providers). Estimates from three of their members suggest that the average dentist anesthesiologist in Texas treats 435 patients per year suggesting that 10,875 anesthetics are performed annually by Texas Dentist Anesthesiologists.

According to the ADA, there are 659 "professionally active" pediatric dentists in Texas. Anecdotal information among active pediatric dentists suggests that, on average, each of these practitioners performs approximately 200 minimal/moderate (mostly level 1 and 2) sedations each year. Based on these numbers, it is estimated that Texas Pediatric Dentists perform approximately 130,000 sedations annually.

Between oral and maxillofacial surgeons, pediatric dentists and dentist anesthesiologists, approximately 411,000 sedation/anesthetics are performed annually in Texas. This group of dentists represents only 1084 of the approximately 7,502 sedation permit holders in the state. Estimating the number of sedation procedures completed by other dentists in Texas (primarily endodontists, periodontists and general dentists) is even more speculative than the estimates above. Likely, the total number of sedation procedures provided by all Texas dentists is somewhere between 500,000 and 1,000,000 annually. For the 5 years of data the BRP evaluated, we estimate between 2,500,000 and 5,000,000 sedation/anesthetic procedures were performed. Five deaths and one brain injury directly related to sedation/anesthesia occurred in that time period.

It is important to or keep in mind that patients receiving nitrous oxide/oxygen, level 1 minimal sedation, level 2 or 3 moderate sedation are either awake or easily roused by quiet voice or gentle touch throughout the sedation. Patients receiving level 4 deep sedation/general anesthesia are difficult or impossible to arouse.

By far, the most common proximate cause of morbidity and mortality in sedation is compromised ventilation. Most of the commonly used sedative drugs will depress ventilation in the sedated patient, sometimes to the point that breathing stops completely. When breathing stops or becomes severely limited, the practitioner must recognize this condition, diagnose the specific reason for the compromise and rectify the situation all within a very few minutes. If panic or indecision sets in, emergency equipment/medications are not immediately available, or there is a lack of familiarity with the equipment/medications, or there is a lack of a clearly understood emergency plan, the chance of a poor outcome rises dramatically. Efficient teamwork among the doctor(s) and support staff is essential to help ensure swift resolution of the situation.
The margin of safety is narrower in certain specific patient groups. In young children, this time period to manage the evolving crisis is dramatically reduced. Obese individuals also decompensate much faster than slender, healthy adults when breathing becomes compromised. Many medically compromising conditions also result in much more rapid decompensation if breathing stops. Young children and elderly/obese/medically-compromised patients pose extra sedation risks.

Almost without exception, when a mortality occurs associated with minimal or moderate sedation (levels 1, 2, 3), the practitioner allowed the patient to reach a level of deep sedation, where the patient became difficult or impossible to arouse by physical stimulation. It is only at this point that ventilation becomes significantly compromised. Minimal and moderate sedation patients that are kept at a minimal and moderate state do not develop airway compromise. Therefore the root cause of minimal/moderate sedation morbidity/mortality is essentially always that the doctor allowed the patient to become deeply sedated. Preventing the loss of responsiveness will prevent the vast majority of minimal/moderate sedation adverse outcomes. Accomplishing this single goal will have the greatest impact to reduce adverse outcomes in minimal/moderate sedation.

Current SBDE rules require that any patient considered for sedation/anesthesia be "suitably evaluated prior to the start of any sedative procedure." and go on to state that, "A focused physical evaluation must be performed as deemed appropriate." Every event in our series involving a high-risk patient also involved very poor pre-operative evaluation and limited or no physical evaluation.

Interestingly, among the cases BRP reviewed involving high-risk patients, all of these patients had some sort of medical consultation done prior to the sedation procedure. Lack of medical consultation does not seem to be a factor in the evolution of the mishap or major event in our patients. Data from this patient series does not support the need to mandate enhanced medical consultation.

If the patient becomes more deeply sedated than permitted, current rules require the level 1, 2, and 3 provider to stop the dental procedure and return the patient to the intended level of sedation. The sedation provider is required to continually verify responsiveness and ventilation.

In addition, the current rules mandate that the sedation provider remain in the dental operatory until the patient has reached a defined level of recovery. While unverifiable, there is a strong suspicion that three of the six major events involved the sedation provider leaving the operatory for some period of time while the patient was still sedated, and the crisis developed/evolved during this time period. Leaving a sedated patient unattended is a major contributor to a patient becoming deeply sedated when only minimal or moderate sedation was intended. (The delivery of dental care is stimulating, and this helps keep minimally and moderately sedated patients responsive. If the dental care stops, the stimulation stops and the patient may become
unintentionally deeply sedated and possibly stop breathing. If the patient has been left alone, there is no one available in the room to rescue the patient.)

Current rules mandate that the dentist have emergency protocols/equipment/medications immediately available in the event of an emergency. Unfortunately, there was a pattern of poor emergency management in the BRP's case reviews: of the 12 cases reviewed where an emergency occurred in the office, emergency management by the dentist was judged to be poor or inadequate in 11 of those cases. The emergency failures observed in the major events and mishaps involved cases where:

- emergency drugs were available but given in the wrong dose
- emergency ventilation equipment was available, but was used ineffectively
- emergency ventilation equipment was not available
- supplemental oxygen was available but not administered when indicated
- the provider was slow to activate EMS - *(this was the most common finding)*

Long delays before activation of the emergency medical system (EMS - 911) were common, but not universal in our cases. For some doctors, making the decision to call 911 represents a personal failure and can become a major obstacle for the doctor to overcome. As the potentially liable individual in the office, making the call to summon assistance may, in the eyes of the doctor, open the door to unwanted investigation by a regulatory agency, such as the SBDE, and subsequent fear of punishment. Lack of hands on practice in crisis management likely also contributes to poor performance during an emergency.

For five of the six major events, the sedation provider received his/her training in a university/hospital facility versus a continuing education course. For the mishaps, the majority of the providers were trained in a university/hospital setting. The data does not support the concern that dentists trained outside of the university/hospital setting have more sedation accidents.

**VII. Review and Analysis of Dental Rules and Laws in other States and Anesthesia Related Organizations**

**Dental Board of California: Pediatric Anesthesia Study, Draft July 2016**

The Dental Board of California undertook a review of pediatric sedation/anesthesia incidents between 2010 and 2015. During this window of time, nine pediatric deaths were noted with various combinations of local anesthesia, sedation, and general anesthesia. Fifty-six additional pediatric hospitalizations were also described, many of which were still being investigated. Limited details are present in the draft report
regarding the deaths. Attempting to determine the proximate and root cause of death from the report would be speculative. The draft report includes an extensive review of dental sedation/anesthesia rules/laws in United States. Of note, twenty-five states have special requirements for pediatric patients. Nine states have a separate permit for sedation of pediatric patients. States are not consistent in the way they define a child.

Combined statement of the American Academy of Pediatrics and the American Academy of Pediatric Dentistry:
Coté, CJ Wilson S. AMERICAN ACADEMY OF PEDIATRICS, AMERICAN ACADEMY OF PEDIATRIC DENTISTRY. Guidelines for Monitoring and Management of Pediatric Patients Before, During and after Sedation for Diagnostic and Therapeutic Procedures: Update. 2016. Pediatrics 2016;138(1);e20161212

Comments pertinent to BRP's inquiry:

- The use of emergency checklists is recommended.
- A protocol for immediate access to back-up emergency services should be clearly outlined.
- Support staff should be specifically trained to be able to assist with a pediatric emergency.
- All team members should practice emergency protocols periodically.
- In moderate sedation, use of capnography or precordial stethoscope is strongly recommended (required if bidirectional verbal communication not possible).
- In deep sedation, use of capnography is required.

American Association of Oral and Maxillofacial Surgeons (AAOMS) - Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParCare 2012) - policy requires that, every five years, members undergo an on-site anesthesia office inspection (by AAOMS inspectors) to ensure proper monitoring and emergency equipment is present as well as to review emergency protocols.

California Dental Board in December 2016 adopted new sedation rules for the sedation of children:

- For deep sedation/general anesthesia-limitations to operator/anesthetist model of practice.
• For moderate sedation - capnography is a required monitor, sedation training equivalent to that of an accredited pediatric dentistry residency, at least one additional staff member trained in Pediatric Advanced Life Support (PALS), for children less than seven years, an additional staff member dedicated to patient monitoring is required.

• (California Legislature and the Governor must approve these rules in order for them to take effect)

October 2016, the American Dental Association (ADA) House of Delegates adopted a resolution to modify their Guidelines for the Use of Sedation and General Anesthesia in Dentistry. In part, this resolution includes a mandate for the use of capnography for patients receiving moderate sedation.

Texas State Board of Dental Examiners’ Review of State Dental Boards, determined that 36 of the 50 state dental boards require some sort of dental office inspection, but the details regarding implementation and structure of these inspections vary widely from state to state. Literature regarding the effectiveness of office inspections is described in the next section.

June 2014, the Texas Medical Board adopted a plan to inspect medical offices that provide anesthesia services. (Texas Administrative Code 192.5)

TAC 192.6 allows MDs to request an inspection with a non-binding advisory (for a fee)

Sunset Staff Report 2016-2017: Texas Medical Board—comments regarding medical office inspections where anesthesia is administered. The board currently registers 2,482 physicians who provide office-based anesthesia. (Approximately 7000 Texas dentists have some type of sedation permit)

Issue 2, key recommendation: "Authorize the board to establish a risk-based approach to its office-based anesthesia inspection, focusing on the length of time since equipment and procedures were last inspected."

Recommendation 2.9 "The board should focus its efforts on the inspection of equipment and office procedures instead of the registered physician to ensure that the inspectors do not waste time re-inspecting equipment approved and procedures." (BRP recommendation will emphasize assessing the competency of the provider if office inspections are implemented)

VIII. Review and Consideration of Scientific Literature

created "checklist" to be used by medical surgical teams prior to the start of a surgical procedure.

Comments pertinent to BRP's inquiry:

- Use of the pre-operative checklist reduced surgically related deaths from 1.5% to 0.8% (highly statistically significant).

- Use of the checklist reduced the overall complication rate from 11.0% to 7.0% (highly statistically significant).

Arriaga AF et al. Simulation-Based Trial of Surgical-Crisis Checklists. New England Journal of Medicine 2013;368:246-53. This article details the results of 17 surgical teams participating in 106 simulated surgical-crisis scenarios.

Comment pertinent to BRP's inquiry:

- Use of an emergency checklist reduced "missed steps" from 23% to 6% in these simulated emergencies using high fidelity human simulators

Ilgen JS et al. Technology-enhanced Simulation in Emergency Medicine: A Systematic Review and Meta-Analysis. Academic Emergency Medicine 2013;20:117-127. This article reviews 85 studies, which compare simulation training to conventional training to no intervention at all.

Comment pertinent to BRP's inquiry:

- Simulation based recurrent emergency training was superior to traditional recurrent emergency training and far superior to no recurrent emergency training at all

Shapiro MJ et al. Simulation based teamwork training for emergency department staff: does it improve clinical team performance when added to an existing didactic teamwork curriculum? Quality and Safety in Healthcare 2004;13:417-21. This article reviews the results of a study to determine if adding team training (involving the staff, not just the doctors) would improve team clinical performance.

Comment pertinent to BRP's inquiry:

- Training involving the entire team improved clinical performance of the team

Bhanankar SM et al. Injury and Liability Associated with Monitored Anesthesia Care. Anesthesiology 2006;104:228-34. This article compares closed claims data for monitored anesthesia care (MAC) vs. general anesthesia. Data was abstracted from the Closed Claims database of the American Society of Anesthesiologists. Monitored
anesthesia care in the operating room is similar to level 3 moderate parenteral sedation, possibly becoming level 4 deep sedation at times.

Comment pertinent to BRP's inquiry:

- The most common cause of death/injury in MAC was associated with respiratory compromise - ventilation became inadequate during the procedure but was not adequately addressed or managed by the anesthesia provider.

Gaulton TG et al. Administrative issues to ensure safe anesthesia care in the office-based setting. Current Opinion in Anesthesiology 2013;26:692-697. The authors in this article review the wide variations between states regarding medical office based anesthesia vs. national administrative based structures to regulate office-based anesthesia. They also comment on literature concerning office Inspection/accreditation and the use of checklists.

Comments pertinent to BRP's inquiry:

- Regarding the effectiveness of office inspections/accreditation: little literature exists to improve outcomes in medicine where office based anesthesia is administered. The few studies available suggest a reduction in complications in accredited facilities, but these studies have also drawn criticism concerning methodological limitations. The authors note,"Although the decrease in adverse events did coincide with an increase in practice accreditation, it is impossible to conclude causality."

- Regarding the use of checklists, the authors present multiple studies all showing that the use of checklists significantly reduce the incidence of complications. The authors were robust in their endorsement of the use of checklists, also noting that federal regulatory agencies such as Centers for Medicaid and Medicare Services (CMS) require the use of surgical safety checklists in their accredited ambulatory surgical centers (ASCs).

IX. Conclusion and Recommendations

The reasons patients die or become permanently disabled in connection with dental care are quite varied. In the BRP case reviews, only a minority of deaths appeared directly related to mishandled sedation/anesthesia. Each of the six major events in this review included at least one significant failure on the part of the sedation provider to follow traditionally accepted core concepts of proper sedation/anesthesia technique. Failures included: poor pre-operative evaluation, poor technique, poor monitoring, and poor emergency management. In fact, all six of the major events included at least two major failures.
In the six major events studied by BRP, if current rules had been closely followed and the failures avoided, there likely would have been no sedation related event. Every patient would have been thoroughly evaluated pre-operatively for the planned sedation/anesthetic, drugs would have been conservatively and cautiously administered, and keeping patients closely monitored both electronically and personally by the dentist throughout the procedure. For the minimal and moderate sedation providers, patients would never have become unresponsive. If a truly unpredictable emergency event had occurred, the well-trained and practiced team would have worked together to efficiently manage the situation, including a rapid call to 911 when appropriate.

Unfortunately, these events did occur and they appear related to failures by the sedation/anesthesia provider at a basic level: poor preparation, poor technique and poor performance when an emergency did occur. It is unclear why practitioners allow this to happen. Equally challenging is to know how to remedy the situation.

The challenge to this panel is to consider whether or not reasonable changes to laws, rules or enforcement will motivate dentists to not be lax, but be meticulously attentive to each step in the sedation/anesthesia process and maintain the highest standard of safety. Rules changes should not limit access to care and should create a regulatory structure to foster best practices in sedation/anesthesia.

The BRP discussed many possible recommendations and suggestions that might be helpful, some clinical in nature, some administrative.

**Clinical recommendations:**

The **SBDE should have the authority to conduct inspections of dentists administering sedation/anesthesia.** Thirty-six states have some type of sedation/anesthesia office provider inspection. The BRP suggests any inspections emphasize evaluation of the competency of the dentist.

The **SBDE have the authority to review sedation records of level 2, 3 and 4 providers. Determination that the records did not meet the standard of care would be used as an indicator for an on-site office inspection.** In the 19 major events/mishaps, there was a strong correlation between poor documentation and poor performance during an office emergency.

The **SBDE mandate that sedation providers have written emergency protocols and that they be required to practice these protocols six times per year.** Of the cases where an emergency occurred in the office, 11 of 13 mishaps were managed poorly. Literature clearly supports not only the use of emergency protocols (checklists) but also the use of pre-operative checklists. This should include a mechanism to encourage rapid activation of EMS when an emergency occurs and assure adequate access for EMS services.
The SBDE mandate that at least one support staff assisting with a sedation procedure (level 2, 3, 4) receive training in the recognition and management of sedation/anesthesia related emergencies. Literature clearly documents that emergency management improves as the entire team is trained as opposed to only the doctor.

The SBDE require level 2, 3, 4 providers who desire to sedate/anesthetize children under 8 years of age to document specific training in the management of this age group of patients.

The SBDE require level 2, 3, 4 providers who desire to sedate/anesthetize high-risk adults (75 years of age and older, ASA 3 or 4, obese - BMI greater than or equal to 30) to document specific training in the management of this group of patients. Each of the major events in this case series involved a child less than 8 years or a high-risk adult.

The SBDE mandate that offices where portable providers function have basic ventilation equipment on-site. Two of the six major events involved a portable provider who attempted to manage an emergency without ventilation equipment.

The SBDE mandate the use of capnography and a precordial stethoscope for level 2, 3 and 4 sedation. Of all the potential recommendations discussed by the BRP, this was the only one that did not garner almost immediate and unanimous support. The recommendation passed but with clear reservation by several members. Valid concerns were raised regarding applicability in level 2 and 3 sedation. Literature support for the use of capnography or a precordial stethoscope in deep sedation is well accepted, but is controversial in moderate sedation. Further consideration and study of the issue is needed by an ongoing committee of the board.

Administrative recommendations:

The SBDE continue to utilize an independent panel of expert sedation/anesthesia providers to advise the Board. This BRP was given only a short period of time to accomplish their assigned task. An ongoing group can continue to discuss and more fully evaluate ideas based on evolving scientific literature that may allow improved patient safety.

The SBDE make public de-identified sedation related major events and mishaps. If other state dental boards would do the same, a much larger pool of information would be available with which to draw better conclusions.

The Texas Legislature make an effort to encourage other state legislatures to share de-identified sedation/anesthesia data publicly. If a majority of states would participate, a much more scientifically valid pool of data would be available for study. This would include both accident data and non-accident data.
The SBDE collect data regarding sedations performed by Texas dentists. (non-accident data)

The SBDE create a system to evaluate and approve sedation/anesthesia continuing education programs.

The SBDE mandate that the sedation record for a dental procedure be a required part of the dental record, even if the sedation provider is a non-dentist.

Administrative suggestions:

The SBDE consider creation of a required online sedation/anesthesia rules examination.

The SBDE consider encouraging or mandating that dentists use a preoperative sedation checklist.

The SBDE consider including more detail in the SBDE rules regarding appropriate pre-operative evaluation and an acceptable sedation/anesthesia record.
TEXAS

Texas Administrative code §110.1 - §110.18 identifies sedation and anesthesia rules as issued by the Texas State Board of Dental Examiners. The rules can be reviewed in their entirety here. The chapters cover rules on Nitrous Oxide/Oxygen Inhalation Sedation, Minimal Sedation, Moderate Sedation, and Deep Sedation or General Anesthesia.

The rules are consistent for all levels of sedation regarding supervision. They indicate a dentist shall not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a sedation procedure unless the dentist holds a permit for the sedation procedure being performed. The rules do not speak to the delegation of sedation to other professionals.

The rules indicate the dentist must induce the nitrous oxide/oxygen inhalation or administer the sedation and must remain in the room with the patient during the maintenance of the sedation. The rules also state no permit holder shall have more than one person under general anesthesia at the same time exclusive of recovery. Staff requirements are also documented. For example, a dentist administering deep sedation must maintain under continuous direct supervision a minimum of two qualified dental auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of deep sedation and/or general anesthesia.

The following are excerpts from the rules themselves:

110.3 Nitrous Oxide/Oxygen Inhalation Sedation

(b) Standard of Care Requirements. A dentist performing nitrous oxide/oxygen inhalation sedation shall maintain the minimum standard of care for anesthesia, and in addition shall:

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a nitrous oxide/oxygen inhalation sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed. This provision and similar provisions in subsequent sections address dentists and are not intended to address the scope of practice of persons licensed by any other agency.

(4) Monitoring.

(A) The dentist must induce the nitrous oxide/oxygen inhalation sedation and must remain in the room with the patient during the maintenance of the sedation until pharmacologic and physiologic vital sign stability is established.
(B) After pharmacologic and physiologic vital sign stability has been established, the dentist may delegate the monitoring of the nitrous oxide/oxygen inhalation sedation to a dental auxiliary who has been certified to monitor the administration of nitrous oxide/oxygen inhalation sedation by the State Board of Dental Examiners.

110.4 Minimal Sedation

(b) Standard of Care Requirements. A dentist performing minimal sedation shall maintain the minimum standard of care for anesthesia, and in addition shall:

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a minimal sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

(4) Monitoring.

The dentist administering the sedation must remain in the operatory room to monitor the patient until the patient meets the criteria for discharge to the recovery area. Once the patient meets the criteria for discharge to the recovery area, the dentist may delegate monitoring to a qualified dental auxiliary.

110.5 Moderate Sedation

(b) Standard of Care Requirements. A dentist must maintain the minimum standard of care as outlined in §108.7 of this title and in addition shall:

(2) maintain under continuous personal supervision auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of moderate sedation;

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a moderate sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

110.6 Deep Sedation or General Anesthesia

(b) Standard of Care Requirements. A dentist must maintain the minimum standard of care for the administration of anesthesia as outlined in §108.7 of this title and in addition shall:

(2) maintain under continuous direct supervision a minimum of two qualified dental problems, and emergencies incident to the use of deep sedation and/or general anesthesia;
(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a deep sedation/general anesthesia procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

110.10 Use of General Anesthetic Agents

(c) No permit holder shall have more than one person under general anesthesia at the same time exclusive of recovery.

FLORIDA

The Florida Board requires that dentists without an anesthesia permit receive training if delegating sedation. Rules can be found [here](#). The Florida Board of Dentistry allows for physician anesthesiologist to practice anesthesia at any level regardless of the dentist’s level of training with some conditions in place. The Florida Board allows for a dentist to supervise a qualified anesthetist under direct supervision.

Dental assistants may monitor Nitrous Oxide inhalation analgesia under the direct supervision of a dentist if conditions are met.

The Florida Board also requires that three properly credentialed individuals be present. General anesthesia permit holders are able to perform sedation for dentists that do not have general anesthesia permits, but then both dentists are considered liable. The permitted dentist is also required to remain with the patient from onset until discharge.

64B5-14.0032 Itinerate/Mobile Anesthesia – Physician Anesthesiologist.

The level of sedation is not restricted to the level of the permit held by the treating dentist. The level of sedation may be any level necessary for the safe and effective treatment of the patient.

A dentist who holds a general anesthesia permit may treat their adult, pediatric, or special needs patients when a physician anesthesiologist performs the sedation services. The following conditions shall apply:

(1) General Anesthesia Permit Holders:

(a) The physician anesthesiologist performs the administration of the anesthesia and the physician anesthesiologist is responsible for the anesthesia procedure;

(b) The dental treatment takes place in the general anesthesia permit holder’s board-inspected and board-registered dental office.
(2) Pediatric Moderate Sedation Permit Holders:

A pediatric dentist, as recognized by the American Dental Association, who holds a pediatric Moderate sedation permit may treat their pediatric or special needs dental patients when a physician anesthesiologist performs the sedation services. The following conditions shall apply:

(a) The physician anesthesiologist performs the administration of the anesthesia, and the physician anesthesiologist is responsible for the anesthesia procedure;

(b) The treatment takes place in the permit holder’s board-inspected and board-registered dental office;

(c) The dental office meets the supply, equipment, and facility requirements as mandated in Rule 64B5-14.008, F.A.C.;

64B5-14.0034 Itinerate/Mobile Anesthesia – General Anesthesia Permit Holders

A general anesthesia permit holder may perform sedation services for a dental patient of another general anesthesia permit holder or moderate or pediatric moderate permit holder in his or her office or another general anesthesia permit holder’s office.

In this setting, the following shall apply:

(a) The dental treatment may only be performed by a treating dentist who holds a valid anesthesia permit of any level;

(b) The treating dentist and the anesthesia provider are both responsible for the adverse incident reporting under Rule 64B5-14.006, F.A.C.

(2) Moderate and Pediatric moderate Sedation Permit Holder’s Office:

A general anesthesia permit holder may perform sedation services for a dental patient of another dentist who holds a moderate sedation permit or a pediatric moderate sedation permit at the office of the treating dentist. In this setting, the following shall apply:

(a) The dental treatment may only be performed by the moderate sedation or pediatric moderate sedation permit holder;

(b) The general anesthesia permit holder may perform general anesthesia services once an additional board-inspection establishes that the office complies with the facility, equipment and supply requirements of Rule 64B5-14.008, F.A.C.;

(c) The treating dentist and the anesthesia provider are both responsible for the adverse incident reporting requirements under Rule 64B5-14.006, F.A.C.
64B5-14.0036 Treatment of Sedated Patients by Dentists without an Anesthesia Permit.

The provisions of this rule control the treatment of patients where an anesthesia permitted dentist sedates the dental patient in his or her board-inspected and board-registered dental office and a Florida licensed dentist without an anesthesia permit performs the dental treatment.

(1) The permitted dentist shall perform the sedation in his or her out-patient dental office where the permitted dentist is registered to perform the anesthesia services;

(2) The permitted dentist shall remain with the patient from the onset of the performance of the anesthesia until discharge of the patient;

(3) The permitted dentist shall have no other patient induced with anesthesia or begin the performance of any other anesthesia services until the patient is discharged;

(4) The treating dentist shall have taken a minimum of four hours of continuing education in airway management prior to treating any sedated patient. Two hours must be in didactic training in providing dentistry on sedated patients with compromised airways and two hours must include hands-on training in airway management of sedated patients. After the initial airway management course, the treating dentist shall continue to repeat a minimum of four hours in airway management every four years from the date the course was last taken by the dentist. The continuing education courses taken may be credited toward the mandatory thirty hours of continuing education required for licensure renewal. The requirement that a dentist must first have taken an initial airway management course before treating a sedated patient shall not take effect until March 1, 2014.

64B5-14.0038 Use of a Qualified Anesthetist.

In an outpatient dental office, and pursuant to Section 466.002(2), F.S., a dentist may supervise a qualified anesthetist who is administering anesthetic for a dental procedure on a patient of the supervising dentist. The type of supervision required is direct supervision as defined in Section 466.003(8), F.S. In an outpatient dental office, the supervising dentist must have a valid permit for administering sedation to the level of sedation that the qualified anesthetist will be administering to the dental patient during the dental procedure. The dentist must maintain all office equipment and medical supplies required by this chapter to the level of the sedation that the qualified anesthetist will administer to the dental patient.

64B5-14.004 Additional Requirements.

After the dentist has induced a patient and established the maintenance level, the assistant or hygienist may monitor the administration of the
nitrous-oxide oxygen making only adjustments during this administration and turning it off at the completion of the dental procedure.

**CALIFORNIA**

California rules are more difficult to maneuver, but can be found [here](#). They do not appear to speak directly to supervision or delegation issues, but they do indicate a dentist may order the administration of sedation. The dentist must hold the same level of sedation permit. They also have a separate permit for the administration of sedation to children. This document states that CRNAs can only administer general anesthesia when supervised by a licensed physician or dentist in California.

1647.3. (a) A dentist who desires to administer or order the administration of conscious sedation, shall apply to the board on an application form prescribed by the board. The dentist shall submit an application fee and produce evidence showing that he or she has successfully completed a course of training in conscious sedation that meets the requirements of subdivision

The Attorney General also refused to find a supervision requirement for CRNAs. In its seminal opinion on CRNA scope of practice issued in 1984, the Attorney General determined that CRNAs may administer all forms of anesthesia on the sole condition that anesthesia be “ordered” by a physician, dentist or podiatrist acting within the scope of his or her license. 67 Ops. Att’y. Gen’l. 122, 139 (1984). In reaching this conclusion, the Attorney General overruled a 1972 opinion of its office—56 Ops. Att’y. Gen’l. 1—that held that CRNAs could only administer general anesthesia when supervised by a licensed physician or dentist. The 1984 AG opinion also included an exhaustive review of early case law that suggested physician supervision was required.
Review of Other States

**Arizona**: No training or permit requirements if DDS is delegating sedation to a CRNA or anesthesiologist.

**Idaho**: Does not require a licensee to obtain a permit if they are outsourcing the sedation. We do have a rule (Use of Other Anesthesia Personnel) which requires the licensee to notify the board if they are using a CRNA, anesthesiologist, or another licensee with a sedation permit.

**Louisiana**: We have two kinds of sedation permits: personal and office. The personal permit is to confirm that the dentist has the correct post dental school training to give sedation. The office permit is to confirm that the office has the correct equipment, emergency drugs, etc. Both are needed if the dentist is giving the sedation. The dentist is not required to have a personal sedation permit if a CRNA or an anesthesiologist is giving the anesthesia. However, the dentist must have an office permit.

**Minnesota**: No training or permit requirements if DDS is delegating sedation to a CRNA or anesthesiologist.

**Missouri**: Requires the dentist to have the permit if the sedation/anesthesia provider is a CRNA. The logic is just as the distinguished gentleman from North Carolina explained, if the dentist is supervising the CRNA, then the dentist should have the appropriate level of training and certification to effectively supervise. The CRNA is an auxiliary and must be under some level of supervision from an MD or a dentist (even a collaborative practice agreement is a level of supervision). If the sedation/anesthesia provider is an MD Anesthesiologist, then the MD is responsible for the sedation, the dentist is not supervising the MD, therefore the dentist does not have to have the permit.

**North Carolina**: A dentist may “outsource” general anesthesia or sedation services to an MD anesthesiologist without obtaining a permit from the dental board. The MD anesthesiologist is responsible for all equipment, drugs, and inspections. The same is not true with a CRNA. State law requires a CRNA to work under the supervision an MD or dentist. Therefore, in order to supervise a CRNA offering sedation services, the dentist must have a permit appropriate for the level of sedation being offered. Example: if the CRNA is being used to provide moderate sedation, the DDS must have moderate sedation permit as well AND the CRNA may not offer sedation services beyond the level the DDS is allowed to provide. (No general anesthesia if the
DDS has a permit for moderate sedation) When hiring a CRNA, the DDS is responsible for all equipment, drugs, permits, inspections, etc.

**Oregon:** A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.

A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.

**Tennessee:** requires the dentist to have a permit if a CRNA is administering but if another dentists or an anesthesiologists is administering then the dentist is not required to have a permit.
Draft Bill Language For Board Consideration
For the Purpose of Assessing Administrative, Non-disciplinary
Monetary Penalties on Minor Issues Related to the Following:

1.) Working without a valid license, registration or permit
2.) Working on a lapsed license, registration or permit
3.) Working on an inactive license, registration or permit

Draft Bill Language for Iowa Code, Chapter 153
An act relating to an administrative penalty for licensees and registrants.

Add Section 153.33 (5), to read as follows:

9. To administratively issue a monetary penalty of up to $500 to any licensee, registrant or trainee of the board who works without a current license, registration, permit or qualification or employs an individual without a current license, registration, permit, or qualification. The assessment and payment of any such administratively issued monetary penalty shall not be considered a disciplinary action or reported as discipline and shall be confidential. A licensee, registrant, or trainee shall be provided the opportunity to appeal the assessment of an administratively issued monetary penalty, initiating a contested case proceeding governed by chapter 17A. Nothing in this section shall prohibit the board from imposing discipline on a licensee, registrant, or trainee for willfully or repeatedly working without a current license, registration, permit or qualification or willfully or repeatedly employing an individual without a current license, registration, permit, or qualification.

a. Any monetary penalties collected pursuant to this section shall be deposited into a fund designed to create training opportunities for licensees and registrants of the board.
153.15 Dental hygienists — scope of term.
A licensed dental hygienist may perform those services which are educational, therapeutic, and preventive in nature which attain or maintain optimal oral health as determined by the board and may include but are not necessarily limited to complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, obtaining and preparing nonsurgical, clinical and oral diagnostic tests for interpretation by the dentist, and preparation of preliminary written records of oral conditions for interpretation by the dentist. Such services, except educational services, shall be performed under supervision of a licensed dentist and in a dental office, a public or private school, public health agencies, hospitals, and the armed forces, but nothing herein shall be construed to authorize a dental hygienist to practice dentistry. Educational services shall be limited to assessing the need for, planning, implementing, and evaluating oral health education programs for individual patients and community groups; and conducting workshops and in-service training sessions on dental health for nurses, school personnel, institutional staff, community groups, and other agencies providing consultation and technical assistance for promotional, preventive, and educational services.

Referred to in §153.23
Section amended
Improving Opioid Prescribing [Webinar]
The CDC Guidelines for Prescribing Opioids for Chronic Pain, and Considerations for Dentistry

The American Dental Association (ADA) and Centers for Disease Control and Prevention (CDC) hosted a joint presentation on nonopioid strategies for pain management in order to decrease reliance on prescription opioid pain relievers following dental surgery.

The webinar provided an overview of the CDC's treatment for chronic pain recommendations and how those recommendations can be applied to management of acute pain.

This 60 minute presentation also addressed:

- When and how opioids should be initiated for pain.
- How to assess risk and address harms of opioid use.
- When and how opioids should be discontinued.
- How nonopioid strategies can be employed in dental practices to improve the efficacy of acute postoperative pain management.

Additional Resources

CDC Guideline for Prescribing Opioids for Chronic Pain

Opioids for Acute Pain: What you need to know [PDF]
Speakers

Debbie Dowell, MD, MPH

Debbie Dowell is Senior Medical Advisor/Chief Medical Officer for the Division of Unintentional Injury Prevention at the Centers for Disease Control and Prevention (CDC), CDR in the US Public Health Service, and was the lead author of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain. She previously led CDC’s Prescription Drug Overdose Team and served as advisor to New York City’s Health Commissioner. Dr. Dowell completed residency and chief residency in Primary Care Internal Medicine at the NYU School of Medicine, where she later joined the faculty as a clinical assistant professor. Dr. Dowell is Board Certified in Internal Medicine and practiced medicine at a community health center in New York City.

Paul A. Moore, DMD, PhD, MPH

Dr. Moore received his DMD and a Ph.D. in Pharmacology from the University of Pittsburgh School of Dental Medicine. His professional career has included private practice in Oakmont PA, a hospital residency in dental anesthesiology at the Presbyterian Hospital Medical Center in Pittsburgh, a postdoctoral fellowship in chronic pain management at the University of North Carolina, and faculty appointments at Harvard School of Dental Medicine, University of Massachusetts Medical Center, and Forsyth Dental Center.

You may also like:

Safe Use Storage and Disposal of Medicines
[Webinar]
Prescription Drug Monitoring Programs
[Webinar]

Preventing Prescription Opioid Diversion
[Webinar]
Course Title  Silver Diamine Fluoride Uses and Applications

Total hours of Instruction 1  Total CEU’s requested 1

Course dates: To be determined

Course Subject: Clinical practice

Course Format: Lecture and Discussion

Additional Documentation:

Title  Silver Diamine Fluoride Uses and Applications

Course Goal:

To meet the required Iowa Dental Board’s Silver Diamine Fluoride (SDF) training for dentists and dental hygienist who use SDF with public health supervision.

1. Detailed Course Description
   This course will give the history of silver nitrate and silver diamine fluoride (SDF) in dental care worldwide. Details will be given on SDF safety precautions, application process and indications for use in general practice and public health supervision. The course objectives serve as the course outline. Since this is a 1-hour course there will be no breaks given.

2. Course Outline
   By the end of this course participants will gain knowledge of:
   1. The composition of silver diamine fluoride.
   2. The indications for use of silver diamine fluoride in public health and general practice settings.
   3. The limitations of SDF use.
   4. The patient selection and site-specific criteria for silver diamine fluoride use.
   5. The critical components of an informed consent.
   6. The Iowa Dental Board rules regarding Silver Diamine Fluoride.
   7. The Iowa Department of Public Health Protocols for Silver Diamine Fluoride Application.

3. Brief speaker bio and credentials
   Mary Kelly has a Master’s in dental public health and a BS in dental hygiene. Mary is currently working part time with the University of Iowa College of Dentistry’s Silver Diamine Fluoride National Institutes of Health Research study, has researched SDF and published in ADHA’s Access magazine about Silver Diamine Fluoride’s prevention and therapeutic benefits.