

VIRGINIA BOARD OF DENTISTRY

AGENDAS

December 6 and 7, 2012

Department of Health Professions

Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center - Henrico, Virginia 23233

PAGE

December 6, 2012

9:00 a.m. Formal Hearing

10:00 a.m.* Executive Committee – Dr. Boyd, Chair

- Approval of Minutes – March 8, 2012
- Bylaws Amendment – Ms. Reen

**P1-P2
P3-P7**

**10:00 a.m.* Probable Cause Reviews of Disciplinary Cases
NO BUSINESS WILL BE CONDUCTED**

**6:30 p.m. Board Member Service Recognition Dinner
*O’Charley’s – 9927 Mayland Drive, Richmond VA 23233
Phone: 804-747-9999*
NO BUSINESS WILL BE CONDUCTED**

*** Or immediately following the conclusion of the formal hearing**

December 7, 2012

Board Business

9:00 a.m. Call to Order – Dr. Boyd, President

Evacuation Announcement – Ms. Reen

Introduction of Board Staff

Public Comment

Approval of Minutes

- September 7, 2012 Board Business Meeting
- October 11, 2012 Telephone Conference Call
- November 16, 2012 Telephone Conference Call

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DHP Director’s Report – Dr. Reynolds-Cane

**Survey Results – Elizabeth Carter, Ph. D., Director
DHP Healthcare Workforce Data Center**

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• Executive Committee – Dr. Boyd	
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Case Recommendations

Closed Session

- Discipline Case # 142784
- Discipline Case # 143977

CONFIDENTIAL DOCUMENTS

Board of Dentistry
Executive Committee
Meeting Material
December 6, 2012

UNAPPROVED - DRAFT

**BOARD OF DENTISTRY
MINUTES OF EXECUTIVE COMMITTEE**

Thursday, March 8, 2012

Department of Health Professions
9960 Mayland Drive, 2nd Floor
Henrico, Virginia 23233
Board Room 4

-
- CALL TO ORDER:** The meeting was called to order at 2:37 p.m.
- PRESIDING:** Robert B. Hall, Jr., D.D.S., President
- MEMBERS PRESENT:** Herbert R. Boyd, III, D.D.S.
Jacqueline G. Pace, R.D.H
Augustus A. Petticolas, Jr., D.D.S.
- STAFF PRESENT:** Sandra K. Reen, Executive Director
Huong Q. Vu, Operations Manager
- QUORUM:** With all members of the Committee present, a quorum was established.
- APPROVAL OF MINUTES:** Dr. Hall requested a motion for approval of the minutes of the April 22, 2011 meeting of the Committee. Dr. Petticolas moved the approval of the minutes. The motion was seconded and passed.
- PRESENTATION ON BUDGET:** Mr. Giles, DHP Budget Manager, thanked the Committee for the opportunity to provide and overview of the budget development process. Mr. Giles then referred the Committee to the handout and went over the following:
- DHP Internal Budget Process 2012-2014
 - Board of Dentistry Direct Budget Expenditures FY13
 - Dentistry 2012-2014 Budget Request
 - Commonwealth of Virginia External Budget Process and Calendar
 - DHP Budget Expenditures by Major Categories FY13
 - DHP Cost Centers' Direct Budget Expenditures FY13
 - DHP Board Direct and Allocated Budget Expenditures FY13
 - Decision Package Narrative Justification (Form NJ)
 - Commonwealth of Virginia Proposed 2012-2014 Budget Published on December 19, 2011
- Mr. Giles commented that DHP does look at each board's budget on a regular basis and the Director will inform the board if fee needs to be increased or decreased. He noted that technology cost is on the rise and boards will have to

increase fee to cover these costs.

REVIEW OF BYLAWS:

Ms. Reen apologized for not having the Bylaws reviewed last year. She added that the Bylaws need to be kept current and that she had not identified any changes to be considered. Dr. Hall deferred the review until the June board meeting and asked the Committee members to submit any suggestions as needed.

Dr. Boyd asked if the Committee would look into the Sturgis' Rules of Order versus Robert's Rules of Order. Ms. Reen stated that she will research information about this matter and bring it to the next meeting.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 4:00 p.m.

Robert B. Hall, Jr., D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

D R A F T
VIRGINIA BOARD OF DENTISTRY
BYLAWS

Article I. Officers
Election, Terms of Office, Vacancies

1. Officers

The officers of the Virginia Board of Dentistry (Board) shall be a President, a Vice-President, and a Secretary-Treasurer.

2. Election.

~~The Board shall annually elect its slate of officers at its regularly scheduled Fall meeting. Prior to the Fall meeting, the President shall appoint a Nominating Committee. The committee shall present the names of candidates for office to the Board for election at its Fall meeting.~~

3. Terms of Office.

The term of office of the President, Vice-President and Secretary-Treasurer shall be for twelve months or until their successors shall be elected. The term of each office shall begin at the conclusion of the Fall meeting and end at the conclusion of the subsequent Fall meeting. No officer shall be eligible to serve for more than two consecutive terms in the same office unless serving an unexpired term.

4. Vacancies.

~~A vacancy occurring in any office shall be filled by a special election at the next meeting of the Board. In the event of a vacancy in the office of president, the vice president shall assume the office of president for the remainder of the term. In the event of a vacancy in the office of vice president, the secretary/treasurer shall assume the office of vice president for the remainder of the term. In the event of a vacancy of the office of secretary/treasurer, the president shall appoint a board member to fill the vacancy for the remainder of the term. In the event that the offices are vacated and succession is not possible, the Board shall be convened to appoint the Nominating Committee which will develop a slate of candidates for the Board's consideration at its next meeting.~~

Article II. Duties of Officers

1. President.

The *President* shall preside at all meetings and conduct all business according to the Administrative Process Act and Robert's Rules. The President shall appoint all committees except where specifically provided by law. The President shall sign certificates and documents authorized to be signed by the President and may serve as an ex-officio member of all committees. He might serve as a substitute for an absent committee member and, in this role, he might participate in voting.

2. Vice-President.

The *Vice-President* shall perform all duties of the President in the absence of the President.

3. Secretary-Treasurer.

The *Secretary-Treasurer* shall authorize posting on the Internet the draft unapproved minutes of meetings of the Board and shall be knowledgeable about the budget of the Board.

Article III. Duties of Members**1. Qualifications.**

After appointment by the Governor, each member of the Board shall forthwith take the oath of office to qualify for service as provided by law.

2. Attendance at meetings.

Members of the Board shall attend all regular and special meetings of the full Board, meetings of committees to which they are assigned and all hearings conducted by the Board at which their attendance is requested by the President or Board Executive Director, unless prevented by illness or other unavoidable cause. In the case of unavoidable absence of any member from any meeting, the President shall reassign the duties of such absent member when necessary to achieve a quorum for the conduct of business.

3. Examinations.

Each member of the Board who is currently licensed as a dentist or as a dental hygienist may participate in conducting clinical examinations.

4. Code of Conduct.

Members of the Board shall abide by the adopted Code of Conduct (Guidance Document 60-9, adopted June 12, 2009).

Article IV. Meeting**1. Number.**

The Board shall hold at least three regular meetings in each year. The President shall call meetings at any time to conduct the business of the Board and shall convene conference calls when needed to act on summary suspensions and settlement offers. Additional meetings shall be called by the President at the written request of any two members of the Board.

2. Quorum.

A majority of the members of the Board shall constitute a quorum at any meeting.

3. Voting.

All matters shall be determined by a majority vote of the members present.

Article V. Committees

As part of their responsibility to the Board, members appointed to a committee shall faithfully perform the duties assigned to the committee. The standing committees of the Board shall be the following:

- Executive Committee
- Regulatory-Legislative Committee
- Credentials Committee
- Examination Committee
- Special Conference Committees

Committee Duties.

1. Executive Committee.

The Executive Committee shall consist of the current officers of the Board and the Past President of the Board with the President serving as Chair. The Executive Committee shall:

- a) order a biennial review of these Bylaws
- b) review the proposed budget presented by the Executive Director, and submit it and recommendations relating to the proposed budget to the Board for approval
- c) periodically review financial reports and may make recommendations to the Board regarding financial matters
- d) select former board members and knowledgeable professionals to be invited to serve as agency subordinates
- e) conduct all other matters delegated to it by the Board.

2. Regulatory-Legislative Committee.

The Regulatory-Legislative Committee shall consist of two or more members, appointed by the President. This Committee shall consider matters bearing upon state and federal regulations and legislation and make recommendations to the Board regarding policy matters. The Board may direct the Committee to review the law for possible changes. Proposed changes in State laws, or in the Rules and Regulations of the Board, shall be distributed to all Board members prior to scheduled meetings of the Board.

3. Credentials Committee.

The Credentials Committee shall review and provide guidance to staff on the action to be taken regarding:

- a) applications for licensure when the application includes information about criminal activity, practice history, medical conditions or other content issues.
- b) applicant or licensee requests for approval of credit for programs when the content or the sponsorship of the course is in question.
- c) hold informal fact-finding conferences at the request of the applicant or licensee to determine if the requirements established by the Board have been met.

4. Examination Committee.

The Examination Committee shall develop and oversee the administration of all Board examinations. This shall include, but not be limited to radiology, jurisprudence and licensure examinations.

5. Special Conference Committees.

Special Conference Committees shall:

- a) review investigation reports to determine if there is probable cause to conclude that a violation of law or regulation has occurred,
- b) hold informal fact-finding conferences, and
- c) direct the disposition of disciplinary cases at the probable cause review and informal fact-finding stages. The committee chair shall provide guidance to staff on implementation of the committee's decisions.

Each year, on a rotating basis, one of the Special Conference Committees shall be designated to receive all investigation reports alleging violations of the existing Board of Dentistry Rules and Regulations pertaining to advertising.

Article VI. Executive Director**1. Designation.**

The Administrative Officer of the Board shall be designated the Executive Director of the Board.

2. Duties.

The Executive Director shall:

- a) Supervise the operation of the Board office and be responsible for the conduct of the staff and the assignment of cases to agency subordinates.
- b) Carry out the policies and services established by the Board.
- c) Provide and disburse all forms as required by law to include, but not be limited to, new and renewal application forms.
- d) Keep accurate record of all applications for licensure, maintain a file of all applications and notify each applicant regarding the actions of the Board in response to their application. Prepare and deliver licenses to all successful applicants. Keep and maintain a current record of all dental and dental hygiene licenses issued by the Board.
- e) Notify all members of the Board of regular and special meetings of the Board. Notify all Committee members of regular and special meetings of Committees. Keep true and accurate minutes of all meetings and distribute such minutes to the Board members within ten days following such meetings.
- f) Issue all notices and orders, render all reports, keep all records and notify all individuals as required by these Bylaws or law. Affix and attach the seal of the Board to such documents, papers, records, certificates and other instruments as may be directed by law.

- g) Keep accurate records of all disciplinary proceedings. Receive and certify all exhibits presented. Certify a complete record of all documents whenever and wherever required by law.
- h) Present the biennial budget with any revisions to be reviewed by the Executive Committee prior to submission to the Board for approval.

Board of Dentistry

Business Meeting

Material

December 7, 2012

**VIRGINIA BOARD OF DENTISTRY
MINUTES
SEPTEMBER 7, 2012**

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:02 a.m. on September 7, 2012 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

BOARD MEMBERS PRESENT: Martha C. Cutright, D.D.S.
Charles E. Gaskins, III, D.D.S.
Jeffrey Levin, D.D.S.
Melanie C. Swain, B.S.D.H-R.D.H
Tammy K. Swecker, R.D.H
James D. Watkins, D.D.S.

BOARD MEMBERS ABSENT: Surya P. Dhakar, D.D.S.
Myra Howard, Citizen Member
Evelyn M. Rolon, D.M.D.

STAFF PRESENT: Sandra K. Reen, Executive Director for the Board
Dianne L. Reynolds-Cane, M.D., DHP Director
Arne Owens, DHP Deputy Executive Director
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

OTHERS PRESENT: Howard M. Casway, Senior Assistant Attorney General

ESTABLISHMENT OF A QUORUM: With seven members of the Board present, a quorum was established.

Dr. Boyd recognized five new Board members. He stated that Dr. Rolon was not available to attend the meeting. He introduced Dr. Gaskins, Ms. Swain, Ms. Swecker, and Dr. Watkins. He thanked Board staff for their assistance in orienting new Board members so they can be ready for hearings and business meetings.

PUBLIC COMMENT: Dr. Robert Allen of Hampton, VA, asked the Board to address non-dentists who own dental offices. He stated that non-dentist owners are predatory and unhealthy to patients. He also asked the Board

for clarification on how long a wife can own the practice once the dentist passes away.

ELECTION OF OFFICERS:

Ms. Reen noted that this item was listed twice on the agenda because the Bylaws do not contemplate the current situation in which both the President and the Vice-President's terms expired at the same time. She stated that it is the Board's decision to hold the election now or at the end of the Board business meeting. Dr. Levin moved to hold the election now. The motion was seconded and passed.

Dr. Cutright noted that the Nomination Committee met this morning and nominates for the 2012-2013 officers:

Herbert R. Boyd, III, DDS – President

Jeffrey Levin, DDS – Vice President

Martha C. Cutright, DDS – Secretary-Treasurer

Dr. Gaskins moved to elect nominees as reported. The motion was seconded and passed.

APPROVAL OF MINUTES:

Dr. Boyd asked if the Board members had reviewed the June 8, 2012, June 14, 2012, July 23, 2012, and August 22, 2012 minutes. Dr. Gaskin moved to accept the minutes. The motion was seconded and carried.

DHP DIRECTOR'S REPORT:

Dr. Reynolds-Cane thanked the Board for its letter regarding regulatory action pending approval. She added that Secretary Hazel is aware of the urgent need of the pending emergency regulations. She deferred comments about regulatory actions to Ms. Yeatts. She invited new and current Board members to attend DHP Board Orientation on September 28, 2012. She added that Dr. Levin will be on the panel discussion.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Levin stated that the last two meetings were canceled. He then asked Elizabeth Carter, Ph.D., BHP Executive Director and Director of the Healthcare Workforce Data Center, to report on current initiatives.

Dr. Carter stated that currently BHP is examining the expansion of the scope of practice of pharmacy technicians. She asked the Board to let her know if it would like to look at the scope of practice for dentists and dental hygienists. She added that she hopes to have reports for the Board on the workforce surveys completed by dentists and dental hygienists with their 2012 renewals at its next meeting.

AADB Mid-Year Meeting. Dr. Levin said that Dr. Cutright and Ms. Reen will attend AADB Annual meeting in San Francisco in October 2012.

SRTA. Dr. Boyd stated that SRTA reports from Dr. Hall and Ms. Pace are in the agenda package. He asked if there are any questions or discussion. Dr. Watkins added that Missouri is now accepting the SRTA exam. He also noted that he is now a SRTA Examination Captain and he plans to attend training in January 2013. Ms. Reen asked Dr. Watkins to forward meeting information to Ms. Vu so a travel request can be submitted. She added that new Board members have the option of serving as SRTA examiners but it is not required. Dr. Watkins asked new members to contact him if they want to be examiners.

Ms. Reen noted that she forgot to cover travel requirements at the Board Member Orientation meeting on Thursday, September 6, 2012. She stressed that all travel must be approved first by Dr. Cane.

Dr. Watkins added that he has the 2013 SRTA exam schedule. He noted that for new Board members who want to be examiners, they must first be observers. Dr. Boyd commented that he finds being an examiner very interesting and encouraged Board members to serve as examiners.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported that the emergency regulations for sedation and anesthesia permits have been approved and will be effective September 14, 2012 and expire on September 13, 2013. She added the followings:

- Dentists who use deep sedation/general anesthesia or moderate/conscious sedation in a dental office must have the permits by March 1, 2013.
- Dentists who administer local anesthesia and minimal sedation are not required to hold a permit.
- Dentists who have self-certified in sedation may be issued a temporary permit to allow continued administration but must have a full permit in conscious/moderate sedation by any method or by enteral only by September 14, 2014, two years after the effective date of the emergency regulations.
- All permits will expire on March 31, 2014 and are subject to annual renewal by March 31 each year concurrent with renewal of dental licenses.
- All licensed dentists will be notified by mail.

She noted that the emergency regulations will expire on September 13, 2013, but the Board may request a 6-month extension until March 13, 2014. She added that the Board at its December 7, 2012 meeting may adopt the proposed regulations which may or may not have the same language as the emergency regulations. She commented that the definitions in the emergency regulations were taken from the Board's work on periodic review. She stated that the Notice of Intended Regulatory Action (NOIRA) will be published on October 8, 2012, with a 30-day comment period until November 7, 2012.

Ms. Reen added that notification letters to dentists have been prepared with guidance from Dr. Hall and Mr. Casway and will be mailed out next week. She stated that licensees are responsible for reading the emergency regulations and deciding if they are required to hold a permit.

Adoption of Exempt Regulations on Temporary Resident's License and Faculty License. Ms. Yeatts stated that HB334 was sought by the VCU School of Dentistry, and she asked Dr. Sarrett to go over the new legal provisions. Dr. Sarrett stated the bill amended the licensure provisions for temporary residents and dental faculty. He added that it added language to allow graduates of dental and dental hygiene programs who are not licensed in Virginia to participate in hands-on clinical courses in CODA accredited programs. He then requested that the proposed regulations be amended at 18VAC60-20-90.C(2) to expressly include the words "program" and "program director."

Ms. Yeatts said the amendments were appropriate, and Dr. Watkins moved to adopt the proposed regulations as amended for exempt action. The motion was seconded and passed.

Adoption of Exempt Regulations on Dental Hygiene Practice in Department of Health. Ms. Yeatts noted that the law allows dental hygienists, employed by the Department of Health (VDH), to provide educational and preventative dental care under remote supervision. She added that the regulations are presented for adoption by the Board. She stated that the protocol from VDH needs be adopted to be incorporated by reference as part of the regulations.

Dr. Levin moved to adopt the final exempt proposed regulations and the VDH protocol. The motion was seconded and passed.

BOARD

DISCUSSION/ACTION:

Review of Public Comment Topics. Dr. Boyd stated that the comments received from Dr. Allen will be considered.

Surveys of Renewing Dentists and Dental Hygienist. Dr. Boyd noted that Dr. Carter covered this earlier.

AADB Survey on Opioids. Ms. Reen said that she brings this to the Board's attention for guidance as recommended by Dr. Hall while he was serving as president. She explained that she or the Board president normally responds to surveys based on adopted statutes, regulations and Board guidance, but this survey is requesting information not addressed in any Board policy. She asked how she should address such requests.

Dr. Watkins moved that the president be authorized to respond to this and similar surveys at his discretion. The motion was seconded and passed.

Study Report on Oral Health in Virginia. Ms. Reen stated that this is provided for possible discussion by the Board but no action is needed. Dr. Boyd noted that the Board will take it as information only.

Liability for Exams. Dr. Levin asked the Board and Dr. Sarrett to discuss who is liable for students and examiners during regional exams administered at the School.

Dr. Sarrett stated that the current laws do not address who is liable while the students take regional clinical exams and added that exams are not part of the education program. He said the school hosts the exams and faculty assist, so he thinks the school could be liable.

Ms. Swecker commented that SRTA does offer malpractice insurance for the students.

Mr. Casway stated that this is not a Board matter because students are not licensed. He added that for Board members who are doing the exams, SRTA should have insurance in place. He suggested that Dr. Sarrett consult with the school's legal counsel about liability.

**REPORT ON CASE
ACTIVITY:**

Ms. Palmatier reported that in the fourth quarter of FY2012 the Board received a total of 93 patient care cases and closed a total of 60 for a 65% clearance rate. She added that the current caseload older than 250 days is 18%, and 80% of all cases were closed within 250 business days. She noted that the Board did not meet the agency's performance goals and reminded Board members to act on cases timely to help in improving performance.

**BOARD COUNSEL
REPORT:**

Mr. Casway stated that he has nothing to report.

**EXECUTIVE
DIRECTOR'S
REPORT/BUSINESS:**

Ms. Reen reported the following:

- The Dental Laboratory Work Group, which was formed by the Board and the VDA to discuss registration of dental labs and the dental lab work order forms, met two times and no agreement was reached. She added that she then presented the latest version of the forms to the VDA Board of Directors and requested recommendations for amending the forms so that the Board might complete work on them and consider issuing them as a guidance document. She said that the VDA plans to give its response following its annual meeting, so the Board will address this at its December meeting.
- While considering the status report on the Sanction Reference Points at the last meeting, staff was asked to bring a proposed definition for "Patient Injury" to the September meeting. She noted that the current definition, the definition proposed by Visual Research, and the one she and Ms. Palmatier developed are provided for discussion. During discussion of the options, Dr. Reynolds-Cane asked Mr. Casway if he might provide some guidance. Mr. Casway asked if the term "physical injury" was required, and Ms. Reen said that the Boards of Medicine and Physical Therapy use "injury." Mr. Casway recommended using the term "injury" and adopting "injury includes any negligent or intentional action which caused harm to the patient" as the definition. Dr. Watkins moved to accept Mr. Casway's definition. The motion was seconded and passed.
- In the past the current Board members have hosted a dinner to recognize the service of departing Board members. She noted the dinners are paid for by the current members and not the Board. She asked if the Board wants to continue this tradition. It was decided by consensus to host a recognition dinner. Ms. Reen asked if a member would volunteer to help staff organize this event. Dr. Boyd volunteered.
- Ms. Palmatier has joined the Board as Deputy Executive Director and is already proving to be a valuable asset. Ms. Reen added that the Board now has three part-time case managers who are dental hygienists; Deborah Southall, Trudy Levitin, and Kelly Williams.

**COMMITTEES AND
LIAISONS
APPOINTMENTS:**

Dr. Boyd made the following assignments:

- Special Conference Committee A – Dr. Cutright, Chair, Ms. Swecker, and Dr. Dhakar
- Special Conference Committee B – Dr. Levin, Chair, Dr. Gaskins, and Ms. Swain
- Special Conference Committee C – Ms. Howard, Chair, Dr. Rolon, and Dr. Watkins
- Exam Committee – Dr. Cutright, Chair, Dr. Watkins, and Ms. Swecker
- Regulatory-Legislative Committee – Dr. Levin, Chair, Dr. Gaskins, Dr. Rolon, and Ms. Swain
- SRTA Dental Exam – Dr. Watkins
- SRTA Dental Hygiene Exam – Ms. Swecker
- ADEX Board of Directors – Dr. Cutright
- ADEX Dental Exam – Dr. Watkins

and noted that he would ask Dr. Hall to complete his term on the SRTA Board of Directors.

Dr. Boyd then noted that the date for Special Conference Committee B at the bottom of the 2013 Calendar needs to be November 22 instead of November 29.

Dr. Robert Allen thanked Ms. Reen for the report on Oral Health in Virginia. He urged everyone to read it.

ADJOURNMENT:

With all business concluded, the meeting was adjourned at 10:55 a.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED
VIRGINIA BOARD OF DENTISTRY
MINUTES
SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:05 p.m., on October 11, 2012, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

MEMBERS PRESENT: Martha C. Cutright, D.D.S.
Charles E. Gaskins, III, D.D.S.
Jeffrey Levin, D.D.S.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBERS ABSENT: Surya P. Dhakar, D.D.S.
Myra Howard
Evelyn M. Rolon, D.M.D.

QUORUM: With seven members present, a quorum was established.

STAFF PRESENT: Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
J. Fielding Yelverton, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT: Erin L. Barrett, Assistant Attorney General
Wayne Halbleib, Senior Assistant Attorney General

Michelle Rice, R.D.H.
Case No.: 145441
The Board received information from Mr. Halbleib in order to determine if Ms. Rice's impairment from mental illness constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.

Closed Meeting: Dr. Levin moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Michelle Rice. Additionally, Dr. Levin moved that Ms. Reen, Ms. Palmatier, Ms. Lee and Ms. Yelverton attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Levin moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by

which the closed meeting was convened. The motion was seconded and passed.

DECISION:

Dr. Levin moved that the Board summarily suspend Ms. Rice's license to practice dental hygiene in that she is unable to practice dental hygiene safely due to impairment resulting from mental illness, and schedule her for a formal hearing. The motion was seconded and a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT:

With all business concluded, the Board adjourned at 5:25 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

MINUTES

SPECIAL SESSION - TELEPHONE CONFERENCE CALL

CALL TO ORDER: The meeting of the Board of Dentistry was called to order at 5:11 p.m., on November 13, 2012, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.

PRESIDING: Herbert R. Boyd, III, D.D.S., President

MEMBERS PRESENT: Martha C. Cutright, D.D.S.
Jeffrey Levin, D.D.S.
Evelyn M. Rolon, D.M.D.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.

MEMBERS ABSENT: Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
Myra Howard

QUORUM: With seven members present, a quorum was established.

STAFF PRESENT: Sandra K. Reen, Executive Director
Indy Toliver, Adjudication Specialist
Donna Lee, Discipline Case Manager

OTHERS PRESENT: Howard Casway, Senior Assistant Attorney General
Wayne Halbleib, Senior Assistant Attorney General

Tamara Banks, R.D.H.
Case No.: 144211 The Board received information from Mr. Halbleib in order to determine if Ms. Banks' impairment from substance abuse constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.

DECISION: Dr. Levin moved that the Board summarily suspend Ms. Banks' license to practice dental hygiene in that she is unable to practice dental hygiene safely due to impairment resulting from substance abuse, and schedule her for a formal hearing. Dr. Levin further moved that the Board offer Ms. Banks a consent order for the indefinite suspension of her license to practice dental hygiene in lieu of a formal hearing. The motion was seconded and a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:40 p.m.

Herbert R. Boyd, III, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

AADB Annual Meeting
October 17-18, 2012

The Hyatt Regency in San Francisco, CA, was the site of the American Association of Dental Boards annual meeting. Sandra Reen, Executive Director of the Virginia Board of Dentistry, and Martha Cutright, D.D.S., Virginia Board member, attended as AADB liaisons. The ADA President, Dr. William Calnon, welcomed the AADB, and Senator William Emerson from CA updated those in attendance on issues specific to healthcare reform such as the Affordable Care Act and the Diversion Program of CA.

The ADA Amicus Brief to the Federal Trade Commission was discussed. The North Carolina Board of Dentistry ordered a public facility to desist teeth whitening. In response to the 2010 complaint filed following this case, the Federal Trade Commission concluded that the NC Board illegally stifled competition. The final order stated that the NC Board was to stop informing non-dentist teeth whitening providers that they were providing illegal services. The ADA Chief Legal Counsel spoke in support of the North Carolina Board of Dentistry. This NC case is being appealed in December 2012. An update on the Federal Trade Commission health-related activities revealed more medical/dental scrutiny since a new director began work in 2009.

Discussions included separate panels of state Board members and attorneys. State Board panel members shared common concerns. One such concern involved state regulation of Botox, dermafillers, and other cosmetic procedures. The majority of those present concluded that these are acceptable procedures due to the fact that they are limited to the head and neck. Ethics and methods of internal professional regulation was another topic of discussion. California, Indiana, North Dakota, and Oklahoma mandate courses. There are various ways to mandate this course: once in a lifetime, for initial licensure, or free with 2 CE hours at license renewal. An ethics program exists at the University of Washington, while the University of Minnesota offers an individual course.

The Board attorneys served on a panel as well. They explained how to effectively utilize the Prescription Drug Monitoring Program. Only one state, Missouri, has not either planned or implemented the program. One speaker presented a corporate ownership case which demonstrated unnecessary treatment.

An open forum allowed individual State Board members time to share problems and solutions that had been addressed in their own states. Kansas allows a registered hygienist to remove decay in underserved areas. Minnesota has an advanced dental therapist, while Montana has a denturist on the state Board. Medicaid fraud, privatized dental Boards, BLS (basic life support) for dentists, AED requirements, and state licenses for the military personnel were additional topics which were discussed.

Dental examinations for licensure were updated. The ultimate goal to establish both written and clinical national dental exams was addressed. Few state members were aware of the Committee for an Integrated Examination currently working on changes in the national written examination. The National Board Dental Exams Part I and Part II will be replaced by one exam to integrate basic, behavioral, and clinical sciences, named Integrated National Board Dental Exam. This exam will emphasize critical thinking, problem solving, and the application of knowledge. Implementation is no sooner than 2017. ADEX is the national clinical exam for state licensure developed by a group of AADB members. SRTA will begin administering ADEX in 2013. NERB and Nevada testing agencies currently use the ADEX exam.

The AADB has developed an Assessment Services Program. The entire cost is the responsibility of the practitioner who participates in the Assessment Services Program. This program has been developed over six years to assist dental boards throughout the discipline process. The Assessment Services Program includes two parts: D-PREP and ERA. D-PREP (Dentist- Professional Review and Evaluation Program) is directed to practitioners who have been sanctioned by the Board on multiple cases. The intent is to determine the underlying cause and suggest remediation. It was noted that clinical skills are often not the issue. There are currently three assessment centers: LSU School of

Dentistry, Marquette School of Dentistry, and the University of Maryland School of Dentistry. The 3-5 days D-PREP assessment includes a complete physical and mental exam. The second part of the Assessment Service Program is the ERA (Expert Review Assessment). This service will be provided to dental boards in need of an independent expert opinion for a case under review. The first group of six expert reviewers has completed the training program. Two states, Oregon and Mississippi, have reported positive results with the D-PREP Pilot Program. The AADB is available to make D-PREP and ERA presentations to state dental boards.

Caucuses met to discuss the replacement of retiring AADB Executive Director, Molly Nadler. She has worked for the AADB for 29 years as well as 10 years with the ADA. The options include hiring an employee who is solely hired by AADB or consider employing a management firm. After lengthy discussion, the House of Representatives recommended that the Executive Committee, who has the final decision, hire a person who is employed solely by the AADB.

The next AADB meeting will meet in New Orleans, LA, on October 30-31, 2013.

Respectfully submitted,
Martha Cutright, D.D.S.

ADEX Annual Meeting Report 2012

The 8th annual meeting of ADEX was held at the Doubletree Chicago-O'Hare- Rosemont Hotel on November 9-11, 2012. Three new member states were represented-Virginia, Mississippi, and New Mexico. To date, there are currently 30 member states with 41 states accepting ADEX. Two new sites for administration include Arizona and Mississippi. Committees of ADEX include the Calibration Committee, Dental Exam Committee, Dental Hygiene Committee, Quality Assurance Committee, and the Budget Committee.

SRTA will begin administering the ADEX Dental Exam in January 2013. Dr. Dick Marshall, President of SRTA, and Dr. Bill Pappas, Chairman of the Calibration Committee of ADEX, met earlier in Charlotte, NC, to establish a calibration for the SRTA examiners. The NYU exam in December 2012 will be utilized as a pilot calibration. NERB and Nevada also administer ADEX.

There are 43 members of the Dental Exam Committee. This committee includes Dental Board appointees, full time educators, regional exam administrators, and consumers. Jim Watkins, D.D.S., is serving the three year term as the Virginia Board of Dentistry representative. In addition, Rick Archer, D.D.S., of VCU School of Dentistry, serves a renewable one year term as the educator representative from District 6.

The Dental Hygiene Exam Committee consists of one educator, one dentist, one consumer, and one dental hygienist from each of the 10 districts. SRTA will begin administering this ADEX Dental Hygiene Exam in 2014. There are 76 sites in 18 states with the addition of SRTA. Because lost points are primarily due to calculus detection and calculus removal, these procedures will be separated into two parts.

The ADEX budget is developed to cover costs of the dental representatives attending the annual meeting. There is no intention for the budget to change based on the number of candidates taking the ADEX exam. The Executive Director of ADEX, Mr. Patrick Braatz, is a volunteer, based in Portland, Oregon.

The Quality Assurance Committee task is to guarantee that the ADEX Exam is achieving its pre-established intended goals. This committee utilizes a testing specialist as well as technical reports from both the Dental and Dental Hygiene Exams to evaluate their end goals. Only certified copies of radiographs will be accepted. Examiners will be evaluated as a whole, not individually, in these statistics. An open format with flexible time, rather than a rigid time schedule, is utilized to decrease the anxiety of the candidate as well as to allow for unexpected complications for the restorative and periodontal clinical sections. In addition, each examiner must calibrate at 80% prior to being eligible to become an examiner.

The computer-based section of the exam has been reduced from 280 to 150 questions with an additional 15 pilot questions. Three hours, rather than six hours, will be allotted for this section. And, it is recommended that ADEX manuals be provided to all candidates and examiners. A separate agency manual with administrative guidelines will be provided by SRTA, NERB and Nevada which will include testing sites and schedules. SRTA was commended for its manual, which will be used as a model.

Virginia is a member of District 6 Caucus which includes the member states of Arkansas, Kentucky, Tennessee, South Carolina, and West Virginia. Dr. Michelle Bedell of South Carolina is currently the director. Two presentations were made at the House of Representatives meeting. Mr. David Johnson of the Federation of State Medical Boards discussed the USMLE, United States Medical Licensing Exam, and spoke on the history and benefits that have resulted from a single medical licensure examination. In short, a taskforce began in 1988, the agreement was reached in 1991, and the first exam was administered in 1992.

Following this example, Guy Champaine, D.D.S., and 2 others formed a committee in 2003 to establish a national exam in dentistry. In 2005 this became known as ADEX, an acronym for American Association

of Dental Examiners. Dr. Champagne presented a power point presentation specifically utilized for those states which are currently not participating in ADEX. It was stressed that ADEX is not a testing agency. Rather, it is an organization of current active state Boards to establish a national test that contains content validity on the actual skills used in dentistry. To date, five sections are included in the examination: Clinical Diagnosis and Treatment Planning, Class II and Class III Restorations, Fixed Prosthodontics, Endodontics , and an optional Periodontics section.

The House of Representatives passed all Dental Exam Committee recommendations for the 2014 ADEX Dental Exam:

1. Change the SAT and ACC criteria in restorative to no more than 1mm for the buccal and lingual proximal box clearance; substandard- more than 1 mm to 2.5mm; critical deficiency- more than 2.5mm
2. Combine the SAT and ACC categories. This will establish 3 scoring levels: acceptable, marginally substandard, and critical deficiency.
3. Report scores of 75 or higher as "pass" rather than specific numerical scores
4. Score anterior and posterior procedures separately. If the candidate passes the first procedure and fails the second, the candidate will retake only the second procedure. If the candidate fails the first procedure, he/she must retake both restorative procedures. This will change the restorative section from compensatory to conjunctive.
5. Utilize a radiopaque radiographable tooth (opaque Real T from Accidental) in 2015 for anterior endo procedure pending feedback from the schools of implementation. The root portion on the endo procedure will be graded on the radiographs.
- *6. Exam 2013: flossing criteria: If 2 examiners rate it as a critical deficiency and cannot pass floss, it is scored as a sub. If all 3 examiners score a critical deficiency, it will be a critical deficiency.
7. CFEs will evaluate all medical histories.
8. Separate restorations can be allowed for occlusal decay and a slot prep if 1mm or more tooth structure exists between the slot prep and the occlusal prep.
9. The criteria for the posterior slot prep and the posterior conventional composite for breaking gingival contact will be the same. Contact does not have to be broken for SAT.
10. Timeline for retake exams:
4 hours – 1 procedure
7 hours- 2 procedures
9 hours- 3 procedures
11. CFEs ask the patients if the blood pressure has been taken the day of the exam. They no longer need to observe the procedure.

*2013 exam

The annual 2013 meeting will be held at the Doubletree Chicago O'Hara-Rosemont Hotel. November 8-10, 2013, are tentative dates. Optional dates in mid October will be researched, and those anticipating attending will be notified.

Respectfully submitted,
Martha C. Cutright, D.D.S.
ADEX House of Representatives member

November 18, 2012

Reported by Dr. James D. Watkins

Eight Annual ADEX Meeting Chicago, IL

Friday, November 9, 2012

ADEX Quality Assurance committee met from 8am until noon. The committee went over the printed agenda items as follows: Roll Call; Greetings from President; Adopt minutes & Agenda.

1. Report of Guy Champagne and Ron Chenette on the changes to the DSCE and CSCE (computerized exam questions reduced from 280 questions to 150 questions).
2. Discussed whether there should be a penalty for rejection of a first lesion.
3. QA finalize dental and dental hygiene technical reports.
4. Combining the SAT & ACC scoring criteria into one category.
5. Pass/Fail reporting of scores. (attach numerical grade of "75" to all passes)
6. Eliminating critical deficiencies that are not being utilized.
7. Simplifying the number of criteria.
8. Having ADEX Candidate and Examiner Manuals that everyone would use and then a separate agency manual with administrative guidelines and dates.
9. Same as #8 for Calibration.
10. Report from Calibration Committee
11. Timing of QA meetings, Technical Reports, etc.
12. Timely release of Grades (esp. failures).
13. Digital Radiography from off-site candidates.

Discussion was had about using the phrase "minimum competency" vs "meets the criteria" and the decision was made to replace (in all ADEX printed materials) with the later phrase.

Meeting was adjourned.

Friday, November 9, 2012 @1:30pm-5:00pm AND Saturday, November 10, 2012 @8:30am until Noon

Dental Examination Committee met to go over a FULL agenda of 42 items to improve the content and structure of the exam as well as improve examiner calibration techniques.

Saturday, November 10, 2012

ADEX Board of Directors meeting from 1:30pm until 4:00pm (Dr. Cutright)

Sunday, November 11, 2012

ADEX House of Representatives meeting from 8:00am until Noon. (Dr. Cutright)

Agenda Items included:

1. President's Address
2. The Long and Winding Road: "A National Medical Licensing Examination"
3. ADEX Structure and Examination- "If You Could See What I See"
4. Trailer from ADEX Communications committee
5. Dental and Dental Hygiene Technical Report
6. Dental examination Overview
7. Hygiene examination Overview
8. Treasurer's Report

**Agenda Item: Regulatory Actions - Chart of Regulatory Actions
(As of November 16, 2012)**

Board of Dentistry

Chapter	Action / Stage Information
Regulations Governing Dental Practice [18 VAC 60 - 20]	<p><u>Action:</u> Sedation and anesthesia permits for dentists</p> <p><u>Stage:</u> Emergency/NOIRA - Register Date: 10/8/12 Effective: 9/14/12 to 9/13/13 Close of comment on NOIRA: 11/7/12 Adoption of proposed regulations: 12/7/12</p>
Regulations Governing Dental Practice [18 VAC 60 - 20]	<p><u>Action:</u> Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30</p> <p><u>Stage:</u> Proposed - At Secretary's Office for 179 days</p>
Regulations Governing Dental Practice [18 VAC 60 - 20]	<p><u>Action:</u> Training in pulp capping for dental assistants II</p> <p><u>Stage:</u> Fast-Track - Register Date: 10/8/12 Effective: 11/22/12</p>
Regulations Governing Dental Practice [18 VAC 60 - 20]	<p><u>Action:</u> Radiation certification</p> <p><u>Stage:</u> Fast-Track - Register Date: 10/22/12 Effective: 12/6/12</p>
Regulations Governing Dental Practice [18 VAC 60 - 20]	<p><u>Action:</u> Recovery of disciplinary costs</p> <p><u>Stage:</u> Final - Register Date: 10/22/12 Effective: 11/21/12</p>
Regulations Governing Dental Practice [18 VAC 60 - 20]	<p><u>Action:</u> ^(E) Changes to temporary and faculty licensure</p> <p><u>Stage:</u> Final - Register Date: 10/22/12 Effective: 11/21/12</p>
Regulations Governing Dental Practice [18 VAC 60 - 20]	<p><u>Action:</u> ^(E) Remote supervision of dental hygienists in public health clinics</p> <p><u>Stage:</u> Final - Register Date: 10/22/12 Effective: 11/21/12</p>

Agenda Item: Response to Petition for Rulemaking

Included in your agenda package are:

A copy of the petition received from Tabitha McGlaughlin

A copy of the initial Agency Notice published in the Register of Regulations

Copies of all comments on the petition

Staff Note:

There was a comment period on the petition from September 10, 2012 to October 10, 2012. Comments were received by email or through the Virginia Regulatory Townhall.

Board action:

The Board may accept the petitioner's request for amendments to regulations and initiate rulemaking by adoption of a Notice of Intended Regulatory Action

OR

The Board may reject the petitioner's request for amendments. If the petition is rejected, the Board must state its reasons for denying the petition.



COMMONWEALTH OF VIRGINIA Board of Dentistry

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
(804) 527-4428 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix.)

Tabitha McGlaughlin - Ursus Lifesavers & Aquatics

Street Address

PO Box 7105

City

Arlington

Email Address (optional)

Tabitha@411cpr.com

Area Code and Telephone Number

703-879-5888

State

VA

Zip Code

22207

Fax (optional)

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18VAC60-20-50 Requirements for continuing education Subsection C.9

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

We wish to have our company be among the list of accepted credentialing organizations. We are fully certified in BLS/AED training, holding current instructor certification cards with American Heart Association and American Safety and Health. Our company is an authorized training center with American Safety and Health. We have been teaching CPR, First Aid, Lifeguarding and Pool Operators for over 15 years in Virginia, Maryland, DC and Pennsylvania. We are authorized by the Maryland board of Dentistry to teach BLS.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

To establish the qualifications for registration, certification, licensure or the issuance of a multistate licensure privilege in accordance with the applicable law which are necessary to ensure competence and integrity to engage in the regulated professions.

Signature:

Date:

8/7/12

July 2002

Cards Template test

Healthcare Provider



Training Center Name **PA Region** TC ID # **PA05008**

TC Info **Summit Health**

Course Location

Instructor Name **Janora Hovetter** Inst. ID #

Holder's Signature *[Signature]*

©2011 American Heart Association. Tampering with this card will alter its appearance. 90-1801

TABITHA MCGLAUGHLIN

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association BLS for Healthcare Providers (CPR and AED) Program.

Issue Date **05/2011** Recommended Renewal Date **05/2013**

This card contains unique security features to protect against forgery.

90-1801 3/11

BLS Instructor



TC Alignment **Summit Health** TC ID # **PA05008**

TC Address **112 North 7th Street**

TC City, State **Chambersburg, PA** ZIP **17201**

Instructor ID # **2112274579**

Holder's Signature *[Signature]*

©2011 American Heart Association. Tampering with this card will alter its appearance. 90-1800

TABITHA MCGLAUGHLIN

This card certifies that the above individual is an American Heart Association Basic Life Support (BLS) Instructor.

Issue Date **05/2011** Expiration Date **05/2013**

This card contains unique security features to protect against forgery.

90-1800 3/11

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Tabitha McGlaughlin
is hereby authorized as:
184-BLS & First Aid Instructor

65896 Training Center ID
85196 Registry No.
11/19/2013 Expiration Date

541-224-3298
800-447-3177
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Terrence Flanigan
is hereby authorized as:
184-BLS & First Aid Instructor

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65896 Training Center ID	66160 Registry No.	4/8/2013 Expiration Date
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541-264-3898
800-447-3177
hsi.com



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News Release & Signatics

Having fulfilled all instructional, training, business, and quality assurance requirements, and having agreed to operate in accordance with the standards and guidelines as set forth in the Training Center Administrative Manual, is hereby awarded the status of

Basic Training Center

with all the rights, responsibilities, and privileges pertaining thereto.

The Training Center is now authorized to offer courses in American Safety & Health Institute programs via authorized Instructors.

Presented this day Monday, April 13, 2009



AMERICAN SAFETY & HEALTH INSTITUTE
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a Health & Safety
Institute company



STATE OF MARYLAND

DHMH**Maryland Department of Health and Mental Hygiene**

4201 Patterson Avenue • Baltimore, Maryland 21215-2299

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

State Board of Podiatric Medical Examiners

Eva Schwartz, Executive Director

May 22, 2009

Terrence T. Flanigan
URSUS Lifesavers & Aquatics
P.O. Box 7105
Arlington, VA 22207

Dear Mr. Flanigan:

The Maryland Board of Podiatric Medical Examiners (Board) reviewed your correspondence wherein you request Board approval of the *CPR for the Professional Rescuer* course that you teach.

The Board reviewed the syllabus and course materials that you submitted and determined that completion of the **URSUS Lifesavers & Aquatics CPR for the Professional Rescuer** course shall be accepted to satisfy the CPR certification requirement for Maryland podiatrists. Please ensure that you issue an appropriate certificate or signed letter to attendees of the course. The aforementioned document must contain the course name, date given, name of attendee, hours of training completed and expiration date of CPR certification.

Please do not hesitate to contact the Board should you have any questions.

Sincerely,

Sally L. Reier
Administrative Officer

410-764-4785 • Fax 410-358-3083 • TTY 800-542-4964

Toll Free 1-877-4MD-DHMH • TTY for Disabled – Maryland Relay Service 1-800-735-2258

Web Site: www.dhmh.state.md.us



STATE OF MARYLAND

Maryland State Board of Dental Examiners

Maryland Department of Health and Mental Hygiene
 Benjamin Rush Bldg. • Spring Grove Hospital Center
 55 Wade Ave./Tulip Drive • Baltimore, Maryland 21228

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

February 17, 2005

Ms. Cathy A. Bercier
 Ursus Lifesavers & Aquatics
 P.O. Box 7105
 Arlington, Virginia 22207

Dear Ms. Bercier:

The Maryland State Board of Dental Examiners (the "Board") has reviewed your request for approval of continuing education credits. Please be advised that pursuant to the review, the Board approved the acceptance "*CPR for the Professional Rescuer*" as an eligible noncredit CPR requirement.

This letter does not serve as certification of course completion or attendance. Please ensure that you issue an appropriate certificate or signed letter to attendees of the course(s), lecture(s), or conference. The document must contain the course name, date given, name of attendee, and number of continuing education hours awarded.

Should you have any additional questions regarding this matter, please do not hesitate to contact the Board's office at 410-402-8500.

Sincerely,

Christine V. Hobbs
 Executive Director

cc: Course Approval File
 Reading File

CVH:am

Toll Free 1-877-AMD-DHMH • TTY for Disabled – Maryland Relay Service 1-800-735-2258
 Web Site: www.dhmrh.state.md.us



DHMH Maryland State Board of Dental Examiners

Maryland Department of Health and Mental Hygiene
 Spring Grove Hospital Center • Benjamin Rush Building
 55 Wade Avenue / Tulip Drive • Catonsville, Maryland 21228
 Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmera, Secretary

April 16, 2009

Tabitha McGlaughlin
 Ursus Lifesavers and Aquatics

Dear Ms. McGlaughlin:

The Maryland State Board of Dental Examiners (the "Board") has reviewed your request for approval of continuing education credits. Please be advised that pursuant to the review, the Board approved the following course.

CPR for the Professional Rescuer

This letter does not serve as certification of course completion or attendance. Please ensure that you issue an appropriate certificate or signed letter to attendees of the course(s), lecture(s), or conference. The document must contain the course name, date given, name of attendee, and number of continuing education hours awarded.

Should you have any additional questions regarding this matter, please do not hesitate to contact the Board's office at 410-402-8509.

Sincerely,

Patsy Sherwood
 Executive Director

cc: Course File

Toll Free 1-877-4MD-DHMH • TTY for Disabled – Maryland Relay Service 1-800-735-2258
 Web Site: www.dhbmh.state.md.us

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PAGE2

08/07/2012 09:22

No.: R194

P.008/008

P25

445 Custon Dr.
Gettysburg, PA 17325
1-888-708-7787

Ursus

P.O. Box 7105
Arlington, VA 22207
1-888-681-1950

www.charts411.com or www.411cpr.com

These are the Certifications given to a student after one of our BLS Courses. They are laminated for durability and so they can't be faked.

URSUS LIFESAVERS & AQUATICS
 P.O. Box 7105 Arlington, VA 22207 1-888-681-1950
 www.411cpr.com

This certifies that Leslie Tsimbidis
 Has successfully completed the requirements for

CPR and AED for the Professional Rescuer
 As established by National Guidelines

Completed 7/19/2012 Renewal Date 7/19/2014

Thomas P. Kelly
 Director of Instruction



Front

Adult/Child CPR For the Professional Rescuer

Check for response.
 Check for breathing for 5-10 seconds. If not breathing or breathing abnormally,
Call 911 and get AED

Check pulse for no more than 10 seconds. No pulse begin chest compressions.

Begin CPR
 Place the heel of one hand on the center of the chest (the lower half of the sternum). Place the other hand on top and interlock your fingers.
 Adult, at least 2 inches 30 times.
 Child, 1/3 the depth of the chest (about 2 inches) 30 times at least 100 times per/min.

Open the airway using head-tilt/chin lift.
 Pinch nostrils, give 2 slow steady breaths.
 Continue CPR until AED arrives.

Turn AED on. Place pads on victim and follow the voice prompts.



Back

Ursus Lifesavers + Aquatics
 Tabitha McLaughlin
Tabitha

PETITIONS FOR RULEMAKING

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Initial Agency Notice

✓ Title of Regulation: 18VAC60-20. Regulations Governing Dental Practice.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Name of Petitioner: Tabitha McGlaughlin.

Nature of Petitioner's Request: To amend 18VAC60-20-50, Requirements for continuing education, to include Ursus Lifesavers and Aquatics as approved providers or BLS training.

Agency Plan for Disposition of Request: The petition will be published on September 10, 2012, in the Virginia Register of Regulations and also posted on the Virginia Regulatory Townhall at <http://www.townhall.virginia.gov> to receive public comment until October 10, 2012. The request to amend regulations and any comments for or against the petition will be considered by the board at its meeting scheduled for December 7, 2012.

Public Comment Deadline: October 10, 2012.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, or email elaine.yeatts@dhp.virginia.gov.

V.A.R. Doc. No. R13-01, Filed August 10, 2012, 2:03 p.m.

BOARD OF MEDICINE

Initial Agency Notice

Title of Regulation: 18VAC85-20. Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, and Chiropractic.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Name of Petitioner: David Weitzman, M.D.

Nature of Petitioner's Request: To amend requirements for licensure for persons who have been duly licensed in another state and have practiced a set number of years to gain unrestricted licensure by reciprocity or other such pathways.

Agency Plan for Disposition of Request: In accordance with Virginia law, the petition has been filed with the Virginia Register of Regulations and will be published on September 10, 2012, and posted on the Virginia Regulatory Townhall at <http://www.townhall.virginia.gov>. Comment on the petition will be received until October 5, 2012. Following receipt of all comments on the petition to amend regulations, the board will decide whether to make any changes to the regulatory language. This matter will be on the board's agenda for its meeting on October 25, 2012.

Public Comment Deadline: October 5, 2012.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, or email elaine.yeatts@dhp.virginia.gov.

V.A.R. Doc. No. R13-02, Filed August 21, 2012, 9:25 a.m.



Logged in: DHP

Agency

Department of Health Professions

Board

Board of Dentistry

Chapter

Regulations Governing Dental Practice [18 VAC 60 - 20]

[Back to List of Comments](#)

Commenter: Dental Business Network *

9/21/12 11:10 pm

What is the companies direction? AHA, Red Cross, National Safety Council?

Reading and reviewing their website, they have instructors from a wide range of agencies. Would the doctor say I want an instructor that uses the American Heart Association's guidelines? Or would they receive a Red Cross one year and then a National Safety Council for their following certification? Or does this company take all of the thoughts of the three or more and come up with their own guidelines? If their own guidelines who is insuring them? If a patient dies in the dental office and the dentist states they were taught by "this" company, does this company have insurance on their staff? If an instructor was from the American Heart Association, the AHA would back the instructors training as they have research to back them and I am sure a lot of lawyers. I would be very concerned that if I was a dentist, I would have to hire a lawyer just to see if the instructors qualifications and their way of teaching would hold up in court? Hopefully, someone can update the website to make it more clear.

* Nonregistered public user

1. American Dental Association and National Dental Association, their constituent and component/branch associations;
2. American Dental Hygienists' Association and National Dental Hygienists Association, their constituent and component/branch associations;
3. American Dental Assisting Association, its constituent and component/branch associations;
4. American Dental Association specialty organizations, their constituent and component/branch associations;
5. American Medical Association and National Medical Association, their specialty organizations, constituent, and component/branch associations;
6. Academy of General Dentistry, its constituent and component/branch associations;
7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;
8. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Health Care Organizations;
9. The American Heart Association, the American Red Cross, the American Safety and Health Institute and the American Cancer Society;
10. A medical school which is accredited by the American Medical Association's Liaison Committee for Medical Education or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association;
11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);
12. The Commonwealth Dental Hygienists' Society;
13. The MCV Orthodontic and Research Foundation;
14. The Dental Assisting National Board; or

Agenda Item: Adoption of Proposed Regulations for Sedation/Anesthesia Permits – Replacement of Emergency Regulations

Included in the agenda package:

A copy of the Notice of Intended Regulatory Action

Copies of comment on the Notice and Questions on the Emergency Regulations

A copy of proposed regulations as recommended by the Regulatory/Legislative Committee

Action:

Adoption of the proposed regulations to replace the emergency regulations currently in effect

NOTICES OF INTENDED REGULATORY ACTION

TITLE 4. CONSERVATION AND NATURAL RESOURCES

DEPARTMENT OF FORESTRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Department of Forestry intends to consider amending **4VAC10-30, Virginia State Forest Regulations**. The purpose of the proposed action is to amend the regulations to implement Chapter 484 of the 2012 Acts of Assembly relating to state forest special use permits to hunt, trap, fish, ride bikes, and ride horses in a state forest. The regulations will establish an annual fee of \$15 for special use permits to hunt, fish, trap, ride bikes, or ride horses.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 10.1-1101 and 10.1-1152 of the Code of Virginia.

Public Comment Deadline: November 7, 2012.

Agency Contact: Ronald S. Jenkins, Administrative Officer, Department of Forestry, 900 Natural Resources Drive, Suite 800, Charlottesville, VA 22903, telephone (434) 977-6555, FAX (434) 293-2768, or email ron.jenkins@dof.virginia.gov.

VA.R. Doc. No. R13-3185; Filed September 18, 2012, 10:22 a.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health intends to consider amending **12VAC5-20, Regulations for the Conduct of Human Research**. The purpose of the proposed action is to amend the regulations for clarity, efficiency, and effectiveness relating to (i) the elements that each review committee shall consider in conducting a review of a proposed human research project; (ii) the expedited review process, including the committee's authority to suspend or terminate approval of research; (iii) the informed consent process; and (iv) the elimination of references to repealed Code of Virginia sections and the addition of a reference to the Virginia Immunization Information System. The proposed amendments are the result of a completed periodic review.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 32.1-12.1 of the Code of Virginia.

Public Comment Deadline: November 7, 2012.

Agency Contact: Joseph Hilbert, Director of Governmental and Regulatory Affairs, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7006, FAX (804) 864-7022, or email joe.hilbert@vdh.virginia.gov.

VA.R. Doc. No. R13-3401; Filed September 17, 2012, 5:15 p.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Medical Assistance Services intends to consider amending **12VAC30-50, Amount, Duration, and Scope of Medical and Remedial Care and Services** and **12VAC30-80, Methods and Standards for Establishing Payment Rate; Other Types of Care**. The purpose of the proposed action is to conform the regulations to the legislative mandate of Item 297 UUUU of Chapter 890 of the 2011 Acts of Assembly to provide case management services for children who receive services through the Part C of the Individuals with Disabilities Education Act (IDEA) program.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Public Comment Deadline: November 9, 2012.

Agency Contact: Molly Carpenter, Policy Analyst, Division of Maternal and Child Health, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-1493, FAX (804) 786-1680, or email molly.carpenter@dmas.virginia.gov.

VA.R. Doc. No. R13-2955; Filed September 12, 2012, 11:41 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Dentistry intends to consider amending **18VAC60-20, Regulations Governing Dental Practice**. The purpose of the proposed action is to revise the regulations to provide for permits for dentists who provide or administer conscious/moderate sedation or deep sedation/general anesthesia in a dental office as required by Chapter 526 of the 2011 Acts of Assembly. The key provisions of the regulations are to establish (i) definitions for words and terms used in sedation and anesthesia regulations; (ii) general provisions for administration, including

Notices of Intended Regulatory Action

recordkeeping and requirements for emergency management; (iii) requirements for deep sedation/general anesthesia permits including training, delegation of administration emergency equipment, and monitoring and discharge of patients; and (iv) requirements for conscious/moderate sedation permits including training, delegation of administration emergency equipment, and monitoring and discharge of patients. Emergency regulations are currently in effect.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: November 7, 2012.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4538, FAX (804) 527-4428, or email sandra.reen@dhp.virginia.gov.

VA.R. Doc. No. R13-2984; Filed September 5, 2012, 2:41 p.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Funeral Directors and Embalmers intends to consider amending **18VAC65-20, Regulations of the Board of Funeral Directors and Embalmers**. The purpose of the proposed action is to implement identification prerequisites for cremation as mandated by Chapter 377 of the 2010 Acts of Assembly.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: November 7, 2012.

Agency Contact: Lisa Russell Hahn, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4424, FAX (804) 527-4637, or email lisa.hahn@dhp.virginia.gov.

VA.R. Doc. No. R13-2543; Filed September 11, 2012, 1:06 p.m.

BOARD OF MEDICINE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Medicine intends to consider promulgating **18VAC85-150, Regulations Governing the Practice of Behavior Analysis**. The purpose of the proposed action is to promulgate regulations for the licensure of behavior analysts and assistant behavior analysts pursuant to Chapter 3 of the 2012 Acts of Assembly.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 54.1-2400 and 54.1-2957.16 of the Code of Virginia.

Public Comment Deadline: November 7, 2012.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, FAX (804) 527-4429, or email william.harp@dhp.virginia.gov.

VA.R. Doc. No. R13-3281; Filed September 12, 2012, 1:25 p.m.

BOARD OF PHARMACY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Pharmacy intends to consider amending **18VAC110-20, Regulations Governing the Practice of Pharmacy**. The purpose of the proposed action is to specify the elements of a continuous quality improvement program in a pharmacy as mandated by Chapter 123 of the 2011 Acts of Assembly. A noticed of intended regulatory action was previously published in 27:24 VA.R. 2579 August 1, 2011.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Comment Deadline: November 7, 2012.

Agency Contact: Caroline Juran, RPh, Executive Director, Board of Pharmacy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4416, FAX (804) 527-4472, or email caroline.juran@dhp.virginia.gov.

VA.R. Doc. No. R11-2888; Filed September 18, 2012, 9:52 a.m.

TITLE 22. SOCIAL SERVICES

BOARD OF SOCIAL SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Social Services intends to consider amending **22VAC40-25, Auxiliary Grants Program**. The Auxiliary Grant (AG) is an income supplement for individuals who receive Supplemental Security Income and certain other aged, blind, or disabled individuals who reside in a licensed assisted living facility or approved adult foster home. The purpose of the proposed action is to (i) add third-party payments to the regulation, (ii) clarify and simplify requirements for assisted living facility (ALF) and adult foster care providers in implementing third-party payments, and (iii) ensure third-party payments are applied appropriately as a payment source. The changes are needed due to Code of Virginia changes made during the 2012 Session of the General Assembly based on recommendations of the 2011 Joint Legislative Audit and

Comments on Anesthesia/Sedation Permit Regulations from Virginia Regulatory Townhall

Board of Dentistry

10/24/12 9:30 pm

Commenter: tontra lowe *

New Sedation Regulations

I have been providing safe, effective oral sedation to patients with high anxiety since 2007 without any issues. I have maintained the use of a pulse oximeter and had the appropriate emergency equipment available. I DO NOT understand why an EKG is necessary for moderate oral sedation, and DO NOT agree with this burdensome requirement. Additionally, the need for the dentist to be in the room during oral sedation is unnecessary when there are properly trained and certified assistants who can monitor the patient appropriately.

I am not providing IV sedation, however, I know oral surgeons who sedate their patients with more intense drugs than the ones I use who do not have EKGs for each patient. Although I certainly understand the need to protect patients and doctors, this is a cruel choice and undermines the whole concept of minimally invasive oral sedation. This really will only hurt patients who need care under sedation due to the inability to find dentists, under the new guidelines, to complete their general dentistry needs. I implore you to change the requirement for having an EKG for moderately sedated patients and make it mandatory only for IV sedation where it is most useful. The pulse oximeter is quite capable of determining the appropriate stats that require monitoring during traditional oral sedation--especially since the patient is able to breathe on his/her own and answer simple commands.

PLEASE reconsider your decision, and remove the mandate for the EKG for moderate oral sedation and the requirement for the dentist to remain in the operatory.

Thank you!

10/24/12 10:48 pm

Commenter: Benjamin T. Watson DDS *

Oral Sedation Regulations

First I would like to agree with you on wanting to place regulations on oral/moderate sedation; public safety has to be the priority. I have practiced oral sedation since 2001. I have taken hundreds of hours of continuing ed in sedation and have received both the Fellowship and Diplomat awards from The Dental Organization for Conscious Sedation. I have all the required emergency equipment so I feel my patients are safe. In all the years I have done oral sedation I have not had what I would classify as an emergency situation. I agree with most of the regulations you placed but have a concern with ywo. First, requiring EKG monitoring for oral sedation. While EKG monitoring is the gold standard for IV I feel it is overkill for oral sedation. The pulse oximeter is very capable of providing the monitoring for oral sedation. In oral sedation the patient is awake and responds to both verbal and physical stimuli. The pulse ox plus is what I have used for years. It allows great monitoring for my patients. Second, trained office personnel should be able to monitor a patient while the dentist is checking a hygiene patient in the next room or operatory. Our assistants have to take training courses so they should be able to monitor oral sedation patients as long as the dentist is in the office and nearby. My assistants are extremely capable of this monitoring and I am always within 100ft or so. I hope you will take these comments under consideration.

10/25/12 1:52 pm

Commenter: bream family dental care *

sedation

I was trained to use sedation when I was in dental school. Demerol and Vistaryl were the drugs of choice then. The newer medications (Triazolam, Valium, Lorazepam) are much safer to use with less side effects. I have had very favorable results using these medications.

10/28/12 12:43 pm

Commenter: Greg from "Gregory S Johnson, DDS, PC *

Board of Dentistry-permit for dental sedation

The revisions are good - with two important exceptions: Moderate oral sedation will require (1) EKG monitoring and (2) the dentist will have to remain in the operatory. EKG monitoring is standard of care for IV sedation, but overkill for oral sedation. I believe these two revisions that rare created for safe IV sedation are too far reaching for the slow onset and milder form of sedation that comes with oral sedation. With regular monitoring of patients vitals and utilization of capnography, any significant change will be seen right away. Furthermore, well trained staff can easily monitor oral sedation patients with the dentist within close proximity. We have been doing oral sedation safely for over 20 years and have appreciated the Boards handling of sedation but feel these two components are too far reaching and will not improve safety but will cause patients fees to increase significantly for a procedure that is hardly ever covered by dental insurance. Thank you for reading my thoughts, Greg Johnson, DDS

10/29/12 12:31 pm

Commenter: Christopher Hamlin, DDS *

Oral Sedation regulations

While applaud the Board of Dentistry's effort to make sedation safer in dental offices, I am dismayed that a valuable tool has been removed from my practice to provide a positive experience for my patients. We have routinely prescribed Atarax for young patients, to be taken in the comfort of the home. We prescribe the amount for the appointment, so an overdose is unlikely and in the event of an inadvertant pharmacological filling error. it is recognized that the medication has an unprecedented margin of safety. We use no other drugs in our office. We do use Nitrous Oxide and our patients are alert and responsive throughout the procedure. For older children we prescribe Valium to be taken at home prior to the appointment. Again, prescribing the amount only for that appointment. I think most would agree that a 5 mg tablet of Valium would be safe for a child in the 7-12 age group. Since we have been in compliance with the "emergency regulations", we have discovered that parents are not willing to pay the extra fees involved for the "sedation" that we must charge for the administration, ordering, record keeping, etc.. Also they are not willing to come in an extra hour in advance of the appointment. There is no insurance code that fits this procedure, therefore there is no insurance reimbursement. The prescriptions were covered by insurance. And we are left with the difficulty of treating these children and the emotional aftermath of the appointments. Pediatric dental offices are overwhelmed with children who have difficulties, for whatever reason, in obtaining dental care. The burgeoning population of autistic children, who require Valium, just for a prophylaxis and examination is staggering. To have this safe and effective medication removed from our armamentarium, has been a huge disaster for our patients.

In review of the untoward situations that have occurred with children in the dental offices, it is important to note that most involved the administration of oral Chloral Hydrate, BY the dentist, IN the dental office. I would suggest that my administering Atarax and Valium in my office would not change this type of occurrence. The problem is more about the kind of medication not where it is administered. So I would propose that the schedule of the type of drugs be limited for prescribing at home, rather than a blanket prohibition of safe and effective medications, which can be administered at home by parents. Sincfor

10/29/12 5:20 pm

Commenter: Michael Rogers, Fairlington Dental *

EKG for conscious oral sedation?

I'm not sure if I read the new proposed regulations correctly, but seriously are you expecting EKG monitoring for giving a patient a few oral pills to mildly sedate them? No EKG monitoring is required for a bartender to

serve 3 drinks, which is the equivalent of what we are giving our patients for light sedation. Please use common sense for our regulations.

11/3/12 10:26 pm

Commenter: Dr. William Griffin City Center Dental Care *

Sedation Regulations for Dentistry

I am writing to express my great concern regarding the recently developed regulations for sedation in dental treatment. These regulations are unnecessarily burdensome on dentists who want to practice sedation dentistry for the comfort of their patients. The regulations will drive up the cost of dental care significantly, they will decrease the number of dentists who offer sedation treatment, and they will result in more dangerous treatment for patients. Following is an explanation of my contentions:

1. The regulations require dentists to purchase an EKG for monitoring patients during even mild to moderate sedation. This machine could cost in the area of \$5,000, and its output would be a waste, because it would not be constantly monitored during treatment, thereby making much of its data meaningless.
2. The regulations would also require dentists to be in the room for the entire time of the sedation treatment. If this does not change, then dentists will have to charge far more for sedation appointments than currently. Right now an assistant or hygienist who has been trained can monitor the sedation, with the dentist still in the building and able to respond to any irregularities. Requiring the dentist to be in the room the entire time will make the cost of treatment far greater, thereby decreasing the number of patients that can afford it.
3. It appears that the board must be afraid that sedation dentistry poses a serious threat to the health of Virginia patients. However, in reality, mild-moderate sedation makes treatment of patients far safer, especially if they are nervous or have heart problems. It keeps them calm and relaxed, and they also heal better after sedation treatment.
4. It is also unfortunate that the regulations do not distinguish between deep sedation and mild-moderate sedation. I believe the regulations are unduly harsh for the mild level of sedation that is induced parenterally.
5. The American Dental Association has spend considerable time developing guidelines regarding appropriate use of mild-moderate sedation in dentistry. They do not require the use of an EKG machine, and they do not require the dentist to be in the room constantly. Perhaps we should follow their lead.
6. There is no state in our country whose dental sedation regulations are as severe as Virginia's. This is over-regulation, the patients would lose out if the regulations are not changed.

For the reasons above, I hope that the Virginia Board of Dentistry will reconsider its current regulations and do what is truly in the best interests of our patients and our profession.

Sincerely,

William Griffin, DDS

Newport News, VA

11/3/12 10:53 pm

Commenter: South Side Dental Center Brad Spano DDS *

Issues with Newly Proposed Sedation Regulations

Dear Board Members and others:

I have practiced Oral Conscious Sedation in Virginia since 2003. I have performed over 500 cases without incident. The new regulations address several issues that were necessary such as permitting which is great.

But there are **two serious problems** with the new regulations:

(1) ECG monitoring is required for mild to moderate oral sedation. This is Overkill for mild to moderate oral conscious sedation. It is needed for deep sedation. There needs to be some verbage that differentiates the two. The intended level of sedation for oral sedation does not have any adverse effect on cardiac function. If anything, it has a positive impact.

(2) The dentist cannot leave the operatory during mild to moderate oral conscious sedation. This is also overkill. My staff is trained to stay with the patient at all times, while constantly monitoring them. This is all that is necessary for mild to moderate sedation.

Two other issues that I think need to be considered are:

1. The ADA had a lot of discussion on the sedation protocols several years ago, and came up with a policy after months of discussion with all of the leading experts in the field. Why is Virginia coming up with regulations that differ from the ADA, when they clearly have not researched the topic to the extent of the ADA or had any national experts give recommendations.
2. The new regulations do not pass the litmus test. Specifically, patients that are scared and nervous inherently have elevated blood pressure and a greater predisposition to cardiac and/or medical issues. Sedation lowers the chance these patients will have a problem. These regulations will allow fewer patients access to sedation services, which will increase the incidence of cardiac and medical emergencies in general dentist's offices throughout Virginia.

Please reconsider the new regulations, specifically in regards to the points above. The citizens of Virginia will be the ones hurt the most if these changes go into effect.

Sincerely,

Brad Spano, DDS

11/5/12 9:28 pm

Commenter: Corey J. Sheppard, D.D.S. *

Sedation Requirements- Revision to recommended

After reviewing the proposed Sedation requirements for the state of Virginia and discussing the proposal in detail with colleagues, we are in agreement that the regulations have a few problems that need to be addressed.

1. ECG monitoring for Moderate Sedation is not necessary to provide proper monitoring for moderate sedation. According to the Academy of Pediatric Dentistry, American Academy of Pediatrics and American Dental Association the following is recommended during moderate sedation (different from Deep Sedation):

During the Procedure

The practitioner shall document the name, route, site, time of administration, and dosage of all drugs administered. There shall be continuous monitoring of oxygen saturation and heart rate and intermittent recording of respiratory rate and blood pressure; these should be recorded in a time-based record. Restraining devices should be checked to prevent airway obstruction or chest restriction. If a restraint device is used, a hand or foot should be kept exposed. The child's head position should be checked frequently to ensure airway patency. A

functioning suction apparatus must be present. (from the guidelines of the AAPD)

ECG monitoring should not be required prior to, during, or after moderate sedation procedures.

2. Continuous monitoring of the patient for moderate sedation should not be required prior to starting the dental procedure.

Most of the time the reason patients are receiving medications for sedation is because of preoperative behavior or uncooperative behavior. The medications are given after baseline vitals are measured and checked and then it takes time for the medications to take effect and peak in order to start the procedure... the patients will not sit in a room and leave monitors on for the 30-45 minutes prior to starting the procedure with the dentist in the room watching the patient bounce off the walls. The area should be quiet, with the parents, and nonstimulating prior to starting the dental procedure, without the dentist in the room. Office personnel should be able to monitor the patient prior to starting the procedure with the dentist. When the patient becomes drowsy by the medications, then monitors can be placed and the dentist can start continuous monitoring for the procedure and able to discharge the patient when appropriate according to the guidelines.

Please consider all recommendations suggested in the comment section when finalizing the sedation regulations and distinguish between Deep and Moderate sedation monitoring requirements. Eliminate the requirement for ECG monitoring equipment and continuous monitoring by the dentist.

Thank you! Corey J. Sheppard, D.D.S.

11/5/12 10:34 pm

Commenter: Caroline Wallace *

new sedation regulations

I have read and agree with the posted comments regarding the new regulations. I hope that the logic requiring the use of an EKG will be seriously reconsidered.

11/6/12 7:24 am

Commenter: Children's Dentistry of Lynchburg *

Sedation Requirements

Sedation Requirements- Revision to recommended

After reviewing the proposed Sedation requirements for the state of Virginia and discussing the proposal in detail with colleagues, we are in agreement that the regulations have a few problems that need to be addressed.

1. ECG monitoring for Moderate Sedation is not necessary to provide proper monitoring for moderate sedation. According to the Academy of Pediatric Dentistry, American Academy of Pediatrics and American Dental Association the following is recommended during moderate sedation (different from Deep Sedation):

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quiet, with the parents, and nonstimulating prior to starting the dental procedure, without the dentist in the room. Office personnel should be able to monitor the patient prior to starting the procedure with the dentist. When the patient becomes drowsy by the medications, then monitors can be placed and the dentist can start continuous monitoring for the procedure and able to discharge the patient when appropriate according to the guidelines.

Please consider all recommendations suggested in the comment section when finalizing the sedation regulations and distinguish between Deep and Moderate sedation monitoring requirements. Eliminate the requirement for ECG monitoring equipment and continuous monitoring by the dentist.

Thank you for your consideration,

Shepherd Sittason D.D.S.

11/6/12 10:18 am

Commenter: Jerry Caravas DDS *

New Sedation Regulations

I have been providing conscious sedation since 2007 and have been constantly amazed at how much patients love this option for dental treatment. It provides a reasonably priced option that is both safe and manageable. I believe the new regulations requiring EKG monitoring as well as the dentist being in the room for the entire appointment will make this option for care unreasonable for most general dentists.

Since most dentists do not provide IV or IO medications, even if we detected an arrhythmia, we would be unable to provide the proper medications to treat the underlying problem. In light of this, it appears the EKG requirement offers little added safety to the patient.

As for the dentist being in the room for the entire appointment, most dental offices are small by nature and the dentist will never be more than 20 feet away from the patient if an emergency should arise.

11/6/12 3:50 pm

Commenter: The Virginia Society of Anesthesiologists *

Needed Revision to Proposed Regulations Governing the Practice of Dental Sedation and Anesthesia

On behalf of the Virginia Society of Anesthesiologists, we respectfully offer the following comments in connection with the Notice of Intended Regulatory Action (NOIRA) filed September 5, 2012 regarding the Regulations Governing the Practice Sedation and Anesthesia Permits for Dentists.

Certified Registered Nurse Anesthetists (CRNAs) are subject to joint regulation by the Boards of Medicine and Nursing. Paragraph D of 18VAC90-30-120 provides as follows:

D. A certified registered nurse anesthetist shall practice in accordance with the functions and standards defined by the American Association of Nurse Anesthetists (Scope and Standards for Nurse Anesthesia Practice, Revised 2005) and under the medical direction and supervision of a doctor of medicine or a doctor of osteopathic medicine or the medical direction and supervision of a dentist in accordance with rules and regulations promulgated by the Board of Dentistry. (Emphasis added).

It should be noted that all medical doctors receive training in anesthesia. Even a doctor who is not an anesthesiologist receives critical care training, including advanced resuscitation techniques. Moreover, Virginia regulation, 18VAC85-20-320, requires doctors providing office-based anesthesia to abide by a number of requirements, including:

- Perform a pre-anesthetic evaluation and examination or ensure that it has been performed;
- Develop the anesthesia plan or ensure that it has been developed;
- Ensure that the anesthesia plan has been discussed and informed consent obtained;

- Ensure patient assessment and monitoring through the pre-, peri-, and post-procedure phases, addressing not only physical and functional status, but also physiological and cognitive status;
- Ensure provision of indicated post-anesthesia care; and
- Remain physically present or immediately available, as appropriate, to manage complications and emergencies until discharge criteria have been met. (Emphasis added).

Additionally, 18VAC85-20-330 requires that “doctors who utilize office-based anesthesia shall ensure that all medical personnel assisting in providing patient care are appropriately trained, qualified and supervised...” (Emphasis added).

The VSA is concerned with proposed changes to 18 VAC 60-20-110 (Requirements for a permit to administer deep sedation/general anesthesia). Section E of this regulation, which is all new language, states:

A dentist not qualified to administer deep sedation and general anesthesia shall only use the services of a dentist with a current deep sedation/general anesthesia permit or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a dentist not qualified to administer deep sedation or general anesthesia shall use either a permitted dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia. (Emphasis added).

The last sentence suggests that CRNAs do not have to be supervised in the outpatient surgery setting, which is clearly contrary to Virginia law.

The VSA supports current regulations contained in Regulations of the Board of Dentistry dealing with Anesthesia, Sedation and Analgesia, 18VAC60-20-107 et seq. In particular, we support the educational requirements provided in 18VAC60-20-110 setting forth the training requirements to administer deep sedation/general anesthesia. We further support the provision set forth in 18VAC60-20-110-B that permits a dentist who has fulfilled the training requirements in subsection A to employ the services of a CRNA. That level of training for the dentist gives true and appropriate meaning to the principle of medical direction and supervision of a CRNA as is required by Virginia law and regulation. A practitioner who does not have appropriate anesthesia and critical care training and experience cannot provide adequate medical direction and supervision to a CRNA.

We hope that any proposed revision to the regulations is consistent with this important principle and complies with applicable law and regulation. **In particular, we ask the Board to amend 18 VAC 60-20-110 Section E to make clear that CRNAs can only operate under the medical direction and supervision of a doctor of medicine, a doctor of osteopathic medicine or a dentist, even in the outpatient surgery context.**

The VSA respectfully submits that the interests of patients are best served by having skilled physicians or dentists supervising CRNAs. This position has been amply borne out by decades of actual experience.

Commenter: Scott golrich *

Dental sedation - proposed new guidelines

As a dentist who has been using both IV and oral sedation in my office since 1993, I have to voice my concern about the request to mandate EKG usage for all moderate sedation cases. The only time I have ever had to call 911 was because I did NOT sedate a patient who developed an anxiety induced angina episode during local anesthesia. The safety is beyond question, and with the routine use of pulse oximetry, and reversal agents for opioids and benzodiazapines, over effect can be quickly controlled. The concept of mandating the dentist to be in the operatory at all times will have a cost increase effect which will likely make sedation unaffordable for many patients, who will in ten avoid treatment to their own detriment. As well trained staff can safely monitor patients, and alert of any concerns with vital signs, it seems to be overkill with these newly proposed regulations. I am certain that many of the prescription drugs provided by physicians, are used either accidly or

otherwise, to create effects similar to or beyond what is considered Moderate conscious sedation in a dental office, yet with NO monitoring whatsoever.

Please reconsider the implementation of these new regulations.

Commenter: C. Frederick Smith, DDS, MS, MAGD, AIAOMMT *

Oral Sedation Regulation

I have been doing mild to moderate conscious oral sedation dentistry for over eight years and have had no problems with the current recommended technique of monitoring the patient with the pulse oximeter. The recent change in the regulations that will go into effect April 1st, 2013, is not something that has been recommended by the American Dental Association, which has reviewed moderate oral sedation extensively. I therefore feel that these changes are much more than are needed. Virginia is the only state which will require these stricter changes and they will decrease the access to dental care for those patients that need to be sedated in order to help them get through their dental treatment. I ask that you reconsider these regulation changes and have them withdrawn before the activation date of April 1st 2013.

The requirement to have the dentist present in the room with the patient the entire time the patient is sedated in the office is also an unnecessary requirement. During the initial and post-op phase of the sedation appointment, or when the dentist needs to check a hygiene patient, the sedated patient can be adequately monitored by a qualified and trained dental assistant or hygienist. In most dental offices the doctor can be summoned in a few seconds to address any concerns that might arise. This requirement is also overkill and should be revoked as soon as possible.

11/7/12 5:50 pm

Commenter: Dr. Thomas Padgett *

Clarification between Minimal sedation and Conscious sedation

Yeatts, Elaine J. (DHP)

From: Hoard, Brian C *HS [BCH3N@hscmail.mcc.virginia.edu]
Sent: Monday, September 17, 2012 10:16 AM
To: Yeatts, Elaine J. (DHP)
Cc: Reen, Sandra (DHP)
Subject: Proposal for Regulations governing practice of sedation and anesthesia for dentists

In response to the request for public comments related to any forthcoming changes in the regulations governing sedation and anesthesia in Dentistry and the establishment of a permit process, I request that the Board of Dentistry adhere to the Definition of General Anesthesia and Levels of Sedation/Analgesia adopted by the American Society of Anesthesiologists (Please google this. Basically, it is an establishment of parameters that define minimal sedation/analgesia, moderate sedation/conscious sedation, deep sedation/analgesia, and general anesthesia). This is what is used by the Sedation Committee and Dept. of Anesthesiology at the U. of Virginia Health System. It is the only reliable and universally accepted mechanism I know of to define levels of sedation.

The reason I bring this up is that the definitions should be what the BOD bases its requirements on. Unfortunately, in the past, there has been a tendency both with the BOD and even my hospital to define levels of sedation by the ROUTE of administration, not by the levels of responsiveness, airway effect, presence of spontaneous ventilation, and cardiovascular function. What I mean by this, for example, is that someone might automatically define PO (oral) sedation as "anxiolysis/mild sedation", intravenous sedation as "conscious/moderate sedation" or even "deep sedation", etc. This is incorrect. A practitioner can push a person into moderate or deep sedation with PO drugs, like Triazolam, if he gives an inappropriately high dose or "stacks" the dosing. He can even push a pediatric patient into general anesthesia with a combination of nitrous oxide and some sort of oral sedation "cocktail". The flip side of this is that a practitioner can also give intravenous Valium and maybe even Valium and Sublimaze at a low enough dose to a larger individual and only have him in a state of anxiolysis. The route of administration--inhalation, oral, IM, or IV--should not factor into whatever guidelines you establish for training, monitoring, etc. regulations. It should be the LEVEL of sedation which factors into this, and those levels, as mentioned earlier, are best defined by those most expert in defining them--The American Society of Anesthesiologists.

My point is, what I do not want to see is the BOD establish a set of guidelines that say you need to have BP, pulse, O2 saturation, and respiration monitoring with "IV sedation". What the BOD should instead say is something like you need to have BP, pulse, O2 saturation, and respiration monitoring with "conscious/moderate sedation" or "deep sedation" or something along those lines, whether those levels of sedation are achieved by oral, inhalation, IM or intravenous routes. Granted, this will rely on the practitioner being "honest" about his assessment of the level of sedation, but, as I said earlier, the parameters are pretty clearly defined.

As far as monitoring requirements, I can only add what the Sedation Committee and the Dept. of Anesthesiology uses as a guideline at the U. of Virginia Health System: Anxiolysis/mild sedation, where there is a normal response to verbal stimulation, no effect on airway/spontaneous ventilation/cardiovascular function--no monitoring devices are required. Conscious/moderate sedation, where there is a purposeful response to verbal or tactile stimulation, no intervention required on airway, adequate spontaneous ventilation, and usually maintained cardiovascular function--BP, pulse, O2 saturation, and respiratory rate monitoring requirements. When you get into deep sedation, ECG monitoring is required in addition to the others, but that is more the realm of sedation used by Oral Surgeons for complex procedures.

Good luck with this--I sympathize with the challenge of coming up with something, because every special interest group is going to be weighing in on this. The DOCS guys will have their point of view, the Oral Surgeons will have theirs, the Anesthesiologists will have theirs, the malpractice attorneys will have theirs.... On that last item, please don't be swayed by an attorney's point of view unless he can back up his claims. I still remember that petition before the BOD for a permitting process about 3-4 years ago that came from an attorney in SW Virginia. In the petition, his stated reason for asking for a permit began with the statement "since all conscious sedation patients eventually wind up in deep sedation" or something like that. NOT TRUE. I even e-mailed him and very respectfully pointed out to him that I was unaware of any literature references, consensus statements, etc. that came to such a conclusion. I asked him for the reference data that was the basis for such a statement--he NEVER replied. Please don't be swayed by FALSE statements--verify everything, take your time with this.

**MACAULAY
& BURTCHE, P.C.**

ATTORNEYS AT LAW

Michele L. Satterlund
Direct: 804.649.8847
Fax: 804.649.3854
msatterlund@macbur.com

November 6, 2012

BY EMAIL

Ms. Sandra Reen
Virginia Board of Dentistry
9960 Mayland Drive
Suite 300
Richmond, VA 23233-1463

**RE: Proposed Regulations Governing Dental Practice
Permits for Administration of Conscious/Moderate Sedation or Deep
Sedation/General Anesthesia**

Dear Ms. Reen,

I am writing on behalf of Virginia Association of Nurse Anesthetists ("VANA") to provide public comment regarding the revision of the Regulations Governing Dental Practice to provide permits for dentists who provide or administer conscious/moderation sedation or deep sedation/general anesthesia in a dental office.

VANA supports provisions in the draft regulations that better ensure safe anesthesia care in the dental office setting and respectfully requests that the Board of Dentistry ("Board") consider the attached amendments. The proposed amendments will safeguard regulatory compliance with the statutory requirements, and will help ensure that all dental patients in Virginia have access to safe anesthesia care.

We thank the Board of Dentistry for its consideration of VANA's comments. Patient safety is, and always has been, the number one priority of nurse anesthetists and we believe all patients have a right to the best in anesthesia treatment.

Best,

Michele Satterlund

Enclosure

cc: Ms. Elaine Yeatts, Virginia Department of Health Professions
Mr. Paul Werbin, Virginia Association of Nurse Anesthetists

**Virginia Association of Nurse Anesthetists
Amendment Language
Proposed Regulations Regarding Sedation and Anesthesia Permits for Dentists
Due: November 7, 2012**

Permit Required for any Dentist Providing or Administering Anesthesia

The enabling legislation requires that any dentist providing or administering sedation or anesthesia in a dental office must obtain a permit. Virginia Code §54.1-2709.5 states:

“A. Except as provided in subsection C, the Board shall require any dentist who provides or administers sedation or anesthesia in a dental office to obtain either a conscious/moderate sedation permit or a deep sedation/general anesthesia permit issued by the Board. The Board shall establish by regulation reasonable education, training, and equipment standards for safe administration and monitoring of sedation and anesthesia to patients in a dental office. (emphasis added).

In other words, whether the dentist himself administers sedation or anesthesia in a dental office, or whether the dentist provides (i.e. supplies or furnishes) a patient with sedation or anesthesia care by delegating the administration to another anesthesia provider, the dentist is required to obtain a permit.

Plain Meaning

The draft regulations misinterpret the statute by allowing a dentist who does not hold a permit to delegate the administration of sedation or anesthesia. For example, 18VAC60-20-110 (E) 1 and 18VAC60-20-120 (H) 1 of the proposed regulations state:

“A dentist not qualified to administer deep sedation and general anesthesia [conscious sedation] shall only use the services of a dentist with a current deep sedation/general anesthesia [conscious sedation] permit or an anesthesiologist to administer deep sedation or general anesthesia in a dental office.....”

While the term “not qualified” is not defined, the proposed regulations indicate that a dentist who does not hold a permit may delegate the administration of anesthesia to an anesthesiologist or to a dentist who holds a permit. This is a misinterpretation of the statute and involves word twisting that the Supreme Court has said is prohibited by the Plain Meaning Rule. “[W]hen we interpret unambiguous status..., we apply the plain meaning rule.” City of Winchester v. American Woodmark Corpo., 250 Va. 451 (1995).

The word “provide” is precise and unambiguous. “Provide” is defined as: “.1 To put at the disposal of, furnish or supply...” Collins World English Dictionary 10th Edition. The Merriam-Webster Unabridged defines “provide” as “to supply or make available.”

The McGraw-Hill Concise Dictionary of Modern Medicine (2002) defines “administer” as:

“Pharmacology *verb* To apply a substance—by injection, inhalation, ingestion or by other means, to the body of a Pt or research subject by either a health practitioner or his authorized agent and under his direction, or by the Pt or research subject himself. Cf Dispense Medtalk → Vox populi Give.”

In light of the Plain Meaning Rule, the statute requires that any dentist giving, dispensing, supplying, furnishing, or making sedation or anesthesia available to patients in a dental setting must hold a permit. The statute makes no exceptions, and an “unqualified” dentist may not delegate anesthesia administration to any other provider unless the dentist holds a permit.

As such, VANA asks that the BOD consider the following amendments to 18VAC60-20-110 (E) 1 and 18VAC60-20-120 (H) 1 which will conform the proposed regulations to the requirements of Virginia Code §54.1-2709.5. (Amendment language in bold and italicized):

18VAC60-20-110 E. Delegation of administration.

1. ~~A dentist not qualified to administer deep sedation and general anesthesia shall only use the services of a dentist with a current deep sedation/general anesthesia permit or an anesthesiologist to administer deep sedation or general anesthesia in a dental office.~~ In a licensed outpatient surgery center, a dentist ~~not qualified~~ *who does not hold a permit* to administer deep sedation or general anesthesia shall use either a permitted dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist **qualified who holds a permit** pursuant to subsection B of this section may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

a. A dentist with a current deep sedation/anesthesia permit;

b. ~~An anesthesiologist;~~ *A physician trained in anesthesiology who is acting within his scope and in accordance with the laws and regulations governing his practice.*

c. ~~A certified registered nurse anesthetist practicing under the~~ *who is acting within his scope and in accordance with the laws and regulations governing his practice.* ~~medical direction and indirect supervision of a dentist who meets the educational requirements of subsection B of this section.~~

Patient Access to Anesthesia Care (Proposed Draft Regulations 18VAC60-20-110 and 18VAC60-20-120)

VANA supports the proposed permit provisions that better ensure safety in dental settings and it applauds the Board for proposing such a detailed and comprehensive approach to safer anesthesia care. However, to ensure that access to anesthesia care is not needlessly limited, especially in rural areas, VANA asks the Board to consider an approach that gives dentists flexibility in regards to the anesthesia educational requirements.

The proposed draft regulations require dentists who wish to apply for a permit to obtain education and training qualifications, regardless of whether the dentist plans to administer the anesthesia, or whether

the dentist plans to delegate administration to another trained provider (See 18VAC60-20-110 (C) 1 and 18VAC60-20-120 (D) 1).

This is an overly burdensome requirement that limits access to care by requiring a duplication of credentials by the dentist and the CRNA provider. In no other office based setting is there a statutory or regulatory rule that requires the practitioner with whom the CRNA practices meet certain anesthesia training requirements.

The minimum education standards for CRNAs include extensive anesthesia training. In fact, the anesthesia training of CRNAs is twice the number of years mandated in the draft regulations for dentist who wish to practice with CRNAs. This is an unnecessary duplication of credentials that will lead to increased health care costs and limit access to anesthesia care.

The duplication of training is particularly confusing in light of this Administration's current initiative to identify outdated or unnecessary regulatory burdens (Regulatory Reform Project). Given that no other law or regulation mandates that a surgical provider obtain anesthesia related training in order to practice with a CRNA, it is an example of the very type of regulatory burden the Regulatory Reform Project is seeking to eliminate.

Further exacerbating the confusion over this unnecessary requirement is the fact that dentists practicing in a hospital or ambulatory surgery center may practice with CRNAs, regardless of the dentist's anesthesia training. In fact, in hospitals and ambulatory surgery centers, it is not at all uncommon that the CRNA may be the only person present with anesthesia training—a fact that is especially important in rural settings.

VANA respectfully requests the Board consider language clarifying that dentists who apply for a permit may forego the anesthesia educational requirements, provided the dentist delegates the anesthesia administration to trained providers, including oral or maxillofacial surgeons, anesthesiologists, dentists who hold a permit, and CRNAs, whose scope of practice, allows administration of deep sedation/general anesthesia. (Amendment language in bold and italicized: Apply to both 18VAC60-20-110 (C) and 18VAC60-20-120 (D)).

18VAC60-20-110. Requirements for a permit to administer deep sedation/general anesthesia.

C. Educational and training qualifications for a deep sedation/general anesthesia permit.

~~1. A dentist may employ or be issued a permit to use deep sedation/general anesthesia on an outpatient basis in a dental office by meeting one of the following educational criteria, or by providing proof that the anesthesia provider to whom the dentist delegates the administration of deep sedation/general anesthesia has the educational and licensing requirements necessary to administer anesthesia. Such providers may include an oral and maxillofacial surgeon; a physician trained in anesthesiology who is acting within his scope of practice and in accordance with the laws and regulations governing his practice; a certified registered nurse anesthetist practicing within his scope and in accordance with the laws and regulations governing his practice; or a dentist who holds a permit to administer anesthesia.~~ and by posting the educational certificate, in plain view of the patient, which verifies completion of the advanced training as required in subdivision 1 or 2 of this subsection. These requirements shall not apply nor interfere with requirements for obtaining hospital staff privileges.

~~1. Has completed~~ a. Completion of a minimum of one calendar year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program in conformity with published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred; or

~~2. b. Completion of an American Dental Association approved~~ a CODA accredited residency in any dental specialty which incorporates into its curriculum a minimum of one calendar year of full-time training in clinical anesthesia and related clinical medical subjects (i.e. medical evaluation and management of patients), comparable to those set forth in published guidelines by the American Dental Association for Graduate and Postgraduate Training in Anesthesia in effect at the time the training occurred.

~~After June 29, 2006, dentists~~ 2. Dentists who administer deep sedation/general anesthesia shall hold current certification in advanced resuscitative techniques with hands-on simulated airway and megacode training for healthcare providers, including basic electrocardiographic interpretation, such as courses in Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals and current Drug Enforcement Administration registration.

B. Exceptions.

~~1. A dentist who has not met the requirements specified in subsection A of this section may treat patients under deep sedation/general anesthesia in his practice if a qualified anesthesiologist or a dentist who fulfills the requirements specified in subsection A of this section, is present and is responsible for the administration of the anesthetic.~~

~~2. If a dentist fulfills the requirements specified in subsection A of this section, he may employ the services of a certified nurse anesthetist.~~

By following the lead of the American Dental Association which gives dentists a choice to practice with CRNAs, Virginia will better ensure uniformity within dental practices, and expand the ability of dentists to provide quality care to a greater number of Virginia's citizens.

Going the Extra Step for Safer Anesthesia Care

Separate Anesthesia Providers

The proposed draft regulations allow a dentist who holds an anesthesia permit to perform both the dental procedure and administer deep sedation or general anesthesia. This dual approach is not the safest method of anesthesia administration and increases the risk of patient harm.

To minimize this risk, and to ensure that dental patients receive the focused attention of each provider, VANA asks the Board to add the following amendment language in the proposed draft regulations under 18VAC60-20-107. The amendment will help ensure that should an unusual complication occur, the patient will received the undivided attention of each provider so as to realize the best possible outcome.

Deep sedation or general anesthesia shall be administered by a provider other than the dentist performing the dental procedure. Such providers may include an oral and maxillofacial surgeon; a physician trained in anesthesiology who is acting within his scope of practice and

in accordance with the laws and regulations governing his practice; a certified registered nurse anesthetist practicing within his scope and in accordance with the laws and regulations governing his practice; or a dentist who holds a permit to administer anesthesia.

Monitoring

Safe patient monitoring requires an ability to discern the difference between a serious incident and a routine change. Patients are safest when monitoring is performed by trained professionals who have the ability to interpret monitoring modalities, and the skill and authority to correct unsafe situations.

To ensure that all dental patients receive the highest level of safe monitoring, VANA asks the Board to consider amending the proposed regulations to include a provision that ensures that only those practitioners trained in the delivery of general anesthesia or deep sedation are permitted to monitor patients.

A patient undergoing deep sedation or general anesthesia shall be monitored by a provider authorized to administer deep sedation nor general anesthesia, and may include an oral and maxillofacial surgeon; a physician trained in anesthesiology who is acting within his scope of practice and in accordance with the laws and regulations governing his practice; a certified registered nurse anesthetist practicing within his scope and in accordance with the laws and regulations governing his practice; or a dentist who holds a permit to administer anesthesia.

Registered Nurses (Proposed Draft Regulations 18VAC60-20-120)

Exposing patients to powerful and life threatening pharmacologist agents is always a serious matter, and it is important that those practitioners administering or monitoring such drugs have the necessary credentials and education as required by their respective licensing board. As such, VANA asks that the Board consider amendment language clarifying that an RN may only practice as permitted by the Board of Nursing and according to the RN's scope of practice.

Draft 18VAC60-20-120 (H) 2 e

e. A registered nurse *practicing within his scope and as permitted by the Board of Nursing, and who is practicing* upon his direct instruction and under the immediate supervision of a dentist who meets the education and training requirements of subsection C.

November 6, 2012

VIA EMAIL

Ms. Elaine J. Yeatts
Agency Regulatory Coordinator
Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Re: Regulations Governing the Practice of Sedation and Anesthesia Permits for
Dentists

Dear Ms. Yeatts:

On behalf of the Virginia Society of Anesthesiologists, we respectfully offer the following comments in connection with the Notice of Intended Regulatory Action (NOIRA) filed September 5, 2012 regarding the Regulations Governing the Practice Sedation and Anesthesia Permits for Dentists.

Certified Registered Nurse Anesthetists (CRNAs) are subject to joint regulation by the Boards of Medicine and Nursing. Paragraph D of 18VAC90-30-120 provides as follows:

D. A certified registered nurse anesthetist shall practice in accordance with the functions and standards defined by the American Association of Nurse Anesthetists (Scope and Standards for Nurse Anesthesia Practice, Revised 2005) and under the medical direction and supervision of a doctor of medicine or a doctor of osteopathic medicine or the medical direction and supervision of a dentist in accordance with rules and regulations promulgated by the Board of Dentistry. (Emphasis added).

It should be noted that all medical doctors receive training in anesthesia. Even a doctor who is not an anesthesiologist receives critical care training, including advanced resuscitation techniques. Moreover, Virginia regulation, 18VAC85-20-320, requires doctors providing office-based anesthesia to abide by a number of requirements, including:

- Perform a pre-anesthetic evaluation and examination or ensure that it has been performed;
- Develop the anesthesia plan or ensure that it has been developed;
- Ensure that the anesthesia plan has been discussed and informed consent obtained;
- Ensure patient assessment and monitoring through the pre-, peri-, and post-procedure phases, addressing not only physical and functional status, but also physiological and cognitive status;
- Ensure provision of indicated post-anesthesia care; and

- Remain physically present or immediately available, as appropriate, to manage complications and emergencies until discharge criteria have been met. (Emphasis added).

Additionally, 18VAC85-20-330 requires that “doctors who utilize office-based anesthesia shall ensure that all medical personnel assisting in providing patient care are appropriately trained, qualified and supervised...” (Emphasis added).

The VSA is concerned with proposed changes to 18 VAC 60-20-110 (Requirements for a permit to administer deep sedation/general anesthesia). Section E of this regulation, which is all new language, states:

A dentist not qualified to administer deep sedation and general anesthesia shall only use the services of a dentist with a current deep sedation/general anesthesia permit or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a dentist not qualified to administer deep sedation or general anesthesia shall use either a permitted dentist, an anesthesiologist, or a certified registered nurse anesthetist to administer deep sedation or general anesthesia. (Emphasis added).

The last sentence suggests that CRNAs do not have to be supervised in the outpatient surgery setting, which is clearly contrary to Virginia law.

The VSA supports current regulations contained in Regulations of the Board of Dentistry dealing with Anesthesia, Sedation and Analgesia, 18VAC60-20-107 *et seq.* In particular, we support the educational requirements provided in 18VAC60-20-110 setting forth the training requirements to administer deep sedation/general anesthesia. We further support the provision set forth in 18VAC60-20-110-B that permits a dentist who has fulfilled the training requirements in subsection A to employ the services of a CRNA. That level of training for the dentist gives true and appropriate meaning to the principle of medical direction and supervision of a CRNA as is required by Virginia law and regulation. A practitioner who does not have appropriate anesthesia and critical care training and experience cannot provide adequate medical direction and supervision to a CRNA.

We hope that any proposed revision to the regulations is consistent with this important principle and complies with applicable law and regulation. **In particular, we ask the Board to amend 18 VAC 60-20-110 Section E to make clear that CRNAs can only operate under the medical direction and supervision of a doctor of medicine, a doctor of osteopathic medicine or a dentist, even in the outpatient surgery context.**

The VSA respectfully submits that the interests of patients are best served by having skilled physicians or dentists supervising CRNAs. This position has been amply borne out by decades of actual experience.

Please let us know if you have any questions or comments.

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, September 17, 2012 8:46 AM
To: ddsmcv2001@gmail.com
Cc: Yeatts, Elaine J. (DHP)
Subject: FW: clarification on Emergency Regulation Sedation/anesthesia permits
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Dr. Carney:

Thank you for pointing out this error in the emergency regulations. The fee for a deep sedation/general anesthesia permit is \$100. I just verified that the applications for the permits address the fee correctly.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Jacqueline Carney [<mailto:ddsmcv2001@gmail.com>]
Sent: Sunday, September 16, 2012 10:28 AM
To: Board of Dentistry
Subject: clarification on Emergency Regulation Sedation/anesthesia permits

I am reading through the regulation listed above to prepare for the changes to my practice and I have a question about the application fees.

On page four of the regulations section K. discusses the Conscious/moderate sedation permit and states the application fee "for a permit to administer conscious/moderate sedation shall be \$100." Then section L. discusses Deep sedation/general anesthesia permit but restates the identical information for a permit to administer conscious/moderate sedation, not deep sedation/general anesthesia: "The application fee for a permit to administer conscious/moderate sedation shall be \$100." I do not see anything listed describing the application fee for deep sedation/general anesthesia.

Could you please clarify?

Thank you,

Jacqueline Carney

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, September 24, 2012 3:07 PM
To: Betty Guarino
Cc: Dentistry Group (DHP)
Subject: RE: is permit needed to IV sedation?
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Ms. Guarino:

Thank you for your follow-up. Unfortunately, Board staff cannot make any conclusion on whether or not Dr. Ellenbogen is required to obtain a permit so the decision is his. As indicated in the September 12, 2012 notice, if he never administers conscious/moderate sedation or deep sedation/general anesthesia, he is not required to hold a permit.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Betty Guarino [<mailto:bguarino@nedentalmanagement.com>]
Sent: Monday, September 17, 2012 1:28 PM
To: 'gary ellenbogen'; Reen, Sandra (DHP)
Subject: RE: is permit needed to IV sedation?

Sandra:

I just spoke with someone in your office just to clarify the Permits for IV Sedation, and what she told me was that if Dr. Ellenbogen does not perform the IV Sedation he is not required to file the permit for the IV Sedation. The only time we should apply for the permit is if Dr. Ellenbogen himself is performing the sedation.

Just want to clarify again that we are in compliance with the rules and regulations of the Board.

Thank you

Betty Guarino
Administrative Director
Northeast Dental Management
66 Route 17, North
Paramus, NJ 07652
201-291-0935 Ext 60001

"A pessimist complains about the wind, an optimist counts on the wind changing, a realist adjusts his sails"

From: gary ellenbogen [<mailto:garyellenbogendds@aol.com>]
Sent: Monday, September 17, 2012 12:31 PM

To: bguarino@nedentalmanagement.com
Subject: Fwd: is permit needed to IV sedation?

Betty, See what a big help Sandra is. Dr. Ellenbogen
gary ellenbogen
garyellenbogendds@aol.com

-----Original Message-----

From: Reen, Sandra (DHP) (DHP) <Sandra.Reen@DHP.VIRGINIA.GOV>
To: gary ellenbogen <garyellenbogendds@aol.com>
Sent: Mon, Sep 17, 2012 11:31 am
Subject: RE: is permit needed to IV sedation?

Dr. Ellenbogen:

Thank you for your inquiry. Permits will be issued to a licensed dentist rather than a practice. The Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. Reviewing these sections should assist you in deciding if you need to obtain a permit.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: gary ellenbogen [<mailto:garyellenbogendds@aol.com>]
Sent: Monday, September 17, 2012 9:01 AM
To: Reen, Sandra (DHP)
Subject: is permit needed to IV sedation?

Dear Sandra,

I wanted to know if it is necessary for my practice to obtain a permit in order to administer conscious/moderate or deep sedation/general anesthesia in my office if the persons administering it are from Horizon Anesthesia (a group of board certified anesthesiologists that also work at INOVA hospitals).. Thank you so much for your anticipated quick response, Dr. Gary Ellenbogen..... 8100 Boone Blvd. Suite 100 Vienna, Va. 22182. 703-734-1095. My email is garyellenbogendds@aol.com

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, September 24, 2012 3:39 PM
To: Philip Vahab
Subject: RE: ATTN: Sandra Reen
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Vahab:

If you never administer conscious/moderate sedation, deep sedation or general anesthesia, you are not required to obtain a permit. The Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. These sections permit dentists who are not qualified or who do not hold a permit to use the services of a qualified dentist who holds a permit, an anesthesiologist or in certain circumstances the services of a certified registered nurse anesthetist.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Philip Vahab [<mailto:pjvahab@gmail.com>]
Sent: Monday, September 17, 2012 2:17 PM
To: Reen, Sandra (DHP)
Subject: ATTN: Sandra Reen

Ms. Reen,

I recently received the "Notice of requirements to Administer Conscious/moderate sedation and deep sedation ect..." dated September 12, 2012.

I am an orthodontist and I work as an independent contractor in a pedodontists office. The pedodontists has an anesthesiologist come in her office to administer anesthesia for her sedation cases. I have never placed braces on a patient under anesthesia. However, if I were to bond braces on a patient that was under conscious sedation administered by the anesthesiologist, would I need a permit?

As I have said I have never done this, but I know that there are some circumstances where a special needs patient may need to have braces applied while under conscious sedation.

Thank you in advance for taking this question. If you are unable to answer this question, please let me know who I can contact to fully understand my responsibilities in this case.

Thank you

Regards,

Philip Vahab, DDS, MS
914-522-0567

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, September 24, 2012 4:06 PM
To: Jack Allara
Subject: RE: regulations
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Allara:

The answer to your first two questions is yes. The permit fee will not be combined with your license renewal fee. You will need to renew both your dental license and permit by March 31 of each year. Please note that initial permits will be issued with an expiration date of March 31, 2014.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Jack Allara [<mailto:jackdds@ntelos.net>]
Sent: Monday, September 17, 2012 3:37 PM
To: Reen, Sandra (DHP)
Subject: regulations

I just received the Emergency regulations and am I correct in seeing that we are now being charged \$100. just for the privilege of providing Conscious Sedation for our patients? Will this be in addition to our license fee? Will this additional fee be added to our renewal next spring? Sincerely, Jack Allara II DDS

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, September 24, 2012 4:51 PM
To: 'Christine Reardon'
Subject: RE: Question on requirements for General Anesthesia regulations
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Reardon:

If you never administer conscious/moderate sedation, deep sedation or general anesthesia, you are not required to obtain a permit. The Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. These sections permit dentists who are not qualified or who do not hold a permit to use the services of a qualified dentist who holds a permit, an anesthesiologist or in certain circumstances the services of a certified registered nurse anesthetist.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Christine Reardon [<mailto:creardon610@yahoo.com>]
Sent: Monday, September 17, 2012 5:09 PM
To: Reen, Sandra (DHP)
Subject: Question on requirements for General Anesthesia regulations

I have a question about the language of the regulation. It states no dentist may use deep sedation/ general anesthesia in a dental office unless a permit is obtained. Does this mean a permit is necessary if a board certified anesthesiologist comes into the office to administer the general anesthesia?

As a dentist I do not administer any moderate/ deep sedation or general anesthesia myself.

Thank you for your assistance in this matter.

Dr. Chrisitne Reardon

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 9:14 AM
To: Laura Givens
Cc: Dentistry Group (DHP)
Subject: RE: AAOMS Certificate Requirement Question
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Laura:

Thank you for bringing this to my attention. You are correct, the certificate that should be posted is the one received for completing and passing the AAOMS Office Anesthesia Exam. I apologize for the poor choice of wording in the notice and greatly appreciate your efforts in sharing the correction with the VSOMS membership.

Smile,
Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Laura Givens [<mailto:Givens@vadental.org>]
Sent: Wednesday, September 19, 2012 1:49 PM
To: Reen, Sandra (DHP)
Cc: Palmatier, kelley (DHP)
Subject: AAOMS Certificate Requirement Question
Importance: High

Hi Sandy,

I have had several phone calls from VSOMS members today regarding the letter that was sent informing them about the requirements for the administration of sedation and anesthesia. There is some confusion because you state in the letter that AAOMS members who complete the office anesthesia through the association must "post in plain view of patients your current AAOMS Board Certification." OMSs are certified by the ABOMS (American Board of OMS) and I believe that what you intended to require them to post is the certificate they receive for completing and passing the AAOMS Office Anesthesia Exam.

I had planned to send an email to VSOMS members this week to make sure they were aware of this new requirement and to have them contact me if they need a new copy of this certificate. Before I do so, please clarify the requirement so that I can inform them correctly.

Thanks for your help!

Laura

Laura Givens
Executive Secretary
Virginia Society of Oral & Maxillofacial Surgeons
3460 Mayland Ct., Ste. 110
Richmond, VA 23233

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 11:56 AM
To: Mark Armanious
Subject: RE: Permit for Sedation in Dental Offices
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Armanious:

First, let me correct the information I gave in the notice about posting an AAOMS Board Certification. The certificate that should be posted is the one received for completing and passing the AAOMS Office Anesthesia Exam. Until such time as you meet both requirements for the exemption – membership in AAOMS and you can provide (and post) the results of the AAOMS periodic office examination – you will be required to obtain a permit from the Board by March 31, 2013 in order to continue administering conscious sedation, deep sedation or general anesthesia. You may want to check with AAMOS regarding your membership and the scheduling of office examinations to see if it is possible to qualify for the exemption before March 31, 2013.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Mark Armanious [<mailto:marmaniousdmd@hotmail.com>]
Sent: Monday, September 17, 2012 2:35 PM
To: Reen, Sandra (DHP)
Subject: Permit for Sedation in Dental Offices

Ms. Reen,

My name is Mark Armanious and I am a new Oral & Maxillofacial Surgeon practicing in Falls Church, VA. I completed my residency training June 30, 2012 and have since applied for membership with AAOMS. I am also in the board certification process and scheduled to take my qualifying written examination in January of 2013. I just need some clarification regarding the need to attain a permit for sedation. Your letter states that a current AAOMS Board Certification must be posted in plain view of patients but I am not sure where this puts me since I am in the process of attaining board certification. Any feedback would be greatly appreciated!

Sincerely,

Mark M. Armanious, DMD

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 9:14 AM
To: Laura Givens
Cc: Dentistry Group (DHP)
Subject: RE: AAOMS Certificate Requirement Question
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Laura:

Thank you for bringing this to my attention. You are correct, the certificate that should be posted is the one received for completing and passing the AAOMS Office Anesthesia Exam. I apologize for the poor choice of wording in the notice and greatly appreciate your efforts in sharing the correction with the VSOMS membership.

Smile,
Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Laura Givens [<mailto:Givens@vadental.org>]
Sent: Wednesday, September 19, 2012 1:49 PM
To: Reen, Sandra (DHP)
Cc: Palmatier, kelley (DHP)
Subject: AAOMS Certificate Requirement Question
Importance: High

Hi Sandy,

I have had several phone calls from VSOMS members today regarding the letter that was sent informing them about the requirements for the administration of sedation and anesthesia. There is some confusion because you state in the letter that AAOMS members who complete the office anesthesia through the association must "post in plain view of patients your current AAOMS Board Certification." OMSs are certified by the ABOMS (American Board of OMS) and I believe that what you intended to require them to post is the certificate they receive for completing and passing the AAOMS Office Anesthesia Exam.

I had planned to send an email to VSOMS members this week to make sure they were aware of this new requirement and to have them contact me if they need a new copy of this certificate. Before I do so, please clarify the requirement so that I can inform them correctly.

Thanks for your help!

Laura

Laura Givens
Executive Secretary
Virginia Society of Oral & Maxillofacial Surgeons
3460 Mayland Ct., Ste. 110
Richmond, VA 23233

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 11:04 AM
To: dentistkwon@gmail.com
Subject: FW: This is general dentist
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Dr. Kwon:

The Emergency Regulations for Sedation/Anesthesia Permits do not address particular drugs and do not permit making an assumption that a particular drug at a particular dose will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

As a licensee, you are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then you are responsible for applying these terms and the associated regulations to your practice. I hope the following regulation (18VAC60-20-107.D.) will assist you in understanding the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide whether or not you are required to hold a permit and about the education and equipment requirements you must meet.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: 권혁수 [mailto:dentistkwon@gmail.com]

Sent: Tuesday, September 18, 2012 2:54 PM

To: Board of Dentistry

Subject: This is general dentist

Dear Virginia board of dentistry department of health professions

I recently got the changed sedation regulations.

My question is Do I need permit for Valium 5mg for dental anxiety patient.

This is oral sedation, but not moderate level ASA 1 or 2 patient.

Let me know any permit or if need, do I need pulse oxymetry equipment?

Thank you.

Dr. Hyuksoo Kwon

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 12:45 PM
To: jbdentist@comcast.net
Subject: RE: oral sedation regs
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Blackburn:

I am working through the many e-mails I received on the emergency regulations and apologize for the time it is taking to respond. I believe you called this morning and asked about the education requirements for administering conscious/moderate sedation and I asked you to send your questions by e-mail. I should have also suggested that it might be helpful for you to review the application and instructions for a permit which are available in the "Forms and Applications" tab at www.dhp.virginia.gov/dentistry.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: kbdentist@comcast.net [<mailto:kbdentist@comcast.net>]
Sent: Tuesday, September 18, 2012 8:56 AM
To: Reen, Sandra (DHP)
Subject: oral sedation regs

Sandra,

My name is Jeff Blackburn and I am a dentist in Midlothian Virginia. I have been trained and have performed over 200 oral/ conscious sedation cases in the last 5 years. I have followed all the regulations and requirements(and standard of care) for the state of virginia. I recently received a packet on revised requirements and I would like to discuss this with you so that I am 100% sure of the changes and anything I may need to do. My work phone # is 378-7888.

I look forward to hearing from you.

Jeff

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 12:10 PM
To: info@smiles4fairfax.com
Subject: FW: CE Letters Attached
Attachments: HowardNgo_SS_DC2011.pdf; HowardNgo_DALSRecert_DC2011.pdf
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Ms. Magalona:

Dr. Ngo will need to apply for and hold a deep sedation/general anesthesia permit if he wishes to continue to administer general anesthesia after March 31, 2013. Applications with instructions for a permit are available in the "Forms and Applications" tab at www.dhp.virginia.gov/dentistry.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Smiles 4 Fairfax Front Desk [mailto:info@smiles4fairfax.com]
Sent: Tuesday, September 25, 2012 7:52 AM
To: Board of Dentistry
Subject: CE Letters Attached

Good Morning Ms. Reen,

We have received the letter from you regarding the Notice of Requirements to Administer Conscious/Moderate Sedation and Deep Sedation/General Anesthesia in a Dental Office after March 31, 2013.

I have attached with this email the CE Letters/Certificates for Dr. Howard Ngo, DDS for the following courses in Washington, D.C. on May 5-7, 2011:

Dental Advanced Life Support (DALs) - 1 Day Recertification (ACLS)
Sedation Solutions - Caring for Challenging Patients

I believe these are sufficient to enable Dr. Ngo to continue to administer general anesthesia to patients. Please let me know if there is anything else needed.

Thank you,
Diana Magalona

--
Patient Care Coordinator
Smiles 4 Fairfax, PLC

11351 Random Hills Road, Suite 290 | Fairfax, VA 22030
p: 703.865.6677 | f: 703.865.6680 | info@smiles4fairfax.com
www.smiles4fairfax.com

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 11:56 AM
To: Mark Armanious
Subject: RE: Permit for Sedation in Dental Offices
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Armanious:

First, let me correct the information I gave in the notice about posting an AAOMS Board Certification. The certificate that should be posted is the one received for completing and passing the AAOMS Office Anesthesia Exam. Until such time as you meet both requirements for the exemption – membership in AAOMS and you can provide (and post) the results of the AAOMS periodic office examination – you will be required to obtain a permit from the Board by March 31, 2013 in order to continue administering conscious sedation, deep sedation or general anesthesia. You may want to check with AAMOS regarding your membership and the scheduling of office examinations to see if it is possible to qualify for the exemption before March 31, 2013.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Mark Armanious [<mailto:marmaniousdmd@hotmail.com>]
Sent: Monday, September 17, 2012 2:35 PM
To: Reen, Sandra (DHP)
Subject: Permit for Sedation in Dental Offices

Ms. Reen,

My name is Mark Armanious and I am a new Oral & Maxillofacial Surgeon practicing in Falls Church, VA. I completed my residency training June 30, 2012 and have since applied for membership with AAOMS. I am also in the board certification process and scheduled to take my qualifying written examination in January of 2013. I just need some clarification regarding the need to attain a permit for sedation. Your letter states that a current AAOMS Board Certification must be posted in plain view of patients but I am not sure where this puts me since I am in the process of attaining board certification. Any feedback would be greatly appreciated!

Sincerely,

Mark M. Armanious, DMD

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 12:57 PM
To: William Griffin
Subject: RE: Sedation Regulations
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Griffin:

The new provisions are underlined and the language being deleted is marked through. Unfortunately, I don't think we have the resources to create a forum.

Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: William Griffin [<mailto:williamgriffindds@gmail.com>]
Sent: Monday, September 24, 2012 5:15 PM
To: Reen, Sandra (DHP)
Subject: Re: Sedation Regulations

Sandra, thank you for getting back to me. I am not exactly sure where to start, but how about this: What has changed from the previous regulations?

Also, might it be possible for there to be some type of online forum for questions?

Thank You,
Bill Griffin

On Mon, Sep 24, 2012 at 4:17 PM, Reen, Sandra (DHP) <Sandra.Reen@dhp.virginia.gov> wrote:

Hi Dr. Griffin:

Currently, there is no summary or overview document available. I would be happy to respond to any questions you have about the requirements. I am currently addressing such questions as they arrive and will plan to post some of those questions and answers on our web page in the near future.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: William Griffin [mailto:williamgriffindds@gmail.com]
Sent: Monday, September 17, 2012 3:47 PM
To: Reen, Sandra (DHP)
Subject: Sedation Regulations

Dear Ms. Reen,

I have been offering sedation dentistry to my patients for about 8 years now, and everything has gone well. However, I am unable to sort through the regulations you recently mailed to me. Is there a source of information that could summarize these issues for simplicity's sake? I will be recertifying in ACLS at the VAGD meeting in Richmond in November, might an explanation of these regulations be expected as part of the course?

Thank You,
Bill Griffin, DDS
Yorktown, VA

--
William T. Griffin, DDS, P.C.
City Center Dental Care
709 Mobjack Place
Newport News, VA 23606
[\(757\)873-3001](tel:(757)873-3001)

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William T. Griffin, DDS, P.C.
City Center Dental Care
709 Mobjack Place
Newport News, VA 23606
[\(757\)873-3001](tel:(757)873-3001)

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William T. Griffin, DDS, P.C.
City Center Dental Care
709 Mobjack Place
Newport News, VA 23606
[\(757\)873-3001](tel:(757)873-3001)

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 5:35 PM
To: Hazem Seirawan
Subject: RE: Conscious moderate sedation permit
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Seirawan:

Since the residency program you completed was accredited by the ADA Commission on Dental Accreditation, the only information you need to send is your certificate of completion. Applicants that have not completed an accredited residency program need to provide information about the number of hours and subject matter of the coursework they completed.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

-----Original Message-----

From: Hazem Seirawan [<mailto:mhseirawan@gmail.com>]
Sent: Wednesday, September 19, 2012 1:11 PM
To: Reen, Sandra (DHP)
Subject: Conscious moderate sedation permit

Dear Sandra Dean:

I am a licensed dentist in the state of Virginia, and a pediatric dentist graduated from accredited ADA program: NOVA Southeastern University in Ft. Lauderdale, FL. I am applying for a conscious moderate sedation permit in VA and I am not sure whether you want a copy of my certificate in pediatric dentistry training, or you want the curriculum of that training. The application states: "A transcript, certification and/or documentation of training content for a permit for administration by any method", what exactly meant by training content?

Thank you!

Mouhammad Hazem Seirawan
259 Hydraulic Ridge Rd. Suite #101
Charlottesville, VA 22901

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 2:47 PM
To: Tricia Tran
Subject: RE: Sedation requirements
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Tran:

I've added my response under each of your questions below.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Tricia Tran [<mailto:tdnth@hotmail.com>]
Sent: Tuesday, September 18, 2012 2:24 PM
To: Reen, Sandra (DHP)
Subject: Sedation requirements

Good afternoon:

I have received the new guidelines in the mail yesterday and I am considering using anesthesia services from an independent anesthesiologist (who would bring in his own emergency equipments) to sedate a few pediatric cases per month and a bit confused about the new regulations. If it's okay, I'd like to ask a few questions to clarify some concerns I have regarding March 31, 2012 deadline.

1. I just want to make sure I understand correctly that as long as I am not providing deep sedation but I do have an anesthesiologist that does it, my practice does not have to get a permit.

RESPONSE: Permits will only be issued to dentists and not dental practices. If you never administer conscious/moderate sedation, deep sedation or general anesthesia, you are not required to obtain a permit. The Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. These sections permit dentists who are not qualified or who do not hold a permit to use the services of a qualified dentist who holds a permit, an anesthesiologist or in certain circumstances the services of a certified registered nurse anesthetist.

2. Does this anesthesiologist need to have his license/or certificate display?

RESPONSE: If the anesthesiologist is a licensed dentist, he is required to comply with the regulations of the Board of Dentistry, including the posting of his license. If the anesthesiologist is a licensed physician, he is required to comply with the regulations for Office-Based Anesthesia of the Board of Medicine.

3. Should he also supply own his sedatives and emergency medicines and should they be located at our practice? In other words, can we order anesthetic medications and antagonists, etc. and have them stored here for him to dispense the medications as long as we keep our log properly?

RESPONSE: I am not aware of a state law or regulation that responds to you question about who should purchase and maintain drugs when a dentist is delegating administration of sedation or general anesthesia to an anesthesiologist.

4. What is the proper storage solution for controlled substances, I know it needs to be locked up and in a limited access but does it need to be bolted to the wall or ground?

RESPONSE: You should review the Code of Federal Regulations, CFR 1301.75, regarding the storage of Schedule II through V controlled substances. If the drugs you want to maintain are Schedule VI drugs, you might contact the Virginia Board of Pharmacy, pharmbd@dhp.virginia.gov, about requirements for maintaining these state controlled drugs.

Thank you for your time and thank you for taking the time to explain my questions very much.

Tricia Tran, DDS

Diplomate, American Board of Pediatric Dentistry

Kidz Dentistry

Providing Advanced Pediatric Dentistry & Orthodontics

6101 Redwood Square Center, Ste. 300

Centreville, VA 20121

(O) 703-222-0111

(F) 703-222-0888

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 5:51 PM
To: Louise Scates
Subject: RE: sedation questions
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Ms. Scates:

If a dentist never administers conscious/moderate sedation or deep sedation/general anesthesia, he is not required to hold a permit. I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered since you report using nitrous.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Louise Scates [<mailto:lwscates@gmail.com>]
Sent: Wednesday, September 19, 2012 1:32 PM
To: Reen, Sandra (DHP)
Subject: sedation questions

To whom it may concern

Could you please tell me what license, if any that i need for my office.

we administer nitrous for anxiety and pain management.
hyg use infrequently, under supervision..

No i.v.
no deep sedation

thank you for your time

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 5:56 PM
To: drmonsalve@verizon.net
Subject: RE: Anesthesia Permit
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Monsalve:

If you never administer conscious/moderate sedation, deep sedation or general anesthesia, you are not required to obtain a permit. The Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. These sections permit dentists who are not qualified or who do not hold a permit to use the services of a qualified dentist who holds a permit, an anesthesiologist or in certain circumstances the services of a certified registered nurse anesthetist.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: drmonsalve@verizon.net [<mailto:drmonsalve@verizon.net>]
Sent: Wednesday, September 19, 2012 4:26 PM
To: Reen, Sandra (DHP)
Subject: Anesthesia Permit

Dear Mrs. Reen,

I am a pediatric dentist practicing in the Northern Virginia area. I have been providing dental treatment to children in my office for the last 5 years with the services of an anesthesia group that provides an anesthesiologist, a nurse, all the monitoring, emergency equipment and medications needed for general anesthesia treatment on healthy patients. Do I need to have a permit to provide general anesthesia in my office and if I do need a permit, what am I required to do to obtain the permit?
Thank you.

Carlos Monsalve DDS
Diplomate, American Board of Pediatric Dentistry.

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, September 25, 2012 5:54 PM
To: jennifer woodside
Subject: RE: permits
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Woodside:

If you never administer conscious/moderate sedation, deep sedation or general anesthesia, you are not required to obtain a permit. The Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. These sections permit dentists who are not qualified or who do not hold a permit to use the services of a qualified dentist who holds a permit, an anesthesiologist or in certain circumstances the services of a certified registered nurse anesthetist.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: jennifer woodside [<mailto:lienwoodside@yahoo.com>]
Sent: Wednesday, September 19, 2012 3:05 PM
To: Reen, Sandra (DHP)
Subject: permits

Good afternoon.

I am a Pediatric Dentist that has an anesthesiologist come into the office to administer IV Sedation. Do I need a permit, despite not administering the drugs?

Thank you for your time.

Jennifer Woodside

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 11:46 AM
To: John T. Will, DDS
Subject: RE: Anesthesia Permit Questions
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Will:

I've added my response after each question below.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: johnwill22@gmail.com [<mailto:johnwill22@gmail.com>] **On Behalf Of** John T. Will, DDS
Sent: Thursday, September 20, 2012 12:51 PM
To: Reen, Sandra (DHP)
Subject: Anesthesia Permit Questions

Hi Sandra,

My name is John Will. I am a dental anesthesiologist working at Children's Dentistry of Charlottesville. We are a large pediatric office employing multiple providers who are qualified to administer conscious/moderate sedation as well as deep sedation/general anesthesia. I have several questions regarding the permit application process to ascertain that we are in compliance with the board's new requirements.

1. I assume that we will need to do a separate application for each dentist to hold a permit to administer sedation/anesthesia. Is this correct? **RESPONSE:** Yes, permits are issued to dentists rather than a practice.
2. Do we need multiple inspections for each dentist that is qualified to administer the sedation, or will we be able to do one inspection that certifies that we have the necessary emergency equipment and documentation required to administer sedation? **RESPONSE:** The policies and procedures for conducting inspections have yet to be developed but will address the management of inspections in practices with multiple permit holders.
3. With regards to ancillary assistants, we have several assistants that will assist in monitoring patients during recovery only, while under the indirect supervision of the dentist administering sedation/anesthesia. Am I correct in interpreting the new guidelines that these assistants will now be required to hold a CAA certification from AAOMS or ADSA? Of course, the dentist administering the sedation/anesthesia is on the premises and immediately available during the recovery period, and evaluates the patient prior to discharge, but I'm just asking for further clarification to make sure that we will be in compliance with the regulations. **RESPONSE:** There are 2 options for meeting the training

requirement for ancillary personnel in 18VAC60-20-135 which I have provided below with the "or" highlighted:

~~After June 29, 2006, dentists~~ Dentists who employ ancillary personnel to assist in the administration and monitoring of any form of conscious/moderate sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have:

1. Minimal training resulting in current certification in basic resuscitation techniques, with hands-on airway training for healthcare providers, such as Basic Cardiac Life Support for Health Professionals or ~~an approved~~, a clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18 VAC 60-20-50 C; **or**
2. Current certification as a certified anesthesia assistant (CAA) by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology (ADSA).

I believe that these are all the questions I have regarding the application process for the sedation and anesthesia permits at this time. If I think of others I will contact you again. Thank you, in advance, for any information you can provide to further clarify the above issues.

**John Will, DDS
434-817-1817**

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 12:43 PM
To: Dr. Michele Mills
Subject: RE: emergency regulations
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Mills:

The section you are asking about, 18VAC60-20-120.H.3, applies only when a patient has self-administered minimal sedation prior to arrival at the dental office. It restricts the personnel who might administer local anesthesia to numb an injection or treatment site for these patients to the licensed professionals listed in 18VAC60-20-120.H.2 who are qualified to administer conscious/moderate sedation.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4438

From: Dr. Michele Mills [mailto:dr_mills@verizon.net]
Sent: Wednesday, September 19, 2012 10:18 AM
To: Reen, Sandra (DHP)
Subject: emergency regulations

Hi Sandra,

Thank you for the copy of the updated regulations. They provided much needed clarity on the anxiolysis and minimal sedation. We stopped using nitrous and meds for anxiolysis a few years back when the regulations changed because they were so unclear. I understand now that we can provide anxiolysis with meds without a permit.

I have one question that from section H3 on page 12. It says "if minimal sedation is self-administered by or to a patient before arrival at the dental office, the dentist may only use the personnel listed in subdivision 2...to administer local anesthesia". That subsection lists dentists with conscious sedation permits, anesthesiologists, etc. Does this **ONLY** apply to patients that self-administer before receiving moderate conscious sedation? We have a few patients that self administer Valium, Xanax prior to routine dental care. Is that acceptable under this part of the regulation?

I understand the board has no authority to "assist in decision making". Can you provide clarification on that one section?

Thank you again. I feel this was a much needed update to the regulation and we appreciate it.

Michele M. Mills, DMD, PC

Mills & Shannon Dentistry
www.millsandshannon.com

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 1:13 PM
To: Chris Houser
Subject: RE: Question
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Houser:

The Emergency Regulations for Sedation/Anesthesia Permits do not address particular drugs and do not permit making an assumption that a particular drug will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

As a licensee, you are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then you are responsible for applying these terms and the associated regulations to your practice. I hope the following regulation (18VAC60-20-107.D.) will assist you in understanding the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide whether or not you are required to hold a permit.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

- A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:
1. Medications used, the appropriate dosages and the potential complications of administration.
 2. Physiological effects of nitrous oxide and potential complications of administration.
- B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:
1. Blood pressure monitoring equipment.
 2. Positive pressure oxygen.
 3. Mechanical (hand) respiratory bag.
- C. Monitoring requirements.
1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
 2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
 3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.
- D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Chris Houser [<mailto:drhouser@hotmail.com>]
Sent: Thursday, September 20, 2012 2:39 PM
To: Reen, Sandra (DHP)
Subject: Question

Sandra,

I'm having a hard time figuring out the difference in the board's definitions of "conscious/moderate sedation" and "minimal sedation".

I use enteral Halcion (Triazolam) for dental phobic patients on a few occasions per year. The dosage I prescribe normally produces what I would characterize as a minimal sedation.

Please advise.

Dr. Chris Houser

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 9:33 AM
To: Alan Mahanes
Subject: Administering Sedation and Anesthesia
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Ms. Gooden:

The Emergency Regulations for Sedation/Anesthesia Permits do not address particular drugs and do not permit making an assumption that a particular drug or a combination of drugs at a particular dose will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

Licenses are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then are responsible for applying these terms and the associated regulations to their practices. I hope the following regulation (18VAC60-20-107.D.) will assist Dr. Mahanes in understanding the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as Dr. Mahanes decides whether or not he is required to hold a permit and to understand the education and equipment requirements associated with minimal sedation.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Alan Mahanes [<mailto:dental@mahanes.hrcoxmail.com>]

Sent: Thursday, September 20, 2012 10:35 AM

To: Reen, Sandra (DHP)

Subject:

Good Morning Sandra,

Dr Mahanes has a question regarding the certification requirements.

"At what point does anxiolysis turn into depression of consciousness. For example, if I prescribe 10mg of Valium and 50mg of Vistaril to reduce or eliminate patient anxiety, what are the clinical parameters that I have/have not depressed their consciousness? "

I appreciate your time regarding this matter and look forward to hearing from you soon.

Thank You,

Mary Gooden

Office Manager

Mahanes Dentistry

(757)430-9448

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 9:43 AM
To: smitasabharwal.dds@gmail.com
Subject: FW: Sedation Permit Requirements
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Dr. Sabharwal:

No, there is no time frame for when training had to be completed. If your training was not obtained through an accredited dental program, you will need to submit enough information about your training so that it is evident that your program was based on the ADA Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry and that it included the required hours of instruction and patient experiences.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Smita Sabharwal [<mailto:smitasabharwal.dds@gmail.com>]
Sent: Thursday, September 20, 2012 10:06 AM
To: Board of Dentistry
Subject: Sedation Permit Requirements

To Whom It May Concern,

Is there a time frame in which the required training for the Conscious/Moderate Sedation permit is valid? (For example, is a course taken 2 and 1/2 years ago still applicable to applying for a permit?) Will a recertification be required, and if so, how often?

Thank you,
Smita Sabharwal DDS

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 9:51 AM
To: dkallas@drkallas.com
Subject: RE: Permit
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Francesca:

The application and instructions for obtaining a permit are available in the "Forms and Applications" tab at www.dhp.virginia.gov/dentistry. Only the dentist who administers the sedation or anesthesia is required to hold a permit.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

-----Original Message-----

From: dkallas@drkallas.com [<mailto:dkallas@drkallas.com>]
Sent: Thursday, September 20, 2012 12:00 PM
To: Reen, Sandra (DHP)
Subject: Permit

Good Morning Director Reen,
My name is Francesca Pregano, I am the office manager of a dental office in Vienna, VA. I would like to know how we can obtain the permit required for conscious/moderate sedation. Our periodontist prescribes a medication (Halcion) for conscious sedation. My second question is, will he need the permit only? or will the owner need the permit for the drug to be used in the facility?
Please let me know at your earliest convenience.
I appreciate your time.
Thank you,
Francesca

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 12:16 PM
To: Carol Beland
Subject: RE: Certification courses
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Ms. Beland:

There are 2 options for meeting the training requirement for ancillary personnel in 18VAC60-20-135 which I have provided below with the "or" highlighted:

~~After June 29, 2006, dentists~~ Dentists who employ ancillary personnel to assist in the administration and monitoring of any form of conscious/moderate sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have:

1. Minimal training resulting in current certification in basic resuscitation techniques, with hands-on airway training for healthcare providers, such as Basic Cardiac Life Support for Health Professionals or an ~~approved~~, a clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18 VAC 60-20-50 C; **or**
2. Current certification as a certified anesthesia assistant (CAA) by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology (ADSA).

The Board does not maintain any listing of courses so you may want to check the offerings of the ADA, AGD, AAMOS and ADSA.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Carol Beland [mailto:CBeland@amdpi.com]
Sent: Thursday, September 20, 2012 1:06 PM
To: Reen, Sandra (DHP)
Cc: drsynnott@verizon.net
Subject: Certification courses

Good afternoon Ms. Reen,

My oral surgeon just brought in a notification of the new requirements to administer Conscious/Moderate sedation effective 03/31/2013. He is fully covered as a diplomate with AAOMS, but I have a concern regarding my two assistants. As you know, Virginia has no dental assisting schools so most of our assistants are not certified. I see in the legislation

that the oral surgeon's assistants but be certified by the AAOMS or ADSA. Would you be able to provide me with locations/contacts of where this course is being held in the state of Virginia? I'll get them registered as soon as I can. Thank you so much for your help!!
Carol

Carol Beland
Practice Manager

Fusion Dental
11503 Sunrise Valley Dr.
Reston, VA 20191-1505
Tel: 703-437-5700 | Fax: 703-391-8828 | Email: CBeland@amdpi.com

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Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 5:12 PM
To: anh tran
Subject: RE: IV sedation certifications for dental offices.
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Tran:

My answers are noted below each of your questions.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: anh tran [<mailto:olympicpc@gmail.com>]
Sent: Sunday, September 23, 2012 1:02 PM
To: Reen, Sandra (DHP)
Subject: IV sedation certifications for dental offices.

Dear Mrs. Reen:

I am an office based anesthesiologist providing IV sedation services to 20 pediatric dentists in Northern Va. Most of the dentist use my services as needed on a regular basis like once a month. And in most offices, oral sedation by the dentist is not even offered to patients. I do like you to clarify the following issues raised by the dentists:

1- Does each of the dental office still need certification/ inspection if I am providing exclusive anesthesia services. The dentist is not directly administering the sedation? Essentially, am I and the dentist excluded from the regulations if this is the case like an oral surgeon? As part of the sedation services, we bring in all the emergency supplies and equipment and monitors for every sedation so the dentist don't have the burden of keeping and monitoring items he or she may not be familiar with.

RESPONSE: If a dentist never administer conscious/moderate sedation, deep sedation or general anesthesia, he is not required to obtain a permit. The Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. These sections permit dentists who are not qualified or who do not hold a permit to use the services of a qualified dentist who holds a permit, an anesthesiologist or in certain circumstances the services of a certified registered nurse anesthetist. The exemption for oral and maxillofacial surgeons only applies to oral and maxillofacial surgeons. Since you are a licensed physician, you are required to comply with the regulations for Office-Based Anesthesia of the Board of Medicine.

2-If the office still need to be certified, then which certification application does the dentist needs to apply for? Permits are only issued to dentists.

3- As you may already be aware, I can not transport controlled drugs from my office to a dental office per DEA DIRECTIVE. Similar to an surgical center or a hospital, or in the event the oral surgeon coming to another dental office for a wisdom teeth extraction under sedation, most drugs are provided by the facility, not purchased by the anesthesiologist, even though we are administering it. Under this case, could the dentist purchase the controlled drugs, even though I would be administering it? Otherwise, I would have to obtain 25

DEA licences- one for each office I go to? At 600.00 dollars per licences for every 3 years or so, that would put a tremendous additional cost to the business and ultimately to patients as well.

RESPONSE: I am not aware of a state law or regulation that responds to your question about who should purchase and maintain drugs when a dentist is delegating administration of sedation or general anesthesia to an anesthesiologist.

You might consider contacting the Drug Enforcement Administration, the Board of Medicine and the Board of Pharmacy regarding your practice.

I appreciate your assisting in this matter. My dentists' client and I are committed in complying with the regulations as soon as possible. Thank you.

--

Anh Tran MD

Phone: 571 234 1964

Cell: 571-243-4451

Fax: 703-991-8761

Email: Olympicpc@gmail.com

12359 Sunrise Valley Dr

Unit 330

Reston Va 20191

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, September 26, 2012 3:45 PM
To: Shenandoah Valley Implant Institute
Subject: RE: Regulations Involving Sedations
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Saunders:

The Board does not use the term light sedation and has no guidance available regarding its meaning and application. Please consider the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" which are defined in 18VAC60-20-10 of the Emergency Regulations.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide where your practices fall within the scope of the regulations.

18 VAC60-10-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
 2. Positive pressure oxygen.
 3. Mechanical (hand) respiratory bag.
- C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Shenandoah Valley Implant Institute [<mailto:sviiimplants@yahoo.com>]
Sent: Thursday, September 20, 2012 4:13 PM
To: Reen, Sandra (DHP)
Subject: Regulations Involving Sedations

Dear Mrs. Reen,

I am writing to you in reference to the regulations involving sedation/anesthesia permits. I have read the regulations on page 13 to include moderate to conscious sedation, however it does not specify whether it applies to light sedation. I contacted the Virginia Board of Dentistry and have been advised to contact you by email. Please clarify as to whether these regulations apply to light sedation. Any additional information you may have would be greatly appreciated.

Sincerely,

Victor G. Saunders, D.D.S.
Shenandoah Vally Implant Institute

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Thursday, September 27, 2012 3:08 PM
To: Givens@vadental.org
Subject: FW: Please review
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Laura:
I've noted my responses following your questions below.
Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Laura Givens [<mailto:Givens@vadental.org>]
Sent: Monday, September 24, 2012 1:01 PM
To: Reen, Sandra (DHP)
Subject: OMS Questions Re: New Emergency Regulations

Good afternoon Sandy,

I had emailed you last week regarding the letter that was sent to all dentists about the Emergency regulations on permits for administering anesthesia. I have several questions regarding the requirements for AAOMS members. I know you have been out of the office so I thought maybe an email would be better than bothering you with a phone call. Please see my questions below.

1. Some of the OMSs of course have more than one office location. Can they make photo copies of their AAOMS certificates to post in the additional offices or do they need an original copy for each?

RESPONSE: Yes, photocopies are permissible.

2. Do the OMSs need any other documentation to provide the Board with other than this certificate? (i.e. copy of evaluation form). This is important to know as I will need to provide each doctor with a copy of this form since I keep them on file.

RESPONSE: Sometime after March 31, 2013, the list of registered oral and maxillofacial surgeons will be reviewed to determine who did not obtain a permit. Those licensees will be asked to send in the results of their most recent AAOMS office examination results.

3. AAOMS gives VSOMS the authority to waive exams for members who are full-time faculty members in a teaching institution (those who are on faculty at VCU) and those members who are full-time in a federal service facility. I've attached that form. Will these members now need to complete the exam through us to be exempted from the permit regulations?

RESPONSE: In keeping with the exemption in §54.1-2701 of the Code of Virginia, the Dentistry Chapter and therefore the requirement to hold a sedation or general anesthesia permit does not apply to any dentist of the United States Army, Navy, Coast Guard, Air Force, Public Health Service or Veterans Administration. There is no exemption for faculty members at teaching institutions so they will either need to qualify for the AAMOS exemption or obtain a permit.

4. We (VSOMS) give new members 2 years from the date they join to complete and pass the anesthesia exam. Will we need to change this deadline to abide by these requirements?

RESPONSE: Until such time as an OMS meets both requirements for the exemption – membership in AAOMS and is able to provide the Board with the results of an AAOMS periodic office examination – an OMS is required to obtain a permit from the Board by March 31, 2013 in order to continue administering conscious sedation, deep sedation or general

anesthesia. VSOMS has full discretion in deciding whether to change its policy in this matter. In making a decision, your membership might want to consider that the Emergency Regulations for Sedation/Anesthesia Permits include provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation. These sections permit dentists who are not qualified or who do not hold a permit to use the services of a qualified dentist who holds a permit, an anesthesiologist or in certain circumstances the services of a certified registered nurse anesthetist.

Our exam process is administered through VSOMS (me) so I have received the above questions many times over in the past week from VSOMS members. I have informed them that I will make sure everyone has all of the necessary documentation so they are able to get their ducks in a row well-before the March 31, 2013 deadline. I first need these questions answered so I know how to help them. If there is any additional information that you feel I should share with the VSOMS members to clarify their requirements, please let me know.

Thanks so much for your help in advance.

Best regards,
Laura

Laura Givens
Executive Secretary
Virginia Society of Oral & Maxillofacial Surgeons
3460 Mayland Ct., Ste. 110
Richmond, VA 23233
(P) 804-523-2185
(F) 804-288-1880

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Thursday, September 27, 2012 4:21 PM
To: cribaby@gmail.com
Subject: FW: Please review
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Dr. Morgan:

The Emergency Regulations only set a delayed date for obtaining a permit. All other provisions went into effect on September 14, 2012. Please note that the Board announced that these regulations were pending implementation in the August 2011, January 2012 and August 2012 editions of BRIEFS (the Board's biannual newsletter) which were sent to licensees via e-mail.

You should come into compliance with the regulations applicable to your practices as soon as possible. Should the Board receive a complaint against you in the interim, it will take into consideration whether or not you took reasonable action to be in compliance.

You state that your office does minimal sedation so I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide where your practices fall within the scope of the regulations. Please note that the General Provisions in 18VAC60-20-107 of the Emergency Regulations do apply to all levels of sedation.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

From: Pam Morgan [mailto:cribaby@gmail.com]
Sent: Thursday, September 20, 2012 1:36 PM
To: Reen, Sandra (DHP)
Cc: Tom and Christy Hubbard/Hamlin
Subject: Virginia Board of Dentistry

Ms. Reen,

We received the notification in our office yesterday in regards to the new requirements for sedation in the dental office. Our pediatric dental office does a minimal sedation and will need to make some significant changes to our office policies to become compliant with the prescribing and administration of medications in the office instead of out of the office. Do we have until March 31, 2013 to become fully compliant with the change? The letter states these emergency regulations go into effect on September 14, 2012, yet we received notification just this week.

Thank you in advance for clarification,
Pamela Morgan, DDS

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Thursday, September 27, 2012 9:51 AM
To: Eliot Bird
Subject: RE: emerg regs
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Bird:

Please consider the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 of the Emergency Regulations and apply these terms and the associated regulations to your practice.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide where your practices fall within the scope of the regulations.

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1. Blood pressure monitoring equipment.
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 3. Mechanical (hand) respiratory bag.
- C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
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D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Eliot Bird [mailto:etbird2@msn.com]
Sent: Monday, September 24, 2012 12:24 PM
To: Reen, Sandra (DHP)
Subject: emerg regs

With regard to the recent emergency regulations mailed out by the Board of Dentistry, does this include the use of N2O2 in conjunction with local anesthetic without the use of any additional analgesics?

Thanks

Eliot Bird DDS

Reen, Sandra (DHP)

From: Chris Houser [drhouser@hotmail.com]
Sent: Thursday, September 27, 2012 11:48 AM
To: Reen, Sandra (DHP)
Subject: RE: Question

Importance: Low

Sandra,

Thank you for your response. I would just like to make a recommendation to the board to clarify their definition of minimal and conscious/moderate sedation - I find them to be very ambiguous. The only difference that I could infer was that conscious/moderate sedation **may** (but not necessarily) require tactile stimulation in order to obtain a response to a verbal command.

Sincerely,
Dr. Houser

From: Sandra.Reen@DHP.VIRGINIA.GOV
To: drhouser@hotmail.com
Subject: RE: Question
Date: Wed, 26 Sep 2012 17:13:03 +0000

Hi Dr. Houser:

The Emergency Regulations for Sedation/Anesthesia Permits do not address particular drugs and do not permit making an assumption that a particular drug will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

As a licensee, you are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then you are responsible for applying these terms and the associated regulations to your practice. I hope the following regulation (18VAC60-20-107.D.) will assist you in understanding the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide whether or not you are required to hold a permit.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

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1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist

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3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Chris Houser [<mailto:drhouser@hotmail.com>]
Sent: Thursday, September 20, 2012 2:39 PM
To: Reen, Sandra (DHP)
Subject: Question

Sandra,

I'm having a hard time figuring out the difference in the board's definitions of "conscious/moderate sedation" and "minimal sedation".

I use enteral Halcion (Triazolam) for dental phobic patients on a few occasions per year. The dosage I prescribe normally produces what I would characterize as a minimal sedation.

Please advise.

Dr. Chris Houser

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, October 01, 2012 10:04 AM
To: 'Dr Sklar Dental Office'
Subject: RE: new conscious/moderate sedation guidelines
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Sklar:

As stated on the first page, the Emergency Regulations are effective from 9/14/12 to 9/13/13. The Administrative Process Act does permit the Board to request a six month extension if we are unable to complete work on the final regulations in the one year time-frame.

The Emergency Regulations only set a delayed date for obtaining a permit. All other provisions went into effect on September 14, 2012. Please note that the Board announced that these regulations were pending implementation in the August 2011, January 2012 and August 2012 editions of BRIEFS (the Board's biannual newsletter) which were sent to licensees via e-mail.

You should come into compliance with the regulations applicable to your practices as soon as possible. Should the Board receive a complaint against you in the interim, it will take into consideration whether or not you took reasonable action to be in compliance.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Dr Sklar Dental Office [<mailto:office@drsklar.com>]
Sent: Friday, September 28, 2012 12:06 PM
To: Reen, Sandra (DHP)
Subject: RE: new conscious/moderate sedation guidelines

Sandra

Thank you for your response and for offering to share our concerns with the Board as it works on final regulations. Does that mean that the regulations outlined in the statute are only temporary? Do the guidelines in the statute go into effect immediately or as of April 2013? While we already implement most of what has been outlined, we want to be sure we comply with the new stipulations that have been added.

Thank you,

Andrew M Sklar, DDS.
703-931-3141

From: Reen, Sandra (DHP) [<mailto:Sandra.Reen@DHP.VIRGINIA.GOV>]
Sent: Wednesday, September 26, 2012 3:33 PM
To: Dr Sklar Dental Office
Subject: RE: new conscious/moderate sedation guidelines
Importance: Low

Hi Dr. Sklar:

Yes, the requirement is that both the dentist and a second person must be with the patient throughout the dental procedure. I appreciate knowing of your concern and will share it with the Board as it works on final regulations.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Dr Sklar Dental Office [mailto:office@drsklar.com]
Sent: Thursday, September 20, 2012 3:38 PM
To: Reen, Sandra (DHP)
Subject: new conscious/moderate sedation guidelines

Dear Sandra-

I have received and read the copy of the statute and believe I understand most of it. I will download the application for a permit and send that in as soon as possible. I assume there will be instructions on the dhp website as to where to send the application.

I do have a question and concern regarding the monitoring requirements. It has always been a requirement that the sedation patient not be left alone at any time. But I see that the monitoring requirements in the new statute specifies that BOTH the doctor and the second person assisting must be in the operatory throughout the dental procedure. Does that really mean the doctor cannot leave the room at any time, even during a long (sometimes several hour) procedure? This seems unreasonable and also potentially more risky for the patient than giving the doctor a needed break while leaving the patient in the care of the assistant.

Thank you for your input and assistance.

Sincerely,

Dr. Andrew M Sklar

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, October 01, 2012 9:43 AM
To: 'mspedo1@gmail.com'
Subject: FW: "emergency regulations" code 54.12709.5
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Dr. Hamlin:

Thank you for reporting your concern about the Emergency Regulations for Sedation/Anesthesia Permits. The Board of Dentistry reviewed multiple national standards in deciding how to update its regulations in the areas of sedation and anesthesia. One of the documents considered was the 2006 – 2007 Reference Manual, Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures, which was developed and endorsed by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry. These guidelines begin with the following statement which is repeated in the text of the guidelines: "The safe sedation of children for procedures requires a systematic approach that includes the following: no administration of sedating medication without the safety net of medical supervision, careful pre-sedation evaluation for underlying medical or surgical conditions"

In the coming months, the Board will announce a public comment period before final promulgation of these emergency regulations. I am having you added to our public participation list so you might receive notice of the opportunity to submit your comments at that time.

The Emergency Regulations do not address particular drugs and do not permit making an assumption that a particular drug at a particular dose will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

As a licensee, you are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 of the emergency regulations and then you are responsible for applying these terms and the associated regulations to your practice. I hope the following regulation (18VAC60-20-107.D.) will assist you in understanding the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

Please note that the general provisions in 18VAC60-70-107 of the emergency regulations apply to all levels of sedations. I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia (minimal sedation) which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide where your practices fit in the scope of the regulations.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.

3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.

2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.

3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: chris hamlin [mailto:mspedo1@gmail.com]
Sent: Wednesday, September 26, 2012 5:11 PM
To: Board of Dentistry
Subject: "emergency regulations" code 54.12709.5

Dear Dr. Reynolds-Cane and Ms. Reen,

While I applaud your efforts to stem potential dental disasters in pediatric dental offices by limiting the prescribing of medications for sedation for children under the age of 12, some clarifications are in order. Our office only prescribes Hydroxyzine or Diazepam, and never together. It is important that we be able to prescribe these medications, to give to the child in the comfort of the child's home an hour before the appointment. Hydroxyzine and Diazepam have a wide margin of safety, as any PDR, or Handbook of Pediatric Drug Therapy will attest. We do not administer any other medications in our office, but do administer Nitrous Oxide.

The children that have experienced morbidity in the dental office, have been administered Chloral Hydrate in conjunction with other medications, delivered IN the dental office. So an attempt to limit the prescribing of drugs for sedation to be taken prior to child's arrival in the office will do nothing to prevent these problems from occurring. It will only add another layer of expense for the patient, more time for the child and parent to remain in the dental office and another layer of complications related to patient flow in the office.

I ask that the effectiveness and safety of Hydroxyzine and Diazepam, as prescribed as antianxiety agents for children under the age of 12, to be taken prior to the arrival in the dental office, be reviewed. Please advise if these two agents fall outside of the regulations.

Thank you.

Sincerely,

Christopher Hamlin, DDS
Board Certified by the American Board of Pediatric Dentistry
Adjunct Faculty in the Dept of Pediatric Dentistry, MCV-VCU
Active Staff of Children's Hospital of the King's Daughters, Norfolk, VA

Yeatts, Elaine J. (DHP)

From: Michele Satterlund [MSatterlund@macbur.com]
Sent: Monday, October 01, 2012 4:09 PM
To: Douglas, Jay P. (DHP); Yeatts, Elaine J. (DHP)
Subject: BOD Draft Regs

Jay & Elaine,

I am reviewing the proposed draft anesthesia permitting regs for dentists. See Town Hall notice below.

If I read the draft language correctly, it appears that a dentist may delegate the administration of conscious/moderate sedation to the following personnel (see draft language under 18VAC60-20-120 (H) 2):

- Dentist with specific training
- Anesthesiologist
- CRNA
- Registered Nurse

The BOD Guidance Document 60-13 does not include RNs as a qualified provider of conscious sedation, so the draft regulatory language is a change that VANA does not believe falls within an RN's scope of practice.

While VANA plans to comment on this, I also wanted to apprise the BON of this draft regulatory change.

The following regulatory stages have been submitted for publication in the Virginia Register

Board of Dentistry	
Agency	Department of Health Professions
Chapter	Regulations Governing Dental Practice (18 VAC 60-20)
Action	Sedation and anesthesia permits for dentists
Stage	Emergency/NOIRA
Comment Period	10/08/2012 - 11/07/2012
Effective Date	9/14/2012
More details on this stage	

You are signed up for the automatic e-mail notification service provided by the Virginia Regulatory Town Hall. If you no longer wish to receive these messages, visit the Town Hall to modify your preferences or remove your account.
<http://TownHall.virginia.gov/L/PublicLogin.cfm>

Please address any questions or comments to Rachael.Harrell@dpb.virginia.gov.

Michele L. Satterlund
Macaulay & Burtch, P.C.
1015 East Main Street
Richmond, VA 23219

Mailing Address:
P.O. Box 8088
Richmond, VA 23223

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, October 01, 2012 12:21 PM
To: 'Hazem Seirawan'
Subject: Conscious moderate sedation permit
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Seirawan:

For the administration of conscious/moderate sedation, the suction apparatus is the standard suctioning equipment a dentist uses in an operatory during dental procedures. The point in listing it in 18VAC60-20-120.I of the regulations, as required emergency equipment, is to be clear that a suction apparatus, whether it is stationary or portable, must be immediately available to the areas where patients will be sedated and will recover as well as during treatment.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

-----Original Message-----

From: Hazem Seirawan [<mailto:mhseirawan@gmail.com>]
Sent: Friday, September 21, 2012 3:54 PM
To: Reen, Sandra (DHP)
Subject: Re: Automatic reply: Conscious moderate sedation permit

Dear Sandra:

With regard to the new emergency requirements for moderate conscious sedation: What exactly meant by suction apparatus? Thank you very much!

Mouhammad Hazem Seirawan, DDS, MPH, MS

On Wed, Sep 19, 2012 at 1:11 PM, Reen, Sandra (DHP)
<Sandra.Reen@dhp.virginia.gov> wrote:

> I am not in to respond to your message personally. I will return to my
> office on Monday, September 24, 2012 and will respond shortly thereafter.
> You might forward your message to denbd@dhp.virginia.gov or call
> 804-367-4538 for assistance in my absence. Sandra K. Reen Executive
Director
> Virginia Board of Dentistry

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Monday, October 01, 2012 10:16 AM
To: Karen Wallace
Subject: RE: Sedation question
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Ms. Wallace:

The Emergency Regulations for Sedation/Anesthesia Permits do not address particular drugs and do not permit making an assumption that a particular drug will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

Licensees are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then are responsible for applying these terms and the associated regulations to their practice. I hope the following regulation (18VAC60-20-107.D.) will underscore the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as licensees decide where their practices fall within the scope of the regulations and whether or not they are required to hold a permit.

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1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Karen Wallace [mailto:kwallace@herbertdentalgroup.com]
Sent: Friday, September 28, 2012 12:33 PM
To: Reen, Sandra (DHP)
Subject: Sedation question

Dear Ms. Reen,

Good afternoon. We have received the Board's Emergency Regulation document regarding dental sedation and need to confirm that the use of Halcion falls within the Minimal sedation distinction according to the Board's definitions, reiterated below.

"Minimal sedations means a minimally depressed level of consciousness, produced by a pharmacological method, which 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, ventilator and cardiovascular functions are unaffected."

"Conscious/moderate sedation means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained."

Thank you for your time.

Best regards,
Karen Wallace

Karen L. Wallace



DRS. JAMES D. BROWN & WALTER C. LINDLEY
2 Cardinal Park Drive SE
Suite 201A
Leesburg, VA 20175
703-777-8777 phone
703-777-6901 fax

www.herbertdentalgroup.com

Please consider the environment before printing this e-mail.

Reen, Sandra (DHP)

To: Shepherd Sittason, D.D.S.
Subject: RE: Sedation Permits
Importance: Low

Hi Dr. Sittason:

Yes, an electrocardiographic monitor (often abbreviated as an EKG) is required for the administration of conscious/moderate sedation.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

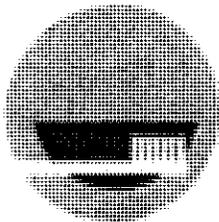
From: Shepherd Sittason, D.D.S. [<mailto:ssittason@smilelynchburg.com>]
Sent: Wednesday, October 03, 2012 4:53 PM
To: Reen, Sandra (DHP)
Subject: Sedation Permits

Sandra Reen,

Confirming that an EKG monitor is required for Moderate Conscious Sedation ?

Thanks,
Shep

Shepherd Sittason, D.D.S.



**Children's
Dentistry &
Orthodontics
of Lynchburg**

105 Paulette Circle
Lynchburg, VA 24502
Phone (434) 237-0125
www.smilelynchburg.com
Fax (434) 237-0498

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Friday, October 05, 2012 5:37 PM
To: 'Jerry Canaan'
Subject: Emergency Regulations
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: High

Hi Jerry:
Please see my responses following the comments/questions below.
Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

From: Jerry Canaan [<mailto:jcanaan@hdjn.com>]
Sent: Thursday, October 04, 2012 9:30 AM
To: Reen, Sandra (DHP)
Subject: question about emergency sedation regs

Sandy,

Below is an email from a client with a question about the regs. I told the client to email you directly, that you don't bite, and you would answer the question. But the client is afraid to do so....alas, I send the questions to you for comment and I will then forward to my client. Thanks.

Jerry

" I have been reading the new emergency regulations by the Board and there are a few confusing aspects. My confusion centers around delegation of administration of conscious sedation.

18VAC60-20-120

H.

2.

a. A dentist with the training required by subsection D (should this be E) to administer by an enteral method
RESPONSE: Yes. The document on the Board's web site, www.dhp.virginia.gov/dentistry, has been corrected.

b. A dentist with the training required by subsection C (should this be D) to administer by any method **RESPONSE:** Yes, see response above.

Is the essence I can delegate to another DDS only up to the level of his training. **RESPONSE:** So long as both dentists hold a permit which authorizes him to administer, the answer is yes. Please note that dentists who hold a permit for deep sedation/general anesthesia automatically qualify to administer conscious/moderate sedation, see 18VAC60-20-120.B. If another DDS is trained to my level or above he can practice to the level of his training. **RESPONSE:** Subsection 2 of 18VAC60-20-120.H requires the delegating dentist to be qualified to administer moderate/conscious sedation so it should be noted that for the purposes of this section "qualified" includes holding a permit. With that understood and factored in this statement would be correct if you added in keeping with the permit held.

d. CRNAs Does this sentence mean that a CRNA can only administer to the trained level of the DDS?

RESPONSE: Yes

If I have an associate or partner DDS and they are not qualified for any level of sedation can I have a CRNA administer for a patient they are working on if it is done under my medical direction and indirect supervision. Indirect supervision

meaning that I have to be in the office or on the premises for direction or assistance if needed. I do not have to be the treating clinical DDS. In other words the treatment team would consist of the other DDS and CRNA. I would just need to be there for medical direction and on the premises? **RESPONSE: No, The Emergency Regulations at 18VAC60-20-120.H subsection 1 clearly states that a dentist not qualified to administer shall only use the services of a permitted dentist or an anesthesiologist to administer conscious/moderate sedation in a dental office.**

This section is a little confusing the way it is worded. I am asking because I have considered a possible merger with a neighboring DDS. If done under my direction we could have a CRNA sedate her patient at the same time I have a patient, but I would be accessible at any given time."

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Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Friday, October 05, 2012 10:25 AM
To: 'Dr Sklar Dental Office'
Subject: RE: new conscious/moderate sedation guidelines
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Sklar:

Unfortunately, I am unable to expand upon the regulation so you will need to rely on the requirement as stated and your own judgment. As indicated previously, I will share your concern with the Board as it works on final regulations.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Dr Sklar Dental Office [<mailto:office@drsklar.com>]
Sent: Friday, September 28, 2012 4:20 PM
To: Reen, Sandra (DHP)
Subject: RE: new conscious/moderate sedation guidelines

Sandra,

Another question occurred to me. How is the statute defining "dental procedure"? If the treatment consists of several "procedures" (e.g. several crowns, an extraction, etc.), can the Dr. leave the operatory, if necessary, between "procedures" leaving the sedated patient in the care of the assistant? Or is "the dental procedure" considered the entire time the patient is sedated?

Thanks again,
Dr. Sklar

From: Reen, Sandra (DHP) [<mailto:Sandra.Reen@DHP.VIRGINIA.GOV>]
Sent: Wednesday, September 26, 2012 3:33 PM
To: Dr Sklar Dental Office
Subject: RE: new conscious/moderate sedation guidelines
Importance: Low

Hi Dr. Sklar:

Yes, the requirement is that both the dentist and a second person must be with the patient throughout the dental procedure. I appreciate knowing of your concern and will share it with the Board as it works on final regulations.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Dr Sklar Dental Office [<mailto:office@drsklar.com>]
Sent: Thursday, September 20, 2012 3:38 PM

Reen, Sandra (DHP)

To: amiv
Subject: RE: Notice of Requirements to Admin Conscious/Moderate Sedation/Deep Sedation/GA in a Dental Office

Importance: Low

Hi Dr. McMillan:

Since the Virginia Board of Dentistry does not review and approve courses, I am unable to give you a definitive answer. Please review the course content being offered to determine that it is a clinically oriented course devoted primarily to responding to clinical emergencies. It might be helpful to compare the course content being offered to the content typically included in hands-on basic resuscitation training to assist you in making a decision.

You should also verify that DOCS is an approved sponsor as addressed in 18VAC60-20-50.C of the **Regulations Governing Dental Practice** which I have provided below. This section of the regulations was not changed so it is not included in the **Emergency Regulations**. Please note that providers who are recognized by the American Dental Association as being a CERP approved provider or by the Academy of General Dentistry as a PACE approved provider are accepted by the Board.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

18VAC60-20-50. Requirements for continuing education.

C. Continuing education credit may be earned for verifiable attendance at or participation in any courses, to include audio and video presentations, which meet the requirements in subsection B of this section and which are given by one of the following sponsors:

1. American Dental Association and National Dental Association, their constituent and component/branch associations;
2. American Dental Hygienists' Association and National Dental Hygienists Association, their constituent and component/branch associations;
3. American Dental Assisting Association, its constituent and component/branch associations;
4. American Dental Association specialty organizations, their constituent and component/branch associations;
5. American Medical Association and National Medical Association, their specialty organizations, constituent, and component/branch associations;
6. Academy of General Dentistry, its constituent and component/branch associations;
7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;
8. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Health Care Organizations;
9. The American Heart Association, the American Red Cross, the American Safety and Health Institute and the American Cancer Society;
10. A medical school which is accredited by the American Medical Association's Liaison Committee for Medical Education or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association;
11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);
12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic and Research Foundation;

14. The Dental Assisting National Board; or

15. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, or Western Regional Examining Board) when serving as an examiner.

From: amiv [mailto:amiv@smileeasy.com]

Sent: Thursday, October 04, 2012 8:02 AM

To: Reen, Sandra (DHP)

Subject: RE: Notice of Requirements to Admin Conscious/Moderate Sedation/Deep Sedation/GA in a Dental Office

Thanks, Sandra,

As a member of the Dental Organization for Conscious Sedation, I have been in discussion with them about getting my assistants properly certified to satisfy the new regulations. They assure me that their three day chairside assistant certification course should meet the guidelines put forth in the new regulations set to take effect next year.

Before I proceed down this pathway, I wanted to find out if the Board indeed recognizes the course that DOCS provides, and if having my assistants take it will satisfy the new regulations.

Thanks,

Alex McMillan IV, DDS

McMillan & Associates

6035 Burke Centre Pkwy Suite 330

Burke, VA 22015

Phone 703-503-9490

Fax 703-503-3083

McMillan & Associates

831 South Washington Street

Alexandria, VA 22314

Phone 703-549-3300

Fax 703-549-0555

amiv@smileeasy.com

Like us on Facebook! <http://facebook.com/McMillanandAssociates>

or

Leave a Google Review! <http://g.co/maps/jz7r8>

From: Reen, Sandra (DHP) [Sandra.Reen@DHP.VIRGINIA.GOV]

Sent: Friday, September 28, 2012 4:46 PM

To: amiv

Subject: RE: Notice of Requirements to Admin Conscious/Moderate Sedation/Deep Sedation/GA in a Dental Office

Hi Dr. McMillan:

Dental assistants are subordinate to a dentist and therefore are ancillary personnel so if they are assisting in the administration and monitoring patients under conscious/moderate sedation 18VAC60-20-135 does apply.

Please note that the administration team for conscious sedation is required by 18VAC60-20-120.J (bottom of page 13 of 15) to consist of the operating dentist and a second person to assist, monitor and observe the patient.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: amiv [mailto:amiv@smileeasy.com]
Sent: Monday, September 24, 2012 5:22 PM
To: Reen, Sandra (DHP)
Subject: RE: Notice of Requirements to Admin Conscious/Moderate Sedation/Deep Sedation/GA in a Dental Office

Thanks for your response.

I would like to bother you with one final question in the general provisions doc that I wasn't certain about, and that dealt with the item on page 14, "Ancillary Personnel". I am interpreting that to refer to someone other than a dental assistant, as I don't involve them with assisting in the administration or monitoring of any of my sedation procedures. They assist with dental procedures only, and either the anesthesiologist, in deep sedation cases, or myself, in conscious/moderate sedation cases are the individuals administering and monitoring. Am I correct in this assumption, and that I won't have to run out and get my assistants additional training beyond BLS so they can work with me in these cases? Thanks again for your time and help with this,

Alex McMillan IV, DDS

McMillan & Associates
6035 Burke Centre Pkwy Suite 330
Burke, VA 22015
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McMillan & Associates
831 South Washington Street
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amiv@smileeasy.com

Like us on Facebook! <http://facebook.com/McMillanandAssociates>

or

Leave a Google Review! <http://g.co/maps/jz7r8>

From: Reen, Sandra (DHP) [Sandra.Reen@DHP.VIRGINIA.GOV]
Sent: Monday, September 24, 2012 4:45 PM
To: amiv
Subject: RE: Notice of Requirements to Admin Conscious/Moderate Sedation/Deep Sedation/GA in a Dental Office

Hi Dr. McMillan:

The only relevant record the Board of Dentistry might have is a supplemental notation that would have been added in 1989 to record that a dentist self-certified that he administers general anesthesia or conscious sedation. Such a self-certification will allow a dentist to apply for a temporary conscious/moderate sedation permit. I have checked your records and there is no record that you self-certified.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: amiv [mailto:amiv@smileeasy.com]
Sent: Monday, September 17, 2012 3:50 PM
To: Reen, Sandra (DHP)
Subject: Notice of Requirements to Admin Conscious/Moderate Sedation/Deep Sedation/GA in a Dental Office

Hi Sandra,

I received the notification for requirements in today's mail.

As I am quite certain you will be inundated with questions with the notification, I wanted to try to get ahead of the curve with some of the requirements and registration circumstances.

In particular, I know that some 6-7 years ago when the state began to be aware of dentists providing oral conscious sedation and beyond in their offices, there was some movement to establish operating parameters. A former colleague of mine even went to Richmond to testify to the Board of Dentistry with some representatives of the Dental Organization for Conscious Sedation (DOCS). As I recall, the outcome was that any dentist in the state practicing with oral conscious sedation, whether in the conscious or moderate form would have to show certification of completion of adequate training, with the DOCS model of training being an informal guideline, along with ACLS certification. That was pretty much it until now.

My question for you, because I don't recall if a registration for those of us practicing oral conscious sedation back then was made or not, is if I have any registration with the Board beyond standard licensure which might pertain to this particular issue. If for nothing else but to save the time of having to send some form of training completion along with the other work these new requirements entail, I would appreciate any additional information you could provide.

Thank you very much,

Alex McMillan IV, DDS

McMillan & Associates
6035 Burke Centre Pkwy Suite 330
Burke, VA 22015
Phone 703-503-9490
Fax 703-503-3083

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Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, October 09, 2012 3:26 PM
To: P Lotfi D.M.D.
Subject: RE: sedation permit
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Lotfi:

The Emergency Regulations for Sedation/Anesthesia Permits do not address particular drugs and do not permit making an assumption that a particular drug will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

As a licensee, you are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then you are responsible for applying these terms and the associated regulations to your practice. I hope the following regulation (18VAC60-20-107.D.) will assist you in understanding the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide whether or not you are required to hold a permit.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

- A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:
1. Medications used, the appropriate dosages and the potential complications of administration.
 2. Physiological effects of nitrous oxide and potential complications of administration.
- B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:
1. Blood pressure monitoring equipment.
 2. Positive pressure oxygen.
 3. Mechanical (hand) respiratory bag.
- C. Monitoring requirements.
1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
 2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
 3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.
- D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: P Lotfi D.M.D. [<mailto:plotfi001@gmail.com>]
Sent: Tuesday, October 09, 2012 12:21 PM
To: Reen, Sandra (DHP)
Subject: sedation permit

Dear Ms. Reen,

I am a general dentist in woodbridge, virginia, I have completed the D.O.C.S. sedation course, and have so far met the virginia requirements to perform oral conscious sedation. My patients are always minimally sedated, and always monitored with pulseox/blood pressure monitor system. I recently received the notice of requirements to administer conscious/moderate sedation. I am confused by the definition and distinction of minimal sedation vs moderate sedation. Im not sure if my protocol requires a permit. I do not perform IV sedation. I do not administer, dispense more than .25mg of halcion prior to the apt.

please advise.

Regards.

Patrick P. Lotfi DMD

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Tuesday, October 09, 2012 2:22 PM
To: 'Daniel Yeager'
Subject: RE: Conscious Sedation Regulations
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Yeager:

Thank you for your recommendations for amending the regulations. I will share them with the Board as adoption of final regulations is considered. I am adding you to the Board's public participation list so we might notify you of the upcoming public comment opportunity.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Daniel Yeager [<mailto:yeagerdj@gmail.com>]
Sent: Monday, October 08, 2012 10:23 AM
To: Reen, Sandra (DHP)
Subject: Re: Conscious Sedation Regulations

Dear Mrs. Reen:

I have several questions concerning the emergency requirements for the administration of conscious/moderate sedation, as provided by the board on 9/12/12. I have been trained for Oral Sedation Dentistry by enteral administration only, and would like some clarification on the regulations.

18VAC60-20-120 governs conscious/moderate sedation as a whole, and standardizes monitoring for the route of administration by intravenous and enteral administration only.

1. Subsection I requires an electrocardiogram monitor.
2. Subsection J requires the operating dentist to remain in the operatory throughout the dental procedure.

I would like to submit to the Board for consideration an amendment to these monitoring requirements:

1. For conscious/moderate sedation by intravenous administration:
 - Patient monitoring must include an electrocardiographic monitor with pulse oximetry and blood pressure.
 - The operating dentist and certified ancillary personnel must remain in the operatory throughout the dental procedure.
2. For conscious/moderate sedation by enteral administration only:
 - Patient monitoring must include pulse oximetry with blood pressure.
 - The operating dentist may leave the operatory during the dental procedure, but not the premises. A certified ancillary personnel must remain with the sedated patient when the operating dentist is not present in the operatory.

Thank you in advance for your consideration.

Sincerely,

Reen, Sandra (DHP)

To: Brian Levitin
Subject: RE: Requirements to administer conscious/moderate sedation
Importance: Low

Hi Dr. Levitin:

Please compare your training to the requirements specific to the three options for qualifying for a conscious/moderate sedation permit. These are the options stated on the application for obtaining a conscious/moderate sedation permit:

- (1) ___ I am applying for a temporary conscious/moderate sedation permit. Prior to January 1989, I certified to the Board that I was qualified to administer anesthesia and conscious sedation and **I am attaching the letter I received from the Board acknowledging my self-certification.** I understand that a temporary permit issued after September 17, 2012 will permanently expire on September 14, 2014. Further, I understand in order to administer conscious/moderate sedation after September 14, 2014, I must qualify for and obtain a permit to administer by any method of administration or by enteral administration only.

or

I qualify and am applying for a permit to administer conscious/moderate sedation by:

- (2) ___ any method of administration and **I am attaching the transcript, certification and/or documentation of training content which confirms that I meet the education requirement checked below:**

_____ Completion of training for administering conscious/moderate sedation according to guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred, while enrolled in a CODA accredited doctoral dental program or a post-doctoral university or teaching hospital program.

_____ Completion of a continuing education course offered by a provider approved in 18VAC60-20-50(C) of the **Regulations Governing Dental Practice** consisting of 60 hours of didactic instruction plus the management of at least 20 patients per participant, demonstrating competency and clinical experience in parenteral conscious sedation and management of a compromised airway. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

or

- (3) ___ an enteral method of administration only and **I am attaching the transcript or the certification and documentation of training content which confirms that I completed** a continuing education course offered by a provider approved in 18VAC60-20-50(C) of the **Regulations Governing Dental Practice** of not less than 18 hours of didactic instruction plus 20 clinically-oriented experiences in enteral and/or combination inhalation-enteral conscious sedation techniques. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

Applications for conscious/moderate sedation permits and deep sedation/general anesthesia permits are available in the Applications & Forms tab on our web page at www.dhp.virginia.gov/dentistry. Please note that an application should include information on the number of hours and content covered and the number of clinically oriented experiences that were included in any continuing education taken to address the requirements in the second option in #2 above or option #3 above.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Brian Levitin [mailto:levitinbri@aol.com]
Sent: Tuesday, October 09, 2012 8:38 PM
To: Reen, Sandra (DHP)
Subject: Re: Requirements to administer conscious/moderate sedation

Mrs. Reen,

Sorry, my fault. Maybe my question didn't come across correctly. I wasn't trying to ask if I should get a permit or not. I know I need to get one. I just wanted to know with the qualifications I gave you in the previous email, where do I stand based off of the new laws for Moderate Sedation requirements. I don't mean the equipment. I understand that part. It's lecture and clinical based requirements I need to know about. I have read over the paper work given to me a couple of times. Does my previous CE and clinical experiences with sedation qualify me? Does that make sense?

Sorry for any confusion. Thanks again for your time.

Dr. Brian Levitin
Levitin Dental Center
3938 Springfield Road
Glen Allen, VA 23059

On Oct 9, 2012, at 3:01 PM, "Reen, Sandra (DHP)" <Sandra.Reen@DHP.VIRGINIA.GOV> wrote:

Hi Dr. Levitin:

Unfortunately, I am unable to assist you in deciding whether or not you should obtain a permit. Licensees are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then are responsible for applying these terms and the associated regulations to their practice. I hope the following regulation (18VAC60-20-107.D.) will underscore the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as licensees decide where their practices fall within the scope of the regulations and whether or not they are required to hold a permit.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.

2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.

3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: levitinbri@aol.com [mailto:levitinbri@aol.com]
Sent: Monday, October 08, 2012 8:27 AM
To: Board of Dentistry
Subject: Requirements to administer conscious/moderate sedation

To Whom it concerns,

I know you are probably being bombarded by emails regarding the changes in requirements for conscious sedation. I myself have a couple too.

I took my initial oral/conscious sedation course about six years ago(it was a 2 day 20 C.E. credit course) and have taken the necessary follow up courses every two years as instructed. All have been done through the VCU school of dentistry. I have maintained and kept up to date ACLS courses along with BLS courses too. I have treated successfully with no problems (so far)140 cases. So based off of that information and the rules in 18VAC60-20-120 section E, where do I stand in terms of compliance? I just want to cover myself should patients go from minimal sedation to moderate sedation.

Thank you in advanced for your time. I know this is a busy transition for our profession but a much needed one!

Dr. Brian Levitin
Levitin Dental Center
3938 Springfield Road
Glen Allen, VA 23059

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Thursday, October 11, 2012 11:57 AM
To: MSatterlund@macbur.com
Cc: Yeatts, Elaine J. (DHP)
Subject: FW: Question
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Hi Ms. Satterlund:

I can confirm that the provisions which address delegation of administration in 18VAC60-20-110(E) for deep sedation and general anesthesia and in 18VAC60-20-120(H) for conscious/moderate sedation of the Emergency Regulations for Sedation/Anesthesia Permits do allow dentists who do not hold a permit to use the services of a dentist who holds a permit, an anesthesiologist or, in a licensed outpatient surgery center, a certified registered nurse anesthetist to administer sedation and general anesthesia.

The Board did not define the terms you are asking about, "qualified dentist" and "not qualified dentist" so I am unable to discuss their meaning or to address your interpretation based on the "no dentist may employ or use" language stated in 18VAC60-20-110(A) and in 18VAC60-20-120(A). I will share your inquiry with the Board so that, as it works on final regulations, it might consider adding clarifying language and possibly moving the provisions addressing dentists who do not hold permits to the General Provisions section, 18VAC60-20-107.

Thank you for bringing this language to my attention.

Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: Michele Satterlund [<mailto:MSatterlund@macbur.com>]
Sent: Wednesday, October 10, 2012 3:53 PM
To: Reen, Sandra (DHP)
Cc: Yeatts, Elaine J. (DHP)
Subject: Question

Dear Ms. Reen,

I am struggling with my understanding of the differences between a "qualified dentist" and a "not qualified dentist" as defined under the proposed dental regulations related to anesthesia permits. I am happy to meet or discuss by phone, which may be easier. Here's my confusion:

Under the proposed regulations, 18VAC60-20-110 Subsection E, it states "A dentist not qualified to administer deep sedation and general anesthesia shall only use the services of a dentist with a current deep sedation/general anesthesia or an anesthesiologist to administer deep sedation or general anesthesia in a dental office."

However, from my reading of Subsection A, it says "...no dentist may employ or use deep sedation /general anesthesia in a dental office unless...issued a permit." (These same requirements are mandated for conscious sedation under 18VAC60-20-120).

A permit requires certain anesthesia related education, which, as I understand it, means all dentists using deep/conscious sedation or general anesthesia will be "qualified."

Under the proposed regulations, I am unclear as to what dentist would be "not qualified," and how would a non-qualified dentist use an anesthesiologist? If the dentist is not qualified, I understand it to mean they could not obtain a permit and hence could not use any practitioner to administer anesthesia.

May I discuss this matter with you? I'm guessing I may be missing a key element.

Thanks so much,

Michele L. Satterlund
Macaulay & Burtch, P.C.
1015 East Main Street
Richmond, VA 23219

Mailing Address:
P.O. Box 8088
Richmond, VA 23223

msatterlund@macbur.com

Direct: 804-649-8847

Mobile: 804-497-9920

Fax: 804-649-3854

www.macbur.com

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Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Friday, October 19, 2012 11:40 AM
To: 'parastu mirmonsef'
Subject: RE: conscious sedation letter
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Hi Dr. Mirmonsef:

The Emergency Regulations for Sedation/Anesthesia Permits do not address particular drugs and do not permit making an assumption that a particular drug will always have the same effect on every patient. The regulations require the treating dentist to determine the level of sedation that should be achieved based on his knowledge of the individual patient and the intended use of a drug.

As a licensee, you are responsible for understanding the meaning of the terms "anxiolysis", "minimal sedation", "conscious/moderate sedation", "deep sedation" and "general anesthesia" as defined in 18VAC60-20-10 and then you are responsible for applying these terms and the associated regulations to your practice. I hope the following regulation (18VAC60-20-107.D.) will assist you in understanding the importance of becoming knowledgeable about the requirements for administration of drugs:

The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

I have provided below the section of the Regulations Governing Dental Practice on anxiolysis and inhalation analgesia which is also currently in effect. This section of regulations was not included in the Emergency Regulations because the section was not changed but it should be considered as you decide whether or not you are required to hold a permit and about the education and equipment requirements you must meet.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.
2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4538

From: parastu mirmonsef [mailto:osha_me@yahoo.com]
Sent: Wednesday, October 17, 2012 12:43 PM
To: Reen, Sandra (DHP)
Subject: conscious sedation letter

Hi Ms. Reen

I received a letter about general dentist administrating Conscious sedation. Would Valium be one drug that would require and fall after the new regulations?

Thank you

Parastu Mirmonsef DDS

Reen, Sandra (DHP)

From: Board of Dentistry
Sent: Monday, November 05, 2012 12:23 PM
To: Reen, Sandra (DHP)
Subject: FW: New Conscious Sedation Requirements Comments for November 7 meeting

From: William W. Martin [<mailto:drmartin@wwmartindds.com>]
Sent: Monday, November 05, 2012 10:58 AM
To: Board of Dentistry
Cc: William W. Martin; Kmelen@aol.com; DrDaveKiger@aol.com
Subject: New Conscious Sedation Requirements Comments for November 7 meeting

Virginia Board of Dentistry,

I am a general dentist in Lynchburg who is concerned about the recent changes implemented by the Board that affect the Oral Conscious Sedation requirements in the Commonwealth of Virginia. I feel these new requirements will adversely affect some of our dental patients and reduce the number of general dentists who offer Oral Conscious Sedation to their patients.

In 2002, I began using Oral Conscious Sedation after being trained through the DOCS organization. I found it beneficial for some patients undergoing longer than usual visits often necessary for extensive cosmetic dental procedures that I incorporated in my practice in 2001. However, I soon became aware of the tremendous need for OCS for dental phobic patients. In fact, I get many referrals from other general dentists who are unable to do routine dental procedures on extremely apprehensive patients.

It is important for non dentists to understand the difficulty and the inconvenience of performing either demanding cosmetic procedures or early intervention dental procedures in hospital-like environments. The requirements for EKG monitoring of mild oral conscious sedation and full time attention of the dentist are both overkill requirements. In ten years of utilizing Oral Conscious Sedation, I have never encountered any life threatening situations.

In my opinion, because a reduction in dental offices offering sedation or because of the costly new regulations, there will be a reduction in people seeking these types of dentistry. This will increase the number of patients that will wait until they have to edentulous. Cosmetic procedure will also decline.

Furthermore, the safety and proper training issues for moderate oral conscious sedation were fully reviewed by the American Dental Association in the last several years. None of the new Virginia requirements were recommended in the ADA studies. Did our Board of Dentistry uncover new information that made it necessary to be the sole state to issue these stringent requirements? Are there many adverse OCS events in other dental practices that made our Commonwealth decide to increase regulations?

I would urge the Board of Dentistry to set aside these new OCS requirements for one year while the ADA mild sedation recommendations were reviewed. I would also like to see a publication of incidents of adverse sedation outcomes in dentistry while using oral conscious sedation.

Sincerely,

William W. Martin, DDS, MAGD
Aesthetic & General Dentistry
115 Wiggington Road

DRAFT Proposed regulations

**BOARD OF DENTISTRY
Sedation/anesthesia permits**

Part I
General Provisions

18VAC60-20-10. Definitions.

A. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, his facility, his partner or associate, or any dentist affiliated with the dentist or his facility by any means or method for the purpose of inducing purchase, sale or use of dental methods, services, treatments, operations, procedures or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures or products.

~~"Analgesia" means the diminution or elimination of pain in the conscious patient.~~

~~"Anxiolysis" means the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness.~~

~~"CODA" means the Commission on Dental Accreditation of American Dental Association.~~

~~"Conscious sedation" means a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal commands, produced by pharmacological or nonpharmacological methods, including inhalation, parenteral, transdermal or enteral, or a combination thereof.~~

~~"Conscious/moderate sedation" means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.~~

~~"Deep sedation/general anesthesia" means an induced state of depressed consciousness or unconsciousness accompanied by a complete or partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or respond purposefully to physical stimulation or verbal command and is produced by a pharmacological or nonpharmacological~~

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

"Dental assistant I " means any unlicensed person under the direction of a dentist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely a secretarial or clerical capacity.

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered to perform reversible, intraoral procedures as specified in this chapter.

"Mobile dental facility" means a self-contained unit in which dentistry is practiced that is not confined to a single building and can be transported from one location to another.

"Portable dental operation" means a nonfacility in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions.

"Radiographs" means intraoral and extraoral x-rays of hard and soft tissues to be used for purposes of diagnosis.

B. The following words and terms relating to supervision as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Direct supervision" means that the dentist examines the patient and records diagnostic findings prior to delegating restorative or prosthetic treatment and related services to a dental assistant II for completion the same day or at a later date. The dentist prepares the tooth or teeth to be restored and remains immediately available to the dental assistant II for guidance or assistance during the delivery of treatment and related services. The dentist examines the patient to evaluate the treatment and services before the patient is dismissed.

"Direction" means the level of supervision that a dentist is required to exercise with a dental hygienist, a dental assistant I or a dental assistant II or that a dental hygienist is required to exercise with a dental assistant to direct and oversee the delivery of treatment and related services.

~~"Enteral" is any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).~~

~~"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.

"General supervision" means that a dentist completes a periodic comprehensive examination of the patient and issues a written order for hygiene treatment that states the specific services to be provided by a dental hygienist during one or more subsequent appointments when the dentist may or may not be present. The order may authorize the dental hygienist to supervise a dental assistant performing duties delegable to dental assistants I.

"Immediate supervision" means the dentist is in the operatory to supervise the administration of sedation or provision of treatment.

"Indirect supervision" means the dentist examines the patient at some point during the appointment, and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist or dental hygienist, or (iii) preparing the patient for dismissal following treatment.

C. The following words and terms relating to sedation or anesthesia as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Conscious/moderate sedation" means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Deep sedation/general anesthesia" means an induced state of depressed consciousness or unconsciousness accompanied by a complete or partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or respond purposefully to physical stimulation or verbal command and is produced by a pharmacological or nonpharmacological method or a combination thereof a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

"Inhalation" means a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

~~"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness.~~

"Local anesthesia" means the loss of sensation or pain in the oral cavity or the maxillofacial or adjacent and associated structures generally produced by a topically applied or injected agent without depressing the level of consciousness.

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes "anxiolysis" (the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness) and includes "inhalation analgesia" (the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness).

~~"Mobile dental facility" means a self-contained unit in which dentistry is practiced that is not confined to a single building and can be transported from one location to another.~~

"Moderate sedation" (see meaning of conscious/moderate sedation)

"Monitoring" means to observe, interpret, assess and record appropriate physiologic functions of the body during sedative procedures and general anesthesia appropriate to the level of sedation as provided in Part IV.

"Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular).

~~"Portable dental operation" means a nonfacility in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions.~~

~~"Radiographs" means intraoral and extraoral x-rays of hard and soft tissues to be used for purposes of diagnosis.~~

18VAC60-20-30. Other fees.

A. Dental licensure application fees. The application fee for a dental license by examination, a license to teach dentistry, a full-time faculty license, or a temporary permit as a dentist shall be \$400. The application fee for dental license by credentials shall be \$500.

B. Dental hygiene licensure application fees. The application fee for a dental hygiene license by examination, a license to teach dental hygiene, or a temporary permit as a dental hygienist shall be \$175. The application fee for dental hygienist license by endorsement shall be \$275.

C. Dental assistant II registration application fee. The application fee for registration as a dental assistant II shall be \$100.

D. Wall certificate. Licensees desiring a duplicate wall certificate or a dental assistant II desiring a wall certificate shall submit a request in writing stating the necessity for a wall certificate, accompanied by a fee of \$60.

E. Duplicate license or registration. Licensees or registrants desiring a duplicate license or registration shall submit a request in writing stating the necessity for such duplicate, accompanied by a fee of \$20. If a licensee or registrant maintains more than one office, a notarized photocopy of a license or registration may be used.

F. Licensure or registration certification. Licensees or registrants requesting endorsement or certification by this board shall pay a fee of \$35 for each endorsement or certification.

G. Restricted license. Restricted license issued in accordance with § 54.1-2714 of the Code of Virginia shall be at a fee of \$285.

H. Restricted volunteer license. The application fee for licensure as a restricted volunteer dentist or dental hygienist issued in accordance with § 54.1-2712.1 or § 54.1-2726.1 of the Code of Virginia shall be \$25.

I. Returned check. The fee for a returned check shall be \$35.

J. Inspection fee. The fee for an inspection of a dental office shall be \$350 with the exception of a routine inspection of an office in which the dentist has a conscious/moderate sedation permit or a deep sedation/general anesthesia permit.

K. Mobile dental clinic or portable dental operation. The application fee for registration of a mobile dental clinic or portable dental operation shall be \$250. The annual renewal fee shall be \$150 and shall be due by December 31. A late fee of \$50 shall be charged for renewal received after that date.

L. Conscious/moderate sedation permit. The application fee for a permit to administer conscious/moderate sedation shall be \$100. The annual renewal fee shall be \$100 and shall be due by March 31. A late fee of \$35 shall be charged for renewal received after that date.

M. Deep sedation/general anesthesia permit. The application fee for a permit to administer deep sedation/general anesthesia shall be \$100. The annual renewal fee shall be \$100 and shall be due by March 31. A late fee of \$35 shall be charged for renewal received after that date.

Part IV

Anesthesia, Sedation and Analgesia

18VAC60-20-107. General provisions.

Note: The Regulatory/Legislative Committee recommended a general requirement for blood pressure and pulse to be taken prior to administration of all forms of anesthesia or sedation.

A. This part (18VAC60-20-107 et seq.) shall not apply to:

1. The administration of local anesthesia in dental offices; or
2. The administration of anesthesia in (i) a licensed hospital as defined in § 32.1-123 of the Code of Virginia or state-operated hospitals or (ii) a facility directly maintained or operated by the federal government.

B. Appropriateness of administration of general anesthesia or sedation in a dental office.

1. Anesthesia and sedation may be provided in a dental office for patients who are Class I and II as classified by the American Society of Anesthesiologists (ASA).
2. Conscious sedation, deep sedation or general anesthesia shall not be provided in a dental office for patients in ASA risk categories of Class IV and V.
3. Patients in ASA risk category Class III shall only be provided general anesthesia, deep sedation, conscious/moderate sedation or minimal sedation by:
 - a. A dentist after he has documented a consultation with their primary care physician or other medical specialist regarding potential risk and special monitoring requirements that may be necessary; or
 - b. An oral and maxillofacial surgeon after performing an evaluation and documenting the ASA risk assessment category of the patient and any special monitoring requirements that may be necessary.

C. Prior to administration of any level of sedation or general anesthesia, the dentist shall discuss the nature and objectives of the anesthesia or sedation planned along with the risks, benefits and alternatives and shall obtain informed, written consent from the patient or other responsible party. The written consent shall be maintained in the patient record.

D. The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a

margin of safety wide enough to render an unintended reduction of or loss of consciousness unlikely factoring in titration, and the patient's age, weight and ability to metabolize drugs.

~~E. A dentist who is administering anesthesia or sedation to patients prior to June 29, 2005 shall have one year from that date to comply with the educational requirements set forth in this chapter for the administration of anesthesia or sedation.~~ When conscious/moderate sedation, deep sedation or general anesthesia is administered, the patient record shall also include:

1. Notation of the patient's American Society of Anesthesiologists classification;
2. Review of medical history and current conditions;
3. Written informed consent for administration of sedation and anesthesia and for the dental procedure treatment to be performed;
4. Pre-operative vital signs;
5. A record of the name, dose, strength of drugs and route of administration including the administration of local anesthetics with notations of the time sedation and anesthesia were administered;
6. Monitoring records of all required vital signs and physiological measures recorded every five minutes; and
7. A list of staff participating in the administration, treatment and monitoring including name, position and assigned duties.

F. Pediatric patients.

No sedating medication shall be prescribed for or administered to a child aged 12 and under prior to his arrival at the dentist office or treatment facility.

Note: The Regulatory/Legislative Committee recommended deletion and further investigation.

G. Emergency management.

1. If a patient enters a deeper level of sedation than the dentist is qualified intended and was prepared to provide, the dentist shall stop the dental procedure treatment until the patient returns to and is stable at the intended level of sedation.
2. A dentist in whose office sedation or anesthesia is administered shall have written basic emergency procedures established and staff trained to carry out such procedures.

18 VAC60-20-108. Administration of minimal sedation (anxiolysis or inhalation analgesia).

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.

2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.

2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.

3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

4. If any other pharmacological agent is used in addition to nitrous oxide/oxygen and a local anesthetic, requirements for the induced level of sedation must be met.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

18VAC60-20-110. Requirements ~~for a permit to administer~~ the administration of deep sedation/general anesthesia.

A. ~~Educational requirements~~ After March 31, 2013, no dentist may employ or use administer deep sedation/general anesthesia in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the board with reports which result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.

B. To determine eligibility for a deep sedation/general anesthesia permit, a dentist shall submit the following:

1. A completed application form;
2. The application fee as specified in 18VAC60-20-30;
3. A copy of the certificate of completion of a CODA accredited program or other documentation of training content which meets the educational and training qualifications specified in subsection C; and
4. A copy of current certification in ACLS or PALS as required in subsection C.

C. Educational and training qualifications for a deep sedation/general anesthesia permit.

~~1. A dentist may employ or be issued a permit to use deep sedation/general anesthesia on an outpatient basis in a dental office by meeting one of the following educational criteria, and by posting the educational certificate, in plain view of the patient, which verifies completion of the advanced training as required in subdivision 1 or 2 of this subsection.~~ These requirements shall not apply nor interfere with requirements for obtaining hospital staff privileges.

- ~~1.a. Has completed~~ Completion of a minimum of one calendar year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program in conformity with published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred; or
- ~~2.b. Completion of an American Dental Association approved~~ a CODA accredited residency in any dental specialty which incorporates into its curriculum a minimum of one calendar year of full-time training in clinical anesthesia and related clinical medical subjects (i.e. medical evaluation and management of patients), comparable to those set forth in published guidelines by the American Dental Association for Graduate and Postgraduate Training in Anesthesia in effect at the time the training occurred.

~~After June 29, 2006, dentists~~ 2. Dentists who administer deep sedation/general anesthesia shall hold current certification in advanced resuscitative techniques with hands-on simulated airway and megacode training for healthcare providers, including basic electrocardiographic interpretation, such as courses in Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals and current Drug Enforcement Administration registration.

~~B. Exceptions.~~

~~1. A dentist who has not met the requirements specified in subsection A of this section may treat patients under deep sedation/general anesthesia in his practice if a qualified anesthesiologist or a dentist who fulfills the requirements specified in subsection A of this section, is present and is responsible for the administration of the anesthetic.~~

~~2. If a dentist fulfills the requirements specified in subsection A of this section, he may employ the services of a certified nurse anesthetist.~~

G.D. Posting. The deep sedation/general anesthesia permit or AAOMS certificate required under subsection A of this section ~~Any dentist who utilizes deep sedation/general anesthesia shall post~~ shall be posted along with the dental license and current registration with the Drug Enforcement Administration, the certificate of education deep sedation/general anesthesia permit or AAOMS certificate required under subsection A of this section. All licenses and permits should be current.

E. Delegation of administration.

1. A dentist not qualified who does not hold a permit to administer deep sedation and general anesthesia shall only use the services of a dentist with a current deep sedation/general anesthesia permit or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a dentist not qualified who does not hold a permit to administer deep sedation or general anesthesia shall use either a permitted dentist, an anesthesiologist or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist qualified pursuant to subsection B who does hold a permit may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

a. A dentist with a current deep sedation/anesthesia permit;

b. An anesthesiologist; or

c. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the educational requirements of subsection B of this section.

3. Preceding the administration of deep sedation or general anesthesia, a permitted dentist may use the services of the following personnel under indirect supervision to administer local anesthesia to numb the injection or treatment site:

a. A dental hygienist with the training required in 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older; or

b. A dental hygienist, dental assistant, registered nurse or licensed practical nurse to administer Schedule VI topical oral anesthetics.

4. A dentist who delegates administration of deep sedation/general anesthesia shall ensure that:

a. All equipment required in subsection F is present, in good working order and immediately available to the areas where patients will be sedated and treated and will recover; and

b. Qualified staff is on site to monitor patients in accordance with requirements of subsection G.

D.F. Emergency Required equipment and techniques. A dentist who administers deep sedation/general anesthesia shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency equipment in the dental facility working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask for children or adults, as appropriate for the patient being treated;
2. Oral and nasopharyngeal airways airway management adjuncts;
3. Endotracheal tubes for children or adults, or both, with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway;
4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;
5. Source of delivery of oxygen under controlled positive pressure;
6. Mechanical (hand) respiratory bag;
7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;
8. Appropriate emergency drugs for patient resuscitation;
9. EKG monitoring equipment and temperature measuring devices;
10. Pharmacologic antagonist agents;
11. External defibrillator (manual or automatic); ~~and~~
12. For intubated patients, an End-Tidal CO² monitor;
13. Suction apparatus;
14. Throat pack; and
15. Precordial or pretracheal stethoscope.

E.G. Monitoring requirements.

1. Monitoring of the patient undergoing deep sedation/general anesthesia, including direct, visual observation of the patient by one member of the treatment team, is to begin prior to induction, and shall take place continuously following induction during the dental treatment and recovery from anesthesia. The person who administered the anesthesia or another licensed practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

4.2. The treatment team for deep sedation/general anesthesia shall consist of the operating dentist, a second person to monitor and observe the patient and a third person to assist the operating dentist, all of whom shall be in the operatory with the patient during the dental procedure treatment. The second person may be the health professional delegated to administer sedation or anesthesia.

~~2. Monitoring of the patient under deep sedation/general anesthesia, including direct, visual observation of the patient by a member of the team, is to begin prior to induction of anesthesia and shall take place continuously during the dental procedure and recovery from anesthesia. The person who administered the anesthesia or another licensed practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.~~

3. Monitoring deep sedation/general anesthesia shall include the following: recording and reporting of blood pressure, pulse, respiration and other vital signs to the attending dentist.

a. EKG readings and baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility to include: temperature, blood pressure, pulse, pulse oximeter, oxygen saturation, respiration and heart rate. b. The EKG readings and patient's vital signs shall be monitored, recorded every five minutes and reported to the treating dentist throughout the administration of controlled drugs and recovery. When depolarizing medications are administered temperature shall be monitored constantly.

e.b. A secured intravenous line must be established during induction and maintained through recovery the procedure.

H. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge and vital signs have been taken and recorded.
2. Postoperative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number for the dental practice.
3. Patients shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

18VAC60-20-120. Requirements for a permit to administer administration of conscious/moderate sedation.

A. After March 31, 2013, no dentist may employ or use administer conscious/moderate sedation in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the board with reports which result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.

B. Automatic qualification. Dentists ~~qualified~~ who hold a current permit to administer deep sedation/general anesthesia may administer conscious/moderate sedation.

C. To determine eligibility for a conscious/moderate sedation permit, a dentist shall submit the following:

1. A completed application form indicating one of the following permits for which the applicant is qualified:
 - a. Conscious/moderate sedation by any method;
 - b. Conscious/moderate sedation by enteral administration only; or
 - c. Temporary conscious/moderate sedation permit (may be renewed one time);
2. The application fee as specified in 18VAC60-20-30;
3. A copy of a transcript, certification or other documentation of training content which meets the educational and training qualifications as specified in D or E, as applicable;
and
4. A copy of current certification in ACLS or PALS as required in subsection F.

B.D. Educational requirements for ~~administration of a permit to administer~~ conscious/moderate sedation by any method.

1. A dentist may be issued a conscious/moderate sedation permit to employ or use any method of conscious sedation by meeting one of the following criteria:

- a. Completion of training for this treatment modality according to guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred, while enrolled at an accredited dental program or while enrolled in a post-doctoral university or teaching hospital program; or
- b. Completion of ~~an approved~~ a continuing education course, offered by a provider approved in 18VAC60-20-50, and consisting of 60 hours of didactic instruction plus the management of at least 20 patients per participant, demonstrating competency and clinical experience in parenteral conscious sedation and management of a compromised airway. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

2. A dentist who was self-certified in anesthesia and conscious sedation prior to January 1989 may be issued a temporary conscious/moderate sedation permit to continue to administer only conscious sedation until September 14, 2014. After September 14, 2014, a dentist shall meet the requirements for and obtain a conscious/moderate sedation permit by any method or by enteral administration only.

G.E. Educational requirement for enteral administration of conscious sedation only. A dentist may be issued a conscious/moderate sedation permit to only administer conscious sedation by an enteral method if he has completed ~~an approved~~ a continuing education program, offered by a provider approved in 18VAC60-20-50, of not less than 18 hours of didactic instruction plus 20 clinically-oriented experiences in enteral and/or combination inhalation-enteral conscious sedation techniques. The course content shall be consistent with the guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred. The certificate of completion and a detailed description of the course content must be maintained.

D.F. Additional training required.

~~After June 29, 2006, dentists~~ Dentists who administer conscious sedation shall hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers, including basic electrocardiographic interpretation, such as Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals as evidenced by a certificate of completion posted with the dental license, and current registration with the Drug Enforcement Administration.

G. Posting. The conscious/moderate sedation permit required under subsection A and issued in accordance with subsection C of this section or the AAOMS certificate issued to an oral and maxillofacial surgeon Any dentist who utilizes deep sedation/general anesthesia shall post shall be posted along with the dental license and current registration with the Drug Enforcement Administration the conscious/moderate sedation permit required under subsection A and issued in accordance with subsection C of this section or the AAOMS certificate issued to an oral and maxillofacial surgeon. All licenses and permits should be current.

H. Delegation of administration.

1. A dentist not qualified who does not hold a permit to administer conscious/moderate sedation shall only use the services of a permitted dentist or an anesthesiologist to administer such sedation in a dental office. In a licensed outpatient surgery center, a dentist not qualified who does not hold a permit to administer conscious/moderate sedation shall use either a permitted dentist, an anesthesiologist or a certified registered nurse anesthetist to administer such sedation.

2. A qualified dentist who holds a permit may administer or use the services of the following personnel to administer conscious/moderate sedation:

a. A dentist with the training required by subsection E to administer by an enteral method;

b. A dentist with the training required by subsection D to administer by any method;

c. An anesthesiologist;

d. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the education and training requirements of subsection D or E; or

e. A registered nurse upon his direct instruction and under the immediate supervision of a dentist who meets the education and training requirements of subsection D.

3. If minimal sedation is self-administered by or to a patient age 13 or above before arrival at the dental office, the dentist may only use the personnel listed in subdivision 2 of this subsection to administer local anesthesia. No sedating medication shall be prescribed for or administered to a child aged 12 and under prior to his arrival at the dentist office or treatment facility. Note: Further investigation requested.

4. Preceding the administration of conscious/moderate sedation, a qualified permitted dentist may use the services of the following personnel under indirect supervision to administer local anesthesia to numb the injection or treatment site:

- a. A dental hygienist with the training required by 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older; or
 - b. A dental hygienist, dental assistant, registered nurse or licensed practical nurse to administer Schedule VI topical oral anesthetics.
5. A dentist who delegates administration of conscious/moderate sedation shall ensure that:
- a. All equipment required in subsection I is present, in good working order and immediately available to the areas where patients will be sedated and treated and will recover; and
 - b. Qualified staff is on site to monitor patients in accordance with requirements of subsection J.

E.I. Emergency Required equipment and techniques. A dentist who administers conscious sedation shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency airway equipment in the dental facility working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face mask for children or adults, as appropriate for the patient being treated;
2. Oral and nasopharyngeal ~~airways~~ airway management adjuncts;
3. Endotracheal tubes for children or adults, or both, with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway and a laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both. ~~In lieu of a laryngoscope and endotracheal tubes, a dentist may maintain airway adjuncts designed for the maintenance of a patent airway and the direct delivery of positive pressure oxygen;~~
4. Pulse oximetry;
5. Blood pressure monitoring equipment;
6. Pharmacologic antagonist agents;
7. Source of delivery of oxygen under controlled positive pressure;
8. Mechanical (hand) respiratory bag; ~~and~~
9. Appropriate emergency drugs for patient resuscitation;
10. Defibrillator;
11. Suction apparatus;
12. Temperature measuring device;

13. Throat pack;

14. Precordial and pretracheal stethoscope; and

15. Electrocardiographic monitor, if a patient is receiving intravenous administration of sedation. Note: Should the term "parental" be used instead of intravenous?

F.J. Monitoring requirements.

1. Monitoring of the patient undergoing conscious/moderate sedation, including direct, visual observation of the patient by one member of the treatment team, is to begin prior to administration of sedation, or if medication is self-administered by the patient, immediately upon the patient's arrival at the dental office, and shall take place continuously during the dental treatment and recovery from sedation. The person who administers the sedation or another licensed practitioner who is qualified to administer the same level of sedation must remain on the premises of the dental facility until the patient is evaluated and is discharged.

1.2. The administration treatment team for conscious sedation shall consist of the operating dentist and a second person to assist, monitor and observe the patient. Both shall be in the operatory with the patient throughout the dental procedure treatment. The second person may be the health professional delegated to administer sedation.

~~2. Monitoring of the patient under conscious sedation, including direct, visual observation of the patient by a member of the team, is to begin prior to administration of sedation, or if medication is self-administered by the patient, when the patient arrives at the dental office and shall take place continuously during the dental procedure and recovery from sedation. The person who administers the sedation or another licensed practitioner qualified to administer the same level of sedation must remain on the premises of the dental facility until the patient is responsive and is discharged.~~

3. Monitoring conscious/moderate sedation shall include the following:

a. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility and prior to discharge; and

b. Blood pressure, oxygen saturation, pulse and heart rate shall be monitored continually during the administration and recorded every five minutes.

~~c. Monitoring of the patient under moderate sedation is to begin prior to administration of sedation, or, if pre-medication is self-administered by the patient, immediately upon the patient's arrival at the dental office and shall take place continuously during the dental procedure and recovery from sedation. The person who administers the sedation or another licensed practitioner qualified to administer~~

the same level of sedation must remain on the premises of the dental facility until the patient is evaluated and is discharged.

K. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge and vital signs have been taken and recorded.
2. Postoperative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number of the dental practice.
3. Patients shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

18VAC60-20-135. Ancillary personnel Personnel assisting in sedation or anesthesia.

~~After June 29, 2006, dentists~~ Dentists who employ ancillary personnel to assist in the administration and monitoring of any form of conscious/moderate sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have:

1. Minimal training resulting in current certification in basic resuscitation techniques, with hands-on airway training for healthcare providers, such as Basic Cardiac Life Support for Health Professionals or ~~an approved,~~ a clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18 VAC 60-20-50 C; or
2. Current certification as a certified anesthesia assistant (CAA) by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology (ADSA).

Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation by Dentists and Other Health Professionals

Developed and Endorsed by

American Academy of Pediatrics and the American Academy of Pediatric Dentistry

Adopted

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Abstract

The safe sedation of children for procedures requires a systematic approach that includes the following: no administration of sedating medication without the safety net of medical supervision, careful pre-sedation evaluation for underlying medical or surgical conditions that would place the child at increased risk from sedating medications, appropriate fasting for elective procedures and a balance between depth of sedation and risk for those who are unable to fast because of the urgent nature of the procedure, a focused airway examination for large tonsils or anatomic airway abnormalities that might increase the potential for airway obstruction, a clear understanding of the pharmacokinetic and pharmacodynamic effects of the medications used for sedation as well as an appreciation for drug interactions, appropriate training and skills in airway management to allow rescue of the patient, age- and size-appropriate equipment for airway management and venous access, appropriate medications and reversal agents, sufficient numbers of people to both carry out the procedure and monitor the patient, appropriate physiologic monitoring during and after the procedure, a properly equipped and staffed recovery area, recovery to pre-sedation level of consciousness before discharge from medical supervision, and appropriate discharge instructions.

Introduction

Invasive diagnostic and minor surgical procedures on pediatric patients outside the traditional operating room setting have increased in the last decade. As a consequence of this change and the increased awareness of the importance of providing analgesia and anxiolysis, the need for sedation for procedures in physician offices, dental offices, subspecialty procedure suites, imaging facilities, emergency departments, and ambulatory surgery centers also has markedly increased.¹⁻³⁷ In recognition of this need for both elective and emergency use of sedation in nontraditional settings, the American Academy of Pediatrics (AAP) and American Academy of Pediatric Dentistry (AAPD) have published a series of guidelines for the monitoring and management of pediatric patients during and after sedation for a procedure.³⁸⁻⁴² The purpose of this updated statement is to unify

the guidelines for sedation used by medical and dental practitioners, add clarifications regarding monitoring modalities, provide new information from medical and dental literature, and suggest methods for further improvement in safety and outcomes. With the revision of this document, the Joint Commission on Accreditation of Healthcare Organizations, the American Society of Anesthesiologists (ASA), the AAP, and the AAPD will use similar language to define sedation categories and the expected physiologic responses.⁴¹⁻⁴⁴

This revised statement reflects the current understanding of appropriate monitoring needs both during and after sedation for a procedure.^{4,5,12,19,21,22,26,45-53} The monitoring and care outlined in this guideline may be exceeded at any time, based on the judgment of the responsible practitioner. Although intended to encourage high-quality patient care, adherence to this guideline cannot guarantee a specific patient outcome. However, structured sedation protocols designed to incorporate the principles in this document have been widely implemented and shown to reduce morbidity.^{29,32-34,37,54,55} This guideline is proffered with the awareness that, regardless of the intended level of sedation or route of administration, the sedation of a pediatric patient represents a continuum and may result in respiratory depression and the loss of the patient's protective reflexes.^{43,57-60}

Sedation of pediatric patients has serious associated risks, such as hypoventilation, apnea, airway obstruction, laryngospasm, and cardiopulmonary impairment.^{2,6,22,45,46,54,60-69} These adverse responses during and after sedation for a diagnostic or therapeutic procedure may be minimized, but not completely eliminated, by a careful preprocedure review of the patient's underlying medical conditions and consideration of how the sedation process might affect or be affected by these conditions.⁵⁴ Appropriate drug selection for the intended procedure as well as the presence of an individual with the skills needed to rescue a patient from an adverse response are essential. Appropriate physiologic monitoring and continuous observation by personnel not directly involved with the procedure allow for accurate and rapid diagnosis of complications and initiation of appropriate rescue interventions.^{46,51,54}

The sedation of children is different from the sedation of adults. Sedation in children often is administered to control behavior to allow the safe completion of a procedure. A child's ability to control his or her own behavior to cooperate for a procedure depends both on his or her chronologic and developmental age. Often, children younger than 6 years and those with developmental delay require deep levels of sedation to gain control of their behavior.⁵⁷ Therefore, the need for deep sedation should be anticipated. Children in this age group are particularly vulnerable to the sedating medication's effects on respiratory drive, patency of the airway, and protective reflexes.⁴⁶ Studies have shown that it is common for children to pass from the intended level of sedation to a deeper, unintended level of sedation.^{56,59,70} For older and cooperative children, other modalities, such as parental presence, hypnosis, distraction, topical local anesthetics, and guided imagery, may reduce the need for or the needed depth of pharmacologic sedation.^{31,71-81}

The concept of rescue is essential to safe sedation. Practitioners of sedation must have the skills to rescue the patient from a deeper level than that intended for the procedure. For example, if the intended level of sedation is "minimal," practitioners must be able to rescue from "moderate sedation"; if the intended level of sedation is "moderate," practitioners must have the skills to rescue from "deep sedation"; if the intended level of sedation is "deep," practitioners must have the skills to rescue from a state of "general anesthesia." The ability to rescue means that practitioners must be able to recognize the various levels of sedation and have the skills necessary to provide appropriate cardiopulmonary support if needed. Sedation and anesthesia in a nonhospital environment (private physician or dental office or freestanding imaging facility) may be associated with an increased incidence of "failure to rescue" the patient should an adverse event occur, because the only backup in this venue may be to activate emergency medical services (EMS).^{46,82} Rescue therapies require specific training and skills.^{46,54,83,84} Maintenance of the skills needed to perform successful bag-valve-mask ventilation is essential to successfully rescue a child who has become apneic or developed airway obstruction. Familiarity with emergency airway management procedure algorithms is essential.⁸³⁻⁸⁷ Practitioners should have an in-depth knowledge of the agents they intend to use and their potential complications. A number of reviews and handbooks for sedating pediatric patients are available.^{32,48,55,88-93} This guideline is intended for all venues in which sedation for a procedure might be performed (hospital, surgical center, freestanding imaging facility, dental facility, or private office).

There are other guidelines for specific situations and personnel that are beyond the scope of this document. Specifically, guidelines for the delivery of general anesthesia and monitored anesthesia care (sedation or analgesia), outside or within the operating room by anesthesiologists or other practitioners functioning within a department of anesthesiology, are addressed by policies developed by the ASA and by individual departments of anesthesiology.⁹⁴ Also, guidelines for the sedation

of patients undergoing mechanical ventilation in a critical care environment or for providing analgesia for patients postoperatively, patients with chronic painful conditions, and hospice care are beyond the scope of this document.

Definitions of Terms for This Report

- "Pediatric patients": all patients through 21 years of age, as defined by the AAP.
- "Must" or "shall": an imperative need or duty that is essential, indispensable, or mandatory.
- "Should": the recommended need and/or duty.
- "May" or "could": freedom or liberty to follow a suggested or reasonable alternative.
- "Medical supervision" or "medical personnel": a current, licensed practitioner in medicine, surgery, or dentistry trained in the administration of medications used for procedural sedation and the management of complications associated with these medications.
- "Are encouraged": a suggested or reasonable action to be taken.
- "ASA Physical Status Classification": guidelines for classifying the baseline health status according to the ASA (see Appendix B).
- "Minimal sedation" (old terminology "anxiolysis"): a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
- "Moderate sedation" (old terminology "conscious sedation" or "sedation/analgesia"): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands (eg, "open your eyes" either alone or accompanied by light tactile stimulation—a light tap on the shoulder or face, not a sternal rub). For older patients, this level of sedation implies an interactive state; for younger patients, age-appropriate behaviors (eg, crying) occur and are expected. Reflex withdrawal, although a normal response to a painful stimulus, is not considered as the only age-appropriate purposeful response (eg, it must be accompanied by another response, such as pushing away the painful stimulus so as to confirm a higher cognitive function). With moderate sedation, no intervention is required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. However, in the case of procedures that may themselves cause airway obstruction (eg, dental or endoscopic), the practitioner must recognize an obstruction and assist the patient in opening the airway. If the patient is not making spontaneous efforts to open his/her airway so as to relieve the obstruction, then the patient should be considered to be deeply sedated.
- "Deep sedation" ("deep sedation/analgesia"): a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (see discussion of reflex withdrawal above) after repeated verbal or painful stimulation (eg, purposefully pushing away the noxious

stimuli). The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. A state of deep sedation may be accompanied by partial or complete loss of protective airway reflexes.

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

Goals of Sedation

The goals of sedation in the pediatric patient for diagnostic and therapeutic procedures are: 1) to guard the patient’s safety and welfare; 2) to minimize physical discomfort and pain; 3) to control anxiety, minimize psychological trauma, and maximize the potential for amnesia; 4) to control behavior and/or movement so as to allow the safe completion of the procedure; and 5) to return the patient to a state in which safe discharge from medical supervision, as determined by recognized criteria, is possible (Appendix A).

These goals can best be achieved by selecting the lowest dose of drug with the highest therapeutic index for the procedure. It is beyond the scope of this document to specify which drugs are appropriate for which procedures; however, the selection of the fewest number of drugs and matching drug selection to the type and goal of the procedure are essential for safe practice.^{53,88,91-93,95-97} For example, analgesic medications such as opioids are indicated for painful procedures. For nonpainful procedures, such as computed tomography or magnetic resonance imaging (MRI), sedatives/hypnotics are preferred. When both sedation and analgesia are desirable (eg, fracture reduction), either single agents with analgesic/sedative properties or combination regimens commonly are used. Anxiolysis and amnesia are additional goals that should be considered in selection of agents for particular patients. However, the potential for an adverse outcome may be increased when 3 or more sedating medications are administered.^{44,98} Knowledge of each drug’s time of onset, peak response, and duration of action is essential. Although the concept of titration of drug to effect is critical, one must know whether the previous dose has taken full effect before administering additional drug. Such management will improve safety and outcomes. Drugs with long durations of action (eg, chloral hydrate, intramuscular pentobarbital, phenothiazines) will require longer periods of observation even after the child achieves currently used recovery and discharge criteria.^{45,99,100} This concept is particularly important for infants and toddlers transported in car safety seats who are at risk of re-sedation after discharge because of residual prolonged drug effects with the potential for airway obstruction.^{45,46}

General Guidelines

Candidates

Patients who are in ASA classes I and II are frequently considered appropriate candidates for minimal, moderate, or deep sedation (Appendix B). Children in ASA classes III and IV, children with special needs, and those with anatomic airway abnormalities or extreme tonsillar hypertrophy present issues that require additional and individual consideration, particularly for moderate and deep sedation.⁹¹ Practitioners are encouraged to consult with appropriate subspecialists and/or an anesthesiologist for patients at increased risk of experiencing adverse sedation events because of their underlying medical/surgical conditions.

Responsible Person

The pediatric patient shall be accompanied to and from the treatment facility by a parent, legal guardian, or other responsible person. It is preferable to have 2 or more adults accompany children who are still in car safety seats if transportation to and from a treatment facility is provided by 1 of the adults.¹⁰¹

Facilities

The practitioner who uses sedation must have immediately available facilities, personnel, and equipment to manage emergency and rescue situations. The most common serious complications of sedation involve compromise of the airway or depressed respirations resulting in airway obstruction, hypoventilation, hypoxemia, and apnea. Hypotension and cardiopulmonary arrest may occur, usually from inadequate recognition and treatment of respiratory compromise. Other rare complications may also include seizures and allergic reactions. Facilities providing pediatric sedation should monitor for, and be prepared to treat, such complications.

Back-up Emergency Services

A protocol for access to back-up emergency services shall be clearly identified, with an outline of the procedures necessary for immediate use. For nonhospital facilities, a protocol for ready access to ambulance service and immediate activation of the EMS system for life-threatening complications must be established and maintained. It should be understood that the availability of EMS services does not replace the practitioner’s responsibility to provide initial rescue in managing life-threatening complications.

On-Site Monitoring and Rescue Equipment

An emergency cart or kit must be immediately accessible. This cart or kit must contain equipment to provide the necessary age- and size-appropriate drugs and equipment to resuscitate a nonbreathing and unconscious child. The contents of the kit must allow for the provision of continuous life support while the patient is being transported to a medical facility or to another area within a medical facility. All equipment and drugs must be checked and maintained on a scheduled basis (see Appendices C and D for suggested drugs and emergency life support equipment to consider before the need for rescue

occurs). Monitoring devices, such as electrocardiography (ECG) machines, pulse oximeters (with size-appropriate oximeter probes), end-tidal carbon dioxide monitors, and defibrillators (with size-appropriate defibrillator paddles), must have a safety and function check on a regular basis as required by local or state regulation.

Documentation Before Sedation

Documentation shall include, but not be limited to, the guidelines that follow:

1. Informed consent. The patient record shall document that appropriate informed consent was obtained according to local, state, and institutional requirements.¹⁰²
2. Instructions and information provided to the responsible person. The practitioner shall provide verbal and/or written instructions to the responsible person. Information shall include objectives of the sedation and anticipated changes in behavior during and after sedation. Special instructions shall be given to the adult responsible for infants and toddlers who will be transported home in a car safety seat regarding the need to carefully observe the child's head position so as to avoid airway obstruction. Transportation by car safety seat poses a particular risk for infants who have received medications known to have a long half-life, such as chloral hydrate, intramuscular pentobarbital, or phenothiazine.^{45,46,100,103} Consideration for a longer period of observation shall be given if the responsible person's ability to observe the child is limited (eg, only 1 adult who also has to drive). Another indication for prolonged observation would be a child with an anatomic airway problem or a severe underlying medical condition. A 24-hour telephone number for the practitioner or his or her associates shall be provided to all patients and their families. Instructions shall include limitations of activities and appropriate dietary precautions.

Dietary Precautions

Agents used for sedation have the potential to impair protective airway reflexes, particularly during deep sedation. Although a rare occurrence, pulmonary aspiration may occur if the child regurgitates and cannot protect his or her airway. Therefore, it is prudent that before sedation, the practitioner evaluate preceding food and fluid intake. It is likely that the risk of aspiration during procedural sedation differs from that during general anesthesia involving tracheal intubation or other airway manipulation.^{104,105} However, because the absolute risk of aspiration during procedural sedation is not yet known, guidelines for fasting periods before elective sedation generally should follow those used for elective general anesthesia. For emergency procedures in children who have not fasted, the risks of sedation and the possibility of aspiration must be balanced against the benefits of performing the procedure promptly (see below). Further research is needed to better elucidate the relationships between various fasting intervals and sedation complications.

Before Elective Sedation

Children receiving sedation for elective procedures should generally follow the same fasting guidelines as before general anesthesia (Table 1). It is permissible for routine necessary medications to be taken with a sip of water on the day of the procedure.

For the Emergency Patient

The practitioner must always balance the possible risks of sedating nonfasted patients with the benefits and necessity for completing the procedure. In this circumstance, the use of sedation must be preceded by an evaluation of food and fluid intake. There are few published studies with adequate statistical power to provide guidance to the practitioner regarding safety or risk of pulmonary aspiration of gastric contents during procedural sedation.¹⁰⁴⁻¹⁰⁹ When protective airway reflexes are lost, gastric contents may be regurgitated into the airway. Therefore, patients with a history of recent oral intake or with other known risk factors, such as trauma, decreased level of consciousness, extreme obesity, pregnancy, or bowel motility dysfunction, require careful evaluation before administration of sedatives. When proper fasting has not been ensured, the increased risks of sedation must be carefully weighed against its benefits, and the lightest effective sedation should be used. The use of agents with less risk of depressing protective airway reflexes may be preferred.¹¹⁰ Some emergency patients requiring deep sedation may require protection of the airway before sedation.

Use of Immobilization Devices

Immobilization devices, such as papoose boards, must be applied in such a way as to avoid airway obstruction or chest restriction. The child's head position and respiratory excursions should be checked frequently to ensure airway patency. If an immobilization device is used, a hand or foot should be kept exposed, and the child should never be left unattended. If sedating medications are administered in conjunction with an immobilization device, monitoring must be used at a level consistent with the level of sedation achieved.

Documentation at the Time of Sedation

1. Health evaluation. Before sedation, a health evaluation shall be performed by an appropriately-licensed practitioner and reviewed by the sedation team at the time of treatment for possible interval changes. The purpose of this evaluation is not only to document baseline status but also to determine whether patients present specific risk factors that may warrant additional consultation before sedation. This evaluation will also screen out patients whose sedation will require more advanced airway or cardiovascular management skills or alterations in the doses or types of medications used for procedural sedation.

A new concern for the practitioner is the widespread use of medications that may interfere with drug absorption or metabolism and, therefore, enhance or shorten the effect time of sedating medications. Herbal medicines (eg, St. John's

wort, echinacea) may alter drug pharmacokinetics through inhibition of the cytochrome P450 system, resulting in prolonged drug effect and altered (increased or decreased) blood drug concentrations.¹¹¹⁻¹¹⁶ Kava may increase the effects of sedatives by potentiating gamma-aminobutyric acid inhibitory neurotransmission, and valerian may itself produce sedation that apparently is mediated through modulation of gamma-aminobutyric acid neurotransmission and receptor function.^{117,118} Drugs such as erythromycin, cimetidine, and others also may inhibit the cytochrome P450 system, resulting in prolonged sedation with midazolam as well as other medications competing for the same enzyme systems.¹¹⁹⁻¹²² Medications used to treat human immunodeficiency virus infection, some antivirals, and some psychotropic medications also may produce clinically important drug-drug interactions.¹²³⁻¹²⁵ Therefore, a careful drug history is a vital part of the safe sedation of children. The clinician should consult various sources (a pharmacist, textbooks, online services, or handheld databases) for specific information on drug interactions.¹²⁶

The health evaluation should include:

- Age and weight
- Health history, including: 1) allergies and previous allergic or adverse drug reactions; 2) medication/drug history, including dosage, time, route, and site of administration for prescription, over-the-counter, herbal, or illicit drugs; 3) relevant diseases, physical abnormalities, and neurologic impairment that might increase the potential for airway obstruction, such as a history of snoring or obstructive sleep apnea;^{127,128} 4) pregnancy status; 5) a summary of previous relevant hospitalizations; 6) history of sedation or general anesthesia and any complications or unexpected responses; and 7) relevant family history, particularly related to anesthesia
- Review of systems with a special focus on abnormalities of cardiac, pulmonary, renal, or hepatic function that might alter the child's expected responses to sedating/analgesic medications
- Vital signs, including heart rate, blood pressure, respiratory rate, and temperature (for some children who are very upset or noncooperative, this may not be possible and a note should be written to document this occurrence)
- Physical examination, including a focused evaluation of the airway (tonsillar hypertrophy, abnormal anatomy—eg, mandibular hypoplasia) to determine whether there is an increased risk of airway obstruction.^{54,129,130}
- Physical status evaluation (ASA classification [see Appendix B])
- Name, address, and telephone number of the child's medical home

For hospitalized patients, the current hospital record may suffice for adequate documentation of presedation health;

however, a brief note shall be written documenting that the chart was reviewed, positive findings were noted, and a management plan was formulated. If the clinical or emergency condition of the patient precludes acquiring complete information before sedation, this health evaluation should be obtained as soon as feasible.

2. Prescriptions. When prescriptions are used for sedation, a copy of the prescription or a note describing the content of the prescription should be in the patient's chart along with a description of the instructions that were given to the responsible person. **Prescription medications intended to accomplish procedural sedation must not be administered without the benefit of direct supervision by trained medical personnel.** Administration of sedating medications at home poses an unacceptable risk, particularly for infants and preschool-aged children traveling in car safety seats.⁴⁶

Documentation During Treatment

The patient's chart shall contain a time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs. Before sedation, a "time out" should be performed to confirm the patient's name, procedure to be performed, and site of the procedure.⁴³ During administration, the inspired concentrations of oxygen and inhalation sedation agents and the duration of their administration shall be documented. Before drug administrations, special attention must be paid to calculation of dosage (ie, mg/kg). The patient's chart shall contain documentation at the time of treatment that the patient's level of consciousness and responsiveness, heart rate, blood pressure, respiratory rate, and oxygen saturation were monitored until the patient attained predetermined discharge criteria (see Appendix A). A variety of sedation scoring systems are available and may aid this process.^{70,100} Adverse events and their treatment shall be documented.

Documentation After Treatment

The time and condition of the child at discharge from the treatment area or facility shall be documented; this should include documentation that the child's level of consciousness and oxygen saturation in room air have returned to a state that is safe for discharge by recognized criteria (see Appendix A). Patients receiving supplemental oxygen before the procedure should have a similar oxygen need after the procedure. Because some sedation medications are known to have a long half-life and may delay a patient's complete return to baseline or pose the risk of re-sedation,^{45,103,131,132} some patients might benefit from a longer period of less-intense observation (eg, a step-down observation area) before discharge from medical supervision.¹³³ Several scales to evaluate recovery have been devised and validated.^{70,134,135} A recently described and simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet environment.¹⁰⁰

Continuous Quality Improvement

The essence of medical error reduction is a careful examination of index events and root cause analysis of how the event could be avoided in the future.¹³⁷⁻¹⁴¹ Therefore, each facility should maintain records that track adverse events, such as desaturation, apnea, laryngospasm, the need for airway interventions including jaw thrust, positive pressure ventilation, prolonged sedation, unanticipated use of reversal agents, unintended or prolonged hospital admission, and unsatisfactory sedation/analgesia/anxiolysis. Such events can then be examined for assessment of risk reduction and improvement in patient satisfaction.

Preparation and Setting up for Sedation Procedures

Part of the safety net of sedation is to use a systematic approach so as to not overlook having an important drug, piece of equipment, or monitor immediately available at the time of a developing emergency. To avoid this problem, it is helpful to use an acronym that allows the same setup and checklist for every procedure. A commonly used acronym useful in planning and preparation for a procedure is SOAPME:

- S** = Size-appropriate **suction** catheters and a functioning **suction** apparatus (eg, Yankauer-type suction)
- O** = An adequate **oxygen** supply and functioning flow meters/other devices to allow its delivery
- A** = **Airway**: size-appropriate airway equipment (nasopharyngeal and oropharyngeal airways, laryngoscope blades [checked and functioning], endotracheal tubes, stylets, face mask, bag-valve-mask or equivalent device [functioning])
- P** = **Pharmacy**: all the basic drugs needed to support life during an emergency, including antagonists as indicated
- M** = **Monitors**: functioning pulse oximeter with size-appropriate oximeter probes^{141,142} and other monitors as appropriate for the procedure (eg, noninvasive blood pressure, end-tidal carbon dioxide, ECG, stethoscope)
- E** = **Special equipment or drugs** for a particular case (eg, defibrillator)

Specific Guidelines for Intended Level of Sedation

Minimal Sedation

Minimal sedation (old terminology “anxiolysis”) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Children who have received minimal sedation generally will not require more than observation and intermittent assessment of their level of sedation. Some children will become moderately sedated despite the intended level of minimal sedation; should this occur, then the guidelines for moderate sedation apply.⁵⁷

Moderate Sedation

“Moderate sedation” (old terminology “conscious sedation” or “sedation/analgesia”) is a drug-induced depression of consciousness during which patients respond purposefully to verbal

commands or following light tactile stimulation (see Definition of Terms for This Report). No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function usually is maintained. The caveat that loss of consciousness should be unlikely is a particularly important aspect of the definition of moderate sedation. The drugs and techniques used should carry a margin of safety wide enough to render unintended loss of consciousness highly unlikely. Because the patient who receives moderate sedation may progress into a state of deep sedation and obtundation, the practitioner should be prepared to increase the level of vigilance corresponding to what is necessary for deep sedation.⁵⁷

Personnel

The Practitioner

The practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). Because the level of intended sedation may be exceeded, the practitioner must be sufficiently skilled to provide rescue should the child progress to a level of deep sedation. The practitioner must be trained in, and capable of providing, at the minimum, bag-valve-mask ventilation so as to be able to oxygenate a child who develops airway obstruction or apnea. Training in, and maintenance of, advanced pediatric airway skills is required; regular skills reinforcement is strongly encouraged.

Support Personnel

The use of moderate sedation shall include provision of a person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration.⁴⁴ This individual must be trained in and capable of providing pediatric basic life support. The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies.

Monitoring and Documentation

Baseline

Before administration of sedative medications, a baseline determination of vital signs shall be documented. For some children who are very upset or noncooperative, this may not be possible and a note should be written to document this happenstance.

During the Procedure

The practitioner shall document the name, route, site, time of administration, and dosage of all drugs administered. There shall be continuous monitoring of oxygen saturation and heart

rate and intermittent recording of respiratory rate and blood pressure; these should be recorded in a time-based record. Restraining devices should be checked to prevent airway obstruction or chest restriction. If a restraint device is used, a hand or foot should be kept exposed. The child's head position should be checked frequently to ensure airway patency. A functioning suction apparatus must be present.

After the procedure

The child who has received moderate sedation must be observed in a suitably equipped recovery facility (eg, the facility must have functioning suction apparatus as well as the capacity to deliver more than 90% oxygen and positive-pressure ventilation (eg, bag and mask with oxygen capacity as described previously)). The patient's vital signs should be recorded at specific intervals. If the patient is not fully alert, oxygen saturation and heart rate monitoring shall be used continuously until appropriate discharge criteria are met (see Appendix A). Because sedation medications with a long half-life may delay the patient's complete return to baseline or pose the risk of re sedation, some patients might benefit from a longer period of less-intense observation (eg, a step-down observation area where multiple patients can be observed simultaneously) before discharge from medical supervision (see also Documentation Before Sedation for instructions to families).^{45,103,131,132} A recently described and simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet environment.¹⁰⁰ Patients who have received reversal agents, such as flumazenil or naloxone, will also require a longer period of observation, because the duration of the drugs administered may exceed the duration of the antagonist, which can lead to re sedation.

Deep Sedation

Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated verbal or painful stimulation (see Definition of Terms for this report). The state and risks of deep sedation may be indistinguishable from those of general anesthesia.

Personnel

There must be 1 person available whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration. At least 1 individual must be present who is trained in, and capable of, providing advanced pediatric life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is required.

Equipment

In addition to the equipment previously cited for moderate sedation, an electrocardiographic monitor and a defibrillator for use in pediatric patients should be readily available.

Vascular Access

Patients receiving deep sedation should have an intravenous line placed at the start of the procedure or have a person skilled in establishing vascular access in pediatric patients immediately available.

Monitoring and Documentation

A competent individual shall observe the patient continuously. The monitoring shall include all parameters described for moderate sedation. Vital signs, including oxygen saturation and heart rate, must be documented at least every 5 minutes in a time-based record. The use of a precordial stethoscope or capnograph for patients difficult to observe (eg, during MRI, in a darkened room) to aid in monitoring adequacy of ventilation is encouraged.¹⁴³ The practitioner shall document the name, route, site, time of administration, and dosage of all drugs administered. The inspired concentrations of inhalation sedation agents and oxygen and the duration of administration shall be documented.

Postsedation Care

The facility and procedures followed for postsedation care shall conform to those described under "Moderate Sedation."

Special Considerations

Local Anesthetic Agents

All local anesthetic agents are cardiac depressants and may cause central nervous system excitation or depression. Particular attention should be paid to dosage in small children.^{64,66} To ensure that the patient will not receive an excessive dose, the maximum allowable safe dosage (ie, mg/kg) should be calculated before administration. There may be enhanced sedative effects when the highest recommended doses of local anesthetic drugs are used in combination with other sedatives or narcotics (see Tables 2 and 3 for limits and conversion tables of commonly used local anesthetics).^{64,144-157} In general, when administering local anesthetic drugs, the practitioner should aspirate frequently so as to minimize the likelihood that the needle is in a blood vessel; lower doses should be used when injecting into vascular tissues.¹⁵⁸

Pulse Oximetry

The new generation of pulse oximeters is less susceptible to motion artifacts and may be more useful than older oximeters that do not contain the updated software.¹⁵⁹⁻¹⁶³ Oximeters that change tone with changes in hemoglobin saturation provide immediate aural warning to everyone within hearing distance. It is essential that any oximeter probe is positioned properly; clip-on devices are prone to easy displacement, which may produce artifactual data (eg, under- or overestimation of oxygen saturation).^{141,142}

Capnography

Expired carbon dioxide monitoring is valuable to diagnose the simple presence or absence of respirations, airway obstruction, or respiratory depression, particularly in patients sedated in

less-accessible locations, such as magnetic resonance imaging or computerized axial tomography devices or darkened rooms.^{47,49,50,143,164-173} The use of expired carbon dioxide monitoring devices is encouraged for sedated children, particularly in situations where other means of assessing the adequacy of ventilation are limited. Several manufacturers have produced nasal cannulae that allow simultaneous delivery of oxygen and measurement of expired carbon dioxide values.^{164,165} Although these devices can have a high degree of false-positive alarms, they are also very accurate for the detection of complete airway obstruction or apnea.^{166,168,173}

Adjuncts to Airway Management and Resuscitation

The vast majority of sedation complications can be managed with simple maneuvers, such as supplemental oxygen, opening the airway, suctioning, and bag-mask-valve ventilation. Occasionally, endotracheal intubation is required for more prolonged ventilatory support. In addition to standard endotracheal intubation techniques, a number of new devices are available for the management of patients with abnormal airway anatomy or airway obstruction. Examples include the laryngeal mask airway (LMA), the cuffed oropharyngeal airway, and a variety of kits to perform an emergency cricothyrotomy.

The largest clinical experience in pediatrics is with the LMA, which is available in a variety of sizes and can even be used in neonates. Use of the LMA is now being introduced into advanced airway training courses, and familiarity with insertion techniques can be life saving.^{174,175} The LMA also can serve as a bridge to secure airway management in children with anatomic airway abnormalities.^{176,177} Practitioners are encouraged to gain experience with these techniques as they become incorporated into pediatric advanced life support courses.

An additional emergency device with which to become familiar is the intraosseous needle. Intraosseous needles also are available in several sizes and can be life saving in the rare situation when rapid establishment of intravenous access is not possible. Familiarity with the use of these adjuncts for the management of emergencies can be obtained by keeping current with resuscitation courses, such as Pediatric Advanced Life Support and Advanced Pediatric Life Support or other approved programs.

Patient Simulators

Advances in technology, particularly patient simulators that allow a variety of programmed adverse events (eg, apnea, bronchospasm, laryngospasm), response to medical interventions, and printouts of physiologic parameters, are now available. The use of such devices is encouraged to better train medical professionals to respond more appropriately and effectively to rare events.¹⁷⁸⁻¹⁸⁰

Monitoring During MRI

The powerful magnetic field and the generation of radiofrequency emissions necessitate the use of special equipment to provide continuous patient monitoring throughout the MRI scanning procedure. Pulse oximeters capable of continuous function during scanning should be used in any sedated or restrained pediatric patient. Thermal injuries can result if appropriate precautions are not taken; avoid coiling the oximeter wire and place the probe as far from the magnetic coil as possible to diminish the possibility of injury. Electrocardiogram monitoring during magnetic resonance imaging has been associated with thermal injury; special MRI-compatible ECG pads are essential to allow safe monitoring.¹⁸¹⁻¹⁸⁴ Expired carbon dioxide monitoring is strongly encouraged in this setting.

Nitrous Oxide

Inhalation sedation/analgesia equipment that delivers nitrous oxide must have the capacity of delivering 100% and never less than 25% oxygen concentration at a flow rate appropriate to the size of the patient. Equipment that delivers variable ratios of nitrous oxide to oxygen and that has a delivery system that covers the mouth and nose must be used in conjunction with a calibrated and functional oxygen analyzer. All nitrous oxide-oxygen inhalation devices should be calibrated in accordance with appropriate state and local requirements. Consideration should be given to the National Institute of Occupational Safety and Health standards for the scavenging of waste gases.¹⁸⁵ Newly constructed or reconstructed treatment facilities, especially those with piped-in nitrous oxide and oxygen, must have appropriate state or local inspections to certify proper function of inhalation sedation/analgesia systems before any delivery of patient care.

Nitrous oxide in oxygen with varying concentrations has been successfully used for many years to provide analgesia for a variety of painful procedures in children.^{15,186-210} The use of nitrous oxide for minimal sedation is defined as the administration of nitrous oxide (50% or less) with the balance as oxygen, without any other sedative, narcotic, or other depressant drug before or concurrent with the nitrous oxide to an otherwise healthy patient in ASA class I or II. The patient is able to maintain verbal communication throughout the procedure. It should be noted that although local anesthetics have sedative properties, for purposes of this guideline, they are not considered sedatives in this circumstance. If nitrous oxide in oxygen is combined with other sedating medications, such as chloral hydrate, midazolam, or an opioid, or if nitrous oxide is used in concentrations greater than 50%, the likelihood for moderate or deep sedation increases.^{211,212} In this situation, the clinician must be prepared to institute the guidelines for moderate or deep sedation as indicated by the patient's response.²¹³

Table 1. APPROPRIATE INTAKE OF FOOD AND LIQUIDS BEFORE ELECTIVE SEDATION*	
Ingested Material	Minimum Fasting Period (h)
Clear liquids: water, fruit juices without pulp, carbonated beverages, clear tea, black coffee	2
Breast milk	4
Infant formula	6
Nonhuman milk: because nonhuman milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period	6
Light meal: a light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.	6

* American Society of Anesthesiologists. Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures. A Report of the American Society of Anesthesiologists. Available at: <http://www.asahq.org/publicationsAndServices/npoguide.html>.

Table 2. COMMONLY USED LOCAL ANESTHETIC AGENTS: DOSES, DURATION, AND CALCULATIONS*			
Local Anesthetic	Maximum Dose with Epinephrine (mg/kg)†		Duration of Action (min) ‡
	Medical	Dental	
<i>Esters</i>			
Procaine	10.0	6	60-90
Chlorprocaine	20.0	12	30-60
Tetracaine	1.5	1	180-600
<i>Amides</i>			
Lidocaine	7.0	4.4	90-200
Mepivacaine	7.0	4.4	120-240
Bupivacaine	3.0	1.3	180-600
Levobupivacaine	3.0	2	180-600
Ropivacaine	3.0	2	180-600
Articaine		7	60-230

* Maximum recommended doses and duration of action. Note that lower doses should be used in very vascular areas.

† These are maximum doses of local anesthetics combined with epinephrine; lower doses are recommended when used without epinephrine. Doses of amides should be decreased by 30% in infants younger than 6 months. When lidocaine is being administered intravascularly (eg, during intravenous regional anesthesia), the dose should be decreased to 3 to 5 mg/kg; long-acting local anesthetic agents should not be used for intravenous regional anesthesia.

‡ Duration of action is dependent on concentration, total dose, and site of administration; use of epinephrine; and the patient's age.

Table 3. LOCAL ANESTHETIC PERCENT CONCENTRATION: CONVERSION TO mg/mL	
Concentration (%)	mg/mL
3.0	30.0
2.5	25.0
2.0	20.0
1.0	10.0
0.5	5.0
0.25	2.5
0.125	1.25

Appendix A. Recommended Discharge Criteria

1. Cardiovascular function and airway patency are satisfactory and stable.
2. The patient is easily arousable, and protective reflexes are intact.
3. The patient can talk (if age appropriate).
4. The patient can sit up unaided (if age appropriate).
5. For a very young or handicapped child incapable of the usually expected responses, the premedication level of responsiveness or a level as close as possible to the normal level for that child should be achieved.
6. The state of hydration is adequate.

Appendix B. ASA Physical Status Classification

Class I	A normally healthy patient.
Class II	A patient with mild systemic disease (eg, controlled reactive airway disease).
Class III	A patient with severe systemic disease (eg, a child who is actively wheezing).
Class IV	A patient with severe systemic disease that is a constant threat to life (eg, a child with status asthmaticus).
Class V	A moribund patient who is not expected to survive without the operation (eg, a patient with severe cardiomyopathy requiring heart transplantation).

Appendix C. Drugs* That May Be Needed to Rescue a Sedated Patient⁴⁴

Albuterol for inhalation
 Ammonia spirits
 Atropine
 Diphenhydramine
 Diazepam
 Epinephrine (1:1000, 1:10 000)
 Flumazenil
 Glucose (25% or 50%)
 Lidocaine (cardiac lidocaine, local infiltration)
 Lorazepam
 Methylprednisolone
 Naloxone
 Oxygen
 Fosphenytoin
 Racemic epinephrine
 Rocuronium
 Sodium bicarbonate
 Succinylcholine

* The choice of emergency drugs may vary according to individual or procedural needs.

Appendix D. Emergency Equipment[†] That May Be Needed to Rescue a Sedated Patient[‡]**Intravenous Equipment**

Assorted IV catheters (eg, 24-, 22-, 20-, 18-, 16-gauge)
 Tourniquets
 Alcohol wipes
 Adhesive tape
 Assorted syringes (eg, 1-, 3-, 5-, 10-mL)
 IV tubing
 Pediatric drip (60 drops/mL)
 Pediatric burette
 Adult drip (10 drops/mL)
 Extension tubing
 3-way stopcocks
 IV fluid
 Lactated Ringer solution
 Normal saline solution
 D₅ 0.25 normal saline solution
 Pediatric IV boards
 Assorted IV needles (eg, 25-, 22-, 20-, and 18-gauge)
 Intraosseous bone marrow needle
 Sterile gauze pads

Airway Management Equipment

Face masks (infant, child, small adult, medium adult, large adult)
 Breathing bag and valve set
 Oropharyngeal airways (infant, child, small adult, medium adult, large adult)
 Nasopharyngeal airways (small, medium, large)
 Laryngeal mask airways (1, 1.5, 2, 2.5, 3, 4, and 5)
 Laryngoscope handles (with extra batteries)
 Laryngoscope blades (with extra light bulbs)
 Straight (Miller) No. 1, 2, and 3
 Curved (Macintosh) No. 2 and 3
 Endotracheal tubes (2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, and 6.0 uncuffed and 6.0, 7.0, and 8.0 cuffed)
 Stylettes (appropriate sizes for endotracheal tubes)
 Surgical lubricant
 Suction catheters (appropriate sizes for endotracheal tubes)
 Yankauer-type suction
 Nasogastric tubes
 Nebulizer with medication kits
 Gloves (sterile and nonsterile, latex free)

[†] The choice of emergency equipment may vary according to individual or procedural needs.

[‡] The practitioner is referred to the SOAPME acronym described in the text in preparation for sedating a child for a procedure.

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American Academy of Sleep Medicine

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Dear Dr. Hall:

By way of introduction, my name is Sam Fleishman, MD, and I am the President of the American Academy of Sleep Medicine (AASM). The purpose of my letter is to solicit your professional opinion on a scope of practice issue regarding dentists licensed in the state of Virginia.

As context, following is background information on sleep medicine, specifically the diagnosis and treatment of obstructive sleep apnea (OSA), which you may find useful in considering my inquiry. Sleep medicine is recognized as a medical subspecialty by the American Board of Medical Specialists (ABMS). To this end, there is a board certification examination offered in sleep medicine by the ABMS and fellowship training programs for resident physicians accredited by the Accreditation Council for Graduate Medical Education. As such, sleep medicine physicians are educated, trained and credentialed to treat the full breadth of sleep disorders, including OSA.

OSA is a prevalent medical disease identified in more than 4 percent of men and 2 percent of women. It is often accompanied by one or more co-morbid conditions that impact the patient's overall health. OSA is characterized by repetitive episodes of complete (apnea) or partial (hypopnea) upper airway obstruction during sleep. These events often result in reductions in blood oxygen saturation and are usually terminated by brief arousals from sleep. Most events are 10 to 30 seconds in duration but occasionally persist for one minute or longer. An apnea-hypopnea index (AHI) is the number of apneas plus the number of hypopneas per hour of sleep. OSA is defined as an AHI of greater than five with a complaint of excessive daytime sleepiness.

Sleep apnea is diagnosed by a licensed physician who has interpreted a sleep study that is conducted either by an overnight in-laboratory test known as polysomnography, which monitors 16 independent parameters, or an out-of-center test often referred to as a home sleep test, which monitors 3-4 independent parameters. A physician, using home sleep testing devices, has considerably less information from which to make their diagnosis which increases the need for specific training and patient evaluation. In most cases, the first-line treatment for OSA is Continuous Positive Airway Pressure (CPAP), which has been validated extensively through peer-reviewed evidence. Select patients who are intolerant of CPAP or have a mild case of OSA may utilize oral appliance therapy (OAT) for management of OSA. In instances where a patient uses OAT, the sleep medicine physician will conduct the sleep test and interpret its results; diagnose the patient

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with OSA; and write a prescription for OAT. At this point the physician and dentist work together managing the treatment.

The oral appliance is configured and fitted by a dentist. An oral appliance is considered Durable Medical Equipment (DME) and is reimbursed similar to other types of DME equipment.

We understand that language in Virginia's dental practice act states:

"Dentistry" means the evaluation, diagnosis, prevention, and treatment, through surgical, nonsurgical or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent and associated structures and their impact on the human body;

Recently, some dentists who provide patients with OAT, per the written order of a board certified sleep medicine physician, have made claims via advertisements and public forums that dentists are within their scope of practice to diagnose sleep apnea by utilizing home sleep tests. This opinion has in large part been fostered by various marketing companies that sell testing equipment and oral appliances.

It is the position of the AASM that a home sleep test is a diagnostic test conducted for the sole purpose of determining a medical disease and can only be ordered and interpreted by a licensed physician. Further we are of the opinion that a licensed dentist is practicing outside the limits of their license to prescribe, conduct and interpret a medical test. We feel very strongly that this particular practice by dentists is false, misleading and deceptive and frankly dangerous to the public. Further it plays on the vanity and possible fear of the public and promotes a substandard practice model for sleep medicine.

The AASM is also of the opinion that a licensed sleep medicine physician is not within their scope of practice to fit an oral appliance. This is the venue of a licensed dentist.

I am asking that the Virginia Board of Dentistry render an opinion on this issue according to language in the practice act referenced above. It is not our intent to pursue any adverse licensing action against any dentists. Rather, it is our intent to use the opinion of the licensing board for educational awareness purposes among our Board of Directors.

We certainly appreciate your consideration of this request. If there is any additional information you need please feel free to contact me directly or the AASM Executive Director, Mr. Jerry Barrett, at (630) 737-9700 or jbarrett@aasmnet.org.

I look forward to your response.

Sincerely,



Samuel A. Fleishman, MD
President

cc: Jerome A. Barrett, Executive Director

Reen, Sandra (DHP)

Subject: FW: Sleep Apnea

From: Richard Berry [<mailto:rberry@aaoms.org>]

Sent: Wednesday, November 07, 2012 2:26 PM

To: Board of Dentistry

Subject: Sleep Apnea

We are writing from the American Association of Oral and Maxillofacial Surgeons (AAOMS). AAOMS is the leading national professional organization of oral and maxillofacial surgeons representing some 9,000 members in the United States.

We have been asked to survey the state dental boards to determine whether dentist oral and maxillofacial surgeons can diagnose and treat sleep apnea. Any information you can provide about Virginia including any policy statement would be greatly appreciated.

Thank you in advance for your assistance.

Richard M. Berry
American Association of Oral and Maxillofacial Surgeons
9700 West Bryn Mawr Avenue
Rosemont, Illinois 60018-5701
(800) 822-6637 extension 4302

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Snoring and Sleep Apnea

People who snore loudly are often the target of bad jokes and middle of the night elbow thrusts; but snoring is no laughing matter. While loud disruptive snoring is at best a social problem that may strain relationships, for many men, women and even children, loud habitual snoring may signal a potentially life threatening disorder: obstructive sleep apnea, or OSA.



Snoring Is Not Necessarily Sleep Apnea

It is important to distinguish between snoring and OSA. Many people snore. It's estimated that approximately 30% to 50% of the US population snore at one time or another, some significantly. Everyone has heard stories of men and women whose snoring can be heard rooms away from where they are sleeping.

Snoring of this magnitude can cause several problems, including marital discord, sleep disturbances and waking episodes sometimes caused by one's own snoring. But, snoring does not always equal OSA; sometimes it is only a social inconvenience. Still, even a social inconvenience can require treatment, and there are several options available to chronic snorers.

Some non-medical treatments that may alleviate snoring include:

Weight loss — as little as 10 pounds may be enough to make a difference.

Change of sleeping position — Because you tend to snore more when sleeping on your back, sleeping on your side may be helpful.

Avoid alcohol, caffeine and heavy meals — especially within two hours of bedtime.

Avoid sedatives — which can relax your throat muscles and increase the tendency for airway obstruction related to snoring.

Your doctor has other treatment options, including the following:

Radio Frequency (RF) of the Soft Palate uses radio waves to shrink the tissue in the throat or tongue, thereby increasing the space in the throat and making airway obstruction less likely. Over the course of several treatments the inner tissue shrinks while the outer tissue remains unharmed. Several treatments may be required, but the long-term success of this procedure has not as yet been determined.

Laser-Assisted Uvuloplasty (LAUP) is a surgical procedure that removes the uvula and surrounding tissue to open the airway behind the palate. This procedure is generally used to relieve

The Oral and Maxillofacial Surgeon

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Snoring and Sleep Apnea

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ORAL AND MAXILLOFACIAL SURGEONS: AN IMPORTANT LINK

Oral and maxillofacial surgeons are the only dental specialists recognized by the American Dental Association who are surgically trained in a hospital-based residency program for a minimum of four years. OMSs train alongside medical residents in internal medicine, general surgery and anesthesiology, and spend time in otolaryngology, plastic surgery, emergency medicine and other specialty areas. Their training focuses almost exclusively on the hard (ie,

snoring and can be performed in the Oral and Maxillofacial Surgeon's office with local or general anesthesia.

Identifying and Treating OSA

Unlike simple snoring, obstructive sleep apnea is a potentially life-threatening condition that requires medical attention. The risks of undiagnosed OSA include heart attack, stroke, irregular heartbeat, high blood pressure, heart disease and decreased libido. In addition, OSA causes daytime drowsiness that can result in accidents, lost productivity and interpersonal relationship problems. The symptoms may be mild, moderate or severe.

Sleep apnea is fairly common. One in five adults has at least mild sleep apnea and one in 15 adults has at least moderate sleep apnea. OSA also affects 1% to 3% of children. During sleep, the upper airway can be obstructed by excess tissue, large tonsils and/or a large tongue. Also contributing to the problem may be the airway muscles, which relax and collapse during sleep, nasal passages, and the position of the jaw.

The cessation of breathing, or "apnea," brought about by these factors initiates impulses from the brain to awaken the person just enough to restart the breathing process. This cycle repeats itself many times during the night and may result in sleep deprivation and a number of health-related problems. Sleep apnea is generally defined as the presence of more than 30 apneas during a seven hour sleep. In severe cases, periods of not breathing may last for as long as 60 to 90 seconds and may recur up to 500 times a night.

Symptoms of Sleep Apnea

Those who have OSA are often unaware of their condition and think they sleep well. The symptoms that usually cause these individuals to seek help are daytime drowsiness or complaints of snoring and breathing cessations observed by a bed partner. Other symptoms may include:

- Snoring with pauses in breathing (apnea)
- Excessive daytime drowsiness
- Gasping or choking during sleep
- Restless sleep
- Problem with mental function
- Poor judgment/can't focus
- Memory loss
- Quick to anger
- High blood pressure
- Nighttime chest pain
- Depression
- Problem with excess weight
- Large neck (>17" around in men, >16" around in women)
- Airway crowding
- Morning headaches
- Reduced libido
- Frequent trips to the bathroom at night

Diagnosing Sleep Disorders

If you exhibit several OSA symptoms, it's important you visit your Oral and Maxillofacial Surgeon for a complete examination and an accurate diagnosis.

At your first visit, your doctor will take a medical history and perform a head and neck examination looking for problems that might contribute to sleep-related breathing problems. An interview with your bed partner or other household members about your sleeping and waking behavior may be in order. If the doctor suspects a sleep disorder, you will be referred to a sleep clinic, which will monitor your nighttime sleep patterns through a special test called polysomnography.

Polysomnography will require you to sleep at the clinic overnight while a video camera monitors your sleep pattern and gathers data about the number and length of each breathing cessation or other

bone) and soft (ie, skin, muscle) tissue of the face, mouth, and jaws. Their knowledge and surgical expertise uniquely qualifies them to diagnose and treat the functional and esthetic conditions in this anatomical area. The scope of oral and maxillofacial surgery practice includes, among others:

- Outpatient Anesthesia
- Dentoalveolar Surgery to manage diseases of the teeth and their supporting soft and hard tissues
- Surgical Correction of Maxillofacial Skeletal Deformities
- Cleft and Craniofacial Surgery
- Facial Trauma Surgery
- Temporomandibular Joint Surgery
- Pathologic Conditions, such as head and neck cancer
- Facial Reconstructive Surgery
- Facial Cosmetic Surgery

For more information about oral and maxillofacial surgery or to find a surgeon in your community, visit [Find a Surgeon](#) at aaoms.org, or call the American Association of Oral and Maxillofacial Surgeons at 847/678-6200.

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problems that disturb your sleep. Often a "split night" study is done during which a C-PAP (continuous positive airway pressure) device is used. During polysomnography, every effort is made to limit disturbances to your sleep.

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Treating Sleep Apnea

Obstructive sleep apnea can be effectively treated. Depending on whether your OSA is mild, moderate or severe, your doctor will select the treatment that is best for you.

American Association of Oral and
Maxillofacial Surgeons
9700 West Bryn Mawr Avenue,
Rosemont, Illinois 60018-5701
Phone 847-678-6200 or 800-822-6637 |
Fax 847-678-6286

Behavior Modification - If you are diagnosed with mild sleep apnea, your doctor may suggest you employ the non-medical treatments recommended to reduce snoring: weight loss; avoiding alcohol, caffeine and heavy meals within two hours of bedtime; no sedatives; and a change of sleeping positions. In mild cases, these practical interventions may improve or even cure snoring and sleep apnea.

Oral Appliances - If you have mild to moderate sleep apnea, or are unable to use C-PAP, recent studies have shown that an oral appliance can be an effective first-line therapy. The oral appliance is a molded device that is placed in the mouth at night to hold the lower jaw and bring the tongue forward. By bringing the jaw forward, the appliance elevates the soft palate or retains the tongue to keep it from falling back in the airway and blocking breathing. Although not as effective as the continuous positive airway pressure (C-PAP) systems, oral appliances are indicated for use in patients with mild to moderate OSA who prefer oral appliances, who do not respond to C-PAP, are not appropriate candidates for C-PAP, or who fail treatment attempts with C-PAP or behavioral changes.

Patients using an oral appliance should have regular follow-up office visits with their Oral and Maxillofacial Surgeon to monitor compliance, to ensure the appliance is functioning correctly and to make sure their symptoms are not worsening.

C-PAP (Continuous Positive Airway Pressure) and Bi-PAP (Bi-Level) - A C-PAP device is an effective treatment for patients with moderate OSA and the first-line treatment for those diagnosed with severe sleep apnea. Through a specially fitted mask that fits over the patient's nose, the C-PAP's constant, prescribed flow of pressured air prevents the airway or throat from collapsing. In some cases a Bi-PAP device, which blows air at two different pressures, may be used.

While C-PAP and Bi-PAP devices keep the throat open and prevent snoring and interruptions in breathing, they only treat your condition and do not cure it. If you stop using the C-PAP or Bi-PAP, your symptoms will return. Although C-PAP and Bi-PAP are often the first treatments of choice, they may be difficult for some patients to accept and use. If you find you are unable to use these devices, do not discontinue their use without talking to your doctor. Your Oral and Maxillofacial Surgeon can suggest other effective treatments.

Surgery for Sleep Apnea

Surgical intervention may be a viable alternative for some OSA patients; however, it is important to keep in mind that no surgical procedure is universally successful. Every patient has a different shaped nose and throat, so before surgery is considered your Oral and Maxillofacial Surgeon will measure the airway at several points and check for any abnormal flow of air from the nose to lungs. Be assured, your doctor has considerable experience and the necessary training and skill to perform the following surgical procedures:

Uvulopalatopharyngoplasty (UPPP) - If the airway collapses at the soft palate, a UPPP may be helpful. UPPP is usually performed on patients who are unable to tolerate the C-PAP. The UPPP procedure shortens and stiffens the soft palate by partially removing the uvula and reducing the edge of the soft palate.

Hyoid Suspension - If collapse occurs at the tongue base, a hyoid suspension may be indicated. The hyoid bone is a U-shaped bone in the neck located above the level of the thyroid cartilage (Adam's apple) that has attachments to the muscles of the tongue as well as other muscles and soft

tissues around the throat. The procedure secures the hyoid bone to the thyroid cartilage and helps to stabilize this region of the airway.

Genioglossus Advancement (GGA) - GGA was developed specifically to treat obstructive sleep apnea, and is designed to open the upper breathing passage. The procedure tightens the front tongue tendon; thereby, reducing the degree of tongue displacement into the throat. This operation is often performed in tandem with at least one other procedure such as the UPPP or hyoid suspension.

Maxillomandibular Advancement (MMA) - MMA is a procedure that surgically moves the upper and lower jaws forward. As the bones are surgically advanced, the soft tissues of the tongue and palate are also moved forward, again opening the upper airway. For some individuals, the MMA is the only technique that can create the necessary air passageway to resolve their OSA condition.

Talk With Your Doctor

Sleep apnea is a serious condition and individuals with OSA may not be aware they have a problem. If someone close to you has spoken of your loud snoring and has noticed that you often wake up abruptly, gasping for air, you should consult your Oral and Maxillofacial Surgeon.

The information provided here is not intended as a substitute for professional medical advice, diagnosis, or treatment. It is provided to help you communicate effectively with your oral and maxillofacial surgeon. Always seek the advice of your oral and maxillofacial surgeon regarding an oral health concern.

The American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization representing more than 9,000 oral and maxillofacial surgeons in the United States, supports its members' ability to practice their specialty through education, research and advocacy. AAOMS members comply with rigorous continuing education requirements and submit to periodic office examinations, ensuring the public that all office procedures and personnel meet stringent national standards.

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Patient Resources

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Obstructive Sleep Apnea

Obstructive sleep apnea is very common and potentially life-threatening medical disorder that prevents airflow during sleep. More than 18 million Americans have sleep apnea, and many are not receiving treatment.

Sleep apnea occurs when tissue in the back of the throat collapses and blocks the airway, reducing the amount of oxygen delivered to all of your organs including your heart and brain. People with sleep apnea may snore loudly and stop breathing for short periods of time. When the blood-oxygen level drops low enough, the body momentarily wakes up. It can happen so fast that you may not be aware you woke up. This can happen hundreds of times a night, and you may wake up in the morning feeling unrefreshed.

In addition to snoring and excessive daytime sleepiness, sleep apnea can cause memory loss, morning headaches, irritability, depression, decreased sex drive and impaired concentration. Sleep apnea patients have a much higher risk of stroke and heart problems, such as heart attack, congestive heart failure and hypertension. Sleep apnea patients are also more likely to be involved in an accident at the workplace or while driving.

Signs of Sleep Apnea

Sleep apnea patients are often older, obese and have thick necks, but men and women of any age or body type can have sleep apnea. The sleep disorder progressively worsens with age and weight gain. Listed below are some common signs of sleep apnea:

- Unintentionally falling asleep during the day
- General daytime sleepiness
- Unrefreshed sleep
- Fatigue
- Insomnia
- Waking from sleep with a choking sound or gasping for breath
- Loud snoring

If you have these symptoms, you might have sleep apnea. The Epworth Sleepiness Scale can help you further determine if you likely have sleep apnea. If the scale shows you may have sleep apnea, schedule an appointment at an AASM Accredited Sleep Center for an overnight sleep study.

Diagnosing Sleep Apnea

A physician is required to perform an overnight sleep study to properly diagnose obstructive sleep apnea. The test, also known as a Polysomnogram, will chart your brain waves, heart beat and breathing during sleep. It also records arm and leg movement.

A sleep specialist will look for other conditions that may mimic or worsen the symptoms of OSA, such as:

- Another sleep disorder
- A medical condition
- Medication use
- A mental health disorder
- Substance abuse

A sleep specialist will take your symptoms into consideration during diagnosis. Prior to the appointment, ask your partner if you snore loudly, stop breathing or gasp for breath during the night. The sleep specialist will also want to know if you gained weight or stopped exercising before your symptoms began.

The sleep specialist may ask you to keep a sleep diary for two weeks to track the following information.

- What time you went to bed each night
- What time you got up in the morning
- How many times you woke up during the night
- Whether you felt rested when you woke up
- If you took naps during the day
- Whether you felt sleepy or rested throughout the day

Treatment Options

Once you are diagnosed with obstructive sleep apnea, a trained AADSM dental sleep specialist near you can provide treatment using the following methods:

- Oral Appliance Therapy
- Upper Airway Surgery

These techniques may be used alone or in combination with other treatments for sleep apnea, including behavioral changes or CPAP. Behavioral therapies include weight loss, avoidance of alcohol and tobacco and sleeping on your side, and may reduce the severity of sleep apnea.

[Find an AADSM Dentist Near You](#)



AMERICAN ACADEMY OF SLEEP MEDICINE

Setting Standards & Promoting Excellence in Sleep Medicine

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AASM and AADSM release joint statement

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American Academy of Sleep Medicine
 Friday, November 09, 2012

As the number of dentists providing oral appliance therapy has increased in recent years, the American Academy of Sleep Medicine (AASM) and American Academy of Dental Sleep Medicine (AADSM) have received inquiries that seek clarification regarding the scope of practice for physicians and dentists in the diagnosis and treatment of obstructive sleep apnea (OSA).

The AADSM and AASM have collaboratively developed a joint policy statement on the diagnosis and treatment of OSA, which provides necessary guidance and emphasizes the distinguishing facets of medical and dental licensing laws and practice acts. The new policy has been sent to medical and dental licensing boards in every state for information and reference when similar inquiries are received on a state level.

[View Joint Policy Statement on the Diagnosis and Treatment of Obstructive Sleep Apnea](#)

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 Members: \$20.00
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American Academy of Sleep Medicine

American Academy of Dental Sleep Medicine



**AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE AND AMERICAN ACADEMY OF SLEEP MEDICINE JOINT
POLICY STATEMENT ON THE DIAGNOSIS AND TREATMENT OF OBSTRUCTIVE SLEEP APNEA**

The American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) are committed to the highest standards for sleep medicine care and ensuring patients receive quality care for obstructive sleep apnea (OSA).

OSA is a highly prevalent syndrome associated with deleterious medical conditions such as hypertension, stroke and congestive heart failure as well as health concerns such as increased motor vehicle accidents and impaired quality of life¹; it is classified as a medical disorder.

The Diagnosis of Obstructive Sleep Apnea

It is the policy of the AASM and AADSM that patients presenting with symptoms of OSA require a face-to-face evaluation conducted by a qualified physician trained in sleep medicine. The AASM defines a qualified physician trained in sleep medicine as one who is licensed by a state to practice medicine and maintains certification from the American Board of Sleep Medicine or one of the sponsoring sleep medicine boards of the American Board of Medical Specialties.

Treatment Therapies for Obstructive Sleep Apnea

Therapies for OSA, including positive airway pressure (PAP) and oral appliance therapy (OAT), must be prescribed by a qualified physician as described above.

Qualified dentists with training and experience in the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures should fit the oral appliance device² as a therapy for OSA. Furthermore, dentists treating patients with OAT must practice within their scope of practice according to dental practice laws in their respective state. The AADSM defines a qualified dentist as one who maintains certification from the American Board of Dental Sleep Medicine³, or one who is the director of an AADSM-accredited dental facility and has completed 30 hours of continuing education (ADA CERP recognized or AGD PACE approved) within the past three years. With regard to continuing education, a minimum of 20 credits must be in dental sleep medicine. Additional credits must be sleep medicine related.

All qualified dentists must follow current AASM Practice Parameters and Clinical Guidelines and current AADSM Treatment Protocols.

Medical and Dental Licensing Laws and Practice Acts

The practice of medicine is governed by state licensing laws, which are commonly referred to as enabling laws. Enabling laws have a corresponding practice act, which governs the practice of medicine in the respective state; without this act any individual, regardless of qualifications, can practice medicine without restriction or penalty. The practice act also defines the scope and limits of practice for physicians. Because medicine is an ever-changing field, each practice act

expires within a set period of time, which enables the state legislature to ensure that the respective laws are reflective of current medical practice.

Common provisions addressed by a practice act include but are not limited to:

- Provides for the delegation of patient care services to other professionals practicing within the scope of their license
- Outlines requirements for collaboration between physicians or dentists with other professionals
- Prohibits fee splitting
- Specifies limits for advertising
- Specifies requirements for continuing medical education and fitness for licensure
- Outlines terms of each license and conditions for renewal
- Specifies penalties for practicing medicine without a license or beyond the scope of license
- Outlines disciplinary action that can be taken including restriction, suspension or revocation of license

All medical practice acts restrict the diagnosis of a medical disease or disorder to a licensed physician. An individual who is not licensed in medicine yet diagnoses a medical disease or disorder is subject to civil and criminal law.

Medical practice laws and practice acts, however, do not include provisions for the performance of any dental operation.

Similar to medicine, licensing laws and practice acts for dentists include scope of practice and provisions for care.

Dental practice acts specify common provision that the performance of any dental operation upon the oral cavity, teeth or associated structure as well as the construction and fit of any appliance used in the oral cavity is under the purview of a licensed dentist.

Common provisions addressed by a dental practice act include but are not limited to:

- Provides for the delegation of patient care services to other professionals practicing within the scope of their license
- Specifies requirements for continuing medical education and fitness for licensure
- Outlines terms of each license and conditions for renewal
- Specifies penalties for practicing dentistry without a license or beyond the scope of license
- Outlines disciplinary action that can be taken including restriction, suspension or revocation of license
- Outlines the dentist's purview to take dental impressions for patients

Dental licensing laws and practice acts, however, do not include provisions for the diagnosis of medical diseases and disorders or the treatment of diseases by dentists without a prescription from a board certified physician. An individual who is not licensed in dentistry yet provides therapy related to the oral cavity is subject to civil and criminal law.

ⁱ Luyster FS; Strollo PJ; Zee PC; Walsh JK. Sleep: a health imperative. *SLEEP* 2012;35(6):727-734.

ⁱⁱ Kushida CA; Morgenthaler TI; Littner MR et al. Practice parameters for the treatment of snoring and obstructive sleep apnea with oral appliances: An Update for 2005. *SLEEP* 2006;29(2): 240-243.

ⁱⁱⁱ Certification by the American Board of Dental Sleep Medicine must be achieved on or prior to January 1, 2018.

VIRGINIA:

BEFORE THE BOARD OF DENTISTRY

IN RE: [REDACTED]

ORDER

Pursuant to §§ 2.2-4019, 2.2-4021 and 54.1-2400(10) of the Code of Virginia (1950), as amended (the "Code"), a Special Conference Committee ("Committee") of the Board of Dentistry ("Board"), [REDACTED], met on November 16, 2007, in Henrico County, Virginia, to receive and act upon evidence that [REDACTED] D.D.S., may have violated certain laws and regulations governing the practice of dentistry in Virginia. [REDACTED]

[REDACTED] Upon consideration of the evidence presented, the Committee adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. [REDACTED], D.D.S., was issued License No. [REDACTED] by the Virginia Board to practice dentistry in the Commonwealth of Virginia. Said license is currently active and will expire on March 31, 2008, unless renewed or restricted.

2. Dr. [REDACTED] violated § 54.1-2706(5), (11), and (12) [*formerly Sections 54.1-2706.A(5), (10), and (11)*] of the Code, in that, from approximately 1997 to 2004, he practiced outside the scope of dentistry and/or failed to conform to acceptable standards of care when he treated Patients A-E, G, H, and J-Q for obstructive sleep apnea without first obtaining a diagnosis of that condition by a physician.

3. Dr. [REDACTED] violated § 54.1-2706(5) and (11) [*formerly Sections 54.1-2706.A(5) and (10)*] of the Code, in that he failed to obtain a follow-up polysomnography to

determine the efficacy of the oral appliance with which he treated Patients F, I, and Q for obstructive sleep apnea.

4. Dr. [REDACTED] violated § 54.1-2706(4) of the Code, and 18 VAC 60-20-170(1) and (2) of the Regulations Governing the Practice of Dentistry, in that he fraudulently obtained the consent of Patients A-C, E, G, and J-O to treatment for sleep apnea. Specifically, his written consent forms state that sleep apnea is a medical condition that must be diagnosed by a physician and that patients who have not been referred by a physician will be referred for a comprehensive physical exam prior to treatment. However, Patients A-C, E, G, and J-O were not diagnosed by, or referred for a physical exam to, a physician prior to Dr. [REDACTED] treating them for sleep apnea.

5. Dr. [REDACTED] violated § 54.1-2706(7) of the Code, and 18 VAC 60-20-180.F(1), (2), and (4) of the Regulations Governing the Practice of Dentistry, in that he engaged in advertising that is expressly or implicitly false, deceptive, misleading, and/or contains claims of superiority. Specifically:

- a. Dr. [REDACTED] published or caused to be published in the [REDACTED] [REDACTED] on or about August 30, 2006, an advertisement entitled "Attention SLEEP APNEA Sufferers!" that states:

A local Doctor's [Dr. [REDACTED]] shocking new free report reveals the real truth about Sleep Apnea and why you don't have to wear CPAP ever again! If you've been told you do not have any other options, and are stuck with CPAP, and feeling like your lungs are being blown out, you've been misinformed! That's right, you'll never again have to worry about the noise, claustrophobia, sore nose, or the dried out mouth & throat, and

repeated upper respiratory infections!!... Don't suffer irritating, uncomfortable CPAP anymore. **YOU DON'T HAVE TO!!!**

b. The free report referred to in the foregoing ad, entitled "The Truth About Sleep Apnea—How to find a dentist who treats Sleep Apnea Quickly, Predictably and Well", states that the purpose of the report is "to help you get the best tolerated, most comfortable treatment for Sleep Apnea", a claim of superior treatment that is not substantiated. The report states that although "[t]he usual recommendation is that you first have a full sleep test to figure out if you have Sleep Apnea, I [Dr. [REDACTED]] personally disagree with that approach, for several reasons", including the fact that "[m]ost sleep laboratories are very backed up and cannot schedule your diagnostic test for about six months", another claim that is not substantiated. The report also states that "I prefer to treat you right away with an Oral Appliance. There is plenty of time for a sleep test later." These statements imply persons with suspected sleep apnea should be treated before they have a definitive diagnostic test, a protocol that is contrary to accepted standards of practice.

6. Dr. [REDACTED] violated § 54.1-2706(5) of the Code, in that he allowed his two dogs to run free throughout his home office while treating patients. By letter dated April 29, 2005, to the Better Business Bureau of Western Virginia, Dr. [REDACTED] stated that the dogs have free rein of the "whole house" and greet patients when they arrive at his practice.

ORDER

WHEREFORE, on the basis of the foregoing Findings of Fact and Conclusions of Law, the Committee, effective upon entry of this Order, hereby ORDERS that [REDACTED] [REDACTED], D.D.S., shall be issued a REPRIMAND.

It is further ORDERED that, commencing within six (6) months from the date the Order becomes final and continuing thereafter for approximately two (2) years, Dr. [REDACTED] practice shall be the subject of four (4) unannounced inspections by an inspector of the Department of Health Professions, each occurring at approximate six-month intervals or as determined at the discretion of the Board. Such inspections shall be conducted during normal business hours and shall include a review of Dr. [REDACTED] office and equipment, and may include an interview with staff. At each inspection, Dr. [REDACTED] shall make his patient dental and/or billing records available to the inspector, and the inspector shall obtain and copy a sample of ten (10) of Dr. [REDACTED] records for patients receiving treatment for obstructive sleep apnea. The records selected should contain entries occurring after the date this Order becomes final, and should include all prescription records and billing records. Dr. [REDACTED] is solely responsible for the payment of a three hundred and fifty dollar (\$350.00) inspection fee to be paid to the Board within thirty (30) days of each inspection. In the event that any such inspection reveals a possible violation of the laws or regulations pertaining to the practice of dentistry in Virginia, or Chapter 34 of Title 54.1 (§§ 54.1-3400 et seq. Virginia Drug Control Act)

of the Code of Virginia (1950), as amended, the Board specifically reserves the right to conduct further proceedings in this matter.

It is further ORDERED that [REDACTED], D.D.S., shall be assessed a MONETARY PENALTY of eleven thousand dollars (\$11,000.00), to be paid to the Board by certified check or money order within thirty-three (33) days from the date this Order becomes final. Failure to pay the full monetary penalty within the time frame stipulated shall constitute grounds for an administrative proceeding.

Violation of this Order may constitute grounds for suspension or revocation of Dr. [REDACTED] license, and an administrative proceeding may be convened to determine whether his license shall be suspended or revoked.

Pursuant to §§ 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public release, inspection and copying upon request.

If [REDACTED], D.D.S., does not consent to the Committee's decision and desires a formal hearing before the Board or a panel thereof, he shall notify, in writing, Sandra K. Reen, Executive Director, Board of Dentistry, Perimeter Center, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233-1463 within thirty-three (33) days from the date of entry of this Order. This Order shall become final upon the expiration of the thirty-three day period unless a written request for a formal hearing is received within such time. Upon receiving timely request for a hearing, the Board or

panel thereof shall then proceed with a hearing as provided in §§ 2.2-4020 and 2.2-4021
of the Code.

FOR THE COMMITTEE

Sandra K. Reen
Executive Director
Virginia Board of Dentistry

ENTERED

Reen, Sandra (DHP)

Subject: FW: RE: Issues facing our Board
Attachments: image001.png; image002.png

Nov 2, 2012 04:52:31 PM, Patrick.Braatz@state.or.us wrote:

**** Corporate ownership of dental practices by non-dentists. Are you seeing an influx of dental practices owned, "operated", or managed by non-dentists? Does your state have laws, regulations, statutes preventing such ownership? Are you considering promulgating such laws as to prevent this? Would you provide me with the current language or the language that is being proposed? Does your state have any specific language concerning how long the survivors can own/manage the dental practice after the death of a dentist?**

Oregon does not truly have corporate ownership as only a dentist can own a dental practice with some exceptions:

679.020 Practice of dentistry or conducting dental office without license prohibited; exceptions. (1) A person may not practice dentistry without a license.

(2) Only a person licensed as a dentist by the Oregon Board of Dentistry may own, operate, conduct or maintain a dental practice, office or clinic in this state.

(3) The restrictions of subsection (2) of this section, as they relate to owning and operating a dental office or clinic, do not apply to a dental office or clinic owned or operated by any of the following:

(a) A labor organization as defined in ORS 243.650 and 663.005 (6), or to any nonprofit organization formed by or on behalf of such labor organization for the purpose of providing dental services. Such labor organization must have had an active existence for at least three years, have a constitution and bylaws, and be maintained in good faith for purposes other than providing dental services.

(b) The School of Dentistry of the Oregon Health and Science University.

(c) Public universities listed in ORS 352.002.

(d) Local governments.

(e) Institutions or programs accredited by the Commission on Dental Accreditation of the American Dental Association to provide education and training.

(f) Nonprofit corporations organized under Oregon law to provide dental services to rural areas and medically underserved populations of migrant, rural community or homeless individuals under 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(l)(2)(B) operating in compliance with other applicable state and federal law.

(g) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as providing dental services by volunteer licensed dentists to populations with limited access to dental care at no charge or a substantially reduced charge.

(4) For the purpose of owning or operating a dental office or clinic, an entity described in subsection (3) of this section must:

(a) Name an actively licensed dentist as its dental director, who shall be subject to the provisions of ORS 679.140 in the capacity as dental director. The dental director, or an actively licensed dentist designated by the director, shall have responsibility for the clinical practice of dentistry, which includes, but is not limited to:

(A) Diagnosis of conditions within the human oral cavity and its adjacent tissues and structures.

(B) Prescribing drugs that are administered to patients in the practice of dentistry.

- (C) The treatment plan of any dental patient.
- (D) Overall quality of patient care that is rendered or performed in the practice of dentistry.
- (E) Supervision of dental hygienists, dental assistants or other personnel involved in direct patient care and the authorization for procedures performed by them in accordance with the standards of supervision established by statute or by the rules of the board.
- (F) Other specific services within the scope of clinical dental practice.
- (G) Retention of patient dental records as required by statute or by rule of the board.
- (H) Ensuring that each patient receiving services from the dental office or clinic has a dentist of record.

(b) Maintain current records of the names of licensed dentists who supervise the clinical activities of dental hygienists, dental assistants or other personnel involved in direct patient care utilized by the entity. The records must be available to the board upon written request.

(5) Subsections (1) and (2) of this section do not apply to an expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.

(6) Nothing in this chapter precludes a person or entity not licensed by the board from:

- (a) Ownership or leasehold of any tangible or intangible assets used in a dental office or clinic. These assets include real property, furnishings, equipment and inventory but do not include dental records of patients related to clinical care.

- (b) Employing or contracting for the services of personnel other than licensed dentists.

- (c) Management of the business aspects of a dental office or clinic that do not include the clinical practice of dentistry.

(7) If all of the ownership interests of a dentist or dentists in a dental office or clinic are held by an administrator, executor, personal representative, guardian, conservator or receiver of the estate of a former shareholder, member or partner, the administrator, executor, personal representative, guardian, conservator or receiver may retain the ownership interest for a period of 12 months following the creation of the ownership interest. The board shall extend the ownership period for an additional 12 months upon 30 days' notice and may grant additional extensions upon reasonable request. [Amended by 1977 c.192 §1; 1985 c.323 §3; 1995 c.286 §29; 1997 c.251 §6; 2003 c.322 §1; 2009 c.223 §1; 2011 c.637 §284; 2011 c.716 §4]

**** Fee splitting issues are popping up here. Specialists and some dentists are offering "rewards", "kickbacks", etc. to dentists for referring patients to them, typically with some type of payment of a part of the treatment fee. Does your state have laws, regulations, statutes in place governing this practice? Are you considering promulgating such laws as to prevent this practice?**

Oregon has a rule in place regarding fee splitting:

818-012-0030

Unprofessional Conduct

The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:

- (3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.

- (4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.

**** Advertising. With the advent of social media, Groupon, Facebook, Twitter, etc. I am concerned about misleading and deceptive information being used through this media in an attempt to increase patient visits. I am also concerned with raffles and drawings being**

used to encourage referrals from all sources. What laws, regulations, statutes, if any, does your state have covering such issues? Again, are any laws, regulations, statutes being promulgated or considered to prevent such practices? How do you investigate complaints related to advertising?

We have recently dealt with this issue and have information about our rules on our web page:

!!NEWSFLASH!! Internet Coupon Advertising

The Board has recently become aware of different companies soliciting Oregon licensees to enter into contracts for marketing and promotion services between the licensee and the company to promote voucher systems for potential patients. The Board has preliminarily determined that these may violate the unprofessional conduct rule OAR 818-012-0030(3) which prohibits offering rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee or employer.

The Board suggests that until this can be fully reviewed by the Board, licensees proceed with caution and if they feel necessary seek legal counsel on this matter or contact the Board office at (971) 673-3200.

May 8, 2012

Laura Hamady
Senior Corporate Counsel
Groupon
600 W. Chicago Ave.
Chicago, IL 60654

Dear Ms. Hamady:

The Oregon Board of Dentistry (OBD) has reviewed with their Senior Assistant Attorney General the most recent iteration of contractual agreements with prospective Oregon Dentists and Groupon and find that the contract that we received a copy of on May 2, 2012 does not violate the prohibition on splitting fees in the ODB rules.

The ODB is not approving a specific contract, but is approving a model which includes an agreement between the practitioner and Groupon that all fees paid by the customer will be passed through to the practitioner and the practitioner will pay an advertising fee directly to Groupon.

If you have any additional questions, please feel free to contact me.

Sincerely yours,

Patrick D. Braatz
Executive Director

November 11, 2011

Seth Brown
Assistant General Counsel
Living Social
1445 New York Ave NW, Suite 200

Washington DC 20005

Dear Mr. Brown:

The Oregon Board of Dentistry (OBD) has reviewed with their Senior Assistant Attorney General the most recent iteration of contractual agreements with prospective Oregon Dentists and Living Social and find that the contract that we received a copy of on September 12, 2011 does not violate the prohibition on splitting fees in the ODB rules.

The ODB is not approving a specific contract, but is approving a model which includes an agreement between the practitioner and Living Social that all fees paid by the customer will be passed through to the practitioner and the practitioner will pay an advertising fee directly to Living Social.

If you have any additional questions, please feel free to contact me.

Sincerely yours,

Patrick D. Braatz
Executive Director

**** Many of these issues and others are centering on professionalism, ethics and values. We all know there is the law and then there are ethics and values and professionalism. What has been done, or is being done in your state by the Board to address professionalism, ethics and values?**

Bottom line on this is that the Board will continue to discipline people who do not get it right!!!

I hope that this helps.

Patrick D. Braatz

Patrick D. Braatz, Executive Director
Oregon Board of Dentistry
1600 SW 4th Ave., Suite 770
Portland, OR 97201-5519
PH. 971-673-3200
FAX 971-673-3202

From: doctorboyd@verizon.net [mailto:doctorboyd@verizon.net]
Sent: Friday, November 02, 2012 12:26 PM
To: Bonnie.Rampersaud@dc.gov; Michele.howard@state.de.us; sue_foster@doh.state.fl.us;
aomarting@sos.ga.gov; david.beyer@ky.gov; LisaA.Turner@ky.gov; laurie.sheffield@maryland.gov;
tfriddle@ncdentalboard.org; Katie.Cox@llr.sc.gov; glenn@tsbde.texas.gov; Dea.Smith@tn.gov;
mnadler@dentalboards.org; dentalboard@dca.ca.gov; dcottrel@mail.nysed.gov;
wvbde@suddenlinkmail.com; Patrick Braatz; mauid.miskell@dora.state.co.us;
Marshall.Shragg@state.mn.us
Cc: Sandra.Reen@DHP.VIRGINIA.GOV
Subject: Issues facing our Board

Good morning to all,

I am the current President of the Virginia State Board of Dentistry and, like you, we are and have been facing some difficult issues in dentistry here in Virginia. I wanted to touch base with you to see if you would provide me with some information that I can share with my Board members around some of these issues. I would appreciate it very much if you would provide me an update of what is going on in your respective states regarding the following areas of concern:

**** Corporate ownership of dental practices by non-dentists.** Are you seeing an influx of dental practices owned, "operated", or managed by non-dentists? Does your state have laws, regulations, statutes preventing such ownership? Are you considering promulgating such laws as to prevent this? Would you provide me with the current language or the language that is being proposed? Does your state have any specific language concerning how long the survivors can own/manage the dental practice after the death of a dentist?

**** Fee splitting issues are popping up here.** Specialists and some dentists are offering "rewards", "kickbacks", etc. to dentists for referring patients to them, typically with some type of payment of a part of the treatment fee. Does your state have laws, regulations, statutes in place governing this practice? Are you considering promulgating such laws as to prevent this practice?

**** Advertising.** With the advent of social media, Groupon, Facebook, Twitter, etc. I am concerned about misleading and deceptive information being used through this media in an attempt to increase patient visits. I am also concerned with raffles and drawings being used to encourage referrals from all sources. What laws, regulations, statutes, if any, does your state have covering such issues? Again, are any laws, regulations, statutes being promulgated or considered to prevent such practices? How do you investigate complaints related to advertising?

**** Many of these issues and others are centering on professionalism, ethics and values.** We all know there is the law and then there are ethics and values and professionalism. What has been done, or is being done in your state by the Board to address professionalism, ethics and values?

I would also appreciate it if you would provide me with the contact information, email is all I would need, for your Board President so that I can communicate directly with them to get their perspective on these, and other issues, that are surfacing in our profession.

I thank you in advance for your consideration and responses to my questions. If I can ever be of help to you, please do not hesitate to contact me and I will do anything that I can to help out.

Have a great day, Reed Boyd, D.D.S., President
Virginia State Board of Dentistry

Disciplinary Board Report for December 7, 2012

Today's report reviews 2012 calendar year case activity then addresses the Board's disciplinary case actions for the first quarter of fiscal year 2013 which includes the dates of July 1, 2012, to September 30, 2012.

The table below includes all cases that have received Board action since January 1, 2012 through November 15, 2012.

Calendar 2012	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan. 2012	27	29	18	47
Feb. 2012	40	25	10	35
March 2012	39	34	12	46
April 2012	31	9	5	14
May 2012	49	17	5	22
June 2012	36	32	10	42
July 2012	35	14	3	17
Aug. 2012	33	17	6	23
Sept. 2012	21	10	1	11
<i>Oct. 2012</i>	<i>35</i>	<i>4</i>	<i>1</i>	<i>5</i>
<i>Nov. 15, 2012</i>	<i>33</i>	<i>17</i>	<i>6</i>	<i>23</i>
Totals	359	198	75	273

For the first quarter, the Board received a total of 89 cases which included patient care cases. A total of 37 patient care cases were closed for a 54% clearance rate. The current pending caseload older than 250 days is 13%. Of the 37 cases closed in the first quarter of 2013, 87% (32 cases) were within 250 days. The Board did not meet the goals for the Agency's Key Performance Measures for the first quarter of 2013. In order to increase the clearance rate, we need to close at least as many patient care cases as were opened and in order to increase the number of cases closed within 250 days, we must prioritize our outstanding cases based on priority and age.

The Board currently has a total of 302 open cases. One hundred fifty-three (153) cases are at probable cause. The Board has 19 cases with the Administrative Proceedings Division ("APD"), 119 cases are in enforcement, 8 cases are scheduled for informal conferences, and 3 for formal hearings. Of the 302 total cases, there are 238 patient care cases in the stages of probable cause, APD, enforcement, or pending a hearing.

Of the 153 total cases at probable cause, 115 are patient care cases. Of the 115, there are approximately 51 cases that have not had an initial review by Board Staff, approximately 20 cases are out with Board Members for review, 13 cases with additional information received pending Board Member review, approximately 10 cases have been returned by Board Members that are waiting for resolution by Board Staff, 1 case has been sent back to enforcement for additional information, 20 cases are pending a

hearing or have been offered a resolution document. Thirty-eight (38) cases are priority D cases which include advertising violations, business practice, records release, continuing competency requirements, or criminal activity.

Between July 1, 2012 and November 30, 2012, the Board summarily suspended the license of two dental hygienists and one dentist. Furthermore, the Department of Health Professions mandatorily suspended the license of one dentist.

As a result of the backlog in cases, Board Staff has asked each Board Member to stay and review cases after informal conferences. Additionally, Dr. Boyd asked each of you to review cases after yesterday's formal hearings. Our first attempt at this "blitz" in November resulted in 10 cases being reviewed. We hope to continue to receive the Board's cooperation with this practice until we no longer have a backlog of cases and our Key Performance Measures are met.

*The Agency's Key Performance Measures.

- We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
- We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
- We will investigate and process 90% of patient care cases within 250 work days.

Virginia Board of Dentistry
December 7, 2012

Agenda Item: Adoption of Proposed Dental Lab forms

The Dental Laboratory Work Group which was formed by the Board and the VDA to discuss registration of dental labs and the dental lab work order forms met two times and no agreement was reached. The latest version of the forms developed by the Work Group were distributed to the VDA Board of Directors meeting in June and recommendations for amending the forms was requested so that the Board might complete work on them. No additional changes were recommended. The current and proposed forms are provided for comparison. The workgroup recommended that the revised forms be issued as a guidance document.

**VIRGINIA BOARD OF DENTISTRY APPROVED
DENTAL LABORATORY WORK ORDER FORM**

This form is prescribed by the Board for use by its licensees as required by §54.1-2719 of the Code of Virginia. A licensee shall provide all the information required to complete the form. A licensee may use a different form only if all the required information on this form is collected and conveyed.

PATIENT NAME, INITIALS or ID#: _____

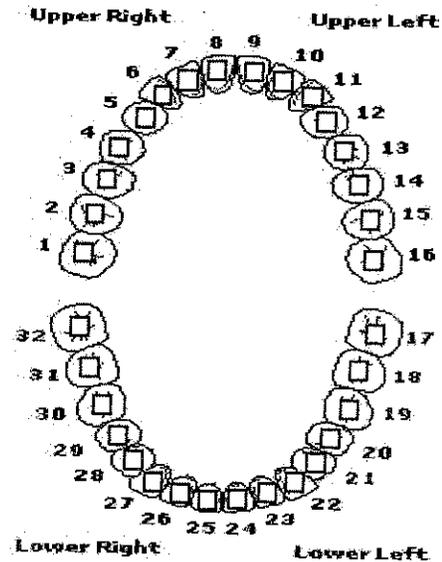
Laboratory Name: _____

Physical Address: _____

E-mail Address: _____

Contact Person: _____

Description of work to be done (include diagrams if needed):



Specify the type and quality of materials to be used:

Dentist's Signature: _____ Date: _____

Dentist's Name Printed: _____ Dental License # _____

Dentist's Address: _____ Telephone: _____

Dentist's Email Address: _____

Instructions to Lab

Laboratory must furnish dentist with subcontractor work order form if the dental lab uses a subcontractor and must comply with all items below:

1. Prior to beginning work, the prescribing dentist must be notified of any foreign subcontractor involved in fabrication or component/materials supply.
2. Prior to beginning work, the prescribing dentist must be notified of any domestic subcontractor involved in fabrication or component/materials supply.
3. Prescribing dentist must be notified of all materials in the delivered appliance/restoration.
4. Prescribing dentist must be notified in writing that materials in the delivered appliance/restoration DO NOT contain more than very small trace amounts (less than 200 ppm) of lead or any other metal not expressly prescribed.
5. Before returning finished case to prescribing dentist, the fabricated appliance/restoration must be cleaned disinfected, and sealed in an appropriate container or plastic bag.

PROPOSED

VIRGINIA BOARD OF DENTISTRY
APPROVED TEMPLATE FOR
DENTAL LABORATORY WORK ORDER FORM

This form is provided by the Board to guide dentists on meeting the legal requirements for work order forms in §54.1-2719 of the Code of Virginia. Dentists have the option of using this form or another form to meet the requirements of the law. Regardless of the form the dentist chooses to use, the information requested below must be included as part of the patient's treatment records and maintained as required by 18VAC60-20-15 of the Regulations Governing Dental Practice.

PATIENT NAME, INITIALS or ID#: _____

Laboratory Name: _____

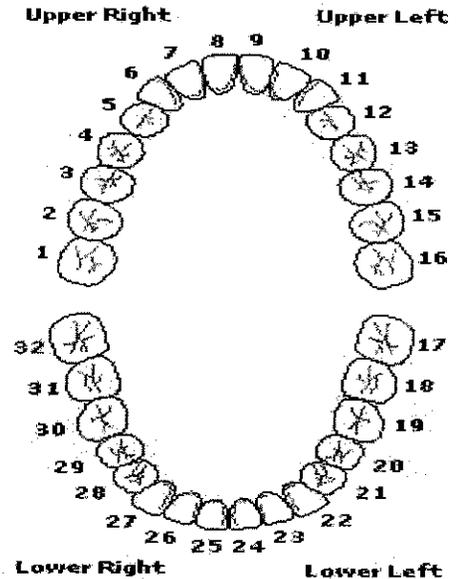
Physical Address: _____

Contact Person: _____

E-mail Address (optional): _____

TYPE OF RESTORATION MATERIALS:

INSTRUCTIONS FOR WORK TO BE DONE (include diagrams if needed):



INSTRUCTIONS FOR RETURNING THE RESTORATION:

- Provide the sanitized restoration in a sealed container.
- Provide the name and physical address of the location where the restoration was fabricated.
- Provide a copy of the information the lab received from a manufacturer on the composition of the casting and ceramic materials used in fabrication, such as an Identalloys sticker.

INSTRUCTIONS FOR SHADING (include diagrams if needed):

INSTRUCTIONS FOR SUBCONTRACTING THIS ORDER:

- _____ to a domestic lab approved
- _____ to an overseas/international lab approved
- _____ to either a domestic or overseas lab approved

PROPOSED

_____ contact me before subcontracting

Dentist's Signature: _____ Date: _____
Dentist's Name Printed: _____ Dental License # _____
Dentist's Address: _____ Telephone: _____
Dentist's Email Address (optional): _____

**VIRGINIA BOARD OF DENTISTRY APPROVED
DENTAL LABORATORY SUBCONTRACTOR WORK ORDER FORM**

This form is prescribed by the Board as required by §54.1-2719 of the Code of Virginia for use by dental laboratories to subcontract work orders from dentists licensed and practicing in Virginia. A dental laboratory shall provide all the information required to complete the form. **A different form may be used only if all the required information on this form is collected and conveyed.** A copy of the signed work order received from the prescribing dentist shall be attached.

PATIENT NAME, INITIALS or ID#: _____

Subcontractor Name: _____

Physical Address: _____

E-mail Address: _____

Contact Person: _____

Contact information of the prescribing dentist:

Name: _____

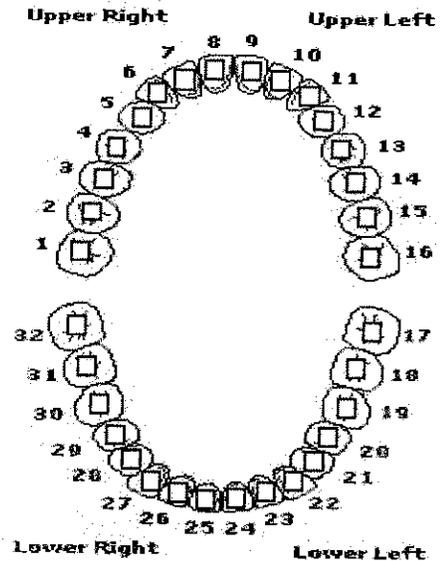
Address: _____

Telephone: _____

Email Address: _____

A copy of the signed work order received from the prescribing dentist is attached.

Yes No



Additional instructions for the handling, construction or repair of the appliance: _____

Contact information of person, firm or corporation issuing Subcontractor Work Order Form:

Signature: _____ Date: _____

Name Printed: _____ Telephone: _____

Address: _____

Email Address: _____

Instructions to Lab

Subcontractor laboratory must comply with all items below:

1. Prior to beginning work, the prescribing dentist must be notified of any foreign subcontractor involved in fabrication or component/materials supply.
2. Prior to beginning work, the prescribing dentist must be notified of any domestic subcontractor involved in fabrication or component/materials supply.
3. Contracting laboratory must be notified of all materials in the delivered appliance/restoration.
4. Contracting laboratory must be notified in writing that materials in the delivered appliance/restoration DO NOT contain more than very small trace amounts (less than 200 ppm) of lead or any other metal not expressly prescribed.
5. Before returning finished case to prescribing dentist, the fabricated appliance/restoration must be cleaned, disinfected, and sealed in an appropriate container or plastic bag.

PROPOSED

VIRGINIA BOARD OF DENTISTRY APPROVED TEMPLATE
DENTAL LABORATORY SUBCONTRACTOR WORK ORDER FORM

This form is provided by the Board to guide owners of dental laboratories (owners) on meeting the legal requirements for work order forms in §54.1-2719 of the **Code of Virginia**. Owners have the option of using this form or another form to subcontract all or part of a dentist's work order to another dental laboratory (subcontractor). Regardless of the form the owner chooses to use, the information requested below must be included in the work order sent to the subcontractor. The owner is required to retain a copy of the order; to attach the copy to the order received from the dentist; and to maintain both orders for three years.

PATIENT NAME, INITIALS or ID#: _____

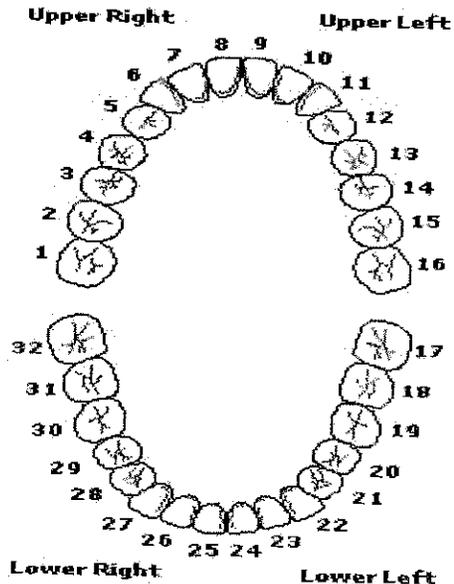
Subcontractor Name: _____

Physical Address: _____

Contact Person: _____

E-mail Address (optional): _____

Instructions:



Signature: _____ Date: _____

Name Printed: _____ Telephone: _____

Address: _____

Email Address(optional): _____

12/ 7/12 DISCUSSION DRAFT
Virginia Board of Dentistry
Policy on Recovery of Disciplinary Costs

Applicable Law and Regulations

- §54.1-2708.2 of the Code of Virginia.
The Board of Dentistry (the Board) may recover from any licensee against whom disciplinary action has been imposed reasonable administrative costs associated with investigating and monitoring such licensee and confirming compliance with any terms and conditions imposed upon the licensee as set forth in the order imposing disciplinary action. Such recovery shall not exceed a total of \$5,000. All administrative costs recovered pursuant to this section shall be paid by the licensee to the Board. Such administrative costs shall be deposited into the account of the Board and shall not constitute a fine or penalty.
- 18VAC60-20-18 of the Regulations Governing Dental Practice. The Board may assess:
 - the hourly costs to investigate the case,
 - the costs for hiring an expert witness, and
 - the costs of monitoring a licensee's compliance with the specific terms and conditions imposed
 up to \$5000, consistent with the Board's published guidance document on costs. The costs being imposed on a licensee shall be included in the order agreed to by the parties or issued by the Board.

Policy

In addition to the sanctions to be imposed which might include a monetary penalty, the Board will specify the costs to be recovered from a licensee in each pre-hearing consent order offered and in each order entered following an administrative proceeding. The amount to be recovered will be calculated using the assessment of costs specified below and will be recorded on a Disciplinary Cost Recovery Worksheet (the worksheet). All applicable costs will be assessed as set forth in this guidance document. Board staff shall complete the worksheet and assure that the cost to be assessed is included in Board orders. The completed worksheets shall be maintained in the case file. Assessed costs shall be paid within 45 days of the effective date of the Order.

Assessment of Costs

Based on the expenditures incurred in the state's fiscal year which ended on June 30, ~~2014~~ 2012, the following costs will be used to calculate the amount of funds to be specified in a board order for recovery from a licensee being disciplined by the Board:

- ~~\$94~~ 103 per hour for an ~~investigation~~ investigator multiplied by the number of hours the DHP Enforcement Division reports being expended to investigate and report the case to the Board.
- ~~\$97~~ 98 per hour for an inspection conducted during the course of an investigation multiplied by the number of hours the DHP Enforcement Division reports ~~being~~ that an inspector expended to inspect the dental practice.
- The applicable administrative costs for monitoring compliance with an order as follows:
 - ~~\$106.00~~ \$110 Base cost to open, review and close a compliance case
 - ~~48.75~~ 62 For each continuing education course ordered
 - ~~15.75~~ 16.25 For passing the Virginia Dental Law Exam

- ~~15.75~~ 16.25 For each monetary penalty and cost assessment payment
- ~~15.75~~ 16.25 For each practice inspection ordered
- ~~31.50~~ 32.50 For each records audit ordered
- ~~31.50~~ 32.50 For passing a clinical examination
- ~~89.00~~ 91.50 For each practice restriction ordered, and
- ~~73.25~~ 75.25 For each report required.
- The amount billed by an expert upon acceptance by the Board of his expert report.
- ~~\$350 for each practice inspection or record audit ordered to be conducted by the DHP Enforcement Division.~~

Inspection Fee

In addition to the assessment of costs addressed above, a licensee shall be charged \$350 for the inspection of his practice as required by 18VAC60-20-30 of the **Regulations Governing Dental Practice.**

**Virginia Board of Dentistry
Calculation of Costs for Recover**

COMPLIANCE WITH SANCTIONS	Compliance Case Manager (CCM)	Executive Director (ED)	Combined Costs	FY12 PROPOSED CHARGE
Base cost to open, review and close a compliance case (\$ per hr * 1.25 hrs) - CCM (\$ per hr * .25 hr) - ED	65.00	118.00	\$29.50	\$110.75
For each continuing education course order (\$ per hr * .5) - CCM (\$ per hr * .25) - ED	65.00	118.00	\$29.50	\$62.00
For passing the Virginia Dental Law Exam (\$ per hr * .25) - CCM only	65.00			\$16.25
For each monetary penalty and cost assessment payment (\$ per hr * .25) - CCM only	65.00			\$16.25
For each practice inspection ordered (\$ per hr * .25) - CCM only	65.00			\$16.25
For each records audit ordered (\$ per hr * .5) - CCM only	65.00			\$32.50
For passing a clinical examination (\$ per hr * .5) - CCM only	65.00			\$32.50
For each practice restriction ordered (\$ per hr * .5) - CCM (\$ per hr * .05) - ED	65.00	118.00	\$59.00	\$91.50
For each report required (\$ per hr * .25) - CCM (\$ per hr * .5) - ED	65.00	118.00	\$59.00	\$75.25

Reen, Sandra (DHP)

Subject: FW: perio optional with ADEX
Attachments: ADEX_Perio_Letter_FINAL.docx

From: adexoffice@aol.com [<mailto:adexoffice@aol.com>]

Sent: Monday, November 19, 2012 11:53 PM

To: Reen, Sandra (DHP)

Subject: Re: perio optional with ADEX

Sandy:

I am currently away from my office in Portland, but attached is the response, that I believe that you have been waiting for.

If you have any questions, please feel free to contact me.

PDB

ADEX

503-724-1104

To: State Boards and Dental Schools

This advisory is being sent to briefly describe the 2013 American Board of Dental Examiners (ADEX) examination in dentistry including a listing of the four examinations that must be passed (with a score of 75 or greater) to achieve "ADEX status" and also "NERB status".

The ADEX Dental Examination is the examination approved by American Board of Dental Examiners, Inc. and is adopted and administered by NERB, SRTA, Florida (administered by the NERB) and Nevada. It consists of a series of clinical examinations, both simulated on computer and manikins as well as clinical performances on patients. These examinations are utilized to assist licensing jurisdictions in making decisions concerning the licensure of dentists.

The 2013 ADEX Dental Examination consists of four required individual, skill-specific clinical examinations: three simulated patient clinical examinations and one clinical examination performed on patients. The three required simulated patient clinical examinations are the computer-based Diagnostic Skills Examination (DSE), the manikin-based Endodontic Clinical Examination, and the Fixed Prosthodontic Clinical Examination. The one required clinical examination performed on patients is the Restorative Clinical Examination which consists of preparing and restoring an anterior and posterior tooth. A candidate is considered to have passed the ADEX examination, and achieved "ADEX status", and "NERB status", when they have passed the four required examinations (the DSE, Prosthodontic, Endodontic and Restorative examinations).

The one optional clinical examination performed on patients is the Periodontal Clinical Examination. ADEX, NERB, SRTA, and Nevada, have just completed a national Occupational Analysis in Dentistry. The survey instrument utilized in the occupational analysis was designed to elicit procedures that dentists perform or supervise, and rank their criticality. The results of this national occupational analysis demonstrate that entry-level dentists while they do perio scaling, the skill is performed less frequently than the supervision of these skills. Literally none of the performance skills tested on the patient based Periodontal Examination were supported for performance testing on the clinical patient-based examination. Therefore the Periodontal Clinical Examination is considered optional by ADEX, but is available to candidates in consideration of specific requirements for licensure in those states that require a clinical examination in Periodontics. Candidate scores for the optional Periodontal examination will be included whenever scores are reported for the required sections of the exam. Note that a failing grade (less than 75) in the optional Periodontal examination does not affect whether a candidate has passed the ADEX examination nor is the candidate required to retake the Periodontal examination (unless they are seeking licensure in a state that requires having passed a clinical Periodontal examination). Many states have not required this skill set performance examination for several years as SRTA has not included this performance examination since 2005. The Diagnostic Skills Examination has undergone a total psychometric review, blueprint to realignment, and is a very robust examination on the cognitive skills in diagnosis and treatment planning in Periodontics, a critical skill set for all dentists.

Candidates are encouraged to check with the state dental board in the state where they wish to practice, to determine exactly what is required for licensure in that state.

We hope that this information helps explain the requirements of the 2013 ADEX examination. Please contact me if you have any questions or concerns.

2013 ADEX Diagnostic Skills Examination (DSE)

A. DSE Basic Format beginning January 1, 2013:

- a. Approximately 150 Computer-based questions plus additional questions that are included as unscored for pilot testing.
- b. Approximately 3-4 hour computer-based exam at Prometric
- c. Has some case-based components
 - i. Has tabs for PMH; PDH; Charting; Clinical Photos; Radiographs

B. DSE Overview:

a. Section 1 – Patient Evaluation – 20%

- i. Anatomical ID
- ii. Pathology of Bone/Teeth/Soft Tissue
- iii. ID of Systemic Conditions
- iv. Radiology Techniques/Errors
- v. Physical Eval/Lab Diagnostics
- vi. Therapeutics

b. Section 2 – Comprehensive Treatment Planning – 40%

- i. Systemic Diseases/Medical Emergencies/Special Care
- ii. Oral Medicine
- iii. Endodontics
- iv. Orthodontics
- v. Restorative Dentistry
- vi. Oral Surgery
- vii. Pediatric Dentistry

c. Section 3 Periodontics/Prosthodontics and Medical Considerations – 40%

- i. Medical Emergencies
- ii. Infection Control
- iii. Medical Considerations in Treatment Planning
- iv. Periodontal Diagnoses and Treatment Planning
- v. Periodontal Treatment and F/U
- vi. Prosthodontic Diagnoses and Treatment Planning
- vii. Prosthodontic Treatment and F/U

Submitted by Paul M. Wiley

Criteria for Periodontal Patient Selection

PERIODONTAL EXAMINATION

Patient Selection

SATISFACTORY

1. The Treatment Consent form, Medical History, Progress Form and Evaluation Form are complete, accurate and current.
2. Both systolic and diastolic blood pressure are less than or equal to 159/94 - OR - systolic and diastolic blood pressure are between 160/95 and 179/109 WITH a written consult from a physician authorizing treatment during the examination.
3. Radiographs are of diagnostic quality, reflect the current clinical condition of the mouth, the periapicals exposed within 3 years and four bitewings within 6 months and are properly mounted with exposure date and patient's name.
4. The Calculus Detection portion of the Evaluation Form is properly completed, indicating:
 - 6-8 teeth selected each with at least one surface of calculus charted.
 - At least 3 of the selected teeth are posteriors (molars, premolars) including at least one molar. All posterior teeth must have at least one approximating tooth within 2 mm distance.
 - Exactly 12 surfaces of subgingival calculus charted, including at least 3 surfaces of interproximal calculus on molars/premolars.
 - At least 8 of the surfaces are on canines, premolars or molars (no more than 4 surfaces on incisors.)
 - Three pockets 4 mm or more in depth, each on a different tooth within the 6-8 teeth selected for treatment.

MINIMALLY ACCEPTABLE

1. The Treatment Consent Form is incorrect or not signed by patient.*
2. The Medical History is incomplete*, missing candidate initials*, patient signature*, or has slight inaccuracies which do not endanger patient or change the treatment.
3. The Progress Form has inaccuracies or is incomplete or missing.*
4. Blood pressure has not been taken or is not recorded* but upon correction meets criteria listed under Satisfactory.
5. Radiographs are available but not submitted with the patient for initial evaluation***
6. The Calculus Detection portion of the Evaluation Form has not been filled out or on first submission is filled out incorrectly demonstrating:
 - fewer than 6 or more than 8 selected teeth, and/or
 - fewer than 3 molars or premolars are included (or no molar) and/or no approximating tooth within 2 mm of one or more of the selected posterior teeth and/or
 - one or more selected teeth without any surfaces of calculus charted, and/or
 - more or less than 12 surfaces of subgingival calculus, and/or
 - fewer than three surfaces of interproximal calculus on molars and/or premolars, and/or more than 4 surfaces of subgingival calculus on incisors**; and /or
 - 3 separate teeth and/or surfaces not indicated for Pocket Depth Qualification; and/or one or more of the teeth are outside the treatment selection.**

* Records and patient must be sent back to the candidate with an Instruction to Candidate requesting correction.

** Records and patient and a are sent back to the candidate and an electronic Instruction to requesting correction.

*** Instruction to Candidate is sent requesting radiographs.

PERIODONTAL EXAMINATION
Patient Selection Continued

MARGINALLY SUBSTANDARD

1. Medical History has inaccuracies which do not endanger the patient but do change the treatment or require further explanation by candidate. A second submission of incomplete and/or incorrect Periodontal Progress Form or Evaluation Form*.
2. Radiographs are of poor diagnostic quality and/or do not meet all of the criteria under Satisfactory.
3. Of the three teeth indicated with pocket measurements of 4 mm or more in depth, only 2 teeth are found to have measurements of 4 mm or more and/or one or more of these teeth are outside the treatment selection on the second submission.

* Records and patient are sent back to the candidate with an Instruction to Candidate for correction.

CRITICAL DEFICIENCY

1. Medical History has inaccuracies or indicates the presence of conditions, which DO endanger the patient, candidate and/or examiners (Periodontal Examination is stopped). A second submission of incomplete and/or incorrect Patient Consent form or Medical History.
2. Systolic and/or diastolic blood pressure is between 160/95 and 179/109 WITHOUT a written consult from a physician authorizing treatment - OR - blood pressure is 180/110 or greater even with a written consult from a physician authorizing treatment.
3. Radiographs are of unacceptable diagnostic quality and/or are missing and not available on request. (Periodontal Examination is stopped).
4. Of the three teeth indicated with sulcus/pocket measurements of 4 mm or more in depth, less than 2 teeth are found to have pockets of 4 mm or more upon measurement.

PERIODONTAL EXAMINATION
Tissue and Treatment Management

SATISFACTORY

1. The patient has adequate anesthesia for pain control, is comfortable and demonstrates no evidence of distress or pain
2. Instruments, polishing cups or brushes and dental floss are effectively utilized so that no unwarranted soft or hard tissue trauma occurs as a result of the scaling and polishing procedures

MINIMALLY ACCEPTABLE

1. There is slight soft tissue trauma that is consistent with the procedure.

MARGINALLY SUBSTANDARD

1. There is inadequate anesthesia for pain control. (The patient is in obvious distress or pain.)
2. There is minor soft tissue trauma that is inconsistent with the procedure. Soft tissue trauma may include, but not be limited to, abrasions, lacerations or ultrasonic burns.
3. There is minor hard tissue trauma that is inconsistent with the procedure. Hard tissue trauma may include root surface abrasions that do not require additional definitive treatment.

CRITICAL DEFICIENCY

1. There is major damage to the soft and/or hard tissue that is inconsistent with the procedure and pre-existing condition. This damage may include, but not be limited to, such trauma as:
 - Amputated papillae
 - Exposure of the alveolar process
 - A laceration or damage that requires suturing and/or periodontal packing
 - One or more ultrasonic burns that require follow up treatment.
 - A broken instrument tip is evident in the sulcus or soft tissue.
 - Root surface abrasions that require additional definitive treatment.

Reen, Sandra (DHP)

From: Reen, Sandra (DHP)
Sent: Wednesday, October 03, 2012 1:14 PM
To: Patrick Braatz
Subject: RE: perio optional with ADEX
Signed By: Sandra.Reen@DHP.VIRGINIA.GOV

Importance: Low

Thank you!

-----Original Message-----

From: Patrick Braatz [mailto:Patrick.Braatz@state.or.us]
Sent: Wednesday, October 03, 2012 12:54 PM
To: Reen, Sandra (DHP)
Subject: RE: perio optional with ADEX

Sandy I will forward your message to ADEXOFFICE@aol.com and then have those that are in a position to respond directly to you.

Thanks.

Patrick D. Braatz
Patrick D. Braatz, Executive Director
Oregon Board of Dentistry
1600 SW 4th Ave., Suite 770
Portland, OR 97201-5519
PH. 971-673-3200
FAX 971-673-3202

"Our Constitution works; our great Republic is a government of laws and not of men. Here the people rule." President Gerald R. Ford

"The Mission of the Oregon Board of Dentistry is to protect the public by assuring that the citizens of Oregon receive the highest possible quality oral health care."

-----Original Message-----

From: Reen, Sandra (DHP) [mailto:Sandra.Reen@DHP.VIRGINIA.GOV]
Sent: Wednesday, October 03, 2012 9:51 AM
To: Patrick Braatz
Cc: marthacutright@comcast.net; Robert Hall; Kathleen White
Subject: RE: perio optional with ADEX
Importance: Low

Hi Patrick:

The Virginia Board of Dentistry needs to take action as a body to decide whether or not the ADEX perio section will be optional for purposes of licensure in Virginia so I might respond to Ms. Krygowski's question below. This question can be addressed at our December 7, 2012 meeting. Rather than relying on the e-mails below for the needed Board discussion, it would be very helpful for the Board to receive an explanation from ADEX regarding the perio section with an inquiry about whether the section will be optional for

purposes of licensure in Virginia.
Thank you for your assistance.
Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
804-367-4437

-----Original Message-----

From: Krygowski, Sarah E. [mailto:Sarah_Krygowski@hsdm.harvard.edu]
Sent: Thursday, September 27, 2012 1:44 PM
To: Lackey, Kathy (DHP)
Subject: FW: NERB perio optional
Importance: High

Dear Ms. Lackey,

We just spoke on the phone regarding the NERB's new policy on the perio section of their licensing exam. This is the email I received from a faculty member at my school, quoting an email from the NERB director. I am wondering if Virginia requires the perio section to be taken and passed in order to obtain a VA state license.

I currently attend Harvard School of Dental Medicine and will be starting an endodontic residency at VCU in July, 2013. Thank you for your help, and please let me know if you have any questions for me.

Best,
Sarah Krygowski

From: Ohyama, Hiroe
Sent: Thursday, September 27, 2012 12:27 PM
Subject: NERB perio optional

Hello all,

I have received an email from the NERB director and he confirmed about a new change for the NERB Perio exam. Please read his note.

"Please be advised that for the ADEX examinations being offered in 2013, that the Periodontal portion of the examination will be optional. In recent years the ADEX examination (now utilized by the NERB) has consisted of a computer-based DSE Diagnosis and Treatment Planning section, an Endodontic section, a Prosthodontic section, a Restorative section and a Periodontal section. We will still be offering all five parts of the ADEX examination at all examination sites but candidates will have the option to take or not take the Periodontal Examination as needed, based on the requirements for licensure in the state or states where they wish to practice. NERB will continue to report results for each portion of the examination taken, so it will be clearly evident whether or not the Periodontal portion part was in fact taken and passed.
Since the Periodontal section is normally part of the ADEX examination,

candidates will be able to decide right up to the day of examination whether or not they wish to take this examination and NERB will simply report the results of the exams taken by each candidate."

I have asked him if candidates could decide to drop period in case they failed the period portion. His answer was "No." If you decided to take the Period exam and could not pass period portion, you have to retake the period in order to pass the NERB/ADEX.

Also, be very careful and plan well about this. If the state(s) you might go in the future require passing the period for the licensing exam, you have to take it at that time.

Please let me know if you have any questions.

Thank you.

Hiroe Ohyama

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