STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS,
BUSINESS & PROFESSIONAL LICENSING
BOARD OF DENTAL EXAMINERS

MINUTES OF MEETING
February 7, 2014

By authority of AS 08.01.070(2) and AS 08.36.040 and in compliance with the provisions of Article 6 of AS 44.62, a scheduled meeting of the Board of Dental Examiners was held February 4, 2014, at 550 W. 7th Ave., Suite 1270, Anchorage, Alaska.

The meeting was called to order by Dr. Thomas Wells at 8:32 a.m.

Roll Call

Those present, constituting a quorum of the board, were:

Dr. Thomas Wells, President – Anchorage
Gail Walden – Dental Hygienist – Wasilla
Dr. Robert Warren – Dentist - Anchorage
Cheryl Fellenberg – Dental Hygienist – (telephonic from Idaho)
Dr. Steven Scheller- Dentist - Fairbanks
Dr. Mary Anne Navitsky –Dentist - Sitka
Robyn Chaney- Public Member – Dillingham
Dr. Thomas Kovaleski – Dentist - Chugiak
Dr. Paul Silveira – Dentist – Valdez

Absent:

Dr. Steven Scheller- Dentist – Fairbanks, excused

In attendance from the Division of Corporations, Business & Professional Licensing, Department of Commerce, Community and Economic Development were:

Sara Chambers, Operations Manager – (telephonic from Juneau)
Angela Birt, Investigator- Anchorage
Debbie Kunow, Licensing Examiner – Juneau

Dr. Wells read the Board's mission statement: "To protect the health, safety and welfare of Alaskans by ensuring that practitioners possess competency, ethical standards, and integrity necessary to offer or deliver quality services to consumers."

Any matters pertaining to investigative procedures should be reserved for executive session.

Agenda Item 1- Agenda

Ms. Kunow stated Ms. Chambers would not be available for the budget review until 10:30, minutes for January 21, 2014 needed to be reviewed and approved; Dr. Julie Robinson would be unavailable for public comment and an additional credentials applicant, Dr. John Blaisdell, had been added to the personal interviews. Ms. Fellenberg would be joining the meeting telephonically during the investigative report and the regulation portions. Dr. Scheller may join telephonically late in the afternoon for regulation discussion. A teleconference line to call in has been set up for 2:00 p.m.

Agenda Item 2- Minutes

The Board reviewed the minutes from the December 6, 2013 meeting. Dr. Warren asked if Ms. Chambers knew the last time the license fees were increased. Ms. Kunow stated the department will review fees closer to end of fiscal year and will assess fees in conjunction with Board expenditures.
Ms. Walden advised that on page 9, the American Association of Oral and Maxillofacial Surgeons should be referred to as AAOMS.
Dr. Warren asked if Dr. Harbolt was back in the state. Ms. Kunow advised Ms. Birt will update the Board during the investigative report.
Ms. Walden stated that on page 12, Dr. Silveira should be the one to contact Dave Logan in reference to other states' regulations involving dental radiological equipment. Dr. Silveira said he had been trying to contact Dave Logan.

On a motion duly made by Chaney, seconded by Kovaleski and approved unanimously, it was

RESOLVED to approve the minutes of December 6, 2013 with amendments.

The Board reviewed the minutes from the January 21, 2014 teleconference. Dr. Kovaleski noted he is from Chugiak.

On a motion duly made by Silveira, seconded by Wells and approved unanimously, it was

RESOLVED to approve the minutes of January 21, 2014 with amendments.

Agenda Item 3- Ethics

There were no ethics violations to report.

Agenda Item 5- Investigative Report

Investigator Angela Birt distributed a probation report and the investigative report to Board members.
Dr. Warren asked if Dr. Harbolt was in the state. Ms. Birt advised no and would discuss him during the probation report.
Ms. Birt announced that Chief Investigator Quinten Warren had left the department to take a position with Medicaid investigations. An interim chief should be appointed by the end of the month.
Currently, there are three licensees that are on probation.
Dr. Ness is out of the country and is aware he has to contact investigations if he returns. He served about six months of his five year probation before he went overseas.
Drs. Adams and Harbolt have paid their fines. Dr. Harbolt's probation will not start until he is in the state. Probationers must notify the state if they are gone more than sixty days. The clock starts again when they return.
Ms. Birt reminded the Board that investigative matters may not be discussed outside of individual reviews because it would be a violation of open meeting laws.
Investigations currently has twenty actions on file, but twelve of those involve one practitioner. The Board accepted the voluntary surrender of this practitioner's license last month. Those cases will be closed because the Board lacks jurisdiction, even though investigations is receiving new complaints every day. Investigations will respond to the complaints, will advise the Board has no jurisdiction, that he is not practicing and unlikely to return to the State.
Ms. Birt has been working with Dr. Wells on the oldest case, a 2011 case, and it should be closed by the end of the week. That leaves seven open cases for 2013 and 2014.
Dr. Glenn Lockwood entered into a consent agreement and Dr. David Nelson surrendered his license.
Ms. Birt advised the Board of general trends when receiving complaints.
One of them involved that "only a licensed person who holds a valid license may own, operate or maintain a dental practice, office or clinic." Many licensees have incorporated for legal reasons. As long as John Doe, DDS, PC has a valid license, that is fine, but if John Doe sells his corporation to another person, that person must use

their own name and must be a licensed dentist. The public has a perception that if you see a business license for XYZ Dental Clinic, owner John Doe, DDS, it presumes that John Doe is a licensed dentist and he's practicing there. If that is not the case, it becomes an issue of false advertising.
Dr. Warren said Frank Thomas-Mears of Multiple Risk Management, Inc. believes there are a lot of licensed dentists that have active dental licenses, but do not have business licenses.
Ms. Birt stated they receive a number of complaints regarding businesses that don't have business licenses. If a dentist owns a business and receives profit, that is evidence of a financial benefit and he must have a business license. Ms. Kunow advised a form letter from the director is included to all new dental licensees informing them that if they start a business, they must acquire a business license.
Ms. Birt said when a call comes in, she contacts the office. In most cases, the license is expired and when told, they renew their business license.
Groupon advertising is still somewhat of an issue because it is considered fee-splitting and violated the ADA Ethics Guidelines. Many office managers sign up for Groupon not realizing the effect on the dentists' license. The Board has an advisory statement on its website.
Ms. Birt included the centralized business licensing statute in the investigative report and suggested the Board may want to include it in a newsletter. Dr. Wells asked if the Board had any authority over the business license. Ms. Birt advised no, but that it is a $300.00 fine for not having a license. Dr. Warren suggested putting this information into the Dental Society newsletter.

Ms. Birt stated the next item involved licensing action and would require executive session.

On a motion duly made by Walden, seconded by Warren, and approved unanimously, it was

> **RESOLVED to go into executive session in accordance with AS 44.62.310(c)(2), for the purpose of discussing an investigative review.**

Board staff to remain during executive session.
Ms. Fellenberg was contacted telephonically.

Off the record at 8:52 a.m.
On the record at 9:17 a.m.

On a motion duly made by Chaney, seconded by Kovaleski, and approved unanimously, it was

RESOLVED to deny the application for licensure for Dr. Robert English II for his failure to meet the criteria in Alaska statute Sec 08.36.110 (C) and (F), and also 08.36.110 (G) and (H).

The Board thanked Angela for her great work.

Dr. Kovaleski asked how the Board will convey the information regarding business licensing and Groupon. Right now, the information requires that people go online. Dr. Kovaleski asked Ms. Kunow about the status of a Board newsletter.
The Board suggested creating a one page flyer to include with license renewals. Ms. Chaney asked if email contacts were available for all dentists. Ms. Walden asked if something could be included on the renewal form that the licensee read the enclosed information.
The Board asked if online renewals will be available by renewal time. Ms. Kunow was unsure as to the status of online renewals.
Dr. Wells suggested creating a one page flyer. Dr. Kovaleski suggested keeping a task list going and, by the September meeting, creating the flyer to include with renewals.
Dr. Warren suggested including Ms. Birt's contact information to report quality issues in practice.
Ms. Walden suggested including dental office ownership.
Dr. Kovaleski requested Ms. Kunow keep track of the items to include and to finalize at the September meeting.

Since the Board was one hour ahead of schedule, Dr. Wells suggested continuing to agenda item 7.
Ms. Fellenberg left the meeting.

Agenda Item 6- Public Comment

There was no public comment.

Agenda Item 7- Miscellaneous Correspondence

The Alaska Dental Society (ADS) provided a letter to the Board regarding ownership of dental practices. Dr. Wells said this issue was somewhat discussed earlier with Ms. Birt.

Dr. Wells called for five minute break.
Off record at 9:24 a.m.
On record 9:33 a.m.

Dr. Wells stated that in the letter from the Dental Society, there were concerns about ownership of dental practices. The regulations state a practice must be owned by a dentist, but the problem is how to enforce that. Ms. Kunow advised the Board does not have the resources; it would have to be a complaint filed through investigations. Dr. Wells expressed concern about paper shuffling. Dr. Kovaleski said it sounded as if the State doesn't have the resources to investigate all business licenses, and it doesn't sound as if the Dental Board would want to get into tracking business licenses. In the correspondence from the Dental Society, it looked as if the Arizona Dental Board has taken on the responsibility of tracking business licenses. Maybe they can be successful because they have the resources.
Ms. Walden said the statute changed with SB92. It sounded as if ADS wants the Board to keep track.
Dr. Wells asked if Dr. Willis (President of ADS) had any particular practices that she was concerned about. Dr. Warren suggested it be brought to Ms. Birt's attention.
Ms. Walden asked if there is a question on the dental license application that addresses whether the applicant is operating under someone or is a self-employed dentist. Ms. Kunow said there are no questions regarding business licensing on the applications, but a form letter is sent to every new licensee with their license with instructions for obtaining a business license if the dentist should open their own business. Ms. Walden suggested adding a question to the application similar to the one on the dental hygiene applications requesting who the dentist might be working for: a dentist or company.
Dr. Guy Burk, in attendance, stated he was at the last ADS meeting and the concern was how to find ownership of a dental practice. In Oregon, there are a lot of corporate interests getting into dentistry. The trend across the country is similar to what has happened to the pharmacists. Corporate big shots got into pharmacy and now they can't even own their own pharmacy practice; they have to work for one of them. Walgreens, for example, is putting dental clinics in all its Walgreens stores. The job of the Dental Board is to protect the public from bad practices. The corporations are making decisions on the dental materials used and basically telling the dentists how to do their job. The argument is they can't be a doctor; the

corporations are making decisions based on dollars and cents. So far, North Carolina has the strongest regulations, created by the Dental Board, against corporate interests coming in and dictating how dentistry is practiced. Dr. Burk asked, "What is 'owning' a dental practice?" If Walgreens says they're selling one percent of a dental practice to Dr. Burk, and he's running everything so they're totally legit in the State, but Dr. Burk is making no decisions in the practice, this could be a concern. Do we want to take control of our own profession or are we going to allow the way the pharmacies went? The State has been sheltered, but this is happening.

Dr. Wells advised the statute is not strong enough. It should probably say total ownership, so it doesn't fall into the situation that the dentist owns two percent and a non-entity is the controlling owner. Ms. Walden cited Sec. 08.36.367(a): Only a person who holds a valid license issued under this chapter may own, operate or maintain a dental practice, office or clinic. This restriction does not apply to labor organization or nonprofit, institution of higher education, a local government, institution or program accredited by Commission on Dental Accreditation (CODA), non-profit organizations that provide dental services to rural areas, a nonprofit charitable corporation described under 501(c)(3) providing dental services by volunteer licensed dentists. Subsection (b) names a licensed dentist as the dental director.

Dr. Burk stated a corporation can have a dental director. Dr. Burk offered to get the North Carolina statutes to the Board. Ms. Walden advised this would require a bill to change the statute. Dr. Burk stated the Board would be the influencing factor for the legislative change. Ms. Kunow advised the Dental Society, with its many members, could contact their representatives.

Dr. Burk suggested the ownership should be revised. He has a lot of young dental friends who have no say in the day-to-day operations in those corporate owned facilities. It has become extremely hard to own your own dental shop and dentists are being pushed out of practice. Corporations will delegate as much as possible to non-dentists. If a dentist has fifteen assistants doing fillings all day, the costs will come down to a point where a general dentist can't survive. The general dentist becomes an employee in that corporate structure and doesn't have a say in that corporate structure. Quality of patient care diminishes when the dentist is paid on the number of patients seen. Dr. Burk recommended the Board take a proactive approach to prevent this from happening.

Dr. Silveira asked who regulates Walgreens, particularly in the dental department.

Dr. Burk reminded the Board their job is to keep the public safe and this might not be in the public's best interest. This tide will reach us eventually.

Ms. Walden stated she did not see how the business entity registration application is the solution.

Dr. Wells advised the statute needs to be changed. Right now, a corporation could hire a licensed dentist, give him one percent ownership, buy twelve clinics, set the rates and supplies, and the Board can't do a thing.
Ms. Walden asked if the regulation specialist could look at this and suggest a regulation that could back up the statute.
Dr. Kovaleski requested the Dental Society contact their representatives.
Dr. Burk stated if the Board discovered a corporation was making clinical decisions, there could be disciplinary action because it would be a company practicing without a dental license. Dr. Wells stated the corporation could still determine what materials come into the office.
Dr. Burk asked if a company came up here and started ordering Chinese composites not regulated by the FDA, and told all their dentists they had to use this material, they would be acting as the dentist. Ms. Walden stated the dentists could leave, that it would be an ethical choice. Dr. Wells said it would be tough to enforce; to audit materials. Dr. Wells reiterated a statute for complete ownership should be instituted.
Ms. Walden stated, right now, if a complaint comes into investigations, Ms. Birt will follow up.
Ms. Kunow will contact the regulations specialist and Dr. Burk will provide North Carolina statutes.

Agenda Item 8- Regulations

Ms. Fellenberg joined the meeting telephonically.

JU2013200315 (Part 2) reviewed by Board.

12 AAC 28.630(b)- the Board [WILL] should be the Board may;
Inspections will be conducted according to the general guidelines described in the Anesthesia Evaluation Manual (8th Edition 2012), copyright and published by the American Association of Oral and Maxillofacial Surgeons (AAOMS).
AAOMS is more specific with its checklists.
The Board asked if there was any way to word the reference so it is always the most current edition without making regulation changes to reflect each change in the most current edition.

12 AAC 28.920(a)- Online courses are not acceptable, unless there is a hands-on component.
12 AAC 28.920(b)- no changes

12 AAC 28.951(c)(3)- language should read: [A COPY OF THE APPLICANT'S CERTIFICATE OF EXAMINATION] evidence of successful completion of written and clinical examinations that meet the requirements of AS 08.36.234 and 12 AAC 28.951(e);
The Board will still require both written and clinical exams, unlike some other states that only require written examinations. Professional Background Information Services (PBIS) includes these exams in their reports.

12 AAC 28.960(a)- no changes
12 AAC 28.960(b) – no changes
12 AAC 28.960(c)- no changes
12 AAC 28.965(b)(3) – no changes
12 AAC 28.965(c)- no changes
12 AAC 28.965(d) – no changes
12 AAC 28.965(e) – no changes
12 AAC 28.965(f) – no changes
12 AAC 28.965(g) – reference to subsection (d) is erroneous; subsection (d) repealed;
Language should read: [IF AN INSPECTOR WHO IS ON THE LIST MAINTAINED UNDER (D) OF THIS SECTION INSPECTS] Inspectors of radiological equipment [AND] determine[S] that the equipment meets the requirements of (b)(3) of this section and shall issue.....

12 AAC 28.956(h) – reference to subsection (d) is erroneous; subsection (d) repealed;
Language should read: [AN INSPECTOR WHO IS ON THE LIST MAINTAINED UNDER (D) OF THIS SECTION AND] Inspectors who perform[S]....

12 AAC 28.970 – no changes

The Board would still like to see all dental radiological equipment registration and inspections delegated to another department's responsibility. Dr. Silveira stated there have not been any health or safety issues with dental radiological equipment. Dr. Wells advised the Board does not have the resources to monitor radiological equipment registration and inspections. Dr. Kovaleski suggested the Alaska Dental Society should contact the legislature to have this requirement moved to another department. It should be under Health and Social Services.

Agenda Item 4 -Budget Review

Second quarter fiscal year (YR) 2014 budget figures distributed to Board members. Operations Manager Sara Chambers addressed the Board concerning updated information for FY 2014. At end of second quarter, the Board has $30,669.00 in surplus. Renewals will occur at the end of December and will generate more revenue. Increases in contractual costs are mostly due to regulations, legal costs and personal services. Personal services costs are directly attributed to the Board's full time investigator.
Dr. Kovaleski inquired as to when the license fees may be increased. Ms. Chambers advised the analysis will begin in the spring and the fees will be determined no later than six months before renewal. Recommendations will be discussed with the Board. Dr. Kovaleski said the next Board meeting is in May and Ms. Chambers indicated the Department would have recommendations by then.
Dr. Wells asked about increasing fees for general sedation permits because of increased costs to the Board for office inspections, even though the inspections will be random. Ms. Chambers stated during the fee analysis, all fees are considered in relation to Board costs. The parenteral sedation permit is $50.00. The Board may want to contact Ms. Birt to determine what her costs to the Board might be.
The Board thanked Ms. Chambers for her time.

Agenda Item 8- Regulations (con't)

Sheila Jensen, certified registered nurse anesthetist (CRNA), joined the meeting in person. Ms. Jensen has been consulting with Dr. Scheller and Ms. Walden regarding regulation language for permit requirements for use of anesthetic agents. Ms. Walden provided a copy of the draft sedation language and a letter from Dr. Kenley Michaud.
Ms. Jensen advised that current regulations require that a CRNA can only work with a dentist who holds an anesthesia permit. This is prohibitive to dentists. Physicians that employ CRNAs are not required to hold anesthesia permits. The CRNA is trained for anesthesia purposes.
Ms. Walden reviewed other states and it is split. Some states allow nurse anesthetists to operate with dentists who do not hold anesthesia permits and others require dentists to hold a permit. Some states require a contract between the dentist and the nurse anesthetist which lay out the specifics of what each provider does. Washington State has some language that is good.
Dr. Wells stated the Dental Board would regulate the dentist and the nurse anesthetist would be regulated by their Board. The nurse anesthetist would be a private contractor with their own liability. Ultimately, it would be up to the

insurance companies to approve the contracts and liabilities. The Board is working on changing the regulation and it will have to go to public comment.
Dr. Burk asked who would be liable if there was an incident. The anesthesiologist is responsible for the airway and the dentist is the one putting cotton in the mouth. Ms. Jensen said that would be laid out in the contract between the dentist and anesthesiologist. The anesthesiologists should be vigil in their duties the same way the dentists are vigil in their duties, although the reality of litigation is that everyone, including the office manager, would go down in case of a death.
Dr. Burk then asked if the Board is going to be insuring that the anesthesiologist bring all the equipment necessary to perform their job and that the facilities are adequate. Ms. Walden advised the Board is working on a checklist. Ms. Jensen said the checklist should go to both the dentist and the anesthesiologist. Ms. Walden said the Board would figure that out through discussion. Ms. Walden stated that any practitioner that does not have a sedation permit should have, at the least, ACLS training if using an anesthesiologist.
Dr. Kovaleski advised this is what Washington is doing. A dentist without a general sedation or parenteral sedation permit can bring in an outside anesthesiologist and provide a checklist. Ms. Walden stated this allows each person to focus on their area of expertise.
Dr. Burk asked since the Board has no regulation over anesthetists, is the dentist not required to have anything. Ms. Walden asked Ms. Jensen to provide her regulations so the Board could review them. Ms. Jensen will provide a copy of scope of practice which is nationwide. Ms. Walden asked if the regulations have a checklist of everything the anesthetist has in their armamentarium. Ms. Jensen stated it is assumed when a person is practicing anesthesia, they have all the drugs, intubation equipment, rescue drugs, etc. There is a broad scope of practice of what CRNAs are licensed to do. There is also opt-out legislation in Alaska that broadens the scope of CRNAs in the sense that they can do what an anesthesiologist can do without direct supervision of a doctor. Currently, there are 120 nurse anesthetists in Alaska.
Dr. Wells stated the Board's intent is to change the regulations and that the CRNAs will be considered as private contractors. The Board has no regulatory authority over them because they are not dentists. The contracts will be something between the dentist, anesthetist and the insurance company. The Board's regulation will only state that the dentist can employ someone licensed in the State of Alaska to administer sedation/anesthesia. They should really be Board eligible.
Dr. Burk suggested the Board, in regulation, make it mandatory for the anesthetist to be held to the same standards as the dentist who holds a sedation or general anesthesia permit. The checklist for the anesthetist should be the same as for the dentist. It's different in an outpatient situation than in a hospital.

Ms. Jensen advised there is an Outpatient Surgery Regulatory Board that the Dental Board might use as a good resource for looking at requirements for office space, practices and other facility requirements.
Ms. Walden stated in her draft sedation language there is a classification for what can be treated in a dental office. American Society of Anesthesiologists (ASA) class I and II can be treated in a dental office, class III has to meet certain qualification and class IV and V obviously don't meet it. Dr. Burk said there are very safe class IIIs that can be treated, but other class IIIs are not. Ms. Jensen advised the ASA classifications should be objective but become very subjective based on a provider's impression. Many issues have to be looked at from a patient safety standpoint.

Ms. Jensen will continue to consult with Dr. Scheller and Ms. Walden.
The Board thanked Ms. Jensen for her time and expertise.

Dr. Wells referred to Dr. Michaud's letter regarding the issue of reporting a death in an office within 48 hours. 12 AAC 28.080 is under the anesthesia portion of the regulations and 12 AAC 28.640 is under the parenteral sedation portion of the regulations. Dr. Wells advised the regulations should have some sort of reporting a death under general dentistry.
Dr. Silveira said Oregon has a regulation that a death must be reported within 24 hours. Dr. Burk stated deaths usually do not occur in an office.
Ms. Walden asked if it should be under general dentistry. Deaths are not always related to sedation.
The Board decided to continue this discussion later.

Ms. Fellenberg joined the meeting telephonically.

<u>New Proposed Regulations</u>
The Board reviewed a new regulation language that was initiated at the December 6, 2013 meeting.

12AAC 28.340(1) – no changes
12 AAC 28.340(4)(F)(i) – no changes
12 AAC 28.770(8) – no changes
12 AAC 28.905- no changes
12 AAC 28.906- no changes
12 AAC 28.915 – no changes

12 AAC 28.937(b)(5) – copies of certificates showing the applicant has completed 30 hours of continuing education <u>during the three years immediately preceding the</u>

date of application as required under 12 AAC 28.410. (This language matches the language in 12 AAC 28.951 for continuing education requirements.)

12 AAC 28.937(c)(4) – an affidavit from the applicant documenting that within the five years immediately preceding application... (This language matches the language in 12 AAC 28.951(c)(6).)

12 AAC 937(c)(7) – no changes
12 AAC 28.951(c)(3) – no changes
12 AAC 28.951(c)(6) – no changes

12 AAC 28.951(c)(7) – should be (b)(6) because the continuing education is submitted by the applicant with the application and not through PBIS.

12 AAC 28.951(c)(11) – affidavits from three licensed dentists documenting the applicant has been in at least 5000 hours of active clinical practice within the five years immediately preceding application. (Language matches 12 AAC 28.937(c)(7).)

12 AAC 28.951(d)- no changes

Dr. Warren left the meeting at 11:50 a.m.

12 AAC 28.951(f) – delete 'if the applicant holds a specialty certification in the omitted subject area.' (The Board no longer credentials specialists.)

12 AAC 28.955(c)(1) – the applicable application fee established in 12 AAC 02.190; (The Board considered the courtesy application as an administrative fee, but will delete courtesy license fee.)

12 AAC 28.955(c)(5) – no changes
12 AAC 28.956(a)(7)(B) – no changes
12 AAC 28.970(b) – no changes
12 AAC 28.970(c) – no changes

Fees update (new regulation project)
The Board reviewed the current licensing fees. Outdated license fees listed below are being repealed. The Board kept the courtesy application fees for dental hygienists and dentists and considered those fees administrative.

12 AAC 02.190. BOARD OF DENTAL EXAMINERS. (a) The following fees for dental hygienists are established:
(1) nonrefundable application fee for
(A) initial license, $85;
(B) courtesy license, $50; KEEP
(C) initial restorative function endorsement, $50;
(2) board conducted examination, $3,000; REPEAL
(3) license fee for all or part of the initial biennial license period, $120;
(4) biennial license renewal fee, $120;
(5) [temporary license or] local anesthetic permit, $50; THERE IS NO TEMPORARY LICENSE
(6) credential review fee, $100;
(7) local anesthetic permit renewal fee, $50;
(8) courtesy license fee, $50; REPEAL
(9) restorative function endorsement fee, for all or part of the initial endorsement period, $50;
(10) restorative function endorsement renewal fee, $50.
(b) The following fees for dentists are established:
(1) nonrefundable application fee for
(A) initial license by examination, $300;
(B) initial specialty license, $400; REPEAL
(C) courtesy license, $50; KEEP
(D) branch office registration or permit, $50; REPEAL
(E) parenteral sedation or general anesthetic permit, $50;
(2) nonrefundable application and review fee for license by credentials, $400;
(3) board conducted clinical examination, $5,000; REPEAL
(4) license fee for all or part of the initial biennial license period, $290;
(5) specialty license fee for all or part of the initial biennial license period, $290; REPEAL
(6) biennial license renewal fee, $290;
(7) biennial specialty license renewal fee, $290; REPEAL
(8) branch office registration, $25; REPEAL
(9) parenteral sedation permit fee for all or part of the initial biennial permit period, $50;
(10) biennial parenteral sedation permit renewal fee, $50;
(11) biennial branch office registration renewal fee, $25; REPEAL
(12) general anesthetic permit fee for all or part of the initial biennial permit period, $50;
(13) biennial general anesthetic permit renewal fee, $50;
(14) courtesy license fee, $50. REPEAL

(c) The following fees are established for submission of dental and dental hygiene continuing education courses for approval under 12 AAC 28.410
(1) initial continuing education course submittal fee, $25;
(2) continuing education course resubmittal fee, $15.

The Board recessed for lunch.
Off record 11:56 a.m.
On record 12:59 p.m.

Ms. Kunow congratulated Dr. Wells on his reappointment by the Governor.
The Board applauded the Governor's decision.

Agenda Item 9 - Personal Interview for Applicants by Credentials

The reviewing Board members updated the Board regarding credentials applicants.
Dr. Kovaleski recommended Dr. John Blaisdell for licensure. Dr. Blaisdell is related to Dr. Jon Tanner from Fairbanks who was tragically killed in a plane crash in October. Dr. Blaisdell is assisting the family with the practice.
Dr. Silveira recommended Dr. Matthew Coplin for licensure. There was a minor malpractice claim which he thought would require litigation, but it was never followed through.
Dr. Navitsky highly recommended Dr. Elizabeth Kutcipal to the Board. Dr. Kutcipal has an Oral and Maxillofacial residency, a Pediatric residency and a Pediatric Oral and Maxillofacial residency.

Dr. Wells welcomed Dr. Elizabeth A. Kutcipal to the Board meeting and explained the interview process. Dr. Kutcipal appeared telephonically. The Board asked the standard interview questions.

On a motion duly made by Natvisky, seconded by Chaney, and approved unanimously, it was

> **RESOLVED to approve the application for a dental license for Dr. Elizabeth A. Kutcipal.**

Dr. Wells welcomed Dr. Matthew D. Coplin to the Board meeting and explained the interview process. Dr. Coplin appeared telephonically. The Board asked the standard interview questions. Dr. Coplin explained the litigation was considered abandoned by the insurance company and the case was closed.

On a motion duly made by Silveira, seconded by Walden, and approved unanimously, it was

RESOLVED to approve the application for a dental license for Dr. Matthew D. Coplin.

Dr. Wells welcomed Dr. John D. Blaisdell to the Board meeting and explained the interview process. Dr. Blaisdell appeared telephonically. The Board asked the standard interview questions.

On a motion duly made by Kovaleski, seconded by Chaney, and approved unanimously, it was

RESOLVED to approve the application for a dental license for Dr. John D. Blaisdell.

Agenda Item 10- Old/New Business

Sedation Checklist

The Board reviewed the sedation checklist. Dr. Wells stated the first checklist looked good for parenteral sedation. The second list was for general anesthesia and looked to be a bit of overkill.

Dr. Wells suggested incorporating inspection fees across the board with the application, rather than charge the individual permitted dentist an inspection fee,. A hundred dollar inspection fee in Alaska will not cover the cost of the inspection, considering travel costs. Currently, there are 53 active parenteral sedation permits. The inspections will be random.

Ms. Walden asked about the difference between someone who has AAOMS versus someone who has advanced training in general sedation. Dr. Wells advised there are no dentists with general training. The dental anesthesiologist would be the first one doing general anesthesia without being an oral surgeon.

AAOMS certified oral surgeons are inspected every five years.

Dr. Kovaleski requested Ms. Kunow check all general anesthesia permit holders to make sure they are AAOMS certified.

Ms. Walden stated that any general sedation permit holder that is not AAOMS certified and is not inspected every five years should be inspected by the Board. Dr. Wells agreed, but that the evaluation would be of a higher calibration. Dr. Wells didn't think the advanced on-site visit would require regulations.

Ms. Walden said the states she researched did not separate out the moderate from the general sedation check lists. It seems like a lot of the equipment is the same.

Dr. Warren returned to the meeting at 1:35 p.m.

Dr. Wells stated this should not preclude the Board from on-site inspections. Dr. Kovaleski agreed. If an oral surgeon was selected for an inspection, he could turn in his AAOMS last visit, and if it was within five years, the Board would accept that in lieu of an inspection.

Ms. Walden stated some states exclude oral surgeons from getting a sedation permit if they are AAOMS certified. They just submit that paperwork to the Board. Ms. Walden read from her draft language, 28.010(b):

> 12 AAC 28.010. PERMIT REQUIREMENTS FOR [USE OF ANESTHETIC AGENTS] DEEP SEDATION AND GENERAL ANESTHESIA. (a) No dentist may administer deep sedation/general anesthesia in a dental office unless a permit has been issued by the board.
>
> (b) 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 in a conspicuous place where the surgeon practices. Though exempt from obtaining a permit, surgeons must comply with all other applicable regulations under this chapter and are subject to the same disciplinary actions as those that obtain a permit.

The oral surgeon would still be under regulation and subject to disciplinary action, but they wouldn't require a permit and wouldn't be required to get inspections. This would be under a separate section.

Dr. Wells said it would be up to the Board to decide that. If a complaint was received involving a general anesthesia office, that should not preclude the Board from conducting an inspection. Dr. Kovaleski said that would also include those who passed the AAOMS inspection.

Ms. Walden suggested reading through that section. Most states have two different categories: one for oral surgeons and one for those that only have advanced education in general sedation. Dr. Wells said that is in the current regulations. Dr. Kovaleski said Ms. Walden's language might simplify the whole process.

Dr. Wells advised what is now controversial is the end-tidal CO2, which is required by AAOMS for the five year inspection. It's not required by the State unless the State has legislation saying so. This State does not. Fourteen states do. Once the Board adopts the new AAOMS guidelines, end-tidal CO2 will be required. Most oral surgeons have it, but it will also be required for parenteral sedation.

HB187

HB187 was tabled at the last meeting. Ms. Kunow said she did not know the status of the bill. The Board was neutral and did not request a letter be written at this time.

2014 Board Spring meeting date

Next Board meeting is May 2, 2014 in conference room 1270.
Dr. Wells is unavailable due to Western Regional Exam Board (WREB) obligations. Dr. Kovaleski and Cheryl Fellenberg are unavailable April 25 and Ms. Fellenberg is unavailable May 9, 2014 because of WREB obligations. The Board decided on May 16, 2014 for the next meeting, meeting place to be determined.

Board member attendance 2014 AADB meeting

The 2014 Fall meeting of the American Association of Dental Boards (AADB) is scheduled for October 7-8, 2014 in San Antonio. Dr. Warren volunteered to attend. He stated continuity is important.

On a motion duly made by Chaney, seconded by Wells, and approved unanimously, it was

> **RESOLVED to approve sending Dr. Robert Warren to the AADB 2014 Fall meeting October 7-8, 2014 with Dr. Paul Silveira as alternate.**

Agenda Item 13- Goals and Objectives

Ms. Walden stated #9 refers to inspections for general sedation and should refer to moderate sedation.

Ms. Walden suggested adding sedation regulation project to goals and objectives.

Dr. Kovaleski suggested changing #5 to a mail out with renewal. Dr. Wells asked if the Board had ever done a newsletter. Dr. Warren said there were newsletters years ago when Wanda was the licensing examiner. Ms. Walden volunteered to type up a simple one-page insert to go out with renewals by the September meeting.
Dr. Warren stated he was going to Kona to speak to the ADS executive committee and would convey the Board's concerns about dental ownership, moving radiological equipment to another department, and reporting quality issues.

Ms. Fellenberg joined the meeting telephonically.

Agenda Item 8- Regulations (con't)

Ms. Walden reviewed the proposed sedation regulation language she had been working on in conjunction with Dr. Scheller.
New section 12 AAC 28.005 would apply to general provisions, medical history requirements and ASA requirements.
Section 12 AAC 28.010 would be amended to include permit requirements for deep/general sedation.
Eligibility requirements for moderate/conscious sedation permit would be included in new section 12 AAC 28.012. This will merge Article 1 with Article 6. Moderate/conscious sedation permit requirements would be broken down into two different options: any moderate sedation method or enteral method.
A new section 12 AAC 28.025 would regulate any anesthesia monitors and/or ancillary personnel. Many states do that.
12 AAC 28.030, Other than Permit Holders, would be amended to incorporate Washington state language for contracting nurse anesthetists.
New section 12 AAC 28.065 would be the requirements for permitting and renewal.
12 AAC 28.080, Mandatory Reporting, could be moved to provision of general dentistry.
Finally, the definitions are spelled out.

Dr. Warren asked if the definition of moderate would include oral conscious and Ms. Walden said it does.

Ms. Walden asked the Board if they feel ASA classifications should be used in 28.005(d), General Provisions. It was only used in one of the states Ms. Walden researched. Dr. Kovaleski agreed that at least class III should be included.

(d) Appropriateness of administration in a dental office. (Include?)
(1) Sedation and/or anesthesia 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) Sedation and/or 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 conscious/moderate sedation, deep sedation, or general anesthesia 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.

12 AAC 28.050 in the current regulations could be repealed and included in all the types of sedation in 28.005(f) under general provisions.

(f) A medical history must be taken before the administration of sedation and/or anesthesia. Patients shall be asked to describe any current treatments, including drugs, impending operations, and pregnancies and to give other information that may be helpful to the person administering the sedation and/or anesthesia. All medications and dosages must be recorded. The dentist is not required to make a medical examination of the patient and draw medical diagnostic conclusions; therefore, if the dentist suspects a problem and calls in a physician for an examination and evaluation, the dentist may then rely upon that conclusion and the diagnosis. Questions asked of and answers received from the patient shall be permanently recorded and signed by the patient before the administration of any sedation and/or anesthesia and this record shall become a permanent part of the patient's treatment record.

The same would be for the written consent (12 AAC 28.040 in current regulations). It would fall under general provisions.

Ms. Walden asked the Board if subsection (g) regarding pediatric patients should be included.

(g) When pediatric patients require sedation and/or 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.

Dr. Kovaleski said more information would be needed.

Subsection (h) encompasses emergency management:

(h) Emergency management.

(1) If a patient enters a deeper level of sedation than the dentist is qualified and prepared to provide, the dentist shall stop the dental procedure until the patient returns to and is stable at the intended level of sedation. While returning the patient to the intended level of sedation, periodic monitoring of pulse, respiration, blood pressure, and pulse oximetry must be maintained.

(2) A dentist whose office utilizes moderate/conscious sedation, deep sedation, or general anesthesia shall have written basic emergency procedures established and staff trained to carry out such procedures.

Ms. Walden asked if AAOMS surgeons should be exempt from permitting, but regulated in some way.
Deep sedation in some states is separate from general and some states put it together. Dr. Wells said this is tough to regulate because the intention might be mild sedation and the patient might go deep. Ms. Walden advised Oregon has minimal, moderate, deep and general sedation and a permit for each one. Dr. Wells asked about oral sedation. Ms. Walden said some states have it separate and some states have it under moderate.

Under 12 AAC 28.010, Dr. Kovaleski did not think oral surgeons should be exempt from the permit. They should be exempted from the inspection if they are members of AAOMS and can show they have been inspected. Dr. Wells advised if there was just cause, a complaint, they would be inspected.

Ms. Walden discussed a grandfather clause in 28.010(c):

(c) Any dentist currently permitted as of the effective date of this revision to provide general anesthesia by the state of Alaska will be grandfathered regarding formal training requirements, but upon renewal of biennial dental license, they must meet current continuing education and all other applicable requirements under this chapter (i.e. Equipment).

The Board will review the education requirements.

Subsection(e) are the other options beside oral surgeons and current regulation 12 AAC 28.010(5) is incorporated:

(e) The board will issue a permit to a dentist licensed in the state for the administration of an anesthetic agent or agents for the purpose of inducing deep sedation/general anesthesia if the applicant offers certified proof that the applicant:

(1) Has completed one of the following education requirements:

(A) 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

(B) 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.

Ms. Walden said there are two education requirements: one for oral and maxillofacial surgeons which is included in current regulation 28.010(1)-(4), and the other educational option would be under (e)(1).
Dr. Wells stated 28.010(4) is redundant and should probably be eliminated. Dr. Kovaleski is unsure what the American Dental Association Specialty Board exactly is. Dr. Wells stated the AAOMS Board makes no recommendations as far as anesthesia. The Board just tests the qualifications. A periodontist would fall under 28.010(5).
Dr. Wells advised 28.010(1) should be repealed because it is the same as (2). Being a member of AAOMS can qualify an oral surgeon as a diplomat. Ms. Walden will research other states, but definitely will include 28.010 (2), and (3). The Board agreed to using subsection 28.010(5) language in current regulation be substituted for 28.010(5)(e)(1) and(2) in the proposed changes.

12 AAC 28.010 new subsection(f) will address procedures for administrating and monitoring and (g) will encompass office equipment standards:

(f) Procedures for Administration and Monitoring.

(1) Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the dental office or facility to include: temperature, blood pressure, pulse, pulse oximeter, oxygen saturation, respiration and heart rate.

(2) Patients must have continual monitoring of their heart rate, blood pressure, and respiration. In doing so, the permittee must utilize electrocardiographic monitoring and pulse oximetry;

(3) Anesthesia records shall be recorded in a timely manner and must include: blood pressure; heart rate; respiration; blood oxygen saturation; drugs administered including amounts and time administered; length of procedure; and any complication of anesthesia. When depolarizing medications are administered temperature shall be monitored constantly.

(4) A secured intravenous line must be established and maintained throughout the procedure.

(5) 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;

(6) 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.

(g) All offices in which deep sedation or general anesthesia is administered must comply with the following equipment standards:

(1) An operating area large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient;

(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the administration of basic life support;

(3) A lighting system which is adequate to permit evaluation of the patients skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any operation underway at the time of general power failure;

(4) Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities. A backup suction device must be available;

(5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate portable backup system;

(6) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating area;

(7) Ancillary equipment that must include the following:

(A) Laryngoscope complete with adequate selection of blades, spare batteries, and bulb;

(B) Endotracheal tubes and appropriate connectors, and laryngeal mask airway (LMA) and other appropriate equipment necessary to do an intubation;

(C) Oral airways;

(D) Tonsillar or pharyngeal suction tip adaptable to all office outlets;

(E) Endotracheal tube forceps;

(F) Sphygmomanometer and stethoscope;

(G) Adequate equipment to establish an intravenous infusion;

(H) Pulse oximeter or equivalent;

(I) Electrocardiographic monitor;
(J) Defibrillator or automatic external defibrillator (AED) available and in reach within sixty seconds from any area where deep sedation/general anesthesia care is being delivered. Multiple AEDs or defibrillators may be necessary in large facilities. The AED or defibrillator must be on the same floor.

Subsection (h) lists emergency equipment and (i) includes discharge requirements.
Subsection (j) lists requirements for continuing education:

(j) A dentist granted a permit to administer deep sedation/general anesthesia under this chapter, must meet the following continuing education requirements for renewal under 12 AAC 28.065. Hourly credits earned from certification in health care provider basic life support (BLS), advanced cardiac life support (ACLS), and Pediatric Advanced Life Support (PALS) courses may not be used to meet the continuing education hourly requirements for obtaining or renewing a general anesthesia/deep sedation permit, however these continuing education hours may be used to meet the renewal requirement for the dental license.

(1) Twelve hours of continuing education every two years;
(2) Maintain records that can be audited, including course titles, instructors, dates attended, sponsors, and number of hours for each course;
(3) The education must be provided by organizations approved (by the board ?) and must be in one or more of the following areas: General anesthesia; conscious sedation; physical evaluation; medical emergencies; monitoring and use of monitoring equipment; pharmacology of drugs; and agents used in sedation and anesthesia.

In addition to the current continuing education requirements for general dentistry, deep sedation/general anesthesia permit holders will have to have an additional twelve hours of CE every two years. Ms. Walden asked if the Board was in favor of the increased CEs. Dr. Kovaleski stated they should be included in the current forty-eight hours. Dr. Warren agreed. Dr. Wells stated ACLS will take up some of the twelve hours. Ms. Walden advised the new language excludes ACLS but can be amended.

The Board agreed to eliminate subsection (k) which had language stating a dentist had to be permitted to use a nurse anesthetist or anesthesiologist. The

Board is heading toward allowing a CRNA to come into a dental office of a non-permitted dentist to perform anesthesia with a contract in place.

In new section 12 AAC 28.012. ELIGIBILITY REQUIREMENTS FOR MODERATE/CONSCIOUS SEDATION PERMIT: (a) No dentist may administer conscious/moderate sedation in a dental office unless a permit has been issued by the board. The requirement for a moderate/conscious sedation permit shall not apply to the following:

(1) 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 in a conspicuous place where the surgeon practices. Though exempt from obtaining a permit, surgeons must comply with all other applicable regulations under this chapter and are subject to the same disciplinary actions as those that obtain a permit.

(2) Qualified dentists who hold a current permit under 12 AAC 28.010 to administer deep sedation/general anesthesia may administer conscious/moderate sedation.

(b) 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; or

(B) Conscious/moderate sedation by enteral administration only.

(2) The application fee;

(3) A copy of a transcript, certification or other documentation of training content which meets the educational and training qualifications as specified by the board under 12 AAC 28.014 or 12 AAC 28.016; and

(4) A copy of current certification in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) as required by the board under 12 AAC 28.014 or 12 AAC 28.016.

The Board agreed to eliminate the language in (a)(1) regarding the exemption of AAOMS surgeons.

New subsection 12 AAC 28.014. REQUIREMENTS FOR <u>ANY METHOD</u> OF MODERATE/CONSCIOUS SEDATION. (a) A dentist applying for a permit to administer moderate/conscious by any method will be issued a permit after the applicant provides certified proof that the following educational requirements have been met:

(1) Has completed one of the following education requirements:

(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 a board approved continuing education course 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) Holds current certification in advanced resuscitative techniques with hands-on simulated airway and mega code 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.

(3) Holds a current Drug Enforcement Administration registration.

(b) All offices in which moderate/conscious sedation by any method is administered must comply with the following equipment standards:

(1) An operating area of size and design to permit access of emergency equipment and personnel and to permit effective emergency management;

(2) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the administration of basic life support;

(3) A lighting system which is adequate to permit evaluation of the patients skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any operation underway at the time of general power failure;

(4) Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities. A non-electrical backup suction device must be available;

(5) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate portable backup system;

(6) Oral and nasal airways of various sizes;
(7) Laryngeal mask airways (LMA);
(8) A blood pressure cuff (sphygmomanometer) of appropriate size and stethoscope, or equivalent monitoring devices;
(9) Pulse oximeter; Defibrillator or automatic external defibrillator (AED) available and in reach within sixty seconds from any area where deep sedation/general anesthesia care is being delivered. Multiple AEDs or defibrillators may be necessary in large facilities. The AED or defibrillator must be on the same floor; and
(10) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating area.

(c) All offices in which moderate/conscious sedation by any method is administered must maintain the following emergency equipment and drugs in the facility and available for immediate use: (Compare with checklist)
(1) Intravenous set-up as necessary for specific procedures, including hardware and fluids;
(2) Sterile needles, syringes, tourniquet and tape;
(3) Narcotic antagonist;
(4) Corticosteroids;
(5) Bronchodilators;
(6) Antihypertensives;
(7) Anticonvulsants;
(8) Alpha and beta adrenergic stimulant;
(9) Vasopressor;
(10) Coronary vasodilator;
(11) Antihistamine;
(12) Parasympatholytic;
(13) Sedative antagonists for drugs used, if available.

(d) All offices in which moderate/conscious sedation by any method is administered must adhere to the following monitoring protocol:
(1) Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility and prior to discharge;
(2) Patients must have continual monitoring of their heart rate, blood pressure, and respiration. In doing so, the permittee must utilize electrocardiographic monitoring and pulse oximetry;
(3) Sedation records shall be recorded in a timely manner and must include: blood pressure; heart rate; reparation; blood oxygen saturation; drugs administered including dosages, time intervals and

route of administration; length of procedure; and any complication of sedation. When depolarizing medications are administered temperature shall be monitored constantly;

(4) A patient may not be left alone in a room and must be monitored by the sedation provider or trained anesthesia monitor (Regs ?);

(5) An intravenous infusion shall be maintained during the administration of a parenteral agent;

(6) The treatment team for conscious/moderate 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; and

(7) 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.

(e) 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.

(4) A discharge entry shall be made in the patient's record indicating the patient's condition upon discharge and the responsible party to whom the patient was discharged.

(e) A dentist who has a permit under this chapter to administer moderate/conscious sedation by any method must meet the following continuing education requirements for renewal under 12 AAC 28.065. Hourly credits earned from certification in health care provider basic life support (BLS), advanced cardiac life support (ACLS), and Pediatric Advanced Life Support (PALS) courses may not be used to meet the continuing education hourly requirements for obtaining or renewing a moderate/conscious sedation permit, however these continuing

education hours may be used to meet the renewal requirement for the dental license.

(1) Participate in at least 12 hours of continuing education every two years;

(2) Maintain records that can be audited, including course titles, instructors, dates attended, sponsors, and number of hours for each course; and

(3) The course must include instruction in venipuncture, intravenous sedation, enteral sedation, physiology, pharmacology, nitrous oxide analgesia, patient evaluation, patient monitoring or medical emergencies.

(f) Delegation of administration. (one option, per concern by Dr Kenley Michaud)

(1) A dentist not qualified 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 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 with a permit may administer or use the services of the following personnel to administer conscious/moderate sedation: (This still needs some work....)

(A) A dentist with a permit issued under 12 AAC 28.016 to administer by an enteral method;

(B) A dentist with a permit issued under 12 AAC 28.014 to administer by any method;

(C) An anesthesiologist;

(D) A certified registered nurse anesthetist under the medical direction and indirect supervision of the permitted dentist under 12 AAC 28.014 or 12 AAC 28.016; 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 12 AAC 28.014 or 12 AAC 28.016.

New subsection 12 AAC 28.016. REQUIREMENTS FOR ENTERAL MODERATE/CONSCIOUS SEDATION. (a) A dentist applying for a permit to administer enteral moderate/conscious will be issued a permit after the applicant provides certified proof that all of the following educational requirements have been met:

(1) Completion of a continuing education program of not less than 18 hours (Is this enough?) 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;

(2) 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.

(3) Holds a current Drug Enforcement Administration registration; and

(b) A dentist that administers enteral moderate/conscious sedation must adhere to the following procedures for administration:

(1) Oral sedatives can be administered in the treatment setting or prescribed for patient dosage prior to the appointment, except as identified in 12 AAC 28.005 (g);

(2) A second individual must be on the office premises who can immediately respond to any request from the dentist administering the drug;

(3) The patient must be continuously observed while in the office under the influence of the drug;

(4) Any adverse reactions must be documented in the records; and

(5) Patients receiving these forms of sedation must be accompanied by a responsible adult upon departure from the treatment facility.

(c) A dentist that administers enteral moderate/conscious sedation must have the following office facilities and equipment:

(1) Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

(2) Portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen enriched ventilation to the patient;

(3) Blood pressure cuff (sphygmomanometer) of appropriate size; and

(4) Stethoscope or equivalent monitoring device.

(d) A dentist that administers enteral moderate/conscious sedation must have the following list of emergency drugs immediately available and maintained. When a sedative drug is used that has a reversal agent, the reversal agent must be in the office emergency kit and the equipment to administer the reversal agent must be stored with the delivery device. Pulse oximetry equipment or equivalent respiratory monitoring equipment must be available in the office.

(1) Bronchodilator;

(2) Sugar (glucose);

(3) Aspirin;
(4) Antihistaminic;
(5) Coronary artery vasodilator; and
(6) Anti-anaphylactic agent.

(e) A dentist who has a permit under this chapter to administer enteral moderate/conscious sedation must meet the following continuing education requirements for renewal under 12 AAC 28.065. Hourly credits earned from certification in health care provider basic life support (BLS), advanced cardiac life support (ACLS), and Pediatric Advanced Life Support (PALS) courses may not be used to meet the continuing education hourly requirements for obtaining or renewing a moderate/conscious sedation permit, however these continuing education hours may be used to meet the renewal requirement for the dental license.

(1) Participate in at least 4 hours of continuing education every two years;
(2) Maintain records that can be audited, including course titles, instructors, dates attended, sponsors, and number of hours for each course; and
(3) The course must include instruction in sedation, physiology, pharmacology, nitrous oxide analgesia, patient evaluation, patient monitoring or medical emergencies.

The Board will further review these requirements.

Dr. Kovaleski asked Dr. Warren what the educational requirements were for oral sedation. Dr. Warren advised the Dental Organization for Conscious Sedation (DOCS) is the leader in that regard. The initial course is three days. Dr. Kovaleski suggested contacting DOCS to make sure the regulations match up with 28.016(a)(1).
Ms. Walden asked if all dentists require DEA registration. Ms. Kunow advised it is a requirement on license applications.

Ms. Kunow asked if the permits are going to be categorized as deep/general, moderate/conscious or three types. Ms. Walden advised three. She also advised Dr. Scheller had recommended a minimal sedation permit be included. Dr. Warren asked what the definition of minimal sedation would be. Ms. Walden said minimal sedation 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, ventilatory and cardiovascular functions are unaffected.

Dr. Warren stated this is an oral conscious sedation; that the dentist can have a conversation with the patient.
Ms. Fellenberg asked if the nitrous would be separate for dental hygienists and dentists. Ms. Walden said she was waiting for instruction from the Board. Minimal sedation for registered dental hygienists (RDHs) would be simple.
Dr. Kovaleski suggested leaving minimal sedation out for dentists, but leave nitrous in for RDHs. Enteral means anything that is swallowed. Ms. Walden stated that the education includes oral and enteral. Dr. Wells agreed to leave nitrous out for dentists.
Ms. Walden asked if the Board had received any complaints involving nitrous. Dr. Wells advised no. Dr. Wells then asked what is minimal. Dr. Kovaleski said that's the problem. Dr. Wells said a dentist can get into moderate sedation with oral drugs. Dr. Kovaleski said that was covered by enteral. Creating another minimal permit could get really complicated.
Dr. Wells then asked how many permits are there going to be: one for mild sedation, one for moderate sedation and one for deep. Ms. Walden said there would be one permit for deep/general, one for moderate by any method and one for enteral. Nitrous would be separate for RDHs. Dr. Kovaleski agreed that dentists should not be regulated for nitrous, that it is like local anesthesia for dentists.

Ms. Walden said Dr. Scheller was interested in the enteral moderate conscious sedation continuing education. Four hours every two years did not seem like much. Dr. Warren advised the initial DOCS course is oral sedation. Dentists learn how to treat fearful patients and how to administer dental plans that achieve more dental work in one visit. The next course is sedation solutions which includes methods for challenging patients and is the next step beyond oral sedation. It focuses on patients with mild to moderate systemic diseases, depression, and diabetes. The Advanced Cardiac Life Support (ACLS) seminar focuses on hands-on dental emergencies and procedures.
Dr. Kovaleski said this is definitely more than eighteen hours.

Dr. Silveira asked if minimal sedation is the prescribed drug amount for anxiety. Dr. Kovaleski stated most general dentists think prescribing valium the night before a procedure, valium an hour before a procedure and then nitrous during the procedure doesn't require a permit. The Board will be instituting an enteral permit, a requirement to do that. A general dentist should have at least eighteen hours of training to know that when valium is mixed with nitrous, medical compromises can happen.

Ms. Walden asked if the emergency drug list was sufficient under 28.016(d) for enteral moderate sedation. The Board agreed, but would also review it.

Ms. Walden will match the emergency drug list under 28.012(c) for moderate sedation by any method with the Board's office checklist.

New subsection 12 AAC 28.025 ANCILLARY PERSONNEL/ANESTHESIA MONITOR. (a) 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, clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in ?????; 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).

Ms. Walden suggested the Board not regulate the individuals, but that personnel records' qualifications be maintained according to the Board's checklist.
Dr. Kovaleski advised his assistants are certified by the Office of Medical Assistance Program (OMAP).
Dr. Wells said (2) is redundant with (1).
Dr. Burk suggested the Board have a regulation that would require simulations of medical emergencies for ancillary staff with Basic Life Support (BLS) twice a year. This would keep the provider and staff up to date.
Ms. Walden suggested including that under 28.005(h) emergency management, subsection (2). Dr. Burk suggested having a logged emergency session biyearly. Ms. Walden suggested having training that matches the Board's checklist biyearly.
Ms. Walden suggested adding possible emergency situations to the checklist that is included in the application and having the applicant sign off that they had performed the session. It could also be included on the renewals.

Ms. Walden then suggested 28.025 be included under 28.005(h), general provisions.

Ms. Chaney called for a five minute break.
Off record at 3:03 p.m.
On record at 3:09 p.m.

Ms. Walden suggested amending 12 AAC 28.030, OTHER THAN PERMIT HOLDERS to read:

12 AAC 28.030. OTHER THAN PERMIT HOLDERS. (a) In addition to a dentist holding a valid permit under 12 AAC 28.010-28.016 for the administration of moderate/conscious sedation, deep sedation, or [AN ANESTHETIC AGENT OR AGENTS FOR THE PURPOSE OF INDUCING] general anesthesia, [AS PROVIDED IN 12 AAC 28.010,] the following persons may administer [AN ANESTHETIC AGENT] sedation/anesthesia upon meeting requirements under this section:

(1) A [REGISTERED NURSE CERTIFIED BY THE ASSOCIATION OF NURSE ANESTHETISITS WHO WHILE IN A DENTAL OFFICE ADMINISTERES THE ANESTHETIC AGENT UNDER THE DIRECT SUPERVISION OF A DENTIST HOLDING A VALID PERMIT UNDER 12 AAC 28.010] certified registered nurse anesthetist (CRNA) or physician anesthesiologist may provide anesthesia services in dental offices where dentists do not have an anesthesia permit when the anesthesia provider ensures that all equipment, facility, monitoring and assistant training requirements as established within this chapter related to anesthesia have been met. The anesthesia provider is exclusively responsible for the pre, intra, and post-operative anesthetic management of the patient.

(2) [A BOARD-ELIGIBLE ANESTHESIOLOGIST WHO WHILE IN DENTAL OFFICE ADMINISTERS THE ANESTHETIC AGENT WHILE UNDER THE DIRECT SUPERVISION OF A DENTIST HOLDING A VALID PERMIT UNDER 12 AAC 28.010] The dentist without a sedation/ anesthesia permit must establish a written contract with the anesthesia provider to guarantee that when anesthesia is provided, all facility, equipment, monitoring and training requirements, for all personnel, as established by the board related to anesthesia, have been met.

(A) The dentist and the anesthesia provider may agree upon and arrange for the provision of items such as facility, equipment, monitoring and training requirements to be met by either party, provided the delineation of such responsibilities is written into the contract.

(B) Any contract under this section must state that the anesthesia provider must ensure anesthesia related requirements as set forth in this chapter have been met.

The bracketed part in the current regulation would be repealed and the underlined would be added. Ms. Walden suggested dental anesthesiologist should be added to (a)(1). Dr. Wells suggested adding Alaska licensed nurse.

Ms. Walden asked about including a list of specific drugs that are used for general anesthesia, but Dr. Wells advised that regulations would have to be changed every time drugs are changed. Drugs used for deep/general anesthesia should not be used for moderate sedation. Ms. Walden will add a statement under general provisions.

Dr. Wells advised the Alaska Board of Dental Examiners has no authority over CRNAs. The dentist is ultimately liable for what goes on in the office. Dr. Silveira will contact Frank Thomas Mears regarding the liability of CRNAs and anesthesiologists in the office.

Dr. Kovaleski asked if dental anesthesiologists are required to have an Alaska dental license. The Board agreed a dental anesthesiologist would have to have a dental license if they are practicing dentistry along with anesthesiology.

The Board agreed to combine deep sedation with general sedation under one permit.

Ms. Walden asked the Board if requiring monitoring should be listed in specific time frames. Dr. Wells did not think so.

Dr. Wells suggested having three permits: deep/general, moderate and minimal/moderate. Ms. Walden stated it could be separated out as moderate enteral and moderate by any method. Dr. Burk advised enteral could become general. A drug can be taken any way. Enteral can be deep, moderate or light.
Dr. Burk suggested having a light sedation permit in addition to a moderate and deep/general permit. There are issues with giving light sedation to minors. The dentist should have some type of training with nitrous. Could a general statement be in regulation that would require a dentist to have a certain amount of training without being permitted? It would cover the Board if the dentist was using drugs he was not trained in. Ms. Walden will research this issue with other states' regulations.

Dr. Wells suggested having a minimal/moderate permit and a deep/general permit without breaking down the moderate by means of method. Ms. Walden suggested separating minimal, moderate and deep/general into three permits. Dr. Kovaleski recommended a moderate permit would be required if a dentist was combining nitrous with IV.

Dr. Burk suggested not adding a minimal permit, but add language to include training with the drug they're prescribing.

The Board agreed to develop moderate and deep/general permits with language in general provisions to include guidelines for light/minimal sedation with no permit.
Ms. Walden will work on this language and present this to the Board at the next meeting.

The Board will review permit language for nitrous for dental hygienists at their next meeting.

The Board thanked Ms. Walden for all her hard work.

Agenda Item 14- Office Business

Travel authorizations distributed to Board members for signature.
Minutes from December 6, 2013 and January 21, 2014 signed by Dr. Wells.

Dr. Silveira made a motion to adjourn the meeting. All in favor.

The meeting adjourned at 3:42 p.m.

Respectfully submitted:

Debbie Kunow
Licensing Examiner

Approved:

Thomas Wells, DDS, President

Date: 05/16/2014