

VIA EMAIL: OPLC-Rules@oplcnh.gov

July 26, 2024

Board of Dental Examiners
c/o Office of Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301

RE: Comments Regarding Den 304 Proposal

Dear New Hampshire Board of Dental Examiners:

On behalf of the 52 members of the New Hampshire Society of Oral and Maxillofacial Surgeons (NHSOMS), we appreciate the hard work that has gone into the draft regulations for Den 304.

Anesthesia is at the core of OMS training and practice. OMS residency education standards require a dedicated 32-week resident rotation on medical and anesthesia service as well as an ongoing outpatient experience in all forms of anesthesia throughout four- to six-years of residency training. OMSs are trained in medical assessment and emergency management on par with our medical colleagues. Our training and ability to deliver treatment safely and affordably to patients via our team model of practice in our offices is unparalleled.

Den 304.03 – Permit Types

NHSOMS supports the development of a facility permit. It is crucial for the Board of Dental Examiners (Board) to maintain control over anesthesia delivery in dental offices to ensure patient safety, standardize procedures and uphold professional accountability. Without this facility permit, the Board would have no mechanism to address adverse events involving a non-dentist anesthesia provider or way to dictate standards for said facilities. This permit also facilitates the monitoring and addressing of any malpractice or negligence, thereby protecting patients and enhancing the overall quality of dental care.

Den 304.07 – Facility or Facility Hosting Requirements

NHSOMS questions the title for this section as paragraph (b) is related personal permit requirements rather than facility or facility hosting permits. NHSOMS recommends revision to reflect the nature of this section.

Additionally, NHSOMS feels strongly that any equipment, supply, or emergency medication requirements be tied to facility permits rather than individual permits. Such an effort would ensure that host facility practices are appropriately equipped with necessary devices, like capnography and ECG, providing greater parity across all practices and enhancing patient safety by establishing a predictable standard.

Finally, while NHSOMS understands and appreciates the level of detail provided in subparagraph (b)(5), we propose maintaining required drugs to specified classes rather than individual formularies wherever possible. As drafted, NHSOMS interprets this section as largely limiting providers to the drugs listed. In an age rife with drug shortages, greater flexibility is needed so providers can quickly pivot between appropriate medications in order to continue providing timely patient care. Additionally, as new drugs

enter the market, it is important to be able to utilize those pharmacologists in a timely manner without the need to reopen the state regulations to accommodate. Such methods are used in other states and have worked well.

Den 304.08 – Administering General Anesthesia, Deep Sedation, or Moderate Sedation

NHSOMS has several concerns with this section as outlined below.

- ***Paragraphs (d) (e) and (g) – 0-8 year olds*** – While we appreciate the Board’s efforts to protect the youngest patients in the state, **we have serious concerns with the proposal as drafted, specifically that the outright banning of the self-administration of deep sedation/general anesthesia to the 0-8 population will create both an access to care and patient safety concern, not solve one.**

A review of claims data provided by FAIR Health for 2018-22¹ shows that OMSs are the dental specialists providing the overwhelming majority of deep sedation/general anesthesia (DS/GA) and IV sedation services in the U.S. to all patients who have private dental insurance, including the majority of patients aged 1-7. These national figures can reasonably be applied to the New Hampshire population. As such, OMSs are providing the majority of anesthetic care in the state.

While few patients in this age range are treated in-office, those that are typically represent emergent cases – oftentimes, patients in pain with facial infections or trauma related fractures that need to be seen and treated as soon as possible. In such instances, providers, particularly solo providers, cannot wait to secure a separate anesthesia provider nor can all providers secure same-day hospital OR time. Under the proposal as written, patients in such instances would need to be turned away or directed to the local ER, which is already severely strained. While moderate sedation is available under the proposal, children may require deeper sedation in such instances due to pain response or lack of cooperation, which may complicate treatment for both the patient and staff during the procedure.

Additionally, no other state in the nation currently has such a provision, and there is no evidence to suggest it is necessary for public safety.

As noted, OMSs provide the majority of DS/GA to this age group, and the removal of our ability to treat this population – especially without any scientific basis – will significantly impact patients’ access to timely care. We recommend the Board establish a pathway for OMS providers to continue providing care to this population. We agree that it is important for providers to have experience and be proficient, as sedating a young child is very different from an adult. We suggest the Board consider an ongoing proficiency standard, included in the ASDA-AAOMS-AAP model anesthesia regulations and currently adopted in states such as Mississippi, Ohio, and South Carolina. Specifically, we suggest the inclusion of this language in lieu of the current provisions found in paragraph (g):

¹ Statistics calculated by AAOMS using data from the U.S. Census Bureau and information provided by FAIR Health based on its privately insured dental claims data for calendar years 2018-22. Of the total 11,960,846 moderate IV and deep sedation / general anesthesia (DS/GA) cases performed in 2018-22, 78 percent – or 9,281,331 – were delivered by OMSs. In the 1- to 7-year-old age group, OMSs provided 39 percent (29,716) of the total DS/GA cases (76,073). In the 8- to 12-year-old age group, OMSs provided 79 percent (155,298) of the total DS/GA cases (196,356). For moderate sedation, in the 1- to 7-year-old age group, OMSs provided 32 percent (2,650) of the total moderate IV sedation procedures (8,408). In the 8- to 12-year-old age group, OMSs provided 74 percent (18,845) of the total moderate IV sedation services (25,587).

Proposed alternative language

(g) General anesthesia, deep sedation, and moderate sedation permit holders wishing to administer deep sedation or general anesthesia to patients eight (8) years of age or younger must have documentation of current completion of PALS and meet one of the following conditions:

- (1) Completion of an accredited dental anesthesiology residency within the last two (2) years with documentation of supervised personal administration of deep sedation/general anesthesia for twenty (20) patients eight (8) years of age or younger during training; or
- (2) Completion of an accredited oral and maxillofacial surgery residency within the last two (2) years with documentation of supervised personal administration of deep sedation/general anesthesia for twenty (20) patients eight (8) years of age or younger during training; or
- (3) Documentation of personal administration of deep sedation/general anesthesia for dentistry for twenty (20) patients eight (8) years of age or younger during the last two (2) years of clinical practice for dentists who currently possess a Board-issued General anesthesia, deep sedation, and moderate sedation permit. Such documentation is required at the time of first renewal of the permit, or as prescribed by the Board.

- (a) If the permittee lacks a sufficient number of pediatric cases for initial endorsement, the permittee may personally administer dental office-based deep sedation or general anesthesia while not involved in the conduct of the surgical procedure to children eight (8) years of age or younger under the direct supervision of a permit holder who meets the qualifications of **[INSERT SECTION]**, which will then be accepted as meeting the case requirement. If within one (1) years of residency completion, cases from residency may also be used to meet the case requirement; and

Such a model not only has precedent in other states – and has been endorsed by the three national dental provider groups holding the highest levels of anesthesia training – but also creates a pathway that balances patient safety with access to care.

- **Paragraph (e) – OBEAM requirements** – While NHSOMS supports the inclusion of the requirement for providers seeking the 9-12 age patient exemption to complete a course such as

the OBEAM, there are other, similar courses available and request clarification that the Board may choose to recognize those courses as applicable. We recommend the following amendment:

Proposed alternative language

- (e) (1) Have completed an advanced airway course with hands-on training, such as the American Association of Oral and Maxillofacial Surgeons (AAOMS) Office-Based Emergency Airway Management (OBEAM) module, or another course approved by the Board, within the previous 6 years; and

This revised language broadens the availability of courses and provides valuable antitrust protections for the Board.

- **Paragraph (e) – Assistant requirements** – NHSOMS has concerns over the assistant requirements for the 9-12 age patient exemption. While we appreciate the Board's intentions, we have concerns about mandating PALS for assistants in the current environment. Staffing challenges are at an all-time high, with dental assistant shortages fueling constant turnover in dental offices.² We propose the following alternative language to provide additional pathways for assistants to meet the Board's goal:

Proposed alternative language:

(e) (2) (b) Ensure that a designated staff member is present during the procedure with the sole responsibility to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation, meeting one of the following criteria:

- i. BLS at the healthcare provider level;
- ii. PALS; or,
- iii. Thirty-six (36) hours of didactic instruction in the underlying physiology and interpretation of monitoring used for patients under deep sedation/general anesthesia and principles of office-based anesthesia and anesthesia equipment taught by either a qualified dental office deep sedation/general anesthesia provider or in a continuing education course approved by the Board; and a minimum of four (4) hours of clinical training in assisting an anesthesia provider in the management of dental office deep

² ADA Health Policy Institute in collaboration with American Dental Assistants Association, American Dental Hygienists' Association, Dental Assisting National Board, and IgniteDA. Dental workforce shortages: Data to navigate today's labor market. October 2022. https://www.ada.org/-/media/project/adaorganization/ada/ada-org/files/resources/research/hpi/dental_workforce_shortages_labor_market.pdf

sedation/general anesthesia emergencies, including the use of bag-valve-mask ventilation with and without airway adjuncts and assisting in advanced airway management, taught by either a qualified dental office deep sedation/general anesthesia provider or in an anesthesia emergency simulation course.

This model is excerpted from the ASDA-AAOMS-AAP model anesthesia regulations and such pathways are currently used several states.

- **Paragraph (f)** – NHSOMS seeks additional information on this section, specifically subparagraph (2), which states that providers treating patients between 9 and 12 years of age with the administration of moderate sedation “with or without inhalation sedation, agents are limited to a single dose of one or more drugs, or a multi-dose of a single drug, using manufacturer guidelines as found in the FDA “Online Repository”, as found at labels.fda.gov.” We ask for clarification to this section as it is unclear if this requirement would also apply to those individuals holding a general anesthesia, deep sedation, and moderate sedation permit or only to individuals with a moderate sedation permit with pediatric qualification.

OMSs may deliver additional medication if the patient is not at a sufficient level of anesthesia, particularly if patients are not experiencing the anticipated effects to lower dosages of anesthetic medication. This is especially the case in the pediatric population where the dosing is weight-based. Often, OMSs will not utilize the maximum dose with the initial dosage and will adjust based on the patient’s response. The anesthesia levels are demarcated by patient response to verbal and painful stimuli. Depending on the anticipated level of sedation, medications can be adjusted and re-dosed as necessary. This is especially important in younger and older populations, who can be more sensitive to anesthetic effects.

While we certainly understand and support the requirement for moderate sedation permit holders, those with advanced training in DS/GA holding the commensurate permit should be allowed to administer additional moderate sedatives. We urge the Board to amend the language in this section accordingly.

Den 304.09 – Facility or Facility Hosting Documentation Requirements

NHSOMS recommends stipulating that such records be kept in a time-oriented model and that a time interval be specified by the Board for such records. NHSOMS suggests that records be maintained in 5-minute intervals, consistent with AAOMS³ and ASA⁴ standards.

Den 304.13 – Morbidity and Mortality Reports

NHSOMS strongly supports reporting the events as proposed but would suggest the Board require such initial notification to occur within 24 hours, in addition to the full report to be submitted within 15 working days as noted. The requirement of early notification will allow the Board an opportunity to better know when such events occur and take any necessary measures to ensure the safety of the public.

³ American Association of Oral and Maxillofacial Surgeons. Office Anesthesia Evaluation Manual – 9th Edition. 2018. Pg. 8.

⁴ American Society of Anesthesiologists. Standards for Basic Anesthetic Monitoring. December 2020. <https://www.asahq.org/standards-and-practice-parameters/standards-for-basic-anesthetic-monitoring>

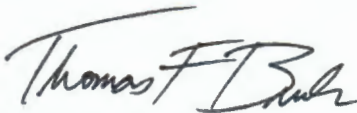
Additionally, NHSOMS recommends that data from such events be published to the Board's website in a condensed and deidentified manner to allow for public inspection and study of the information. Such transparency would allow state dental societies to provide any necessary education to New Hampshire dentists based on the data's findings and guide discussions for future amendments to state regulations. Such reports are being published in other states, including California and Texas. Alternatively, NHSOMS recommends reporting such information to a national registry, such as DAIRS, to allow for the national study of any adverse event data. It is important that any changes to the way anesthesia is administered be guided by data, but we need access to the data to draw any conclusions.

General recommendation

While the majority of this document focuses on pediatric anesthesia delivery, we noted that staffing requirements for adult patients are absent. NHSOMS recommends that the regulations include a requirement for at least one other person besides the dental provider to be present during the administration of moderate sedation, and two individuals – the anesthesia monitor and surgical assistant – during the administration of DS/GA. This team approach is nationally recognized and important during any adverse events.

We thank you for the opportunity to submit these considerations and look forward to our continued collaboration on this and other issues affecting dentistry. Please contact me at 925-250-4607 or drthomasburk@gmail.com for questions or additional information.

Sincerely,

A handwritten signature in black ink that reads "Thomas F. Burk". The signature is written in a cursive style with a large, sweeping initial "T".

Thomas F. Burk, DMD, MD
President, N.H. Society of Oral and Maxillofacial Surgeons

VIA EMAIL: OPLC-Rules@oplc.nh.gov

August 6, 2024

Board of Dental Examiners
c/o Office of Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301

RE: Supplemental Comments Regarding Den 304 Proposal

Dear New Hampshire Board of Dental Examiners:

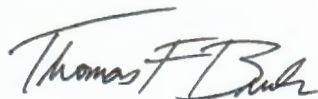
On behalf of the 52 members of the New Hampshire Society of Oral and Maxillofacial Surgeons (NHSOMS), we thank the Board for the opportunity to discuss this draft during the Aug. 5 public hearing. We would like to share additional thoughts we had beyond to our previously submitted comments.

Specifically, we request further clarification on section Den 304.08(e)(2)c, which in part addresses special needs patients. "Children with special needs" can be very broad, subject to interpretation, and range in both needs and risk during the administration of deep sedation or general anesthesia. For example, it would be inappropriate to consider a patient with high-functioning autism in the same manner as an ASA III or greater patient or one with moderate-severe tonsillar hypertrophy. As such, we would appreciate clarification in this area, including the ability to allow for provider discretion as it would be impossible to codify every possibility in this area.

Oral and maxillofacial surgeons receive extensive training on treating a wide variety of patient populations during our four- to six-year residency program. This rigorous training equips us with the expertise to make informed decisions about patient care, ensuring that treatments are safe, effective, and tailored to individual patient needs, which ultimately leads to better patient outcomes and higher standards of care.

We thank you for the opportunity to submit these considerations and look forward to our continued collaboration. Please contact me at 925-250-4607 or drthomasburk@gmail.com for questions or additional information.

Sincerely,

A handwritten signature in black ink that reads "Thomas F. Burk". The signature is written in a cursive, flowing style.

Thomas F. Burk, DMD, MD
President, N.H. Society of Oral and Maxillofacial Surgeons

Oral and maxillofacial surgeons:
The experts in face, mouth and
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July 29, 2024

Board of Dental Examiners
c/o Office of Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301

RE: Comments Regarding Den 304 Proposal

Dear New Hampshire Board of Dental Examiners:

On behalf of the 9,000 members of the American Association of Oral and Maxillofacial Surgeons (AAOMS) – including the 52 members practicing in New Hampshire – we offer our comments on the New Hampshire Board of Dental Examiners' (NHBDE) proposed rule changes to Den. 304.

Anesthesia is fundamental to OMS training and practice. OMS residency programs require a dedicated 32-week rotation in medical and anesthesia services, along with continuous outpatient experience in all forms of anesthesia throughout the four- to six-year residency. OMSs receive training in medical assessment and emergency management equivalent to that of our medical colleagues. Our comprehensive training and capability to provide safe, cost-effective treatment through a team-based model in our offices are unparalleled.¹

Additionally, a review of claims data from FAIR Health for 2018-22² reveals that oral and maxillofacial surgeons (OMSs) are the primary providers of deep sedation/general anesthesia and IV sedation services in the U.S. for patients with private dental insurance. Given that OMSs deliver most of the dental office-based anesthetic care nationwide, we are uniquely qualified to provide informed opinions on this regulation and anesthesia delivery in general.

¹Wiemer S., Mediratta, J., Triana R., Rieck, K., et. al. What Is the Incidence of Anesthesia-Related Adverse Events in Oral and Maxillofacial Surgery Offices? A Review of 61,237 Sedation Cases From a Large Private Practice Consortium. *J Oral Maxillofac Surg.* 2024; <https://doi.org/10.1016/j.joms.2024.04.014>. Accessed July 19, 2024.

² Statistics calculated by AAOMS using data from the U.S. Census Bureau and information provided by FAIR Health based on its privately insured dental claims data for calendar years 2018, 2019 and 2020. Of the total 6,240,366 moderate and deep sedation/general anesthesia (DS/GA) cases performed in this period, 79 percent – or 4,911,840 – were delivered by OMSs. In the 1- to 7-year-old age group, OMSs provided 44 percent (16,707) of the total DS/GA cases (38,257). In the 8- to 12-year-old age group, OMSs provided 81 percent (85,919) of the total DS/GA cases (105,791). For moderate sedation, in the 1- to 7-year-old age group, OMSs provided 34 percent (1,439) of the total moderate IV sedation procedures (4,244) and in the 8- to 12-year-old age group, provided 76 percent (10,378) of the total moderate IV sedation services (13,698).

Concerns with 0-8 Anesthesia Administration Proposal

AAOMS strongly opposes the provisions that expressly prohibit general anesthesia, deep sedation, and moderate sedation permit holders from self-administering deep sedation or general anesthesia (DS/GA) to patients 8 years and under without the use of a separate anesthesia provider.

Many young patients seen in-office, especially those aged 0-8, frequently present with urgent conditions like severe facial infections or trauma-related fractures that require immediate intervention. For providers, particularly solo practitioners, it is not feasible to wait for an anesthesia provider or to quickly secure hospital operating room time. The proposed regulations, as they stand, would push these patients to seek care in already overwhelmed emergency rooms, which could delay critical treatment and jeopardize patient safety. While moderate sedation is an option, it might not be sufficient for these patients, who may need deeper sedation for safe and effective treatment.

As we emerge from the pandemic, healthcare access is already strained to the breaking point. If we add another layer – one that is not supported by science nor found in any other state – we risk creating more barriers to much-needed care. When access to care is strained, it is the most vulnerable patients who suffer. We urge the NHBDE to retract this requirement and conduct a careful analysis of its implications on financial cost, human resources, and patient access to care. In a post-pandemic environment rife with workforce shortages, the state cannot afford to upend the current delivery model without appropriate justification. Doing so would negatively impact patient access to care and harm vulnerable patients.

Recommendation for ASDA-AAOMS-AAP Model Regulations

As an alternative, AAOMS strongly recommends that the Board incorporate the ASDA-AAOMS-AAP model regulations³ to establish a pathway for OMSs to continue providing care to young patients. These regulations, developed by the three dental specialty groups with the highest levels of anesthesia training and the largest percentage of administration to patients as noted by the FAIR Health data, balance patient safety with access to care and include ongoing proficiency standards for providers.

We thank you for the opportunity to submit these thoughts and look forward to our continued collaboration on this and other issues affecting dentistry. Please contact Ms. Sandy Guenther, Manager of State Government Affairs and Advocacy Engagement, at sguenther@aaoms.org or 800-822-6637 with any questions.

Sincerely,



Mark A. Egbert, DDS, FACS
AAOMS President

CC: Thomas F. Burk, DMD, MD, President, NHSOMS
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³ www.AAOMS.org/ModelRegs

Journal Pre-proof



What is the Incidence of Anesthesia Related Adverse Events in Oral and Maxillofacial Surgery Offices? A Review of 61,237 Sedation Cases from a Large Private Practice Consortium.

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What is the Incidence of Anesthesia Related Adverse Events in Oral and Maxillofacial Surgery Offices? A review of 61,237 sedation cases from a large private practice consortium.

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**What is the Incidence of Anesthesia Related Adverse Events in Oral and Maxillofacial
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Consortium.**

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Abstract: 325 words

Background: The safety of the anesthesia team model performed in oral and maxillofacial surgery (OMS) offices has been criticized by professional and mainstream media.

Purpose: This study aims to assess the incidence of adverse anesthetic events (AE) associated with the OMS anesthesia team model and identify risk factors associated with AEs.

Study design, setting, sample: This was a retrospective cohort study utilizing a patient database from Paradigm Oral Health[®], Lincoln, Nebraska, a managed service organization (MSO). Subjects included were 14 and older, undergoing open-airway intravenous anesthesia for ambulatory OMS procedures using the OMS anesthesia team model at multiple private practices in the MSO network between June 30th, 2010, and September 30th, 2022. Exclusion criteria included patients younger than 14 or patients with incomplete medical records.

Predictor variable: Primary predictor variables were age, sex, American Society of Anesthesiologists physical status classification system (ASA) score, type of surgical procedure performed, and the types of medications administered during sedation.

Main outcome variable: The presence of an AE. The definition of an AE was modeled on the World Society of Intravenous Anesthesia (SIVA) definition. All AEs were identified through surrogate markers which were identified through chart review. One example of an AE is ventricular fibrillation, which necessitates application of medications, here the medication is the surrogate marker.

Covariates: None.

Analyses: The data were analyzed using t-tests and χ^2 tests. *P* values ≤ 0.05 were considered statistically significant.

Results: Included in the study were 61,237 sedation cases (53.87% female and 46.13% male), for 56,076 unique patients ranging from 14 to 98 years of age (mean 33.26 ± 18.35). An AE incidence of 3 per 100,000 per year (25 total events) was observed. Neither age, sex, ASA score, nor type of surgical procedure exhibited statistically significant associations with AEs. A statistically significant association was found between AEs and fentanyl ($P = 0.0008$).

Conclusions and Relevance: This investigation shows a smaller incidence of AEs than previous studies of the OMS anesthesia team model.

Introduction

The safety of the oral and maxillofacial surgery (OMS) anesthesia team model performed in an OMS office outside the hospital operating theater is often under scrutiny. On the contrary, the provision of such anesthetics to relatively healthy patients undergoing minor procedures is heralded as the ideal model in efficiency, economy, and safety in the ever-evolving healthcare landscape. This ability to provide anxiolysis and anesthesia to patients is not only taken seriously by the profession, but also regulated heavily at various institutional, state, and national levels. The safety of the OMS anesthesia team model has also been studied thoroughly and deliberately. Hubbell was the first to publish the term “team anesthesia” to describe office-based outpatient general anesthesia as practiced by oral and maxillofacial surgeons.¹ Since that time, numerous studies have demonstrated the safety of sedation for outpatient oral and maxillofacial surgical procedures provided in accordance with the OMS anesthesia team model.²⁻⁷

Despite well-documented evidence of safety, the OMS anesthesia team model has come under scrutiny in both lay media as well as professional society position statements. Sister organizations have attempted to create practice guidelines that do not always pay heed to the OMS anesthesia team model and often exclude OMS from contributing to these guidelines. The American Association of Oral and Maxillofacial Surgeons (AAOMS) considers it a priority to preserve and protect the OMS anesthesia team model.⁸ Large databases maintained by third parties such as the US census bureau and FAIR Health data based on privately insured dental claims data suggest that oral and maxillofacial surgeons are the dental specialists providing the overwhelming majority of deep sedation/general anesthesia (DS/GA) and intravenous (IV) sedation services in the United States to patients who have private dental insurance. This data shows a low rate of adverse events in OMS offices compared to the total anesthetics performed.

²⁻⁷ A new avenue for data collection of the OMS-led anesthesia care team is the emergence of management service organizations (MSOs) and their centralized data banks. These data banks include a large pool of surgeons with training and experience in DS/GA. Data scientists can mine the appropriate clinical data and provide cumulative assessments about outcomes and best-practice approaches to patient care.

The purpose of this study is to estimate the incidence of adverse anesthetic events (AEs) associated with the OMS anesthesia team model and identify risk factors associated with AEs in a large private OMS practice consortium during a 143-month period. The authors hypothesized that the actual incidence of adverse anesthetic events occurring in OMS practices would compare favorably to outcomes reported in the literature by other non-anesthesiology specialties who also routinely perform procedural sedation. The specific aims of the study were to identify the number of AEs in the cohort, and the baseline demographic characteristics, comorbid disease status (ASA), type of surgical procedure performed, and the types and dosages of medications administered during the procedure to identify risk factors associated with adverse anesthetic events within the study cohort.

Materials and Methods

Study design/sample: To answer the research question, what is the incidence of anesthesia adverse events in private practice oral and maxillofacial surgery offices, a retrospective cohort study was designed. On 12/27/2022 the IRB determined that this protocol met criteria for exemption from IRB review in accordance with 45 CFR 46.10. IRB ID: 2022-10-09. The study population was composed of all patients undergoing non-intubated, open-airway IV anesthesia for ambulatory oral and maxillofacial surgical procedures from June 30th, 2010, to September 30th, 2022 at a private practice consortium. The information came from Paradigm Oral Health[®],

Lincoln, Nebraska, an MSO consisting of a large group of private practice oral and maxillofacial surgeons with a shared patient information database that was well organized and easily searchable.

To be included in the sample patients had to meet a several inclusion criteria. First having a surgical procedure and concomitant IV anesthetic provided by the same OMS team during the time frame of the study. Research subjects had to be age 14 or older. Sufficient documentation of medications used during the encounter, postoperative recovery events, and demographic characteristics were also necessary for inclusion. Exclusion criteria included patients under the age of 14. If there was insufficient documentation of medications used during the encounter, postoperative recovery events, demographic characteristics, or if the sedation procedure was completed by a provider who was not an oral and maxillofacial surgeon, the patient was also excluded. All the surgeons in the cohort were graduates of accredited oral and maxillofacial surgery residency programs in the United States and were current with all licensure and certification requirements.

Data collection methods: All patients to be considered for inclusion in the study were identified from a database search or a survey sent to the treating surgeons. The survey was conducted as we were unable to query outside hospital databases to search for Emergency Department visits or hospital admissions. The survey was sent through a protected, end-to-end, encrypted email to OMS within the MSO. No survey was administered to patients, only retrospectively to the treating providers to validate data integrity. Medical and dental insurance procedural codes (CPT/CDT) were used to identify patients who received IV sedation. (Table 1). To do this a centralized structured query language (SQL) database was queried which contained records from 12 unique practices, some of which had multiple locations. The dataset included records from 65

separate providers. Patient records in this database included vital signs and monitor outputs which were recorded electronically directly from monitors. Once the cohort was identified, the demographic and perioperative parameters of interest were abstracted.

Once the data was collected from the database the entries were cross-referenced to eliminate any possible duplicate sedation cases. All the data were then compiled into a comprehensive master data set. The anesthesia team model was standardized across all the surgical practices that were involved in the study. For each sedation, patient monitoring was performed along with the AAOMS standard of care at the time of the procedure.⁹ Sedation data was de-identified and the data was stored in a secure, password-protected server. Only the principal investigator and co-investigators had access to the dataset. All data abstracted for the study currently resides in the MSO electronic medical record and clinical databases.

Variables: The primary outcome variable for this study was the presence of an AE which was coded as present or absent. The definition of an AE was modeled on those reported in consensus documentation from the World Society of Intravenous Anesthesia (SIVA) International Sedation Task Force to track worldwide intervention-based AEs related to procedural sedation (**Table 2**). All the AEs in the cohort were identified by identifiable surrogate markers which were extracted as variables from the multiple databases which were used along with chart review (**Table 2**).

Multiple risk factors were used as predictor variables. This includes demographic variables age, sex, and American Society of Anesthesiologists Physical Status Classification System (ASA score) (**Table 3**). Other predictor variables were the type of surgical procedure performed, and the types of medications (fentanyl, ketamine, midazolam, propofol) administered during the procedural sedation (**Table 3**).

Data Analysis: T-tests and χ^2 tests were employed to depict relationships between baseline patient characteristics and medications with adverse events. *P*-values are reported for all baseline characteristics and the aforementioned medications (**Table 4**). The alpha level was set at ≤ 0.05 . All analyses were completed using R[®], version 4.2.2.

Results

Demographic characteristics for the subjects in the study cohort were presented with frequency counts of AEs in (**Table 4**). The total cohort included 61,237 sedation encounters, including 60,166 (98.25%) deep sedation/general anesthesia encounters and 1,071 (1.75%) moderate sedation encounters. In 61,237 sedations, 25 (0.04%) AEs were identified, equivalent to 3 AEs per 100,000 sedations per year. Descriptive statistics for the IV sedation medications administered during the sedation encounters are depicted in (**Table 3**). *T*-tests and χ^2 tests were used to identify variables as independent risk factors for AEs are depicted in (**Table 4**).

In terms of risk factors for AEs, age, sex, ASA Classification or procedure were not associated with AE ($P > 0.07$). A statistically significant association was identified between AEs and the use of fentanyl (RR = 0.15, $P = 0.0008$). No statistically significant associations were identified for AEs relative to the other three types of IV sedation medications: midazolam, propofol, or ketamine ($P > 0.18$).

Many of the AEs identified through surrogate markers did not have descriptions in the operative reports so we were unable to classify them completely. The 65 providers who had patients in this cohort were surveyed to ascertain whether any of their patients required emergency medical services (EMS) activation or hospitalization. Ten survey responses were received (15.38%). None of the responding providers recalled activating EMS or having to

transfer a patient to a hospital for an anesthesia complication. There was no mention in the patients' charts of medication errors, performing basic life support/advanced cardiovascular life support, securing an advanced airway, activating EMS, or hospital admissions. No mortalities were reported in this cohort of 61,237 OMS clinic procedural sedations. The incidence of AEs falls within the previously reported levels of morbidities in outpatient sedations.

Discussion

The purpose of this study is to estimate the incidence of AEs associated with the OMS anesthesia team model and identify risk factors associated with AEs in a large private OMS practice consortium during a 143-month period. This is perhaps the largest review of outpatient office procedural sedations in OMS literature. The authors hypothesized that the incidence of adverse anesthetic events occurring in OMS practices would compare favorably to outcomes reported in the literature by other non-anesthesiology specialties who also routinely perform procedural sedation. The specific aims of the study were to identify the incidence of AEs in the cohort, and the baseline demographic characteristics, comorbid disease status (ASA), type of surgical procedure performed, and the types and dosages of medications administered during the procedure to identify risk factors associated with AEs within the study cohort.

The incidence of AEs in the sample of 61,237 sedations was 0.04% per 143 months, or 3 per 100,000 per year. There were no mortalities in the study sample. Patient age, sex, ASA classification, and the type of surgical procedure performed did not have statistically significant associations with the presence of AEs in the study sample. A statistically significant association was identified for one of the four types of IV sedation medications administered during the procedure, fentanyl. Midazolam, propofol, and ketamine did not have a statistically significant association with AEs. Although the use of fentanyl was associated with AEs, this should be

interpreted carefully as nearly all the patients in the cohort received that medication, which is congruent with the observation that most AEs in this cohort were identified through the reversal agent surrogate markers.

The incidence of AEs in this sample is smaller than the incidence reported from the previous Mayo Clinic practice study.¹⁰ This study and the previous Mayo Clinic practice study report incidence which are smaller than any other previously reported studies in the OMS literature. As discussed in previous papers, this is perhaps due to heterogeneity in the reporting of what is considered an AE among the different studies. Previous studies have included syncope, injuries associated with positional changes, phlebitis, and emesis without aspiration as complications, which increases the rate of complication without necessarily requiring the intervention of a provider or leading to an AE consistent with current intervention-based World SIVA International Sedation Task Force consensus definitions.¹¹ These AEs do not necessarily have the contextual relevance to the ambulatory setting in which other non-anesthesia proceduralists practice and tend to generally be underreported.¹²⁻¹⁴ Having consistent, relevant criteria for measuring AEs in the OMS team model allows clear and accurate comparisons regarding the safety of the OMS anesthesia team model. This practice will also make it possible to compare outcomes of procedural sedation across multiple medical and dental specialties. The same outcome measures that were tracked in a previous study of a large cohort from Mayo Clinic were deliberately followed in this paper.

Despite the large dataset, our study was not without the weaknesses inherent in a retrospective study. Additionally, the study relied on a surgeon survey to verify that no subjects in the cohort were transferred to a hospital or required EMS activation. This method of verification introduces the possibility of recall bias and may have resulted in an artificially low

number of AEs, especially given the low rate of provider response. The study also lacked a reliable method to corroborate the reported data with different dental board records or emergency room admissions data as was done in a previous study with the Mayo Clinic study. While the variability between several practices and surgeons were adjusted for, human error looms large. A national database would add significant value to a study such as this. A national database would also eliminate the necessity for studies to rely on surrogate markers to identify AEs. While not unique to this study, the use of surrogate markers is different than counting actual AEs and may have resulted in an underrepresentation of the actual number of AEs.

The anesthesia team model allows OMS to care for patients in a private office safely and efficiently. The low incidence of AEs in this study is the result of deliberate and intentional parameters and guidelines that are set in place by the OMS specialty. This begins with an investment in structured and mandated training standards for both surgeons and teams. It continues with conducting strict peer reviews of facilities and techniques, all while focusing on continued educational requirements. This strict education and training allow OMS to provide safe, comfortable, and cost- efficient care for our patients. The training of OMS residents as non-anesthesiologists providing anesthetic care outside the hospital systems is critical in this endeavor. The Commission on Dental Accreditation (CODA) requirements for an accredited OMS program requires 32 weeks of combined anesthesia and medical service rotations, with 20 weeks dedicated to anesthesia and 4 weeks to pediatric anesthesia.¹⁵ OMS Residents function as anesthesia residents during this time and must complete a minimum of 300 cases of general anesthesia and deep sedations, including 50 cases involving children under the age of 13. Additionally, AAOMS recommends continued commitments to anesthesia education that includes a mastery-based simulated practice of airway emergencies in the office called Office-

based Emergency Airway Management (OBEAM) among others. These are coupled with state and local legislations that ensure personnel, equipment, and facility safety for the care of the OMS patient.

The precautionary measures and safeguards ingrained in the OMS specialty appear to be effective. As various medical and dental fields increasingly embrace the concept of ambulatory anesthesia and procedural sedation, the OMS anesthesia team model emerges as a technique with very few AEs. Patient selection, procedural intricacy, adept technique, comprehensive team training, and robust infrastructure collectively stand as paramount factors in ensuring the safe administration of anesthesia.

Authorship Confirmation Statement

1. Steven J. Wiemer, DDS, MD:
2. Jai Kumar Mediratta, DDS:
3. Reese R. Triana, MPH:
4. James Card, MSDS:
5. David Rallis, DDS, MD:
6. Kevin L. Rieck DDS, MD, FACS:
7. Eric Holmes, BA
8. Deepak G. Krishnan, DDS, FACS:

All persons who meet authorship criteria are listed as authors, and all authors certify that they have participated sufficiently in the work to take public responsibility for the content, including participation in the concept, design, analysis, writing, or revision of the manuscript. Furthermore, each author certifies that this material or similar material has not been and will not be submitted to or published in any other publication before its appearance in the Journal of Oral and Maxillofacial Surgery. All persons who have made substantial contributions to the work reported in the manuscript (e.g., technical help, writing and editing assistance, general support), but who do not meet the criteria for authorship, are named in the Acknowledgements and have given us their written permission to be named. If we have not included an Acknowledgements, then that indicates that we have not received substantial contributions from non-authors.

Acknowledgements-

"We extend our profound gratitude to Quinn Rhodes, MBDS for his invaluable expertise in statistical analysis and machine learning. His contributions have been pivotal in advancing the robustness and insights of this research."

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Tables

Table 1. CPT AND CDT CODES USED TO IDENTIFY SUBJECTS UNDERGOING IV SEDATION FOR AMBULATORY ORAL AND MAXILLOFACIAL SURGICAL PROCEDURES

Wiemer et al. Safety of Outpatient Procedural Sedation. J Oral Maxillofac Surg 2020.

Sedation CPT codes

- **Moderate sedation: 99141; 99142; 99143; 99144; 99145; 99148; 99149; 99150**
- **Deep sedation: 99141-47; 99142-47; 99143-47; 99144-47; 99145-47; 99148-47; 99149-47; 99150-47**

Sedation CDT codes

- D9220 deep sedation/general anesthesia—first 30 minutes
- D9221 deep sedation/general anesthesia—each additional 15 minutes
- D9222 deep sedation/general anesthesia—first 15 minutes
- D9241 IV conscious sedation/analgesia—first 30 minutes
- D9242 IV conscious sedation/analgesia—each additional 15 minutes

Abbreviations: CPT, Current Procedural Terminology; CDT, Current Dental Terminology; IV, intravenous.

Table 2. DEFINITIONS OF INTERVENTION-BASED AES CONSISTENT WITH PROCEDURAL WORLD SIVA INTERNATIONAL SEDATION TASK FORCE CONSENSUS DEFINITIONS *Wiemer et al. Safety of Outpatient Procedural Sedation. J Oral Maxillofac Surg 2020.*

AE	Definition	Surrogate Markers
Medication error	A preventable event caused by inappropriate medication administration	Administration of antihistamines and reversal agents
Patient combativeness	Patient movement or behavioral dyscontrol unresponsive to pharmacologic or behavioral intervention	Procedure abortion and administration of reversal agents
Seizure or seizure-like activity	Intraoperatively or postoperatively identified convulsions, spasms, myoclonus, or automatisms	Administration of anticonvulsant medication in addition to what is typically used for routine ambulatory IV sedation
Cardiac dysrhythmia	Bradycardia, tachycardia, or other identifiable pathologic arrhythmia on intraoperative ECG monitoring	Administration of antiarrhythmic medications
Myocardial infarction/angina	Patient reported substernal chest pain, 12-lead ECG confirmed ST elevation or non-ST elevation myocardial infarction	Administration of nitroglycerin or aspirin
Cardiopulmonary depression	Adverse changes in heart rate, blood pressure, or oxygen saturation, or ventilatory status consistent with sentinel risk of AE	Chest compressions, administration of other advanced cardiac life support medications or other vasoactive medications, intubation
Airway emergency	Bronchospasm, laryngospasm, apnea, or other airway issues requiring sentinel intervention	Intubation, supraglottic airway insertion, administration of neuromuscular blockade, or nebulized medications
ED visit	ED visit because of an anesthesia complication within 24 hours after receiving IV sedation for OMS procedure	Cross-referenced independent institutional database search of ED admissions based on the electronic medical record numbers of study cohort subjects within 24 hours of IV sedation procedure
Hospital admission	Hospital admission because of an anesthesia related complication within 24 hours after receiving deep IV sedation for OMS procedure	Cross-referenced independent institutional database search of hospital admissions based on the electronic medical record numbers of study cohort

Mortality

Death caused by anesthesia complication within 6 months of receiving deep IV sedation for OMS procedure

subjects within 24 hours of IV sedation procedure

Cross-referenced independent institutional database search of mortality dates based on the electronic medical record numbers of study cohort subjects within 6 months of IV sedation procedure

Note: Additional surrogate markers to further identify and cross reference AEs during database abstraction are also depicted.

Abbreviations: AEs, adverse events; ECG, electrocardiogram; ED, emergency department; IV, intravenous; OMS, Oral and maxillofacial surgeon; SIVA, Society of Intravenous Anesthesia; ST, S-T segment.

Sentinel risk AE descriptor: severe oxygen desaturation (oxygen saturation <75% at any time or prolonged <90% for >60 seconds); prolonged apnea (>60 seconds); cardiovascular collapse/shock; and cardiac arrest/absent pulse.

Sentinel airway intervention: tracheal intubation; supraglottic airway insertion; and administration of neuromuscular blockade.

Table 3. BASELINE DEMOGRAPHIC CHARACTERISTICS AND FREQUENCY COUNTS OF AES IDENTIFIED WITHIN THE STUDY COHORT

Variable	k = 61,237
Sex	
Female	32,988 (53.87%)
Male	28,249 (46.13%)
Age	
Mean (SD)	33.26 (18.35)
Median	25
Q1,Q3	18, 46
Range	14 - 98
ASA	
1	37,242 (60.82%)
2	22,408 (36.59%)
3	1,570 (2.56%)
4	15 (0.02%)
NA	2 (0.00%)
Procedure	
Extraction	51,841 (84.66%)
Implant	7,289 (11.90%)
Other	2,107 (3.44%)
Intraoperative Dose of Sedation Medication.	
Fentanyl (mcg)	
n (%)	59,482 (97.13%)
mean (sd)	65.99 (32.03)
Ketamine (mg)	
n (%)	41,973 (68.54%)
mean (sd)	21.17 (10.29)
Midazolam (mg)	
n (%)	59,638 (97.39%)
mean (sd)	4.47 (4.31)
Propofol (mg)	
n (%)	55,130 (90.03%)
mean (sd)	72.89 (90.78)

Table 4. BIVARIATE ANALYSIS OF PREDICTOR VARIABLES AND AES.

Variable	AE Yes	AE No	P Value
Age (years)†	(<i>k</i> = 25) 37.12 ± 24.13	(<i>k</i> = 61,212) 33.26 ± 18.35	0.43
Sex			
Female – <i>k</i> (%)	13 (52%)	32,975 (54%)	1
Male – <i>k</i> (%)	12 (48%)	28,237 (46%)	
ASA Class			
1 – <i>k</i> (%)	14 (56%)	37,228 (60.81%)	0.31
2 – <i>k</i> (%)	7 (28%)	22,401 (36.6%)	
3 – <i>k</i> (%)	2 (8%)	1,568 (2.56%)	
4 – <i>k</i> (%)	0 (0%)	15 (.02%)	
Type of Surgical Procedure Performed			
Extraction – <i>k</i> (%)	20 (80%)	51,821 (84.66%)	0.71
Implant – <i>k</i> (%)	2 (8%)	7,287 (11.9%)	0.77
Other – <i>k</i> (%)	3 (12%)	2,104 (3.44%)	0.07
Sedation medication provided intraoperatively during sedation encounter			
Fentanyl – <i>k</i> (%)	21 (84%)	59,461 (97.1%)	0.0008*
Ketamine – <i>k</i> (%)	15 (60%)	41,958 (68.5%)	0.48
Midazolam – <i>k</i> (%)	23 (92%)	59,615 (97.4%)	0.29
Propofol – <i>k</i> (%)	20 (80%)	55,110 (90%)	0.18

Note: Age: *t*-test, Sex, ASA Class, Drugs Given: χ^2 test.

* Denotes a statistically significant p-value

† Mean ± standard deviation

Abbreviation: AEs, adverse anesthetic event.



New Hampshire

DENTAL SOCIETY

31 July 2024

Dear Members of the New Hampshire Board of Dental Examiners:

On behalf of the over 700 Members of the New Hampshire Dental Society (NHDS), I would like to offer our thoughts and concerns regarding draft rules changes to Den.304 pending before this Board today.

As you know, the Mission Statement of the NHDS is to advocate for dentistry and the public oral health. The issue, on which the NHDS has been working in partnership with the legislature, the Board and other members of the oral health community since 2018, raises a number of key concerns.

1. The proposed rule changes do not necessarily enhance patient safety and could, potentially, create unanticipated safety issues. Dental teams working in the settings outlined in this rule have years of experience and training in the type of adverse situations to which Den.304 speaks. In fact, there is no evidence that such changes are warranted, as the attached report demonstrates. Requiring a third, non-team member could delay treatment in emergency situations if a case had to be delayed or paused in order to deliver deep sedation, when moderate sedation was insufficient. Such a situation would unnecessarily add time and increased risk to the patient.
2. Requiring an additional clinical professional to the operatory inevitably will increase costs. Dental care is already for many an untenable expense. During previous Board meetings, nurse anesthetists have insisted without evidence that there would be no additional cost, but the state's dental Medicaid office, along with other oral health stakeholders like NHDS, are not unconvinced that the presence of an additional professional would not add to the patient's bill. As written, the proposed changes could delay care and access to patients most in need, especially in emergency situations. If a patient can't get care from an oral surgeon, they may be forced go to the emergency room, a situation every health care stakeholder seeks to avoid.
3. The NHDS feels that if an additional professional is added to the operatory in these very infrequent but very delicate situations, they should be subject to the rules and standards of the Board of Dental Examiners and, in the event of an adverse event, should be thereby held accountable just as are dentists, hygienists and the rest of the dental team. Presently, nurse anesthetists are not required to follow the Dental Practice Act or the Code of Ethics.

The NHDS is as always willing to offer our assistance to the Board of Dental Examiners in this process. After all, it was the NHDS that consistently advocated for the Board to be charged with the review of such rules rather than the Legislature. Still, we believe solutions can be reached by including the expertise of the state's oral surgeons – particularly those who, if necessary, have the qualifications and experience to perform deep sedation on young children. We stand with the NH Society of Oral and Maxillofacial Surgeons and the American Association of Oral and Maxillofacial Surgeons, all of whom have offered their constructive input and ideas throughout this process.

Thank you.

Warmest Regards,

Michael P. Auerbach
Executive Director
New Hampshire Dental Society

Kelley, Tina

From: Dr. Roger Achong <drachong@concordpediatricdentistry.com>
Sent: Sunday, August 4, 2024 10:00 PM
To: Puneet Kochhar; OPLC: Rules
Subject: modification to Den 304

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

Hello Dr. Kochhar,

Regarding the modification to Den 304 and more specifically on page 17 at the very top.

Page 17.

8) Staffing for procedures under moderate sedation, deep sedation, or general anesthesia shall be as follows:

a. The operating dentist maintains an unexpired ACLS certification, as well as an unexpired PALS certification if patients under the age of 13 years are treated at facility;

If the operating dentist is treating patients then an unexpired ACLS certification is required. And if patients under the age of 13 years are to be treated then an unexpired PALS certification is required also.

Thus, it can also be said that If the operating dentist is treating patients under the age of 13 years then an unexpired PALS certification is required. And if patients over the age of 13 years are to be treated then an unexpired ACLS certification is required also.

I share this as a board certified pediatric dental specialist who treats children in the normal dental office environment as young as 48 to 72 hours old. It would possibly be unnecessary for many, not all, pediatric dentists to have an unexpired ACLS certification when sedation / general anesthesia is used on their pediatric patients.

As defined by the American Red Cross and other sources, ACLS focuses on advanced cardiac care for adult patients, whereas PALS focuses on advanced care for pediatric patients experiencing life-threatening emergencies such as respiratory emergencies, shock, and cardiac arrest.

What's the Difference Between ALS/ACLS vs. PALS?

I ask you to please make a modification to 8a. such that ACLS is not required by dentists who only see pediatric patients under the age of 13 years. PALS is required by dentists who see pediatric patients under the age of 13 years.

Thank you for your kind consideration.

Sincerely,

Dr. Achong.

--

Roger A. Achong, D.M.D., M.S.
Fellow, American Academy of Pediatric Dentistry
Fellow, Royal College of Dentists of Canada
Diplomate, American Board of Pediatric Dentistry
Fellow, American Society of Dentistry for Children
Fellow, American Orthodontic Society
Fellow, International College of Dentists

=====

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"We Love Taking Care of Kids"

=====

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"Enhance Your Smile"

Kelley, Tina

From: Dr. Nader Moavenian <drm@nhoms.com>
Sent: Monday, August 5, 2024 9:29 PM
To: OPLC: Rules
Subject: Feedback on draft for Den 304

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

As a practicing oral and maxillofacial surgeon (OMS) in New Hampshire for the past 20 years, I would like to provide feedback on the draft regulations for Den 304. I appreciate the opportunity to offer recommendations.

I strongly oppose the provisions in Den 304.08 that remove the ability for OMSs to self-administer deep sedation/general anesthesia to patients aged 0-8 years. No other state in the nation currently has such a provision, and there is no evidence to suggest it is necessary for public safety. OMSs provide the majority of DS/GA to this age group, and the removal of our ability to treat this population—especially without any scientific basis—will significantly impact patients' access to timely care, inflicting undue pain, burden, and access to care challenges. I strongly urge the revision and consideration of the alternative proposed by the New Hampshire Society of Oral and Maxillofacial Surgeons, which has been endorsed by other dental anesthesia provider groups and modeled after provisions currently existing in other states.

Additionally, I urge the Board to provide alternative options to the PALS requirement in Den 304.08 for dental assistants monitoring patients aged 9-12. Staffing challenges are at an all-time high, with dental assistant shortages fueling constant turnover in dental offices. Providing flexibility is necessary to ensure patients receive timely access to care while also balancing patient safety. Again, I strongly urge consideration of the alternative proposed by the New Hampshire Society of Oral and Maxillofacial Surgeons and currently used in other states.

Finally, I urge the Board to consider tying medication and equipment requirements to the facility permit, implementing time-oriented anesthesia records maintained in 5-minute intervals, public reporting of morbidity and mortality data in a deidentified manner, and adopting staffing requirements for the treatment of adult patients receiving moderate sedation, deep sedation, and general anesthesia in accordance with the OMS team model.

These recommendations aim to bolster patient safety, streamline regulatory processes, and ensure timely access to proficient dental care across all age groups. By implementing these suggestions, we can strengthen our ability to oversee anesthesia administration, adapt to healthcare challenges such as drug shortages, and uphold high standards of care within dental practices throughout New Hampshire.

I am grateful to the Board for thoughtfully considering these comments. We share a commitment to delivering safe patient care

Yours Truly,

Dr. Nader Moavenian
CEO/Founder, NHOMS LLC
Diplomat of the Board of Oral and Maxillofacial Surgeon NH Lic 03216

Board of Dentistry,

Thank you for all the hard work and time you voluntarily to keep the public safe. After reading over the proposed changes to Den 304.01 I have some suggestions you might consider before you submit for final rule making.

1. 304.03 (f) could have what qualifications are needed for the dentist to obtain the moderate sedation with pediatric qualification for ages 9 and older beneath it for clarity.
2. 304.07 (a)(2)(b) and (c) The board may consider that the yankauer and portable suction able to be used in a power failure is brought by the anesthesia provider and duplication is not cost effective or enhancing public safety in any way.
3. 304.07(a)(3)(c) and (d) Supraglottic airways and a cricothyrotomy kit with regards to their use on a patient under anesthesia / sedation is outside the hosting dentist airway management techniques. This is part of the reason the hosting dentist has an outside anesthesia provider providing anesthesia / sedation services. They will never use these airway adjuncts and it is provided by the anesthesia provider. This is not cost effective for the hosting dentist and provides no additional safety to the public since the hosting dentist does not know how to use these adjuncts nor will they be taught in ACLS or PALS.
4. 304.07(a)(4) This is standard monitoring equipment and would be brought by the anesthesia / sedation provider and should not be required to have at the facility. This is not cost effective for the hosting dentist and provides no additional safety to the public.
5. Please consider requiring a wheelchair as part of the facility and hosting permit inspection. This would aid in the facilitate transportation of the patient upon discharge from the dental facility.
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 - b. Benadryl for an allergic reaction.
 - c. Albuterol metered dose inhaler for bronchospasm or asthma.
 - d. Aspirin non-enteric coated chewable 162mg or equivalent,
7. 304.08 (b)The board might consider the unintended consequence of not specifying medication that should or should not be used in moderate sedation. Certain medications such as propofol, for example, are used in deep sedation / general anesthesia and the way 304.8 (b) is written, a moderate sedation qualified dentist

could use such a medication. Moderate sedation should be limited to medications that can be reversed quickly should an emergency arise, or should the patient slip passed moderate sedation into deep sedation / general anesthesia where airway management is need. Dentists who provide moderate sedation are not trained in medications used for deep sedation / general anesthesia and this nonspecific rule would allow medications used for deep sedation and general anesthesia to be used under the auspices of moderate sedation. I would ask the Board to allow the newly formed anesthesia subcommittee made up of anesthesia experts to look further into this and provide the board with a recommendation that protects the public and allows the dentist to provide moderate sedation in a safe manner.

8. 304.08 (c) Should the Board consider the following changes to the sentence below for clarity (changes in bold and strike though).
 - a. A dentist shall not delegate to a dental assistant or hygienist any task that is outside of their scopes of practice, as defined in Den 400 and Den 501.01(b), such as placement of an intravenous catheter, ~~or~~ drawing up **medications**, ~~or and~~ administering medications.
9. 304.08 (e) Can the Board clarify what the qualifications are for a dentist to provide deep sedation / general anesthesia for pediatric patients ages 9-12.
10. 304.08 (g) Can the board clarify who the provider can be administering and monitoring the sedation in this section such as: A second oral surgeon, dental anesthesiologist, physician anesthesiologist, or nurse anesthesiologist.

Kelley, Tina

From: Timothy Smith <drtim@childrensdentistnh.com>
Sent: Tuesday, August 13, 2024 1:53 PM
To: OPLC: Rules
Subject: OPLC Modification

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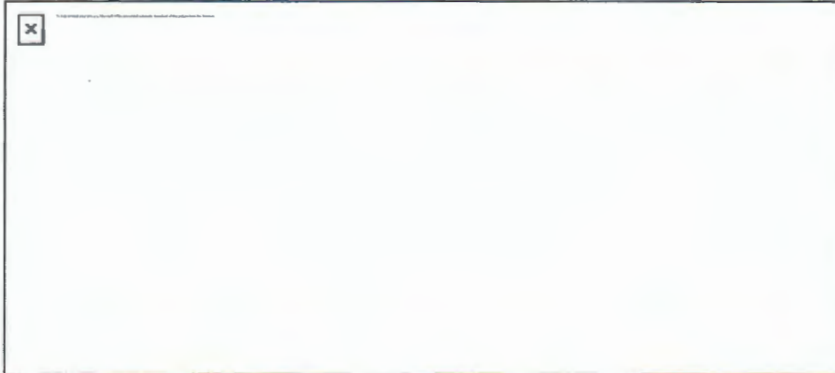
304.07 discuss the "Facility Hosting Requirements" and specifically says *"The operating dentist maintains an unexpired ACLS certification, as well as an unexpired PALS certification if patients under the age of 13 at the facility"*

As a pediatric dentist who provides treatment solely for the pediatric population, I would like to challenge the proposal that the operating dentist must have both ACLS and PALS when delivering care with an anesthesia provider (whom has both PALS and ACLS). PALS training has given us adequate knowledge and proficiency to respond effectively to pediatric emergencies, and ACLS certification is unnecessary.

Thank you for your consideration,
Tim Smith

--

Dr. Timothy Smith
Pediatric Dentist
Creating Healthy Smiles for Infants, Children and Teens...Lasting a lifetime!



603-527-2500 603-536-2500 603-444-1500 603-509-2500

www.childrensdentistnh.com



Kelley, Tina

From: Matthew Smith <smithmann@yahoo.com>
Sent: Tuesday, August 13, 2024 10:00 PM
To: OPLC: Rules
Subject: Sedation comment

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

Rules committee,

I would like to challenge proposal below:

304.07 discuss the "Facility Hosting Requirements" and specifically says *"The operating dentist maintains an unexpired ACLS certification, as well as an unexpired PALS certification if patients under the age of 13 at the facility"*

I believe if, as a pediatric dentist, we are treating patients under the age of 13 PALS certification would appropriate and sufficient to competently handle all emergency situations found in any sedation setting.

Thank you,
Matt Smith

August 13, 2024

Dear Members of the New Hampshire Board of Dental Examiners,

On behalf of the New Hampshire Department of Health and Human Services (DHHS) Division of Medicaid Services (DMS), I would like to share our concerns regarding the draft rules changes to Den.304 that are currently pending with the Board.

1. The proposed rule changes were intended to improve patient safety but could unintentionally create additional safety issues or harm. Dental teams in their current configuration include a Board-Certified Oral Surgeon (the vast majority possessing dual DMD/MD degrees) with the appropriate additional staff as described in Den 304.05. These teams have the extensive training required in Den 304.03 in addition to clinical experience which have allowed them to safely practice under the current rules. The requirement to bring in a third non-dental team member, at the moment a situation changes to require deep sedation, could significantly delay the timely delivery of care. This is most concerning for any emergency procedures being performed, where time is of the essence.
2. When a surgical procedure on a child under the age of 9 has to be delayed to a future appointment due to the lack of availability of a third non-dental team member, there is increased risk that in the interim the patient will need emergency care in an emergency department of a hospital. This not only increases the cost of care for this individual, but it also puts them at risk of needing more invasive treatment as the original condition has worsened. The proposed rule changes create an additional barrier to access to oral health care for children with some of the highest dental needs in the state.
3. Dental team members, as they are currently configured, are all subject to Board of Dental Examiners rules. The proposed rule changes bring in a member of the dental care team that is not subject to these same rules. Should an adverse event occur, all members of the team should be subject to the same set of rules.

The DMS believes that Den.304 should reflect the extensive training of oral surgeons which qualifies them to provide deep sedation for young children under the age of 9 without requiring the addition of another non-dental team member to provide anesthesia.

Thank you for your consideration of our concerns.

Respectfully submitted,



Sarah A. Finne, DMD, MPH
NH DHHS DMS Dental Director

Kelley, Tina

From: wpreich@comcast.net
Sent: Thursday, August 15, 2024 3:48 PM
To: OPLC: Rules
Subject: DEN 304, opposition

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To all New Hampshire dental board members and OPLC staff,

I would like to describe my experience and opinion regarding proposed DEN304 being proposed by the New Hampshire board of dentistry. And more importantly, my concern for the safety of dental patients in the state of New Hampshire.

It is my opinion that only Doctors with approved and accredited residency training and certification in Anesthesia can provide IV anesthesia to patients. And I believe the general public needs to be made aware of the Doctors Anesthesia certification prior to any IV sedation procedure.

I believe the public needs to be made aware if a Nurse Anesthetist (CRNA) is administering Anesthesia. And that the public needs to be made aware that the second provider in these cases- the Dentist- May not have completed an approved and accredited residency training in Anesthesia.

The current and proposed model creates a false sense of security for the patient and Dentist. In this scenario, you have a dentist without approved and certified residency anesthesia training performing dentistry/surgery/sedation on a patient in conjunction with a Nurse Anesthetist (CRNA).

I Support dental anesthesia providers that have completed certified and approved residency training program requirements, and anesthesia and surgical airway placement for all ages. No exceptions. This model should support any deep/general/moderate IV sedation case with multiple IV or inhalational agents being used. No exception. All ages apply.

The age of the patient is irrelevant. (With the exception of infants). The training of the providers is what matters.

And this is why no state in America has adopted anything less stringent. Separating patients eight and under would only create a false sense of security and allow patients to be sedated by an unprepared team. I wholeheartedly hope and pray that the dental board of New Hampshire understands this risk to the public. I have expressed this concern at the beginning of this process at a live dental board Meeting.

At the most recent dental board meeting the New Hampshire Oral Surgery society also expressed concern regarding how this ruling would affect access to care for patients eight and under.

Someone on the board said that access to care will not be an issue. I disagree with this. Dental insurance such as Delta dental does not Provide reimbursement for anesthesia provided by CRNA's. Many patients will not be able to afford a CRNA second provider model.

Thank you for your time and consideration in this matter. And thank you all for your time devotion to the profession of Dentistry in New Hampshire.

Sincerely,
Dr. Peter Reich

Kelley, Tina

From: dave pak <davepakoms@gmail.com>
Sent: Thursday, August 15, 2024 6:26 AM
To: OPLC: Rules
Subject: Regarding addendum for Den 304

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I have included the whole of my emails here to ensure completeness. I apologize for creating a string rather than having all my proposed thoughts in one email.

Dear Members of the OPLC,

Den 304 covers the use of general anesthesia and sedation by dentists, but does not have permits, evaluations, or means of qualifications for mobile anesthetists or mobile anesthesiologists. I propose that any mobile anesthetist or anesthesiologist also undergo an evaluation process under the Dental Board if they are to practice within the influence or realm of dentistry. Similarly, like provider and facility inspections, an inspector/evaluator, selected by the members of the dental board, could evaluate the mobile provider, their staff, and equipment for anesthesia; commensurate to the level of intended anesthesia. Upon completion, a permit could be issued (e.g. perhaps yearly or binnannually with their medical or dental license). This permit, in conjunction with the host provider's anesthesia and facility permits, in line with their level of anesthesia use, would provide more unified anesthesia protocols and tracking opportunities within the dental community.

In addition, an Affidavit or form of attestation, listing the various needs or attesting to the requirements relevant to the particular level of anesthesia and the respective host and facility requirements in Den 304, could be requested by the Dental Board per job site from the mobile anesthetist or mobile anesthesiologist, since their locations of practice can vary so much. The attestation should be valid for a limited time, perhaps 14 days (or X number of days considering the turnaround for the board to review and respond). If a series of cases are expected, then the option to choose a longer attestation could be made available involving that particular job site; otherwise, repeated renewals would be expected. Time limits should be considered for the attestations because hosts, hosting staff, and the hosting facility do not routinely experience the anesthesia for which they request and are not likely to possess the comparable awareness and skills for diagnosing and executing any anesthesia or emergency protocols that may be familiar with individuals involved with anesthesia frequently and routinely in their practice. The host and hosting staff also do not work with the mobile provider daily, so the dynamics of working together would be unfamiliar. The attestations, therefore, serve to help unify the host, hosting staff, facility, and the mobile provider as one team, better ensuring that the anesthesia policies are followed and that diagnosing and up-to-date protocols can be executed in a more efficient manner.

Also to point out, that all of this would suggest that the host, staff, facility, and mobile provider assume the necessary requirements and knowledge of the anesthesia level being used.

--

Dave C. Pak, D.M.D., M.D., M.S.

Dave C. Pak, D.M.D., M.D., P.A.

248 N. Main St

Rochester, NH 03867

Off Exit 14, from Spaulding Turnpike (Rt 16)

P: 603 332 0818

Fax: 603 332 1204

Board of Dentistry,

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Kelley, Tina

From: Horne, Christine
Sent: Monday, August 7, 2023 10:26 AM
To: Kelley, Tina
Subject: FW: Comments for Today

Importance: High

From: Whelehan, Jessica <Jessica.M.Whelehan@oplcnh.gov>
Sent: Monday, August 7, 2023 8:26 AM
To: Horne, Christine <Christine.M.Horne@oplcnh.gov>
Subject: FW: Comments for Today
Importance: High

Hi Chris:

Please see the Dental Society's email/comments, below. I think they may need to be discussed during the rules discussion at the BoDE meeting today!

Jes

Jessica M. Whelehan | Rules and Legislative Liaison
NH Office of Professional Licensure and Certification
7 Eagle Square, Concord, New Hampshire 03301
Website - www.oplcnh.gov
Facebook - <https://www.facebook.com/NHOPLC>
Instagram - <https://www.instagram.com/nhoplc/>
Twitter - https://twitter.com/NH_OPLC

STATEMENT REGARDING LEGAL INTERPRETATION OR ADVICE

Board staff are not authorized to provide any legal advice, but are able to refer you to the statutes/rules. You should seek advice regarding its applicability to your specific situation from your personal or corporate legal counsel. The statutes and rules established for OPLC and your specific profession are located at www.oplcnh.gov.

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From: mauerbach@nhds.org <mauerbach@nhds.org>
Sent: Monday, August 7, 2023 6:34 AM
To: Whelehan, Jessica <Jessica.M.Whelehan@oplcnh.gov>; drkochhar@alldentalcare.com
Subject: Comments for Today

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Hi, all! I wanted to share some comments for today's meeting as you review the rules changes. I know these are still in development, but we wanted to continue to provide input. Thank you!

-Mike

On 2 August, the NHDS had an opportunity to review the Board's proposed changes to Den.304 as posted on the BoDE website. The NHDS is extremely concerned that, as written, the proposed rules changes may fail to foster meaningful updates to Den.304 and, instead, create confusion among dentists and potentially access and safety issues for patients.

- A number of NHDS Members – specialists and general dentists alike – have expressed concerns that Section 304.02, as outlined in this proposal, potentially create patient safety issues and liability concerns for licensees. Licensees must obtain a facility inspection for each of the offices in which they provide care. It is the NHDS's opinion that the same standards should be applied to health care professionals who are administering to patients in a dental practice but not subject to the oversight of the NH Board of Dental Examiners. Logic: patient safety is not just a function of provider training and expertise. Safety is substantially affected by the structure design, clinical materials, and support staff available at each site. Therefore, respect for patient safety must include site-specific evaluation of compliance with clinical safety standards. It is not reasonable to assume that adequate individual professional credentials are adequate for a high level of operational compliance with safety standards in practice at each and every site absent a site-specific safety standards review.
- In 6(d) of subsection (a) of Section 304.03, counsel indicates that the Board must either exempt or not exempt board-eligible dentists from the requirements of that section. The NHDS believes, given the choice between exemption and no exemption, "exemption" must remain in place. This relieves the BODE and OPLC of the undue burden of evaluating each individual practitioner, and avoids the risk of interfering with existing referral patterns and access to care for patients in urgent need of treatment.
- In Section 304.05, counsel indicates correctly that there exists, as written, no process by which waivers are approved or renewed. The Board must articulate such protocols.
- The recently-passed Board of Dental Examiners rules package requires that the Board's membership include a dentist who is Board-certified to administer general anesthesia and deep sedation. The NHDS believes that the Board should delay implementation of any sedation rules changes until that individual can lend their expertise and experience to this important issue.

Michael P. Auerbach, Executive Director
New Hampshire Dental Society
23 South State Street
Concord, NH 03301
Tel. 603-225-5961 (o); 781-956-2156 (c)
E-Mail. mauerbach@nhds.org

The NHDS is the professional association of dentists advocating for the advancement of the oral health of the public and the practice of dentistry in New Hampshire.

VIA EMAIL: OPLC-Rules@opl.nh.gov

July 26, 2024

Board of Dental Examiners
c/o Office of Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301

RE: Comments Regarding Den 304 Proposal

Dear New Hampshire Board of Dental Examiners:

On behalf of the 52 members of the New Hampshire Society of Oral and Maxillofacial Surgeons (NHSOMS), we appreciate the hard work that has gone into the draft regulations for Den 304.

Anesthesia is at the core of OMS training and practice. OMS residency education standards require a dedicated 32-week resident rotation on medical and anesthesia service as well as an ongoing outpatient experience in all forms of anesthesia throughout four- to six-years of residency training. OMSs are trained in medical assessment and emergency management on par with our medical colleagues. Our training and ability to deliver treatment safely and affordably to patients via our team model of practice in our offices is unparalleled.

Den 304.03 – Permit Types

NHSOMS supports the development of a facility permit. It is crucial for the Board of Dental Examiners (Board) to maintain control over anesthesia delivery in dental offices to ensure patient safety, standardize procedures and uphold professional accountability. Without this facility permit, the Board would have no mechanism to address adverse events involving a non-dentist anesthesia provider or way to dictate standards for said facilities. This permit also facilitates the monitoring and addressing of any malpractice or negligence, thereby protecting patients and enhancing the overall quality of dental care.

Den 304.07 – Facility or Facility Hosting Requirements

NHSOMS questions the title for this section as paragraph (b) is related personal permit requirements rather than facility or facility hosting permits. NHSOMS recommends revision to reflect the nature of this section.

Additionally, NHSOMS feels strongly that any equipment, supply, or emergency medication requirements be tied to facility permits rather than individual permits. Such an effort would ensure that host facility practices are appropriately equipped with necessary devices, like capnography and ECG, providing greater parity across all practices and enhancing patient safety by establishing a predictable standard.

Finally, while NHSOMS understands and appreciates the level of detail provided in subparagraph (b)(5), we propose maintaining required drugs to specified classes rather than individual formularies wherever possible. As drafted, NHSOMS interprets this section as largely limiting providers to the drugs listed. In an age rife with drug shortages, greater flexibility is needed so providers can quickly pivot between appropriate medications in order to continue providing timely patient care. Additionally, as new drugs

enter the market, it is important to be able to utilize those pharmacologics in a timely manner without the need to reopen the state regulations to accommodate. Such methods are used in other states and have worked well.

Den 304.08 – Administering General Anesthesia, Deep Sedation, or Moderate Sedation

NHSOMS has several concerns with this section as outlined below.

- ***Paragraphs (d) (e) and (g) – 0-8 year olds*** – While we appreciate the Board’s efforts to protect the youngest patients in the state, **we have serious concerns with the proposal as drafted, specifically that the outright banning of the self-administration of deep sedation/general anesthesia to the 0-8 population will create both an access to care and patient safety concern, not solve one.**

A review of claims data provided by FAIR Health for 2018-22¹ shows that OMSs are the dental specialists providing the overwhelming majority of deep sedation/general anesthesia (DS/GA) and IV sedation services in the U.S. to all patients who have private dental insurance, including the majority of patients aged 1-7. These national figures can reasonably be applied to the New Hampshire population. As such, OMSs are providing the majority of anesthetic care in the state.

While few patients in this age range are treated in-office, those that are typically represent emergent cases – oftentimes, patients in pain with facial infections or trauma related fractures that need to be seen and treated as soon as possible. In such instances, providers, particularly solo providers, cannot wait to secure a separate anesthesia provider nor can all providers secure same-day hospital OR time. Under the proposal as written, patients in such instances would need to be turned away or directed to the local ER, which is already severely strained. While moderate sedation is available under the proposal, children may require deeper sedation in such instances due to pain response or lack of cooperation, which may complicate treatment for both the patient and staff during the procedure.

Additionally, no other state in the nation currently has such a provision, and there is no evidence to suggest it is necessary for public safety.

As noted, OMSs provide the majority of DS/GA to this age group, and the removal of our ability to treat this population – especially without any scientific basis – will significantly impact patients’ access to timely care. We recommend the Board establish a pathway for OMS providers to continue providing care to this population. We agree that it is important for providers to have experience and be proficient, as sedating a young child is very different from an adult. We suggest the Board consider an ongoing proficiency standard, included in the ASDA-AAOMS-AAP model anesthesia regulations and currently adopted in states such as Mississippi, Ohio, and South Carolina. Specifically, we suggest the inclusion of this language in lieu of the current provisions found in paragraph (g):

¹ Statistics calculated by AAOMS using data from the U.S. Census Bureau and information provided by FAIR Health based on its privately insured dental claims data for calendar years 2018-22. Of the total 11,960,846 moderate IV and deep sedation / general anesthesia (DS/GA) cases performed in 2018-22, 78 percent – or 9,281,331 – were delivered by OMSs. In the 1- to 7-year-old age group, OMSs provided 39 percent (29,716) of the total DS/GA cases (76,073). In the 8- to 12-year-old age group, OMSs provided 79 percent (155,298) of the total DS/GA cases (196,356). For moderate sedation, in the 1- to 7-year-old age group, OMSs provided 32 percent (2,650) of the total moderate IV sedation procedures (8,408). In the 8- to 12-year-old age group, OMSs provided 74 percent (18,845) of the total moderate IV sedation services (25,587).

Proposed alternative language

(g) General anesthesia, deep sedation, and moderate sedation permit holders wishing to administer deep sedation or general anesthesia to patients eight (8) years of age or younger must have documentation of current completion of PALS and meet one of the following conditions:

- (1) Completion of an accredited dental anesthesiology residency within the last two (2) years with documentation of supervised personal administration of deep sedation/general anesthesia for twenty (20) patients eight (8) years of age or younger during training; or
- (2) Completion of an accredited oral and maxillofacial surgery residency within the last two (2) years with documentation of supervised personal administration of deep sedation/general anesthesia for twenty (20) patients eight (8) years of age or younger during training; or
- (3) Documentation of personal administration of deep sedation/general anesthesia for dentistry for twenty (20) patients eight (8) years of age or younger during the last two (2) years of clinical practice for dentists who currently possess a Board-issued General anesthesia, deep sedation, and moderate sedation permit. Such documentation is required at the time of first renewal of the permit, or as prescribed by the Board.

- (a) If the permittee lacks a sufficient number of pediatric cases for initial endorsement, the permittee may personally administer dental office-based deep sedation or general anesthesia while not involved in the conduct of the surgical procedure to children eight (8) years of age or younger under the direct supervision of a permit holder who meets the qualifications of **[INSERT SECTION]**, which will then be accepted as meeting the case requirement. If within one (1) years of residency completion, cases from residency may also be used to meet the case requirement; and

Such a model not only has precedent in other states – and has been endorsed by the three national dental provider groups holding the highest levels of anesthesia training – but also creates a pathway that balances patient safety with access to care.

- **Paragraph (e) – DBEAM requirements** – While NHSOMS supports the inclusion of the requirement for providers seeking the 9-12 age patient exemption to complete a course such as

the OBEAM, there are other, similar courses available and request clarification that the Board may choose to recognize those courses as applicable. We recommend the following amendment:

Proposed alternative language

- (e) (1) Have completed an advanced airway course with hands-on training, such as the American Association of Oral and Maxillofacial Surgeons (AACMS) Office-Based Emergency Airway Management (OBEAM) module, or another course approved by the Board, within the previous 6 years; and

This revised language broadens the availability of courses and provides valuable antitrust protections for the Board.

- **Paragraph (e) – Assistant requirements** – NHSOMS has concerns over the assistant requirements for the 9-12 age patient exemption. While we appreciate the Board's intentions, we have concerns about mandating PALS for assistants in the current environment. Staffing challenges are at an all-time high, with dental assistant shortages fueling constant turnover in dental offices.² We propose the following alternative language to provide additional pathways for assistants to meet the Board's goal:

Proposed alternative language:

(e) (2) (b) Ensure that a designated staff member is present during the procedure with the sole responsibility to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation, meeting one of the following criteria:

- i. BLS at the healthcare provider level;
- ii. PALS; or,
- iii. Thirty-six (36) hours of didactic instruction in the underlying physiology and interpretation of monitoring used for patients under deep sedation/general anesthesia and principles of office-based anesthesia and anesthesia equipment taught by either a qualified dental office deep sedation/general anesthesia provider or in a continuing education course approved by the Board; and a minimum of four (4) hours of clinical training in assisting an anesthesia provider in the management of dental office deep

² ADA Health Policy Institute in collaboration with American Dental Assistants Association, American Dental Hygienists' Association, Dental Assisting National Board, and IgniteDA. Dental workforce shortages: Data to navigate today's labor market. October 2022. https://www.ada.org/-/media/project/adaorganization/ada/ada.org/files/resources/research/hpi/dental_workforce_shortages_labor_market.pdf

sedation/general anesthesia emergencies, including the use of bag-valve-mask ventilation with and without airway adjuncts and assisting in advanced airway management, taught by either a qualified dental office deep sedation/general anesthesia provider or in an anesthesia emergency simulation course.

This model is excerpted from the ASDA-AAOMS-AAP model anesthesia regulations and such pathways are currently used several states.

- **Paragraph (f)** – NHSOMS seeks additional information on this section, specifically subparagraph (2), which states that providers treating patients between 9 and 12 years of age with the administration of moderate sedation “with or without inhalation sedation, agents are limited to a single dose of one or more drugs, or a multi-dose of a single drug, using manufacturer guidelines as found in the FDA “Online Repository”, as found at [labels.fda.gov](https://www.fda.gov/labels).” We ask for clarification to this section as it is unclear if this requirement would also apply to those individuals holding a general anesthesia, deep sedation, and moderate sedation permit or only to individuals with a moderate sedation permit with pediatric qualification.

OMSs may deliver additional medication if the patient is not at a sufficient level of anesthesia, particularly if patients are not experiencing the anticipated effects to lower dosages of anesthetic medication. This is especially the case in the pediatric population where the dosing is weight-based. Often, OMSs will not utilize the maximum dose with the initial dosage and will adjust based on the patient’s response. The anesthesia levels are demarcated by patient response to verbal and painful stimuli. Depending on the anticipated level of sedation, medications can be adjusted and re-dosed as necessary. This is especially important in younger and older populations, who can be more sensitive to anesthetic effects.

While we certainly understand and support the requirement for moderate sedation permit holders, those with advanced training in DS/GA holding the commensurate permit should be allowed to administer additional moderate sedatives. We urge the Board to amend the language in this section accordingly.

Den 304.09 – Facility or Facility Hosting Documentation Requirements

NHSOMS recommends stipulating that such records be kept in a time-oriented model and that a time interval be specified by the Board for such records. NHSOMS suggests that records be maintained in 5-minute intervals, consistent with AAOMS³ and ASA⁴ standards.

Den 304.13 – Morbidity and Mortality Reports

NHSOMS strongly supports reporting the events as proposed but would suggest the Board require such initial notification to occur within 24 hours, in addition to the full report to be submitted within 15 working days as noted. The requirement of early notification will allow the Board an opportunity to better know when such events occur and take any necessary measures to ensure the safety of the public.

³ American Association of Oral and Maxillofacial Surgeons. Office Anesthesia Evaluation Manual – 9th Edition. 2018. Pg. 8.

⁴ American Society of Anesthesiologists. Standards for Basic Anesthetic Monitoring. December 2020. <https://www.asahq.org/standards-and-practice-parameters/standards-for-basic-anesthetic-monitoring>

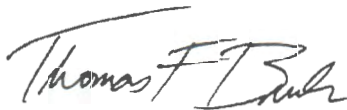
Additionally, NHSOMS recommends that data from such events be published to the Board's website in a condensed and deidentified manner to allow for public inspection and study of the information. Such transparency would allow state dental societies to provide any necessary education to New Hampshire dentists based on the data's findings and guide discussions for future amendments to state regulations. Such reports are being published in other states, including California and Texas. Alternatively, NHSOMS recommends reporting such information to a national registry, such as DAIRS, to allow for the national study of any adverse event data. It is important that any changes to the way anesthesia is administered be guided by data, but we need access to the data to draw any conclusions.

General recommendation

While the majority of this document focuses on pediatric anesthesia delivery, we noted that staffing requirements for adult patients are absent. NHSOMS recommends that the regulations include a requirement for at least one other person besides the dental provider to be present during the administration of moderate sedation, and two individuals – the anesthesia monitor and surgical assistant – during the administration of DS/GA. This team approach is nationally recognized and important during any adverse events.

We thank you for the opportunity to submit these considerations and look forward to our continued collaboration on this and other issues affecting dentistry. Please contact me at 925-250-4607 or drthomasburk@gmail.com for questions or additional information.

Sincerely,

A handwritten signature in black ink that reads "Thomas F. Burk". The signature is written in a cursive style with a large, prominent "T" and "B".

Thomas F. Burk, DMD, MD
President, N.H. Society of Oral and Maxillofacial Surgeons

VIA EMAIL: OPLC-Rules@oplcnh.gov

August 6, 2024

Board of Dental Examiners
c/o Office of Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301

RE: Supplemental Comments Regarding Den 304 Proposal

Dear New Hampshire Board of Dental Examiners:

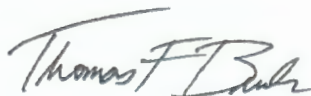
On behalf of the 52 members of the New Hampshire Society of Oral and Maxillofacial Surgeons (NHSOMS), we thank the Board for the opportunity to discuss this draft during the Aug. 5 public hearing. We would like to share additional thoughts we had beyond to our previously submitted comments.

Specifically, we request further clarification on section Den 304.08(e)(2)c, which in part addresses special needs patients. "Children with special needs" can be very broad, subject to interpretation, and range in both needs and risk during the administration of deep sedation or general anesthesia. For example, it would be inappropriate to consider a patient with high-functioning autism in the same manner as an ASA III or greater patient or one with moderate-severe tonsillar hypertrophy. As such, we would appreciate clarification in this area, including the ability to allow for provider discretion as it would be impossible to codify every possibility in this area.

Oral and maxillofacial surgeons receive extensive training on treating a wide variety of patient populations during our four- to six-year residency program. This rigorous training equips us with the expertise to make informed decisions about patient care, ensuring that treatments are safe, effective, and tailored to individual patient needs, which ultimately leads to better patient outcomes and higher standards of care.

We thank you for the opportunity to submit these considerations and look forward to our continued collaboration. Please contact me at 925-250-4607 or drthomasburk@gmail.com for questions or additional information.

Sincerely,



Thomas F. Burk, DMD, MD
President, N.H. Society of Oral and Maxillofacial Surgeons

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American Association of Oral and Maxillofacial Surgeons

Mark A. Egbert, DDS, FACS
President

Karin Wittich, CAE
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VIA EMAIL: OPLC-Rules@oplc.nh.gov

July 29, 2024

Board of Dental Examiners
c/o Office of Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301

RE: Comments Regarding Den 304 Proposal

Dear New Hampshire Board of Dental Examiners:

On behalf of the 9,000 members of the American Association of Oral and Maxillofacial Surgeons (AAOMS) – including the 52 members practicing in New Hampshire – we offer our comments on the New Hampshire Board of Dental Examiners' (NHBDE) proposed rule changes to Den. 304.

Anesthesia is fundamental to OMS training and practice. OMS residency programs require a dedicated 32-week rotation in medical and anesthesia services, along with continuous outpatient experience in all forms of anesthesia throughout the four- to six-year residency. OMSs receive training in medical assessment and emergency management equivalent to that of our medical colleagues. Our comprehensive training and capability to provide safe, cost-effective treatment through a team-based model in our offices are unparalleled.¹

Additionally, a review of claims data from FAIR Health for 2018-22² reveals that oral and maxillofacial surgeons (OMSs) are the primary providers of deep sedation/general anesthesia and IV sedation services in the U.S. for patients with private dental insurance. Given that OMSs deliver most of the dental office-based anesthetic care nationwide, we are uniquely qualified to provide informed opinions on this regulation and anesthesia delivery in general.

¹ Wiemer S., Mediratta, J., Triana R., Rieck, K., et. al. What Is the Incidence of Anesthesia-Related Adverse Events in Oral and Maxillofacial Surgery Offices? A Review of 61,237 Sedation Cases From a Large Private Practice Consortium. *J Oral Maxillofac Surg* 2024; <https://doi.org/10.1016/j.joms.2024.04.014>. Accessed July 19, 2024.

² Statistics calculated by AAOMS using data from the U.S. Census Bureau and information provided by FAIR Health based on its privately insured dental claims data for calendar years 2018, 2019 and 2020. Of the total 6,240,366 moderate and deep sedation/general anesthesia (DS/GA) cases performed in this period, 79 percent – or 4,911,840 – were delivered by OMSs. In the 1- to 7-year-old age group, OMSs provided 44 percent (16,707) of the total DS/GA cases (38,257). In the 8- to 12-year-old age group, OMSs provided 81 percent (85,919) of the total DS/GA cases (105,791). For moderate sedation, in the 1- to 7-year-old age group, OMSs provided 34 percent (1,439) of the total moderate IV sedation procedures (4,244) and in the 8- to 12-year-old age group, provided 76 percent (10,378) of the total moderate IV sedation services (13,698).

Concerns with 0-8 Anesthesia Administration Proposal

AAOMS strongly opposes the provisions that expressly prohibit general anesthesia, deep sedation, and moderate sedation permit holders from self-administering deep sedation or general anesthesia (DS/GA) to patients 8 years and under without the use of a separate anesthesia provider.

Many young patients seen in-office, especially those aged 0-8, frequently present with urgent conditions like severe facial infections or trauma-related fractures that require immediate intervention. For providers, particularly solo practitioners, it is not feasible to wait for an anesthesia provider or to quickly secure hospital operating room time. The proposed regulations, as they stand, would push these patients to seek care in already overwhelmed emergency rooms, which could delay critical treatment and jeopardize patient safety. While moderate sedation is an option, it might not be sufficient for these patients, who may need deeper sedation for safe and effective treatment.


As we emerge from the pandemic, healthcare access is already strained to the breaking point. If we add another layer – one that is not supported by science nor found in any other state – we risk creating more barriers to much-needed care. When access to care is strained, it is the most vulnerable patients who suffer. We urge the NHBDE to retract this requirement and conduct a careful analysis of its implications on financial cost, human resources, and patient access to care. In a post-pandemic environment rife with workforce shortages, the state cannot afford to upend the current delivery model without appropriate justification. Doing so would negatively impact patient access to care and harm vulnerable patients.

Recommendation for ASDA-AAOMS-AAP Model Regulations

As an alternative, AAOMS strongly recommends that the Board incorporate the ASDA-AAOMS-AAP model regulations³ to establish a pathway for OMSs to continue providing care to young patients. These regulations, developed by the three dental specialty groups with the highest levels of anesthesia training and the largest percentage of administration to patients as noted by the FAIR Health data, balance patient safety with access to care and include ongoing proficiency standards for providers.

We thank you for the opportunity to submit these thoughts and look forward to our continued collaboration on this and other issues affecting dentistry. Please contact Ms. Sandy Guenther, Manager of State Government Affairs and Advocacy Engagement, at sguenther@aaoms.org or 800-822-6637 with any questions.

Sincerely,



Mark A. Egbert, DDS, FACS
AAOMS President

CC: Thomas F. Burk, DMD, MD, President, NHSOMS
Edward J. Miller Jr., DMD, District I Trustee, AAOMS
Karin K. Wittich, CAE, Executive Director, AAOMS
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³ www.AAOMS.org/ModelRegs

Journal Pre-proof

What is the Incidence of Anesthesia Related Adverse Events in Oral and Maxillofacial Surgery Offices? A Review of 61,237 Sedation Cases from a Large Private Practice Consortium.

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What is the Incidence of Anesthesia Related Adverse Events in Oral and Maxillofacial Surgery Offices? A review of 61,237 sedation cases from a large private practice consortium.

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**What is the Incidence of Anesthesia Related Adverse Events in Oral and Maxillofacial
Surgery Offices? A Review of 61,237 Sedation Cases from a Large Private Practice
Consortium.**

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Card, MSDS⁵; David Rallis, DDS, MD^{1,5}; Kevin L. Rieck DDS, MD, FACS^{1,5}; Eric Holmes,
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Abstract: 325 words

Background: The safety of the anesthesia team model performed in oral and maxillofacial surgery (OMS) offices has been criticized by professional and mainstream media.


Purpose: This study aims to assess the incidence of adverse anesthetic events (AE) associated with the OMS anesthesia team model and identify risk factors associated with AEs.

Study design, setting, sample: This was a retrospective cohort study utilizing a patient database from Paradigm Oral Health[®], Lincoln, Nebraska, a managed service organization (MSO). Subjects included were 14 and older, undergoing open-airway intravenous anesthesia for ambulatory OMS procedures using the OMS anesthesia team model at multiple private practices in the MSO network between June 30th, 2010, and September 30th, 2022. Exclusion criteria included patients younger than 14 or patients with incomplete medical records.

Predictor variable: Primary predictor variables were age, sex, American Society of Anesthesiologists physical status classification system (ASA) score, type of surgical procedure performed, and the types of medications administered during sedation.

Main outcome variable: The presence of an AE. The definition of an AE was modeled on the World Society of Intravenous Anesthesia (SIVA) definition. All AEs were identified through surrogate markers which were identified through chart review. One example of an AE is ventricular fibrillation, which necessitates application of medications, here the medication is the surrogate marker.

Covariates: None.



Analyses: The data were analyzed using t-tests and χ^2 tests. *P* values ≤ 0.05 were considered statistically significant.

Results: Included in the study were 61,237 sedation cases (53.87% female and 46.13% male), for 56,076 unique patients ranging from 14 to 98 years of age (mean 33.26 ± 18.35). An AE incidence of 3 per 100,000 per year (25 total events) was observed. Neither age, sex, ASA score, nor type of surgical procedure exhibited statistically significant associations with AEs. A statistically significant association was found between AEs and fentanyl ($P = 0.0008$).

Conclusions and Relevance: This investigation shows a smaller incidence of AEs than previous studies of the OMS anesthesia team model.

Introduction

The safety of the oral and maxillofacial surgery (OMS) anesthesia team model performed in an OMS office outside the hospital operating theater is often under scrutiny. On the contrary, the provision of such anesthetics to relatively healthy patients undergoing minor procedures is heralded as the ideal model in efficiency, economy, and safety in the ever-evolving healthcare landscape. This ability to provide anxiolysis and anesthesia to patients is not only taken seriously by the profession, but also regulated heavily at various institutional, state, and national levels. The safety of the OMS anesthesia team model has also been studied thoroughly and deliberately. Hubbell was the first to publish the term "team anesthesia" to describe office-based outpatient general anesthesia as practiced by oral and maxillofacial surgeons.¹ Since that time, numerous studies have demonstrated the safety of sedation for outpatient oral and maxillofacial surgical procedures provided in accordance with the OMS anesthesia team model.²⁻⁷

Despite well-documented evidence of safety, the OMS anesthesia team model has come under scrutiny in both lay media as well as professional society position statements. Sister organizations have attempted to create practice guidelines that do not always pay heed to the OMS anesthesia team model and often exclude OMS from contributing to these guidelines. The American Association of Oral and Maxillofacial Surgeons (AAOMS) considers it a priority to preserve and protect the OMS anesthesia team model.⁸ Large databases maintained by third parties such as the US census bureau and FAIR Health data based on privately insured dental claims data suggest that oral and maxillofacial surgeons are the dental specialists providing the overwhelming majority of deep sedation/general anesthesia (DS/GA) and intravenous (IV) sedation services in the United States to patients who have private dental insurance. This data shows a low rate of adverse events in OMS offices compared to the total anesthetics performed.

²⁻⁷ A new avenue for data collection of the OMS-led anesthesia care team is the emergence of management service organizations (MSOs) and their centralized data banks. These data banks include a large pool of surgeons with training and experience in DS/GA. Data scientists can mine the appropriate clinical data and provide cumulative assessments about outcomes and best-practice approaches to patient care.

The purpose of this study is to estimate the incidence of adverse anesthetic events (AEs) associated with the OMS anesthesia team model and identify risk factors associated with AEs in a large private OMS practice consortium during a 143-month period. The authors hypothesized that the actual incidence of adverse anesthetic events occurring in OMS practices would compare favorably to outcomes reported in the literature by other non-anesthesiology specialties who also routinely perform procedural sedation. The specific aims of the study were to identify the number of AEs in the cohort, and the baseline demographic characteristics, comorbid disease status (ASA), type of surgical procedure performed, and the types and dosages of medications administered during the procedure to identify risk factors associated with adverse anesthetic events within the study cohort.

Materials and Methods

Study design/sample: To answer the research question, what is the incidence of anesthesia adverse events in private practice oral and maxillofacial surgery offices, a retrospective cohort study was designed. On 12/27/2022 the IRB determined that this protocol met criteria for exemption from IRB review in accordance with 45 CFR 46.10. IRB ID: 2022-10-09. The study population was composed of all patients undergoing non-intubated, open-airway IV anesthesia for ambulatory oral and maxillofacial surgical procedures from June 30th, 2010, to September 30th, 2022 at a private practice consortium. The information came from Paradigm Oral Health[®].

Lincoln, Nebraska, an MSO consisting of a large group of private practice oral and maxillofacial surgeons with a shared patient information database that was well organized and easily searchable.

To be included in the sample patients had to meet a several inclusion criteria. First having a surgical procedure and concomitant IV anesthetic provided by the same OMS team during the time frame of the study. Research subjects had to be age 14 or older. Sufficient documentation of medications used during the encounter, postoperative recovery events, and demographic characteristics were also necessary for inclusion. Exclusion criteria included patients under the age of 14. If there was insufficient documentation of medications used during the encounter, postoperative recovery events, demographic characteristics, or if the sedation procedure was completed by a provider who was not an oral and maxillofacial surgeon, the patient was also excluded. All the surgeons in the cohort were graduates of accredited oral and maxillofacial surgery residency programs in the United States and were current with all licensure and certification requirements.

Data collection methods: All patients to be considered for inclusion in the study were identified from a database search or a survey sent to the treating surgeons. The survey was conducted as we were unable to query outside hospital databases to search for Emergency Department visits or hospital admissions. The survey was sent through a protected, end-to-end, encrypted email to OMS within the MSO. No survey was administered to patients, only retrospectively to the treating providers to validate data integrity. Medical and dental insurance procedural codes (CPT/CDT) were used to identify patients who received IV sedation. (Table 1). To do this a centralized structured query language (SQL) database was queried which contained records from 12 unique practices, some of which had multiple locations. The dataset included records from 65

separate providers. Patient records in this database included vital signs and monitor outputs which were recorded electronically directly from monitors. Once the cohort was identified, the demographic and perioperative parameters of interest were abstracted.

Once the data was collected from the database the entries were cross-referenced to eliminate any possible duplicate sedation cases. All the data were then compiled into a comprehensive master data set. The anesthesia team model was standardized across all the surgical practices that were involved in the study. For each sedation, patient monitoring was performed along with the AAOMS standard of care at the time of the procedure.⁹ Sedation data was de-identified and the data was stored in a secure, password-protected server. Only the principal investigator and co-investigators had access to the dataset. All data abstracted for the study currently resides in the MSO electronic medical record and clinical databases.

Variables: The primary outcome variable for this study was the presence of an AE which was coded as present or absent. The definition of an AE was modeled on those reported in consensus documentation from the World Society of Intravenous Anesthesia (SIVA) International Sedation Task Force to track worldwide intervention-based AEs related to procedural sedation (**Table 2**). All the AEs in the cohort were identified by identifiable surrogate markers which were extracted as variables from the multiple databases which were used along with chart review (**Table 2**).

Multiple risk factors were used as predictor variables. This includes demographic variables age, sex, and American Society of Anesthesiologists Physical Status Classification System (ASA score) (**Table 3**). Other predictor variables were the type of surgical procedure performed, and the types of medications (fentanyl, ketamine, midazolam, propofol) administered during the procedural sedation (**Table 3**).

Data Analysis: T-tests and χ^2 tests were employed to depict relationships between baseline patient characteristics and medications with adverse events. *P*-values are reported for all baseline characteristics and the aforementioned medications (**Table 4**). The alpha level was set at ≤ 0.05 . All analyses were completed using R^{*}, version 4.2.2.

Results

Demographic characteristics for the subjects in the study cohort were presented with frequency counts of AEs in (**Table 4**). The total cohort included 61,237 sedation encounters, including 60,166 (98.25%) deep sedation/general anesthesia encounters and 1,071 (1.75%) moderate sedation encounters. In 61,237 sedations, 25 (0.04%) AEs were identified, equivalent to 3 AEs per 100,000 sedations per year. Descriptive statistics for the IV sedation medications administered during the sedation encounters are depicted in (**Table 3**). *T*-tests and χ^2 tests were used to identify variables as independent risk factors for AEs are depicted in (**Table 4**).

In terms of risk factors for AEs, age, sex, ASA Classification or procedure were not associated with AE ($P > 0.07$). A statistically significant association was identified between AEs and the use of fentanyl (RR = 0.15, $P = 0.0008$). No statistically significant associations were identified for AEs relative to the other three types of IV sedation medications: midazolam, propofol, or ketamine ($P > 0.18$).

Many of the AEs identified through surrogate markers did not have descriptions in the operative reports so we were unable to classify them completely. The 65 providers who had patients in this cohort were surveyed to ascertain whether any of their patients required emergency medical services (EMS) activation or hospitalization. Ten survey responses were received (15.38%). None of the responding providers recalled activating EMS or having to

transfer a patient to a hospital for an anesthesia complication. There was no mention in the patients' charts of medication errors, performing basic life support/advanced cardiovascular life support, securing an advanced airway, activating EMS, or hospital admissions. No mortalities were reported in this cohort of 61,237 OMS clinic procedural sedations. The incidence of AEs falls within the previously reported levels of morbidities in outpatient sedations.

Discussion

The purpose of this study is to estimate the incidence of AEs associated with the OMS anesthesia team model and identify risk factors associated with AEs in a large private OMS practice consortium during a 143-month period. This is perhaps the largest review of outpatient office procedural sedations in OMS literature. The authors hypothesized that the incidence of adverse anesthetic events occurring in OMS practices would compare favorably to outcomes reported in the literature by other non-anesthesiology specialties who also routinely perform procedural sedation. The specific aims of the study were to identify the incidence of AEs in the cohort, and the baseline demographic characteristics, comorbid disease status (ASA), type of surgical procedure performed, and the types and dosages of medications administered during the procedure to identify risk factors associated with AEs within the study cohort.

The incidence of AEs in the sample of 61,237 sedations was 0.04% per 143 months, or 3 per 100,000 per year. There were no mortalities in the study sample. Patient age, sex, ASA classification, and the type of surgical procedure performed did not have statistically significant associations with the presence of AEs in the study sample. A statistically significant association was identified for one of the four types of IV sedation medications administered during the procedure, fentanyl. Midazolam, propofol, and ketamine did not have a statistically significant association with AEs. Although the use of fentanyl was associated with AEs, this should be

interpreted carefully as nearly all the patients in the cohort received that medication, which is congruent with the observation that most AEs in this cohort were identified through the reversal agent surrogate markers.

The incidence of AEs in this sample is smaller than the incidence reported from the previous Mayo Clinic practice study.¹⁰ This study and the previous Mayo Clinic practice study report incidence which are smaller than any other previously reported studies in the OMS literature. As discussed in previous papers, this is perhaps due to heterogeneity in the reporting of what is considered an AE among the different studies. Previous studies have included syncope, injuries associated with positional changes, phlebitis, and emesis without aspiration as complications, which increases the rate of complication without necessarily requiring the intervention of a provider or leading to an AE consistent with current intervention-based World SIVA International Sedation Task Force consensus definitions.¹¹ These AEs do not necessarily have the contextual relevance to the ambulatory setting in which other non-anesthesia proceduralists practice and tend to generally be underreported.¹²⁻¹⁴ Having consistent, relevant criteria for measuring AEs in the OMS team model allows clear and accurate comparisons regarding the safety of the OMS anesthesia team model. This practice will also make it possible to compare outcomes of procedural sedation across multiple medical and dental specialties. The same outcome measures that were tracked in a previous study of a large cohort from Mayo Clinic were deliberately followed in this paper.

Despite the large dataset, our study was not without the weaknesses inherent in a retrospective study. Additionally, the study relied on a surgeon survey to verify that no subjects in the cohort were transferred to a hospital or required EMS activation. This method of verification introduces the possibility of recall bias and may have resulted in an artificially low

number of AEs, especially given the low rate of provider response. The study also lacked a reliable method to corroborate the reported data with different dental board records or emergency room admissions data as was done in a previous study with the Mayo Clinic study. While the variability between several practices and surgeons were adjusted for, human error looms large. A national database would add significant value to a study such as this. A national database would also eliminate the necessity for studies to rely on surrogate markers to identify AEs. While not unique to this study, the use of surrogate markers is different than counting actual AEs and may have resulted in an underrepresentation of the actual number of AEs.

The anesthesia team model allows OMS to care for patients in a private office safely and efficiently. The low incidence of AEs in this study is the result of deliberate and intentional parameters and guidelines that are set in place by the OMS specialty. This begins with an investment in structured and mandated training standards for both surgeons and teams. It continues with conducting strict peer reviews of facilities and techniques, all while focusing on continued educational requirements. This strict education and training allow OMS to provide safe, comfortable, and cost-efficient care for our patients. The training of OMS residents as non-anesthesiologists providing anesthetic care outside the hospital systems is critical in this endeavor. The Commission on Dental Accreditation (CODA) requirements for an accredited OMS program requires 32 weeks of combined anesthesia and medical service rotations, with 20 weeks dedicated to anesthesia and 4 weeks to pediatric anesthesia.¹⁵ OMS Residents function as anesthesia residents during this time and must complete a minimum of 300 cases of general anesthesia and deep sedations, including 50 cases involving children under the age of 13. Additionally, AAOMS recommends continued commitments to anesthesia education that includes a mastery-based simulated practice of airway emergencies in the office called Office-

based Emergency Airway Management (OBEAM) among others. These are coupled with state and local legislations that ensure personnel, equipment, and facility safety for the care of the OMS patient.

The precautionary measures and safeguards ingrained in the OMS specialty appear to be effective. As various medical and dental fields increasingly embrace the concept of ambulatory anesthesia and procedural sedation, the OMS anesthesia team model emerges as a technique with very few AEs. Patient selection, procedural intricacy, adept technique, comprehensive team training, and robust infrastructure collectively stand as paramount factors in ensuring the safe administration of anesthesia.

Authorship Confirmation Statement

1. Steven J. Wiemer, DDS, MD:
2. Jai Kumar Mediratta, DDS:
3. Reese R. Triana, MPH:
4. James Card, MSDS:
5. David Rallis, DDS, MD:
6. Kevin L. Rieck DDS, MD, FACS:
7. Eric Holmes, BA
8. Deepak G. Krishnan, DDS, FACS:

All persons who meet authorship criteria are listed as authors, and all authors certify that they have participated sufficiently in the work to take public responsibility for the content, including participation in the concept, design, analysis, writing, or revision of the manuscript. Furthermore, each author certifies that this material or similar material has not been and will not be submitted to or published in any other publication before its appearance in the Journal of Oral and Maxillofacial Surgery. All persons who have made substantial contributions to the work reported in the manuscript (e.g., technical help, writing and editing assistance, general support), but who do not meet the criteria for authorship, are named in the Acknowledgements and have given us their written permission to be named. If we have not included an Acknowledgements, then that indicates that we have not received substantial contributions from non-authors.

Acknowledgements-

"We extend our profound gratitude to Quinn Rhodes, MBDS for his invaluable expertise in statistical analysis and machine learning. His contributions have been pivotal in advancing the robustness and insights of this research."

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Tables

Table 1. CPT AND CDT CODES USED TO IDENTIFY SUBJECTS UNDERGOING IV SEDATION FOR AMBULATORY ORAL AND MAXILLOFACIAL SURGICAL PROCEDURES Wiemer et al. Safety of Outpatient Procedural Sedation. J Oral Maxillofac Surg 2020

Sedation CPT codes

- **Moderate sedation: 99141; 99142; 99143; 99144; 99145; 99148; 99149; 99150**

Sedation CDT codes

- **Deep sedation: 99141-47; 99142-47; 99143-47; 99144-47; 99145-47; 99148-47; 99149-47; 99150-47**
- D9220 deep sedation/general anesthesia—first 30 minutes
- D9221 deep sedation/general anesthesia—each additional 15 minutes
- D9222 deep sedation/general anesthesia—first 15 minutes
- D9241 IV conscious sedation/analgesia—first 30 minutes
- D9242 IV conscious sedation/analgesia—each additional 15 minutes

Abbreviations: CPT, Current Procedural Terminology; CDT, Current Dental Terminology; IV, intravenous.

Table 2. DEFINITIONS OF INTERVENTION-BASED AES CONSISTENT WITH PROCEDURAL WORLD SIVA INTERNATIONAL SEDATION TASK FORCE CONSENSUS DEFINITIONS Wiemer et al. Safety of Outpatient Procedural Sedation. J Oral Maxillofac Surg 2020.

AE	Definition	Surrogate Markers
Medication error	A preventable event caused by inappropriate medication administration	Administration of antihistamines and reversal agents
Patient combativeness	Patient movement or behavioral dyscontrol unresponsive to pharmacologic or behavioral intervention	Procedure abortion and administration of reversal agents
Seizure or seizure-like activity	Intraoperatively or postoperatively identified convulsions, spasms, myoclonus, or automatisms	Administration of anticonvulsant medication in addition to what is typically used for routine ambulatory IV sedation
Cardiac dysrhythmia	Bradycardia, tachycardia, or other identifiable pathologic arrhythmia on intraoperative ECG monitoring	Administration of antiarrhythmic medications
Myocardial infarction/angina	Patient reported substernal chest pain, 12-lead ECG confirmed ST elevation or non-ST elevation myocardial infarction	Administration of nitroglycerin or aspirin
Cardiopulmonary depression	Adverse changes in heart rate, blood pressure, or oxygen saturation, or ventilatory status consistent with sentinel risk of AE	Chest compressions, administration of other advanced cardiac life support medications or other vasoactive medications, intubation
Airway emergency	Bronchospasm, laryngospasm, apnea, or other airway issues requiring sentinel intervention	Intubation, supraglottic airway insertion, administration of neuromuscular blockade, or nebulized medications
ED visit	ED visit because of an anesthesia complication within 24 hours after receiving IV sedation for OMS procedure	Cross-referenced independent institutional database search of ED admissions based on the electronic medical record numbers of study cohort subjects within 24 hours of IV sedation procedure
Hospital admission	Hospital admission because of an anesthesia related complication within 24 hours after receiving deep IV sedation for OMS procedure	Cross-referenced independent institutional database search of hospital admissions based on the electronic medical record numbers of study cohort

Mortality

Death caused by anesthesia complication within 6 months of receiving deep IV sedation for OMS procedure

subjects within 24 hours of IV sedation procedure
Cross-referenced independent institutional database search of mortality dates based on the electronic medical record numbers of study cohort subjects within 6 months of IV sedation procedure

Note: Additional surrogate markers to further identify and cross reference AEs during database abstraction are also depicted.

Abbreviations: AEs, adverse events; ECG, electrocardiogram; ED, emergency department; IV, intravenous; OMS, Oral and maxillofacial surgeon; SIVA, Society of Intravenous Anesthesia; ST, S-T segment.

Sentinel risk AE descriptor: severe oxygen desaturation (oxygen saturation <75% at any time or prolonged <90% for >60 seconds); prolonged apnea (>60 seconds); cardiovascular collapse/shock; and cardiac arrest/absent pulse.

Sentinel airway intervention: tracheal intubation; supraglottic airway insertion; and administration of neuromuscular blockade.

Table 3. BASELINE DEMOGRAPHIC CHARACTERISTICS AND FREQUENCY COUNTS OF AES IDENTIFIED WITHIN THE STUDY COHORT

Variable	k = 61,237
Sex	
Female	32,988 (53.87%)
Male	28,249 (46.13%)
Age	
Mean (SD)	33.26 (18.35)
Median	25
Q1,Q3	18, 46
Range	14 - 98
ASA	
1	37,242 (60.82%)
2	22,408 (36.59%)
3	1,570 (2.56%)
4	15 (0.02%)
NA	2 (0.00%)
Procedure	
Extraction	51,841 (84.66%)
Implant	7,289 (11.90%)
Other	2,107 (3.44%)
Intraoperative Dose of Sedation Medication.	
Fentanyl (mcg)	
n (%)	59,482 (97.13%)
mean (sd)	65.99 (32.03)
Ketamine (mg)	
n (%)	41,973 (68.54%)
mean (sd)	21.17 (10.29)
Midazolam (mg)	
n (%)	59,638 (97.39%)
mean (sd)	4.47 (4.31)
Propofol (mg)	
n (%)	55,130 (90.03%)
mean (sd)	72.89 (90.78)

Table 4. BIVARIATE ANALYSIS OF PREDICTOR VARIABLES AND AES.

Variable	AE Yes	AE No	P Value
Age (years)†	(<i>k</i> = 25) 37.12 ± 24.13	(<i>k</i> = 61,212) 33.26 ± 18.35	0.43
Sex			
Female – <i>k</i> (%)	13 (52%)	32,975 (54%)	1
Male – <i>k</i> (%)	12 (48%)	28,237 (46%)	
ASA Class			
1 – <i>k</i> (%)	14 (56%)	37,228 (60.81%)	0.31
2 – <i>k</i> (%)	7 (28%)	22,401 (36.6%)	
3 – <i>k</i> (%)	2 (8%)	1,568 (2.56%)	
4 – <i>k</i> (%)	0 (0%)	15 (.02%)	
Type of Surgical Procedure Performed			
Extraction – <i>k</i> (%)	20 (80%)	51,821 (84.66%)	0.71
Implant – <i>k</i> (%)	2 (8%)	7,287 (11.9%)	0.77
Other – <i>k</i> (%)	3 (12%)	2,104 (3.44%)	0.07
Sedation medication provided intraoperatively during sedation encounter			
Fentanyl – <i>k</i> (%)	21 (84%)	59,461 (97.1%)	0.0008*
Ketamine – <i>k</i> (%)	15 (60%)	41,958 (68.5%)	0.48
Midazolam – <i>k</i> (%)	23 (92%)	59,615 (97.4%)	0.29
Propofol – <i>k</i> (%)	20 (80%)	55,110 (90%)	0.18

Note: Age: *t*-test, Sex, ASA Class, Drugs Given: χ^2 test.

* Denotes a statistically significant p-value

† Mean ± standard deviation

Abbreviation: AEs, adverse anesthetic event.



New Hampshire

DENTAL SOCIETY

31 July 2024

Dear Members of the New Hampshire Board of Dental Examiners:

On behalf of the over 700 Members of the New Hampshire Dental Society (NHDS), I would like to offer our thoughts and concerns regarding draft rules changes to Den.304 pending before this Board today.

As you know, the Mission Statement of the NHDS is to advocate for dentistry and the public oral health. The issue, on which the NHDS has been working in partnership with the legislature, the Board and other members of the oral health community since 2018, raises a number of key concerns.

1. The proposed rule changes do not necessarily enhance patient safety and could, potentially, create unanticipated safety issues. Dental teams working in the settings outlined in this rule have years of experience and training in the type of adverse situations to which Den.304 speaks. In fact, there is no evidence that such changes are warranted, as the attached report demonstrates. Requiring a third, non-team member could delay treatment in emergency situations if a case had to be delayed or paused in order to deliver deep sedation, when moderate sedation was insufficient. Such a situation would unnecessarily add time and increased risk to the patient.
2. Requiring an additional clinical professional to the operatory inevitably will increase costs. Dental care is already for many an untenable expense. During previous Board meetings, nurse anesthetists have insisted without evidence that there would be no additional cost, but the state's dental Medicaid office, along with other oral health stakeholders like NHDS, are not unconvinced that the presence of an additional professional would not add to the patient's bill. As written, the proposed changes could delay care and access to patients most in need, especially in emergency situations. If a patient can't get care from an oral surgeon, they may be forced go to the emergency room, a situation every health care stakeholder seeks to avoid.
3. The NHDS feels that if an additional professional is added to the operatory in these very infrequent but very delicate situations, they should be subject to the rules and standards of the Board of Dental Examiners and, in the event of an adverse event, should be thereby held accountable just as are dentists, hygienists and the rest of the dental team. Presently, nurse anesthetists are not required to follow the Dental Practice Act or the Code of Ethics.

The NHDS is as always willing to offer our assistance to the Board of Dental Examiners in this process. After all, it was the NHDS that consistently advocated for the Board to be charged with the review of such rules rather than the Legislature. Still, we believe solutions can be reached by including the expertise of the state's oral surgeons – particularly those who, if necessary, have the qualifications and experience to perform deep sedation on young children. We stand with the NH Society of Oral and Maxillofacial Surgeons and the American Association of Oral and Maxillofacial Surgeons, all of whom have offered their constructive input and ideas throughout this process.

Thank you.

Warmest Regards,

Michael P. Auerbach
Executive Director
New Hampshire Dental Society

Kelley, Tina

From: Dr. Roger Achong <drachong@concordpediatricdentistry.com>
Sent: Sunday, August 4, 2024 10:00 PM
To: Puneet Kochhar; OPLC: Rules
Subject: modification to Den 304

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

Hello Dr. Kochhar,

Regarding the modification to Den 304 and more specifically on page 17 at the very top.

Page 17.

8) Staffing for procedures under moderate sedation, deep sedation, or general anesthesia shall be as follows:

a. The operating dentist maintains an unexpired ACLS certification, as well as an unexpired PALS certification if patients under the age of 13 years are treated at facility;

If the operating dentist is treating patients then an unexpired ACLS certification is required. And if patients under the age of 13 years are to be treated then an unexpired PALS certification is required also.

Thus, it can also be said that If the operating dentist is treating patients under the age of 13 years then an unexpired PALS certification is required. And if patients over the age of 13 years are to be treated then an unexpired ACLS certification is required also.

I share this as a board certified pediatric dental specialist who treats children in the normal dental office environment as young as 48 to 72 hours old. It would possibly be unnecessary for many, not all, pediatric dentists to have an unexpired ACLS certification when sedation / general anesthesia is used on their pediatric patients.

As defined by the American Red Cross and other sources, ACLS focuses on advanced cardiac care for adult patients, whereas PALS focuses on advanced care for pediatric patients experiencing life-threatening emergencies such as respiratory emergencies, shock, and cardiac arrest.

What's the Difference Between ALS/ACLS vs. PALS?

I ask you to please make a modification to 8a. such that ACLS is not required by dentists who only see pediatric patients under the age of 13 years. PALS is required by dentists who see pediatric patients under the age of 13 years.

Thank you for your kind consideration.

Sincerely,

Dr. Achong.

--

Roger A. Achong, D.M.D., M.S.
Fellow, American Academy of Pediatric Dentistry
Fellow, Royal College of Dentists of Canada
Diplomate, American Board of Pediatric Dentistry
Fellow, American Society of Dentistry for Children
Fellow, American Orthodontic Society
Fellow, International College of Dentists

Dr. Roger A. Achong; Dr. Patrick F. Capozzi; Dr. Danielle C. Hinton; Dr. Elliot C. Chiu; Dr. Michael T. Capozzi; Dr. Leila Fussell;

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New London Pediatric Dentistry
P.O. Box 311, 299 Main Street, New London, NH 03257 tel: (603) 877-0061

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Dr. Emilio R. Hernandez (orthodontist)
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16 Foundry Street, Suite 207, Concord, NH 03301 tel: (603) 333-2538
"Enhance Your Smile"

Kelley, Tina

From: Dr. Nader Moavenian <drm@nhoms.com>
Sent: Monday, August 5, 2024 9:29 PM
To: OPLC: Rules
Subject: Feedback on draft for Den 304

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

As a practicing oral and maxillofacial surgeon (OMS) in New Hampshire for the past 20 years, I would like to provide feedback on the draft regulations for Den 304. I appreciate the opportunity to offer recommendations.

I strongly oppose the provisions in Den 304.08 that remove the ability for OMSs to self-administer deep sedation/general anesthesia to patients aged 0-8 years. No other state in the nation currently has such a provision, and there is no evidence to suggest it is necessary for public safety. OMSs provide the majority of DS/GA to this age group, and the removal of our ability to treat this population—especially without any scientific basis—will significantly impact patients' access to timely care, inflicting undue pain, burden, and access to care challenges. I strongly urge the revision and consideration of the alternative proposed by the New Hampshire Society of Oral and Maxillofacial Surgeons, which has been endorsed by other dental anesthesia provider groups and modeled after provisions currently existing in other states.

Additionally, I urge the Board to provide alternative options to the PALS requirement in Den 304.08 for dental assistants monitoring patients aged 9-12. Staffing challenges are at an all-time high, with dental assistant shortages fueling constant turnover in dental offices. Providing flexibility is necessary to ensure patients receive timely access to care while also balancing patient safety. Again, I strongly urge consideration of the alternative proposed by the New Hampshire Society of Oral and Maxillofacial Surgeons and currently used in other states.

Finally, I urge the Board to consider tying medication and equipment requirements to the facility permit, implementing time-oriented anesthesia records maintained in 5-minute intervals, public reporting of morbidity and mortality data in a deidentified manner, and adopting staffing requirements for the treatment of adult patients receiving moderate sedation, deep sedation, and general anesthesia in accordance with the OMS team model.

These recommendations aim to bolster patient safety, streamline regulatory processes, and ensure timely access to proficient dental care across all age groups. By implementing these suggestions, we can strengthen our ability to oversee anesthesia administration, adapt to healthcare challenges such as drug shortages, and uphold high standards of care within dental practices throughout New Hampshire.

I am grateful to the Board for thoughtfully considering these comments. We share a commitment to delivering safe patient care

Yours Truly,

Dr. Nader Moavenian
CEO/Founder, NHOMS LLC
Diplomat of the Board of Oral and Maxillofacial Surgeon NH Lic 03216

Board of Dentistry,

Thank you for all the hard work and time you voluntary to keep the public safe. After reading over the proposed changes to Den 304.01 I have some suggestions you might consider before you submit for final rule making.

1. 304.03 (f) could have what qualifications are needed for the dentist to obtain the moderate sedation with pediatric qualification for ages 9 and older beneath it for clarity.
2. 304.07 (a)(2)(b) and (c) The board may consider that the yankauer and portable suction able to be used in a power failure is brought by the anesthesia provider and duplication is not cost effective or enhancing public safety in any way.
3. 304.07(a)(3)(c) and (d) Supraglottic airways and a cricothyrotomy kit with regards to their use on a patient under anesthesia / sedation is outside the hosting dentist airway management techniques. This is part of the reason the hosting dentist has an outside anesthesia provider providing anesthesia / sedation services. They will never use these airway adjuncts and it is provided by the anesthesia provider. This is not cost effective for the hosting dentist and provides no additional safety to the public since the hosting dentist does not know how to use these adjuncts nor will they be taught in ACLS or PALS.
4. 304.07(a)(4) This is standard monitoring equipment and would be brought by the anesthesia / sedation provider and should not be required to have at the facility. This is not cost effective for the hosting dentist and provides no additional safety to the public.
5. Please consider requiring a wheelchair as part of the facility and hosting permit inspection. This would aid in the facilitate transportation of the patient upon discharge from the dental facility.
6. 304.07(a) The board might consider a basic emergency medication kit with the following:
 - a. epi pens x 2 or equivalent that are age specific based on the population seen at the facility for allergic reaction.
 - b. Benadryl for an allergic reaction.
 - c. Albuterol metered dose inhaler for bronchospasm or asthma.
 - d. Aspirin non-enteric coated chewable 162mg or equivalent,
7. 304.08 (b)The board might consider the unintended consequence of not specifying medication that should or should not be used in moderate sedation. Certain medications such as propofol, for example, are used in deep sedation / general anesthesia and the way 304.8 (b) is written, a moderate sedation qualified dentist

could use such a medication. Moderate sedation should be limited to medications that can be reversed quickly should an emergency arise, or should the patient slip passed moderate sedation into deep sedation / general anesthesia where airway management is need. Dentists who provide moderate sedation are not trained in medications used for deep sedation / general anesthesia and this nonspecific rule would allow medications used for deep sedation and general anesthesia to be used under the auspices of moderate sedation. I would ask the Board to allow the newly formed anesthesia subcommittee made up of anesthesia experts to look further into this and provide the board with a recommendation that protects the public and allows the dentist to provide moderate sedation in a safe manner.

8. 304.08 (c) Should the Board consider the following changes to the sentence below for clarity (changes in bold and strike though).
 - a. A dentist shall not delegate to a dental assistant or hygienist any task that is outside of their scopes of practice, as defined in Den 400 and Den 501.01(b), such as placement of an intravenous catheter, ~~or~~ drawing up **medications**, ~~or and~~ administering medications.
9. 304.08 (e) Can the Board clarify what the qualifications are for a dentist to provide deep sedation / general anesthesia for pediatric patients ages 9-12.
10. 304.08 (g) Can the board clarify who the provider can be administering and monitoring the sedation in this section such as: A second oral surgeon, dental anesthesiologist, physician anesthesiologist, or nurse anesthesiologist.

Kelley, Tina

From: Timothy Smith <drtim@childrensdentistnh.com>
Sent: Tuesday, August 13, 2024 1:53 PM
To: OPLC: Rules
Subject: OPLC Modification

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

304.07 discuss the "Facility Hosting Requirements" and specifically says *"The operating dentist maintains an unexpired ACLS certification, as well as an unexpired PALS certification if patients under the age of 13 at the facility"*

As a pediatric dentist who provides treatment solely for the pediatric population, I would like to challenge the proposal that the operating dentist must have both ACLS and PALS when delivering care with an anesthesia provider (whom has both PALS and ACLS). PALS training has given us adequate knowledge and proficiency to respond effectively to pediatric emergencies, and ACLS certification is unnecessary.

Thank you for your consideration,
Tim Smith

--

Dr. Timothy Smith
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Kelley, Tina

From: Matthew Smith <smithmann@yahoo.com>
Sent: Tuesday, August 13, 2024 10:00 PM
To: OPLC: Rules
Subject: Sedation comment

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

Rules committee,

I would like to challenge proposal below:

304.07 discuss the "Facility Hosting Requirements" and specifically says *"The operating dentist maintains an unexpired ACLS certification, as well as an unexpired PALS certification if patients under the age of 13 at the facility"*

I believe if, as a pediatric dentist, we are treating patients under the age of 13 PALS certification would appropriate and sufficient to competently handle all emergency situations found in any sedation setting.

Thank you,
Matt Smith

August 13, 2024

Dear Members of the New Hampshire Board of Dental Examiners,

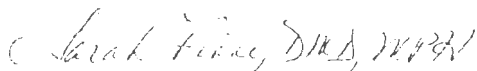
On behalf of the New Hampshire Department of Health and Human Services (DHHS) Division of Medicaid Services (DMS), I would like to share our concerns regarding the draft rules changes to Den.304 that are currently pending with the Board.

1. The proposed rule changes were intended to improve patient safety but could unintentionally create additional safety issues or harm. Dental teams in their current configuration include a Board-Certified Oral Surgeon (the vast majority possessing dual DMD/MD degrees) with the appropriate additional staff as described in Den 304.05. These teams have the extensive training required in Den 304.03 in addition to clinical experience which have allowed them to safely practice under the current rules. The requirement to bring in a third non-dental team member, at the moment a situation changes to require deep sedation, could significantly delay the timely delivery of care. This is most concerning for any emergency procedures being performed, where time is of the essence.
2. When a surgical procedure on a child under the age of 9 has to be delayed to a future appointment due to the lack of availability of a third non-dental team member, there is increased risk that in the interim the patient will need emergency care in an emergency department of a hospital. This not only increases the cost of care for this individual, but it also puts them at risk of needing more invasive treatment as the original condition has worsened. The proposed rule changes create an additional barrier to access to oral health care for children with some of the highest dental needs in the state.
3. Dental team members, as they are currently configured, are all subject to Board of Dental Examiners rules. The proposed rule changes bring in a member of the dental care team that is not subject to these same rules. Should an adverse event occur, all members of the team should be subject to the same set of rules.

The DMS believes that Den.304 should reflect the extensive training of oral surgeons which qualifies them to provide deep sedation for young children under the age of 9 without requiring the addition of another non-dental team member to provide anesthesia.

Thank you for your consideration of our concerns.

Respectfully submitted,



Sarah A. Finne, DMD, MPH
NH DHHS DMS Dental Director

Kelley, Tina

From: wpreich@comcast.net
Sent: Thursday, August 15, 2024 3:48 PM
To: OPLC: Rules
Subject: DEN 304, opposition

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

To all New Hampshire dental board members and OPLC staff,

I would like to describe my experience and opinion regarding proposed DEN304 being proposed by the New Hampshire board of dentistry. And more importantly, my concern for the safety of dental patients in the state of New Hampshire.

It is my opinion that only Doctors with approved and accredited residency training and certification in Anesthesia can provide IV anesthesia to patients. And I believe the general public needs to be made aware of the Doctors Anesthesia certification prior to any IV sedation procedure.

I believe the public needs to be made aware if a Nurse Anesthetist (CRNA) is administering Anesthesia. And that the public needs to be made aware that the second provider in these cases- the Dentist- May not have completed an approved and accredited residency training in Anesthesia.

The current and proposed model creates a false sense of security for the patient and Dentist. In this scenario, you have a dentist without approved and certified residency anesthesia training performing dentistry/surgery/sedation on a patient in conjunction with a Nurse Anesthetist (CRNA).

I Support dental anesthesia providers that have completed certified and approved residency training program requirements, and anesthesia and surgical airway placement for all ages. No exceptions. This model should support any deep/general/moderate IV sedation case with multiple IV or inhalational agents being used.

No exception. All ages apply.

The age of the patient is irrelevant. (With the exception of infants). The training of the providers is what matters.

And this is why no state in America has adopted anything less stringent. Separating patients eight and under would only create a false sense of security and allow patients to be sedated by an unprepared team. I wholeheartedly hope and pray that the dental board of New Hampshire understands this risk to the public. I have expressed this concern at the beginning of this process at a live dental board Meeting.

At the most recent dental board meeting the New Hampshire Oral Surgery society also expressed concern regarding how this ruling would affect access to care for patients eight and under.

Someone on the board said that access to care will not be an issue. I disagree with this. Dental insurance such as Delta dental does not Provide reimbursement for anesthesia provided by CRNA's. Many patients will not be able to afford a CRNA second provider model.

Thank you for your time and consideration in this matter. And thank you all for your time devotion to the profession of Dentistry in New Hampshire.

Sincerely,
Dr. Peter Reich

Kelley, Tina

From: dave pak <davepakoms@gmail.com>
Sent: Thursday, August 15, 2024 6:26 AM
To: OPLC: Rules
Subject: Regarding addendum for Den 304

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

I have included the whole of my emails here to ensure completeness. I apologize for creating a string rather than having all my proposed thoughts in one email.

Dear Members of the OPLC,

Den 304 covers the use of general anesthesia and sedation by dentists, but does not have permits, evaluations, or means of qualifications for mobile anesthetists or mobile anesthesiologists. I propose that any mobile anesthetist or anesthesiologist also undergo an evaluation process under the Dental Board if they are to practice within the influence or realm of dentistry. Similarly, like provider and facility inspections, an inspector/evaluator, selected by the members of the dental board, could evaluate the mobile provider, their staff, and equipment for anesthesia; commensurate to the level of intended anesthesia. Upon completion, a permit could be issued (e.g. perhaps yearly or binnannually with their medical or dental license). This permit, in conjunction with the host provider's anesthesia and facility permits, in line with their level of anesthesia use, would provide more unified anesthesia protocols and tracking opportunities within the dental community.

In addition, an Affidavit or form of attestation, listing the various needs or attesting to the requirements relevant to the particular level of anesthesia and the respective host and facility requirements in Den 304, could be requested by the Dental Board per job site from the mobile anesthetist or mobile anesthesiologist, since their locations of practice can vary so much. The attestation should be valid for a limited time, perhaps 14 days (or X number of days considering the turnaround for the board to review and respond). If a series of cases are expected, then the option to choose a longer attestation could be made available involving that particular job site; otherwise, repeated renewals would be expected. Time limits should be considered for the attestations because hosts, hosting staff, and the hosting facility do not routinely experience the anesthesia for which they request and are not likely to possess the comparable awareness and skills for diagnosing and executing any anesthesia or emergency protocols that may be familiar with individuals involved with anesthesia frequently and routinely in their practice. The host and hosting staff also do not work with the mobile provider daily, so the dynamics of working together would be unfamiliar. The attestations, therefore, serve to help unify the host, hosting staff, facility, and the mobile provider as one team, better ensuring that the anesthesia policies are followed and that diagnosing and up-to-date protocols can be executed in a more efficient manner.

Also to point out, that all of this would suggest that the host, staff, facility, and mobile provider assume the necessary requirements and knowledge of the anesthesia level being used.

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Dave C. Pak, D.M.D., M.D., M.S.

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