MINUTES
TENNESSEE BOARD OF DENTISTRY
ANESTHESIA COMMITTEE MEETING

Date: December 5, 2016

Location: Tennessee Department of Health
665 Mainstream Drive
Nashville, TN 37243

Members Present by teleconference:	J. David Johnson, D.D.S. Steven Maroda D.D.S., Board Member
Members Present:	John R. Werther, D.M.D., M.D., Chairman Bill W. Akin, D.D.S. H. Clifton Simmons III, DDS George A. Adams, DDS
Staff Present:	Dea Smith, Executive Director Jennifer Putnam, Assistant General Counsel

Dr. John Werther called the meeting to order at 4:11 p.m.

Given that Dr. Johnson was in Chicago and traveling to the airport he was offered the first opportunity to speak but instead declined and recommended that Ms. Putnam give a review. She reviewed the Performance Audit Report dated July 2016 that was completed by non-healthcare practitioners, mainly CPAs, as well as the history of previous impetus for on-site office inspections.

The issue of on-site inspection came up about 5 years ago via a line of inquiry from former Board president Ruth Bailey. At that time, and according to previous anesthesia committee minutes "*Dr. Johnson opposed any office inspection process by any entity outside the purview of dentistry as such a requirement would be costly, duplicative, and unnecessary. Further, it would bring the potential for increased bureaucracy and conflicts of interest from outside parties. The committee agreed with Dr. Johnson* "and there was no recommendation for office inspection.

In 2014, the Chair of the Board of Dentistry, Dr. Charles Holt raised the issue of adequacy of oversight of anesthesia permit holders. The committee discussed and recommended a medication and equipment list specifically be instituted along with written acknowledgment by the permit holder that the dentist is aware of the anesthesia rules and has complied with medication and equipment requirements every 2 years with license renewal. That process has been in place since 2015. Of approximately 700 sedation permits, less than 10%, roughly 50-60 licensees were found lacking based on the audit. The primary problems (in descending order of frequency) are compliance with continuing education hours (the vast majority), ACLS, and equipment-medications. The Audit Review misrepresented the actual work done by the Board, including the percentage of noncompliance. Despite the fact that accurate factual

information was submitted to the auditors to provide correct information to the Board of Dentistry, this information was NOT included in the Performance Audit Review final report. Thus the Audit Review as published is not an accurate description of the Board of Dentistry efforts to date. There are currently 668 licensees as of the time of the anesthesia committee meeting. This is down from approximately 700. There have been some renewals and some who have opted to retire or downgrade the permit to a lower level of anesthesia. The initial objective with Dr. Holt's initiative was to collapse the number of permit holders if they were out of date and it appears that this process is working.

The issue of facility permit was discussed. An individual practitioner has a permit. The facility permit is separate from a provider permit. This is done in veterinary medicine. Staff indicated it is easy for them to track provider and facilities this way. It is problematic however if there are 2 or more licensees at a single facility, when specifically an inspection might be done since the licensees may have permits that renew at different times. The AAOMS office inspection model is for practitioner and each facility to be evaluated every 5 years.

Dr. Johnson provided numerous documents to the committee in advance as well as an email to the committee on December 5. In his December 5 email he opined that there was general consensus of the community that an on-site inspection was needed and made several recommendations thereto. Specifically, he stated that he is a proponent for the American Association of Oral and Maxillofacial Surgeons (AAOMS) Office Anesthesia Evaluation (OAE) but did not favor office anesthesia evaluation or inspection "outside the purview of dentistry."

Dr. Simmons submitted an August 2007 editorial from the ADSA Pulse and argued against the need for office inspection for either facility or dentist. Dr. Johnson countered that there may be a bias in this editorial in favor of the itinerant provider model. In part due to concerns expressed by Dr. Johnson that if the Board of Dentistry did not institute office inspections—that an outside entity might take this over--Ms. Putnam noted that even if the committee said no office anesthesia inspections were required at this time, the Board will continue its individual paper audit.

There are no outside parties that can come in and take over the process of office inspection from the Board of Dentistry. Dr. Simmons inquired as to whether all levels of anesthesia permits were to be inspected. He also wondered how many non-OMS dentists have deep sedation/general anesthesia per minutes in the state of Tennessee. Dr. Simmons noted that 10 years ago this issue came up and the response was to increase continuing education requirements. He recommended potentially considering that as an alternative to office inspections since education/better training should be proportional to better safety, particularly since continuing education lapse is the number one finding on the written audit and failure to timely maintain ACLS is the second.

Dr. Bill Akin mentioned one issue not addressed is initial permitting. He has a general anesthesia permit. Perhaps we might contact dentists with permits and offer them the option to decrease the level of anesthesia permit voluntarily depending on their personal circumstances, current level of training and interest. Dr. George Adams noted that operating room availability for pediatric dentistry is MUCH MORE difficult in recent years and that we have to be careful about decreasing access to care for patients particularly in non-urban counties. Hospitals in Nashville actively remove pediatric dentists off staff or severely limit their operating room time. Dr. Adams noted that 1 million children are currently under TennCare.

Dr. Werther responded to the Audit report noting that there is no evidence to indicate that office anesthesia inspection leads to improved patient safety. Safety and anesthetic adverse events occur in dental offices, even in the most heavily regulated and heavily inspected states in the US. The auditors refer to "best practices" of selected surrounding states. This phrase is, at best, misleading since there is no agreed measure of effectiveness and no evidence that these states worked together to develop their independence statutes. Nationwide, the issue of state office anesthesia inspection varies widely: no report, self-report, inspection at first license, ongoing inspections with variable time intervals. Permit revocation for failure to comply with the Board of Dentistry anesthesia audit would seem a simple solution to the problem of those who do not comply but, as Ms. Putnam pointed out, given that the anesthesia permit is a property right, such a simple solution is not possible and dentists would have to be afforded their due process rights to a hearing which is not immediate. The Board has a variety of options with respect to office anesthesia inspection including, but not limited to:

1. Keep the rules as they are, continue to monitor progress on the written audit and consider further study. In any event, the Board retains at will authority to require office inspections at the current time.
2. Consider on-site inspection at the initial application only.
3. On-site inspection with initial permit application with subsequent written reporting requirements.
4. Require on-site inspection initially and every 5 years thereafter (AAOMS office anesthesia model)

After much discussion, the issue of whether to recommend on-site office inspection to the Board was taken to a vote:

1. Dr. George Adams: **NO**, does not feel a change in CE is required.
2. Dr. Clifton Simmons: **NO**, suggested increasing continuing education requirements as a more effective means of increasing patient safety.
3. Dr. Bill Akin: **NO**. He is not opposed to the concept of office inspection but will vote no because he does not think it will improve safety. He doesn't think a one time every 5 year look at an office is an effective way to manage the issue. Continuing education should be in person. Keep CE as is: more targeted. He is not for a mandatory facility inspection.
4. Dr. David Johnson: **YES**, but he is not in favor of inspection of a few pieces of equipment and medication, prefers a more comprehensive office exam along the line of the AAOMS office anesthesia evaluation process.
5. Dr. Werther: Abstain.

Thus by a vote of 3 NO, 1 YES, 1 abstention-- the committee does not recommend that the Board institute an on-site office anesthesia inspection process at this time.

The committee indicated ongoing willingness to help with matters relating to anesthesia and specifically office inspection. This would include appearance at the board meeting January 12-13 if that would be beneficial for the Board.

There being no further business, Dr. Werther adjourned the meeting at 5: 57 p.m.