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I believe Rule 110.2, (b), (3) already allows the TSBDE to conduct "office evaluations" prior to issuance of a permit. This would imply the TSBDE could conduct anesthesia office evaluations for any reasonable cause. That said, I agree with Commission Staff's evaluation that the TSBDE lacks the resources to effectively implement anesthesia provider evaluations. Should the legislature choose to mandate these inspections, I would hope the legislature allows the TSBDE latitude with appropriate expertise to develop an appropriate evaluation process for sedation providers that benefits the public. These provider evaluations should not be contracted to private trade organizations and should start with level 4 providers, with lessons learned applied later to other parenteral sedation providers. In the meantime, the SBDE can be gathering data regarding the issues that contribute to the perceived increase in anesthesia related complaints.

As a former Board member, I did not review all anesthesia related complaints, but I'm sure I reviewed a significant number. These complaints are self-reported by dentists desiring to comply with Rule 108.6. The Board and the TDA through their informative Newsletters in recent years have increased awareness of the requirement to self-report any hospitalization or death of a patient that possibly relates to any dental treatment. As a Board member, I have personally encouraged all colleagues to rigidly comply with Rule 108.6. Those of us providing anesthesia are generally well aware of this Rule but new licensees may be unaware. There is always the possibility of under-reporting and over-reporting. Not all of these investigated anesthesia complaints/reports were generated because the anesthesia led to hospitalization or death. I self-reported the hospitalization of a special needs patient at the SASSLC because the patient had an extremity infection (toe) that went septic a week after anesthesia for dental care in their clinic. The hospitalization had nothing to do with the anesthesia or dental care but out of an abundance of precaution both the dentist and I reported the hospitalization. In fact during this time, I probably had 3-4 self-reports dismissed because of issues unrelated to anesthesia provided, but related to the subsequent pre-existing medical status of the patient. During this time, I also know of one general dentist who received 5-6 complaints (I reviewed at least 2) from his oral surgeon competitors in the DFW area related to his providing mobile sedation and extractions in other dental offices, without purported "SOC" follow-up for sedated patients and surgeries. All of these cases were dismissed but took valuable Board staff time (approx. 1.5 years to investigate, review, and dismiss each complaint) away from the timely resolution of other complaints.

Much has been said in Commission Staff's Report about the "medical model" for providing anesthesia services either in the office, a surgery center or a hospital. This same medical model does not allow the operating surgeon doing the procedure to also be providing the procedural sedation. A separate qualified anesthesia provider must be administering the procedural sedation to insure patient safety. This would be something to seriously consider implementing for level 4 (deep sedation/general anesthesia) providers.

I use the term "Provider Evaluations" because the implementation of "office/facility inspections" (which is different than provider evaluations) offers little benefit and can be implemented in a manner that discourages the use of highly specialized mobile dentist anesthesiologists with 2-3 years of CODA accredited residency training. Currently, accredited Dental Anesthesia programs are required to be 3 years in duration with specialized training in providing mobile general anesthesia services to our most vulnerable patient populations, including special needs and pre-cooperative children in a safe and humane manner. States such as CA and Ohio have implemented provider evaluations that periodically re-evaluate (5 years) the provider while providing general anesthesia with follow-up evaluation of anesthesia knowledge and anesthesia equipment to insure standard of care is being met.

In states such as FL, the "facility inspection" rules were implemented, discouraging independent mobile anesthesia services by requiring "inspections" in each office location where parenteral or general anesthesia was provided. Additionally, monitoring and anesthesia equipment could not be removed from the office, nor moved from operatory to operatory within the inspected office. Imagine the financial implications of mobile anesthesiologists (physician or dental) with multiple offices utilizing their services having to spend 4-6 hours repeating the same evaluation process in each office location not to mention the replication and maintenance of valuable anesthesia monitors and machines in each facility. Obviously, this implementation strategy was anti-competitive, decreased access to care, and prohibitively costly to patients and practitioners, resulting in a dramatic decrease of dental anesthesia specialists wanting to practice in FL.

Thank you for the opportunity to comment on the Sunset Commission Staff's Report.

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