NEVADA STATE BOARD of DENTAL EXAMINERS

Board Teleconference Meeting

LLDP COmmittee

Wednesday, may 7, 2025

6:00 p.m.

PUBLIC BOOK

STATE OF NEVADA

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DEPARTMENT OF BUSINESS AND INDUSTRY
OFFICE OF NEVADA BOARDS, COMMISSIONS AND COUNCILS STANDARDS
NEVADA STATE BOARD OF DENTAL EXAMINERS

PUBLIC MEETING NOTICE & BOARD MEETING AGENDA

Legal, Legislative, and Dental Practice Committee

Meeting Date & Time
Wednesday, May 7, 2025
6:00 p.m.

Meeting Location
Nevada State Board of Dental Examiners
2651 N. Green Valley Pkwy, Ste. 104
Henderson, NV 89014

Video Conferencing/ Teleconferencing Available
To access by phone, +1(646) 568-7788

To access by video webinar,
https://us06web.zoom.us/j/82692318526
Webinar/Meeting ID#: 826 9231 8526
Webinar/Meeting Passcode: 254705

PUBLIC NOTICE:

Public Comment by pre-submitted email/written form and Live Public Comment by teleconference is available after roll call (beginning of meeting and prior to adjournment (end of meeting). Live Public Comment is limited to three (3) minutes for each individual.

Members of the public may submit public comment in written form to: **Nevada State Board of Dental Examiners, 2651 N. Green Valley Pkwy, Ste. 104, Henderson, NV 89014; FAX number (702) 486-7046; e-mail address nsbde@dental.nv.gov.** Written submissions received by the Board on or before Tuesday, May 6, 2025, by 12:00 p.m. may be entered into the record during the meeting. Any other written public comment submissions received prior to the adjournment of the meeting will be included in the permanent record.

The Nevada State Board of Dental Examiners may: 1) address agenda items out of sequence to accommodate persons appearing before the Board or to aid the efficiency or effectiveness of the meeting; 2) combine items for consideration by the public body; 3) pull or remove items from the agenda at any time. The Board may convene in closed session to consider the character, alleged misconduct, professional competence or physical or mental health of a person. *See* NRS 241.030. Prior to the commencement and conclusion of a contested case or a quasi-judicial proceeding that may affect the due process rights of an individual the board may refuse to consider public comment. *See* NRS 233B.126.

Persons/facilities who want to be on the mailing list must submit a written request every six (6) months to the Nevada State Board of Dental Examiners at the address listed in the previous paragraph. With regard to any board meeting or telephone conference, it is possible that an amended agenda will be published adding new items to the original agenda. Amended Nevada notices will be posted in compliance with the Open Meeting Law.

We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Board, at (702) 486-7044, no later than 48 hours prior to the meeting. Requests for special arrangements made after this time frame cannot be guaranteed.

Pursuant to NRS 241.020(2) you may contact at (702) 486-7044, to request supporting materials for the public body or you may download the supporting materials for the public body from the Board's website at http://dental.nv.gov In addition, the supporting materials for the public body are available at the Board's office located at 2651 N. Green Valley Pkwy, Ste. 104, Henderson, NV 89014.

Note: Asterisks (*) "**For Possible Action"** denotes items on which the Board may take action.

Note: Action by the Board on an item may be to approve, deny, amend, or table it.

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1. **Call to Order**

    a. Roll Call/Quorum

2. **Public Comment (Live public comment by teleconference and pre-submitted email/written form):**

    The public comment period is limited to matters specifically noticed on the agenda. No action may be taken upon the matter raised during the public comment unless the matter itself has been specifically included on the agenda as an action item. Comments by the public may be limited to three (3) minutes as a reasonable time, place and manner restriction, but may not be limited to based upon viewpoint. The Chairperson may allow additional time at his/her discretion.

    Members of the public may submit public comment via email to nsbde@dental.nv.gov, or by mailing/faxing messages to the Board office. Written submissions received by the Board on or before May 6, at 12:00 p.m. may be entered into the record during the meeting. Any other written public comment submissions received prior to the adjournment of the meeting will be included in the permanent record.

    The Chair may prohibit comment if the content of that comment is a topic that is not relevant to, or within the authority of, the Nevada State Board of Dental Examiners, or if the content is willfully disruptive of the meeting by being irrelevant, repetitious, slanderous, offensive, inflammatory, irrational, or amounting to personal attacks or interfering with the rights of other speakers.

3. **Chairperson's Report:** Dr. West, Chair/President (For Possible Action)

    a. Request to Remove Agenta Item(s) (For Possible Action)

    b. Approve Agenda (For Possible Action)

4. **Old Business:** (For Possible Action)

    a. NA

5. **New Business:** (For Possible Action)

a. Review, Discussion and Possible Recommendation of the Legal, Legislative, and Dental Practice Committee Bylaws to the Full Board – NRS 631.190 (For Possible Action)

b. Review, Discussion and Possible Recommendation for Developing Additional Specialties in NAC 631.190 to the Full Board – NRS 631.190, NAC 631.190 (For Possible Action)

i. Orofacial Pain
ii. Oral Medicine
iii. Dental Anesthesiology
iv. Dentofacial Orthodontics

c. Review, Discussion and Possible Recommendation for Developing Mobile Dental Unit Regulations to the Full Board - 631.190 to the Full Board – NRS 631.190, NRS 631.3122 (For Possible Action)

d. Review, Discussion and Possible Recommendation for Developing CE Live Patient Regulations to the Full Board – NRS 631.190 to the Full Board – NRS 631.190, NRS 631.215, NRS 631.2715, NAC 631.2205, NAC 631.2206 (For Possible Action)

e. Review, Discussion and Possible Recommendation for Developing Expanded Function Dental Assistant Regulations to the Full Board – NRS 631.052, NRS 631.053, NRS 631.31285 thru NRS 631.313. (For Possible Action)

6. Public Comment (Live public comment by teleconference):

The public comment period is limited to matters specifically noticed on the agenda. No action may be taken upon the matter raised during the public comment unless the matter itself has been specifically included on the agenda as an action item. Comments by the public may be limited to three (3) minutes as a reasonable time, place and manner restriction, but may not be limited to based upon viewpoint. The Chairperson may allow additional time at his/her discretion.

Members of the public may submit public comment via email to nsbde@dental.nv.gov, or by mailing/faxing messages to the Board office. Written submissions received by the Board on or before May 6, at 12:00 p.m. may be entered into the record during the meeting. Any other written public comment submissions received prior to the adjournment of the meeting will be included in the permanent record.

The Chair may prohibit comment if the content of that comment is a topic that is not relevant to, or within the authority of, the Nevada State Board of Dental Examiners, or if the content is willfully disruptive of the meeting by being irrelevant, repetitious, slanderous, offensive, inflammatory, irrational, or amounting to personal attacks or interfering with the rights of other speakers.

7. **Announcements:**

8. **Adjournment:** (For Possible Action)

Legal, Legislative, and Dental Practice Committee - Nevada State Board of Dental Examiners

Establishment

The Legal, Legislative, and Dental Practice Committee ("Committee") is hereby established as a standing committee of the Nevada State Board of Dental Examiners ("Board").

Purpose

The Committee shall provide recommendations and guidance on a range of issues that support the Board's regulatory mission. The Committee's responsibilities include legal matters relevant to the practice of dentistry and the Board's statutory functions pertaining to legislative matters that are proposed, pending, or existing laws and regulations. The Committee also considers issues affecting the scope and standards of dental practice, as well as any other topics related to the legal, legislative, or practice-related responsibilities of the Board.

Membership

1. The Committee shall be composed of at least 3 members, appointed by the Board, but no more than 5 members.
2. The Executive Director shall serve as ex-officio, non-voting member and provide administrative support as needed.
3. The Board President appoints a Chair to the Committee at the 1st or 2nd board meeting of the calendar year.
4. The Board President appoints Committee Members to serve at the 1st or 2nd board meeting of the calendar year and voted on by the Board.
5. Any Committee Member may consult with he Board President to discuss the removal of any Committee Member from the Committee for actions that are unethical and /or result in unprofessional conduct.

Meetings

1. The Committee shall meet twice per year, or more frequently as deemed necessary by the Chairperson or the Board.
2. Meetings shall be conducted in accordance with applicable open meeting laws and Board procedures.
3. A majority of Committee members shall constitute a quorum for conducting business.

4. The Committee shall keep minutes of its meetings and submit them to the Board for review.

Authority and Responsibilities

The Committee shall have the authority to:

1. Review and analyze legal issues that may affect the Board or the regulation of dental practice in Nevada.
2. Recommend appropriate responses or policy actions to the full Board.
3. Review and evaluate proposed legislation or administrative regulations relevant to dentistry.
4. Recommend Board positions, comment letters, or advocacy strategies.
5. Review existing regulations for consistency, clarity, and relevance, and propose amendments or repeals as appropriate.
6. Evaluate issues related to the scope of practice, standards of care, and clinical guidelines in dentistry and dental hygiene.
7. Consider matters involving clinical practice trends, innovations, and emerging professional roles (e.g., dental therapists, EFDA).
8. Provide guidance on interpretations of practice standards and Board rules.
9. Submit recommendations to the Board for consideration and action.
10. Work collaboratively with other Board committees or subcommittees when topics intersect jurisdiction.

Reporting and Recommendations

1. The Committee shall submit formal recommendations to the Board for consideration and approval.
2. The Committee does not have independent decision-making authority but services in an advisory capacity to the Board.

Amendments

These bylaws may be amended by a majority vote of the Board, provided that notice of proposed amendments is given in advance.

Effective Date

These bylaws shall take effect immediately upon approval by the Board of Dental Examiners.

STANDARD 2 – EDUCATIONAL PROGRAM

2-1 The orofacial pain program **must** be designed to provide advanced knowledge and skills beyond the D.D.S. or D.M.D. training.

Curriculum Content

2-2 The program **must** either describe the goals and objectives for each area of resident training or list the competencies that describe the intended outcomes of resident education.

Intent: *The program is expected to develop specific educational goals that describe what the resident will be able to do upon completion of the program. These educational goals should describe the resident's abilities rather than educational experiences the residents may participate in. These specific educational goals may be formatted as either goals and objectives or competencies for each area of resident training. These educational goals are to be circulated to program faculty and staff and made available to applicants of the program.*

Examples of evidence to demonstrate compliance may include:
Written goals and objectives for resident training or competencies

2-3 Written goals and objectives **must** be developed for all instruction included in this curriculum.

Example of Evidence to demonstrate compliance may include:
Written goals and objectives
Content outlines

2-4 The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions designed to achieve the program's written goals and objectives or competencies for resident training.

Intent: *The program is expected to organize the didactic and clinical educational experiences into a formal curriculum plan. For each specific goal or objective or competency statement described in response to Standard 2-2, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge, and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal curriculum plan.*

Examples of evidence to demonstrate compliance may include:
Written curriculum plan with educational experiences tied to specific written goals and objectives or competencies
Didactic and clinical schedules

Biomedical Sciences

2-5 Formal instruction **must** be provided in each of the following:

a. Gross and functional anatomy and physiology including the musculoskeletal and articular system of the orofacial, head, and cervical structures;

b. Growth, development, and aging of the masticatory system;

c. Head and neck pathology and pathophysiology with an emphasis on pain;

d. Applied rheumatology with emphasis on the temporomandibular joint (TMJ) and related structures;

e. Sleep physiology and dysfunction;

f. Oromotor disorders including dystonias, dyskinesias, and bruxism;

g. Epidemiology of orofacial pain disorders;

h. Pharmacology and pharmacotherapeutics; and

i. Principals of biostatistics, research design and methodology, scientific writing, and critique of literature.

2-6 The program **must** provide a strong foundation of basic and applied pain sciences to develop knowledge in functional neuroanatomy and neurophysiology of pain including:

a. The neurobiology of pain transmission and pain mechanisms in the central and peripheral nervous systems;

b. Mechanisms associated with pain referral to and from the orofacial region;

c. Pharmacotherapeutic principles related to sites of neuronal receptor specific action pain;

d. Pain classification systems;

e. Psychoneuroimmunology and its relation to chronic pain syndromes;

f. Primary and secondary headache mechanisms;

g. Pain of odontogenic origin and pain that mimics odontogenic pain; and

h. The contribution and interpretation of orofacial structural variation (occlusal and skeletal) to orofacial pain, headache, and dysfunction.

Behavioral Sciences

2-7 Formal instruction **must** be provided in behavioral science as it relates to orofacial pain disorders and pain behavior including:

a. cognitive-behavioral therapies including habit reversal for oral habits, stress management, sleep problems, muscle tension habits and other behavioral factors;

b. the recognition of pain behavior and secondary gain behavior;

c. psychologic disorders including depression, anxiety, somatization and others as they relate to orofacial pain, sleep disorders, and sleep medicine; and

d. conducting and applying the results of psychometric tests.

Clinical Sciences

2-8 A majority of the total program time **must** be devoted to providing orofacial pain patient services, including direct patient care and clinical rotations.

2-9 The program **must** provide instruction and clinical training for the clinical assessment and diagnosis of complex orofacial pain disorders to ensure that upon completion of the program the resident is able to:

a. Conduct a comprehensive pain history interview;

b. Collect, organize, analyze, and interpret data from medical, dental, behavioral, and psychosocial histories and clinical evaluation to determine their relationship to the patient's orofacial pain and/or sleep disorder complaints;

c. Perform clinical examinations and tests and interpret the significance of the data;

Intent: *Clinical evaluation may include: musculoskeletal examination of the head, jaw, neck and shoulders; range of motion; general evaluation of the cervical spine; TM joint function; jaw imaging; oral, head and neck screening, including facial-skeletal and dental-occlusal structural variations; cranial nerve screening; posture evaluation; physical assessment including vital signs; and diagnostic blocks.*

d. Function effectively within interdisciplinary health care teams, including the recognition for the need of additional tests or consultation and referral; and

Intent: *Additional testing may include additional imaging; referral for psychological or psychiatric evaluation; laboratory studies; diagnostic autonomic nervous system blocks, and systemic anesthetic challenges.*

e. Establish a differential diagnosis and a prioritized problem list.

2-10 The program **must** provide training to ensure that upon completion of the program, the resident is able to manage patients with special needs.

***Intent**: The program is expected to provide educational instruction, either didactically or clinically, during the program which enhances the resident's ability to manage patients with special needs.*

Examples of evidence to demonstrate compliance may include:
Written goals and objectives or competencies for resident training related to patients with special needs
Didactic schedules

2-11 The program **must** provide instruction and clinical training and direct patient experience in multidisciplinary pain management for the orofacial pain patient to ensure that upon completion of the program the resident is able to:

a. Develop an appropriate treatment plan addressing each diagnostic component on the problem list with consideration of cost/risk benefits;

b. Incorporate risk assessment of psychosocial and medical factors into the development of the individualized plan of care;

c. Obtain informed consent;

d. Establish a verbal or written agreement, as appropriate, with the patient emphasizing the patient's treatment responsibilities;

e. Have primary responsibility for the management of a broad spectrum of orofacial pain patients in a multidisciplinary orofacial pain clinic setting, or interdisciplinary associated services. Responsibilities should include:

    1. intraoral appliance therapy;
    2. physical medicine modalities;
    3. diagnostic/therapeutic injections;
    4. sleep-related breathing disorder intraoral appliances;
    5. non-surgical management of orofacial trauma;
    6. behavioral therapies beneficial to orofacial pain; and
    7. pharmacotherapeutic treatment of orofacial pain including systemic and topical medications.

***Intent**: This should include judicious selection of medications directed at the presumed pain mechanisms involved, as well as adjustment, monitoring, and reevaluation.*

Common medications may include: muscle relaxants; sedative agents for chronic pain and sleep management; opioid use in management of chronic pain; the adjuvant analgesic use of tricyclics and other antidepressants used for chronic pain; anticonvulsants, membrane stabilizers, and sodium channel blockers for neuropathic

pain; local and systemic anesthetics in management of neuropathic pain; anxiolytics; analgesics and anti-inflammatories; prophylactic and abortive medications for primary headache disorders; and therapeutic use of botulinum toxin injections.

Common issues may include: management of medication overuse headache; medication side effects that alter sleep architecture; prescription medication dependency withdrawal; referral and co-management of pain in patients addicted to prescription, non prescription and recreational drugs; familiarity with the role of preemptive anesthesia in neuropathic pain.

2-12 Residents **must** participate in clinical experiences in other healthcare services (not to exceed 30% of the total training period).

Intent: *Experiences may include observation or participation in the following: oral and maxillofacial surgery to include procedures for intracapsular TMJ disorders; outpatient anesthesia pain service; in-patient pain rotation; rheumatology, neurology, oncology, otolaryngology, rehabilitation medicine; headache, radiology, oral medicine, and sleep disorder clinics.*

2-13 Each assigned rotation or experience **must** have:

a. written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b. resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
c. evaluations performed by the designated supervisor.

Intent: *This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.*

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-14 Residents **must** gain experience in teaching orofacial pain.

Intent: *Residents should be provided opportunities to obtain teaching experiences in orofacial pain (i.e. small group and lecture formats, presenting to dental and medical peer groups, predoctoral student teaching experiences, and/or continuing education programs.*

2-15 Residents **must** actively participate in the collection of history and clinical data, diagnostic assessment, treatment planning, treatment, and presentation of treatment outcome.

2-16 The program **must** provide instruction in the principles of practice management.

Intent: *Suggested topics include: quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care*; *medicolegal issues, workers compensation, second opinion reporting; criteria for assessing impairment and disability; legal guidelines governing licensure and dental practice, scope of practice with regards to orofacial pain disorders, and instruction in the regulatory requirements of chronic opioid maintenance.*

Examples of evidence to demonstrate compliance may include:
Course outlines

2-17 Formal patient care conferences **must** be held at least ten (10) times per year.

Intent: *Conferences should include diagnosis, treatment planning, progress, and outcomes. These conferences should be attended by residents and faculty representative of the disciplines involved. These conferences are not to replace the daily faculty/resident interactions regarding patient care.*

Examples of evidence to demonstrate compliance may include:
Conference schedules

2-18 Residents **must** be given assignments that require critical review of relevant scientific literature.

Intent: *Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care. This should include the development of critical evaluation skills and the ability to apply evidence-based principles to clinical decision-making.*

Relevant scientific literature should include current pain science and applied pain literature in dental and medical science journals with special emphasis on pain mechanisms, orofacial pain, head and neck pain, and headache.

Examples of evidence to demonstrate compliance may include:
Evidence of experiences requiring literature review

Program Length

2-19 The duration of the program **must** be at least two consecutive academic years with a minimum of 24 months, full-time or its equivalent.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-20 Where a program for part-time residents exists, it **must** be started and completed within a single institution and designed so that the total curriculum can be completed in no more than twice the duration of the program length.

Intent: *Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.*

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

Evaluation

2-21 The program's resident evaluation system **must** assure that, through the director and faculty, each program:

a) periodically, but at least two times annually, evaluates and documents the resident's progress toward achieving the program's written goals and objectives of resident training or competencies using appropriate written criteria and procedures;

b) provides residents with an assessment of their performance after each evaluation. Where deficiencies are noted, corrective actions **must** be taken; and

c) maintains a personal record of evaluation for each resident that is accessible to the resident and available for review during site visits.

Intent: *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific goals and objectives or competencies for resident training described in response to Standard 2-2.*

Examples of evidence to demonstrate compliance may include:
Written evaluation criteria and process
Resident evaluations with identifying information removed
Personal record of evaluation for each resident
Evidence that corrective actions have been taken

STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program **must** be designed to provide distinct and separate knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted standards as set forth in this document.

Intent: *The goal of the curriculum is to allow the resident to attain knowledge and skills representative of a clinician competent in the theoretical and practical aspects of oral medicine. The curriculum should provide the resident with the necessary knowledge and skills to enter a profession of academics, research or clinical care in the field of oral medicine.*

2-2 The program **must** have a written curriculum plan that includes structured clinical experiences and didactic sessions designed to achieve the program's written goals and objectives and competencies.

Intent: *The program is expected to organize the didactic and clinical educational experiences into a formal written curriculum plan.*

Program Duration

2-3 The duration of the program **must** be at least two consecutive academic years with a minimum of 24 months, full-time or its equivalent.

2-4 At least one continuous year of clinical education **must** take place in a single educational setting.

2-5 If the program enrolls part-time residents, there **must** be written guidelines regarding enrollment and program duration.

2-6 Part-time residents **must** start and complete the program within a single institution, except when the program is discontinued or relocated.

Intent: *The director of an accredited program may enroll residents on a part-time basis providing that (1) residents are also enrolled on a full-time basis, (2) the educational experiences, including the clinical experiences and responsibilities, are equivalent to those acquired by full-time residents and (3) there are an equivalent number of months spent in the program.*

2-7 Residents enrolled on a part-time basis **must** be continuously enrolled and complete the program in a period of time not to exceed twice the duration of the program length for full-time residents.

Biomedical Sciences

2-8 Education in the biomedical sciences **must** provide the scientific basis needed to understand and carry out the diagnostic and therapeutic skills required of the clinical, academic and research aspects of oral medicine.

Intent: *Various methods may be used for providing formal instruction, such as traditional course presentations, seminars, self-instruction module systems and rotations through hospital, clinical and research departments. It is recognized that the approach to be utilized will depend on the availability of teaching resources and the educational policies of the individual school and/or department.*

2-9 A distinct written curriculum **must** be provided in internal medicine.

2-10 Formal instruction in the biomedical sciences **must** enable graduates to:

a) detect and diagnose patients with complex medical problems that affect various organ systems and/or the orofacial region according to symptoms and signs (subjective/objective findings) and appropriate diagnostic tests;

b) employ suitable preventive and/or management strategies (e.g. pharmacotherapeutics) to resolve oral manifestations of medical conditions or orofacial problems; and

c) critically evaluate the scientific literature, update their knowledge base and evaluate pertinent scientific, medical and technological issues as they arise.

Examples of evidence to demonstrate compliance may include:
Course outlines
Didactic Schedules
Resident Evaluations

2-11 Formal instruction **must** be provided in each of the following:

a) anatomy, physiology, microbiology, immununology, biochemistry, neuroscience and pathology concepts used to assess patients with complex medical problems that affect various organ systems and/or the orofacial region;

b) pathogenesis and epidemiology of orofacial diseases and disorders;

c) concepts of molecular biology and molecular basis of genetics;

d) aspects of internal medicine and pathology necessary to diagnose and treat orofacial diseases;

e) concepts of pharmacology including the mechanisms, interactions and effects of prescription and over-the-counter drugs in the treatment of general medical conditions and orofacial diseases;

f) principles of nutrition, especially as related to oral health and orofacial diseases;

g) principles of research such as biostatistics, research methods, critical evaluation of clinical and basic science research and scientific writing; and

h) behavioral science, to include communication skills with patients, psychological and behavioral assessment methods, modification of behavior and behavioral therapies.

Example of Evidence to demonstrate compliance may include:
Course outlines
Didactic Schedules
Resident Evaluations

Clinical Sciences

2-12 The educational program **must** provide training to the level of competency for the resident to:

a) perform a comprehensive physical evaluation and medical risk assessment on patients who have medically complex conditions and make recommendations for dental treatment plans and modifications;

b) select and provide appropriate diagnostic procedures including bodily fluid studies, cytology, culture and biopsy for outpatients and inpatients to support or rule out diagnoses of underlying diseases and disorders;

c) establish a differential diagnosis and formulate an appropriate working diagnosis prognosis, and management plan pertaining but not limited to:

1. oral mucosal disorders,
2. medically complex patients,
3. salivary gland disorders,
4. acute and chronic orofacial pain, and
5. orofacial neurosensory disorders.

d) critically evaluate the results and adverse effects of therapy;

e) ameliorate the adverse effects of prescription and over-the-counter products and medical and/or dental therapy;

f) communicate effectively with patients and health care professionals regarding the nature, rationale, advantages, disadvantages, risks and benefits of the recommended treatment;

g) interpret and document the advice of health care professionals and integrate this information into patient treatment; and

h) organize, develop, implement and evaluate disease control and recall programs for patients.

Examples of Evidence to demonstrate compliance may include:
Written competency statements organized by areas described above
Course outlines
Records of resident clinical activity
Patient records
Resident evaluations

2-13 The educational program **must** provide ongoing departmental seminars and conferences, directed by the teaching staff to augment the clinical education.

Intent: *These sessions should be scheduled and structured to provide instruction in the broad scope of oral medicine and related sciences and should include retrospective audits, clinicopathological conferences, pharmacotherapeutics, research updates and guest lectures. The majority of teaching sessions should be presented by members of the teaching staff.*

2-14 The educational program **must** provide training to the level of competency for the resident to select and provide appropriate diagnostic imaging procedures and the sequential interpretation of images to support or rule out the diagnosis of head and neck conditions.

2-15 The educational program **must** ensure that each resident diagnose and treat an adequate number and variety of cases to a level that (a) the conditions are resolved or stabilized and (b) predisposing, initiating and contributory factors in the etiology of the diseases or conditions are controlled.

2-16 The educational program **must** ensure that each resident prepares and presents departmental clinical conferences.

2-17 Clinical medical experiences **must** be provided via rotation through various relevant medical services and participation in hospital rounds.

Intent: *At least two months of the total program length should be in hospital medical service rotations.*

2-18 If residents participate in teaching activities, their participation **must** be limited so as not to interfere with their educational process.

Intent: *The teaching activities should not exceed on average ½ day per week.*

2-19 Each assigned rotation or experience **must** have:

a) written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;

b) resident supervision by designated individuals who are familiar with the objectives of the rotation or experience; and
c) evaluations performed by the designated supervisor.

Intent: *This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.*

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations
Written objectives of rotations
Resident evaluations

2-20 The program **must** provide instruction in the principles of practice management.

Intent: *Suggested topics include: management of allied dental professionals and other office personnel; quality management; principles of peer review; business management and practice development; principles of professional ethics, jurisprudence and risk management; alternative health care delivery systems; informational technology; and managed care*.

Examples of evidence to demonstrate compliance may include:
Course outlines

STANDARD 2 – EDUCATIONAL PROGRAM

Curriculum Content

2-1 The program **must** list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

Intent: *The program is expected to develop specific competency-statements that describe what the resident will be able to do upon completion of the program. These statements should describe the resident's abilities rather than educational experiences the residents may participate in. These competency statements are to be circulated to program faculty and staff and made available to applicants of the program.*

Examples of evidence to demonstrate compliance may include:
Written competency requirements

2-2 Upon completion of training, the resident **must** be:

a) Able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;
b) Able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;
c) Competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients' physiological and psychological factors;
d) Competent in patient preparation for sedation/anesthesia, including pre-operative and post-operative instructions and informed consent/assent;
e) Competent in the use of anesthesia-related equipment for the delivery of anesthesia, patient monitoring, and emergency management;
f) Competent in the administration of local anesthesia, sedation, and general anesthesia, as well as in psychological management and behavior modification as they relate to anxiety and pain control in dentistry;
g) Competent in managing perioperative emergencies and complications related to anxiety and pain control procedures, including the immediate establishment of an airway and maintenance of ventilation and circulation;
h) Competent in the diagnosis and non-surgical treatment of acute pain related to the head and neck region; and
i) Able to demonstrate in-depth knowledge of current literature pertaining to dental anesthesiology.

Intent: *The program's specific competency requirements and the didactic and clinical training and experiences in each area described above are expected to be at a level of skill and complexity beyond that accomplished in pre-doctoral training and consistent with preparing the dentist to utilize anxiety and pain control methods safely in the most comprehensive manner as set forth in the specific standards contained in this document.*

Examples of evidence to demonstrate compliance may include:
Written competency requirements
Didactic coursework, including lecture schedules and assigned reading
Case review conferences
Records of resident clinical activity including procedures performed in each area described above
Resident logs
Patient records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) standards
Resident evaluations

2-3 The program **must** have a written curriculum plan including structured didactic instruction and clinical experience designed to achieve the program's written competency requirements.

Intent: *The program is expected to organize the didactic and clinical educational experience into a formal written curriculum plan.*

For each specific competency statement described, the program is expected to develop educational experiences designed to enable the resident to acquire the skills, knowledge and values necessary in that area. The program is expected to organize these didactic and clinical educational experiences into a formal written curriculum plan.

Examples of evidence to demonstrate compliance may include:
Formal written curriculum plan with educational experiences tied to specific competency requirements
Didactic schedules
Clinical schedules

Didactic Components

2-4 Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum **must** be provided and include:

a) Applied biomedical sciences foundational to dental anesthesiology,

Intent: *Instruction should include physiology, pharmacology, anatomy, biochemistry, pathology, physics, pathophysiology, and clinical medicine as it applies to anesthesiology. The instruction should be sufficiently broad to provide for a thorough understanding of the body processes related to anxiety and pain*

control. Instruction should also provide an understanding of the mechanisms of drug action and interaction, as well as information about the properties of drugs used.

b) Physical diagnosis and evaluation,

Intent: *This instruction should include taking, recording and interpreting a complete medical history and physical examination, and understanding the indications for and interpretations of diagnostic procedures and laboratory studies.*

c) Behavioral medicine,

Intent: *This instruction should include psychological components of human behavior as related to the management of anxiety and pain.*

d) Methods of anxiety and pain control,

Intent: *This instruction should include a detailed review of all methods of anxiety and pain control and pertinent topics (e.g., anesthesia delivery devices, monitoring equipment, airway management adjuncts, and perioperative management of patients).*

e) Complications and emergencies,

Intent: *This instruction should include recognition, diagnosis, and management of anesthesia-related perioperative complications and emergencies.*

f) Pain management, and

Intent*: This instruction should include information on pain mechanisms and on the evaluation and management of acute and chronic orofacial pain.*

g) Critical evaluation of literature.

Intent: *This instruction should include an understanding of scientific literature pertaining to dental anesthesiology and the development of critical evaluation skills, including an understanding of relevant research and statistical methodology.*

Clinical Components

2-5 The program **must** ensure the availability of adequate patient experiences in both number and variety that afford all residents the opportunity to achieve the program's stated goals and competency requirements in dental anesthesiology.

Examples of evidence to demonstrate compliance may include:
Records of resident clinical activity, including specific details of the variety, type, and quantity of cases treated and procedures performed

2-6 The following list represents the minimum clinical experiences that **must** be obtained by each resident in the program at the completion of training:

a) Eight hundred (800) total cases of deep sedation/general anesthesia to include the following:
   (1) Three hundred (300) intubated general anesthetics of which at least fifty (50) are nasal intubations and twenty-five (25) incorporate advanced airway management techniques. No more than ten (10) of the twenty five (25) advanced airway technique requirements can be blind nasal intubations.
   (2) One hundred and twenty five (125) children age seven (7) and under, and
   (3) Seventy five (75) patients with special needs, and
b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation.

Intent: *The resident should be competent in the various methods of sedation and anesthesia for a variety of diagnostic and therapeutic procedures in the office or ambulatory care setting and the operating room. The resident should gain clinical experience in current monitoring procedures, fluid therapy, acute pain management and operating room safety. Instruction and experience in advanced airway management techniques are important parts of the training program and may include but are not limited to the following devices and techniques: blind nasal intubation, bougie, fiberoptic intubation, intubating laryngeal mask airway (LMA), light wand, and video laryngoscopes.*

General Anesthesia Experience/Anesthesia Service

2-7 At a minimum, a total of twenty-four (24) months over a thirty-six (36) month period **must** be devoted exclusively to clinical training in anesthesiology, of which a minimum of six (6) months are devoted to dental anesthesiology.

Examples of evidence to demonstrate compliance may include:
Anesthesia rotation schedules
Records of resident clinical activity

2-8 Residents **must** be assigned full-time for a minimum of twelve (12) months over a thirty six (36) month period to a hospital anesthesia service that provides trauma and/or emergency surgical care.

Intent: *This service should be under the direction of an anesthesiologist with a full time commitment, and each resident should participate in all of the usual duties and responsibilities of anesthesiology residents, including preanesthetic patient evaluation, administration of anesthesia in the operating room on a daily scheduled basis, postanesthetic patient management, and emergency call.*

Outpatient Anesthesia for Dentistry

2-9 At the completion of the program, each resident **must** have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

1. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.
2. Experience as the provider of supervised anesthesia care.

Intent: *Adequate experience in the unique aspects of dental anesthesia care with and without the use of an anesthesia machine and operating room facilities should be provided. Supervising dentist anesthesiologists shall have completed a CODA-accredited dental anesthesiology residency program or a two-year anesthesiology residency for dentists consistent with or equivalent to the training program described in Standard 2. A one-year anesthesiology residency for dentists completed prior to July 1993 is acceptable provided that continuous significant practice of general anesthesia in the previous two years is documented.*

Examples of evidence to demonstrate compliance may include:
Anesthesia rotation schedules
Records of resident clinical activity
Schedules of dental anesthesia faculty

Medicine Rotations

2-10 Residents **must** participate in at least four (4) months of clinical rotations from the following list. If more than one rotation is selected, each **must** be at least one month in length.

a) Cardiology,
b) Emergency medicine,
c) General/internal medicine,
d) Intensive care,
e) Pain medicine,
f) Pediatrics,
g) Pre-anesthetic assessment clinic (max. one [1] month), and
h) Pulmonary medicine.

Intent: *The dental anesthesia resident should have a strong foundation in clinical medicine that can be achieved through rotations in the above-mentioned areas. When the resident entering the program has minimal clinical medicine experience, the program director should attempt to increase the time in these rotations beyond the minimum number of months required. The goal is to give the resident experience in medical evaluation and long-term management of patients. Therefore, only one month of the four months of this requirement may be met in the pre-anesthetic assessment clinic, although longer periods of time may be arranged as desired.*

Examples of evidence to demonstrate compliance may include:
Description and schedule of rotations

2-11 Each assigned rotation or experience **must** have:

a) Written objectives that are developed in cooperation with the department chairperson, service chief, or facility director to which the residents are assigned;
b) Resident supervision by designated faculty who are familiar with the objectives of the rotation or experience; and
c) Evaluations performed by designated faculty.

Intent: *This standard applies to all assigned rotations or experiences, whether they take place in the sponsoring institution or a major or minor activity site. Supplemental activities are exempt.*

Examples of evidence to demonstrate compliance may include:
Written objectives of rotations
Description and schedule of rotations
Resident evaluation reports

2-12 Residents **must** be competent to request and respond to requests for consultations from dentists, physicians, and other health care providers.

Intent: *Programs are expected to define the educational goals or competency statements in this area. Residents should be able to interact appropriately with other health care providers.*

Examples of evidence to demonstrate compliance may include:
Consultation records or patient records
Written competency requirements
Resident evaluations

2-13 The program **must** provide instruction and clinical experience in physical evaluation and medical risk assessment, including:

a) Taking, recording, and interpreting a complete medical history;
b) Understanding the indications of and interpretations of laboratory studies and other techniques used in physical diagnosis and preoperative evaluation;

c) Interpreting the physical evaluation performed by a physician with an understanding of the process, terms, and techniques employed; and
d) Using the techniques of physical examination (i.e., inspection, palpation, percussion, and auscultation).

Intent: *It is intended that medical risk assessment be conducted during formal instruction as well as during in-patient, same-day surgery, and ambulatory patient care. The program is expected to define the type of documentation of physical evaluation and medical risk assessment that is required to be entered into inpatient and ambulatory care records. The program is expected to ensure that such data are being recorded.*

Examples of evidence to demonstrate compliance may include:
Course outlines
Patient records
Resident evaluations
Record review policy
Documentation of record review

Other Components

2-14 The program **must** provide residents with an understanding of rules, regulations, and credentialing processes pertaining to facilities where anesthesia care is provided.

Intent: *Information about the credentialing processes involved in hospitals, free-standing surgical centers, and private offices should be provided.*

Examples of evidence to demonstrate compliance may include:
Didactic schedules

2-15 Residents **must** be given assignments that require critical review of relevant scientific literature.

Intent: *Residents are expected to have the ability to critically review relevant literature as a foundation for lifelong learning and adapting to changes in oral health care.*

Examples of evidence to demonstrate compliance may include:
Evidence of experiences requiring literature review

2-16 The program **must** conduct and involve residents in a structured system of continuous quality improvement for patient care.

Intent: *Programs are expected to involve residents in enough quality improvement activities to understand the process and contribute to patient care improvement.*

Examples of evidence to demonstrate compliance may include:
Description of quality improvement process including the role of residents in that process
Quality improvement plan and reports

Program Length

2-17 The duration of a dental anesthesiology program **must** be a minimum of thirty six (36) months of full-time formal training.

Examples of evidence to demonstrate compliance may include:
Program schedules
Written curriculum plan

2-18 Where a program for part-time residents exists, it **must** be started and completed within a single institution and designed so that the total curriculum can be completed in a period of time not to exceed twice the duration of the program for full-time residents.

Intent: *Part-time residents may be enrolled, provided the educational experiences are the same as those acquired by full-time residents and the total time spent is the same.*

Examples of evidence to demonstrate compliance may include:
Description of the part-time program
Documentation of how the part-time residents will achieve similar experiences and skills as full-time residents
Program schedules

Evaluation

2-19 The program's resident evaluation system **must** assure that, through the director and faculty, each program:

a) Periodically, but at least twice annually, evaluates and documents the resident's progress towards achieving the program's written competency requirements and minimum anesthesia case requirements using appropriate written criteria and procedures;
b) Provides residents with an assessment of their performance after each evaluation; where deficiencies are noted, corrective actions must be taken; and
c) Maintains a personal record of evaluation for each resident which is accessible to the resident and available for review during site visits.

Intent: *While the program may employ evaluation methods that measure a resident's skills or behavior at a given time, it is expected that the program will, in addition, evaluate the degree to which the resident is making progress toward achieving the specific competency and anesthesia case requirements described in response to Standards 2-1, 2-2, and 2-6.*

Examples of evidence to demonstrate compliance may include:
Written evaluation criteria and process
Resident evaluations
Resident case logs
Personal record of evaluation for each resident
Evidence that corrective actions have been taken

STANDARD 4 - CURRICULUM AND PROGRAM DURATION

Curriculum Approach: Evidence-Based Dentistry (EBD)

Evidence-based dentistry (EBD) is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences. *(Adopted by the American Association of Orthodontists House of Delegates 05/24/2005)*

The advanced dental education program **must** be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted Standards of the discipline's practice as set forth in specific Standards contained in this document.

Intent: The intent is to ensure that the didactic rigor and extent of clinical experience exceeds pre-doctoral, entry level dental training or continuing education requirements and the material and experience satisfies Standards for the discipline.

Advanced dental education programs **must** include instruction or learning experiences in evidence-based practice. Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Examples of Evidence to demonstrate compliance may include:

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic Program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary Grand Rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or "searching publication databases and appraisal of the evidence")
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

The level of discipline-specific instruction in certificate and degree-granting programs **must** be comparable.

Intent: The intent is to ensure that the student/residents of these programs receive the same educational requirements as set forth in these Standards.

If an institution and/or program enrolls part-time students/residents, the institution **must** have guidelines regarding enrollment of part-time students/residents. Part-time students/residents **must** start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis **must** assure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

4-1 Program Duration: Advanced dental education programs in orthodontics and dentofacial orthopedics must be a minimum of twenty-four (24) months and 3700 scheduled hours in duration.

Examples of evidence to demonstrate compliance may include:

- Class schedules and outlines

4-2 Biomedical Sciences: A graduate of an advanced dental education program in orthodontics must be competent to:

a. Develop treatment plans and diagnosis based on information about normal and abnormal growth and development;
b. Use the concepts gained in embryology and genetics in planning treatment;
c. Include knowledge of anatomy and histology in planning and carrying out treatment; and
d. Apply knowledge about the diagnosis, prevention and treatment of pathology of oral tissues.

Examples of evidence to demonstrate compliance may include:

- Course outlines and case treatment records
- Outcome assessment of clinical performance

4-3 Clinical Sciences:

4-3.1 Orthodontic treatment must be evidence-based. (EBD is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.) *(Adopted by the American Association of Orthodontists House of Delegates 05/24/2005***)**

Examples of evidence to demonstrate compliance may include**:**

- orthodontic literature applied to clinical treatment decisions
- integration of current systematic literature reviews with treatment conferences

- ethics applied to patient management

4-3.2 An advanced dental education program in orthodontics and dentofacial orthopedics requires extensive and comprehensive clinical experience, which must be representative of the character of orthodontic problems encountered in private practice.

***Intent**: The intent is to ensure there is diversity in the patient population so that the students/residents will learn to treat a variety of orthodontic problems from the primary to adult dentition.*

Examples of evidence to demonstrate compliance may include:

- Case treatment records
- Percentage of each category of patient care

4-3.3 Experience must include treatment of all types of malocclusion, whether in the permanent or transitional dentitions, and should include treatment of the primary dentition when appropriate.

Examples of evidence to demonstrate compliance may include:

- Case treatment records

4-3.4 A graduate of an advanced dental education program in orthodontics must be competent to:

a. Coordinate and document detailed interdisciplinary treatment plans which may include care from other providers, such as restorative dentists and oral and maxillofacial surgeons or other dental specialists;
b. Treat and manage developing dentofacial problems which can be minimized by appropriate timely intervention;
c. Use dentofacial orthopedics in the treatment of patients when appropriate;
d. Treat and manage major dentofacial abnormalities and coordinate care with oral and maxillofacial surgeons and other healthcare providers;
e. Provide all phases of orthodontic treatment including initiation, completion and retention;
f. Treat patients with at least one contemporary orthodontic technique;

***Intent**: It is intended that the program teach one or more methods of comprehensive orthodontic treatment.*

g. Manage patients with functional occlusal and temporomandibular disorders;
h. Treat or manage the orthodontic aspects of patients with moderate and advanced periodontal problems;
i. Develop and document treatment plans using sound principles of appliance design and biomechanics;
j. Obtain and create long term files of quality images of patients using techniques of photography, radiology and cephalometrics, including computer techniques when appropriate;
k. Use dental materials knowledgeably in the fabrication and placement of fixed and removable appliances;
l. Develop and maintain a system of long-term treatment records as a foundation for understanding and planning treatment and retention procedures;
m. Practice orthodontics in full compliance with accepted Standards of ethical behavior;

***Intent**: A program may be in compliance with the standard on ethical behavior when ethical behavior is acquired through continuous integration with other courses in the curriculum.*

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Case treatment records

n. Manage and motivate patients to participate fully with orthodontic treatment procedures;
o. Study and critically evaluate the literature and other information pertaining to this field;
p. Identify patients with sleep-related breathing disorders/sleep apnea;
q. Identify patients with Craniofacial Anomalies and Cleft Lip and Palate;
r. Treat and effectively manage malocclusions that require four (4) quadrants of bicuspid extractions or of comparable space closure;
s. Treat and effectively manage Class II malocclusions, defined as a bilateral end-on or greater Class II molar or a unilateral full cusp Class II molar, through a non-surgical treatment approach; and

Examples of evidence to demonstrate compliance may include:

- Course outlines
- Clinical outcomes assessment
- ABO Assessment Tools: Discrepancy Index, Cast-Radiograph Evaluation, Case Management Forms

t. Manage patients with intellectual and developmental disabilities.

4-4 Supporting Curriculum. The orthodontic graduate must have understanding of:

a. Biostatistics;
b. History of Orthodontics and Dentofacial Orthopedics;
c. Jurisprudence;
d. Oral Physiology;
e. Pain and Anxiety Control;
f. Pediatrics;
g. Periodontics;
h. Pharmacology;
i. Preventive Dentistry;
j. Psychological Aspects of Orthodontic and Dentofacial Orthopedic Treatment;
k. Public Health Aspects of Orthodontics and Dentofacial Orthopedics;
l. Speech Pathology and Therapy;
m. Practice Management; and
n. The variety of recognized techniques used in contemporary orthodontic practice.

Examples of evidence to demonstrate compliance may include:

- Course outlines